

Case report

‘Everybody looks at my pubic bone’ — a case report of an adolescent patient with body dysmorphic disorder

Sobanski E, Schmidt MH. ‘Everybody looks at my pubic bone’ — a case report of an adolescent patient with body dysmorphic disorder. *Acta Psychiatr Scand* 2000; 101: 80–82. © Munksgaard 2000.

Objective: Body dysmorphic disorder (BDD) was described for the first time more than 100 years ago, but it is still unknown to many clinicians. Although the onset usually occurs during adolescence, BDD has received little attention in the adolescent psychiatric literature.

Method: The case and treatment of a 16-year-old female patient is described.

Results: The patient, suffering from the overvalued belief of a dislocated pubic bone, a comorbid mild depressive episode, BDD associated rituals and social avoidance, was treated successfully with a combination of exposure and response prevention and 125 mg/day of doxepine.

Conclusion: If BDD is diagnosed early in the course and treated appropriately, it is possible to obtain a satisfying outcome.

E. Sobanski, M. H. Schmidt

Department of Child and Adolescent Psychiatry,
Central Institute of Mental Health,
D-68072 Mannheim, Germany

Key words: body dysmorphic disorder; depression;
behavioral therapy; somatoform disorders

E. Sobanski MD, Department of Child and Adolescent
Psychiatry, Central Institute of Mental Health,
D-68072 Mannheim, POB 122 129,
D-68072 Mannheim, Germany

Accepted for publication September 9, 1999

Introduction

Body dysmorphic disorder is characterized by an excessive preoccupation with a real minor or imagined defect in physical appearance. The patients' degree of insight into the exaggerated nature of their dysmorphophobic concerns varies from obsessive thoughts with good insight, and overvalued ideas to delusions where insight is absent. The onset of symptoms usually occurs during adolescence and the course tends to be chronic without appropriate treatment.

Case report

The 16-year-old girl had been suffering for about 6 months from the belief that her pubic bone was becoming increasingly dislocated and prominent, such that everyone would stare at and talk about it. The girl could not remember a particular occurrence which had brought on the symptom and had no insight into its psychological nature. She was totally convinced that she could only be helped by a surgical correction of her pubic bone. In an attempt

to achieve a smaller hip girth and also to influence the pubic bone she had reduced her body weight from 48 kg to 44 kg with a height of 1.68 m, which corresponds to a body mass index (BMI) of 15.8 kg/m². The weight reduction led to amenorrhoea. One month before admission to our clinic she was admitted to a paediatric clinic where anorexia nervosa was diagnosed. She was fed with high-caloric nutrient solution and gained 2 kg. Two weeks before the referral to our clinic the girl had become totally housebound because she was extremely ashamed of her looks. She spent almost the entire day in her bedroom, wearing excessively large pyjamas. At admission her mood was depressed and her drive reduced. She cried often and reported anhedonia, hopelessness and loss of interest. She denied suicide ideation. Up to 10 times a day she lowered herself to the ground and measured, with her fingers, the distance between her pelvic girdle and the soil in order to check the position of her pubic bone. She was constantly preoccupied with thoughts about it.

The girl was the eldest daughter of a couple with university education, and had a 5-year-old sister.

No particular problems in family interaction could be assessed and there was no family history for psychiatric disorders. Pregnancy and early development occurred without problems. She was described by her parents as being ambitious at school and a little reserved and shy towards her peers, with no long-term close friendships but with regular dates with her classmates. She had dated for 1 month with a boy of her age, but had discontinued the relationship because she felt too occupied by it. She had no previous sexual experience.

The patient was treated for 10 weeks at our clinic. She was obliged to gain 2 kg weight, receiving from the second week onwards 125 mg/day of doxepine and therapy with exposure and response prevention. We first set up an anxiety hierarchy of avoided situations with raising degree of difficulty: 1, wearing jeans in her own room; 2, wearing jeans in the ward and meeting others; 3, wearing jeans, going to town and visiting a pub; and 4, visiting her school and meeting classmates. She was treated with three sessions of 60–90 min per week. At first she was extremely upset by the training programme and had thoughts such as: 'I am an outsider. Everybody looks at my pubic bone. If it would be normal, everything would be fine. I need a surgical correction.' Gradually it became easier for her to face formerly avoided situations. At the end of treatment, the girl's BDD symptoms were distinctly improved. Despite her still being certain about the dislocation of her pubic bone, the belief was less distressing for her and no longer impaired her daily life. She had stopped camouflaging and checking her pubic bone. She dated with her peers and attended school regularly; the depressive symptoms had completely vanished. When she was seen after 6 months for follow-up the therapeutic results had remained stable.

Discussion

Patients with BDD do not consult mental health professionals primarily because of the somatic explanation of their concerns, seeking treatment by general practitioners, dermatologists, dentists and plastic surgeons, resulting in low prevalence in clinical psychiatric populations. To date there has been little research concerning BDD. Two cross-sectional surveys were carried out 1993 in the United States by Phillips et al. (1) and 1996 in the United Kingdom by Veale et al. (2). One epidemiological survey was carried out 1997 in Italy by Faravelli et al. (3), who reported a 1-year prevalence of BDD of 0.7%. In terms of adolescents there have been only a few case studies (4, 5), and no larger surveys at all.

Besides BDD the patient described in the case report suffered from typical comorbid features, namely a mild depressive episode (ICD-10: *F 32.0*), associated rituals and social avoidance. According to the scientific literature depression is the most frequently related psychiatric disorder. Between 60% and 94% of patients with BDD have a lifetime diagnosis of depression (1, 2). Most individuals with BDD perform ritualistic behaviours related to their dysmorphophobic beliefs that resemble obsessive-compulsive disorder (OCD) compulsions. Between 6% and 30% fulfil the diagnostic criteria for a concurrent OCD (1, 2, 6). Virtually always, BDD results in social impairment, in particular avoidance of social interactions. Available studies show a percentage for social phobia in BDD patients varying between 10% and 43% (1, 2, 7). In a series of 100 patients, 32 had been completely housebound for at least 1 year (6). Despite the low BMI of 15.8 kg/m² and the amenorrhoea the patient described did not suffer from anorexia nervosa, because other core symptoms such as weight phobia and disturbance of the whole-body image were not present.

The dysmorphophobic symptoms were treated successfully with exposure and response prevention. At the end of treatment the girl's social and occupational functioning had improved distinctly. Several studies published in recent years report that up to 70% of patients with BDD benefit from systematic exposure to avoided situations and prevention of anxiety-reducing behaviours (8, 9). Although there is growing evidence that BDD symptoms, as well as comorbid depression, respond preferentially to SSRIs the comorbid depressive symptoms of our patient were treated with doxepine, because no data are available concerning the use of SSRIs in adolescents for this condition.

The case report shows that it is possible to obtain a satisfying outcome if BDD is diagnosed early and treated appropriately. Severe complications such as being housebound, or suicide attempts, which occur in up to 25% (10), can thereby be avoided. Therefore, it is necessary that more clinicians are informed about the disorder. More scientific data are needed concerning epidemiology, aetiology and treatment strategies.

References

1. PHILLIPS KA, McELROY S, KECK PE, POPE HG, HUDSON JI. Body dysmorphic disorder: 30 cases of imagined ugliness. *Am J Psychiatry* 1993;**150**:302–308.
2. VEALE D, BOOCKOK A, GOURNAY K et al. Body Dysmorphic Disorder, a survey of fifty cases. *Br J Psychiatry* 1996;**169**: 196–201.
3. FARAVELLI C, SALVATORI S, GALASSI F, AIAZZI L, DREI C, CABRA S. Epidemiology of somatoform disorders: a

- community survey in Florence. *Soc Psychiatr Psychiatr Epidemiol* 1997;**32**:24–29.
- BRADDOCK LE. Dismorphophobia in adolescence: a case report. *Br J Psychiatry* 1982;**140**:199–201.
 - PHILLIPS KA, ATALA K, ALBERTINE RS. Case study: body dysmorphic disorder in adolescents. *J Am Child Adol Psychiatry* 1995;**9**:1216–1220.
 - PHILLIPS KA, McELROY S, KECK P, HUDSON JI, POPE G. A comparison of delusional and nondelusional body dysmorphic disorder in 100 cases. *Psychopharmacol Bull* 1994;**2**:179–186.
 - HOLLANDER E, COHEN LJ, SIMEON D. Body dysmorphic disorder. *Psychiatr Ann* 1993;**23**:359–364.
 - GOMEZ-PEREZ JC, MARKS IM, GUIRREZ-FISSAC JL. Dismorphophobia: clinical features and outcome with behavior therapy. *Behav Psychiatr* 1994;**9**:229–235.
 - McKAY D, TODARO J, NEZIROGLU F, CAMPISI T, MORITZ EK, YARYURA-TOBIAS JA. Body dysmorphic disorder: a preliminary evaluation of treatment and maintenance using exposure with response prevention. *Behav Res Ther* 1997;**35**:67–70.
 - PHILLIPS KA. *The broken mirror: understanding and treating body dysmorphic disorder*. New York: Oxford University Press, 1996.

Invited comment

This case is a useful addition to the literature on body dysmorphic disorder (BDD), which remains under-researched and often difficult to treat. The location of the perceived defect in her pubic bone is unusual, as most patients are usually preoccupied with some aspect of their face and have multiple perceived defects. The patient reported no particular reason for focusing on her pubic bone and one would have thought that dieting would probably have made her pubic bone more prominent.

The onset of BDD usually occurs during adolescence, when individuals are at the most sensitive about their appearance and may be teased or bullied. However, most patients take up to 10–15 years before they seek help from a mental health professional and even then may present with symptoms of depression or social phobia, as they are too ashamed to reveal their true problem. BDD is at the stage of public awareness and research as OCD in the 1970s and further publicity will hopefully lead to earlier referrals and appropriate treatment. Too many patients are still being treated with pimozide and antipsychotic drugs, for which there is little efficacy. In this case, the authors treated the patient successfully with a standard programme of behaviour therapy, namely exposure and response prevention (E&RP) in combination

with doxepine. The engagement of a patient in a psychological understanding of the problem and the treatment rationale is crucial. In this respect, patients may be recommended to read *The Broken Mirror* by Katherine Phillips (2). E&RP may be less successful in those patients who are more concerned with an internal aversion towards their appearance as opposed to an external fear of negative evaluation of others. Such patients may require a more cognitive approach, with identification of their core beliefs about their appearance and the use of rational role-plays and behavioural experiments (3). As the authors state, the pharmacological treatment of choice in BDD is an SSRI, for which high doses may be required for a prolonged period of time. Doxepin has a moderate serotonin reuptake inhibition and low noradrenergic reuptake inhibition. SSRIs are used for adolescents in OCD and could be safely justified if the patient had not responded. No data exist on whether CBT and an SSRI enhances efficacy especially when there is a comorbid depression, but this is the best current pragmatic approach. There remain a core group of patients who are very difficult to treat, who are a high suicide risk and who have a very poor quality of life. Further research is required on the psychopathology of BDD and randomized controlled trials on CBT and SSRIs.

*David Veale, Consultant Psychiatrist
Grovelands Priory Hospital
The Bourne, Southgate
London N14 6RA
& Hon Senior Lecturer
Royal Free Hospital School of Medicine
UK*

References

- SOBANSKI E, SCHMIDT MH. 'Everybody looks at my pubic bone' — a case report of a patient with body dysmorphic disorder. *Acta Psychiatr Scand* 2000;**101**:80–82.
- PHILLIPS K. *The broken mirror: understanding and treating body dysmorphic disorder*. New York: Oxford University Press, 1996.
- VEALE D, GOURNAY K, DRYDEN W et al. Body dysmorphic disorder: a cognitive behavioural model and pilot randomised controlled trial. *Behav Res Ther* 1996;**34**:717–729.