



Body dysmorphic disorder from the perspective of the plastic surgeon

Transtorno dismórfico corporal sob a perspectiva do cirurgião plástico

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Article received: February 21, 2018.
Article accepted: February 10, 2019.

Conflicts of interest: none.

DOI: 10.5935/2177-1235.2019RBCP0016

■ ABSTRACT

Body dysmorphic disorder (BDD) is found with a certain frequency in aesthetic-related care. However, it is underdiagnosed due to the difficulty in differentiating a personal dissatisfaction with body image of a pathological complaint. For BDD patients, the discomfort generated by their “defect” is often disproportionate to that observed on physical examination. In addition, in an attempt to correct their “defect”, the patients undergoes various surgical procedures, which are often considered insufficient by the patients to solve their problem. Hence, this study aimed to expand the already existing discussions in the specialized literature. Since there are only a few studies on the topic, we plan to discuss this condition so as to contribute towards identification of the characteristics of this disorder, thus, avoiding unnecessary surgical procedures and guiding the specialist’s actions in case of a legal dispute.

Keywords: Reconstructive surgical procedures; Psychiatry; Body image; Body dysmorphic disorders; Aesthetics.

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■ RESUMO

O transtorno dismórfico corporal é encontrado com uma certa frequência nos atendimentos relacionados à estética. Entretanto, permanece subdiagnosticado devido à dificuldade de diferenciar uma insatisfação pessoal natural com a imagem corporal de uma queixa patológica. Para os pacientes com TDC, o incômodo gerado pelo seu “defeito” costuma ser desproporcional ao que observamos no exame físico. Além disso, na tentativa de corrigir aquilo que não lhe agrada, ele se submete a diversos procedimentos cirúrgicos que, em grande parte das vezes, considerará insuficiente para a resolução do seu problema. Nesse sentido, buscamos, com este trabalho, ampliar as discussões já existentes na literatura especializada. Assim, assumindo a escassa bibliografia, tencionamos, além de construir discussões acerca dessa afecção, o que pode contribuir para a identificação dos traços desse transtorno, evitando, por conseguinte, a realização de procedimentos cirúrgicos desnecessários e nortear as ações do especialista no que diz respeito à possibilidade de uma disputa judicial.

Descritores: Procedimentos cirúrgicos reconstrutivos; Psiquiatria; Imagem corporal; Transtornos dismórficos corporais; Estética.

INTRODUCTION

The search for beauty or attractive appearance to others seems to be the object of fascination for humanity. Although it involves stereotypes that vary according to cultural standards, the notion of beauty, a dynamic concept of quest for perfection, may at some point, approach what has been termed psychic disorder, as already described by studies conducted in the area of psychiatry.

When we made a historical incursion, we realized that while endemic diseases and pests decimated a large number of people, obesity prevailed, as a synonym for health and well-being. Currently, we are observing a movement contrary to this perception, whose presuppositions show the supremacy of slenderness, i.e., being slim is considered beautiful. In this new context, delimiting the thin line between personal desire for aesthetic improvement and body dysmorphia can be a difficult task¹.

In the literature, dysmorphophobia was first described by Morsellini in 1886². However, in Pitanguy et al.³ referred to this term in 1976 in Brazilian literature. Dysmorphophobia is also known as the eponym of the Quasimodo Complex⁴ and more recently as body dysmorphic disorder (BDD); dysmorphophobia was established as a disease in Volume III of the *Diagnostic and Statistical Manual of Mental Disorders* of 1987 (DSM-III-R) and is reported as “*Body Dysmorphic Disorder*” in the current DSM V, published in 2013⁵.

In clinical practice, we observed that the patients affected by BDD present extreme dissatisfaction with their appearance, which translates into intense suffering. We also found reports of functional impairments in social and work life, high levels of stress and comorbidities. These factors contribute to the constant search for aesthetic procedures, culminating in mostly poor results^{4,6,7}.

We understand that when performing physical examination, specialists often notice minimal or nonexistent changes. From this viewpoint, it is up to the surgeon to identify the patient’s type of disorder and to refer him, if necessary, to the psychiatrist. We emphasize, however, that in most cases this type of psychopathology may go unnoticed, and the professional should, therefore, try to protect himself against possible legal disputes⁸. This is the reason of this study.

Thus, on the basis of extensive research and clinical experience, we will try to develop the ideas presented here, with the intention of collaborating with the mosaic of studies carried out in the plastic surgery research field.

OBJECTIVE

In this study, we intend to demonstrate the relevance of BDD in patients seeking plastic surgery services and to focus the attention of the physician on this condition, that is often forgotten.

We also seek to reiterate the importance of correct screening so that the team can refer patients for the appropriate treatment, thus, avoiding unnecessary aesthetic procedures. We also propose, in the case of BDD diagnostic uncertainty, to suggest possible ways for the surgeon to protect himself against the possibility of future legal problems.

METHODS

We conducted qualitative and quantitative research, wherein we searched for articles, dissertations, book chapters and theses that focus on BDD, dysmorphophobia and Quasimodo syndrome. To broaden our theoretical scope, in what concerns specifically databases, we emphasize PubMed, SciELO, Lilacs and Bireme.

DISCUSSION

Starting from the current expansion of aesthetic surgical procedures, which exceeded 10 million in 2005, according to Crerand et al.⁹, and reached 629 thousand in Brazil alone in 2009¹⁰, the exaggerated worship of physical form is evident. Among the factors that motivate the requirement for such aesthetic surgical procedures is the common notion that a sculptural body is necessary to achieve professional and personal success. Similarly, an increasingly precocious aesthetic concern among young people, the endless quest for perfection (facilitated by the vast tools of Plastic Surgery), constant discussions about diet, exercise, and fashion, which corroborate certain patterns of beauty, can feed among other factors, the experience lived in BDD. Such lifestyle conditions provide an environment conducive to the development of this condition, thus, making it more evident.

Bellino et al.¹¹ reported that 0.7% of the general population experiences the disease, while Macley reported an incidence of 1% to 2%¹². Aouizerate et al. reported that 9.1% of the population may seek cosmetic surgery¹³. Although there are several social factors involved, the etiology is not fully understood to date. It is believed that the etiology may be associated with the patients' own psychological status regarding their image, as built from childhood and influenced by the external environment during development^{14,15}. In addition, the patients who present an exaggerated self-criticism of their aesthetic appearance may be more likely to progress to this pathological condition¹⁶.

More recent studies suggest the involvement of neurobiological abnormalities. For example, it is possible to detect neurotransmitter changes using functional magnetic resonance. Moreover, the studies

also reported abnormal activations of specialized areas, as assessed by analytical and detailed visual processing, in these patients; these abnormal activations were more intense in patients with severe symptoms⁷.

It is also observed that the patient may identify with the image of a certain person or character, leading him to seek ways that make him appear similar to the figure with whom he identifies himself. This identification may be related to what is considered an ideal of beauty and is often embodied in famous personalities, family members, or even inanimate figures, such as dolls¹⁷.

BDD often develops in adolescence; the condition evolves gradually, with the initial concerns that were considered "normal" degenerating to pathological, over time (months to years). However, in some cases, BDD is suddenly triggered by important emotional events. At this point, the degree of *insight* involved, i.e., the self-perception of disease is variable. Hence, the patient's level of perception of his illness is minimal compared to the discomfort generated by the defect. Therefore, in objective terms, the sites involved in the complaints are similar to those of non-pathological conditions. However, we note that the level of suffering generated is intensified, which can lead to extreme stress, obsession, and emotional torture.

In this pathological context, the presence of another comorbidity, such as social phobia, becomes less important than it was in the past when very little was known about the disease¹⁸.

Specialized studies indicate that a significant proportion of 12–15% of the patients have a correlation with obsessive compulsive disorder (OCD)⁶, characterized by the presence of compulsive and repetitive behavioral stereotypes, such as the act of looking at oneself too long in the mirror or applying makeup excessively, a factor that can lead to confusion in the distinction between BDD and OCD. Moreover, depression, anxiety, abusive use of psychoactive substances, and even suicidal idealization are emphasized in 22 to 28% of the cases¹⁹.

We have commonly observed that obsessive-compulsive disorder and other psychiatric conditions are associated with eating disorders, such as anorexia and bulimia, which are also associated with dysmorphophobia¹⁷. The degree of severity may range from almost normal to mild to severe impairment of functionality in patients who only leave the house at night to avoid public encounters.

In severe cases described in the available literature, there are events of violence against the physician, including murders, fruits of achieved "failure"^{6,8,13}. Therefore, we should be aware of BDD in patients seeking aesthetic care who report of various

procedures performed, which were unsatisfactory or unnecessary.

Consequently, even in those who have had little or no previous surgery, it is up to the specialist to carry out careful anamnesis, with the purpose of eliciting a diagnosis due to unfounded complaints of minimal or unnoticeable defects, refined physical examination, and administration of a questionnaire²⁰ investigating the degree of discomfort generated by the “deformity”. If necessary, the doctor may contact surgeons who have treated the patient previously or even seek medical history⁸.

We propose that treatment should be conducted mainly by the psychiatrist and the psychologist and should involve cognitive-behavioral measures and lifestyle changes, inclining towards a more active lifestyle. We also understand that medication can be used, such as selective serotonin reuptake inhibitors and tricyclic antidepressants, which can produce satisfactory results. After this follow-up, the patient may return to the plastic surgery outpatient clinic for reassessment²¹.

Based on our discussion thus far, we understand that from a legal viewpoint, the plastic surgeon must protect himself against possible judicial litigation. Hence, preoperative documentation is of great value in the case of BDD. We also emphasized the use of a questionnaire, such as COPS²².

The surgeons may also protect themselves by ensuring that the patients signs a Free and Informed Consent Term (FICT), through which the patient can authorize that his current physician can contact other experts already consulted, thus, valuable information may be obtained from the patient’s records that may reveal presence of the disorder. Finally, we believe that the patient should agree that the final surgery outcome may not be exactly as he expects, since the surgical process is subject to biological variations and interferences inherent to the surgeon⁸.

Considering the possibility of a legal dispute, we must mention that we were unable to find guidelines that a plastic surgeon must follow in this respect in the available literature. However, considering the cases already described, we understand that these can serve as a reference for the specialist in such situations.

In judicial dispute cases, we also noted that a patient’s lawyer could question the validity of the signed FICT in the court, based on the presence of BDD, which in the light of law, would compromise the judgment of his client. Nevertheless, we believe that such an argument could be invalidated, since there is no established diagnosis of BDD in the patient’s medical history. Thus, although signing this document is a legal practice to ensure that the patient is aware of

all the risks involved in a surgical procedure, we defend that it is the physician’s duty to inform the patient of the possible material risks and complications and of clarifying that the final surgical result is influenced by interference from factors not related to medical conduct, thus, avoiding questioning of the document’s validity and possible allegations of negligence⁸.

CONCLUSION

Considering the BDD prevalence and its relevance among patients seeking aesthetic surgeries, we emphasize the diagnostic possibility of BDD in patients with unfounded and distorted complaints. Due to the challenging nature of the disease, the surgeon must be careful in his approach, including proper anamnesis and careful observation. We believe that demonstrating receptivity and understanding is fundamental, rather than merely referring the patient to the psychiatrist.

We reiterate that surgery in these cases will often lead to unsatisfactory results for both the patient and the surgeon and may even lead to judicial outcomes.

Regarding the appropriate treatment, we suggest selective serotonin reuptake inhibitors and cognitive behavioral therapy, according to the condition’s severity.

With respect to other considerations, we suggest that more studies are needed with the aim of facilitating diagnosis and standardization of conducts. In addition, we believe that it is necessary to estimate the real prevalence of psychopathology in the population, which could imply decreased requirement for unnecessary surgical procedures and fewer lawsuits.

Finally, from the legal viewpoint, the physician must guard against possible legal problems involving the surgical outcomes and the dissatisfaction of a BDD patient. To do so, the physician must use all various resources available, considering that there are no laws or well-defined guidelines for a legal dispute between BDD patient and his doctor.

COLLABORATIONS

- MTD** Analysis and/or data interpretation, conceptualization, final manuscript approval, writing - original draft preparation, writing - review & editing.
- MPDC** Analysis and/or data interpretation, final manuscript approval, project administration, writing - original draft preparation, writing - review & editing.
- LDC** Writing - original draft preparation, writing - review & editing.

- GVD** Writing - original draft preparation, writing - review & editing.
- AAS** Writing - original draft preparation, writing - review & editing.
- LVD** Writing - original draft preparation, writing - review & editing.
- LDC** Writing - original draft preparation, writing - review & editing.
- YMO** Writing - original draft preparation, writing - review & editing.

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