Adv Gen Pract Med, 2019, 2(1): 13-15
DOI: 10.25082/AGPM.2019.01.004

CASE REPORT

A complex presentation of body dysmorphic disorder, social phobia and unresolved grief

D.A. Lachmansingh

Abstract: This case is a complex presentation of Body Dysmorphic Disorder (BDD), social phobia and unresolved grief in a 23 year old male with no social support. He appears to have benefitted immensely from a combination of Cognitive Behavioral Therapy (CBT), antidepressant medication and Occupational Therapy. Identification of patients with BDD presenting in surgical and medical practices is essential and can be facilitated by validated screening tools such as the Body Dysmorphic Disorder Questionnaire (BDDQ). At the moment, the best evidence-based treatment is CBT and Selective Serotonin Reuptake Inhibitors (SSRIs). Nonetheless, novel approaches to therapeutic applications include the investigation of eye-tracking focus on body parts in BDD.

Keywords: Body Dysmorhic Disorder, social phobia, CBT, eye-tracking focus

1 Case

A 23 year old male college student, was referred to our Psychiatric Services by his GP for obsession of appearance. His primary complaint was an adamant necessity to have corrective rhinoplasty.

The patient perceived to have a bump on his nasal ridge. A few weeks prior to assessment by our services, he attended a consultation with plastic surgeons. They felt that a psychiatric review was warranted prior to considering any surgical intervention.

During the mid teens, he reported the occurrence of an incident involving a close member of his family inflicting physical trauma resulting in a "bump" on his nose ridge thereafter. Since then, the patient has been fixating excessively and now wishes to have a rhinoplasty. He has a fixed, firm belief that his problems will be solved upon completion of the surgery. It is his impression that there would also be a return of his confidence and self esteem.

Over the past two years, the student grew a very long fringe to hide his nose, owing to a degree of perceived ridicule from colleagues. He admitted finding it hard to socialize with others owing to said deformity. Additionally, avoidance and anxiety features were described. These included being socially isolated, being dependent on and unable to leave his house without the company of his mother. The patient was unable to commute independently via public transportation. He had no physical or telecommunication contact with anyone. He was unable to eat publicly in restaurants/cafes and could not engage in sporting activities. Staying up until the early hours of the morning while engaging in "online computer gaming", was his only interest. However, he never displayed a picture of himself on his gaming profile.

The student voiced discomfort when individuals looked at his face or made eye-contact. Nevertheless, he denied any fear of fatness, but did have a thin physique. He also denied any actual self harm or intent, symptoms of depression and symptoms of hallucinations.

There was no previous psychiatric history and prior to this presentation, the patient was taking no psychotropic medications. Additionally there was no known history of deliberate self harm.

According to his mother, the patient's father was described as being quite "aggressive". There were a number of physical altercations between the patient and his father, who died of a Myocardial Infarction (MI) 3 years ago. With regards to other elements of the family history, his mother is well with no known psychiatric illness and the patient has no siblings.

Upon moving from a North American country at age 8, the patient was enrolled in school. He progressed well from primary to secondary education and completed his school leaving certificate examinations (high school

Received: July 6, 2019 ; **Accepted:** July 23, 2019; **Published:** July 25, 2019

* **Correspondence to**: D.A. Lachmansingh, Department of Psychiatry, St. Stephen's Hospital, Glanmire, Co. Cork, IRELAND; Email: davidlachmansingh@yahoo.com

Citation: Lachmansingh DA. A complex presentation of body dysmorphic disorder, social phobia and unresolved grief. *Adv Gen Pract Med*, 2019, **2**(1): 13-15.

Copyright: © 2019 David Antoine Lachmansingh. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

diploma equivalent). However, he made very few friends and was always on the periphery of social groups and cliques. Regarding further education, an attempt at attending a course in Physical Therapy was made, however this was abandoned after a month owing to a reportedly perceived “flare-up” of a skin rash while the patient was massaging a subject. The patient did indicate that he suffered from urticaria and this was also communicated to us by his GP. There has been no known diagnosis of Autism or specifically Asperger’s Syndrome. He denied any use of alcohol, tobacco or illicit substances as well as any forensic history.

With regards to his social situation, he currently lives with his mother. He has no friends or family in the country. A collateral history from his mother (with the patient’s permission) indicated that the he had become totally isolated and dependent on her. She noted that specific anxiety problems existed along with a complicated bereavement for the patient’s father who had died recently.

An overall risk assessment was non-contributory as there had been no significant risk of dangerousness, self harm or vulnerability. There was no apparent risk of self-neglect, however it should be noted that without the help of his mother, the patient would be unable to feed himself an appropriate diet or budget financially.

On examination, the patient appeared to be thin on appearance with his hair grown in an extremely full fringe hiding the upper part of his face. Though being timid in manner, there was an adamant element especially when addressing his wishes for rhinoplasty. He was found to be anxious and mildly depressed. He displayed no thoughts of self harm and there was no evidence of any thought disorder or apparent perceptual disturbances. His insight into understanding his mental difficulties was partial.

Most likely, this was a complex case of Body Dysmorphic Disorder (BDD), social phobia and unresolved grief in a young man with no social support.

Initially the patient was referred for CBT and Social Activation and was also commenced on escitalopram 10mg once daily. Logically, cosmetic surgery would have been inappropriate at the time of presentation.

So far, he is engaging and has completed more than 2 months of Cognitive Behavioral Therapy (CBT). He feels less anxious and is able to take on more responsibilities from his mother. His resistive attitude as displayed earlier has dissipated, and remarkably he has voiced less interest for surgery. He is still taking the said dosage of escitalopram and has also benefited immensely from Occupational Therapy. Our services are continuing to provide him with support.

2 Discussion

BDD is commonly diagnosed with co-morbidities, particularly anxiety disorders e.g. social phobia, as well as depressive disorders and so on and so forth[1,2]. In this case however there is an added component of grief. Though there seems to be a lack of studies investigating grief in BDD, it would be reasonable to infer that this patient’s grief could be both a predisposing and perpetuating factor for his current condition.

In the cosmetic surgery setting, rates of up to 15% of BDD patients have been reported[3]. Many of these patients have poor outcomes - both in terms of satisfaction with surgery as well as psychological wellbeing. Numerous studies have supported this, and have also indicated increased rates of aggression towards surgeons[4]. Such patients are also at increased risk of finding/perceiving further deformities unrelated to the primary complaint. As a result of these challenges, there is a necessity for healthcare professionals at surgical practices to accurately identify patients with BDD[3,4]. This is essential in order to provide said patients with appropriate psychiatric care and psychological support.

A useful tool that can be used to help screen for BDD is the Body Dysmorphic Disorder Questionnaire (BDDQ). Despite being validated in the facial plastic surgery patient population, and having a sensitivity of 100% and specificity of 90.3%, its use may not be very popular amongst surgeons. It has been suggested that routine implementation of a useful screening tool such as the BDDQ may result in more accurate detection of the problem and hence improved patient care[4].

Mentioning patient care, the treatment of choice for BDD is CBT[5], and there was no hesitation in considering this for the above patient. However, not all patients benefit from CBT alone. Selective Serotonin Reuptake Inhibitors (SSRIs) are the established medication of choice in patients with BDD[7]. They tend to work well in combination with CBT for those patients who respond poorly to the latter only. In cases where there is treatment resistance and significant impairment of daily function leading to risk of self neglect etc, augmenting antipsychotic agents can be considered. Nonetheless there seems to be a lack of evidence comparing these to SSRIs. Further research aimed at investigating eye-tracking focus, on affected body parts in BDD, has been suggested. This provides hope for the development of further therapeutic applications[?].

One should appreciate that a diagnosis of BDD does not automatically contraindicate surgery. Depending on the circumstances and especially on a case by case basis, occasionally surgery and psychiatric care, with or

Advances in General Practice of Medicine © 2019 by Syncsci Publishing. All rights reserved.

without intensive psychological support may be recommended[4].

3 Conclusion

So in conclusion, BDD may manifest in a complex fashion and early detection is critical for prompt psychiatric care. This can be facilitated by screening tools such as the BDDQ in surgical settings where there is a reasonable clinical suspicion. Finally there is robust evidence for current psychological and pharmacological treatment practises, however further research efforts are being conducted in an effort to develop future therapeutic options.

References

[1] Phillips KA. Body dysmorphic disorder: Recognizing and treating imagined ugliness. World psychiatry: official journal of the World Psychiatric Association (WPA), 2004, **3**(1): 12-17.

[2] Jafferany M, Osuagwu FC, Khalid Z, *et al*. Prevalence and clinical characteristics of body dysmorphic disorder in adolescent inpatient psychiatric patients - a pilot study. Nordic Journal of Psychiatry, 2019, **73**(4-5): 244-247. https://doi.org/10.1080/08039488.2019.1612943

[3] Kerfant N, Henry AS, Ta P, *et al*. Body dysmorphic disorder and aesthetic surgery: A systematic review. Annales De Chirurgie Plastique Et Esthetique, 2015, **60**(6):512-517. https://doi.org/10.1016/j.anplas.2015.06.003

[4] Joseph AW, Ishii L, Joseph SS, *et al*. Prevalence of Body Dysmorphic Disorder and Surgeon Diagnostic Accuracy in Facial Plastic and Oculoplastic Surgery Clinics. JAMA Facial Plastic Surgery, 2016, **19**(4): 269-274. https://doi.org/10.1016/j.anplas.2015.06.003

[5] Greenberg JL, Phillips KA, Steketee G, *et al*. Predictors of Response to Cognitive-Behavioral Therapy for Body Dysmorphic Disorder. Behavior Therapy, 2019, **50**(4): 839-849.

[6] Dong N, Nezgovorova V, Hong K, *et al*. Pharmacotherapy in body dysmorphic disorder: relapse prevention and novel treatments. Expert Opinion on Pharmacotherapy, 2019, **10**: 1211-1219. https://doi.org/10.1080/14656566.2019.1610385

[7] Toh WL, Castle DJ and Rossell SL. How individuals with body dysmorphic disorder (BDD) process their own face: a quantitative and qualitative investigation based on an eye-tracking paradigm. Cognitive Neuropsychiatry, 2017, **22**(3): 213-232. https://doi.org/10.1080/13546805.2017.1300090

Advances in General Practice of Medicine © 2019 by *Syncsci Publishing*. All rights reserved.