Quality of Life Before and After Cosmetic Surgery: Should Body Dysmorphic Disorder Be Considered an Absolute or Relative Contraindication for Cosmetic Surgery?

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ABSTRACT

Body Dysmorphic Disorder (BDD) has historically been regarded as a strong contraindication for cosmetic plastic surgery. New research now suggests that the contraindications to cosmetic surgery in patients with BDD may not be so absolute. This paper reviews diagnostic criteria, diagnostic challenges, and current standard of treatment of BDD. It then presents the idea of insight analysis in the BDD patient as a significant factor in determining if patients with BDD may or may not benefit from cosmetic surgery or procedures.

INTRODUCTION TO BDD AND INSIGHT

Body Dysmorphic Disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as "a preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns. The preoccupation causes clinically significant distress or impairment in social, occupational or other areas of functioning. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Specify if:

- Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed").
- With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.
- With poor insight: The individual thinks that the body dysmorphic disorder beliefs are probably true.
- With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic disorder beliefs are true."[1]

METHODS

A literature search was conducted via PubMed, Access Medicine, University of Pennsylvania Access System, Google Scholar September 2021-April 2022.
Seventeen articles were selected based on their relevance to the research question. Articles were considered relevant if the study was recent, had an appropriate sample size. All articles were concerned with the quality of life before and after cosmetic surgery in patients who were diagnosed or diagnosable with BDD. Results of studies varied.

RESULTS

(This is not a complete list of all studies which were analyzed)

Arguments Against Cosmetic Surgery in BDD

23.1% participants found an improvement with the treated body part with 69% of these improved patients developing a new flaw/ increased concern about another area/ worry that an improved body part would become ugly again. 7% of all patients who elected to undergo cosmetic surgeries led to both a noted decrease in concern with the treated body part and improvement in BDD symptoms. 13. n=289 (Phillips KA)

Arguments Which Can Be Applied Either Way

An androgenetic alopecia study in 2018 focused on self-esteem in patients and found a correlation relating higher post-operative satisfaction with higher initial levels of self-esteem 14. (Liu F et al)

Arguments For Cosmetic Surgery in BDD

Random assessment of patients at rhinoplasty consultations. Diagnosed. Of the 31 patients selected, 81% patients were classified as being in complete remission from BDD, with 90% of patients still pleased with the surgical outcome 1 year later [4]. (Felix et al)

Cosmetic surgery consult patients were followed for 5 years, some with diagnosed BDD, others without. Patients were re-evaluated 5 years later by telephone in order to ask about their cosmetic surgeries, satisfaction with the surgeries, BDD diagnosis, handicap, and other psychiatric comorbidities. N=24, 10 with BDD and 14 without. Of the 10 BDD patients, 7 had undergone cosmetic surgeries. Of the 14 non-BDD patients, 8 had undergone surgeries. Patient satisfaction with surgical intervention was high in both BDD and non-BDD patients. 6 of the 7 BDD patients who were operated on still had a BDD diagnosis as well as higher levels of handicap and psychiatric comorbidity than non-BDD patients. 3 non-BDD patients had developed a BDD at follow-up. (Tignol J et al)

DISCUSSION AND CONCLUSION

As is the case with many different psychiatric disorders, the diagnosis of BDD can be a somewhat subjective process since there are no quantifiable criteria that must be met (e.g. hours per day looking in the mirror, number or work days or social gatherings missed per month, etc.). Truthfulness on the patient's behalf is assumed by the provider responsible for diagnosis who, then, must use their clinical judgement for diagnosis. For example, the term "clinically significant distress or impairment"[1] could mean something slightly different to many clinicians. Additionally, in order to be diagnosed with BDD, one of the criteria which must be met is a "preoccupation with one or more perceived defects that are not observable or appear slight to others." This creates another subjective decision which relies on the detail-orientation of the clinician, and is also complicated by the fact that "degree of deformity" lies on a spectrum and cannot be separated from the clinician's own standards and ideals of beauty.

Overall, more research must be conducted in the area of BDD in the cosmetic surgery setting and screening tools must begin to be utilized because the importance of helping those who will benefit from cosmetic surgery is equally important as shielding those who will not.

References (Full list in text)

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