Severity in dysmorphophobia: description of two cases

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Gravedad en la dismorfofobia: descripción de dos casos

Summary

Many authors dysmorphophobia (body dysmorphic disorder) as a disorder within the obsessive-compulsive spectrum*. Both the phenomenological features and response to serotonergic drugs support this idea. Nonetheless, it is included in the somatoform disorder section within the main diagnostic classifications. Two cases of dysmorphophobia are presented. Both patients were admitted to the psychiatric unit due to secondary complicacions of the disorder. After reviewing the available literature, we discuss the severity that this condition may reach. Comorbid disorders and other complications such as suicide attempts are often present. In addition patients usually hide their suffering. Furthemore, it is important for clinicians to assess the body dysmorphic disorder carefully and rule it out.*

Key words: *Body dysmoprhic disorders. Dysmorphophobia. Severity. Suicide risk.*

Resumen

Muchos autores consideran la dismorfofobia, o trastorno dismórfico corporal, como un trastorno dentro del denominado espectro obsesivo-compulsivo. Las características semiológicas y la respuesta a fármacos serotoninérgicos apoyan esta idea. Sin embargo, en las principales clasificaciones diagnósticas está considerado dentro de los trastornos somatomorfos. Se presentan dos casos de dismorfofobia en los que fue necesario el ingreso psiquiátrico debido a complicaciones secundarias de este trastorno. Tras revisar la literatura disponible se discute la gravedad que puede alcanzar esta entidad debido a la alta comorbilidad con otros trastornos psiquiátricos y complicaciones como los intentos de suicidio, así como la tendencia de los pacientes a ocultar su padecimiento. De igual modo se destaca la importancia para el clínico de explorar y descartar explícitamente la presencia del mismo.

Palabras clave: *Trastorno dismórfico corporal. Dismorfofobia. Gravedad. Riesgo de suicidio.*

INTRODUCTION

In the original description of *dysmorphophobia*, Enrico Morselli[1] used the concept of phobia as understood at the end of the XIX century, that is, as a form of insanity with fixed ideas[2]. The present description of this construct, according to operative diagnostic criteria, only counts on a separate category in the DSM-IV[3] (body dysmorphic disorder), on the contrary to the ICD-10[4] that includes it within the hypochondriac disorder. Probably, the useful argument that the DSM-IV uses to locate dysmorphophobia within the somatoform disorders, as occurs in the ICD-10, has scarce foundation. From a conceptual point of view, dysmorphophobia means a disorder of the body image perception, separated into a perceptive component and another affective-behavioral one[5], similar to the body image distortion observed, for example, in eating disorders[6]. On the other hand, the semiological similarity and the comobidity studies suggest its consideration as a disorder within the so-called obsessive-compulsive spectrum[7-9]. According to this assumption, dysmorphophobia would share etiopathogenic mechanisms similar to those of the obsessive-compulsive disorder. This hypothesis is also supported by the antidepressive response observed in different therapeutic studies[10-13].

The DSM-IV makes it possible to diagnose dysmorphophobia even when the patient's ideas are delusional, a fact that would only be a degree of greater seriousness within the same entity[14,15]. Body dysmorphic disorder seems to be chronic and affects men and women equally [16], can be serious, leading to an important deterioration in academic, work and social functioning[17] and suicide attempts[18].

In the following, two cases are presented. They required psychiatric admission due to complications secondary to dysmorphophobia, the first being due to suicide attempt, due to a psychotic picture secondary to toxic consumption.

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CASE 1

A 26 year old male who is admitted after suicide attempt with drug poisoning. He had been diagnosed of dysmorphophobia 6 years before in another center and had a previous admission to the Acute Unit 1 month before the present admission, also after a suicide attempt with drug poisoning. On discharge, he was diagnosed of *dilusional dysmorphophobia*, and once discharged, he was prescribed olanzapine 20 mg/day and clonazepam 4 mg/day on an out-patient basis. Two years after the initial diagnosis of dysmorphophobia, and in spite of the contraindication of his psychiatrist, he underwent a rhinoplasty operation. He obtained temporary relief of his symptomatology with it. At the time of admission, he manifested having attempted suicide because he only saw two solutions to his problems: «have a new operation or kill myself.» He presented intense malaise and anguish secondary to the conviction that his friends, work colleagues and up to 90% of the rest of the persons noticed the defect that, according to him, his nose had; they noticed that he had been operated on and they mocked him behind his back. He mentioned that the inflammation produced by the rhinoplasty had disappeared and that he could see now how he really was after the operation. He said that his nasal septum was too narrow, with an enlarged nasal raphe, and that the deformity was most obvious in the right profile. Furthermore, he considered that rhinoplasty for cosmetic purposes was a reprehensible event and he felt ashamed. He spent several hours a day in front of the mirror, checking his defect. He continuously thought, also for hours, about the idea that people were laughing at him behind his back. Both the physical examination as well as the complementary tests performed (routine blood, biochemistry and thyroid hormones) were normal. Initially pimocide at a dose of 6 mg daily together with dipotassium chlorazepate 45 mg/day and lormetazepam 2 mg/day were prescribed. Clorimipramine was also introduced until a dose of 300 mg/day was reached. After 20 days of treatment with Pimocide, it was withdrawn due to the intense psychomotor restlessness it caused. Besides the drug treatment, thought blocking techniques were initiated (to control the insistent and intruding ideas) and massive exposure therapy in order to desensitize the patient regarding his self-referential ideas, together with relaxation technique. After one month of admission, his evolution was favorable, and he had euthymic mood, absence of ideation or suicide planning, and denied that he intended to request a rhinoplasty operation again. The diagnosis on discharge was delusional dysmorphophobia.

CASE 2

A 21 year old woman brought to the emergency service involuntarily due to the presence of shouting in her home that alarmed her neighbors. As psychiatric background, she presented an anxious-depressive disorder at 7 years of the death of her mother and received psychological treatment. She had attempted suicide on two occasions, one by venoclysis and the last, 2 years before this present admission, by drug poisoning. She was not receiving any psychiatric treatment. Medically, at 2 years of age she underwent a skin graft due to accidental burn with boiling oil; she was operated on for strabismus at 11 years of age and again one year ago, for very unclear reasons (according to the relative, and she also had an ophthalmology report that did not show any disorder susceptible of operation).

On admission, the patient presented intense anxiety, with emotional lability and temporal disorientation. She reported that two weeks ago, she had felt «that my eyes went blank and that everyone was looking at me». Since then, she said that she is afraid and feels like the cameras installed by the neighbors are watching her, she noticed that she could guess the thoughts of the people and predict the immediate future, she stated that her eyes «were larger and more pronounced» and that she was pregnant. She also stated that she heard the voice of a priest in her head that advised her and tried to help her since she believed that they wanted to kill her due to her eyes. On the day of her admission, she tried to pull her eye out with a spoon and cut her veins. The onset of the psychotic picture coincided with the abusive consumption of cocaine, alcohol and amphetamine derivatives.

The patient reported that she had had «a complex» about her eyes since she was very young. One year before admission, she was re-operated on by her own request in order to definitively correct the defect, however her condition worsened after the operation. She began to continually observe her eyes in the mirror, she was obsessed with the thought that people were looking at her eyes and laughing at her. The last year and a half, she had hardly left home, lacked motivation and had a feeling of sadness, ate little and lost weight (not observed). Together with this isolation in her home, she went out at night on the week-ends and compulsively consumed alcohol and different toxic agents, such as cocaine, amphetamines and cannabis. The first days of her admission, she repeatedly requested to be seen by an ophthalmologist, threatening suicide if her request was not satisfied.

Risperidone was administered up to a maximum dose of 6 mg/day, dipotassium chlorazepate 10 mg/day and lormetazepam 2 mg/day. Evolution during the 15 days that her admission lasted was favorable, with complete remission of the psychotic symptoms, without residual symptoms. She manifested certain doubts on the seriousness of her eye defect but that, in any event, the request for the ophthalmologist was adequate. All this made hospital discharge and her being treated as an outpatient possible, with a diagnosis on discharge of acute polymorphic psychotic disorder with schizophrenia symptoms (of possible toxic origin) and dysmorphophobia and with treatment with risperidone 3 mg/day, dipotassium clorazepate 10 mg/day and lormetazepam 2 mg/day.

DISCUSSION

Both cases include the characteristics of body dysmorphic disorder, an exaggerated concern for an imaginary defect (or if it does exist, it is mild and the concern is clearly exaggerated) that can have a delusional character, rituals, such as checking in front of the mirror, pursing surgery or other medical, non-psychiatric treatment, with limited response to them; significant clinical malaise and deterioration in social and work function. In addition, both had elevated seriousness derived from the disorder.

Although dysmorphic symptoms can appear secondary to other disorders, such as depression, psychosis, anorexia nervosa, etc, in the second case, the dysmorphophobia picture preceded the psychosis in time and can be considered comorbid to the borderline personality disorder that was verified with the posterior follow-up of the patient.

Dysmorphophobia can become very serious due to several reasons. In the first place, it is an underdiagnosed entity and its high rates of prevalence among patients seen in the hospitalized[19] and out-patient[7] psychiatry services are surprising when its presence is specifically examined. It is unlikely that the patients will request psychiatric help and the comorbidity rates[20,21] or secondary disorders are high. They frequently present depressive pictures, anxious symptoms, with social anxiety, suicide ideas and attempts, harmful consumption and dependence on drugs. Finally, attention has been called on the aggressivity that some patients may demonstrate against the physicians or surgeons[22]. Phillips et al.[23] reported how a considerable number of patients admitted fantasies of aggression towards their surgeon, in a study that shows the inefficacy of surgical and medical treatments (non-psychiatric) in most of the patients.

Thus, dysmorphophobia can be considered a potentially serious diagnosis that should be kept in mind by the clinician since early psychiatric treatment can largely benefit those patients who suffer it, avoiding subsequent medical, such as unnecessary interventions, as well as psychiatric complications.

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