Plastic Surgery Addiction in Patients With Body Dysmorphic Disorder

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Definition of the ideal body changes over time and across cultures. In the 18th century, full-bodied women were considered attractive. Today, a woman with a slim, long-legged figure is the token of beauty. In different cultures, different shapes of women are in style. In the West, but also in other cultures, a woman with a full figure is considered attractive. However, for people suffering from body dysmorphic disorder (BDD), appearance is not simply a matter of style. According to the DSM-IV, people with BDD have a pervasive distortion of their self-image and a persistent preoccupation with a particular part of their body or overall appearance.

When Body Image Becomes a Disorder

Body dysmorphic disorder is also known as dysmorphophobia. It manifests itself as an aberrant dissatisfaction with one’s physical appearance and concerns with one’s appearance from three to eight hours a day (Phillips, 2001). Of Americans, 30% to 40% have minor concerns with their appearances (Watkins, 2004). However, those minor concerns are transient and do not interfere with their functioning or social/occupational performance. In the United States, BDD affects about 2% of the population (Phillips, 2001), which is equivalent to 5 million Americans and strikes males and females equally (Phillips and Diaz, 1997). In one study, the onset occurred before age 18 in about 70% of the cases (Albertini and Phillips, 1999). People with BDD often change their social and professional lifestyles to avoid appearing in public and spending time, trying to look presentable (Phillips and Castle, 2001).

It is estimated that about 50% of suffering patients seek some sort of professional medical help in the form of plastic surgery or dermatological treatment (Phillips et al., 1993). In one study, out of 268 patients presenting for dermatological treatment, 11.9% screened for BDD (Phillips et al., 2000). In another study of 289 people (250 adults and 39 children) who met DSM-IV diagnostic criteria for BDD, 76.4% of them were looking for nonsurgical treatment and 66.0% of adults received it (Phillips et al., 2001). Because BDD is not typically recognized by plastic surgeons and practicing general practitioners, these patients can undergo a succession of invasive procedures. Veale (2000) reported on 25 patients with BDD who had undergone a total of 46 cosmetic procedures before they were diagnosed with BDD. The same article indicated that nine of those 25 patients had performed self-surgery. Plastic surgery provides no benefit for patients suffering from BDD because it is never good enough, and the obsession persists. In all cases obsession may move from one body part to another. Surgeries and dermatological treatments rarely to almost never improve BDD symptoms and oftentimes worsen them (American Society for Dermatologic Surgery, undated). Another study showed that a majority of the BDD sufferers received nonsurgical treatments, but responded poorly to them (Phillips and Castle, 2001; Phillips et al., 1993). About 63% of patients get treatment in both surgery and nonsurgical treatments. In a survey of cosmetic surgeons, 7% replied that patients with BDD stop seeking treatment after one procedure, 13% that they sometimes, and 63% of cosmetic surgeons replied that patients with BDD stop seeking for repeated surgeries (Knoer et al., 1967).
Patients who are dissatisfied with their operations feel guilty and angry with themselves or the surgeon for not making their appearance better, or in some cases, for making it worse. Men with BDD who received plastic surgery tend to direct their anger at the surgeon (Phillips, 2001). Nevertheless, even after "unsuccessful" procedures, BDD sufferers continue getting repeated plastic surgeries in pursuit of correcting their perceived ugliness. Ironically, all of those people would be considered of above-average attractiveness.

The average time frame to diagnosis for BDD is 10 to 15 years after onset, due in part to the secretive nature of patients about their preoccupation, but also due to inadequate training and experience in diagnosing BDD for internists, dermatologists, plastic surgeons and even health care professionals (Sarwer et al., 2003). Bodily dysmorphic disorder is considered a significantly more difficult and complicated disorder than any other anxiety disorder due to the attendant delusion and distortions, which can cause clinical depression accompanied, in more than 80% of the cases, with suicidal ideation (Phillips, 1998; Phillips et al., 2004). In 20% of the cases, completed suicide results in the endangered lives of about 1 million Americans. The course of the illness starts at around age 18, oftentimes during the first year of college. Onset can be sparked by drastic changes in one's life. Body dysmorphic disorder may be as significant as chronic depression, social phobia or substance abuse, all three of which can be secondary to BDD (Phillips, 2001). Patients with BDD are often misdiagnosed with having substance abuse disorders or depression.

Challenges of Treating an Image Disorder

Current successful treatments for BDD include cognitive-behavioral therapy (CBT) and medication (selective serotonin reuptake inhibitors or clomipramine [Klonopin]) (Patterson et al., 2003; Slaughter and Sun, 1999). Due to their recent development, these treatments are only beginning to show signs of effectiveness. Although some studies indicate different degrees of success of medication treatment for BDD, CBT still should be considered. The greatest challenge is convincing patients that their condition is a result of distorted mental imagery. When patients accept a referral to a mental health care professional and receive medication only, 58% of patients show partial or complete symptom resolution (Patterson et al., 2003). It is often the combination of medication and CBT that brings the best results (Neziroglu and Yaryura-Tobias, 1997). At the beginning of treatment, patients face several significant challenges. First, patients need to be educated about the nature and course of BDD. Second, patients often have difficulty coping with their disease and BDD paradox. The patient believes that their defect is real and visible. The therapist does not see it and does not agree that the defect exists. Maybe it is real and then maybe it is not. What matters is what patients with BDD "do" with their belief. And what they do is truly fascinating: the internalized (mis)perception prompts these patients to ritualize their behavior by either constantly checking the "problem part" in the mirrors and reflective surfaces or by avoiding mirrors altogether. Either strategy results in major levels of distress and anxiety. It would be counterproductive for a mental health practitioner to habituate such a patient by exposure to the internalized irrational stimuli for then anxiety would only increase further. Exposure to external referents thus becomes the only choice. By using mirrors that grotesquely distort the patient's "real" image, we reverse the process of habituation. Through exposure to the exaggeratedly distorted image, patients externalize reactions to their own physical deformity. The key is in the gradual initiation of outside processes through which patient gains control of concurrent anxiety. The therapist's role is to teach patients how to control this anxiety when they face their distorted images in the crooked mirrors. Gradually, patients habituate to the anxiety present when they are faced with the "ugly" part of their body for it is not the "ugliness" that is being attacked but the "shame." Exposures are done in a gradual hierarchical order starting with the least difficult one and moving up to the most feared one.

This distorted mirror exposure intervention involves 15, 90-minute therapy sessions. While the small sample size does not allow for any significant generalizations regarding efficacy, five of the seven treated patients with BDD improved. One of the two patients failed to demonstrate treatment gains, whereas the second nonresponder is still receiving services.

A successful case involved a 45-year-old female with BDD who had 17 plastic surgeries prior to participating in this distorted mirror exposure (Gorbis, 2003). She had not responded to several prior treatments for OCD and BDD, including a variety of SSRIs. The patient was demoralized because her condition had persisted for many years, and she met criteria for severe BDD and OCD. She scored 32 on the Yale-Brown Obsessive-Compulsive Scale for Body Dysmorphic Disorder (BDD-YBOCS).

The patient was afraid of getting old, looking ugly and being imperfect. She established rituals in an effort to protect herself from aging and becoming ugly. She performed 20 to 30 facial wraps a day, washed her face 40 times daily, scrutinized the symmetry of her body parts, put cosmetics on in a particular order and frequently looked into mirrors seeking reassurance that she was attractive. Her facial rubs and other rituals of perfection required more than eight hours. In one instance she missed her 35th birthday party and appeared at the party location 32 hours later because she was so absorbed in perfecting the look of her face. During treatment she was exposed to the distorted mirrors, instructed to wear matching jewelry and clothes, and put makeup on one eye but not the other. The distorted mirrors exaggerated her perceived imperfections. By the end of treatment, scores on the BDD-YBOCS had decreased from 32 to 10. Five-year follow-up revealed that she had not undergone any further surgeries.

Distorted mirrors were used to assist three additional patients in understanding the exaggerated nature of their perceived imperfections. One patient had undergone two plastic surgeries and, like most others with BDD, was not satisfied with the results. Another patient never had plastic surgery, but did need a number of surgeries to reconstruct body parts that were destroyed and distorted by her obsessive-compulsive behavior (e.g., obsessively working out to the point of injury). The last patient was treated before having plastic surgery. In total, patients exposed to the distorted mirror intervention initially obtained an average score of 33 on the BDD-YBOCS scale and an average score of 7.29 at termination. Follow-up interviews conducted with patients who were successfully treated revealed no posttreatment plastic surgery.

Conclusion

In our social and cultural environment that focuses solely on external beauty without any regard to our self-worth, society solidifies obsession with appearance. The lack of cooperation from plastic surgeons, lack of information available to the general public and lack of knowledge about BDD exhibited by the medical community may contribute to the 20% suicide rate among sufferers of BDD.

It is our goal to make the initial signs of BDD recognizable to the public and make sure that differential diagnoses and referrals are made properly and appropriately by physicians. Statistics show that 5 million Americans are afflicted by BDD, but at this point we can recognize the sufferers only due to the actual manifestation of this disease,
which is plastic surgery. This means that only people with financial means to afford plastic surgery are becoming visible. Although we do not know the exact statistics yet as studies are still in progress, it is our suspicion that there are millions of people who suffer with BDD.

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References:

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