Body dysmorphic and/or obsessive-compulsive disorder: where do the diagnostic boundaries lie?

Transtorno dismórfico corporal e/ou obsessivo-compulsivo: onde ficam as fronteiras diagnósticas?

Dear Editor,

Obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD), although described in different sections of psychiatric classifications, present with many phenomenological similarities[1-3] and the latter is included in the obsessive-compulsive (OC) spectrum.[4]

BDD is characterized by irrational preoccupations with nonexistent or minimal physical defects, which interfere in the individual's activities. Patients usually show mirror checking, avoidant and reassurance seeking behaviors that resemble OCD; both usually present early onset, chronic and fluctuating course and are frequently comorbid.[2,3]

Herein we report a clinical case that raised considerable debate regarding the diagnostic boundaries between these disorders.

Case report: S.P.O., a 50 year-old married woman, presented excessive preoccupation with her hair for six years, after she lightened it believing that dark hair made her look older. She began to ask blond women the type and name of products they used on their hair, writing down the information "so as not to forget it", using the same pen and with "perfect" letters, in a ritualized manner. She went to beauty and cosmetic shops several times a day, checked product catalogues and when at home, phoned to recheck the information. She admitted that "this was absurd", but could not control herself, otherwise she would become extremely anxious. She noted that attendants avoided her and was ashamed to think they were making fun of her. Sometimes they would call her family members, because she spent hours in the stores asking the same questions and bothering other clients. She developed depressive mood, insomnia, appetite and weight loss, hopelessness, apathy, self-depreciation, isolation, and suicidal ideation.

Since adolescence she avoided going out during daylight, because she was ashamed of her "big and tortuous" nose and "enormous" hands and feet. She also believed her skin had many spots and used excessive sun protection measures. These thoughts continuously made her suffer and interfered considerably in her life and relationships.

She also presented cleaning and ordering compulsions, which led to frequent quarrels with her husband and children.

Family history: one sister with OC symptoms and excessive worries about her low weight, another sister with panic attacks, father and one brother with alcoholism and one aunt with depression, who committed suicide.

In the Structured Clinical Interview for Axis I DSM-IV Disorders she met diagnostic criteria for OCD, BDD, and recurrent depressive disorder. Initially, she scored 28 in the Yale-Brown Scale (OCD severity, maximum: 40) and 41 in the Beck Depression Inventory, obtaining global improvement with paroxetine 40mg/day and cognitive-behavior techniques directed to her dysmorphic and OC symptoms (cognitive restructuring and exposure with response prevention).

Family studies suggest common etiological factors for OCD and BDD and treatment approaches are similar, including serotonin reuptake inhibitors and cognitive-behavior therapy.[2]

The most consistent difference between these disorders is the level of insight, typically worse in BDD patients.[2,5] Esthetic preoccupations are overvalued (egosyntonic) and not obsessive (egodystonic) ideas;[5] however, critical appraisal is not an "all or nothing" phenomenon, but a *continuum* or dimensional construct, with different degrees of impairment in both conditions.[2,5,6]

This case demonstrates the overlap between OCD and BDD, and the difficulties in their differential diagnosis. These phenomenological similarities may have not only theoretical or nosological implications, but involve etiological and therapeutic aspects of importance.[3,6]

Further studies are required to determine whether BDD would be better conceptualized as an OC spectrum disorder[4], or even an OCD subtype.[2,6]

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