In the Mirror: Depression With Dysmorphia and Obsessive-Compulsive Disorder

To the Editor: Body dysmorphic disorder (BDD) characteristically presents with excessive, debilitating, and persistent preoccupations with a perceived defect or flaw in appearance.[1–3] Symptoms often impair normal functioning but may not be revealed unless the patient is asked directly about perceived defects. Concerns most commonly include the skin, hair, lips, nose, and chin.[1,4] People with such obsessive-compulsive behaviors often have somatic complaints regarding skin, hair, or facial features. Complaints can become chronically recurrent, debilitating, and delusional.[1,2,5]

Diagnostically, BDD is included in *DSM*-5 under obsessive-compulsive disorder (OCD) and related disorders due to overlap in phenomenology, treatment protocol, and reponse.[6] BDD is often comorbid with major depressive disorder (MDD), social anxiety disorder, and obsessive disorder.[7] The prevalence of BDD in the general population is about 2% and around 6% among psychiatric patients.[1,2,4,8] BDD can incur significant costs to patients and the health care system from elective surgical or cosmetic procedures to improve perceived disfigurements.[1,2,4,8]

Patients with BDD often present with a history of eating disorders, OCD symptoms, anxiety, or depression, which necessitates a comprehensive evaluation. Untreated, it can cause functional impairment in occupational, social, and academic settings, with distress, shame, disability, and suicidality.[1,8–10] People with BDD exhibit impaired decision making, response inhibition, decreased attentional set-shifting, and difficulty with emotional processing.[11] These deficits may impair affective processing, increase impulsivity, and yield cognitive dysfunction. Affected individuals have a high risk for completed suicide.[11]

Case report. A 44-year-old woman with diagnoses of OCD and BDD presented for evaluation of depression with suicidal thinking. She was performing mirror-checking behaviors for over 8 hours daily and met *DSM*-5 criteria for clinical depression. Fixed delusions were related to her facial skin.

Patient history. At the initial interview, a guarded, tense woman with meticulously styled hair and makeup was observed. Her physical appearance was lean and muscular. She described a 2½-year history of perceptual distortions related to her face and reported recurrently watching facial skin "shifts" occur 15–20 times daily. She stated that her facial texture and bony structure would "fall" and looked "like a death mask." She spent over 8 hours daily performing ritualized behaviors, applying makeup, washing her face, and checking the mirror again. At night, she awakened to look in the mirror and saw herself as "black and blue all over." Insight into the nature of these events was present, but she appeared unable to reject these as distortions. Beliefs were held with such conviction that she reported "fighting for reality" and "not knowing what is real anymore."

The patient described a long history of disordered eating beginning at age 19 years with episodes of overeating high-caloric foods followed by many hours of exercise. These behaviors soon transformed into bodybuilding and weightlifting, culminating at age 21 in a bodybuilding exhibition. Subsequently, she quit the sport due to fatigue from caloric restriction and discomfort with public displays of her physique. In her 20s, she began to exhibit symptoms of OCD, such as recurrently checking the stove, lights, and door locks.

Three years prior to admission, she received an identity badge picture for her job. Her perception of this photo was "horrible." It precipitated a persistent cascade of distortions related to facial appearance. She said her face would "swell-up" and "deflate" after taking nutritional supplements. These perceptual distortions were triggered by being in public, looking in any mirror, and being alone in her apartment. She adhered to regimented exercise and a restrictive nutritional regimen.

It was unclear initially whether her facial perceptions and compulsive checking represented an exacerbation of OCD symptoms or were a manifestation of BDD. The Yale-Brown Obsessive Compulsive Scale specific for body dysmorphic disorder (BDD-YBOCS)[12] and the Brown Assessment of Beliefs Scale (BABS)[13] along with clinical interviewing assessed the etiology and basis of her beliefs. These tools differentiate the obsessions and compulsions of body dysmorphia from frank delusion and would guide an intervention plan.

Complicating the clinical picture upon intake was an episode over the prior 2 weeks of isolating herself in her apartment with all the shades drawn. This episode was accompanied by symptoms of hopelessness, depression, decreased interest in exercise, and complete cessation of work via a physician's excuse. The *DSM*-5 diagnoses were MDD, OCD, and BDD.

Assessment and initiation of treatment. At this initial interview, the BDD-YBOCS form was administered not only to confirm a diagnosis of BDD and OCD but also to assess symptom severity.[1] The patient scored 46/48. Clomipramine 25 mg daily was prescribed to treat OCD and depression. She reported medication side effects including panic attacks, insomnia with fatigue, and facial structure "swelling," "falling," or "deflating." These problems caused the patient to discontinue pharmacotherapy. At the next visit, she was encouraged to restart the medication and counseled about how to cope with these concerns. Cognitive-behavioral therapy (CBT) was additionally initiated on an outpatient basis at this time.

On the 4th day of clomipramine at 25 mg, the patient experienced less desire to perform compulsive face washing. However, she continued to report symptoms of intrusive, ego-dystonic thoughts that centered around the character and quality of her facial skin.

On the 5th day of clomipramine therapy, the BABS and BDD-YBOCS forms were again completed. The BDD-YBOCS score decreased to 42/48, which is within the severe range. The BABS assesses insight and delusional thoughts in people with OCD and BDD; her score of 16/24 indicates the presence of delusions of reference. The patient still had the conviction that people were taking notice of her appearance; she noted, "I look like a freak." Based on interrater reliability testing, a score of 16 on the BABS scale indicated poor insight and delusional ideas and differentiated these symptoms from manifestations of psychosis.[2]

Outcomes of therapy and follow-up. Following the initiation of treatment, the compulsions diminished, although her concerns regarding clomipramine side effects persisted. A therapeutic alliance and counseling about the medication facilitated her accepting a dose of 100 mg daily, and after 2 weeks, efficacy was noted. Psychotherapy continued biweekly.

With these 2 interventions, the patient began to experience a decrease in depressive and compulsive symptoms. The BDD-YBOCS was readministered twice to monitor treatment response and assess severity. The scores 26/48 and 19/48 evidenced improvement. A >30% reduction in the BDD-YBOCS score indicates a good clinical response, and reduction of >40% reflects

success.[1] At discharge, she was rated at 19/48, a 60% decrease from admission. This reduction indicates a good treatment response.[1] Improvement in severity of impairment was evident at clinical interviews. She appreciated freedom from distressing compulsions and anxiety-provoking delusions.

This case illustrates a multipronged approach that included addressing the patient's depressive symptoms, cotreating with a psychologist, and prescribing medication. The patient exhibited a partial remission of BDD symptoms. Her case emphasizes the importance of a pharmacologic intervention in persons with high-severity BDD and OCD, especially those with MDD and suicidal thoughts.

An important step in evaluating individuals with body dysmorphia is to classify the degree of insight, which may present on a continuum from minimal insight with delusional obsessions to appropriate insight with few obsessions.[3,5] Scales for assessing severity and insight differentiate obsessions and compulsions from body dysmorphia and from MDD-related delusions or mood symptoms. Validation of feelings of shame, distress, and humiliation was important for demonstrating rapport clinically.[1,8] Intervention for patients with minimal insight aims to resolve comorbid mood disorders, utilize testing specific to BDD, and monitor clinical response.[3,14]

Our patient evidenced poor insight at admission and was unable to recognize her beliefs as distorted. She was isolated and incapacitated, and these issues were worsened by comorbid depression. Limited insight and dysmorphic delusions with suicidal thoughts prompted precautions about suicide.[1,16] The combination of CBT with a psychologist, pharmacotherapy with clomipramine (indicated for all 3 psychiatric conditions), and metrics for evaluating clinical response yielded a successful outcome.

Body dysmorphic disorder is unlikely to resolve without intervention; conjoint medicinal and psychotherapeutic treatments are recommended.[8,17] Selective serotonin reuptake inhibitors and CBT, including exposure and response prevention techniques, are recommended.[8,14,17] Although there is literature about pharmacotherapy and counseling to treat patients with OCD and BDD, less evidence exists about interventions for patients simultaneously suffering from OCD, BDD, and depression.[14,16] Anxiety and shame might increase risk for suicide, supporting the indication for prompt treatment.[10,16] For those patients with comorbid depression, OCD, and BDD, treatment response of all conditions should be evaluated. Validation scales help elucidate the etiology of mood symptoms and the presence of delusions in persons with BDD and OCD, and these should be utilized in their assessment. A combination of CBT and medication is usually prescribed for patients copresenting with BDD and MDD.

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