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•Case report•

Case report of body dysmorphic disorder in a suicidal patient

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Summary: Few reports exist about the treatment of body dysmorphic disorder (BDD) in patients who are suicidal. This case report describes a 19-year-old male with BDD who had delusional-intensity beliefs about facial disfigurement that had gradually intensified over a 2-year period. However, he was initially misdiagnosed with depression partly because he was admitted immediately after a suicide attempt that was associated with depressive symptoms and social withdrawal, symptoms that subsequently proved to be secondary to his BDD. The symptoms resolved completely and his social functioning returned to normal after 8 weeks of inpatient treatment with fluoxetine and cognitive behavioral therapy. This report is a reminder that suicidal behavior and ideation can have many causes; to avoid misdiagnosis and inappropriate treatment, clinicians should consider other possibilities before assuming that suicidal behavior or ideation is the direct result of depression. We discuss the many changes in the understanding and diagnostic classification of BDD since it was first reported by Enrico Morselli in 1886.

Keywords: body dysmorphic disorder; major depressive disorder; suicidal behavior; misdiagnosis; China

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1. Case history

A 19-year old male university student was brought to the hospital after a suicide attempt related to his obsessive preoccupation with his facial appearance. His accompanying family members reported that he believed his face was so ugly that it required a skin graft. Two years earlier, at the age of 17, he had developed acne. From that time onward he experienced disturbed sleep and become increasingly preoccupied with the appearance of his face. He had repetitive thoughts such as, "If I squeeze my pimples today, they will grow back tomorrow. I cannot deal with my acne." During the past 18 months he increasingly believed that his face had turned ugly and his skin pores were overly enlarged. He would spend four to six hours per day checking his facial skin, sometimes washing it 5-6 times daily. He told others, "If I wash my face often enough, maybe my skin pores will shrink in size." He repetitively looked in the mirror and said he felt scared when looking at his 'ugly' face. Several times he had scheduled cosmetology consultations to ask plastic surgeons to perform a skin graft, but he was told there was no reason for treatment. However, he continued to believe that his facial pores were grossly enlarged and that others made fun of him because of this. Frequent internet searches convinced him that the only way to deal with the problem was to have a skin graft. He became socially withdrawn, fearing that others would laugh at him. When he had to be in crowded areas, he felt restless and believed that others were laughing at his ugly face. After cutting his wrist in despair about his condition, his family members brought him to our hospital.

At the time of the initial examination, his facial skin appeared normal in color, texture, and elasticity. He looked handsome and wore clean clothes. During the interview he said little and spoke softly and slowly. At times he covered his face with his hands. He repetitively stated that when looking in the mirror the size of his facial pores were as long as toothpicks and that his appearance was so marred by his ugly face he was unable to interact with others. He also reported that his internet searches convinced him that the only solution was a skin graft, but his request for a skin graft had been refused by numerous medical experts; he believed the reason for their refusal was because his skin problem was so severe that it could not be treated. His feelings of hopelessness and worthlessness led to the suicide attempt of cutting his wrist: "I feel very bad. There is no meaning to my life. I would rather die."

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His initial diagnosis on inpatient admission was depression. He had no history of mania, allergies, smoking, or substance use. His physical exam was normal, and his mental status examination showed clear consciousness and correct orientation. His personality had been outgoing, but irritable. There was no family history of mental illness. Laboratory tests, an electrocardiogram, an electroencephalogram, and a cranial computerized tomography (CT) scan excluded any somatic disease. During a case review with senior clinicians, his diagnosis was changed to body dysmorphic disorder (BDD). After discussing treatment options with the patient, he was treated with fluoxetine and cognitive behavioral therapy (CBT).

The initial dose of fluoxetine was 20 mg/d; after one week it was increased to 40 mg/ d. As part of the CBT he recorded the onset and content of his disturbing thoughts and the emotional reactions triggered by them; he then reviewed these records with his therapist and gradually learned to identify and modify his self-destructive thoughts. For example, when experiencing the thought, 'I think others are laughing at my ugly face', the therapist encouraged him to find objective evidence to support this belief. He gradually noticed that his thoughts lacked objective evidence; this helped to alleviate his anxiety, depression, and shame. After two weeks of treatment, his mood normalized and his thoughts about the worthlessness of life disappeared. He was still preoccupied with his imagined facial distortion, but he began to tolerate looking at himself in the mirror. The dose of fluoxetine was then increased to 60 mg/d and the CBT was continued. After 6 weeks of inpatient treatment he understood that his preoccupations about his skin were irrational but he was still not stable. Ongoing therapy focused on increasing his confidence to overcome his irrational thoughts and on using objective evidence and rational attitudes to counter his irrational thoughts. By the eighth week of treatment, the preoccupations with his perceived facial distortion had disappeared, so he was discharged from hospital. During the two months of follow-up visits after discharge, he re-engaged in his university studies and was able to interact well with other students.

2. Discussion

Body dysmorphic disorder (BDD) is characterized by obsessive preoccupation with an imaginary or trivial physical anomaly that is perceived as a severe flaw to one's appearance which requires extreme measures to hide or repair. The thoughts are pervasive and intrusive and can lead to distress, shame, and social isolation.[1] The condition was first described in 1886 by Enrico Morselli[2] who used the term 'dysmorphophobia' to label individuals with a normal appearance who are convinced that they have ugly physical flaws that are noticeable by others. The condition was not classified as a formal psychiatric disorder until 1987 when it was renamed 'body dysmorphic disorder' and included among the Somatoform Disorders in the 3rd revised edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III-R).[3] At that time BDD excluded cases in which the preoccupation was of delusional intensity (when delusional, the 'Delusional Disorder, Somatic Type' label was applied). In the subsequent 4th edition of the DSM (DSM-IV)[4] released in 1994, BDD remained in the Somatoform Disorders group of disorders but the diagnosis was expanded to include cases where the preoccupation was delusional (in which case a co-morbid diagnosis of Delusional Disorder, Somatic Type was given). In the most recent 5th revision of the DSM (DSM-5)[5] released in 2013, BDD has been reclassified within the 'Obsessive-Compulsive and Related Disorders' group of disorders and the level of insight about the believed physical change is specified; if the preoccupation is delusional, this is specified, but a co-morbid diagnosis of Delusional Disorder, Somatic Type is not applied (unless other types of delusions are present). The DSM-5 diagnostic criteria are as follows:

(a) preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others;

(b) at some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns;

(c) the preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning;

(d) the appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

One study[6] reported that 13.8% of individuals with atypical major depression had comorbid BDD and another study[7] found that depression was commonly comorbid with BDD. These results suggest a close relationship between the two conditions. However, in the current case the patient's depressive symptoms were clearly secondary to his preoccupation with imagined facial skin anomalies. He initially believed his appearance had changed and subsequently feared meeting others; he then became increasingly depressed and anxious, and finally made a suicide attempt. He was not concerned about body fat or weight, but he did have a history of repetitive mirror checking and excessive grooming, so he fulfilled the DSM-5 criteria for BDD. His beliefs were of delusional intensity, so the BDD diagnosis was specified as 'with absent insight/ delusional beliefs'.

There is some debate about whether or not a co-morbid diagnosis of major depressive disorder (MDD)

is merited in this case. In DSM-5[5] a MDD diagnosis is not considered if the symptoms can be explained by a psychotic disorder (criteria D, page 161). BDD is not included among the psychotic disorders, but in this case BDD included delusional beliefs, so it was of psychotic intensity. Rigid application of DSM-5 criteria would probably result in the addition of a co-morbid MDD diagnosis, but we considered the depressive symptoms completely secondary to the BDD (which was of delusional intensity), so we chose not to add the MDD diagnosis.

Current recommendations for treating BDD include pharmacotherapy and cognitive behavioral therapy (CBT).[8] Phillips and colleagues[9] suggest that a selective serotonin reuptake inhibitor (SSRI) should be the first-line medication for the pharmacological treatment of BDD; and one controlled study[1] reported that fluoxetine (one of several commonly available SSRIs) was effective in the treatment of BDD. Cororve and Gleaves[10] concluded that CBT was also effective in treating BDD. In the current case the patient's severe symptoms of BDD resolved over the course of 8 weeks of inpatient treatment with fluoxetine and CBT.

Community surveys in Europe report that the prevalence of BDD ranges from 0.7% to 2.4%.[11,12] However, relatively few of these cases are identified in clinical settings, possibly because the symptoms are not reported to clinicians (presumably because the individual feels embarrassed about them). In our case the young man was initially diagnosed with a major depressive disorder because his suicide attempt prior to admission put the focus on his depressive symptoms which, in retrospect, were clearly secondary to the BDD. A previous study[13] reported that 30% of individuals with BDD had a history of prior suicide attempt, so this is not an unusual occurrence.

The case highlights the need for clinicians to avoid assuming that suicidal behavior or ideation is the direct result of a depressive disorder.[14] In a substantial subgroup of patients there are other mental disorders that are the primary cause of the suicidal behavior or ideation. Failure to recognize this could lead to misdiagnosis[15] and to inappropriate treatments.

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Conflict of interest statement

The authors declare that they have no conflict of interest related to this manuscript.

Informed consent

The patient signed an informed consent form and agreed to the publication of this case report.

因自杀行为而就诊的躯体变形障碍 1 例报告

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概 述： 对治疗伴自杀行为的躯体变形障碍 (body dysmorphic disorder, BDD) 的病例报道较少。本文报道了一位患有 BDD 的 19 岁男性患者，两年来认为自己面部变丑，这一信念逐渐加重，几乎达妄想程度。然而，他最初被误诊为抑郁障碍，部分原因是他企图自杀，当时存在抑郁症状和社会退缩。后来经证实，这些症状是继发于 BDD 的。经过 8 周住院治疗，采用氟西汀和认知行为治疗相结合，患者的症状彻底改善，社会功能也恢复正常。这一病例提醒我们，自杀行为和意念有多方面原因；为了避免误诊和不恰当的治疗，临床医生只有在排除其它可能的原因后才能推断自杀行为和意念是抑郁症的直接结果。本文也讨论了自 1886 年 Enrico Morselli 首度报道 BDD 后，在理解 BDD 和 BDD 的诊断标准上的诸多变化。

关键词： 躯体变形障碍；抑郁症；自杀行为；误诊；中国

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