

Case report

When the mirror lies: body dysmorphic disorder

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Summary

Body dysmorphic disorder is a chronic disorder involving imagined or partial appearance defects that lead to significant impairment in everyday life. It is quite prevalent but often remains a clinically under diagnosed psychiatric condition. Severe cases of the body dysmorphic disorder were often camouflaged by concurrent diseases like major depressive disorder, obsessive-compulsive disorder, substance use disorder and social anxiety disorder. The case presented here was a 17-years-old boy who was previously diagnosed as a case of obsessive compulsive disorder. The constellation of symptoms prompted evaluation for body dysmorphic disorder and subsequently targeted treatment. This case report highlighted the complexities associated with diagnosing and providing treatment of body dysmorphic disorder.

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Introduction

Italian physician Enrique Morselli first described body dysmorphic disorder (BDD) in 1891 by using the term dysmorphophobia, defined as the fear of having a deformity.¹ It is characterized by preoccupation with an imagined defect in one's appearance. Alternatively, there may be a minor physical abnormality, but the concern is regarded as grossly excessive. The most frequent areas of concern are the face and head, and the main worries are related to problems such as acne, wrinkles, scars, the size and shape of the nose or ears, asymmetric or disproportional face or excessive facial hair.² BDD has high co-morbidity rates with mood disorders, anxiety disorders (most commonly social anxiety disorder and obsessive-compulsive disorder), substance use disorders and eating disorders.³ Those with early-onset BDD (diagnosed at age 17 and younger) were more likely to have a gradual onset, severe symptoms, and a history of physical violence due to BDD and psychiatric hospitalization.⁴

The current prevalence of BDD is 1.8% and individuals with BDD, relative to individuals without BDD, reported significantly more often a history of cosmetic surgery (15.6% vs. 3.0%), higher rates of suicidal ideation (31.0% versus 3.5%) and suicide attempts due to appearance concerns (22.2% versus 2.1%).⁵ It was found that in cases with BDD just providing the diagnosis and psycho education and cognitive behavior therapy (CBT) was more effective than pharmacotherapy.⁶ Here was a case of body dysmorphic disorder where he was diagnosed as a case of obsessive-compulsive disorder (OCD) previously who later improved with psychotherapy combined with pharmacotherapy.

Case summary

A 17-years-old unmarried Muslim male student was brought to tertiary psychiatric hospital in Bangladesh for excessive repeated thought about own physical appearance along with repeated mirror checking, violent and aggressive behaviors with minor provocation and sudden anger outbursts for 2 years. Despite being a decent looking guy, he constantly felt he had flawed nose, beard area and shoulders and kept nagging about it repeatedly. He would check mirror for countless times, kept troubling his mother and sister with probing questions about his looks. He kept checking mirror up to a point that he did it in the midnight and awoke his mother and sister to support his queries. With the increasing bothering, both the mother and sisters started disagreeing with him out of annoyance and frustrations. As a result, he became violent and aggressive, occasionally started hitting them. Gradually the situations worsened with his increasing symptoms, where he started breaking things suddenly out of anger both in his home and irrespective of wherever he was. He became nude in front of family members on 2 occasions during his anger outbursts. He started thinking everyone was talking about his appearances and called him fat even no one actually did. He got some psychiatric medications but did not experience any change. He lived within the household of a member of 5 including the parents, him and his 2 other siblings. All the other family members were physically healthy. However, his youngest paternal uncle was a diagnosed case of OCD whereas his maternal uncle and grandfather also had mental illness. He was delivered by caesarean section due to prolonged labor with a normal developmental history. He was a difficult child showing tantrums since early age. He also suffered from hepatitis A at age 7. No

substance history was reported other than smoking. There was history of frequent school changes for different reasons mostly due to adjustment issues in the beginning and then corona virus disease (COVID) 19 situations and then because of his thinking that other students talked about his looks. On mental state examination, he seemed to be dressed according to the social and cultural way, maintaining a good hygiene, repeatedly brushing his hair with hands in an attempt to keep them set in a place. On eliciting thought, ideas of reference were present, but no obsession, delusion, suicidal or homicidal thoughts or perceptual abnormalities were found. Initially although did not think he had any mental illness and only preoccupied with his looks, later he wanted to try medications, half convinced about having a mental illness. He was diagnosed as a case of body dysmorphic disorder. After some routine investigations, fluoxetine 20 mg (up to 40 mg a day), aripiprazole 10 mg and lorazepam 1 mg were given. Three sessions of psychotherapy were given on inpatient basis where psycho education was given to family members and patient. Family members were told about withdrawal of inappropriate reinforcement and provocation. The therapist invested a large amount of time in training to increase coping abilities. Cognitive behavioral therapy (CBT) was given before his discharge from the hospital. Patient was compliant to drug, took psychotherapy sessions, came for follow up and showed quite an improvement.

Discussion

Patients with body dysmorphic disorder were often under diagnosed or misdiagnosed in clinical settings due to co-morbid psychopathology masking the underlying condition. In a study, major depression was present in 75%, social anxiety disorder in 40%, substance use disorders in 30-50% and OCD in 33% of patients with BDD whereas it was said that they also tended to develop cluster C personality disorder.⁷ Even after making the diagnosis of BDD, the course of illness was further perplexed somewhat because of the patient's response to therapy.

Inpatient admission might be needed when an individual with BDD was not able to keep up with daily responsibilities or posed immediate risk or danger to themselves or others.^{3,8,9} BDD was commonly missed in these patients or could be misdiagnosed as OCD due to the similarity of BDD's and OCD's characterization of obsessions and compulsive behaviors like previously said. This was what happened in this particular case. He was first diagnosed as a case of OCD, then for his extreme behavioral disturbances was admitted to hospital and then was re-evaluated and later got a diagnosis of BDD. Initially it was difficult to be sure about if the nature of his aggression needed to be addressed separately as it was repeatedly occurring. But later any other diagnosis was ruled out. Treatment during admission consisted of targeted interventions focused on achieving immediate goals and stabilization. Successful treatment and remission of BDD required patients to develop skills in identifying maladaptive thoughts and cognitive errors, restructuring cognitions and core

beliefs, behavioral experiments and strategies, relapse prevention and access to post treatment booster sessions. This was the aim that the patient was provided CBT besides his pharmacological management. By giving the patient psycho education, cognitive restructuring and exposure and ritual prevention as per findings of effectively from studies.¹⁰ The need to educate the family about the disease, its course and how to behave and handle the situations were vital and therefore given much importance. BDD was a disorder with poor prognosis.¹¹ So needless to say, much attention should be given to ensure follow ups.

Conclusion

Body dysmorphic disorder can cause horrendous suffering and poor functioning in many aspects of life. It is important to recognize characteristic symptoms that prompt investigation of BDD rather than assume other conditions are responsible for the patient's current presentation. This will help to implement an appropriate treatment regimen targeting BDD specifically.

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