ARTICLE

Body dysmorphic disorder: a new concern for dentists

Avesh Sachan, Thakur Prasad Chaturvedi[1], Adit[2]

BDS, MDS, Senior Resident, [1]BDS, MDS, Professor, Department of Orthodontics, [2]BDS, MDS, Assistant Professor, Department of Oral Medicine, Faculty of Dental Sciences, Institute of Medical Sciences, Banaras Hindu University, Varanasi, Uttar Pradesh, India

Abstract

Body dysmorphic disorder (BDD) preoccupations can affect any body part. However it is found that patients were more preoccupied with breasts, hips, legs, weight, height, genitalia, excessive body hair, body build, and hair thinning. BDD patients mentioned some aspect of their faces. For this reason, dentists, plastic surgeons, maxillofacial surgeons, and orthodontists might be the first clinicians to become involved with these patients. BDD patients were concerned about facial profile, teeth, chin, smiling, talking, and laughing. These factors had an impact on their abilities to work, socialise, meet friends, and date and, therefore, reduced their abilities to function normally in society. Early identification of orthodontic patients who have BDD is of the utmost importance, and dentist/orthodontic clinicians should consider referring these patients for further evaluation before beginning treatment.

Sachan A, Chaturvedi TP, Adit. Body dysmorphic disorder: a new concern for dentists. Dysphrenia. 2012;3:134-6.
Keywords: Physical appearance. Face. Psychiatric illness.
Correspondence: dr.aveshsachan@gmail.com
Received on 4 May 2012. Accepted on 7 June 2012.

Introduction

Body dysmorphic disorder (BDD) was previously known as dysmorphophobia or body dysmorphia. BDD is a mental condition that is characterised by a distressing or impairing preoccupation with an imagined or a slight defect in appearance.[1] Changes in the classification of psychiatric illness mean that dysmorphophobia has been redefined into delusional and nondelusional variants; the nondelusional variant is now called BDD.

Body image plays an important role for patients seeking orthodontic treatment. It affects how patients feel about their physical appearance and, in extreme cases, can lead to subjective fears of ugliness. When there is a physical defect that although within normal limits, seems far more noticeable to the patient, this may be diagnosed as BDD.[2,3] At some point, most clinicians will encounter the patient who presents requesting treatment for a non-existent or very minor facial deformity - this may signify the existence of the condition dysmorphophobia, which was first described by Morselli in 1886.

Prevalence

BDD affects two per cent of the general population and between six per cent and 15% of dermatologic and cosmetic surgery patients.[4] Although one study reported a preponderance of BDD in women, with a three-fold incidence of that in men, others found equal distributions between men and women, or a higher incidence in men. The onset of BDD is usually during adolescence although patient may wait a number of years before requesting treatment. The majority of patients suffering from BDD are unmarried and many are also unemployed.[5-7] With the growing tendency for people to seek cosmetic enhancements, patients with BDD are likely to consult orthodontists for treatment. A more recent study reported a 7.5% incidence of BDD in an orthodontic patient sample compared with a 2.9% incidence in a general public sample.[8] This study suggested that a higher percentage of the general population affected with BDD could be seeking orthodontic treatment.

Specific feature

The main cognitive feature of BDD is an obsession with an imagined or greatly exaggerated defect in appearance and the belief that the imagined defect represents a personal inadequacy. Concerns frequently affect some part of the face and head. A person's level of functioning can vary considerably. Most people are capable of at least limited social functioning and find ways to avoid full exposure of their "defect" in public. They tended to cover their mouths while talking and rarely smiled during the interviews. These avoidance strategies include camouflage by applying makeup or wearing concealing clothes.[9] In contrast, others become virtually housebound, as shown by Phillips et al.[9]

At the initial appointment patients may be secretive and reluctant to discuss the problem or they may be intrusive and present with pictures and photographs which aim to prove that there is problem, although they have mild malocclusions, which would be accepted by most people, or no obvious malocclusion. They were not considered to require treatment for facial esthetics or dental esthetics/dental health (the latter was assessed with the Index of Orthodontic Treatment Need Dental Health Component and Aesthetic Component). This visit may be followed by letters or phone calls explaining further details of the problem, all of which

should be documented carefully in patient's note.

Veale et al.[10] found that 86% of their BDD sample mentioned some aspect of their face. Common preoccupations include the shape, size, or another aspect of the head, nose, eyes, eyelids, eyebrows, ears, cheeks, lips, mouth, jaws, and teeth. For these reason dentists, orthodontists, maxillofacial surgeons and plastic surgeons are frequently the first clinicians to become involved with the patient. Other compulsive behaviours are designed to examine, improve, or hide the perceived defect and include excessive mirror checking, excessive grooming, hair styling, seeking reassurance, comparing oneself with others, skin picking, and trying to convince others of the defect's ugliness.

As orthodontists/dentists, we should be alert for patients extraordinarily concerned about insignificant or negligible dental flaws or defects, such as dental rotations, interdental spacing, malalignment of a midline, tooth-mass discrepancies, and other minimal imperfections. The patient's chief complaint needs to be thoroughly evaluated and a determination made regarding whether it is a real defect or, if extremely slight, minor or insignificant. Patients reporting multiple requests for orthodontic treatment or seeking evaluations with several colleagues, either before or after treatment, should raise our suspicions for BDD. Concerns are usually very specific and many patients see surgery as a solution to all their problems.

Patients with BDD who undergo cosmetic therapy typically are dissatisfied with the results. Hodgkinson[11] warned that these patients are "profoundly dissatisfied with the results," and Cunningham and Feinmann[12] stressed the relevance of BDD in patient satisfaction with treatment. Most of clinicians reported that a patient with BDD had threatened them legally or physically.

Doctor shopping

Many patients suffering from BDD will go "doctor shopping" (from one clinician to another), until they find someone who is willing to treat them. Because of this, it is important that patients are asked if they have sought previous opinions. Requesting correspondence from doctors they have seen previously may save considerable problems later on.

Diagnosis

Three criteria must be fulfilled for a diagnosis of BDD to be made:[13]

1. There is preoccupation with a defect in appearance. Either the defect is imagined or, if there is a defect, the person's concern is excessive.

2. The preoccupation causes significant distress in social, occupational, and other important areas of functioning.

3. The preoccupation is not better accounted for by another mental disorder, e.g., anorexia nervosa.

Associated psychiatric disorders

BDD can be the primary problem or secondary to other psychiatric disorders. BDD is often present with depressive disorders (a lifetime prevalence of 83%), social phobias (35% lifetime prevalence), and obsessive-compulsive disorder (29% lifetime prevalence).[14-16] BDD has also been found in conjunction with substance abuse. It is difficult to establish whether the two disorders actually co-exist or whether the depression is secondary to BDD. It is important that if depression does exist, it is treated as this may result in considerable benefits for the patient.

A screening guide for dentist/orthodontist

It might not be feasible to have psychological evaluations of all patients, but a few carefully chosen questions during the initial consultation could help to identify patients who might cause problems. These questions could include the following:

1. Are you happy with your appearance?

2. Is there anything that you would like to change about your appearance and, if so, what?

3. Is there anything that you avoid because of the way that you look?

4. Have you sought help before?

5. What do you expect to achieve from your treatment?

6. How does the patient rate the severity of their dental/dentofacial concern or defect?

7. How would the patient rate the amount of worries or distress produced by their defect, or "unattractive" appearance?

8. Does concern defect cause significant distress socially?

9. Why is treatment sought?

10. Have previous evaluations concerning their dental "defect" been performed?

11. Why are additional evaluations sought?

12. Have the expectations for this particular dental procedure reasonable?

13. Are requests for other cosmetic/dental/orthodontic procedures ever been obtained?

14. Have these other cosmetic procedures been performed? Are these frequent? How many?

15. Is there previous history of dissatisfaction with previous cosmetic procedures? Are these multiple?

16. Does the individual report any history of psychiatric or psychological disturbances or any previous referrals for psychological/psychiatric evaluations?

Treatment

The key is to take a full history and ensure that you are fully aware of the patient's expectations and whether they are within the realms of reality. If there is any uncertainty, referral should be made to a psychiatrist or clinical psychologist for a thorough psychological analysis. Patients suspected of having BDD should be referred to a psychiatrist for definitive diagnosis and management. Treatment of BDD consists of pharmacotherapy and behavioural therapy. Sometimes, performing the orthodontic procedure requested might be an integral part of the patient's treatment, but this should always be based on the recommendation of the treating psychiatrist.

Pharmacotherapy

The primary treatment modalities for BDD include the use of selective serotonin reuptake inhibitors (SSRIs). Evidence for SSRIs in the treatment of BDD supports the use of SSRIs such as fluoxetine, fluvoxamine, escitalopram, and citalopram. In general, higher SSRI doses than those prescribed for depression appear to be needed. This is similar to the treatment of obsessive-compulsive disorder (OCD). Phillips[17] pointed out that most SSRI studies for BDD have a mean time to treatment response of six to 16 weeks.

Behavioural therapy

In this type of psychotherapy the therapist helps the affected individual resist the compulsions associated with the BDD such as repeatedly looking in mirrors or excessive grooming (response prevention). If the individual avoids certain situations because of fear of ridicule, he or she should be encouraged to gradually and progressively face feared situations. If the individual plans to seek invasive medical/surgical treatment, the therapist should attempt to dissuade the patient or ask permission to talk with the surgeon.[18] The therapist helps the individual to understand how some of his or her thoughts and perceptions are distorted and helps the patient replace these perceptions with more realistic ones. Family behavioural treatment can be useful, especially if the affected individual is an adolescent. Support groups if available, can help.

Conclusion

It is vitally important that dentists/orthodontists create adequate awareness of this condition and identify its characteristics and symptomatology to allow for referral for diagnosis and appropriate management. The consequences or penalties for preliminary screening misdiagnosis of this condition could be high, and we can carry this heavy psychological load for many years. As orthodontic clinicians, we certainly know about "difficult" patients, and, even worse, they are a potential source of legal problems. Early identification of patients who have BDD is of the utmost importance, and the use of questionnaire might be a valuable tool for this purpose. Clinicians should consider referring these patients for further evaluation before beginning treatment.

Further reading

Chaturvedi S, Kamath P, Prasad R, Vishwanath A. Body dysmorphic disorder (BDD) and the orthodontics. Virtual J Orthod [serial online]. 2011 May [cited 2012 Jun 7]. Available from: http://www.vjo.it/wp-content/uploads/2011/03/BDD.pdf

Chaubey S, Chaturvedi TP, Tripathi MN. Dental implications of tardive dyskinesia: a concise review. Dysphrenia. 2012;3:126-8.

Nehra DK, Bathla JC, Kumar P, Kumar V. Psychological management of body dysmorphic disorder. Dysphrenia. 2012;3:183-6 .

References

1. Veale D. Body dysmorphic disorder. Postgrad Med J. 2004;80:67-71.

2. Fava GA. Morselli's legacy: dysmorphophobia. Psychother Psychosom. 1992;58:117-8.

3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed., revised. Washington, DC: American Psychiatric Association; 1987.

4. Wilson JB, Arpey CJ. Body dysmorphic disorder: suggestions for detection and treatment in a surgical dermatology practice. Dermatol Surg. 2004;30:1391-9.

5. Veale D, Boocock A, Gournay K, Dryden W, Shah F, Willson R, et al. Body dysmorphic disorder. A survey of fifty cases. Br J Psychiatry. 1996;169:196-201.

6. Phillips KA. Body dysmorphic disorder: the distress of imagined ugliness. Am J Psychiatry. 1991;148:1138-49.

7. Thomas CS. A study of facial dysmorphophobia. Psychiatr Bull. 1995;19:736-9.

8. Hepburn S, Cunningham S. Body dysmorphic disorder in adult orthodontic patients. Am J Orthod Dentofacial Orthop. 2006;130:569-74.

9. Phillips KA, McElroy SL, Keck PE Jr, Pope HG Jr, Hudson JI. Body dysmorphic disorder: 30 cases of imagined ugliness. Am J Psychiatry. 1993;150:302-8.

10. Veale D, Gournay K, Dryden W, Boocock A, Shah F, Willson R, et al. Body dysmorphic disorder: a cognitive behavioural model and pilot randomised controlled trial. Behav Res Ther. 1996;34:717-29.

11. Hodgkinson DJ. Identifying the body-dysmorphic patient in aesthetic surgery. Aesthetic Plast Surg. 2005;29:503-9.

12. Cunningham SJ, Feinmann C. Psychological assessment of patients requesting orthognathic surgery and the relevance of body dysmorphic disorder. Br J Orthod. 1998;25:293-8.

13. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Publishing; 1994.

14. Oosthuizen P, Lambert T, Castle DJ. Dysmorphic concern: prevalence and associations with clinical variables. Aust N Z J Psychiatry. 1998;32:129-32.

15. Phillips KA. Body dysmorphic disorder: clinical aspects and treatment strategies. Bull Menninger Clin. 1998;62(4 Suppl A):A33-48.

16. Wilhelm S, Otto MW, Lohr B, Deckersbach T. Cognitive behavior group therapy for body dysmorphic disorder: a case series. Behav Res Ther. 1999;37:71-5.

17. Phillips KA, McElroy SL, Hudson JI, Pope HG Jr. Body dysmorphic disorder: an obsessive-compulsive spectrum disorder, a form of affective spectrum disorder, or both? J Clin Psychiatry. 1995;56 Suppl 4:41-51; discussion 52.

18. Rosen JC, Reiter J, Orosan P. Cognitive-behavioral body image therapy for body dysmorphic disorder. J Consult Clin Psychol. 1995;63:263-9.