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BODY DYSMORPHIC DISORDER: CASE REPORT

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SUMMARY

The desire for self-mutilation in the absence of any discernible psychopathology is relatively rare. Self-mutilation is most commonly a manifestation of an underlying psychopathology such as depression, schizophrenia, personality disorder, transexuality, body dysmorphic disorder and factitious disorder. In this article, a case in which a 29-year-old single Kenyan lady of African origin demanded a surgical operation to modify and reduce the size of her external genitalia is presented. Although female genital mutilation is still widespread in the country, this case is of interest in that the woman did not seek the usual circumcision but sought to specifically reduce the size of her labia minora so that she could feel like a normal woman. The unique challenges in her management are discussed. Possible aetiological factors in patients who demand surgical removal or modification of parts of their bodies without an obvious cause is discussed.

INTRODUCTION

People may desire to have parts of their bodies altered for various reasons. General surgeons and plastic surgeons in particular often have to cut, modify or reconstruct parts of the body in order to cure some disease or enhance beauty as in elective plastic surgery to remove wrinkles or fat deposits. In some cases, however, the patients' demands and expectations border on the bizarre. In such cases, there could be an underlying psychopathology. Conditions that may present with self-mutilation include paraphilias, schizophrenia, depression, delirious states or dementia, personality disorder, body dysmorphic disorder (BDD) and factitious disorder (Munchausen Syndrome) (1, 2). In addition to these, the primary cause could be a gender related disorder or an amputee related disorder.

Amputee related disorders refer to conditions in which the subject derives sexual gratification by relating to a person with an amputation. Alternatively,

the person may desire and demand that an amputation of a limb (usually the lower, but also upper limb) be carried out. This enables them to fulfill their wishes (3). In gender-related disorder, the subject believes that he or she is in a wrong body and may demand that their external genitalia be modified accordingly. Some may carry out crude operations on themselves if they cannot get qualified medical personnel to assist them. Psychotic patients may also carry out such operations in response to command hallucinations. Confused patients, due to delirious states or dementia, and mentally retarded individuals may mutilate their bodies due to poor judgement. Depressed patients may also mutilate their bodies to atone for their guilt feelings. In body dysmorphic disorder (4), the subjects believe that parts of their bodies are malformed and they may go to great lengths to have these corrected. In this contribution, the authors report on a young woman who demanded that her external sex organs be modified despite the fact that no abnormalities were noted on physical examination.

CASE REPORT

A twenty nine-year old Kenyan woman presented at the Psychiatric Clinic of Kenyatta National Hospital as a referral from the gynaecological clinic. When asked about the presenting complaints she said it was all in the file and in any case, she did not understand why she was sent to see the psychiatrist since she was not "crazy" and all she wanted was a mere operation. She bitterly complained that the hospital was wasting her time and that had she gone to a private facility, she would have had the operation and continued with her life. Three months prior to this presentation, she had consulted with the gynaecologists who subsequently referred her for psychiatric evaluation before scheduling her for excision. Discussion of the case with the referring gynaecologist confirmed there was no labial enlargement that could account for her presenting complaint of a "left vulval mass that was causing her discomfort while walking". During the first interview, she denied any current or past psychiatric history, personally or in the family, wondering aloud whether the psychiatrist had started thinking that they were a family of "crazy people". She refused to discuss anything that, in her view, had no relevance to her requested operation. She nevertheless consented to a physical examination, which was essentially normal as confirmed by one of the authors M.W.K.

During subsequent interviews, she gradually opened up, revealing that she had had the problem since school days when she was in form two (16 years). She had noticed that her labia were bigger than those of her peers. She denied having teased or having received comments about the same. The desire to have the operation was enhanced seven years prior to this consultation, after watching a video entitled "female external genitalia". The video concluded, "there was room for corrective surgery" for those who wish to have smaller labia giving no other indications for such operations. The patient reported no previous injuries to her external genitalia. Three years prior to this consultation, she had invested in a full-size dressing mirror, but denied that its purpose was for examining or monitoring the labia. She also denied having preoccupations with her ideal body weight. She stated that she felt like a "half woman" due to the perceived body defect. She confided in one of the female authors that she had lost a boyfriend and attributed this to the enlarged labia. The boyfriend however had never openly complained about her external genitalia. She

since had another boyfriend (of one year) with whom she was relating sexually, using the male condom to prevent pregnancy, as they had not yet made any commitments to get married. The current boyfriend had not complained about the "defect in the labia". She abhorred the practice of circumcision. She did not have any psychological or physical symptoms and signs of depression or anxiety. Apart from the unusual preoccupation, her mental state examination during the first and subsequent visits was essentially normal. One could not fail, nonetheless, but to detect a state of inner anguish in this woman.

Despite repeated appeals to come along with a significant member of her family for further probing, she never brought anyone along saying that she was the one with the problem and did not see the relevance of her relatives accompanying her to the hospital. This was in spite of repeatedly emphasizing the need of corroborative history at each psychotherapeutic visit. Laboratory investigations, including Liver Function Tests (LFTs), Thyroid Function Tests (TFTs), Renal Function Tests (RFTs), hypothalamo-pituitary-adrenal axis (HPA) tests and complete blood counts were not done due to financial constraints and lack of physical stigmata for the existence of the respective conditions. In any event, fifteen years is a long time for such conditions to have manifested physically. After a few sessions of psychotherapy, she agreed to take medication as well. Empirically she was started on fluoxetine 20 mg twice a day and risperidone 3 mg twice a day. The latter was tapered off to 3 mg nocte after one month. These medications were chosen on the premise that patients presenting with this secondary to an atypical underlying psychotic or affective condition may not present with the classical symptoms of either. Further, the treating team felt that in the absence of corroborative information from close family members-who she refused to bring along-symptoms and signs of either of the above may have been denied by her in an attempt not to appear "crazy". Some response was noted to this treatment in that she became less preoccupied with having the operation. She was lost to follow up after four months.

DISCUSSION

Broadly speaking this case falls under the general rubric of self-mutilation (or the desire for), which unfortunately, is not a diagnosis, but a symptom of other underlying psychopathologies, though none of

these were identified, most likely due to the patient's denial as exemplified by unwillingness to bring along her significant others. Monosymptomatic delusional disorder may present as in this case, though the age of onset does not support this diagnosis (4). Psychologically, the patient was distressed and said that she did not feel like a full woman due to her perceived defect. Because of that, the diagnoses is unlikely to have been gender identity disorder, she did not wish to change her sex. DSM IV criteria for schizophrenia, delusional disorder or major depressive disorder were not met in this case (4).

Some parallels can be drawn between this case and BDD (5-7). These include obsession with a defect that is either minor or non-existent, even to expert observers, ritual checking or monitoring of the "defect" necessitating a goal-directed behaviour to have the "defect" corrected, and repeated hospital visits in search of surgery to have the alleged defect corrected. This case has fewer symptoms than the ones involving the exposed parts of the body, as might be expected (6,7). There are a few similarities between this case and amputee identity disorder (AID) (8,9) - the age of onset in adolescence and the feeling of incompleteness. Her sex life was reported not to be satisfying and she felt it could be better if the operation was performed. The cultural aspects were considered as well. It is known that in some cultures in Kenya it is desirable for a woman to be circumcised failure of which may mean that she cannot be married. It should however be noted that the patient was very specific on the type of operation she wanted. She did not simply want to be circumcised.

This case presented with peculiar management problems. These included initial rejection of therapy (she insisted she was not "crazy" and needed no psychiatric intervention), missed appointments complicating the therapeutic progress, refusal to be accompanied by relatives to assist in getting corroborative history.

In conclusion, most cases of BDD do not initially present to psychiatrists, as exemplified by this case. They run the danger of getting the operation that they so passionately want but experience has shown that such procedures never work in this group of patients (8, 9). Their rejection of psychiatric help is understandable since in their own perception the removal of the offending defect is all that can cure them. They require an understanding and patient approach,

once confidence and trust has been cultivated, a course of weekly cognitive behavioural therapy sessions for three to four months is all that is needed for mild cases. In florid cases, the addition of drugs such as selective serotonin reuptake inhibitors (SSRIs) to reduce initial anxiety or depression is recommended (9).

The following conclusions were drawn from this case: The need to unearth any underlying psychopathology in bizarre presentations especially among patients resisting corroborative input from their significant others; The need for collaboration between specialists; The importance for doctors to understand the normal anatomy and variations in size for the external genitalia; In bizarre presentations like this one, surgical corrections per se may not satisfy the patient and may indeed start off a cycle for further operations as the first "may not be quite right" (6,7).

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