Body dysmorphic disorder: Borderline category between neurosis and psychosis

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ABSTRACT

Body dysmorphic disorder is an under-recognised chronic problem, which is established as independent diagnostic entity. Its clinical features, co-morbidity, course, and prognosis have been studied in detail. But the issue of its psychotic and non-psychotic variants and the question of dimensional or categorical method of classifying this disorder still poses a diagnostic dilemma. This case report tries to highlight on this issue.

Key words: Body dysmorphic disorder, delusional and non-delusional variant, psychotic and non-psychotic variants

INTRODUCTION

Body dysmorphic disorder (BDD) is an under-recognised chronic problem that is defined as an excessive preoccupation with an imagined or a minor defect of a localised facial feature or body part, resulting in decreased social, academic, and occupational functioning. Studies have reported rates of BDD of 7% and 15% in patients seeking cosmetic surgery and a rate of 12% in patients seeking dermatologic treatment.[1]

BDD has both psychotic and nonpsychotic variants, which are classified as separate disorders in DSM-IV (delusional disorder and a somatoform disorder). Despite their separate classification, available evidence indicates that BDD’s delusional and non-delusional forms have many similarities (although the delusional variant appears more severe), suggesting that they may actually be the same disorder, characterized by a spectrum of insight. In fact, it is one of the diagnostic entities that falls on the borderline between neurotic and psychotic spectrum of disorders.

THE CASE

Mr. S is a 27-year-old male from middle socio-economic status. Patient was referred to the psychiatry outpatient department from the plastic surgery department for clearance of rhinoplasty surgery. Patient was interviewed in detail and his history dated back to 17 years of age when he was in his final year of schooling was noted. He started noticing pimples and acne on his face that embarrassed him to face his colleagues. He observed that few of them cleared but few on the face left black marks and those on the nose turned into comedones. Most of them cleared with treatment from a dermatologist. But the patient’s concern with the healed scars on the face and nose started increasing and he started becoming preoccupied with them. He felt embarrassed in facing his classmates and would feel shy to face the public or relatives who would come to his house.

Patient adopted measures like covering his nose with his hands while speaking to others or while listening to the lectures in the class so that others would not see it. Over time, he started developing rituals such as repeatedly watching his nose in the mirror, frequently washing his face after he returns back home from outside, would apply powder over the nose to cover up the imagined area of scars.
on the nose and had tried to reshape his nose on his own by using a stone which resulted in bleeding and worsening of the condition.

Patient developed anxiety in social situations because of his referential thinking involving his imagined ugly appearance. He also developed misinterpretations of other people's behavior and comments linking them to his facial disfigurement. Patient spent enormous amount of time and money in reshaping his nose even at times stealing money from home. He developed depressed mood, death wishes and suicidal thoughts as a result of lack of improvement with treatment from various doctors. Patient had frequent change of jobs giving the reason as his inability to cope up with works involving social contact as a result of his ugly nose. He also started attributing his failures in academics and professional life to the imagined deformity in the nose. Patient did have recurrent suicidal ideation secondary to preoccupation with imagined deformity and occupational dysfunction but there was no active attempt.

Patient did have history of stammering since childhood, which exacerbated after his social anxiety increased. He had history of alcohol and tobacco harmful use. Patient is the first among the five siblings and his mother used to be very critical of his appearance from his childhood. There is family history of stammering but there was no other significant mental illness in the family. He had difficult temperament from his childhood although adequate information could not be obtained.

At the time of presentation to us, patient had nonpervasive sad mood, decreased concentration in his work, significant social anxiety, and avoidance of social situations due to referential thinking, stammering, strong beliefs that his nose is ugly and deformed (amounting to delusional component), low dose of risperidone was started during the course of treatment to observe progression of muscular relaxation. He was explained about the excess of compulsive rituals that he was performing and home based exposure response prevention was initiated. He was started on sertraline and clonazepam and their doses were hiked up on subsequent visits. In view of the delusional component, low dose of risperidone was started in addition during the course of treatment to observe for additional improvement. Since there was no obvious improvement above that obtained with SRI, it was stopped.

Patient is on continuous follow up with us for the past six months. He reported of decrease in his social anxiety and intensity of stammering. His compulsive rituals also decreased except for mirror watching. His visits with other specialty doctors for change of nasal deformity was reduced to almost 1 visit in the above period. But his belief about imagined nasal deformity was still at delusional level. Patient discontinued medications 15 days back and came with relapse of symptoms. He was restarted on medications and was advised follow-up with his family member.

**Psychometric assessments**

On Eysenck Personality Questionnaire, he is found to be a person of introvert personality getting high scores on neuroticism and low scores on psychoticism. On Middle Sex Hospital Questionnaire, he gets significant scores on the scales of free-floating anxiety, phobia, obsession, somatization, depression and hysteria.

On Multiphasic Questionnaire, he gets significant scores on the clinical scales of paranoid, psychopathic deviation, depression and anxiety. On Social Phobia Inventory, he gets a score of 52, which is interpreted as extreme. On Beck's Depression Inventory, he gets a score of 18 which is interpreted as mild.

On Yale Brown Obsessive Compulsive scale modified for Body Dysmorphic Disorder (BDD-Y-BOCS), he gets a score of 24 which is interpreted as moderate. Rorschach record with few popular responses, poor form level, rejection of responses at the time of inquiry, low number of FC responses, C+ CF is greater than FC responses, unusual and bizarre responses, emphasis on major detail (D) responses and the presence of m responses is suggestive of a psychotic record with mixed features of anxiety and depression. Themes about sexual preoccupation, extramarital relations, pessimism, lack of assertiveness, and delinquent behavior (lying) were brought out on TAT stories.

**Treatment plan**

Contract was established with the patient about avoiding visits to other doctors of different specialities for the treatment of his deformity. His preoccupation with his stammering as one of the reasons for his failure in occupational functioning was taken as the target in the treatment. Patient was educated about his anxiety contributing to his stammering and he was started on progressive muscular relaxation. He was explained about the excess of compulsive rituals that he was performing and home based exposure response prevention was initiated. He was started on sertraline and clonazepam and their doses were hiked up on subsequent visits. In view of the delusional component, low dose of risperidone was started in addition during the course of treatment to observe for additional improvement. Since there was no obvious improvement above that obtained with SRI, it was stopped.

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**DISCUSSION**

The patient discussed here presents as a prototype case of BDD described in various studies. As described in various studies, the age of onset for the reported case was in adolescence and the duration between the onset of illness and contact with the mental health professional was almost
ten years during which period there were frequent visits to dermatologists and plastic surgeons. His premorbid personality assessment also showed a mixture of avoidant, paranoid, and emotionally unstable personality (impulsive type) as observed in literature.[2]

Factors that may predispose persons to BDD include low self-esteem, critical parents, and significant others, early childhood trauma and unconscious displacement of emotional conflict. They also had an earlier onset of major depression and higher lifetime rates of major depression (26%), social phobia (16%), obsessive compulsive disorder (6%), and psychotic disorder diagnoses, as well as higher rates of substance use disorders in first-degree relatives.[3,4] The reported case had comorbid OCD, social phobia with mild depression and stammering. The co-presence of BDD and OCD features appears to possibly individuate a particularly severe form of the syndrome, with a greater load of psychopathology and functional impairment and a more frequent occurrence of other comorbid mental disorders.[5] Adults with BDD have markedly impaired functioning and notably poor quality of life.[6]

BDD may have a closely related psychotic subtype that significantly overlaps with, or may even be the same disorder as, the BDD variant of delusional disorder, somatic type. Although the clinical features and phenomenology are almost similar to non delusional BDD, delusional BDD patients had significantly lower educational attainment, were more likely to have attempted suicide, had poorer social functioning on several measures, were more likely to have drug abuse or dependence, were less likely to currently be receiving mental health treatment, and had more severe BDD symptoms.[7]

The question arises as to include this category under neurotic or psychotic disorders or whether an intermediate category needs to be created for such disorders whose extreme severity results in a psychotic variant similar to obsessive compulsive psychosis. This disorder has features predominantly of neurotic subtype such as its phenomenology similar to hypochondriasis and obsessive compulsive disorder, comorbidity with anxiety spectrum disorders and good response to selective serotonin reuptake inhibitors. On the other hand, many earlier authors considered BDD a prodrome or variant of schizophrenia.[8]

Contrary to what might be expected, BDD’s delusional form, although classified as a psychotic disorder, appears to respond to serotonin-reuptake inhibitors alone[9] which questions its existence as a distinctive category under psychotic subtype. In addition, the delusional variant does not differ from the non-delusional variant on many of the measures except its severity which might point to the existence of a single disorder. The case of BDD discussed above had comorbid anxiety spectrum disorders with impaired insight and significant impairment in occupational functioning and quality of life in view of delusional component. This necessitates the inclusion of poor insight or good insight specifiers and dimensional system of classifying such disorders. Although the initial response to SSRIs and anxiolytic showed significant improvement in his symptoms, during the course of illness a low dose of neuroleptic was added to augment the response but no added improvement was observed as quoted in the literature.

**Recommendations**

It is likely that a number of disorders span a spectrum from delusional to nondelusional thinking, with unlimited shades of gray in between. Future research may indicate that obsessional disorders such as BDD, anorexia, OCD, and hypochondriasis, as well as other disorders such as major depression, should have qualifiers or subtypes – for example, “with good insight,” “with poor insight,” and “with delusional (or psychotic) thinking” – with an implied continuum of insight embraced by a single disorder.

Such approach will not only improve our classification system but also may have important treatment implications. For example, the preliminary finding that delusional BDD responds preferentially to SSRIs but not to neuroleptic agents contradicts conventional wisdom about the treatment of psychosis. Inclusion of a psychotic subtype for BDD should be considered for future editions of DSM.[10] These and other data suggest that a dimensional view of psychosis (in particular, delusions) in these disorders may be more accurate than DSM’s current categorical view.

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