Returning for Aesthetic Procedures: Compliance or Compulsion?

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Approximately 40% of cosmetic surgery patients and approximately 60% of patients who undergo minimally invasive cosmetic procedures are repeat patients.[1] Approximately two-fifths of patients undergo more than 1 procedure at a time. The first percentage could be interpreted as a strong statement that a large percentage of patients are satisfied with their initial procedure and the care they received from the treating surgeon and treatment team. Coupled with studies suggesting that approximately 90% of aesthetic patients are satisfied with the outcome of their procedures, it is clear that many patients are happy with the care they are receiving.

The issue, however, is nuanced. For example, consider the more than 3 million minimally invasive procedures annually.[2] These patients are informed that the effects of these procedures endure for limited periods of time, often as brief as 3 to 6 months. Providers also instructed patients that continued benefits to physical appearance likely will require ongoing treatment. Thus, for many patients, returning for additional procedures is a sign of appropriate compliance with a treatment plan rather than interest in a new treatment or treatment of a second physical feature (although anecdotal reports from providers and patients indicate this is common as well).

Although ongoing compliance with treatment is desired across all forms of health care, in the case of aesthetic procedures, compliance is separated by compulsion by a relatively fine line. Compulsive behaviors are defined as repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession.[3] The compulsive behaviors are undertaken to prevent or reduce anxiety, although they are often ineffective in doing so.

Compulsive or ritualistic behavior is a hallmark feature of obsessive-compulsive disorder, where the compulsive behaviors are preceded by obsessions, defined as recurrent, persistent, and unwanted thoughts, urges, or impulses.[3] These thoughts lead to marked anxiety or distress that the individual attempts to suppress or neutralize by a compulsive behavior.

Obsessive-compulsive disorder is closely associated with body dysmorphic disorder (BDD), arguably the psychiatric condition of greatest relevance to aesthetic practice.[4,5] BDD is defined as a preoccupation with 1 or more perceived defects in physical appearance that are not observable or appear slight to others.[3] Persons with BDD also have obsessive thoughts about their appearance and compulsively engage in repetitive behaviors (eg, mirror checking, excessive grooming) or mental acts (eg, comparing his or her appearance with that of others) in response to the obsessive thoughts about their appearance. The preoccupation with one's appearance causes clinically significant distress or impairment in social or occupational functioning and often leads patients back for

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repeated aesthetic procedures. The extent of distress and impairment in functioning likely differentiates an aesthetic patient with "normative" appearance concerns from one with BDD.[6]

Less than 3% of adults are believed to suffer with BDD. The onset of symptoms is often in adolescence, but the disorder is often misdiagnosed as depression or social anxiety for years before identified. The nose, face, and skin are the features most frequently at the center of the individual's concern, although any feature of the body can play that role. Although the percentage of individuals affected by BDD is relatively small, the obsessions and compulsive behaviors can lead to profound distress. The disorder is associated with high rates of suicidality, leaving experts to consider it one of the more lethal psychiatric conditions.

Over the past 20 years, studies conducted throughout the world have suggested that 5% to 15% of patients who present for aesthetic treatments meet diagnostic criteria for BDD.[4-6] In a busy aesthetic practice, that can translate to several new patients each month who have the disorder. Some new patients will present with great concern and emotional distress with minor imperfections in their appearance that are often perceived as correctable by the treating provider. Other patients will seek repeated treatment of the feature from either the same provider or other, new providers. This is where the fine line between compliance and compulsion come together. Regardless, patients are often convinced that the only way they will feel better about their appearance is by changing it.

Unfortunately, evidence suggests that the majority of patients with BDD experience a worsening or no change in their symptoms with treatment.[7,8] Some may subsequently asked for a revision or new procedure. Others may turn to another provider in the community for care. Still others have threatened legal action or violence against the providers with some following through on these threats.[7,8] For these reasons, BDD is seen by many as a contraindication to aesthetic procedures.[4-6,9] Although many aesthetic providers agree with this scientific evidence and routinely screen for symptoms of BDD in their patients, others appear less concerned about these risks of performing procedures on patients with the condition.[10,11]

Although screening for BDD in all new patients is recommended, it is unclear if it is commonplace. For patients who are returning regularly for treatments, either continued course of minimally invasive treatments or new treatment to address the same concern, symptoms of BDD should be evaluated as well. Patients suspected of having BDD should be referred to a mental health professional in the community with knowledge and expertise in BDD to make sure that additional treatment is psychologically appropriate.

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