

## Case report

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# A case report of schizophrenia with an atypical presentation of body dysmorphic disorder

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### Summary

Although body dysmorphic disorder is a psychiatric disorder. Sometimes, it can be a variant of a variety of psychiatric syndromes like schizophrenia, mood disorders, OCD etc. Here is an atypical case report of a 28 years old male patient who presented with body dysmorphic disorder later on diagnosed as having schizophrenia. The difficult part in this diagnosis is to make the difference between the psychotic and the non-psychotic form of the disorder. Finally, its successful treatment with antipsychotic drugs, thus contributing to what has been documented on the subject.

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### Introduction

Body dysmorphic disorder (BDD) or dysmorphophobia was first described by an Italian physician named Enrico Morselli more than 100 years ago.<sup>1</sup> Later on BDD was described by many distinguished psychiatrists such as Emil Kraepelin and Pierre Janet<sup>2,3</sup> and, over the years, numerous case studies have been reported from around the world.<sup>4</sup> Patients with BDD believe they look ugly or deformed, for example, they think that they have a large and 'repulsive' nose, or severely scarred skin), but in reality they look normal. As a result of their bodily concerns, they may stop working and socializing, become housebound, and even commit suicide.<sup>5,6</sup> They respond to these beliefs with compulsive behaviors, such as repeatedly combing hair or covering up perceived blemishes that are unpleasant and difficult to control. BDD typically follows a chronic course<sup>7</sup> and often associated with low quality of life. There is Comorbid major depressive disorder, substance use disorders, obsessive-compulsive disorder (OCD), and social phobias frequently associated with this condition.<sup>5,8-10</sup> The fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental disorders 5 (DSM-5) characterizes BDD as a preoccupation with a perceived defect or a markedly excessive concern where there is a slight physical anomaly, with associated significant distress and/or functional impairment.<sup>11</sup> Although it is generally considered that BDD is a psychiatric disorder in its own entity, a few authors have suggested that a variety of

psychiatric disorders like schizophrenia, mood disorders, OCD etc. can present with this non-specific symptom.<sup>12</sup> Several authors have considered BDD as a prodrome or variant of schizophrenia.<sup>13</sup> In fact, many recent reports suggest that BDD may be the only presenting symptom in prodromal phase of schizophrenia.<sup>14</sup> This report highlights a case of BDD, which was later diagnosed as schizophrenia. The purpose of this paper is to present a case on schizophrenia complicated with BDD and other psychiatric co-morbidities that may be difficult to manage even in a tertiary level psychiatrist hospital in developing country. Lessons learnt from this subject may help psychiatrists in managing case especially in resource-limited settings.

### Case report

A 28 years old, unmarried, Muslim, male, studied up to class 10, currently unemployed for 12 years, healing from urban background of Polash Norshindi presented with the complaints of social isolation and extreme fear of women, self-muttering and irrational thinking about body parts, suspiciousness and hearing of voice, occasional aggressive and violent behavior, sleep disturbance, restlessness and loss of appetite. His Informant was patient himself and his mother. Symptoms were aggravated for last one and half month but total duration of illness was for 12 years. And it was continuous type in nature. According to the informant and the client himself he was reasonably well 12 years back. He was in class eight at that time. His parents shifted him from one school to another better

school as quality of the previous school was not good. Both the schools were coeducational. Patient said that he noticed his female classmates were laughing at him without any reason. They were talking about him that he was not a good-looking person. He often did not want to go to school. He gradually developed fear of women, finally it became so strong that now he has fear about not only women but also other people and he preferred to live alone. In 2006 he appeared in SSC examination but withdrawn himself from the examination after appearing only in English 1st paper. From then his study was stopped. After that he preferred to stay alone in home and became socially isolated. He gave a history of masturbation from his early life when he was in class 5. He said that he collected female clothes and used to masturbate on those clothes. But his mother never found any female clothes in his room. He developed self-muttering; his mother noticed that when he was alone, he was talking to himself by moving his hands like he was talking to someone else. But when she asked him about this, he stopped to doing this. He had some irrational thinking about his body parts. He thought that his limbs were slightly curved. His facial look was ugly. He used to see himself on the mirror repeatedly. He asked his mother to bring some cosmetics (cream) for him. He used to check other people's legs for comparing with his own. He thought that due to excessive masturbation his body parts become disfigured. He usually heard some unseen female voice talking bad about him. Mentioned him as insane and ugly looking. They were laughing loudly at him, Initially his schoolmates but later on women of all ages. He also had suspiciousness about his grandmother that she wanted to do harm to him. There were occasional violent and aggressive behavior. He used to beat his mother and his sister without any provocation. He broke household things previously. He became restless, there was sleep disturbance, loss of appetite, lack of self-care for the last one and half months. He did not go to bed at night, walked to and fro in the house from one room to another. Went to the toilet repeatedly for micturition thinks that he had DM. sleep at late night or early in the morning for shorter period. With these complains he is admitted for better management. Regarding Family history, His father was died 2 months back due to cancer. Mother is alive. He had 1 brother and 2 sisters. One of his maternal aunts had psychiatric illness. One of his uncles (Father's cousin) had psychiatric illness. In his family the family members are well behaved and caring to him but the patient is occasionally violent and aggressive towards them. His Birth history and Early developmental milestones was normal, childhood uneventful, schooling and education up to SSC mentioned previously, performance was good, unemployed for 12 year. In 2005 he was treated by a renowned psychiatrist and given 6 cycle of electro convulsive therapy (ECT) along with medication but there was no improvement. In 2008 he was admitted in national institute

of mental health (NIMH) but could not provide any evidence. From 2010 he was under treatment of a psychiatrist. He was treated with Inj. Flupentixol depot, tab. Clozapine, tab. Trifluoperazine, tab. Procyclidine. But he took medication irregularly. Before the illness he had a good relationship with the family members and peer group. He used to spend his leisure period by watching TV. His predominant mood was obsessive trait. He maintained moral standard and respectful to religion. His ultimate concern was living a peaceful life. On mental state examination he was wearing t-shirt and lungi came to the examination room with permission and proper greetings. He was overall kempt and combed. Body built was average. Nutrition was also average. He was anxious and irritable. He showed no psychomotor over activity and Followed social norms. Eye to eye contact was Established but not maintained. Rapport was established but difficult to maintain. Rate, rhythm, and volume was normal. Answering was relevant to the question. Content seems to be relevant. There was no pressure of speech. Fluency was normal. Mood was depressed. Affect was irritable and congruent. Persecutory delusions- (His grandmother was trying to do harm), delusion of reference present, occasional suicidal ideation present. No poverty of thought, pressure of thought or thought block. There was no insertion, withdrawal, broadcasting. Auditory hallucination. (2<sup>nd</sup> and 3<sup>rd</sup> person) present. He was orientated about time, place and person. His attention was focused, concentration was sustained. Memory was intact. Intelligent, judgment, abstract was present. He said that he had physical illness, but no mental illness and he needed treatment for physical illness. He had no anemia, jaundice, cyanosis and edema. His pulse was 75 beats/min and blood pressure as 120/80 mmHg. Nervous system and other systemic examination revealed nothing significant. Relevant laboratory investigations showed nothing abnormal. Primarily we diagnosed this as a case body dysmorphic disorder as because there was body parts related complain and he was preoccupied with size and shape of the body. Our second thought was major depressive disorder as there was social isolation, depressed mood and suicidal ideation. But as there was persecutory delusion, delusion of reference, 2<sup>nd</sup> and 3<sup>rd</sup> person auditory hallucination, loss of function, partially impaired insight and a long history finally we had diagnosed this is a case of Schizophrenia. Family history of psychiatric illness was the predisposing factor, precipitating factor was lack of social support, and perpetuating factors were disease process, social stigma and irregular taking of medication. He was given, tab. clozapine (200 mg), tab. risperidon (6 mg), tab. sertraline (100 mg), in divided doses and tab. clonazepam (2 mg) at night. After improvement explorative psychotherapy, supportive therapy and family therapy, psycho education, exposure and response prevention, systemic desensitization, thought challenge and imagery technique were

given. As the onset of the disease was at early age, male gender, it could be predicted that along with good drug compliance and psychosocial support patient can maintain normal life.

### Discussion

Patients with BDD have overvalued ideas about their 'defective' appearance. A number of other psychiatric disorders like schizophrenia are also accompanied by odd or unusual fixed ideas about body image (as in our patient). For example, in some cases of schizophrenia patients may have somatic delusions for which they seek cosmetic surgery but other diagnostic features like bizarre delusions and auditory hallucinations also be present.<sup>14,15</sup> Social anxiety and avoidance is also common among people with BDD.<sup>16</sup> Our patient has strong social phobia. It is possible, however, that the observed correlation reflects greater suggestibility or influence by task demand characteristics with increasing social anxiety. They may describe themselves as looking unattractive or deformed. Concerns most often focus on the face or head (e.g., acne or skin color, balding, or head size) but can include any parts of body or the entire body. They are often associated with fears of rejection and feelings of low self-esteem, shame, embarrassment, unworthiness, and being unlovable. Insight is usually poor, and nearly half of patients are delusional (i.e., completely certain that they look abnormal and that their view of the 'defect' is accurate).<sup>6,17</sup> In addition, a majority have delusions of reference, thinking that others take special notice of the 'defect', perhaps staring at it, talking about it, or mocking it. The age of onset for the reported case was in adolescence and there was a long gap between the onset of illness and contact with the mental health professional and there was also drug noncompliance. His premorbid personality assessment also showed a mixture of avoidant, paranoid, and emotionally unstable personality (impulsive type) as observed in literature. 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.<sup>18,19</sup> The reported case had comorbid OCD, social phobia with severe depression. When BDD and OCD features present along with delusion, possibly this indicate 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.<sup>20</sup> Adults with BDD have markedly impaired functioning and notably poor quality of life.<sup>21</sup> Though BDD is considered as a neurotic disorder, our patient responded well to antipsychotic (clozapine and risperidone) who, in longitudinal course turned

out to be a case of schizophrenia. This indicates that body dysmorphic disorder may be a variant or early presentation of schizophrenia as noted earlier.<sup>15,22,23</sup>

### Conclusion

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. However, studies of all aspects of BDD are needed - in particular, treatment studies, epidemiology studies (in which BDD symptoms are specifically inquired about and differentiated from other disorders such as hypochondriasis and OCD), cross-cultural studies, and investigation of BDD-related disability and the disorder's cost and burden to society. Research is also needed on whether BDD may be more closely related to social phobia, OCD, or depression than to most of the other somatoform disorders with which it is classified. Research on BDD's pathogenesis, including its underlying neurobiology, has just begun; such work may ultimately lead to more effective treatments and prevention of this severe mental disorder. This increased understanding of BDD may also have useful implications for other disorders, in that it may be more valid and clinically useful to conceptualize their delusional forms as a variant of the nonpsychotic parent disorder rather than as a separate psychotic disorder. Research on this clinically relevant question is greatly needed.

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