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Two Sides of a Face is not Equal – A Case Study

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Abstract

Body dysmorphic Disorder is characterized by a preoccupation with an imagined or exaggerated defect in physical appearance that causes significant distress or impairment in important areas of functioning. A slight anomaly is excessive and bothersome to the patient. One Study found that an average patient had concerns about four body regions during the course of the disease. " The body dysmorphic disorder patient is really miserable in the middle of his daily routines, conversations while reading, during meals, in fact everywhere and all the time worried by the fear of deformity which may reach a very painful intensity even to the point of weeping and desperation" (Enirico Morselli-1981). We present a case study of a woman who had experienced similar symptoms and reported that her both cheeks are not equal in shape and falling down.

Keywords: *Body dysmorphic Disorder, Body dysmorphic syndrome, Dysmorphophobia.*

Introduction

Body dysmorphic Disorder (BDD) or Dysmorphophobia is a severe psychiatric illness. The most common age of onset is between 15 to 30 years and women are affected more than men. Patients with BDD have a belief that one's appearance is defective, thoughts are pervasive and intrusive.[1] It is characterized by the exaggerated belief that the body is deformed or

defective. The most common concerns involve imagined or slight facial flaws. Other body parts concerns are hair, breasts, genitalia and some aspects of the nose, ears, eyes, mouth, lips or teeth.[2] Symptoms of depression, anxiety, ideas or delusion of reference, suicidal thoughts, obsessive and compulsive personality are common in patients with BBD. The patient excessively engaged in mirror checking avoidance reflective surfaces or attempts to hide the presumed deformity with make up or clothing. They develop significant social and occupational impairment and some patients may become house bound while some commits suicide. The person's medical history may reveal several visits to Plastic surgeons and Dermatologists to correct the imagined defect and may undergo unnecessary surgical procedures.[3]

The disorder was recognized and named as dysmorphophobia more than hundred years ago by Email Kraepelin who considered it a compulsive neurosis. Pierre Janet called it ob de la honte du corps (obsession with shame of the body). Freud wrote about the condition in his description of the wolf- man who was excessively concerned about his nose. Dysmorphophobia was first included in somatoform disorder in DSM – III in 1980. It was first documented in 1981 by Enrique Morselli who dubbed the condition dysmorphophobia.[4] In DSM IV – TR, BDD may be identified with the following essential features.[5]

a) Preoccupation with an imaginary defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
b) The preoccupation causes clinically significant distress or impairment in social, occupational of important areas of functioning.
c) The preoccupation is not better accounted for by another mental disorder (i.e. dissatisfaction with body shape and sized in anorexia nervosa).

In the DSM-V (2013), BDD is grouped in a new category; i.e. Obsessive Compulsive Spectrum. The DSM-V also includes operational criteria such as repetitive behaviors or mental acts and notes that subtype muscle dysmorphia which involves belief that one's body is too small or not muscular enough.

Case Report

Mrs. C. a 35 year old female, house wife, living with her mother-in- law, two daughters and husband, belongs to lower-middle socio economic status, attended our psychiatric OPD with the chief complaints that both of her cheeks are not in proper shape and size and falling downwards for which she cannot live peacefully. She has no interest in her daily activity, crying most of the time, can't mix with others, not attending social gatherings, not sitting in her own shop and repeated suicidal thoughts.

One day she felt that the left cheek was in proper place but when she suddenly yawned and saw that her right cheek is fell down. Typical complaint is if her left cheek is falling down, the right cheek is moving up and vice-versa. She experienced this

since last one and a half year. She had been preoccupied with her appearance and about 7 to 8 hours/day she was checking her face in mirror and comparing her cheeks. She asks her family members several times whether she looks fine, but she is not satisfied by their responses. She thinks that others are looking at her, family members are not observing her face properly and if she asks they are laughing at her by telling that she has gone mad.

She can not concentrate on her domestic work, not able to sit her own shop, avoids social interaction and gatherings. She reported feeling of anxiety, depression, shame and embarrassment and feels that her life is valueless. Before coming to psychiatric OPD she had consulted 3 Neurologists but no benefit. Rather after taking medicine she felt that her body was heavy, swelling and both the cheeks started moving in opposite direction very fast.

Management

Combination of cognitive behavior therapy (CBT) and SSRI was started to promote the social functioning of the patient was evaluated by modified BDD – YBOCS, HAM-A, HAM-D, BDI-II and MARDS. The scores revealed severe severity level of preoccupation, interference, distress, resistance of obsessions and compulsive behavior, poor insight, depression, and anxiety.[6]

The patient was educated regarding the disorder, its nature, symptoms, ways to identify irrational thoughts and related compulsive behaviors. She was taught to identify maladaptive thinking about her appearance and cognitive errors, challenging these negative thoughts for their validity and accuracy and restructuring new rational beliefs. Behavioral intervention begin with preparing a list of difficult situations for which patient would typically use a compulsive response to fear. Patient was exposed to the social situations and helped to decrease mirror checking behavior. She was taught gradual shifting of focus from symptoms to personal and social problems by gradually exposing to anxiety provoking situations. Exposure and response prevention (ERP) also taught to the patient by helping her to learn strategies to eliminate avoidance and ritual behaviors such as comparing with others, reassurance behaviors and excessive mirror checking. Homework assignments were given in between sessions in order to help to master new skills. Her family members are also included in the family therapy. CBT was found effective in improving BDD symptoms and other associated symptoms like anxiety, depression, insight, self esteem and body image.[7,8] At present she is doing well.

Discussion

BDD is a chronic condition which results in significant social and psychological handicap. Obsession thoughts make ruminations about the deformities. Comorbidities included mood disorder, anxiety disorder, OCD, and personality disorders. Therapist faces challenges while treating patients with CBT, as many are insufficiently motivated for treatment because of poor insight. In this case motivational interviewing technique and habit reversal training

were used. Inter personal therapy (IPT) sessions helped the patient to reduce interpersonal distress, poor self esteem, depression, anxiety and body image concerns. Combination of CBT and SSRIs showed best results in this case.

Conclusion

It is a small attempt to highlight the clinical pictures and the influence of perfectionism on psychological wellbeing. Patients with BDD generally visit dermatologist, plastic surgeons and dentists due to lack of insight. There should be a proper referral to mental health professionals to reduce unnecessary sufferings and chonicity. These patients should be treated with combination of CBT and SSRI rather than antipsychotics.[9]

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