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Dysmorphophobia

By G. G. HAY

Introduction and Review of the Literature

Patients are occasionally referred to a psychiatrist with the primary complaint of a cosmetic defect in their appearance, and in a previous communication 45 such patients, dissatisfied with their noses and requesting cosmetic surgery, were studied (Hay, in press).

Often, however, the complaint is in regard to some other bodily feature such as the chin or breasts, and occasionally patients are seen whose concern is for some external physical defect which they think is noticeable to other people whereas objectively they have no cause at all for complaint, their appearance being well within normal limits. The term dysmorphophobia has been used in the literature to describe this symptom, but it must be made clear at the outset that dysmorphophobia does not include disorders of the body image or schema such as are commonly seen in neurological disorders and in states of clouding of consciousness—which have an organic basis. In dysmorphophobia there is no evidence of coarse brain disease, and the disorder is one of the 'psychological' body image.

These patients are of particular interest in psychiatry, as dysmorphophobia has often been considered an ominous symptom in the sense that the patient may be an early schizophrenic.

Bychowski (1943) gives detailed case histories of patients where changes in the body image appeared as the initial phase of a psychosis and the illness then seemed to crystallize round these complaints, and Fenichel (1945) mentions bodily complaints in incipient schizophrenia, interpreting this as a sign of regression to narcissism. Stekel (1950) mentions dysmorphophobics to illustrate a discussion as to whether obsessions can develop into delusions: 'There are people who occupy themselves continually with a specific part of the body, e.g. nose, ears, eyes, bald head, bosom, genitals, etc. The thoughts can be very tormenting and are frequently connected with feelings of inferiority—they can be elaborated into a whole compulsive system.' He then goes on to state his opinion that monosymptomatic hypochondriacal obsessions frequently occur in psychotic conditions. That is to say, the initial diagnosis may be obsessive compulsive neurosis but a few years later the patient is found to be suffering from schizophrenia.

Gillies (1958) specifically mentions the type of case we are considering, quoting for instance patients complaining of asymmetry of the face or deformity of the nose, when the face is pleasing and so on. Korkina (1959) described 41 cases, emphasizing the rarity of the syndrome and stating that many of her cases were referred to her from the Institute of Medical Cosmetics in Moscow. She included eight cases who thought they smelt, but the remaining 33 were typical dysmorphophobics; 35 of the total received a diagnosis of schizophrenia. Some authors, such as Mayer-Gross, have indeed felt that all patients who hold sensitive ideas of reference in regard to their bodies or bodily functions, e.g. patients who feel that they smell, are schizophrenic—and Anderson (1964), although stressing the diagnostic difficulty in such patients felt that the majority were probably mild cases of that illness.

There is thus abundant evidence for considering dysmorphophobia to be a malignant symptom, in the sense that it may be delusional, and even if it appears to be an obsessional preoccupation the case may still be one of pseudoneurotic schizophrenia. Yet from the classical writers onwards it has been realized that certain deviant and sensitive (in the Kretschmerian meaning of the term) personalities may have superficially similar complaints, and be preoccupied with and complain about their

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appearance for no apparent reason. Morselli (1886), who first coined the term dysmorphophobia, described several cases, pointing out that the patient could be perfectly healthy, perhaps rather sensitive and emotional, and then might suddenly develop the complaint, following which he would be completely preoccupied by it. His patients had various complaints, including being concerned over a 'ridiculous' nose, small hands, a dimple on the chin, etc. He thought the condition rare and described it along with phobic and obsessional states.

Janet (1908) described numerous patients who had an unwarranted feeling of dissatisfaction with their physical appearance. He thought that these patients were neurotic and that although they resembled hysterics in some ways there were important differences, and he stressed the obsessional side of their symptomatology.

This opinion of Janet's—that dysmorphophobia is something rooted in the personality—is supported by Dietrich (1962). He says the term phobia is used because the patients present with a fear of upsetting other members of society aesthetically, and he argues that although dysmorphophobia can occur in a wide variety of illnesses the complaint is usually rooted in a particular personality type. 'The syndrome arises largely out of neurotic conditions or crises of personality development.'

Other workers have felt that such cases can often not be diagnosed as neurotic or psychotic without long-term studies. For instance Walter (1965) describes two cases of dysmorphophobia, and in discussing these and similar cases stresses the difficulty in diagnosis. He contrasts the hypochondriac with the dysmorphophobic—the former wanting to draw attention to himself by saying he is not normal; the latter wishing to appear normal but feeling that other people notice he is not.

As there are differing views in regard to the symptom, and because many of the above papers have only described individual or small series of cases, the opportunity has been taken to study a comparatively large group of such patients so that the concept of dysmorphophobia can be discussed and its nosological status considered.

Method and Case Material

There were 17 patients in the present sample. All were given a full standard psychiatric interview, following which they completed a battery of psychological tests. These were:

1. The *hysteroid obsessoid questionnaire*—used to assess such traits of personality (Caine and Hawkins, 1963).

2. The *five punitive scales*—employed to measure the general hostility and direction of hostility (Foulds, Caine and Creasy, 1960; Foulds, 1965). These scales consist of two intro-punitive scales (self-criticism and guilt) and three extro-punitive (acting-out hostility, criticism of others and projected hostility). The amount of general hostility is the sum of all five scales, and is used as a symptom measure. The direction of hostility is given by (2SC + G)—(AH + CO + PH), and is used as an attitude measure.

3. The *personal illness scale* of the Symptom Sign Inventory (Foulds, 1965).

In addition the patients also completed the *Eysenck personality inventory* (*Form A*) and the *Mill Hill vocabulary scale*.

Finally, a control group was obtained, matched for age and sex, from the nursing staff of a general hospital. These controls were selected at random by the matron's secretary. They were asked if they would take part in a research project and were told that they did not have to give their names. They were then handed an envelope containing the same psychological tests as the patients and asked to complete and return the forms.

Results

Table I shows the different bodily features about which the various patients complained.

The figures for age and sex distribution are shown in Table II.

Of the five women, all of whom were under 30, one was married and four single. Of the 12 men, one of five under 30 was married and six of the seven over 30.

(a) *The psychological tests*

Table III shows the means and standard deviations for the group of patients on the various test measures compared with the figures for the control group.

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TABLE I

Feature of concern	No. of patients	Sex of patient
Penis	3	Male
Mouth and smile	3	Male
Breasts	2	Female
Lines under eyes	2	Female
Buttocks	1	Male
Arms	2	Male
Legs	1	Male
Eyebrows	1	Female
Stomach	1	Male
Chin	1	Male
	17	

TABLE II

Years	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	Total
Male	2	2	1	2	4	0	0	1	0	12
Female	0	4	1	0	0	0	0	0	0	5

Mean age 29·4 S.D. 9·46

TABLE III

	Hysteroid obsessoid score	General hostility score (E + I)	Direction of hostility (I − E)	Personal illness scale	E.P.I.(A) 'E' score	E.P.I.(A) 'N' score	IQ
Patients Mean	18·5	25·0	+6·1	9·4	8·4	15·4	95·7
S.D.	5·25	7·47	4·65	4·49	3·89	4·56	7·98
Controls Mean	23·0(24)	15·5(12)	−0·3(0)	1·8(2)	11·5(12)	9·1(9)	—
S.D.	4·49(5·5)	6·12(6·5)	5·77(5)	1·76	3·71(4·3)	4·17(4·8)	—
't'	2·8	4·03	3·4	6·3	2·38	4·2	—
P:	0·05	0·01	0·01	0·01	0·05	0·01	

Available data for the general population are given in brackets after the control values and it can be seen that the control group is representative of the general population as far as figures are available.*

*Foulds has not at the time of writing given figures for the standard deviation of his personal illness scale in normals but he uses a score of 4 or more on this scale for the diagnosis of 'personal illness'.

Dysmorphophobics are seen to be severely disturbed as a group, differing significantly from the control group on all the test measures used. The patients were more obsessoid and introverted and tended to be intropunitive, but the highly significant findings were their high scores on all the symptom measures—that is to say, neuroticism, the general hostility score and the personal illness scale.

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(b) *The psychiatric diagnoses*

Eight case summaries are given in the next section, but for fuller details of all 17 the original thesis should be consulted.

Kurt Schneider's concepts and classification of personality abnormalities and personality disorders were used (Schneider, 1958 and 1959). The patients diagnosed as schizophrenics exhibited at least one of Schneider's (1959) first rank symptoms of that illness. Using this conceptual framework, 11 of the 17 patients were thought to be suffering from severe personality disorders, 5 were schizophrenic, and one had a depressive illness. All those with personality disorders were sensitive or insecure personalities (using Schneider's terminology) though two of them also showed marked attention-seeking traits. The high incidence of serious psychiatric disorder in this group is obvious.

Case Summaries

Case 56

Mr. N., a painter and decorator aged 23, complained about the appearance of his mouth and requested cosmetic surgery. When he was 17, he dressed up to go out one evening and his younger sister commented, 'You look very nice but you have got a small mouth'. This comment triggered off much rumination and self-examination. He studied himself in the mirror and agreed his mouth was small. He kept comparing himself with other people and became more and more pre-occupied. 'I thought of nothing else.' He became self-conscious and embarrassed meeting people, particularly girls. No other remark was made about him but he continued to be extremely distressed about himself, and by the age of 21 he was virtually a recluse. He bought a camera and tried taking photographs of himself, holding the camera at arm's length, so that he could study them carefully. 'I became continually aware of it all the time. I held my mouth tense so that it might look wider, tried to pull my ears back and my mouth up at the corners.' Eventually he took an overdose and was admitted to hospital.

He described himself as always having been shy and reserved, sensitive in the sense of vulnerable, with a tendency to brood. He was perfectionistic, particularly over his work. He had no girl friend, feeling too shy and nervous to ask a girl out. There was no family history of nervous or mental illness.

On examination he presented as a quiet, reserved and self-conscious young man. He complained of being completely pre-occupied with the thought of his appearance. 'I just cannot push it away; I know it's there.' He felt his mouth looked less obvious when he was smiling or laughing, and he tried to do this for that reason. There was no evidence of schizophrenia.

Diagnosis: sensitive personality disorder with an abnormal psychogenic development in regard to his mouth triggered off by one chance remark. His concern about himself was an over-valued idea and he could not be re-assured.

Case 58

Miss A., aged 20, complained of lines under her eyes about which she was so concerned that she wanted to commit suicide. She had been well up to a year before she was first seen. At that time she had an argument with her boy friend and became extremely upset, following which 'something happened suddenly in my head. My eyes felt full and bulging. I felt completely cut off from things and everybody. I looked in the mirror and seemed different. They weren't my eyes.' Following the onset of this florid depersonalization she slept poorly and felt she was becoming ugly because with not sleeping she developed lines under her eyes. She became self-conscious and pre-occupied about her appearance. Two months after the onset of her condition she worsened markedly. She started waking in the small hours, became more depressed and lost weight. She complained of a pulling or pushing feeling behind her eyes and eventually took an overdose.

When seen she complained that everything looked grey as if a cloud had descended over the world. Definite diurnal variation of mood was noted. Her mother described her as being a meticulous, perfectionistic girl, extremely fastidious about her clothes and appearance. However, she had been happy in the main, was popular and active. There was a family history of mental illness, her father having committed suicide at the age of 52. He had been diagnosed as suffering from endogenous depression.

On examination the girl was of normal appearance but tense and miserable, extremely self-conscious about what she called lines under her eyes and requesting plastic surgery. 'I am constantly thinking about them, about my face and how I have changed. Make-up is just a waste of time. Life is not worth living.' There were no hallucinations or delusions. No evidence of thought disorder was elicited or any first rank symptoms of schizophrenia.

Diagnosis was of a depressive illness with marked depersonalization occurring in a girl of insecure obsessional personality. She was given a full course of ECT (twelve treatments in all) and her depression improved. The biological features of depressive illness (early morning waking, diurnal variation and weight loss) remitted, but she continued to complain of tension and of feeling self-conscious about her appearance. She continued to threaten suicide because of 'the lines'. She was eventually recommended for a modified leucotomy operation, following which she improved in that she became less tense and stopped continually complaining about her symptoms. She was in fact able to be discharged home. She was re-interviewed in detail post-operatively and there were still no detectable schizophrenic symptoms.

Case 60

Mr. I., a third year chemistry student aged 22, complained of feeling self-conscious about his chin. He stated

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that when he was about fourteen he noticed in his mirror that his chin was receding but he only really bothered about this when he started at technical college. He would often sit with his hand up to his face to cover his chin, and his embarrassment was decidedly worse in the presence of girls. He was worried that his appearance would affect his chances of getting married. He felt his disfigurement was very noticeable, and had started to take elaborate precautions to prevent people seeing him 'side on'. For example, he always walked the long way round in the library to prevent the female librarian seeing him in profile. He had recently read about plastic surgery and asked for an operation which he hoped would make him feel more self-confident and more at ease generally.

He had suffered from asthma in childhood and had been very much a lone wolf at school. He had always felt insecure and lacking in self-confidence with a tendency to hypochondriasis. He was extremely self-critical, a hard worker, with a tendency to develop tension states at times of stress. There was no family history of nervous or mental illness.

On examination he described the worry about his chin as a thought which he tried to resist but which he did not look on as being silly. The diagnosis was an insecure personality and it was felt that he was to some extent rationalizing his more basic difficulties in mixing and socializing by his presenting complaint. He looked on this, however, as something that was perhaps remediable. His appearance was completely within normal limits.

Case 62

Mr. R., aged 30, complained that his penis was small. When he was 13 and undressed for P.T. at school another boy had said, 'Look at his little one.' He was very upset and tried to avoid P.T. and swimming as much as possible. He was particularly concerned over swimming as the cold water seemed to shrivel up his penis even more. He tried stuffing cotton wool down his trunks to make himself look bigger, and having read about channel swimmers covering themselves with grease he put grease on his penis before he went into the bath.

At 18 he had his first experience of sexual intercourse and following this asked the girl if she had achieved satisfaction, and what was it that produced satisfaction in her. 'Is it the penetration?' He stated she was a big girl and since then he has gone with small, slight women, thinking that his disproportionately small penis would not be so noticeable to a woman of smaller build.

When he was 19 he went to see his own doctor, complaining that his penis was small, but was told nothing was wrong. In the army he always undressed carefully in front of the other men and went quickly in and out of a shower. He married at the age of 23, but his wife was frigid and his first thought was that this was due to his inadequacy. He wanted to have intercourse frequently and wanted a lot of attention from his wife but she did not seem to reciprocate. They had frequent rows and a divorce was pending.

He had been out with two other women. On one occasion he took a women he had met in a pub back to her home and had intercourse with her. Before he did so, however, he told her, 'I have only got a little one but I will do my best.' He stated he was particularly worried that if he got a divorce he would not be able to marry a widow or a divorcée because he could not bear to be compared with another man.

He started masturbating infrequently at the age of 10, but when 14 was told by another boy that his penis might be made larger by this activity. He therefore did it more often but said he was always rather worried about it. He described himself as always having been labile in mood and admitted to being sensitive in the sense of vulnerable, tending to brood and bottle up and worry over various comments that had been made about him. He showed numerous obsessional traits and was extremely neat and tidy and very conscientious, but one had the impression of a certain amount of attention-seeking in his make up.

On examination his external genitalia were quite normal but he was firmly convinced that his penis was small and that this was quite a marked abnormality, not a minor thing. He had thought over the years about the possibilities of hormone treatment or some operation and had never been re-assured by any doctors that he was in fact normal. There was no evidence of schizophrenic thought disorder, nor were any first rank symptoms elicited.

Diagnosis: severe personality disorder of sensitive type with some labile and attention-seeking traits. His complaints were in the nature of over-valued ideas held with complete conviction and were not accessible to reassurance. His whole life had been dominated and affected by his belief that his penis was abnormally small.

Case 63

Mr. R., a married electrician's assistant, aged 37, complained that his arms were thin, and gave the history that twelve years previously, when on a beach with some friends, a remark was passed about his skinny arms. He became extremely concerned and self-conscious about his appearance, feeling his arms were small in proportion to the rest of him. He would never take off his shirt or jacket in company, even in the height of summer. He tried exercises, weight lifting, and special body building foods. He was teased at work for keeping his jacket on when it was hot, and he arranged to start work twenty minutes early in the morning so that he would get into his overalls before the other men arrived. If visitors called at his house when he was not wearing a jacket, he would run into another room.

He was happily married, with three children, but said he had always felt self-conscious, with the feeling that people were noticing him and talking about him. He described himself as a person who could never take a joke about himself, and remarks easily upset him. He felt that being tall (6 ft. 1 in.) was a hindrance in that people thought that you could do all sorts of things, 'like dealing with a fight in a pub'. There was no family history of nervous or mental illness.

On examination the patient was quiet and reticent, morose and dysthymic. He complained of attracting attention because of his thin arms and height. There was no evidence of schizophrenic thought disorder and no first rank symptoms were elicited.

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Diagnosis: sensitive personality disorder, with an abnormal psychogenic development following the remark about his arms twelve years before. His concern about his appearance appeared to be an over-valued idea.

Case 67

Mr. F., aged 39, complained that his penis was not normal. He said he was well enough up to four years before, at which time he was having a brief affair with a woman at work and asked her if she would carry out fellatio with him. She refused to do this and in the following few days he began to feel that the men at work were talking about him behind his back. He thought the woman had talked at work about what he had asked her to do and that the other men felt he was dirty and perverted.

He eventually tried to gas himself and was admitted to hospital and treated with a course of ECT with good results. He then remained well for three years. He was stripped to the waist having a wash at work and heard the foreman say to another man, looking in his direction, 'He has had an operation.' He could not think at the time what was meant, but later in the day while urinating he looked at his own penis and 'all of a sudden things clicked. He must have thought that I had had an operation done in the hospital to put my penis right. I realized my penis wasn't normal and that the woman who saw it must have told everyone about it. The men at work thought that while I was in hospital I had had an operation.'

Following this, he said the men at work seemed to make remarks such as, 'All right, F.?', looking at the fly of his trousers. He was quite convinced he has a deformity of his penis. He felt people were staring at him and began to think that they were putting thoughts into his head by hypnosis. He wondered whether he was being drugged in some way.

His marriage had never been happy, the patient often being unfaithful, and also morbidly jealous of his wife. He stated however that he had always been a happy enough man in the main though always sensitive in the sense of being self-conscious about his appearance. In particular, from puberty he was concerned about having a blue chin and he had always tended to powder his chin to cover up the blueness.

On examination he was firmly convinced that he had an anatomical deformity of his genitals and he was requesting a corrective operation. The diagnosis was thought to be paranoid schizophrenia and the complaint about his penis a primary delusion.

Case 69

Miss I., aged 20, complained of lines under her eyes. When aged 17, while combing her hair at a university dance, she noticed in the mirror that she had lines under her eyes. She felt upset and self-conscious. However, the next day the lines seemed to have gone and she felt happier, but nine months before she was first seen she had a few nights of bad sleep and noticed again the appearance of lines under her eyes. She became panicky, feeling that if she did not sleep well soon her appearance would get worse and that if this continued she would soon look old and unattractive.

She complained of having to think continually about the lines. 'I make it worse by not sleeping and worrying. I don't feel comfortable or at ease any more.' On close questioning, she admitted that some months before she had had 'peculiar sensations' in which she appeared to get thoughts in her head which were not her own thoughts. She also admitted to auditory hallucinations, hearing her name called out when nobody was around whilst she was fully awake. She felt the lines under her eyes were different to the lines other people have under their eyes. 'They are deeper and run at a different angle.'

She had always been an easily hurt, vulnerable girl, tending to sulk and brood about any comments or criticisms that had been made about her. There was no family history of nervous or mental illness.

The patient was thought to be suffering from a schizophrenic illness, but her presenting complaint appeared phenomenologically to be a phobia, not a delusion. She resisted thinking about the lines and agreed that her concern over them was silly. It seemed therefore that her illness was 'pathoplastically veiled'.

Case 71

Mrs. L., aged 21, complained that her bust was small. At puberty she was very self-conscious about her figure, feeling that this was what primarily attracted men, and kept hoping that she would develop a better figure for this reason. As a teenager she started courting but always wore loose fitting clothes and would never go swimming. She became pregnant and had to get married at the age of 18 and stated that her husband seemed to be 'breast conscious', and the only time she felt really happy was when she had breast enlargement at the end of her first pregnancy. Her husband commented on this and seemed pleased. The worry about her figure dominated her whole life. She would not undress in front of her husband and started to refuse intercourse; she said as soon as he touched her breasts she would become frigid and turn away. She had seen a plastic surgeon, requesting augmentation mammaplasty, but operation had been refused. She was asking for some sort of hormone treatment. She felt she was definitely 'out of proportion' and therefore not attractive, but she could see that her complaint seemed silly to other people. 'It's illogical even to me but that's what I feel. I know that I've got a thing about it but it's very real to me.'

All her life she had shown obsessional and hysterical features. She had suffered from phobias as a child and overt obsessive compulsive rituals had been present since her teens. She had always had a temper and in times of stress showed episodes of frank attention-seeking behaviour in which she would scream or shout.

On examination, she was a difficult, querulous patient, showing a good deal of bitterness and self-pity about her lot in life. She continually pleaded for some treatment to increase the size of her bust, feeling that this would solve all her difficulties. She was not depressed and there was no evidence of schizophrenia. Her appearance was undoubtedly within normal limits.

Diagnosis was a severe personality disorder (obsessional and attention seeking), and it was thought that her

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complaint was being utilized as an excuse for her frigidity. Surgery was considered to be contra-indicated.

Discussion

All this group of dysmorphophobics were severely psychologically disturbed, and in fact five were psychotic, while the absence of schizophrenic symptoms in the remainder does not exclude the possibility that such symptoms may still develop. The presenting complaint in 12 cases (see Table I), including all 11 personality disorders, appeared phenomenologically to be an over-valued idea. Case 58 was the only patient thought to be suffering from an affective disorder. Here the complaint of lines under the eyes and a feeling of fullness in the eyes seemed to have arisen in the setting of severe depersonalization, and she also complained of a so-called 'vital feeling'—a heavy or pulling sensation at the back of her eyes, as is sometimes seen in depressive illness. In four of the five schizophrenics the complaint was delusional in nature. In the fifth (Case 69) the complaint of lines under the eyes seemed more obsessive compulsive or phobic in quality. This case was in fact one of pseudo-neurotic schizophrenia, and when initially seen it was only on close enquiry that the true nature of the illness became evident. Similar care was taken in excluding pseudo-neurotic schizophrenia in the other patients where the diagnosis was of a personality disorder, and it therefore appears that dysmorphophobia is non-specific as a symptom and can occur in different psychiatric syndromes.

In contrast to patients complaining about the appearance of their noses, eight dysmorphophobics in this series admitted that a remark had never been made about them. Their worry and concern was purely subjective. In a further four cases only one isolated comment had ever been made. In Cases 56 and 63, both severe personality disorders, this had acted as a key experience and triggered off an abnormal psychogenic development. The other two patients (Cases 59 and 71) were already worried and pre-occupied about themselves, but chance remarks were enough to worsen markedly the clinical picture.

Mention must be made again of Dietrich's (1962) work, as the findings in this study support his thesis that the symptom is rooted in a particular kind of personality. The personality disorders in the dysmorphophobic sample were all either sensitive or insecure in type, and in four of the five schizophrenics the pre-morbid personality was markedly sensitive. The content and presenting complaints of a psychotic illness partly depend, of course, on the patient's earlier life experiences. This was well illustrated by one patient who had thought for many years that his legs were short. When he developed a schizophrenic illness, at the age of 35, the form of the symptom changed and he developed delusions to the effect that people were staring at him and talking about him because of his short legs. What was previously an obsessional preoccupation had become delusional—the content of his complaint remaining the same. It does appear then that dysmorphophobia is a symptom which is prone to occur in patients of a particular personality type.

Summary

Seventeen patients whose presenting complaint was dysmorphophobia were studied. They were found to be severely psychologically disturbed as a group and five were psychotic. Dysmorphophobia was found to be non-specific as a symptom but was shown to be a complaint prone to occur in patients of a particular personality type (sensitive and/or insecure, using Schneider's terminology).

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