

Delusional disorder-somatic type (or body dysmorphic disorder) and schizophrenia: a case report

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Abstract

With regard to delusional disorder-somatic subtype there may be a relationship with body dysmorphic disorder. There are reports that some delusional disorders can evolve to become schizophrenia. Similarly, the treatment of such disorders with antipsychotics has been documented. This report describes a case of delusional disorder - somatic type - preceding a psychotic episode and its successful treatment with an antipsychotic drug, thus contributing to what has been documented on the subject.

Key words: Delusional disorder; Somatic; Body dysmorphic disorder; Schizophrenia

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Introduction

The classification of body dysmorphic disorder (BDD) is controversial; whereas BDD is classified as a somatoform disorder, its delusional variant is classified as a psychotic disorder.^{1,2} This psychotic variant is also referred to as delusional disorder somatic type. It is sometimes very difficult to distinguish cases of delusional disorder of somatic subtype from severe somatization disorder, and claims have been made that there is a continuum between these illnesses.³ The condition differs from other conditions with hypochondriacal symptoms in degree of reality impairment.

The reported prevalence of BDD differs between studies; ranging from 2% of patients who requested plastic surgery⁴ to 12% of patients with obsessive-compulsive disorder.⁵ Fifty percent of BDD patients are reportedly delusional.⁶ The disorder may be under diagnosed because many of the patients with somatic delusions present to other specialists such as dermatologists or plastic surgeons, more often than to psychiatrists in the unremitting search for curative cosmetic procedures which they are usually denied.⁷ But if the surgeon does not perceive the illogicality of the complaint an operation

may take place. While some successes have been reported, the general consensus is that most cases need psychiatric rather than surgical intervention and that surgery may seriously worsen the mental disorder in the longer term.⁷

A previous or family history of psychotic disorder is uncommon and in younger patients, a history of substance abuse or head injury is frequent.⁸ Although anger and hostility are commonplace, shame, depression, and avoidant behavior are even more characteristic. Suicide, apparently motivated by anguish, is not uncommon.⁸ Somatic delusional disorders are quite difficult to treat, as evidenced by a treatment success rate of approximately one-third.⁹ Treatment with antipsychotic drugs have been reported to be useful in the management.^{10,11,12,13} Delusional disorder is thought to be fairly stable and less than 25% of all patients with delusional disorder progress to schizophrenia.¹⁴ The relationship between delusional disorder and schizophrenia is not of inevitable progression from the former to the latter. Studies have found that while schizophrenia spectrum disorders were more prevalent in the biologic relatives of the schizophrenic adoptees, the same was not the case for delusional disorder thus pointing out that from a genetic perspective, delusional disorder may not be part of the schizophrenia spectrum.^{15,16} These findings were supported by another study that found delusional disorder (compared with schizophrenia, affective illness and psychotic disorders not otherwise specified) as the least prevalent (2.7%) among the probands of patients with schizophrenia.¹⁷

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The case describes a case of delusional disorder - somatic subtype - preceding schizophrenic illness in a young man.

Case Report

A 22 year old single student (Mr. A.O.) was brought for treatment in the early part of 2007 by his older brother (a surgeon) to whom he had complained, about 3 months earlier, of a bigger right thumb. The brother had on many occasions told him after repeated examinations that the thumb was normal in appearance and functioning – in comparison to the left thumb. All these reassurances were not satisfactory to the patient who then went to see an orthopedic surgeon with the same complaints, seeking a surgical intervention to “normalize” the right thumb. The orthopedic surgeon, apparently, sensing a possible psychological problem in the patient reported the case to the patient’s brother who then brought him for evaluation. On further enquiry, he reported that the thumb was functioning well and not painful and surgical operation was the only solution to his problem.

Apart from sad mood related to his “thumb problem” there was no symptom related to an affective or psychotic disorder and no history of current or past history of use of psychoactive substances.

He was in the second year of a 2-year National Diploma program in the state vocational college and was doing well in his academic work. He had no problems relating with colleagues. He had a cordial relationship with family members and friends as well as with a female friend whom he wished to marry. He had no problem with his finances.

On physical examination, there was a missing right upper canine which he said was removed by a traditional dentist about 3 months before presentation (about the same time as the complaint about the thumb). The reason for the removal was because the canine tooth was “pointing in a different direction” compared to the other canines and people had started noticing the abnormality. The canine was not painful and not a carious tooth. He regretted the removal afterwards because the gap left was more noticeable and “badly pointing”. He had no other abnormality on physical examination. On mental state examination, he was conscious, with good orientation, was well groomed, was spontaneous in speech and was coherent. He did not manifest other abnormal symptoms such as auditory hallucinations or passivity phenomena. No abnormalities were detected other than the somatic delusion of a perceived larger thumb. Diagnosis of dysmorphobia was made on account of his somatic delusion of a perceived larger thumb -which he held on to despite explanations to the contrary – and this occurring in the absence of schizophrenic or affective symptoms, substance use disorder or general medical condition and without marked impairment of functioning. He was commenced on trifluoperazine 5mg twice daily and was followed up in the clinic initially every two weeks and later monthly for eight months. He improved significantly over this period and remission was achieved on trifluoperazine 5mg three times daily. He completed his academic course and proceeded to an industrial attachment, a pre-requisite for a Higher National Diploma. This he did in Port Harcourt, in the southern delta region of the country and was subsequently lost to follow-up.

Following a 7 month period where he had remained uncommunicative, he was brought by the mother with a five weeks history of laughing and mumbling inaudible words to himself, undue irritability and poor sleep. He was hearing voices of unseen people discussing him in clear consciousness; the discussion focused on the defect in his teeth and the need for him to return to school after his industrial attachment. The discussion could sometimes be amusing. He had also preferred solitude to being in the midst of people which resulted in disruption of his training. When asked about his strange behaviors he would become irritable and frequently threatened violence. The sleep duration was also reduced from his usual 7-8 hours of sleep to less than 3 hours of intermittent sleep pattern. There was no history of substance use and no preceding physical illness since last seen. No family history of mental illness was noted.

A diagnosis of schizophrenia was made on account of a five week history of third-person auditory hallucination, self absorbed behaviours and a decline in socio-occupational functioning.

He was recommenced on trifluoperazine 5mg three times daily which was increased a week later to 5mg-5mg-10mg; he was stabilized on the dose. Two months into the management, he had improved with symptom remission and a return to his premorbid level of functioning.

Discussion

The subject of this report first presented with features suggestive of delusional disorder, somatic type and later with features suggestive of a paranoid schizophrenia. Paranoid schizophrenia subtype was considered because of the presence of a third person auditory hallucination that was derogatory, irritability and threat of violence. The two diagnoses were separated by period of remission from the initial diagnosis following discontinuation of medication. The initial diagnosis was made on the basis of the delusion in the absence of other psychotic symptoms that would imply the presence of schizophrenia, schizoaffective disorder, mania or depression and substance use disorder and the symptoms had been present for at least 3 months thus satisfying the tenth edition of the International Classification of Diseases (ICD-10)¹⁸ that requires the symptoms to have persisted for at least 3 months. Of note is that the patient’s personality and psychosocial functioning were not significantly affected by the disorder. This is unlike the non-delusional body dysmorphic disorder in which the patient is preoccupied with imagined or slight defect in appearance, the disorder causing notable distress, impairment in socio-occupational functioning, and is more likely to be associated with markedly poor quality of life.^{19,20} In fact, the quality of life of individuals with BDD is said to be poorer than those found in major depressive disorder, dysthymia, obsessive-compulsive disorder, social phobia, panic disorder, premenstrual dysphoric disorder and post traumatic stress disorder.²⁰ The recognition of the patient’s irrationality by the elder brother probably saved the thumb from unwarranted surgical manoeuvre as had occurred with the removal of the tooth. The patient was treated with an antipsychotic drug and remission was achieved. This treatment choice was supported by previous studies that demonstrated response of delusional disorders to both typical and atypical antipsychotics.^{10,11,12,13}

The presentation of the patient after periods of medication discontinuation with third person auditory hallucination, self absorbed behaviours, and decline in socio-occupational functioning lasting for more than four weeks met the ICD-10 criteria for schizophrenia. One might be tempted to think that the initial presentation was part of the second diagnosis, the former occurring in the prodromal phase of the later. This is unlikely because the ICD-10 clearly describes the prodromal phase of schizophrenia as a phase in which symptoms and behaviour, such as loss of interest in work, social activities, and personal appearance and hygiene, together with generalized anxiety and mild degrees of depression and preoccupation, preceded the onset of psychotic symptoms by weeks or even months. This ICD description is quite different from the patient's morbid conviction of a perceived abnormality of an otherwise normal thumb and probably a normal tooth that was inadvertently removed. The preoccupation in this case report was marked (to a delusional intensity) without loss of interest, social activities, and personal hygiene.

Conclusion

It is therefore proposed that the reported case describes one of schizophrenia preceded by a somatic delusional disorder.

References

1. American Psychiatric Association (APA). *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington, DC: Author; 1994.
2. Phillips KA, Menard W, Pagano ME, Fay C, Stout RL. Delusional versus non delusional body dysmorphic disorder: Clinical features and course of illness. *Journal of Psychiatric Research* 2006;40(2): 95-104.
3. McElroy SL, Phillips KA, Keck PE, Hudson JL, Pope HG. Body dysmorphic disorder: does it have a psychotic subtype? *Journal of Clinical Psychiatry* 1993, 54, 389-95.
4. Andreason NC, Bardach J. Dysmorphobia: a symptom or disease? *Am J Psychiatry* 1977;134:673-76.
5. Simeon D, Hollander E, Stein DJ, Cohen L, Arowitz B. Body dysmorphic disorder in the DSM-IV field trial for obsessive-compulsive disorder. *Am J Psychiatry* 1995;152:1207-301.
6. Phillips KA, McElroy SL, Keck PE Jr, Pope HG Jr, Hudson JL. A comparison of delusional and nondelusional body dysmorphic disorder in 100 cases. *Psychopharmacol Bull* 1994;30:179-186.
7. Vulink NCC, Denys D. Body dysmorphic disorder: an overview. *Dutch Journal of Psychiatry* 2005; 47(1): 21-27.
8. Gelder M, Gath D, Mayou R, Cowen P. *Delusional Disorders in Oxford Textbook of Psychiatry*. 3rd ed. London, Oxford University Press. 1996. 294-307.
9. Opjondsmoen S. Hypochondriacal psychoses: a long-term follow up. *Acta Psychiatrica Scandinavica* 1988; 77:587-597.
10. Buckley PF, Sajatovich M, Meltzen HY. Treatment of delusional disorders with clozapine (letter). *Am J Psychiatry* 1994; 151: 1394-1395.
11. Songa DS, Roman B. Treatment of Somatic Delusional Disorder With Atypical Antipsychotic Agents. *Am J Psychiatry* 1996 ; 153(4):578-9.
12. Andrews E, Bellard J & Walter-Ryan, WG. Monosymptomatic hypochondriacal psychosis manifesting as delusions of infestation: case studies of treatment with haloperidol. *Journal of Clinical Psychiatry* 1986; 47: 188 -190.
13. Opjondsmoen S, Retterstol N. Outcome in delusional disorder in different periods of time: possible implications for treat with neuroleptics. *Psychopathology* 1993; 26:90.
14. Kaplan HI, Sadock BJ. *Delusional disorder: In Concise Textbook of Clinical Psychiatry*, Middle East edition. Mass Publishing Company, Egypt 1996:150-156.
15. Kendler KS, Hays P. Paranoid Psychosis (Delusional Disorder) and Schizophrenia: A Family History Study. *Arch Gen Psychiatry* 1981; 38(5):547-551.
16. Kendler KS, Gruenberg AM, Strauss JS. An Independent Analysis of the Copenhagen Sample of the Danish Adoption Study of Schizophrenia III. The Relationship Between Paranoid Psychosis (Delusional Disorder) and the Schizophrenia Spectrum Disorders. *Arch Gen Psychiatry* 1981; 38(9):985-7.
17. Kendler KS, Walsh D. Schizophreniform disorder, delusional disorder and psychotic disorder not otherwise specified: clinical features, outcome and familial psychopathology. *Acta Psychiatrica Scandinavica* 1995; 91(6):370 - 8.
18. World Health Organization (WHO). *The ICD-10 classification of mental and behavioral disorder: diagnostic criteria for research* (10th revision). Geneva: World Health Organization; 1992.
19. Phillips, KA, Crino, RD. Body dysmorphic disorder. *Current Opinion in Psychiatry* 2001; 14(2):113-118.
20. Phillips K A. *The broken mirror Understanding and treating body dysmorphic disorder*. New York, Oxford University Press. 1995:130.