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Dysmorphophobia—A Long-term Study

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SUMMARY This study examines the mental health of 187 patients who had a rhinoplasty fifteen years earlier. Of 101 who had the operation following disease or injury 9 are now severely neurotic and one schizophrenic; of 86 who had the operation for aesthetic reasons 32 are now severely neurotic and 6 schizophrenic. The differences between the two groups are significant, and show that dysmorphophobia is an ominous symptom.

Introduction

Morselli (1886) first coined the term dysmorphophobia for the complaint of some physical defect which the patient thinks is noticeable to others, although his appearance is within normal limits.

Hay (1970b) suggested that there is abundant evidence for regarding dysmorphophobia as a malignant symptom. He studied 17 patients who presented with this symptom and found that 5 were psychotic, 11 had severe personality disorder, and one a depressive illness. The fact that these patients were referred to a psychiatrist makes it not surprising that such a high level of psychological disturbance was present. However, in an earlier paper (1970a) he studied 45 patients who asked for a cosmetic rhinoplasty, 29 of whom were originally referred to surgeons and 16 to a psychiatrist. Of the total, 18 were found not to have personality disorders and only one was psychotic. He made no mention of any long-term follow-up on these patients.

Dysmorphophobic patients may be referred with this complaint to a psychiatrist because they already have some other signs of schizophrenia. Only a long-term follow-up of all unselected dysmorphophobics can tell us whether the complaint is truly an ominous symptom. We are unaware of such a study.

Method

The notes of all patients who requested a cosmetic rhinoplasty at the Plastic and Jaw Unit in Sheffield between 1955 and 1960 were studied. No attempt was made to grade the degree of deformity, though pre-operative photographs made it obvious that the alleged deformities were minimal. Patients who were thought to be psychologically disturbed when first seen were not operated on and are therefore not included in this series. An attempt was made to obtain a control group matched for age and sex who had been in the hospital at the same time and on whom rhinoplasty was done for deformity caused by injury or disease.

The patients' family doctors were consulted and asked about the mental health of each group in the years since the operation. They co-operated fully and were able to give much helpful information.

The severely neurotic patients were all well known, as they visited their surgeries frequently, and all were on psychotropic drugs, either tranquillizers or antidepressants, and had been for many years. Only those who were considered to have severe psychological disturbance were interviewed, i.e. 47 in all. Only one patient refused to be interviewed and apparently lived the life of a recluse, but her doctor had supplied reliable information. Schneider's classification of personality abnormalities was used, as were his criteria for the diagnosis of schizophrenia. Patients described as mildly neurotic were not included in the study, so it is conceivable that the incidence of psychiatric illness could have been greater.

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TABLE

Number of patients operated 1955–60 and present mental health

	No.	Now severely neurotic	Stable	Significance
Rhinoplasty for aesthetic reasons	86	32	54	$P < \cdot001$
Rhinoplasty following disease or recent injury	101	9	92	

	No.	Now schizophrenic	Stable	Significance
Rhinoplasty for aesthetic reasons	86	6	80	$P < 0{\cdot}05$
Rhinoplasty following disease or recent injury	101	1	100	

Results

The mean age at the time of operation and the time since operation at which the patients were interviewed were for the first group 28 years and 15 years respectively, and for the control group 27 years and 15·5 years respectively. In the first group 53 per cent of the patients were female and 47 per cent male, whilst in the controls there were 56 per cent male and 44 per cent female.

The results were analysed using the log-likelihood G Test with the d.f. as for $\chi^2 = 1$. The Table shows clearly the significantly greater incidence of serious psychological disturbance in the first group compared with the controls.

Discussion

The high incidence of personality disorder

The figures for severe psychological disturbance were unexpectedly high when compared to the prevalence rate for neurosis in the general population and in the controls.

Plastic surgeons in Sheffield are well aware of the psychological significance of requests for cosmetic surgery and avoid operating on those who appear to be psychologically disturbed; they have excellent liaison with the psychiatrist, though they are selective in whom they refer. It is not possible, therefore, to say how many of these 187 patients were psychologically normal at the time of operation about 15 years earlier.

Selection of patients for plastic surgery

Little has been written on patient selection for surgery. Klabunde and Falces (1964) in a survey of 300 patients, stated that 95·6 per cent of all rhinoplastic procedures apparently resulted in pleased, satisfied patients, although approximately 10 per cent may have needed one or more secondary procedures. These patients had at least a one-year follow-up.

Barsky (1944) said that a disfigurement bore no inevitable proportional relationship to the mental distress it might engender. He divided neurotics into the basic neurotic and the situational type (where neurosis is a temporary lack of adaptation to a particularly trying situation). In the former he suggested that surgery would relieve the anxiety just as it would repair the defect.

Clarkson and Stafford Clark (1960) made a more complicated classification, dividing patients into psychotic and non-psychotic. Of the psychotics, one group had obvious deformity, and here it was felt that operation might help, whereas others had no obvious deformity and no surgery was indicated. In the non-psychotic group, some had obvious deformity and surgery was indicated, while others had minor deformity only and disturbed personalities, and there were variable indications for surgery.

Hay (1970a) simplified the classification, again dividing the patients into two groups. The first were those who tended to be minimally disfigured and were either neurotic patients using the symptom as an excuse or scapegoat for deeper emotional difficulties, or else early psychotics. In these cases he felt surgery was risky. In the second group, the patients, although distressed because of their more marked deformities, had fundamentally well-adjusted personalities. In these cases he felt that the patient was likely to benefit from surgery.

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Finally, Druss *et al* (1971) suggested that co-operation between plastic surgeon and psychiatrist could be helpful in two instances: the diagnosis of somatic delusions in puzzling or unclear circumstances, and the conjoint treatment of the willing patient, who has some insight and realistic expectations.

Pathology of schizophrenia

The significantly increased incidence of schizophrenia in our results confirms the view that dysmorphophobia is an ominous symptom. The six patients were all suffering from 'dementia', in that all exhibited florid symptoms, were quite incapable of leading an individual existence outside hospital and were still receiving hospital treatment.

M. Bleuler (1941), studied 500 schizophrenic patients over a period of 15 years and found that, roughly speaking, 25 per cent of his cases recovered completely, 25 per cent developed mild personality defect, 25 per cent marked personality defect and 25 per cent dementia. This would imply in our study that many more of the 86 patients should have been schizophrenic but are now included in the severe psychological disturbance group. It seems unlikely that up to 24 of the original 86 patients were schizophrenic; it is more likely that patients with Schneiderian schizophrenia have a poor chance of recovery.

These findings certainly support the hypothesis that schizophrenia is essentially a breakdown of the ego boundaries. Jaspers (1913–46) and many others have described distortions of the body image in both schizophrenia and temporal lobe epilepsy. Delgado (1959) found that electrical stimulation of the temporal lobe induced in the subjects doubts about their sexual identity. Indeed, it may be that schizophrenia represents some dysfunction of the temporal limbic lobe system.

In this context, it is of interest that two of our patients had at some time during their lives expressed doubts about their gender. In one case it was possible to trace the gradual breakdown of the patient's ego boundaries. She was a young woman who first expressed dissatisfaction with her nose, then with her finger, then her labia, and finally developed doubts about her gender. She is now a chronic hospital patient, and when interviewed was grossly thought-disordered, giggling, grimacing and hallucinating.

It is also interesting that in the case records of the other five schizophrenic patients no mention is made of the original dysmorphophobia, and the illness made itself apparent approximately 6 to 7 years after the rhinoplasty.

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