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# Complications of dysmorphophobia. Description of a self-mutilation case

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Dysmorphophobia, also known as Body Dysmorphic Disorder (BDD), can become a serious illness that results in severe complications such as social isolation, self-mutilations, suicide attempts, and even suicide. Many authors currently include BDD among the spectrum of obsessive-compulsive disorders. There are two distinguishable variants of BDD: psychotic and non-psychotic. The current trend considers these variants as one same disorder characterized by an insight spectrum. However, the psychotic variant exhibits more severe symptoms. We present a case of dysmorphophobia with psychotic symptoms that required psychiatric hospitalization due to serious complications. We discuss the presence of tactile and propioceptive sensations in some BDD patients and their contribution to their distress. Finally, we discuss a great propensity of BDD patients to conceal their symptoms. Thus, it is important for the clinician to specifically inquire about these symptoms, especially in high-risk groups, to prevent occurrence of serious complications.

**Key words:**
Dysmorphophobia. Body dysmorphic disorder. Self-mutilation. Complications.

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## Complicaciones de la dismorfofobia. Descripción de un caso de automutilación

La dismorfofobia, o trastorno dismórfico corporal, puede alcanzar una gravedad importante y originar severas complicaciones, como aislamiento social, automutilaciones, intentos de suicidio e incluso suicidio consumado. La tendencia actual de muchos autores es incluirla dentro de los trastornos del llamado espectro obsesivo-compulsivo. En la dismorfofobia se distinguen una variante psicótica y una no psicótica, aunque actualmente se tiende a considerar que ambas formas constituyen un mismo trastorno caracterizado por un espectro de *insight* en el que los pacientes afectados por la forma delirante muestran mayor gravedad. Presentamos un caso de dismorfofobia con síntomas psicóticos que requirió un ingreso psiquiátrico debido a las graves complicaciones derivadas de este trastorno. Discutimos la presencia de sensaciones táctiles y propioceptivas presentes en algunos pacientes con dismorfofobia y la contribución de éstas al aumento de su malestar. Por último discutimos la tendencia de los pacientes a ocultar sus síntomas, que hace recomendable interrogar explícitamente acerca de ellos, en especial en grupos de alto riesgo.

**Palabras clave:**
Dismorfofobia. Trastorno dismórfico corporal. Automutilación. Complicaciones.

## INTRODUCTION

In dysmorphophobia or body dysmorphic disorder (BDD) as it is called in the present diagnostic classifications[1,2], the patient has an excessive concern for one or several aspects of his/her physical appearance, that he/she considers ugly or deformed, which may reach the point of torturing the subject[3]. Appearance of patients with dysmorphophobia is generally normal or, if the defect does exist, concern is disproportionate[4]. The most frequently affected body parts are the face skin, nose or hair, although any other zone may be the focus of the subject's distress. Some associated behaviors[4] are prolonged observation in front of the mirror or other reflective surfaces, persistently questioning close persons about one's appearance, comparing the supposedly malformed part with that of others or camouflaging it with make-up, clothing or certain body postures that make it less perceptible. BDD may cause significant deterioration in social-work functioning of the patient, social isolation and sometimes appearance of suicidal ideation, suicide attempts or even suicide[4].

In the following, we present the case of a patient who required psychiatric admission due to the serious injuries caused in the context of a dysmorphophobia.

## CLINICAL CASE

A 27 year old man who was referred from the plastic surgery service where he was seen due to self-caused injury with firearm in the nasal pyramid.

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The patient began to feel concern about the appearance of his nose when he was 14 years old after he was punched in the nose by a classmate, causing a nose fracture whose sequel was a discreet deviation. Confrontations with this person and other classmates continued and he anxiously relived the episode that caused the fracture whenever he observed his nose and saw it twisted. This concern intensified progressively and was accompanied by behaviors such as prolonged observation of his nose in the mirror for about 2 h a day. The opinions of those closest to him, who assured him that hardly any abnormality could be seen, could not comfort the patient, who was firmly convinced that the defect was significant. He avoided speaking at close distance with persons, and when he did so, he adopted facial postures that made it less noticeable, postures he had previously tried out in front of the mirror. Gradually, he stayed at home and avoided contact with persons outside of his family, especially women, as he considered that he could not be attractive to them. The deterioration in his social functioning, together with concern about his appearance, precipitated a depressive episode that ended up with an attempt to hang himself that he concealed from his family.

He had a rhinoplasty for the first time at 20 years of age. He classified it a disaster, considering it to be artificial. His seclusion increased during the next two years. He remained at home most of the time to avoid being seen and stopped going to class. He felt that the people in the street perceived his defect and stared at him and he was ashamed of having undergone a rhinoplasty, something inappropriate of a man in his opinion. He was extremely anguished, although his family mostly lacked knowledge of his stress. His affection was markedly hypothymic and he occasionally had suicidal ideation, crystallized in a suicide attempt by phleboclysis and he had planned to hurl himself in front of a train, which he finally did not do.

He underwent a second operation two years after the first rhinoplasty and was satisfied with the esthetic result. However, he felt uncomfortable due to the multiple functional problems and tactile and propioceptive sensations that he describes as unbearable: dryness, subjective sensation of breathing difficulty, and perception of roughness in the nasal fossa, corresponding to the grafted cartilage, that he could not avoid manipulating continuously. Although his social functioning improved slightly after the esthetic improvement, concern about the discomfort in his nose was persistent and accompanied by prolonged observation for hours. Two years before his admission, he had considered the possibility of eliminating his nose for the first time. Although this idea first seemed to be *rash* to him, he considered it more tolerable than the possibility of undergoing a new operation. Progressively, he structured a carefully detailed plan: he gathered abundant information in books, television and internet on the nose anatomy and possible therapeutic alternatives (prosthesis, for example), using it to write a letter addressed to the surgeon who was going to treat him, giving him detailed technical solutions on how it could be repaired. In reality, he aimed to pretend that the episode that was going to occur later on had been accidental and that the letter had been elaborated to be given to the surgeon who would operate him for a third rhinoplasty. He joined a hunting federation to be able to obtain a firearm license, and acquired a shotgun, choosing the date for the event as the initiation of his vacations, in order not to miss many days of class during his hospitalization. That night, he went to an open field where, supplied with several cure dressings and ear plugs, he self-inflected two shots at the point of his nose that he considered to be the origin of his discomfort.

The psychopathological examination showed scarce emotional expressiveness and cold contact as well as moderate mood decrease. He continued to consider the self-mutilation episode as the only possible solution and stated he would act in the same way if he was in a similar situation.

The psychological evaluation showed average general intelligence (IQ 106), as evaluated with the Wechsler Adult Intelligence Scale-third version (WAIS-III). The results on the neuropsychological tests were within normal limits for his age group and the personality evaluation with the Rorschach test showed an introversive style, with some emotional rigidity, low self-esteem and concern for his body image.

The complementary examinations done were normal.

## DISCUSSION

Since Enrico Morselli[5] defined dysmorphophobia more than one century ago, many authors have tried to describe it. Janet[6] and Kraepelin[7] related it with the obsessive-compulsive disease and López Ibor[8,9] considered it a depressive equivalent, although he stated that «psychopathologically, the type of disorder that these patients have must be described as an obsession». The present tendency is to include it within the spectrum of obsessive-compulsive disorders[10] (OCD), given that it has many similarities with it, such as distribution by gender, onset age, frequent chronic course and incapacity grade[11]. Both have high comorbidity with major depression and other anxiety disorders and are comorbid between them[12]. Phenomenologically, the concern of the dysmorphophobic subject is very close to an obsession. In both disorders, there are recurrent, persistent and uncomfortable thoughts that produce anxiety and are difficult to control[4,10,12]. These concerns are generally accompanied by repetitive behaviors that are frequently ritualistic, that are similar to the OCD compulsions[4,12]. Furthermore, both preferentially respond to treatment with serotonin reuptake inhibitors and to cognitive-behavior therapy techniques such as exposition with response prevention[12]. However, there are some differences. In dysmorphophobia, the ideas are egosyntonic and lack intrusive character characteristic of the OCD ideas[10]. In addition, patients with BDD have less disease awareness[13] and gene-

rally lack the sensation of the absurdity of the symptoms[10]. Typical beliefs of dysmorphophobia are generally more overevaluated than those of OCD[10] and the patients who suffer it even present delusional ideation in a proportion superior to 50 % versus 5 % of the patients with OCD[13]. Although the etiology of dysmorphophobia has still not been fully explained, the data presently available on its biological origin point to an important role of serotonin in its genesis, similar to that which occurs in OCD[10]. However, the social factors take on more importance in the case of dysmorphic disorder[10].

One psychotic and one non-psychotic variant are distinguished in dysmorphophobia. They are classified as separate disorders in both the DSM-IV[1] (the former as a somatic type delusional disorder and the latter as a somatomorphic disorder) and the ICD-10[2] (the non-psychotic form within hypochondriac disorder and the psychotic one among the persistent delusional idea disorders). The fundamental psychotic symptom in the BDD is the delusional conviction in the pathological belief (that is, the absolute conviction that one's consideration of the defect is real and not distorted) that occurs in up to 53 % of the patients, at least for several weeks during its course[14]. Other frequent psychotic symptoms are reference ideas and delusions[15], which may contribute to social isolation[16].

The case that we present is one of delusional dysmorphophobia, given that the patient was totally convinced for months that the esthetic defect existed and his view of it was not distorted. Furthermore, he had reference ideas during its course, which made him seclude himself at home to avoid being seen.

However, in most of the comparative studies published[17,18], psychotic and non-psychotic patients were very similar in terms of demographic factors, phenomenology, disease course, associated clinical traits, family psychiatric history and response to treatment. Both forms responded with priority to serotonin reuptake inhibitors, that may even improve insight in some patients with delusional beliefs[16,19]. It must also be remembered that in most of the patients, it is difficult to distinguish an overevaluated idea from a delusional one and that the degree of conviction about the defect may fluctuate during the course of the disorder, sometimes associated to environmental circumstances or to stress[14,20]. At present, there is a tendency to consider that both forms make up one same disorder characterized by a spectrum of insight[16], in which the severity of the patients affected by the delusional form is greater[21] and there is greater social and work involvement.

One symptom of dysmorphophobia that has been practically absent from the literature for much time is tactile and associated propioceptive perceptions. In the case presented herein, these symptoms are prominent in the stage prior to admission, becoming so unsupportable that they led him to eliminate his nose with a firearm. In a study of 30 cases published by Phillips et al. in 1993[22], 37 % (n = 11) had subtle tactile sensations, such as facial tension. These discomforts share some traits with obsessive phenomena. They are persistent, intrusive, recurrent concerns causing intense anxiety and are sometimes accompanied by compulsive observation behaviors in front of the mirror or repeated manipulation. However, as the dysmorphophobic concerns related to one's physical appearance, they lack the condition of absurdity characteristic of obsessive ideas and are experienced as egosyntonic. We consider that it is a phenomenon that should be studied in the assessment of a patient with BDD.

Although tragic outcomes such as that which we present are not common, it is not rare that dysmorphophobic patients, either exasperated after being rejected for surgery or disappointed with its results, try, in a desperate attempt to solve the defect, to fix it themselves with DIY (do it yourself) interventions[23]. In most of the cases, this is a simple intervention, such as placing a clip on the nose to make it smaller, although some dramatic cases of self-mutilation have also been described or other more deplorable cases in which the patients have made an attempt against the surgeon's life[24,25] and then committed suicide.

It is considered that the body dysmorphic disorder is underdiagnosed[4,21,26]. These patients frequently consult with other physicians before, especially plastic surgeons and dermatologists[4], but they may do so with any other specialists[27]. After treatment, they are generally unsatisfied[28] with the result, although some patients may stop being concerned about this part of their body and focus it on a different one[27].

Probably, only a minimum number of patients affected by dysmorphophobia reach the mental health services since the shame that this suffering causes them makes them keep it a secret. When they do reveal it, this generally occurs after several years of suffering. In a prevalence study in hospitalized psychiatric patients conducted by Grant et al.[26], 13.1 % had criteria for BDD. None of them had been diagnosed of this by their physician and all reported they would not have mentioned it unless specifically questioned about it. Given the significant stress that this disorder causes the person suffering it, its repercussion on his/her work, academic and social life and the disastrous consequences that are derived from it, such as suicide attempts or unnecessary and iatrogeny causing surgery, many authors recommend explicitly questioning the patient on the symptoms of dysmorphophobia, especially in high risk patient groups, such as those with atypical depression, OCD, social phobia, and those requesting esthetic surgery.

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