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Virtual Journal of Orthodontics

Body Dysmorphic Disorder (BDD) and the orthodontist

Abstract:

Body dysmorphic disorder (BDD) (previously known as dysmorphophobia¹ is sometimes referred to as body dysmorphia or dysmorphic syndrome²) is a (psychological) somatoform disorder in which the affected person is excessively concerned about and preoccupied by a perceived defect in his or her physical features (body image).

Key words: Body dysmorphic disorder (BDD), dysmorphophobia¹, orthodontics.

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To cite this article:

S. Chaturvedia, P. Kamathb, R.
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Virtual Journal of Orthodontics
[serial online] 2011 May
Available at: <http://www.vjo.it>

Virtual Journal of Orthodontics

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CCIAA n° 31515/98 - © 1996
ISSN-1128-6547 NLM U. ID:
100963616 OCoLC: 40578647

Introduction

Body dysmorphic disorder (BDD) (previously known as dysmorphophobia¹ is sometimes referred to as body dysmorphia or dysmorphic syndrome²) is a (psychological) somatoform disorder in which the affected person is excessively concerned about and preoccupied by a perceived defect in his or her physical features (body image).

It was first described in 1886 and documented by Morselli as dysmorphophobia³ and eventually recognized as a disorder by the American Psychiatric Association in 1987. The sufferer may complain of several specific features or a single feature, or a vague feature or general appearance, causing psychological distress that impairs occupational and/or social functioning, sometimes to the point of severe depression and anxiety, development of other anxiety disorders, social withdrawal or complete social isolation, and more⁴. Incidence:

BDD affects 2% of the general population in the United States and between 6% and 15% of dermatologic and cosmetic surgery patients⁵. A recent study reported a 7.5% incidence of BDD in an orthodontic patient sample compared with a 2.9% incidence in a general public sample⁶. Also there is a preponderance of BDD in women, with a 3-fold incidence of that in men⁷⁻⁹.

Onset of symptoms generally occurs in adolescence or early adulthood, where most personal criticism of one's own appearance usually begins. With the growing tendency for people to seek cosmetic enhancements, patients with BDD are likely to consult orthodontists for treatment. The percentage of patients with BDD who seek surgery suggests that between 300,000 and 400,000 might request orthodontic treatment once and perhaps several times during their lifetime. Thus, it is vitally important that orthodontists create adequate awareness of this condition and identify its characteristics and symptomatology to allow for referral for diagnosis and appropriate management.

Etiology:

The exact cause of BDD differs from person to person. However, it could be a combination of biological, psychological, and environmental factors from their past or present. Abuse and neglect can also be contributing factors¹⁰⁻¹¹. BDD can often occur with OCD, where the patient unmanageable practices habitual behaviors that may literally take over his or her life. A history of, or genetic predisposition to obsessive-compulsive disorder may make people more susceptible to BDD. Other phobias like social

phobia or social anxiety disorder may also be co-occurring.

Symptoms:

Common symptoms of BDD include:

- Obsessive thoughts about perceived appearance defects.
- Major depressive disorder symptoms.
- Delusional thoughts and beliefs related.
- Social and family withdrawal, social phobia, loneliness and self-imposed social isolation.
- Suicidal ideation.
- Anxiety; possible panic attacks.
- Chronic low self-esteem.
- Feeling self-conscious in social environments; Strong feelings of shame.
- Avoidant personality and/or dependent personality.
- Inability to work or an inability to focus at work due to preoccupation with appearance.
- Decreased academic performance
- Problems initiating and maintaining relationships.

- Alcohol and/or drug abuse.
- Repetitive behavior (such as constantly (and heavily) applying make-up; regularly checking appearance in mirrors).
- Compulsive skin-touching, especially to measure or feel the perceived defect.
- Excessive dieting or exercising, working on outside appearance.

Compulsive behaviors

Common compulsive behaviors associated with BDD include:

- Compulsive mirror checking, glancing in reflective doors, windows and other reflective surfaces. Alternatively, an inability to look at one's own reflection or photographs of oneself; also, the removal of mirrors from the home.
- Attempting to camouflage the imagined defect: for example, using cosmetic camouflage, wearing baggy clothing, maintaining specific body posture or wearing hats.
- Use of distraction techniques: an attempt to divert attention away from the person's perceived defect, e.g. wearing extravagant clothing or excessive jewelry.
- Excessive grooming behaviors: skin-picking, combing hair, plucking eyebrows, shaving, etc.

Diagnosis

The disorder generally is diagnosed in those who are extremely critical of their mirror image, physique or self-image, even though there may be no noticeable disfigurement or defect. The three most common areas that those suffering from BDD will feel critical of have to do with the face: the hair, the skin, and the nose. Outside opinion will typically disagree and may protest that there even is a defect. The defect exists in the eyes of the beholder, and one with BDD really does feel as if they see something there that is defective.

To be diagnosed with BDD a person must fulfill the following criteria¹²:

- "Preoccupation with an imagined or slight defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive."
- "The preoccupation causes clinically significant distress or impairment in

social, occupational, or other important areas of functioning."

- "The preoccupation is not better accounted for by another mental disorder

BDD in orthodontics

As orthodontists, we should be alert for patients extraordinarily concerned about insignificant or negligible dental flaws or defects, such as dental rotations, interdental spacing, misalignment of a midline, tooth-mass discrepancies, and other minimal imperfections. Patients reporting multiple requests for orthodontic treatment or seeking evaluations with several colleagues, either before or after treatment, should raise our suspicions for BDD.

Most frequently requested dental treatments among patients with BDD in decreasing order: tooth whitening, jaw surgery and braces⁸.

BDD is known to significantly affect quality of life and is associated with depression and obsessive-compulsive disorder. It is therefore important to determine the patients' concerns and whether they have previously received treatment. It is essential to elicit when the concerns started and what impact they are having on their lives. It is also important when managing BDD patients to establish the

events that led to the development of BDD, although a patient's recall of events is retrospective and can be biased. Additional time for pertinent medical-history recording might be necessary and is frequently useful for the orthodontic clinician when evaluating a patient likely to have BDD. Importantly, a person exhibiting characteristics of obsessive-compulsive disorder (OCD) might have BDD, since the manifestations of the 2 conditions are similar. Questions directed toward specific BDD criteria, as well as for assessing OCD, should be included in the patient's medical and dental history. 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. Since persons affected with BDD might concomitantly have OCD, or since co morbidity with other potential psychiatric disorders could be present every effort should be made to refer these patients to a psychiatrist, and the orthodontist should not attempt to reach such a diagnosis alone. Further still, some persons might even notice correction of their bodily defect but not acknowledge it or attribute it to their overall satisfaction. If they have small defects that they are extremely concerned about, it might

be in their interest to correct the defects as long as they have appropriate psychiatric or psychological support during treatment. Treatment of BDD consists of pharmacotherapy and behavioral 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 psychiatrist¹³⁻¹⁴.

Management:

Studies have found that Cognitive Behavior Therapy (CBT) has proven effective¹⁵. Due to believed low levels of serotonin in the brain, another commonly used treatment is SSRI drugs (Selective Serotonin Reuptake Inhibitor). In extreme cases patients are referred for surgery as this is seen as the only solution after years of other treatments and therapy. A combined approach of Cognitive Behavior Therapy (CBT) and anti-depressants is more effective than either alone.

Conclusion:

As health care providers delivering esthetic treatments to patients, orthodontists should be aware of BDD and its implications. Patients seen for routine orthodontic evaluation, especially those exhibiting any characteristics of BDD, should be assessed further. As

orthodontists, should be alert for patients extraordinarily concerned about trivial or negligible dental flaws or defects, such as dental rotations, minimal interdental spacing, misalignment of a midline, tooth-mass discrepancies, and other nominal imperfections. Patients reporting multiple requests for orthodontic treatment or seeking evaluations with several colleagues, either before or after treatment, should raise our suspicions for BDD. Also, those reporting a disproportionate level of dissatisfaction with previous medical cosmetic procedures, including orthodontic and dental, should increase our concern. These patients have been shown to be rarely satisfied with the results of treatment. Many factors can contribute to how patients perceive themselves and the outcomes of treatment. For example, resiliency, self-efficacy, and coping have great impacts on treatment outcomes. If patients understand the limitations of their treatments, they will probably have more realistic expectations. 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.

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