Awareness and Identification of Body Dysmorphic Disorder by Aesthetic Surgeons: Results of a Survey of American Society for Aesthetic Plastic Surgery Members

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**Background:** A critical issue for aesthetic surgeons may be whether some patients have psychiatric conditions that contraindicate cosmetic procedures.

**Objective:** This study reports on the results of an e-mail survey of American Society for Aesthetic Plastic Surgery (ASAPS) members about their awareness of and experiences with body dysmorphic disorder (BDD).

**Methods:** In August 2001, all active ASAPS members with e-mail addresses listed in the ASAPS membership registry were e-mailed the “2001 Body Image Survey.” Participants were given until August 31 to complete the 8-question survey. The responses were compiled by an independent research firm.

**Results:** Two hundred sixty-five ASAPS members responded to the survey. Respondents indicated that they believed 2% of patients seen for an initial cosmetic surgery consultation suffer from BDD. Eighty-four percent indicated that they have refused to operate on persons with BDD. Eighty-four percent indicated that they had operated on a patient whom they believed was appropriate for surgery, only to realize after operation that the patient had BDD. Eighty-two percent of these surgeons believed that these patients had a poor postoperative outcome. However, only 30% of respondents indicated that they believed BDD was always a contraindication to cosmetic surgery.

**Conclusions:** The estimated rate of BDD reported by participants in the survey is consistent with the rate of occurrence in the general population but lower than the rate reported for cosmetic surgery patients in other studies. This suggests that although most surgeons are aware that BDD exists among their patients, they may underestimate the rate at which it occurs. (Aesthetic Surg J 2002;22:531-535.)

A common psychological profile of patients undergoing aesthetic surgery has yet to be identified. Encouragingly, several recent empirical studies have suggested that aesthetic surgery procedures can lead to improvements in body image, quality of life, and depressive symptoms. However, an equally critical issue may be whether some patients have psychiatric conditions that contraindicate aesthetic surgery procedures.

All of the psychiatric conditions are likely to be encountered among the population of patients undergoing aesthetic surgery. Certain disorders, particularly those that involve physical appearance, may occur more frequently in this population. It may be safe to assume that most aesthetic surgeons are unlikely to treat a patient who is experi-
encing significant psychopathology such as severe anorexia nervosa, active psychosis, or profound depression. Other psychopathology, particularly in its milder forms, may not be identified by the surgeon and may negatively impact postoperative outcome. 

Perhaps the most relevant psychiatric condition for aesthetic plastic surgeons is body dysmorphic disorder (BDD). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA, 1994) defines BDD as a preoccupation with an imagined defect in appearance. If a slight defect is present, the person’s concern is markedly excessive. The preoccupation must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. The preoccupation also must not be better accounted for by another mental disorder, such as the concern with body shape associated with anorexia nervosa.

The current DSM-IV criteria, for BDD are somewhat vague. The first criterion, if loosely applied, could describe most patients undergoing aesthetic surgery, who often present with “defects” well within the range of a normal appearance. Assessment of a defect as “imagined” or “slight” can be highly subjective. The second criterion—that the preoccupation causes significant distress and disruption in daily functioning—may be the more important for identifying BDD among patients undergoing aesthetic surgery. However, determining the degree of preoccupation or distress can be difficult. Several investigations of patients undergoing cosmetic surgery have suggested that they report a heightened degree of body image dissatisfaction with the specific feature considered for surgery. For some patients, however, it may be difficult to assess when this more normative dissatisfaction becomes a disruptive preoccupation.

BDD is estimated to affect 1% to 2% of the general population. Studies have suggested that the rate of BDD is higher among persons who seek cosmetic medical treatments. An investigation of 100 female patients undergoing cosmetic surgery in the United States that used a questionnaire specifically designed to assess the presence of BDD found that 7% met diagnostic criteria. Two studies of dermatology patients in which a different questionnaire was used found that 12% to 15% met diagnostic criteria. A study of 415 patients undergoing cosmetic surgery in Japan that used a clinical interview diagnosed 15% of patients with BDD. Although methodological differences among the studies can explain the differences in percentages of patients with BDD, it appears that 7% to 15% of patients who seek cosmetic medical treatments may have BDD.

Patients with BDD seek cosmetic medical treatments with great frequency. In a study of 250 adults with BDD, approximately 75% sought nonpsychiatric medical treatments, and 66% received them. Unfortunately, patients have not benefited from these treatments. Seventy-two percent of the procedures led to no change, and 16% led to a worsening of BDD symptoms. In 2 other studies, more than 75% of patients with BDD reported dissatisfaction with the results of their cosmetic treatments. Nine individuals with BDD in one of those studies were so dissatisfied with their appearance that they performed “do-it-yourself” cosmetic procedures.

There are other concerns with operating on persons with BDD beyond dissatisfaction with the postoperative result. BDD has been included as part of a malpractice lawsuit against at least one plastic surgeon. Although this case was dismissed on appeal, many have seen the case as a warning of the potential hazards of operating on persons with BDD. There is also some evidence to suggest that persons with BDD may become violent toward their surgeon. In the well-known story of the patient who murdered Dr Vazquez Anon, descriptions of the patient are consistent with symptoms of BDD. The patient who murdered Dr Michael Tavis also appeared to suffer from BDD. Given the evidence that most persons with BDD do not benefit from cosmetic procedures, coupled with the potential for patients with BDD to become litigious or violent, BDD is often considered a contraindication for cosmetic surgery.

Recent research has provided important information on the relationship between BDD and cosmetic surgical treatments. However, little is known about aesthetic surgeons’ knowledge of BDD. This survey was undertaken to assess surgeons’ awareness of and experiences with patients with BDD.

Methods

Potential participants were all active ASAPS members listed in the membership registry in 2001. In late
August 2001, they were e-mailed a copy of the “2001 Body Image Survey.” The instructions with the e-mail read as follows: “ASAPS is cooperating on a study on body image and body dysmorphic disorder (BDD). Please assist in this research by completing this 8-question survey. Thank you.” In particular, participants were asked to indicate the percentage of their patients whom they thought had BDD, the symptoms of BDD that they had identified among patients, their treatment of patients identified as having BDD, the postoperative outcomes for these patients, and whether they believed BDD was a contraindication for cosmetic medical treatment. Participants were given until August 31, 2001, to complete the survey. At the beginning of the survey, BDD was described as a “psychiatric condition defined as an excessive preoccupation with an imagined or slight defect in appearance, which leads to significant distress or impairment in social, occupational or other areas of functioning.” This description was taken directly from the DSM-IV. Respondents were to use this description as they answered the subsequent questions. These questions were selected to assess ASAPS members’ knowledge about the disorder, the percentage of patients undergoing aesthetic surgery they believe have the disorder, and their experiences in treating patients they believed had BDD. Responses were compiled by an independent research firm and then made available to the author for interpretation.

Results

Two hundred sixty-five ASAPS members responded to the survey by the August 31, 2001. Because of limitations of the survey, no specific information on the respondents, such as sex, age, or years in practice, was available.

The median estimate for the percentage of all patients seen for an initial cosmetic surgical consultation believed to suffer from BDD was 2%. The median estimate for both female patients and male patients was also 2%.

Respondents indicated that they have observed many of the typical behaviors of patients with BDD. Ninety-three percent of respondents indicated that they had observed excessive concern or distress with minor or nonexistent appearance features. Eighty-eight percent had noted that patients indicated dissatisfaction with previous cosmetic procedures. More than 80% reported that patients had unusual or excessive requests for cosmetic procedures. More than half indicated that patients had made references to others taking special notice of their appearance or held the belief that a cosmetic procedure would transform their life (Table).

Surgeons reported that they have treated patients they believed might have BDD in several ways. Eighty-four percent indicated that they have refused to perform surgery. Sixty-four percent reported scheduling a second consultation. Half indicated that they had recommended a psychiatric consultation, and 21% delayed surgery so that the patient could receive psychiatric treatment. A small minority, 13%, reported that they have treated these patients in other, nonspecified ways. Only 10% reported that they treated patients with BDD no differently than other patients undergoing cosmetic surgery.

Most respondents (84%) indicated that they had the experience of operating on a patient whom they believed was appropriate for surgery, only to realize after operation that the patient may have BDD. Of surgeons who had this experience, 82% believed that the patient had a poor operative outcome with regard to the BDD symptoms. Forty-three percent indicated that the patient was

<table>
<thead>
<tr>
<th>Behavior</th>
<th>% of respondents</th>
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<tbody>
<tr>
<td>Excessive concern with, or distress over, minor or nonexistent appearance flaws</td>
<td>93</td>
</tr>
<tr>
<td>Dissatisfaction with previous cosmetic surgery</td>
<td>88</td>
</tr>
<tr>
<td>Unusual or excessive requests for cosmetic surgery</td>
<td>81</td>
</tr>
<tr>
<td>References to others taking special note of the perceived appearance flaw</td>
<td>64</td>
</tr>
<tr>
<td>Belief that the procedure will transform patient’s life or solve all problems</td>
<td>53</td>
</tr>
<tr>
<td>Camouflaging (heavy makeup or clothes that hide body)</td>
<td>41</td>
</tr>
<tr>
<td>Difficulty in day-to-day functioning</td>
<td>30</td>
</tr>
<tr>
<td>Skin picking</td>
<td>23</td>
</tr>
</tbody>
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Table. BDD behaviors observed by ASAPS members
more preoccupied with the perceived defect than before surgery, and 39% reported that the patient was free of preoccupation with the original defect but was now focused on a different feature. Seventeen percent reported that the patient was less preoccupied with the defect after surgery, and only 1% believed that the patient was free of preoccupation.

Forty percent of respondents indicated that a patient with BDD had threatened them. Twenty-nine percent reported being threatened legally, 2% were threatened physically, and 10% were threatened both legally and physically. Thirty percent of respondents believed that BDD is always a contraindication to cosmetic surgery. When asked about providing additional information to patients about BDD, approximately half of the respondents (51%) indicated that they would be interested in distributing a brochure on BDD to prospective patients.

Discussion

Results of this study suggest that aesthetic surgeons are aware that BDD occurs among a small percentage of their prospective patients. Their reported estimates of the percentage of patients with BDD are consistent with the estimated rate of occurrence in the general population, and with the estimated equivalent rate across the sexes. However, these percentages are less than the 7% to 15% of patients undergoing cosmetic surgery who met diagnostic criteria in BDD previous studies. Thus although surgeons are aware that BDD exists among prospective patients, they do not estimate the disorder to occur as frequently as has been found in studies specifically investigating the rate of BDD among patients who sought cosmetic medical treatment.

Respondents indicated that they have observed many of the symptoms of BDD among their patients. The most frequent symptom observed was an excessive concern with or distress over minor or nonexistent flaws in appearance. This symptom, observed by 93% of the surgeons surveyed, is a hallmark of BDD. More than 80% of respondents indicated that they observed behavior associated with BDD that was related specifically to cosmetic surgery—either dissatisfaction with a previous procedure or an unusual or excessive request for surgery. Less than half of the surgeons surveyed had observed any of the other common features of the disorder, such as skin picking and camouflaging. Furthermore, only 30% of respondents indicated that they had observed difficulty in day-to-day functioning as a result of the appearance preoccupation. These smaller percentages underscore the importance of surgeons asking a patient about the degree of disruption in daily functioning related to his or her appearance concerns.

Once surgeons identified a patient with BDD, most indicated that they have addressed the disorder as part of the preoperative treatment plan. Most indicated that they have refused to operate on an individual with BDD. Almost two thirds had scheduled a second consultation. Smaller percentages have involved mental health care professionals in the treatment of these patients. Fifty percent have recommended a psychiatric consultation, and 1 in 5 has delayed surgery for psychiatric treatment.

More than 80% of respondents indicated that they did not realize they were treating a patient with BDD until after surgery. Given the secretive nature of BDD, coupled with patients’ beliefs that they will only feel better about themselves by changing their outward appearance, this result is not surprising. Of the surgeons who operated on these patients, 43% reported that the patient was more preoccupied with the perceived defect than before surgery, and 39% reported that the patient was now preoccupied with a different perceived defect. These percentages are consistent with studies of patients with BDD that found that few patients with BDD report improvements in their symptoms after cosmetic medical treatment. Taken from the surgeons’ perspective, results from this study provide additional information suggesting that most patients with BDD do not benefit from cosmetic treatments.

Recently, there has been growing concern that persons with BDD may seek legal action after an unsatisfactory surgical result. On the basis of the results of this survey, Lynn G. v Hugo was not an isolated case, because almost one third of respondents indicated that they had been threatened legally by a patient they believed suffered from BDD. Ten percent of respondents indicated that patients with BDD had threatened them both physically and legally, and 2% acknowledged being threatened physically. Although these percentages are small, they illustrate the potential risks of operating on patients with BDD.

Given these risks, coupled with both patients’ and sur-
geons’ reports that cosmetic procedures typically do not improve the symptoms of BDD, it is surprising that only 30% of surgeons indicated that they believed that BDD was always a contraindication to cosmetic surgery. Perhaps these surgeons evaluate patients with BDD on a case-by-case basis and have not adopted an absolute policy that they will not operate on these patients. Results from this study, however, provide further evidence that treating patients with BDD can be a “high-risk” endeavor, and ultimately BDD may contraindicate cosmetic surgery.4-7,9,19

Although this study provides important new information on surgeons’ awareness of and experiences with patients with BDD, it has several limitations. First, only a small percentage of ASAPS members responded to the survey. Second, although a brief e-mail survey was used in the hope of achieving a high response rate, a lengthier and more detailed survey would have likely provided additional and valuable information on surgeons’ experiences with patients with BDD. Similarly, asking surgeons to provide demographic and descriptive information about their practices would have allowed for an investigation of other variables that may influence surgeons’ treatment of persons with BDD.

Clearly, most surgeons are aware that BDD exists among their patients, although it appears that they may underestimate the rate at which it occurs. The surgeons surveyed appeared to have a good awareness of some of the symptoms and characteristics of BDD. Most surgeons indicated that they take additional steps to assess a patient’s appropriateness of surgery when they have BDD. Although surgeons recognize that most patients with BDD do not benefit from cosmetic treatments, most do not agree that BDD always is a contraindication to cosmetic surgery. These results underscore the importance of attempting to assess the presence of BDD symptoms as part of the surgeon’s routine preoperative assessment.9,25

References