

### The symptom in the body. Monosymptomatic psychosis and hypochondriasis: A report of two cases

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Dear Editor

#### Introduction

Body symptoms having a psychotic nature make up a catch all phrase in the current nosology. They generate diagnostic doubts and controversies so that they end up within entities of different nature, such as the delusional ideas disorder, delusional delusional dysmorphophobia or schizophrenia.<sup>1,2</sup> Within this context, we are presenting two clinical cases which are apparently different with a common denominator: the body as a symptom. A brief historical review leads us to consider hypochondria as a disorder in its own right and independent of its seriousness and helps us to substantiate the difference between delusional doubt, even without introspection, and the delusional certainty.

#### Clinical cases

A 56-year old woman, married, with three children, who is an administrative worker. Since her menopause ten years ago, she has had obsessive ideas on suffering a disease, with continuous self-observation for banal physical signs and visits to specialists. She performs avoidant behaviors regarding her personal hygiene, such as showering in the dark to avoid seeing her body. Her experience of absurdity of these ideas is first partial and then disappears, always with little resistance. The picture entails significant functional interference, with limited social relations and elimination of practically all her activities. This takes place within the context of a previously timid, fearful and dependent personality, and deaths in her setting.

A 53-year old male, married, with two children, who worked as an architect until being fired. He underwent a thyroidectomy due to thyroid carcinoma after a difficult diagnostic process in which he needed to seek second opinions. His previous personality was analytic and meticulous.

In the medical office, anxious body experiences are manifested. The picture began with the sensation of facial asymmetry, paresis and paresthesia in the ipsilateral hemibody. Convinced that he suffers a degenerative disease, it is impossible to reduce this belief in spite of the normality of the successive tests and visits to specialists. The symptoms have evolved to vomiting, vertigo, generalized algias, asthenia, macroglosia, loss of skin turgor, anhidrosis and alteration of intestinal rhythm. He shows different parts of his body and provided photos prior to the onset of the picture to give authenticity to the symptoms, which are not observed. He insists in seeking the confirmation of the symptoms in his family and friends.

#### Discussion

The first description of hypochondria has been attributed to the disciple of Hippocrates Diocles of Carystus. Since then, many authors have been debating over the centuries if its etiopathogeny is somatic or mental. Boissier de Sauvages de Lacroix initiated the debate between simple and delusional hypochondria for the first time. In 1880, Cotard classified the syndrome with its eponymous as hypochondrial delusion, understanding it as worsening of hypochondria.<sup>3,4</sup>

The term *monosymptomatic hypochondriacal psychosis* was coined by Munro and Riding in 1975.<sup>5</sup> In the French school, hypochondrial delusion was closely related with the concept of acute delusion. Morel postulated that the natural development of the delusion follows a succession of themes, so that the hypochondrial fear constitutes the first phase, which derives into delusions of persecution and culminates in a megalomania. The patient, after seeing his health affected in the first place and then his life, assumes he is someone important.<sup>6</sup> In opposition to the idea of succession of delusional themes, Bleuler considers that this logic corresponds to healthy thinking, not to a paranoid one and he also postulates the existence of the *hypochondrial hebephrenia*.<sup>7,8</sup> Gérente, following Cotard, stresses the psychic hyperalgesia, and the pathological self-observation of the hypochondriacs. He also separates simple hypochondria once again from the delusional one.<sup>3,6</sup>

Since Dupré and Camus coined the term "*cénesthopaties*" (cenesthopathies) in 1907, several authors have approached the hallucination of body sensations.<sup>9</sup> In the psychopathology of the German school, the role attributed to the sensorceptive alterations predominates over that of hypochondriac delusions. Schneider includes the sensations of corporal hallucinations as first-rank symptoms of schizophrenia<sup>10</sup> and Kraepelin integrates the symptoms of hypochondriac delusions, kinesthetic hallucinations and the ideas of body influence in the *Parafrenia Fantástica* (fantastic paraphrenia).<sup>11</sup> With Leonhard's concept of

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Hypochondriac Paraphrenia, it acquires the consideration of a differentiated nosologic entity, characterized by cenesthopathies.<sup>6,12</sup>

In the third edition-revised of the DSM classification, the concept of *delusional disorder* replaces *paranoid disorder* of its predecessor DSM-III, the introduction of the somatic subtype becoming established, among other changes.<sup>13</sup> Under the nomenclature of *acute delusional disorder*, the somatic subtype became reaffirmed in the successor DSM-IV.<sup>14</sup> On the contrary, no subtypes have been specified in the ICD-10, although somatic symptoms are accepted as delusional theme.<sup>1</sup> In the current DSM-5, this subtype, whose most frequent themes are beliefs of deformity, that one is emitting an unpleasant smell, of being infested by different organisms, and non-functioning of the organs remains invariable.<sup>15</sup> However, other authors assure that hypochondriasis constitutes the most characteristic delusional theme.<sup>16</sup> The conceptualization of the subtype is complex and it is sometimes arduous to distinguish it from somatomorph disorders.<sup>16,17</sup>

Regarding hypochondria, it was already separated from the psychotic disorders in the DSM-II on being included in the *neuroses*.<sup>18</sup> In subsequent editions of the American classification and in the current ICD-10, it was maintained along the same line, conserving its nosological identity within the group of somatomorph disorders,<sup>1,13,14</sup> until it was finally eliminated in the DSM-5.<sup>15</sup>

This entity and the remaining somatomorph disorders are currently included within the *Somatic Symptom Disorder (SSD)* of the DSM-5, defined by the existence of non-medically explained somatic symptoms, which entail significant functional repercussion, disproportionate beliefs, thoughts, and/or behaviors regarding health. Within the SSD and *related* group, the *illness anxiety disorder* includes the cases of hypochondria in which there are no somatic symptoms that provoke the disproportionate concern about suffering or acquiring a disease, of if they exist, they are very mild.<sup>15,19,20</sup> In any case, the differential diagnosis with delusion disorder should be made.<sup>15</sup>

For López Ibor, *corporeality* is the living experience, the body as a phenomenological reality.<sup>21</sup> Along this line, we believe that somatic symptoms without organic explanation can be the onset or end of a psychopathological succession:<sup>22</sup> they can constitute the so-called *somatization*, as the climax of a story of stress,<sup>23</sup> or they can acquire a further interpretative quality that substantiates a hypochondriac, obsessive or even delusional disorder.<sup>2,24,25</sup> Somatic complaints are also present as non-nuclear hallucinatory phenomena in certain psychotic disorders, which requires a differential diagnosis. However, in acute hypochondria, an unspecified sensation generates excessive fears, without a shadow of doubt, that mirrors a delusional disorder.<sup>17</sup> This seems more a repetitive doubt, with checking behaviors for

health arising from an exaggerated interpretation of some body sensation<sup>19</sup> than a somatomorph disorder as classified in the ICD-10<sup>1</sup> and the DSM-IV,<sup>14</sup> leaving the cognitive setting of doubt and fear in the background,<sup>19</sup> which we consider fundamental. This situation, illustrated with the first clinical case leads us to consider if hypochondria should be classified as a somatomorphic disorder, since when it becomes acute in terms of interference, lack of criticism or resistance, it then loses its own denomination and is called delusional disorder.<sup>1,15</sup> If, as some authors recommend, it would have been included within the DSM-5 classification of obsessive disorders and related disorders,<sup>18,26,27</sup> the specification with *delusional ideas* could be used, stressing the cognitive aspects of the disease more than the body sensations. In this way, the possibility would exist that the acuteness of the disease would move between neurosis and psychosis, without seeing its nature altered, a latent idea underlying the fact that obsessive disorders (and related) have been separated in the DSM-5, as some authors have defended.<sup>26,28,29</sup>

On its part, the second case represents a typical hypochondriac type monosymptomatic psychosis in which the patient is convinced that he suffers a serious disease based on many body sensations, some of which could have even been cenesthopathies. In spite of the repetitive behaviors in search of acquiescence, the essential aspect of the picture is the delusional certainty with which he manages different symptoms, some of them really present, although non-specific, to conclude that he suffers a degenerative disease that neither the physicians nor the complementary tests can detect.

For us, these cases seem to be illustrative of a phenomenological different in the mental disorders regarding the body which is not captured in the current classifications: delusional certainty and doubt without introspection in the hypochondriac topic.

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