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Dysmorphophobia – A Centenary Discussion

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The term 'dysmorphophobia' was first defined by Morselli (1886) who wrote of it as "a subjective feeling of ugliness or physical defect which the patient feels is noticeable to others, although his appearance is within normal limits". A century later there is continuing debate as to its status as symptom, syndrome or discrete psychiatric illness. Misleadingly, it is not a phobia and there is no fear of physical abnormality *per se* – the ugliness of others is tolerated, although the patient may well be apprehensive regarding the response he anticipates his appearance will provoke in others. As a symptom the feeling may be expressed as a preoccupation with appearance, an obsession, overvalued idea or frank delusion. The accompanying self-consciousness may similarly range to full-blown delusions of reference. To some extent the failure of some authors, reporting on dysmorphophobic patients, to specify clearly the level at which the belief is held, has confounded clarification of the phenomenon.

The term dysmorphophobia is not applied to the disturbances of body image which may accompany primary or secondary organic brain disease, but has been seen as a non-specific symptom occurring in a wide range of psychiatric disorders (Crisp, 1981). Hay (1970*a*) reporting on a series of 17 dysmorphophobics, found 11 to have severe personality disorders, five to be schizophrenic and one to be suffering from a depressive illness. Generally, dysmorphophobia has been considered an ominous symptom, which may herald the onset of a psychotic breakdown (Bychowski, 1943); even when the patient is not considered schizophrenic at presentation, this may later emerge as the diagnosis (Hay, 1983). Connolly & Gipson (1978), examining two groups of patients 15 years after rhinoplasty, found a significant preponderance of psychiatric morbidity in the group who had had the operation for aesthetic reasons, of whom six of 86 had become schizophrenic, compared with the group who had had the operation following disease or injury.

However, in spite of the strikingly high psychiatric morbidity reported (Edgerton *et al*, 1960; Jacobsen *et al*, 1960; Hay, 1970*a*; Connolly & Gipson, 1978), it is also the case that in a substantial number of patients, concern with appearance occurs independent of other classifiable psychiatric illness. Thomas (1984) has argued for the existence of dysmorphophobia as a discrete psychiatric disorder, and suggested that the term secondary or symptomatic dysmorphophobia be used where other mental illness is diagnosed. In addition, he further differentiates those cases where the feeling of being deformed is an overvalued idea from those where the isolated belief reaches delusional intensity. It is suggested that the latter be diagnosed as a dysmorphic presentation of monosymptomatic hypochondriacal psychosis, a subgroup proposed by Munro (1980). Similarly, Schachter (1971) distinguishes between dysmorphic neuroses and dysmorphic delusions. Others also (Andreasen, 1977; *British Medical Journal* 1978; Munro, 1980) have emphasised this distinction which is important both theoretically and because of treatment implications. Monosymptomatic hypochondriacal psychosis has been reported as dramatically responsive to treatment with pimozide (Riding & Munro, 1975), whereas it is ineffective in neurotically determined dysmorphophobias. Braddock (1982) has commented on the difficulty which may arise in judging the delusional intensity of a belief in the clinical setting, and a trial of pimozide has been suggested as a useful diagnostic differentiating test by Riding & Munro (1975).

A further difficult, subjective clinical judgement which must be made, is the decision as to what constitutes normal appearance, and at what point a minimal, or noticeable deformity is acknowledged and the complaint considered justified. Harris (1982*a*) has described a group whose appearance was considered abnormal by some and normal by others. It is apparent that 'normal' is not synonymous with 'beautiful' or 'attractive' and it is not culturally abnormal to wish to be more attractive. A considerable body of research has detailed the social and interpersonal consequences of physical appearance with the overwhelming conclusion that attractiveness has a halo effect on perception – "what is beautiful is good" (Dion *et al*, 1972) and conversely a very negative stereotype prevails for the physically unattractive (Lacey & Birtchnell, 1986). This sociocultural aspect cannot be ignored, particularly perhaps in female patients. It is less culturally normal for a man to wish to manipulate his appearance and those that do so are likely to be, or to be judged to be disturbed. In a series of patients with minimal deformity requesting rhinoplasty, half the women

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but all the men received a psychiatric diagnosis (Edgerton *et al*, 1960).

Although the original definition of dysmorphophobia states that the appearance is within normal limits, much of the literature on dysmorphophobia refers to data which includes patients with minimal deformity. Diagnostic criteria proposed for dysmorphophobia allow for a slight physical anomaly to be present, but with the patient's concern judged disproportionately great (Andreasen & Bardach, 1977); again caution must be exercised in deciding how much concern is too much concern. MacGregor (1981) has emphasised that a minor deformity cannot be judged unless its meaning to the individual in his society is known, and cites the case of a Puerto Rican woman whose intense distress about a small facial scar, sustained in an accident, was more explicable when it was learnt that within her ethnic group such a scar was inflicted as a punishment for adultery. For those with noticeable deformity the impact of cultural and social influences on their lives has been widely acknowledged and psychological distress is seen as largely secondary to stigma and teasing (Hay, 1970*b*). Harris (1982*b*) has described a common pattern of experience in patients with a variety of physical deformities. In those patients with minimal deformity the complaint has been seen as fuelled by intrapsychic conflict. However, it must be remembered that there is no proportional relationship between the severity of a physical defect and the psychological distress generated. 'Funny' features such as 'bat ears' or 'buck teeth' may be more distressing, as teasing is less likely to be tempered by compassion. A minimal deformity then may be socioculturally significant and obversely the presence of noticeable deformity does not preclude the presence of psychiatric difficulties. A deformity may be used as an excuse for behaviour that has in fact other origins or even act as a focus for psychotic delusions (Clarkson & Stafford-Clark, 1960).

Body parts take on a psychological significance and symbolic function reflecting both cultural influences and family attitudes, and a complaint about a particular feature may reflect an underlying psychological conflict whatever the degree of deformity. Psychodynamic theories have tended to differentiate more by body parts than degree of deformity. The nose has been seen as experienced, via the process of identification, as a paternal/masculine feature (Meyer *et al*, 1960; Jacobsen *et al*, 1960) and, via symbolism, as a phallus. A woman's request for rhinoplasty has been interpreted as an attempt to free herself from a conflicted identification with her father to move with more ease into a feminine role. Several reports exist of men with anxieties concerning sexuality with overt or latent homosexuality requesting effeminate noses (Linn & Goldman, 1949; Hill & Silver, 1950). A repertory grid study (Birtchnell, 1985) tentatively supports these theories. Similarly, the breast symbolises femininity, sensuality and the ability to nurture. Those seeking breast augmentation may be attempting to recover a sense of their womanliness, while those requesting reduction may be uncomfortable with adult sexuality (Birtchnell & Lacey, 1988).

Recognition that a complaint about appearance might be understood in terms of psychological defence mechanisms resulted in much initial criticism of cosmetic surgery, which was seen as responding to the superficial request, with the attendant risks of dissatisfaction, decompensation, and symptom substitution. However, excellent results from surgery on the minimally deformed have been reported (Edgerton *et al*, 1960; Hay, 1973) and it has been suggested that neurotic, and even psychotic, patients can benefit from operation, particularly when prepared by a psychiatrist. Inevitably, there will be some overlap in presentation, and it may seem a nicety of judgement as well as a highly subjective one, but it is important to maintain a distinction (and many studies have not) between those patients with minimal deformity (the 'normal' but less than attractive) who might considerably benefit from operation and those with dysmorphophobia (Birtchnell, 1984) for whom psychiatric intervention would be more appropriate.

The clinical impression in the psychiatry/plastic surgery liaison clinic at St George's Hospital, London, is that dysmorphophobics are distinguished not only by an exaggerated and disproportionate distress about a minimal or indeed non-existent deformity, but also often by the vagueness of the complaint, e.g. "the skin under my eyes joins my nose in a funny way", rather than for example "the tip of my nose is rather bulbous". In addition, there is intense importunity to have 'something done' although they often cannot specify what kind of operation they think might help. Expectations concerning the benefits of the operation may be unrealistic and there may be a history of dissatisfaction with previous surgery or 'surgeon shopping'. While not always suffering from formal diagnosable personality disorder there is general agreement that these patients have personality problems (Janet, 1908; Jacobsen *et al*, 1960; Dietrich, 1962). They have been described as sensitive and/or insecure (Hay, 1970*a*) and having schizoid, narcissistic or obsessional traits (Andreasen & Bardach, 1977; Thomas, 1984). Whilst obsessionality is greater than in controls, they do not

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resemble obsessional neurotics, but they may be considerably depressed (Hardy & Cotterill, 1982). These then are the core of patients with primary dysmorphophobia where surgery is contraindicated.

Unfortunately, it is difficult to persuade these patients to receive psychiatric treatment and it is not yet clear what treatment might benefit them. To some extent this is because reports of treatment have not always clearly made the distinction between neurotically determined dysmorphophobia, monosymptomatic hypochondriacal psychosis, and those with minimal but socioculturally significant deformity, who could benefit from surgery. Reports exist on the treatment of dysmorphophobia with antidepressants (Jenike, 1984) and a trial of pimozide might prove useful (Riding & Munro, 1975). Behavioural psychotherapy has been reported as successful in a small number of cases (Beary & Cobb, 1981; Braddock, 1982), while insight directed psychotherapy has generally been seen as unrewarding (Druss *et al*, 1971). If research is to elucidate further the phenomenon of dysmorphophobia, a careful definition of the term is required. The level of intensity at which the belief is held and the degree of deformity should be clearly specified, as well as perhaps some assessment of the degree of distress in a cultural perspective and consideration of the psychodynamics. Only then will it be possible to clarify the demography, aetiology and prognosis of this condition and develop appropriate treatment.

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