Body Dysmorphic Disorder: A Growing Problem?

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Body dysmorphic dsorder (BDD) is characterised by a preoccupation with an imagined defect in one's appearance or, in the case of a minor physical anomaly, the individual's concern is markedly excessive, causing significant distress in their life. One of the most common areas of preoccupation is the dentofacial region, with up to 20% of patients diagnosed with BDD expressing specific concern regarding their dental appearance. With the increased ability to undertake dental aesthetic and reconstructive procedures, in addition to the use of facial aesthetic procedures, it is paramount for all dental clinicians to have an understanding of this condition. BDD patients often request multiple aesthetic procedures, but remain unsatisfied with their treatment results. It is imperative for the dental clinician to diagnose this condition prior to instigating clinical treatment, and to make an appropriate referral.

Body dysmorphic dsorder (BDD) is a disorder of body image that remains challenging to diagnose. It is not possible surgically to 'cure' patients with this condition, which requires referral to a clinical psychologist or psychiatrist, ideally through their general medical practitioner. The prevalence of BDD in the population is estimated to be approximately 1%.[1] However, data on the prevalence of BDD in the UK community are generally lacking. In one study, 86% of a sample of patients diagnosed with BDD specified their dentofacial appearance as the cause of their concern.[2] In another study, approximately 20% of a sample of 500 patients diagnosed with BDD expressed specific concern regarding their dental appearance.[1] Therefore, dentists, orthodontists and facial aesthetic surgeons must be aware of the condition. This is particularly important for dental clinicians, as the condition tends to receive little exposure within dental journals. However, commencing treatment on such patients risks not only potential medicolegal problems for the clinician, but also antagonism and even violence.

Figure 1 The Italian professor of psychiatry Enrico Morselli (1852-1929) coined the diagnostic category of 'dysmorphophobia' in 1891, although he made reference to an earlier paper from 1886 in which he began to discuss the concept. The term was introduced into English with the publication of Eugenio Tanzi's textbook in 1910.

BODY DYSMORPHIC DISORDER

The Italian professor of psychiatry Enrico Morselli (*Figure 1*) described a condition termed 'Dysmorphophobia' in 1891. The condition has been redefined as two separate entities: delusional and non-delusional variants. It is only relatively recently that the non-delusional variant was classified as body dysmorphic disorder (BDD) in the *Diagnostic and Statistical Manual of Mental Disorders*.[3]

BDD is characterised by a preoccupation with an insignificant or non-existent appearance defect that causes significant distress to patients and interferes with their social life. The most common preoccupations involve the skin, nose, eyes and eyelids, lips, mouth, jaws and chin. However, any part of the body may be involved and the preoccupation may involve several body parts simultaneously.[4] The criteria required to make a diagnosis of BDD

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have been listed (American Psychiatric Association).[3] They are that:

1. There is a preoccupation with an imagined or minimal defect in appearance. If the defect is minimal, the individual's concern is excessive.
2. The preoccupation causes substantial emotional distress and impaired social and occupational functioning.
3. The preoccupation is not caused by other mental disorders.

Although the perceived physical anomaly may concern any part of the body, the face is commonly involved. Patients may have specific or vague concerns. Their preoccupation with a particular feature may remain unchanged, or their complaints may shift from one body part to another over time. Although patients' insight into the severity of their concerns is variable, they are often deeply convinced of the severity of their defect. It is not possible for clinicians simply to talk patients out of their concern.

BDD usually commences in adolescence, with a gradual onset.[5] However, sudden onset may also occur, particularly following major life events, such as the termination of a relationship or leaving home.[6] Mild symptoms in adolescence may subside over time, but moderate to severe symptoms tend to follow a more chronic path. There is frequent comorbidity in patients with BDD, particularly with depression, social phobia, substance abuse, obsessive compulsive disorder (OCD), and eating disorders.[7] The general dental practitioner is likely to be the first clinician to observe the characteristic dental erosive pattern due to vomiting in patients with eating disorders.

The nature of BDD is such that it very much takes hold of the patient's life. Significant social problems, including social isolation and work-related problems (due to avoidance of social interaction), result from a conviction that those around them consistently notice their 'defect'. Up to 50% of BDD patients admit to suicidal ideation.[8]

There are few data on the prevalence of BDD. Figures from 0.7% to over 5% have been given, with an equal sex incidence.[9] However, the prevalence among patients seeking facial aesthetic treatment may well be higher.[10] People with BDD are often single or separated.

Patient interview/consultation:

- Excessive concerns regarding a minor or imperceptible appearance defect
- Over-specific concerns, often with the patient bringing diagrams and pictures to demonstrate how they should be treated
- Vague description of concerns (as opposed to over-specific)
- Patient admits to chronic mirror-checking behaviour
- Dissatisfaction with previous clinician(s)/clinical treatment
- 'Doctor-shopping', particularly if previous clinicians have refused to undertake treatment
- Illogical desires, such as that a clinical procedure will change their life, job prospects or personal relationships
- Unrealistic expectations of clinical treatment result

Past medical history:

- Previous history of psychiatric treatment, particularly for depression
- Anxiety disorders, particularly obsessive-compulsive disorder (OCD) and social phobia (avoiding social situations, even being housebound)
- History of substance abuse
- History of eating disorders

Social and family history:

- Unemployed
- Unmarried/divorced and/or living alone
- Family support: does the patient have a poor relationship with their family?

Recognised patterns of behaviour:

- Unusually demanding or suspicious behaviour
- Frequent cancellation and rebooking of appointments
- Camouflaging behaviour, such as covering the mouth with a hand or scarf

Figure 2 Indications and 'giveaway' signs of body dysmorphic disorder.

DIAGNOSIS IN THE DENTAL SURGERY

The diagnosis of BDD is vital for clinicians involved in any form of dentofacial appearance-altering treatment, such as orthodontics, orthognathic surgery or aesthetic dentistry. Timely diagnosis will enable appropriate referral to mental healthcare professionals, either via the general medical practitioner or possibly through a specialist hospital unit, such as an orthodontic, maxillofacial or craniofacial unit with direct access to a clinical psychologist or liaison psychiatrist. This will ultimately avoid much stress for the patient and the clinician, and help to avoid possible future medicolegal problems.

Diagnosis is essentially based on the patient interview, past medical history and observation of recognised patterns of behaviour (*Figure 2*). There is no single question that will disclose a diagnosis of BDD. Patients will initially be asked an open question regarding the reason for their consultation and their concerns. Patients with BDD are likely to have excessive concerns about a minor or imperceptible defect in their appearance. Patients may be over-specific about a perceived appearance flaw, but may also sometimes be rather vague in their description of a defect. In addition, a history of 'doctor shopping', dissatisfaction with previous clinicians and treatment, and unusually demanding behaviour are 'red flag' signs. It is possible that patients may hide any previous psychiatric history from clinicians for fear that it will prevent them from receiving treatment. Another factor is that patients may well blame their 'defect' for lack of success in life, work or personal relationships. Such patients are likely to have unrealistic expectations that treatment will solve all their problems.

It is important to ask patients how much time they spend thinking about their defect, and how long they spend looking in a mirror per day. Engaging in any such compulsive appearance-related behaviour for more than one hour per day is a cause for concern.[2] Patients may

also use camouflaging techniques, such as covering their mouth with their hand or a scarf. Frequent cancellation and rebooking of appointments and a suspicious attitude should also alert the clinician.

TO TREAT OR NOT TO TREAT

BDD is a psychiatric disorder; therefore, any form of clinical treatment is likely to leave the patient unhappy, often more so than before treatment was instigated. Patients often find fault in the treatment result, and may find new 'defects'. There are situations in which treatment may be provided when a minor defect actually exists, but this must be undertaken jointly with the support of a clinical psychologist or psychiatrist. Therefore, the overall recommendation is not to undertake clinical treatment of patients with BDD.[11]

INFORMING THE PATIENT

Patients should be informed that clinical treatment by the dental clinician would not be beneficial for them in the long term.

It is important to inform patients without offending them. It is also vital for clinicians not to allow patients to talk them into providing treatment. Patients should be informed in a polite and straightforward manner, and clinicians should stress the fact that they are acting in the best interests of the patient. After obtaining the patient's consent, referral to the general medical practitioner is advisable, and it will be his or her decision as to whether or not subsequent referral to a clinical psychologist or psychiatrist is required.

MANAGEMENT

People diagnosed with BDD should be treated by a clinical psychologist or psychiatrist with experience in managing the disorder. Having confirmed the diagnosis, treatment may be undertaken by psychotherapy, pharmacotherapy or a combination of the two.

Cognitive-behavioural therapy in particular has been shown to be effective in the management of BDD. Two methods of cognitive-behavioural therapy specifically have demonstrated beneficial results:

1. Exposure therapy: This deals with the patient's ability to 'expose the defect' in a social setting.
2. Response prevention: Techniques to prevent the patient from using established behaviour patterns, such as mirror-checking and camouflaging behaviour.[12]

Pharmacotherapy may also be effective in the management of BDD. Selective serotonin reuptake inhibitors are currently the first-line medication, helping to reduce obsessive-compulsive behaviour.[13]

CONCLUSION

With the increased ability to undertake dental aesthetic and reconstructive procedures, in addition to the use of facial aesthetic procedures such as Botox® (injections containing *Clostridium botulinum* type A neurotoxin complex) and dermal fillers, it is paramount for general dental practitioners to have an understanding of BDD.

Clinical intervention, without the support of a clinical psychologist or psychiatrist, will often exacerbate a patient's symptoms and lead to greater problems. The challenge for dental clinicians is therefore to diagnose the condition prior to instigating clinical treatment.

REFERENCES

1. Phillips KA. *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder*. New York: Oxford University Press; 2005:56.
2. 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.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: APA; 1994.
4. Phillips KA. Body dysmorphic disorder: the distress of imagined ugliness. Am J Psychiatry. 1991;**148**:1138-49.
5. Castle DJ, Morkell D. Imagined ugliness: a symptom which can become a disorder. Med J Aust. 2000;**173**:205-7.
6. Phillips KA, Mernard W, Fay C, Weisberg R. Demographic characteristics, phenomenology, comorbidity, and family history in 200 individuals with body dysmorphic disorder. Psychosomatics. 2005;**46**:317-25.
7. Neziroglu F, Yaryura-Tobias JA. A review of cognitive behavioral and pharmacological treatment of body dysmorphic disorder. Behav Modif. 1997;**21**:324-40.
8. Veale D. Advances in cognitive behavioural understanding of body dysmorphic disorder. Body Image. 2004;**1**:113-25.
9. Otto MW, Wilhelm S, Cohen LS, Harlow BL. Prevalence of body dysmorphic disorder in a community sample of women. Am J Psychiatry. 2001;**158**:2061-3.
10. Ishigooka J, Iwao M, Suzuki M, Fukuyama Y, Murasaki M, Miura S. Demographic features of patients seeking cosmetic surgery. Psychiatry Clin Neurosci. 1998;**52**:283-7.
11. Phillips KA, Pagano ME, Menard W, Fay C, Stout RL. Predictors of remission from body dysmorphic disorder: a prospective study. J Nerv Ment Dis. 2005;**193**:564-7.
12. 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.
13. Phillips KA, Dwight MM, McElroy SL. Efficacy and safety of fluvoxamine in body dysmorphic disorder. J Clin Psychiatry. 1998;**59**:165-71.

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