Body dysmorphic disorder and aesthetic dentistry

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Body Dysmorphic Disorder and Aesthetic Dentistry

Abstract: This paper outlines the features and presentation of body dysmorphic disorder (BDD), a psychological syndrome which results in patients seeking treatment for an imagined defect in appearance. The assessment of patients with suspected body dysmorphic disorder is outlined, as well as management strategies.

Clinical Relevance: Clinicians working in the field of aesthetic dentistry should be aware that some patients presenting for treatment may have body dysmorphic disorder. Aesthetic dental treatment for such patients is not beneficial and carries some risks. Advice for clinicians on assessment and management is outlined.

Requests for aesthetic dental treatment and the availability of such treatment options are increasing as expectations of the appearance of teeth change. Clinicians are rightly concerned about the patient who appears to be overly preoccupied and distressed by minor (or non-existent) defects; such patients may be suffering from a psychological disorder called body dysmorphic disorder (previously termed dysmorphophobia). This paper outlines the features of body dysmorphic disorder (BDD), and describes techniques for assessment and management.

Body dysmorphic disorder: an overview

The diagnostic criteria for BDD are outlined in the Diagnostic and Statistical Manual of Diseases, version 4.0.1 The criteria are:

- Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive in relation to the nature of the defect.
- 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 (eg anorexia nervosa).

The primary symptom of BDD is preoccupation with perceived defects. Concerns may be specific to particular body parts or a more pervasive vague concern about something 'not being right'. The feature is felt to be unbearably ugly, leading to high levels of shame and distress2 and low levels of self-esteem.3 Individuals with BDD are convinced of the severity of the defect, no matter how minor it may seem to others.4 Aspects of appearance most commonly the focus of this preoccupation are the skin (eg blemishes and moles), hair and nose, thus the face is frequently involved. There is some suggestion of differences according to gender, men being more likely to be preoccupied with their genitals, height, hair and body build, while for women the focus is likely to be their weight, hips, legs and breasts.5 However, the focus often shifts between body parts over the course of the disorder. Individuals with BDD have thoughts and concerns about the body part (eg everyone is staring at it; this body part is 'disgusting') which are experienced as uncontrollable and intrusive. These thoughts are likely to be worse in social situations. Up to 77% of people with BDD could be said to be delusional in their beliefs at some point in their disorder.6 The usual age of onset of symptoms is late adolescence (the average age reported in a large sample of patients was 16.4 years). However, people with BDD can go undiagnosed for many years and the typical age of presentation of psychiatric services is in the early 30s.7 The disorder is equally common amongst men and women.6 BDD is commonly misdiagnosed, and this may relate to the finding that people with BDD are often reluctant to disclose their symptoms and psychological distress.

The course of the illness is continuous, that is it is unusual for symptoms to show periods of remission. Complete remission is rare and its occurrence is related to the duration and severity of symptoms, such that people who have relatively mild BDD, which is not long established, are most likely to remit.7 Comorbidity is frequent in individuals with BDD: the condition is commonly associated with the presence of other psychiatric disorders,
such as depression, anxiety, social phobia and obsessive compulsive disorder. For example, approximately 38% of people with BDD have previously experienced a social phobia. Alcohol dependence is also common, as individuals may attempt to manage their distress by using alcohol. Of great importance for clinicians who may treat individuals with BDD, suicidal ideation (considering suicide or making plans to commit suicide) is common, being reported in 78% of cases, and 17 to 33% of cases have attempted suicide. This is a critically important point in the assessment of individuals with BDD. BDD may be prodromal of schizophrenia in late adolescence and early adulthood.

The individual with BDD may engage in a variety of compulsive behaviours in relation to his/her body part. These behaviours are termed 'compulsive' because they occur at very high rates and are repetitive. Examples include:

- Checking the body part in the mirror;
- Comparing the self to others;
- 'Skin picking' (seeking to remove the blemish by plucking it or scratching it);
- Applying make up;
- and Camouflaging the body part with clothes.

These rituals, while reducing anxiety in the short term, are counter-productive in terms of reducing anxiety in the longer term, as they tend to lead to increased focusing of the perceived problem and anxiety rather than reassurance. The rituals may occupy a number of hours each day, leading to impairment in ability to function in work or relationships. For instance, 27% of people with BDD report having been housebound at some point in the disorder. This should be differentiated from a diagnosis of agoraphobia; individuals with BDD are housebound as a secondary consequence of their anxiety from their perception that people will stare at them, judge them and so on.

Individuals with BDD often believe cosmetic treatment is the only way to deal with the defect and, in turn, seek help from clinicians such as maxillofacial surgeons, dermatologists and plastic surgeons. A number of surveys of individuals with BDD have indicated that 71–76% had sought cosmetic treatment, and approximately 65% of all cases had received cosmetic treatment. The treatments most commonly undergone were rhinoplasty, liposuction, breast augmentation, though minimally invasive procedures were also common (collagen injections, tooth whitening). Refusal of treatments is less common than might be expected; only 35% of treatments requested by people with BDD were refused.

Prevalence

In community samples, the estimated prevalence of individuals varies from 0.7–3%. Estimates amongst young student samples range from 2.2–28%. The reason for such large variation is probably the criteria used to define a 'case'. Where strict psychiatric criteria are adopted, the estimated prevalence tends to be lower. It would be anticipated that, in populations seeking cosmetic or aesthetic dental care, the prevalence of BDD should be higher. Although, the research on BDD and dental treatment is relatively sparse, various published case reports document patients with BDD attending for treatment in general dentistry and maxillofacial surgery. Hepburn and Cunningham conducted a survey of 40 patients attending for adult orthodontic treatment and found an estimated prevalence of 7.5% for BDD, suggesting that individuals with BDD are likely to seek orthodontic treatment. This is supported by a recent investigation of patients presenting to two maxillofacial surgery outpatient clinics, where 10% of patients were found to demonstrate symptoms of BDD. De Jongh and co-workers surveyed a community sample about their intentions to receive cosmetic dental treatment and found that those who reported being preoccupied with a defect of appearance were nine times more likely to consider tooth whitening and six times more likely to consider orthodontic treatment, compared to those without such a preoccupation. It follows that clinicians working in the field of aesthetic dentistry are likely to be visited by patients with BDD and, as such, need to be aware of this condition and how to assess and manage patients suspected of having BDD.

Assessment of patients who are suspected of having BDD

Cunningham and Feinman outline the importance of systematic and detailed assessment of individuals who are suspected to have BDD attending for dental treatment. The first consideration is to ensure that the setting is conducive to disclosure and discussion of the underlying problem; this includes allowing sufficient time to discuss the individual case, minimizing the number of people present (while ensuring that a chaperone is present) and ensuring privacy from interruptions. The patient will also need to be reassured that the information they give will remain confidential within their healthcare team.

Management strategies for people with BDD

Provision of the requested cosmetic treatment

Once a formal diagnosis of BDD has been made, it is not advisable to commence with cosmetic treatment. Provision of the requested cosmetic treatment appears to be of little benefit to the patient and there is some possible harm. Cerand et al found that 91% of procedures administered to people with BDD resulted in no change in BDD symptoms. Further, there is strong suggestion that people with BDD express high levels of dissatisfaction with treatment. This often leads to further treatment (usually with different clinicians) or the shifting of the preoccupation to another part of the body. Additionally, there are numerous possible adverse effects for the treating
What is the main complaint?
- Is the patient’s perception of the blemish proportionate?
- When did the patient first become aware of the problem?
- Why has the patient sought help now?
- What does the patient expect/hope for from treatment?
- How much does the problem interfere with daily life?
  - Is the patient’s assessment of the degree of interference proportionate?
- Is there anybody else exerting pressure for the patient to have treatment?
- Is there support from family/friends for the patient?
- Has the patient seen anyone else about this problem?
  - Other dental/medical teams (is the patient ‘doctor shopping’, that is going from healthcare professional to healthcare professional until they get the treatment they desire)
- Is there any psychiatric/psychological involvement?
- Are there any signs of depression?
  - Sleep disturbance
  - Lethargy
  - Inability to enjoy life
  - Hopelessness/Helplessness
- Are there any signs of anxiety?
  - Restlessness
  - Agitation
  - Somatic symptoms: dizziness, shortness of breath, stomach pains
- Has the person ever been diagnosed as having an eating disorder?
- Has the person ever been diagnosed with an obsessive compulsive disorder?
- Is there evidence of substance misuse? Note units of alcohol per week, also use of legal and illegal drugs.
- Is there any suicidal ideation? The three questions given in Figure 2 have been validated for use as a screening tool for people who are at risk of attempting suicide. If the patient scores within the range identified as at risk, an immediate referral should be made to their general medical practitioner stating your concerns.

Figure 1. Areas to cover in an interview with a patient who is suspected to have BDD.18

A recent Cochrane review23 suggested that both pharmacotherapy and psychotherapy may be effective in the treatment of BDD.

Pharmacological and psychological therapy
A recent Cochrane review23 suggested that both pharmacotherapy and psychotherapy may be effective in the treatment of BDD.

Psychological management of BDD, specifically cognitive behavioural therapy (CBT) is recommended as the first line of management by the National Institute for Health and Clinical Excellence (NICE, http://www.nice.org.uk/Guidance/CG31). CBT is based on the premise that the emotions, such as anxiety and distress, are affected by thoughts (or ‘cognitions’) and beliefs, and by behaviour. CBT works by encouraging the reassessment of thoughts and actions. CBT often includes exposure to the feared stimulus (e.g. social setting) and response prevention whereby the patient is encouraged to face his/her anxiety without engaging in repetitive ritual. This process is repeated until the patient no longer feels anxious. CBT can also involve changing beliefs connected to patients’ dissatisfaction with their body, teaching stress management techniques and provision of information about the condition.24 Randomized controlled trials have indicated that, for example, reports that 55% of patients in a CBT group improve, in comparison, none of the no treatment control group improved
and 14% were symptomatically worse.24

There is good evidence for the effectiveness of anti-depressive drugs in people with BDD. Randomized controlled trials of selective serotonin reuptake inhibitors (eg fluoxetine, clomipramine) indicate that, on average, 53% of individuals with BDD improved compared to 18% in the placebo control group.25 Given the prevalence of delusions amongst people with BDD, it has been suggested that anti-psychotic agents might be prescribed. However, there is no evidence for the effectiveness of anti-psychotic agents in patients with BDD, even when delusions are present.

Conclusions

Patients with BDD are likely to present for aesthetic or cosmetic dental treatment. This is potentially problematic since aesthetic dental treatment has little benefit for people with BDD and has potentially negative consequences for patient and the treating clinician. Clinicians should be aware of this possibility and be familiar with specific strategies to recognize and assess people with suspected BDD and appropriately manage them by referral to specialist services.

Resources for clinicians
2. For information leaflets suitable for patients, and for information for clinicians working with individuals with body dysmorphic disorder, see the National Institute for Health and Clinical Excellence (NICE) http://www.nice.org.uk/Guidance/GG31

References

Book Review


This is a beautiful looking book produced by Quintessence with brief descriptions in English and German.

Page 16 opens with some over prescription for some very minor chipping of upper front teeth with the tooth surface loss being most notable on the upper central incisors. The patient had 10 veneers placed without any description of how this was done or how long they had been in position. A vast amount of red lipstick was added to the visual effect.

The book then starts to degenerate into obscene over prescription. The second case shows a virtually intact smile being over-treated with 14 ‘no prep veneers’. Again, no description is given of what was done, nor indeed any clinical information offered as justification for this amount of treatment.

Page 26 shows a case of probable ‘Sipper’s Gob’, where just the upper central incisors were eroded with no obvious erosion on the lower teeth. Apparently, the patient had her bite opened by 6.5 mm for 14 ‘no prep veneers’. Some directly applied composite, probably to the upper front teeth, could have been justified to treat the incisal erosion, but there can be no clinical justification for the treatment prescribed in which the upper lateral incisors end up being nearly twice the height of the two central incisors.

Page 28 shows a young man who had 28 ‘no prep veneers’ for some very minor spacing which could realistically have been corrected with a bit of simple orthodontics and some retention. In this reviewer’s opinion, there can be little or no justification for this over prescription and over contouring, when either orthodontics or just simple composite bonding techniques would have produced a perfectly acceptable result.

The bright red lipstick makes another startling re-appearance on page 32, where the patient simply wanted whiter teeth, but instead she had 12 ‘no prep veneers’. A photograph was taken in black and white just to make it absolutely clear that the author never considered anything as obvious as nightguard vital bleaching. Apparently, the referring dentist was so ‘impressed’ (spelt ‘gullible’) that she decided to have 12 veneers herself. The difference in colour between the upper and lower teeth is very obvious on page 35. Simple nightguard bleaching would have done well in this case, with a fraction of the biologic or financial cost incurred with the treatment to cure her of the ‘porcelain deficiency disease’.

The next case was of a good looking, graceful lady in her mid 60s who had, indeed, a bit of darkening and erosion but was treated with multiple veneers which made her look like, in this reviewer’s opinion, as if she had suddenly acquired some very bad, very false, very white teeth.

A case of partial anodontia is presented on page 46 with the patient being treated with six veneers. I cannot see how the veneers placed on top of two prominent canine teeth could have been done with a ‘no preparation approach’ as stated by the author. The anatomy of the veneers were sadly very matt and unlike the natural anatomy of her beautiful natural teeth.

There is a nice case on page 49 of closure of a median diastema with some small bits of porcelain.

There could be some justification for the case on page 51 to improve the visibility with some porcelain veneers but, likewise, simpler techniques of direct bonding would have had the same effect.

The American and media ‘airhead’ obsession with wider buccal corridors appears on page 53 but, mercifully, without too much in the way of bright red lipstick.

Overall, this book demonstrates just how much one can overprescribe the porcelain technique if one is obsessed by doing ‘no preparation veneers’ and wishes to treat ‘porcelain deficiency disease.’ The book will appeal to some and the photography and layout is certainly of very good quality. What is a lot less impressive is an awareness of the probable need for maintenance and that veneers do not last a lifetime (Burke and Lucarotti. Ten-year outcome of porcelain laminate veneers placed within the general dental services in England and Wales. J Dent 2009; 37: 31–38). The book is very much a testament to the statement that if all you have got is a hammer, everything looks like a nail. There is certainly nothing in here for the thinking dentist but it will probably appeal to ‘airhead’ dentists or gullible patients as an atlas of dental art and nice dental photography. I doubt if a technician will get anything useful out of it technically and clinically as it only offers the briefest of descriptions about the procedures involved.

It is difficult to know at whom this book is aimed. It certainly does not give a balanced view of technique, treatment planning or option planning, including the negative aspects of treatment required for patient consent.

Sadly, the old adage that ‘the front and back of this book are too far apart’ applies.

Martin Kelleher
King’s College Hospital NHS Foundation Trust