

Body Dysmorphic Disorder (BDD) and the Orthodontist

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Abstract

For patients seeking orthodontic treatment body image plays a significant role. But sometimes, some patients are excessively concerned about and preoccupied by a perceived defect in his or her physical features (body image). They focus on a physical defect that is un-noticeable by others and are suffering from psychological (somatoform) disorder known as Body dysmorphic disorder (BDD).

Therefore, it is essential that orthodontists are aware of the condition as these are cases either with no deformity or are most unsatisfied group.

This article concerns about identification of BDD, its etiology, symptoms, role in orthodontics and management.

Keywords: Body Dysmorphic Disorder.

Introduction

As Orthodontic treatment is not only limited in aligning the teeth, it also provides facial aesthetics and physical attractiveness hence, patients seeking orthodontic treatment expect an overall positive change in their appearance. Sometimes patients come with either small or no deformity or request for retreatment for a well finished case, these patients generally suffer from body dysmorphic disorder (BDD).

During the course of the disorder, the individual often performs repetitive behaviors like mirror checking, excessive grooming, skin picking, reassurance seeking or mental acts in response to the appearance concerns for example comparing his or her appearance with that of others. Furthermore, the preoccupation also causes considerable distress or impairment in social, occupational, or other important areas of human function.

History

Morselli in 1886 first described documented BDD as dysmorphophobia.⁽¹⁾ BDD first appeared in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) under the name 'dysmorphophobia' in 1987.⁽²⁾

Afterwards, BDD was classified under somatoform disorders in DSM-IV. Currently, BDD is described in DSM-V under obsessive-compulsive and related disorders.⁽³⁾

Etiology

The age of onset of BDD is usually during adolescence,⁽⁴⁾ but it can also begin in childhood. The exact cause differs from person to person. However, it could be a combination of biological, psychological, and environmental factors from their past or present.⁽⁵⁾ Abuse and neglect can also be contributing factors.⁽⁶⁾

Bienvenu et al.⁽⁷⁾ found that 8% of BDD patients had a family member with the same condition, while Phillips et al.⁽⁸⁾ reported that 5.8% of the first degree relatives of the patients, also had the same disorder. A study by Monzani et al.⁽⁹⁾ which examined the heritability of dysmorphic concerns in a large sample of twins found that 44% of the variation in liability to dysmorphic concerns was attributable to genetic factors, environmental factors and measurement error that account for the remaining variance.

Phillips⁽¹⁰⁾ suggested that BDD arises from the unconscious displacement of sexual or emotional conflict or feelings of inferiority, guilt or poor self-image onto a body part.

Prevalence

The exact prevalence of BDD is unknown. Under-diagnosis and under-representation is likely as patients are often 'secretive' about their symptoms.^(11,12)

According to National population-based surveys:

Country	Prevalence in percentage (%)
United States ⁽¹³⁾	2.4%
Germany. ^(14,15)	1.7-1.8%
Australian ⁽¹⁶⁾	2.3%

Sex Predilection:

BDD occurs in both the sexes although reports of sex bias are variable.

Phillips⁽¹⁰⁾ quotes a ratio of 1.3:1, female: male, but in later papers⁽¹⁷⁾ the ratio is said to be approximately 1:1.

It is seen that the higher rates for females are more likely in the samples which includes self-referrals, a pre-occupation with overall body shape or weight, and milder forms of BDD.⁽¹¹⁾

Crerand et al.⁽¹⁸⁾ assessed non-psychiatric medical treatment and found that 71% of subjects with BDD sought, and 64% received, non-psychiatric.

Treatment for their 'defect' or 'flaw'. Among the 528 procedures delivered, the most frequently requested were dermatologic. Of the types of dental treatment sought, the most frequently requested was tooth whitening (7.7%), followed by orthodontic treatment (4.9%).⁽¹⁸⁾ An additional study showed that those who demonstrated features of BDD were 9 times more likely to consider tooth whitening, and 6 times more likely to consider orthodontic treatment in the near future, compared with those without BDD traits.⁽¹⁹⁾ hence, it is important for orthodontists to be vigilant in identifying affected patient to avoid unnecessary treatment and distress to both patient and clinicians.

Common symptoms & compulsive behavior associated with BDD

Common symptoms of BDD

- ✓ 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).

Common Compulsive Behaviors of BDD

- ✓ 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: skinpicking, combing hair, plucking eyebrows, shaving, etc.
- ✓ Compulsive skin-touching, especially to measure or feel the perceived defect.

- ✓ Excessive dieting or exercising, working on outside appearance.

Management

Studies have found that Cognitive Behavior Therapy (CBT) has proven effective.⁽²⁰⁾ 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.⁽²¹⁾

Conclusions

As orthodontists providing aesthetic treatment to patients, should be aware of BDD and its implications. BDD is a psychiatric disorder in which an individual has a pre-occupation with a 'slight' or 'perceived' defect in appearance. These individuals sometimes seek inappropriate or unnecessary treatment from multiple health care providers including orthodontist, and are frequently dissatisfied with the results of treatment. This could potentially increase the medico-legal risk for the clinician.

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.

BDD remains a challenge to diagnose and further research is needed to ascertain the appropriate management for affected orthodontic patients.

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