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# A study of facial dysmorphophobia

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The psychopathology of 20 subjects who presented to psychiatrists with facial dysmorphophobia was examined. Seven had body dysmorphic disorder and 13 had dysmorphophobic symptoms secondary to an underlying psychiatric disorder (usually depression). The body dysmorphic group had a younger age of onset and overvalued ideas about their appearance. In both groups there was a high proportion of associated personality disorder, usually of the anxious (avoidant) type.

In dysmorphophobia or body dysmorphic disorder, the patient has a subjective feeling of ugliness or physical defect which he or she believes is noticeable to others although appearance is within normal limits (Hay, 1970a). It has been considered to be a rare psychiatric syndrome.

There has been controversy as to whether this disorder is just a symptom of an underlying disease or a separate disease entity (Andreasen & Bardach, 1977; Thomas, 1984). The condition did not feature in ICD-9 (World Health Organization, 1978) but in ICD-10 (WHO, 1992) it is classified under hypochondriacal disorder and in DSM-III-R (American Psychiatric Association, 1987) under body dysmorphic disorder. In the ICD-10 definition, the dissatisfaction with appearance must be present for longer than six months, cause persistent distress or social disability and not be of delusional intensity.

This investigation aimed to identify any associated psychiatric disorder; classify the nature of the belief; and determine the premorbid personality of patients with dysmorphophobia.

## The study

A letter requesting referral of any patients who had dysmorphophobia or perceived facial disfigurement was sent to 221 consultant psychiatrists in the North Western Region of England three times over three and a half years (1986/89).

A full clinical history and a standardised assessment of the mental state using the Present State Examination was performed. Psychiatric diagnoses were made using the DSM-III-R and the Diagnostic Criteria for Research (DCR) of the ICD-10 classifications.

The nature of the dysmorphophobic belief was determined by following Jaspers' classification of abnormal beliefs (Jaspers, 1946). The premorbid personality of the dysmorphophobic subjects was ascertained by interviewing a relative or another informant using the Standardised Assessment of Personality (Mann *et al*, 1981).

## Findings

Twenty-five patients were referred over three years by 23 different psychiatrists (of whom two referred two patients). Most patients were

originally referred by their general practitioners ( $n=23$ ) but one was referred by a consultant physician and another by the courts to the psychiatrists. One subject failed to attend, three had clear evidence of an abnormality and the other was dysmorphophobic about his chest but not about his face. There were thus 20 patients considered to be of normal appearance by the investigator who entered the study.

Seven subjects had a body dysmorphic disorder (or hypochondriacal disorder), nine had major depression (or depressive disorder), one had a depressive organic mood syndrome (or organic depressive disorder), one had paranoid schizophrenia, one had normal weight bulimia (or bulimia nervosa) and one had a social phobia using the DSM-III-R and DCR of ICD-10 respectively.

In the body dysmorphic group, all the beliefs, with the exception of one which was obsessional, were classified as overvalued ideas. In the secondary group, six of the beliefs were overvalued ideas; the remaining seven beliefs were delusion-like ideas. Six of these delusion-like ideas were secondary to depression and one was secondary to the somatic hallucination that his nose was growing in size.

The body dysmorphic group were predominantly male, outnumbering females by 6:1 whereas females outnumbered males 7:6 in the secondary group. There was no difference in mean age at assessment but the body dysmorphic group had a younger median age of onset of disorder of 14 years compared with 21 years for the secondary group (Mann-Whitney U-test:  $Z=2.19$ ,  $P=0.03$ ). Only three

patients in this series, one from the body dysmorphic group and two from the secondary group, identified their facial appearance with one or other parent. There was a family history of mental illness (usually depression) in 40% and teasing in 45% of cases from either group.

One subject had a normal premorbid personality, 14 (70%) had self-conscious (three grade 1, 11 grade 2) traits, four had obsessional (all grade 2) traits and one had an anxious (grade 1) trait (Mann *et al.*, 1981). When applying the rules of DCR of ICD-10 there were nine anxious (avoidant), four anankastic (obsessive-compulsive), one paranoid and one schizotypal personality disorders; and when applying the DSM-III-R there were 10 avoidant, four obsessive-compulsive and one schizoid personality disorders. A summary of the findings is given in Table 1.

### Comment

Only 25 subjects were referred over three and a half years. The apparent low prevalence of dysmorphophobia, as seen in psychiatric practice, may be due to its rarity or possibly because such patients prefer to see a surgeon or a dermatologist and refuse referral to a psychiatrist (MacDonald Hull *et al.*, 1991; Phillips, 1991).

There were more secondary dysmorphophobias than primary cases. Most subjects in the secondary dysmorphophobic group suffered from depression but other psychiatric disorders were represented. In an American series of dysmorphophobia very high rates of comorbidity for mood (71%), anxiety (70%) and psychotic (30%) disorders were found (Phillips *et al.*, 1993). This preponderance of associated mental disorder is to be expected among samples of patients presenting to psychiatrists but may not be representative of the general population who have body dysmorphic disorder.

In the current series male subjects outnumbered females 3:2. Among the primary or body dysmorphic group the sex ratio increased to 6:1. This excess of males contrasts to an American epidemiological study in which the prevalence of body dysmorphic disorder was 4% among women and less than 1% in males (Rich *et al.*, 1992). Dermatologists and plastic surgeons report an excess of females (Hardy & Cotterill, 1982; Goin & Goin, 1981). To some extent the variations in sex ratio between different studies are due to selection biases, differing inclusion criteria and the effect

Table 1. Key messages

Dysmorphophobic symptoms often occur in association with other major mental disorders, particularly depression.

Primary body dysmorphic disorder has a younger age of onset (usually adolescence) than secondary dysmorphophobia.

The belief is typically an overvalued idea.

Abnormal personalities, particularly self-conscious (anxious avoidant) are over represented in both primary and secondary cases of dysmorphophobia.

Identify and treat any associated psychiatric disorder. Use serotonin reuptake inhibitors for depression and neuroleptics for psychosis.

Cognitive behavioural psychotherapy may be helpful in body dysmorphic disorder.

of different modes of referral. Hay (1970b) did find a non-significant trend for females to be referred to plastic surgeons and males to psychiatrists, perhaps reflecting societal expectations that it is more 'acceptable' for women to be concerned about their appearance than it is for men (Goin & Goin, 1981).

Among dysmorphophobic subjects it is possible to distinguish body dysmorphic disorder from secondary dysmorphophobia by younger age of onset and longer history. In most cases, the belief was an overvalued idea but delusion-like ideas were common among the secondary dysmorphophobias.

The high proportion of patients with a positive family history of mental illness, in both groups, is a significant predisposing factor. The effect presumably being mediated by genetic mechanisms, disordered family experiences and shared adverse life experiences (Olley, 1974). None of the relatives in this study, as in other studies (Phillips, 1991), suffered from dysmorphophobia.

Almost half the patients in both groups reported being teased about their appearance. Such harassment may affect personality development through the evolution of self-conscious traits and predispose to later dissatisfaction with appearance (Olley, 1974). The high proportion of associated personality disorder suggests that patients with such personality structures, particularly self-conscious (anxious/avoidant) types, are more vulnerable to develop dysmorphophobic symptoms.

This model of pathogenesis or predisposition may be particularly relevant to the patients with secondary dysmorphophobia who only focus on their appearance when they become significantly depressed, for example. However whether self-conscious traits render someone more vulnerable to the development of dysmorphophobic beliefs in depression or are just frequently associated with depression remains unclear. Cutting *et al* (1986) found that up to a fifth of depressed patients admitted consecutively to a South London hospital had such personality structures.

The direction of the relationship between body dysmorphic disorder and personality disorder is more complex. Such patients often have an onset of illness at or around puberty when the personality is still developing and in this situation the dysmorphophobia may contribute to abnormal personality development.

In summary, dysmorphophobia is often a symptom secondary to an underlying psychiatric disorder such as depression. However

in a third of cases, a primary dysmorphophobia or body dysmorphic disorder could be identified. It is a moot point whether some of the secondary dysmorphophobias should be classified as cases of body dysmorphic disorder comorbid with another major mental disorder. The role of associated abnormal personality development (particularly self-conscious or anxious avoidant traits) in body dysmorphic disorder as well as secondary dysmorphophobia is emphasised.

It is important to take a careful history of the evolution of the dysmorphophobic symptom and identify any associated psychiatric disorder. Treatment of the associated psychiatric disorder often leads to improvement in the level of functioning and a reduction in intensity of the dysmorphophobic belief. In this study and that of Phillips *et al* (1993) series depression was very common. In the latter series serotonin reuptake inhibitors were considered helpful to over half of the group.

Neuroleptic medication is usually indicated in psychotic states, with pimozide being considered especially effective in the delusional variant of body dysmorphic disorder (Munro, 1980) although others have found a poor response to this neuroleptic and subsequent good response to a serotonin reuptake inhibitor (Phillips & McElroy, 1993).

Medication is often ineffective in primary body dysmorphic disorder but cognitive behavioural psychotherapy has shown promising results in one small series of five patients (Neziroglu & Yaryura-Tobias, 1993) and in a larger series of 54 females (Rosen, J. C., personal communication 1994).

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