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Body Dysmorphic Disorder: a Guide to Identification and Management for the General Dental Practitioner

Abstract: Body Dysmorphic Disorder (BDD) is a relatively common psychiatric condition in which the individual is disproportionately concerned about an aspect of his/her appearance. People with BDD are highly likely to seek cosmetic dental treatment. However, the provision of such treatment is contra-indicated. This article will identify simple techniques for practitioners to screen for and manage patients with BDD.

CPD/Clinical Relevance: This article addresses the management of patients with a specific psychiatric illness who are likely to present for cosmetic dental treatments.

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Throughout the course of our lives, almost all of us have felt dissatisfied with our appearance and tried to improve it. After all, we are hounded by images and messages from all sides telling us that we are not pretty enough or we are not skinny enough. Who wouldn't like a flatter stomach, a more chiselled body, blemish-free skin? If we had the chance to use a magic wand to look better, most of us would. In fact, most of us try on a daily basis. From spending hours in changing rooms ensuring that clothes are as flattering as they can be, going on fad diets, (which just make us miserable) and spending fortunes on the latest moisturising cream promising to knock years off us, we have all tried to alter our image to some degree. However, for some people, these concerns are not just about disliking a body part; they're preoccupied with it. Every waking thought revolves around their perceived flaw and imperfection and their worries about their looks lead to distress and emotional pain, resulting in an interference in their quality of life. They no longer want to go to work for fear that people will notice the slight facial blemishes. They are terrified to go to their high school prom due to concerns that their thinning hair will be noticed. They can't engage in meaningful relationships due to the daily inner voice telling them that their breasts are 'tiny'. In reality, these supposed flaws are usually not noticeable to those around them, or considered minimal. However, for the sufferer, the problem looks repulsive and abhorrent, magnified by the mind's eye.

Such people are considered to suffer from a mental illness known as Body Dysmorphic Disorder (BDD), which is classified under the Chapter of 'Obsessive Compulsive and Related Disorders' in the *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition (DSM-5®).[1]

The criteria used for diagnosis are outlined in Table 1. In previous DSM editions, BDD was classified both as a somatoform disorder and a delusional variant was also classified as a psychotic disorder. However, there was evidence to suggest that these two variants had more similarities than differences and that they were likely to be the same disorder, characterized by a spectrum of insight.[2] As such, DSM V extended the original criteria and added a specifier, indicating the degree

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1. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others. 2. At some point during the course of the disorder, the individual has performed repetitive behaviours (eg mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (eg comparing his or her appearance with that of others) in response to the appearance concerns. 3. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. 4. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Table 1. Diagnostic criteria for body dysmorphic disorder.

Appearance Concerns	Associated Behaviours and Consequences
Nose misshapen	Believes others take special notice Avoids mirrors Had nose surgery
Thinning hair	Excessive hair combing Checks mirrors excessively Social avoidance Avoids haircuts Gets a hair weave
Spectacles	Wears tinted glasses to hide eyes
Hair too curly	Frequent hair perms and straightening Compares self with others
Penis too small	Stuffs shorts and wears shirt down to knees to cover crotch
Breasts too small	Wears padded bras Unable to go to school, work, swim or socialize
Ugly face	Checks mirrors, car bumpers and windows excessively Difficulty interviewing for jobs
Fat waist	Checks mirrors and store and car windows Changes clothes frequently Sits and stands only in certain positions so waist isn't visible under clothing

Table 2. Examples of preoccupations, behaviours and consequences.[28]

of insight regarding BDD beliefs. As a result, the delusional variant of BDD is no longer considered a delusional disorder but rather as a specific form, in which a patient with absent insight/delusional beliefs is '*completely convinced that the body dysmorphic disorder beliefs are true*'.[1] These patients may be challenging to treat, so it is useful to ascertain whether this specifier is relevant at an early stage.

Patients presenting to the dental clinician may well suffer from BDD, with varying levels of insight, and dentists may be the first to spot them. In this review, how to identify when a patient's aesthetic concern is considered 'normal' and when alarm bells should be ringing will be the focus. The best way to manage such patients and advise on the process of referral will also be addressed.

Body dysmorphic disorder: an overview

Prevalence

Body dysmorphic disorder appears to be a relatively common mental health condition, although exact prevalence is difficult to ascertain due to the shame commonly associated with the illness. A number of epidemiological studies have been conducted throughout the years and prevalence rates of between 0.7%-2.4% have been reported amongst different populations.[3–5] It is, however, important to note that prevalence varies, depending on the setting that patients are in. Interestingly, it has been shown that the prevalence rates of BDD in those having cosmetic dental surgery or orthodontic treatment range from 4.2-7.5%,[6] implying that dentists are more likely to encounter sufferers of BDD than the general population.

Clinical features

Amongst sufferers, the body part causing the most distress varies from person to person. However, there are certain areas that are more frequently cited as troublesome than others. These include nose, eyes, ears, balding, genitals and breasts, and it is not uncommon for a patient to have an issue with more than one of these body parts at any one time.[7] Table 2 lists examples of real life concerns from patients suffering with BDD, together with their associated behaviours and consequences.

Veale *et al* found that 86% of patients perceived themselves to have a facial defect, with 12% reporting specific teeth defects,[8] whilst Phillips discovered that 20% of sufferers had concerns with their teeth.[7] As such, it is highly likely that dentists, orthodontists, plastic surgeons and other specialists working in the facial region will become involved with such patients and, thus, need to be aware of their identification and management. Orthodontic examples might include concerns over the size and shape of a patient's teeth, as well as the perceived 'straightness' of teeth, whilst complaints that may present to the general dentist may include dissatisfaction with the whiteness of a patient's teeth.

The high levels of distress experienced by sufferers of BDD can sometimes lead to patients attempting to take their own life. In a study conducted by Phillips it was found that 79.5% of 185 subjects had experienced suicidal ideation and 27.6% had a history of a suicide attempt, which was found to be 45 times higher than levels experienced by the general population.[9] These extremely

Name of Screening Tool	Number of Items	Comments
Body Dysmorphic Disorder Questionnaire[6] (Figure 1)	4 items	■ Easy and brief, so suitable in dental practice ■ High value of sensitivity (94%–100%) ■ High value of specificity (89–93%)[15,16]
Yale-Brown Obsessive Compulsive Scale Modified for body dysmorphic disorder[17]	12 items	■ It rates the severity of BDD symptoms by asking patients to base their answers on the last week ■ First five items relate to thoughts, the second five relate to behaviours and final two assess insight and avoidance ■ Most BDD treatment studies use this scale as it is considered gold standard[18] ■ Less useful in dental practice as it requires specialist training and is lengthy to administer
Cosmetic Procedure Screening Scale[19]	9 items	■ Originally developed to help identify sufferers of BDD who might express dissatisfaction with a cosmetic procedure, but underlying basis may be useful as a screening tool before dental cosmetic procedures ■ This scale has convergent validity, test-retest reliability and acceptable internal consistency ■ This scale also has a high sensitivity for the diagnosis of BDD in those who are likely to seek a cosmetic procedure[19] ■ Although an excellent measure, likely to be unwieldy for use in dental setting
Dysmorphic Concern Questionnaire[20, 21,22] (Figure 2)	7 items	■ This questionnaire doesn't aim to establish a diagnosis of BDD but, rather, to assess Dysmorphic concern as a symptom ■ Although not developed to screen clinically for BDD, it has uses in non-psychiatric clinical settings, such as the dentist, as a brief self-report screening tool
Marks and Matthew Suicidal Ideation Scale[23]	3 items	■ This is a useful screening tool given that BDD is associated with high levels of suicidal ideation ■ It is a quick and easy assessment tool so easy to use in the dental practice ■ Arguably should be used whenever assessing patient for BDD using any of the other tools

Table 3. Screening tools for BDD.

high rates indicate the necessity for dental professionals to spot sufferers and to refer them for psychiatric help immediately rather than carrying out dental treatment.

Assessment of patients

If a clinician suspects that a patient may be suffering from BDD, it is important that a basic assessment is carried out to check if he/she is suitable for dental treatment or whether he/she would be better placed to receive psychological support. In numerous research papers, both dental-related and otherwise, it has been found that those suffering from BDD are rarely satisfied with the treatment they initially sought help for, as the issue is a mental one rather than a physical one.[10] This can have far-reaching effects for dentists treating them, making early detection and appropriate management of paramount importance.[11] Below is a useful guide on how best to assess patients.

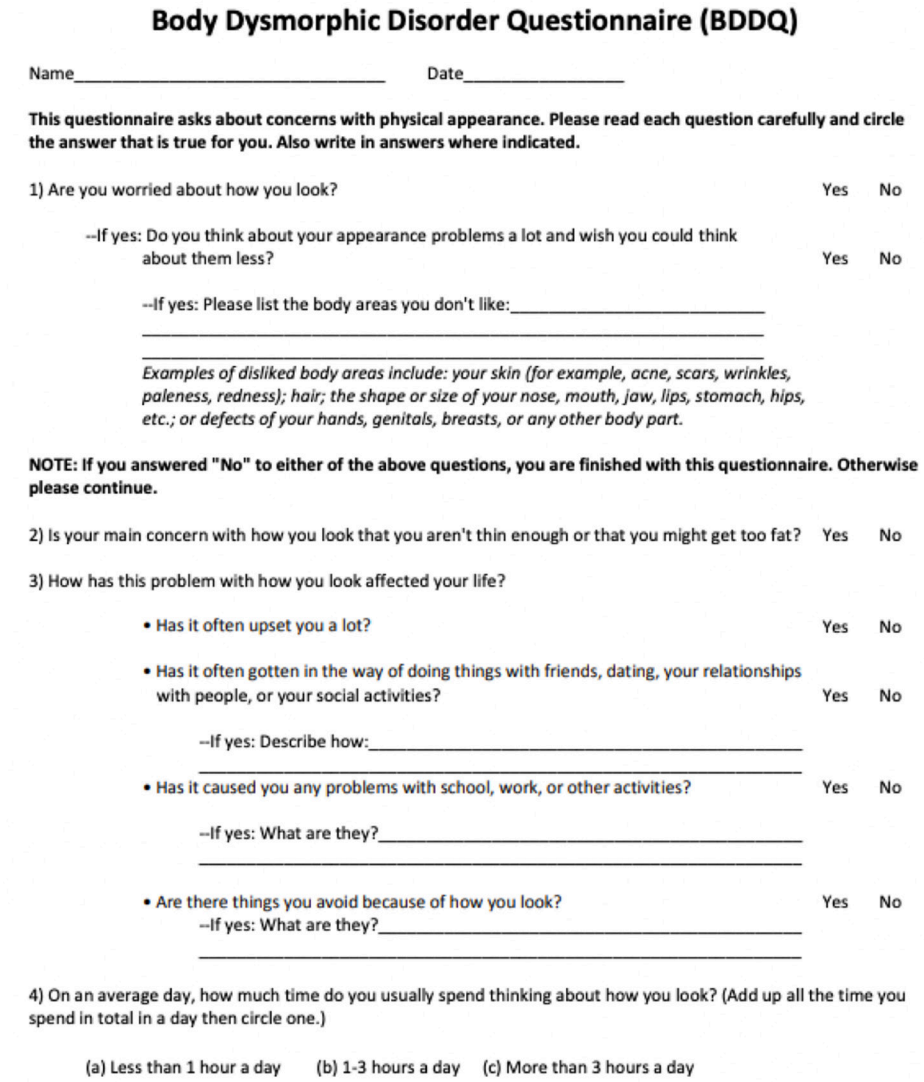
Tip 1: Create a safe environment

Before raising any concerns dentists may have, it is crucial that they follow this step in order to maximize a patient's feeling of security in the dentist and to allow an open and honest dialogue. Dentists should make it clear that any information disclosed will remain confidential unless they feel they are at risk of harming themselves or others. It is also important that the dentist limits the number of people in the room to make the patient feel less intimated.

Tip 2: Schedule a longer appointment time

It is advisable to schedule a longer appointment time than usual as this will allow ample time for discussion, which will reduce the risk of the patient feeling rushed and pressurized.[12] This will maximize the likelihood of making the correct diagnosis and signposting the patient to accessing the correct professional help.

If a new patient presents to the surgery with tell-tale signs of BDD, but there isn't sufficient time to have an in depth discussion with him/her, it is prudent to schedule in another appointment with



Body Dysmorphic Disorder Questionnaire (BDDQ)

Name_____ Date_____

This questionnaire asks about concerns with physical appearance. Please read each question carefully and circle the answer that is true for you. Also write in answers where indicated.

1) Are you worried about how you look? Yes No

--If yes: Do you think about your appearance problems a lot and wish you could think about them less? Yes No

--If yes: Please list the body areas you don't like:_____

Examples of disliked body areas include: your skin (for example, acne, scars, wrinkles, paleness, redness); hair; the shape or size of your nose, mouth, jaw, lips, stomach, hips, etc.; or defects of your hands, genitals, breasts, or any other body part.

NOTE: If you answered "No" to either of the above questions, you are finished with this questionnaire. Otherwise please continue.

2) Is your main concern with how you look that you aren't thin enough or that you might get too fat? Yes No

3) How has this problem with how you look affected your life?

- Has it often upset you a lot? Yes No
- Has it often gotten in the way of doing things with friends, dating, your relationships with people, or your social activities? Yes No

--If yes: Describe how:_____

- Has it caused you any problems with school, work, or other activities? Yes No

--If yes: What are they?_____

- Are there things you avoid because of how you look? Yes No

--If yes: What are they?_____

4) On an average day, how much time do you usually spend thinking about how you look? (Add up all the time you spend in total in a day then circle one.)

(a) Less than 1 hour a day (b) 1-3 hours a day (c) More than 3 hours a day

Figure 1. Body Dysmorphic Disorder Questionnaire.

a larger time allocation. Any treatment which the patient requests should be delayed until this discussion has been carried out rather than carrying out rushed, and potentially damaging, treatment during that first appointment.

Tip 3: Take a thorough medical history

Although many patients suffering from BDD will present to the practice unaware of their condition, some will have already been diagnosed but may be reluctant to divulge this information, especially if not directly questioned about it. Therefore, it is good practice to get into the habit of asking all patients if they have ever been diagnosed with a mental health condition. It is likely that many patients may still not share this information but, by asking the question, there is an increased probability that more will share than if the question wasn't asked. Another useful clue may be to ask patients if they are taking any medications. Many people diagnosed with BDD may be taking antidepressants, with the medication of choice being selective serotonin re-uptake inhibitors,[13] and medication treatment is often essential for more severely ill and suicidal patients. Therefore, a declaration of regular medication may help a clinician build up a more comprehensive image of a patient's background and any underlying mental health issues he/she may have.

Tip 4: Ask yourself whether the distress reported by the patient is proportionate given the extent of the disfigurement present.

It is important to realize that BDD patients attending a dental clinic are likely to want some form of cosmetic dental treatment, such as braces or tooth whitening. As a result, patients might exaggerate or deviate from the truth in an attempt to encourage the dentist to agree to offer treatment.[14] This could skew the assessment results, leading to misdiagnosis. Therefore, it is important that the clinician does not necessarily take the discussion at face value. However, it is also important to realize that patients often have beliefs about their appearance that they may truly feel and, as such, the clinician has to be careful to deny these statements and try to validate the extent of the distress from the stated disfigurement.

Tip 5: Use a screening tool

There are many screening tools available to help establish whether a patient might suffer from BDD. Some are lengthier than others and may not be appropriate for use in a dental surgery. It is recommended that dentists familiarize themselves with all the screening tools available and then decide which one they feel most comfortable with and which they think will be most amenable to their day-to-day practice. It is important to note that these are just screening tools and not diagnostic tools. Dentists are not qualified to make a formal diagnosis of BDD using these tools but they can help determine whether a referral should be made.

A screening tool also means that the decision is based on a relatively objective measure in addition to clinical opinion. Ideally, a formal diagnosis will be made following a face-to-face interview with a trained clinician. Examples of commonly used screening tools with information on their scoring system and uses can be found in Table 3, with samples of some of the questionnaires included displayed in Figures 1-3.

Table 4 provides two

Dysmorphic Concern Questionnaire

Have you ever:				
1. Been very concerned about some aspect of your appearance?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)
2. Considered yourself misformed or misshapen in some way (e.g. nose/hair/skin/sexual organs/overall body build)?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)
3. Considered your body to be malfunctional in some way (e.g. excessive body odour, flatulence, sweating)?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)
4. Consulted or felt you needed to consult a plastic surgeon/dermatologist/physician about these concerns?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)
5. Been told by others/doctor that you are normal in spite of you strongly believing that something is wrong with your appearance or bodily functioning?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)
6. Spent a lot of time worrying about a defect in your appearance/bodily functioning?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)
7. Spent a lot of time covering up defects in your appearance/bodily functioning?	Not at all (0)	Same as most people (1)	More than most people (2)	Much more than most people (3)

Figure 2. Dysmorphic Concern Questionnaire.

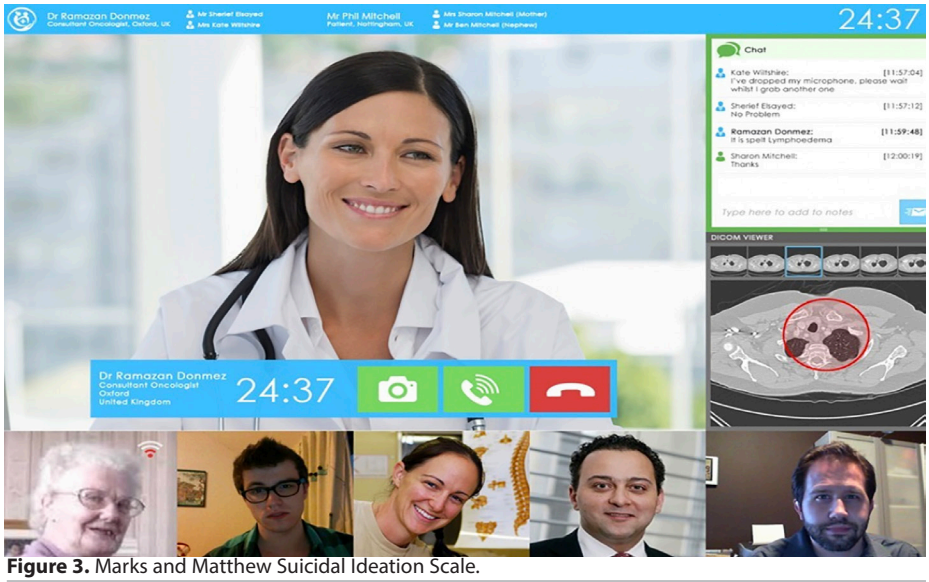


Figure 3. Marks and Matthew Suicidal Ideation Scale.

examples of possible cases of BDD, identifying the key features as they may present in dental practice.

Is it safe to carry out the treatment?

The short answer is no. Instead, the patient should be referred for specialist psychological support. Once this has been undertaken, it will become clear what dental treatment, if any, is appropriate. The reasons for this are discussed in more detail below.

Treatment is bad for the patient

A patient presenting to a dentist in obvious distress about a perceived defect and a convincing argument as to why he/she needs treatment can be difficult to refuse. However, numerous studies have been conducted over the years which have demonstrated that surrendering to the patient's requests have not benefited the patient at all.

One such study, conducted by Phillips *et al*, found that more than two-thirds of patients who received physical treatment with no accompanying psychiatric support experienced no alleviation or worsening in their BDD symptoms, usually because the patient's concerns had simply been transferred to another body part or he/she was worried that the improvement would get worse again.[24] In this particular study, only 7.3% of all treatments resulted in both a decrease in concern with the treated body part as well as an alleviation in BDD symptoms. Similar findings were reported by Crerand *et al*, in which 91% of patients experienced no change in overall BDD symptoms after treatment[25] and Veale *et al*, in which 81% of patients who had sought a consultation or operation were dissatisfied or very dissatisfied.[8] These findings are clear indications that provision of the requested treatment is clearly not in the patient's best interest when he/she is suffering from BDD.

Treatment is bad for the dentist

Unfortunately, not only can treating BDD patients be detrimental to the patient themselves, but it can also prove detrimental to the treating clinician as a result of the patient's unattainably high standard, of which the dentist will almost always fall short. As a consequence of the perceived failure to improve a patient's image, it is not uncommon for him/her to attempt litigation against his/her clinician. In 2001, all members of the American Society for Aesthetic Plastic Surgery (ASAPS) were emailed the '2001 Body Image Survey', of which 265 members responded. The survey revealed that 40% of respondents had been threatened by a patient suffering from BDD; 29% had been threatened legally, 2% physically and 10% both legally and physically.[26] It is important to be aware that legal action may be taken against a clinician, even when consent has been taken, as demonstrated in the Lynn vs Hugo case of 2001.[27] Although the patient didn't succeed in her claim, it raised the interesting, and potentially concerning point that patients suffering from BDD may well be declared unfit to consent due to their impaired mental ability. This may well result in a clinician being found liable in a court of law, emphasizing how critical it is not to proceed with treatment when BDD is suspected, but rather to signpost a patient towards psychiatric or psychological services for further treatment.

Concerns about talking to patients about BDD

It is natural that a dentist will feel uncomfortable talking with a patient about what is potentially a serious psychiatric diagnosis. However, it is important to bear in mind the following:

1. The dentist is acting in the best interests of the patient: Although the patient may feel that the dentist is being vindictive and certainly doesn't appreciate that this

Miss A, aged 30 years, presented at an orthodontic clinic requesting treatment for her 'crooked' upper anterior teeth. She also felt her teeth were too yellow and was keen to discuss tooth whitening. She was generally anxious in the dental surgery. She had a Class I occlusion with moderate crowding and an average overbite. A number of teeth showed signs of erosion. The orthodontist advised her that fixed braces would be required for a period of 2 years to correct her crowding and bite with extractions required to alleviate the crowding. Miss A described how she could not abide a gap during any of the treatment and asked again about tooth whitening. Miss A was currently working and had an active social life. She had joined a dating website and regularly went on dates. She was very unhappy with the appearance her teeth and keen to correct the crowding and improve her appearance. She had looked on the internet about the possibility of having braces.	Mr B, aged 28, was referred to the orthodontic department by his dentist for an assessment of his Class II division 2 malocclusion with increased overbite. He had recently registered with the GDP and at his first appointment discussed the issues concerning him, prompting the referral. On examination Mr B had a significant skeletal II background with increased overbite, complete to the palate and retroclined upper labial segment. His teeth were in good condition and his oral hygiene excellent. Further discussion during the examination revealed that Mr B was also concerned about the appearance of his chin and deep groove under his bottom lip. Mr B was married and unemployed. He placed much emphasis on the importance of an anterior bite and stressed how he felt his facial appearance gave him a lack of self confidence, and may be related to his difficulty in finding employment. He had looked on the internet for information on osteotomies.
Additional Medical History	
Miss A was on no current medication and had been hospitalized as a child for tonsillectomy. She had previously been diagnosed with an eating disorder, for which she had received psychiatric treatment. She attended a GDP in the area for some time and had little more than check-ups in that time. She had not had any treatment for her erosion but was aware that it was linked to her previous eating disorder.	*Mr B was allergic to Penicillin and was taking fluoxetine. He had undergone surgery twice in the previous four years, having been administered a General Anaesthetic on both occasions.* *He registered with this dentist recently although had been living in the area some time, and on closer questioning revealed that he had seen a number of dentists in the area, including another orthodontist, about the possibility of an osteotomy.*
Overall Assessment	
Miss A clearly has a history of psychiatric illness, which is often a co-morbidity in BDD, though note that a diagnosis of an eating disorder would normally exclude a co-existing diagnosis of body dysmorphophic disorder. This case suggests a failure of communication and a difference in priorities between the dentist and the patient. For a single woman in her 30s, appearance is a key issue and it is understandable that the patient is concerned about the appearance of her teeth. There is little evidence that her concerns are disproportionate and her questioning about the process of orthodontics highlights her lack of information to date rather than unrealistic expectations per se. Further information about her psychological state (including depression and suicidal ideation) would be important to ascertain as well as information on any impact of the perceived defect on her daily life (though note she has a good social life and is working).	Mr B, though attending for a seemingly appropriate treatment, shows many features of body dysmorphic disorder. His concerns that the appearance of his teeth and chin is preventing him getting a job are disproportionate to the actual problem. Accessing information on the internet is an accepted background in many instances, but may be an indication of preoccupation with a condition or treatment. Discovering that he has seen someone else about the possibility of an osteotomy is also an indication of his preoccupation with appearance. He has had surgery twice in the previous four years. It would be important to ascertain what this was for and whether it could conceivably be connected to body dysmorphic disorder. He is taking an anti-depressant medication suggesting low mood, a symptom of body dysmorphic disorder. It would be important to gain further information about his psychological state, including any suicidal ideation.

Table 4. Examples of possible cases of body dysmorphic disorder.

is in their best interest, in the long run, he/she will hopefully come to realize this. Even if not, a dentist should be reassured that he/she is doing the right thing and shouldn't be disheartened if he/she experiences animosity and aggression from the patient.

2. It is likely that the patient is experiencing distress: Try to focus on the fact that the patient could benefit from help. A phrase that is often helpful is, 'The solution to your stress is not further dental treatment at this time'. Perhaps combined with focusing on the future, 'Once you feel in a better place in terms of your worries and anxieties, that is a much better position for us to think about what dental treatment you need'.

3. The dentist is not alone: When faced with a difficult patient, it can sometimes

be overwhelming and clinicians may feel that they have been backed into a corner with no support. This can leave them feeling anxious and worried about potential repercussions they may if they give in to the patient. Keep good notes, and speak to a representative of your defence organization or a colleague.

Making a referral

Guidance from the National Institute for Health Care Excellence recommends that, in the majority of cases, the most appropriate care can be provided in primary care settings, so referral to the individual's General Medical Practitioner should be considered as the first step. Alternatively, the dental team may consider a direct referral to clinical psychology services. Furthermore, there are some considerations which might suggest that it is appropriate to seek urgent support from psychiatric and psychological services. This is particularly the case if the patient has expressed suicidal thoughts. Where such thoughts are current, emergency referral to psychiatry via Accident and Emergency services should be made.

When writing a referral letter, there are certain key points a dentist should make sure to include:

- Patient's name;
- Patient's date of birth;
- Patient's address;
- Any dental problems;
- Any treatment performed;
- Concerns the dentist may have including findings from any screening tools;
- Recommendations for onward referral.

It is important that the patient is aware that the referral letter is being made and that permission has been granted. If a patient refuses to allow the clinician to send the letter, the dentist can still make a referral if he/she feels that the situation is sufficiently concerning to warrant such a step, for example if there is danger to the patient (such as suicidal ideation) or to others.

As with all treatment, it is crucial to keep very careful contemporaneous notes with a detailed record of any referrals that may have been made. This will be particularly important if referral is made without consent. The reasons for taking these steps should be clearly documented.

Conclusion

Body dysmorphic disorder is a distressing psychiatric illness where the individual is disproportionately concerned about his/her appearance. People with BDD are likely to present for cosmetic dental treatments. Dental practitioners should be equipped with techniques for screening individuals for BDD, discussing their concerns with patients and making appropriate referrals.

Useful Resources for Clinicians

1. For further information on BDD, including relevant reading and online questionnaires, see the Body Dysmorphic Disorder Foundation **http://bddfoundation.org/**
2. For guidance on assessment of people with BDD, see Cunningham SJ, Feinman C. Psychological assessment of patients requesting orthognathic treatment and the relevance of body dysmorphic disorder. *Br J Orthod* 1998; **25**: 293–298.
3. 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/CG31**
4. For a patient friendly website if wanting to offer patients a place that will understand them, see 'Mind' and direct them to the BDD specific section **https://www.mind.org.uk/information-support/types-of-mental-health-problems/body-dysmorphic-disorder-bdd/#.WZHLpXeGPOQ**

Compliance with Ethical Standards
Conflict of Interest: The authors declare that they have no conflict of interest.
Informed Consent: Informed consent was obtained from all individual participants included in the article.

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