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Body Dysmorphic Disorder – Borderline Category Between Neurosis and Psychosis

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ABSTRACT

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

Keywords: Body dysmorphic disorder, delusional and nondelusional variant

Body dysmorphic disorder (BDD) is an under-recognized chronic problem that is defined as an excessive preoccupation with an imagined or a minor defect of a localized 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 Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (delusional disorder and a somatoform disorder). Despite their separate classification, available evidence indicates that BDDs delusional and nondelusional 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.

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CASE REPORT

A 27-year-old male from middle socioeconomic status, was referred to psychiatry OPD from the plastic surgery department for clearance for 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. He started noticing pimples and acne on his face, which embarrassed him to face his peers. 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 do not watch it. Over time, he started developing rituals such as repeatedly watching his nose in the mirror, frequently washing his face after he returned 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 harmful tobacco use. Patient was the first among the five siblings. His mother used to be very critical of his appearance from his childhood. There was family history of stammering but there was no other significant mental illness in the family. He had a difficult temperament from his childhood although adequate information was not available.

At the time of presentation to us, patient had non-pervasive 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 level) with absent insight and attributed all his failures to the physical problem. There was significant impairment in social, occupational and academic functioning. There were obsessions related to contamination and compulsive washing, checking and obsessive images, blasphemous thoughts and sexual obsessions. Patient was diagnosed to have BDD - delusional variant with obsessive compulsive disorder mixed type, social anxiety disorder, dysthymia with mild depressive episode without somatic complaints and stammering according to DSM-IV criteria.

Psychometric Assessments

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

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

On BDD-Y-BOCS (Yale Brown Obsessive Compulsive Scale modified for Body Dysmorphic Disorder), he got 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 specialties 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 selective serotonin reuptake inhibitor (SSRI), it was stopped.

Patient is on continuous follow-up with us for the past 6 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 were reduced to almost one 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 he was advised follow-up with his family member.

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 10 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 have 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 obsessive compulsive disorder, social phobia with mild depression and stammering.

The co-presence of BDD and obsessive compulsive disorder 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.[2]

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 nondelusional BDD, delusional BDD patients have significantly lower educational attainment, are more likely to have attempted suicide, have poorer social functioning on several measures, are more likely to have drug abuse or dependence, are less likely to currently be receiving mental health treatment and have more severe BDD symptoms.[6]

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 SSRIs. On the other hand, many earlier authors considered BDD a prodrome or variant of schizophrenia.[7]

Contrary to what might be expected, BDD's delusional form, although classified as a psychotic disorder, appears to respond to serotonin-reuptake inhibitors alone,[8] which questions its existence as a distinctive category under psychotic subtype. In addition, the delusional variant does not differ from the nondelusional 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 SSRI 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, obsessive-compulsive disorder 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.[9] These and other data suggest that a dimensional view of psychosis (in particular, delusions) in these disorders may be more accurate than DSMs current categorical view.

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Zinc Supplementation should be Considered in the Combination of Chloroquine/Hydroxychloroquine Against COVID-19

The new severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has rapidly spread to nearly every country causing coronavirus disease-19 or COVID-19. At present, there are no approved vaccines or pharmaceutical treatments available for prevention or treatment of COVID-19 infection. Globally, social distancing and self-quarantine are the only protective measures to slow the rate of COVID-19 infections.

Zinc is a common stimulant of antiviral immunity. In COVID-19 morbidity and mortality, zinc deficiency could be significant for the outcome of patients with severe clinical courses including elderly patients, and patients with hypertension, coronary heart disease, diabetes or chronic obstructive lung disease. It is also speculated that younger adults or infants and adolescents with zinc deficiency might be at higher risk for SARS-CoV-2 infections. Hence, it is postulated that effective zinc supplementation during treatment of COVID-19 with chloroquine/hydroxychloroquine (CQ/HCQ) that have zinc ionophore characteristics can result in increased intracellular zinc levels in general and in lysosomes. In patients who are at high risk in developing severe COVID-19, oral administration of adequate doses of zinc should be considered.

Supplementation of zinc is recognized to be clinically safe if dosing ranges and upper limits of dosing are based on suggested dietary allowances. In a randomized, double-blind, placebo-controlled trial, oral zinc supplementation with 45 mg zinc per day for 12 months confirmed a significant lower prevalence of infections in the elderly and it was well-tolerated.

Therefore, CQ/HCQ in combination with zinc should be considered in the treatment of COVID-19 patients as an added study arm for COVID-19 clinical trials.

Source: Derwand R, Scholz M. Med Hypotheses. 2020;142:109815.

Concussion Linked to Risk for Dementia, Parkinson's, ADHD

According to new research, published in *Family Medicine and Community Health*, a BMJ journal, concussion is linked with increased risk for subsequent development of attention-deficit/hyperactivity disorder (ADHD), as well as dementia and Parkinson's disease.

Investigators noted that the link between concussion and risk for ADHD and for mood and anxiety disorder was stronger in females than in males. History of multiple concussions made the association between concussion and subsequent mood and anxiety disorder, dementia and Parkinson's disease stronger, compared with history of just one concussion. The retrospective, population-based cohort study also revealed that controlling for socioeconomic status and overall health did not significantly affect this association… (*Medscape*)