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# Dysmorphophobia: A Question of Definition

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**Summary:** Dysmorphophobia is an uncommon psychiatric syndrome characterized by a subjective feeling of ugliness or physical defect. Although appearance is within normal limits, the patient feels that this is noticeable to others. Views on the nature of this condition are illustrated by two case histories. It is proposed that dysmorphophobia is a discrete psychiatric illness. The symptoms arise in individuals with schizoid, narcissistic, or obsessional personality traits and should be distinguished from those phenomena which are secondary to morbid psychological processes.

There is no general agreement on the definition of the term dysmorphophobia. It was coined in 1886 by Morselli, who described 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". His subjects were sensitive, emotional and complained of such defects as "a ridiculous nose, small hands or a dimple on the chin". These symptoms are usually regarded as a disturbance of body image. This may be induced by organic states, by drugs and, notably, in gross cerebral pathology (Head, 1920). In this paper the term dysmorphophobia has been confined to those symptoms where the disturbance of body image arises from psychological mechanisms. The disturbance of body image may progress to a primary delusion, a delusion-like idea, or an overvalued idea (Jaspers, 1946). Hay (1970a, b) suggested that his dysmorphophobic subjects were expressing overvalued ideas, since then, few authors have qualified the nature of the beliefs held by these patients. Where the belief is a single, solitary delusion in an otherwise intact personality, then presumably the diagnosis should be that of a monosymptomatic psychosis (Munro, 1980).

The content of the belief has been evaluated by Schilder (1935), who suggested that some subjects identified part of their body with that of another person. In the USA, Meyer *et al* (1960) found that two-thirds of female patients awaiting cosmetic rhinoplasty identified their noses with those of their fathers; in Britain, in Hay's series (1970b), 28 per cent of females associated their noses with their fathers and 20 per cent with their mothers. Schilder thought that part of the body may be symbolic in some patients, e.g. the nose may be representative of the phallus. Other authors saw dysmorphophobia as arising from subconscious conflict (Hill and Silver, 1950). Andreasen and Bardach (1977) found that 2 per cent of patients requesting cosmetic surgery had dysmorphophobia, but this estimate was open to the criticism that it was subjective and dependent upon the observer's "aesthetic perception" (Harris, 1982). Connolly and Gipson (1978), and Hay (1970b) had an equal sex ratio in their samples but it is unlikely that this represented the whole dysmorphophobic population. It is interesting for instance, that there is a sex difference in the way general practitioners refer their patients; female patients tended to be referred to an ENT surgeon and male patients to a psychiatrist (Hay, 1970b). The mean age of presentation was in the third decade with many having symptoms dating back to early adolescence (Andreasen and Bardach, 1977; Connolly and Gipson, 1978; Hay, 1970a and b). The most frequently observed personality traits in these patients were introversion, obsessionalism, schizoidness, neuroticism, or narcissism.

One of the semantic difficulties in the use of the term dysmorphophobia is that some regard it as a symptom of an underlying disease (Bychowski, 1943) rather than as a discrete entity. Some of these problems are illustrated by data from six recent studies of patients with dysmorphophobia or minimal deformity seeking plastic surgery, (Table I).

The outstanding feature is the strikingly high psychiatric morbidity. It follows from the evidence here that dysmorphophobia is an ominous symptom which often presages one of at least five serious psychiatric disorders and is not just an indicant of nascent schizophrenia (Hay, 1970a). The wide spectrum of disorders in which this condition appears does raise the question as to whether dysmorphophobia is always an overvalued idea. Since only two studies

TABLE I

*Psychiatric morbidity in patients with dysmorphophobia or minimal deformity seeking plastic surgery (numbers in various diagnostic groups)*

| Author | Psychosis | Schizophrenia | Depression | Personality disorder | Severe neurosis | Total |
|---|---|---|---|---|---|---|
| Edgerton *et al* (1960) | 15 | | | 35 | 20 | 98 |
| Jacobson *et al* (1960) | 7 | | | 7 | 4 | 18 |
| Hay (1970a) | | 5 | 1 | 11 | | 17 |
| Hay (1970b) | 1 | | | 18 | | 45 |
| Connolly and Gipson (1978) | | 6 | | | 32 | 86 |
| Hardy and Cotterill (1982) | | | 5 | | | 12 |

specify this view (Hay, 1970a, b) speculation over the nature of the phenomenon of dysmorphophobia remains unclear.

The view that dysmorphophobia may be a symptom of an underlying disease is indisputable on clinical grounds. However, as can be seen in the six series in Table I there was no diagnosis in 111 patients (Edgerton *et al*, 1960; Hay, 1970b; Connolly and Gipson, 1978; Hardy and Cotterill, 1982). It is suggested that the term dysmorphophobia should be applied only to those patients without any other classifiable psychiatric illness and that secondary or symptomatic dysmorphophobia should be used when some other mental illness is responsible. Two cases in which the diagnosis of dysmorphophobia was considered are described.

*Case 1*

A 15 year-old girl was seen by a child psychiatrist complaining that she felt miserable and depressed. There were no identifiable life events nor any biological features of a depressive illness. Her family lived in a small, isolated village. She had an 8 year-old sister and a 13 year-old brother; the father was a machine operator who had suffered with 'nerves' in the past and mother was a quality control inspector. It was interesting to note how dependent the girl was on her mother and how the maternal grandmother defended the child's reluctance to mix. Her premorbid state was described as shy, sensitive and vulnerable to teasing and she was obsessionally tidy with her clothes. At interview, she sat with her head lowered and her hair falling over her face. She was trembling, restless and spoke little. Her mood was depressed and this was reflected in her thoughts with feelings of unworthiness and suicidal rumination. A provisional diagnosis of depression was made and clomipramine, 25 mgms bd was prescribed. This made her sleepy and was changed to imipramine.

After six months, there was little improvement. However, rapport was better and she admitted for the first time that she felt her nose was ugly and that this had been the source of teasing for several years. Her nose in fact appeared normal apart from a very small bump over the bridge line. After referral to a plastic surgeon, she underwent a nasal refracture and hump reduction. She made a good post-operative recovery both psychologically and physically. She was now able to mix socially, had taken the dog for walks for the first time in three years and no longer complained of feeling depressed. Her improvement continued and when last seen in the outpatient clinic she intended to become a nursing auxiliary.

*Case 2*

A 15 year-old young man complained that he felt his mouth had been stretched. At the age of 13 years, during a lonely summer holiday, he became interested in the music of John Fox. In an effort to imitate this man's prominent jaw, he made a conscious effort to protrude his jaw at all times. This phase went on for well over a year and in its wake it left the subjective feeling of ugliness that his face had been stretched. In the past, at the age of six years, he was seen by a paediatrician for recurring attacks of asthma and vague abdominal pain; no organic disease was found, but a lot of parental anxiety was noted. In particular, his father was worried that the boy might have colitis.

The family dynamics, in contrast to the first case, were very abnormal; his mother was 42 years-old and suffered from schizophrenia. His father was 17 years older than her and was a cold, critical, obsessional character. During the early stages of the mother's illness, the father and son became very close in a rather abnormal fashion, with the father asking his son to observe mother for any signs of a possible relapse. There was no real affection for either parent, open hostility was evident between father and son, and the mother was regarded as weak and pathetic. It was noted that father colluded with the son in his belief that his mouth had been stretched. The patient was doing well at school and his teachers felt that he could achieve ten 'O' levels. He was particularly good at art, and a self-portrait at this period revealed an over-prominent jaw. He had few friends and described himself as "a bit of a loner".

On examination he was a tall, thin young man and had quite a handsome facial appearance. Throughout the interview, he raised his left hand to cover his mouth, making his speech often difficult to understand. The content of his speech was centred around the belief that his mouth had been stretched, but the belief was not of delusional intensity. His other

thoughts were somewhat philosophical: "I question and doubt everything. I think about how I think". He also expressed exasperation that nobody believed his problem. There were no Schneiderian first rank symptoms. His mood was euthymic and cognitive state was normal.

He was treated initially as an out-patient and after seven months started attending school at the adolescent unit, as he refused to go to his local school. Two months later, still convinced that there was something physically wrong, he saw his local dentist, who referred him to the local oral surgery department. After thorough investigations, with photographs, x-rays and morphanalysis, (a procedure of taking facial x-rays and photographs in three planes to assess crainofocial symmetry (Rabey, 1977)), he was pronounced normal. During this time, he became noticeably more withdrawn and depressed. Current management consists of attending school daily and making efforts not to become involved in discussion about whether or not his face or mouth is deformed; he appears to be improving and no longer raises his hand to cover his face.

## Comment

Both cases illustrate how much distress can be caused in patients who have subjective feelings of ugliness. Such feelings are common in adolescence but usually transitory in nature. In fact almost all adolescents show a disturbance of self-image during this period (Simmons and Rosenberg, 1973). The disturbance is most frequently between the ages of 12 and 14, which is when the symptoms started in the second case and just after in the first. However, the distress, severity and longevity of the symptoms distinguish our two cases from this normal adolescent phenomena. The first case had a minimal deformity and it might be argued that this is not dysmorphophobia. However, Andreasen and Bardach (1977) did include such patients in their definition.

The question of what constitutes a minimal abnormality was considered by Harris (1982). He described a group of aesthetically disfigured persons whose appearance was regarded as normal by some and abnormal by other observers. Those observers who regarded the subjects as having a normal appearance had a low sense of aesthetic perception. In contrast, the subjects themselves and the other observers who regarded their appearance as abnormal had a high sense of aesthetic perception. This is particularly relevant to the second subject, who was artistic and presumably had a very high sense of aesthetic perception. Doctors and surgeons may have a sharpened, if not high sense of aesthetic perception due to their continual surveillance for pathology (Goin and Goin, 1981). Shaw *et al* (1975) suggest that this perception may differ greatly from that of the community at large and over-prescription of treatment may result. However, this point is disputed by Hay (1973) who suggests that surgery may be strikingly beneficial in those with minor deformity and that, as such, it is psychotherapeutic (Harris, 1982).

Interestingly, the first case responded very well to surgery. The assumption could be that the distress and anxiety were purely limited to the disfigurement and constituted a type of situational neurosis (Barsky, 1944). This has prompted some surgeons to suggest early correction of such abnormalities before they affect psychogenic development. In both the cases the belief was considered to be an overvalued idea, as it was comprehensible in the context of the person's personality and life experiences (Jaspers, 1946). Although the belief sometimes took precedence over all other ideas for a long time, it did not have the false unshakeable quality of a belief of morbid origin characteristic of a delusion (Fish, 1967). Making this sort of phenomenological statement is not always easy in the clinical setting; Munro (1980) implied this when he suggested that patients with single delusions may be included in dysmorphophobic populations. It is important to distinguish these two groups, as the former group of monosymptomatic psychosis may respond to pimozide (Riding and Munro, 1975), in contrast to the dysmorphophobics, who show no improvement. As the distinction between an over-valued idea and a delusion may be difficult, a trial of the drug pimozide may be indicated.

Social factors were prominent in the first case: she had led a sheltered existence in a small village with the support of a large extended family with rare opportunity to mix with "outsiders". The second case showed a very gross disturbance of family functioning. The mother was a schizophrenic whose role in the family was reduced to that of a hopeless pathetic woman who was despised by both her son and her husband. In many ways the most unhealthy member of the trio was the father whose coldness, rigidity and detachment made him a person to whom it was difficult to relate. It is also interesting to note that in keeping with Schilder's (1935) finding, the subject identified with a musician protruding his jaw in imitation. The family history of schizophrenia is of some concern, since he would have a 12 per cent chance of developing schizophrenia, (Gottesman and Shields, 1976). This, together with Connolly and Gipson's (1978) findings of six schizophrenics out of a population of 86 undergoing cosmetic rhinoplasty at 15 years, means that he must be considered to be at risk for schizophrenia.

In conclusion, feelings of ugliness can occur in a wide variety of psychiatric conditions including schizophrenia, depression, personality disorder and severe neurosis. As these symptoms are non-specific, it is my opinion that they should be called dysmorphophobic symptoms. The term dysmorphophobia should then be used to describe a discrete syndrome as Hay (1983)

hypothesized when suggesting its application to patients whose symptoms are personality based. The typical picture is a young individual (male or female) with one or more of the following personality traits:—schizoid, narcissistic or obsessional. He (or she) believes that he is ugly and that his ugliness is noticeable to others, although his appearance is within normal limits. His belief is an over-valued idea and he is free from a major psychiatric syndrome as alluded to earlier. When such a state exists then the concept of dysmorphophobia as a separate disease entity is elevated. It is interesting to note that anorexia nervosa, a condition of adolescents characterized by a disturbed body image has been afforded separate disease status in both the DSM III and ICD9.

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**References**

ANDREASEN, N. C. & BARDACH, J. (1977) Dysmorphophobia: symptom or disease? *American Journal of Psychiatry*, **134**, 673–5.

BARSKY, A. J. (1944) Psychology of the patient undergoing plastic surgery. *American Journal of Surgery*, **65**, 238–43.

BYCHOWSKI, G. (1943) Disorders of the body image in the clinical pictures of the psychoses. *Journal of Nervous and Mental Disease*, **97**, 310–34.

CONNOLLY, F. H. & GIPSON, M. (1978) Dysmorphophobia—A longterm study. *British Journal of Psychiatry*, **132**, 568–70.

EDGERTON, M. T., JACOBSON, W. E. & MEYER, E. (1960) Surgical–psychiatric study of patients seeking plastic (cosmetic) surgery: ninety-eight consecutive patients with minimal deformity. *British Journal of Plastic Surgery*, **13**, 136–45.

FISH, F. (1967) Disorders of thought and speech. In *Fish's Clinical Psychopathology*, (ed. M. Hamilton). Bristol: John Wright, pp. 39–48.

GOIN, J. M. & GOIN, M. K. (1981) Some 'effects', effective and otherwise. In *Changing the Body. Psychological Effects of Plastic Surgery*. Baltimore: Williams and Wilkins, pp. 113–14.

GOTTESMAN, I. I. & SHIELDS, J. (1976) Critical review of recent adoption, twin and family studies. *Schizophrenia Bulletin*, **2**, 360–400.

HARDY, G. E. & COTTERILL, J. A. (1982) A study of depression and obsessionality in dysmorphophobic and psoriatic subjects. *British Journal of Psychiatry*, **140**, 19–22.

HARRIS, D. L. (1982) Cosmetic surgery—where does it begin? *British Journal of Plastic Surgery*, **35**, 281–6.

HAY, G. G. (1970a) Dysmorphophobia. *British Journal of Psychiatry*, **116**, 399–406.

—— (1970b) Psychiatric aspects of cosmetic nasal operations. *British Journal of Psychiatry*, **116**, 85–97.

—— (1973) Changes in psychometric test results following cosmetic nasal operations. *British Journal of Psychiatry*, **122**, 89–90.

—— (1983) Paranoia and dysmorphophobia. *British Journal of Psychiatry*, **142**, 309.

HEAD, H. (1920) *Studies in Neurology, Vol. 2*. Oxford University Press.

HILL, G. & SILVER, A. G. (1950) Psychodynamic and aesthetic motivations for plastic surgery. *Psychosomatic Medicine*, **12**, 345–57.

JACOBSON, W. E., EDGERTON, M. T., MEYER, E., CANTER, A. & SLAUGHTER, R. (1960) Psychiatric evaluation of male patients seeking cosmetic surgery. *Plastic and Reconstructive Surgery*, **26** (4), 356–72.

JASPERS, KARL (1946) Delusion and awareness of reality. In *General Psychopathology*. 7th Edition. Translated 1963 by S. Hoenig and M. Hamilton. Manchester: Manchester University Press.

MEYER, E., JACOBSON, W. E., EDGERTON, M. T. & CANTER, A. (1960) Motivational patterns in patients seeking plastic surgery. *Psychosomatic Medicine*, **22** (3), 193–203.

MORSELLI, E. (1886) Sulla Dismorfofobia e sulla tafefobia. *Bolleltino Accademia delle Scienze Mediche di Genova*, **VI**, 100–19.

MUNRO, A. (1980) Monosymptomatic hypochondriacal psychosis. *British Journal of Hospital Medicine*, **24**, 34–8.

RABEY, G. P. (1977) Current principles of morphanalysis and their implications in oral surgery practice. *British Journal of Oral Surgery*, **15**, 97-109.

RIDING, J. & MUNRO, A. (1975) Pimozide in the treatment of monosymptomatic hypochondriacal psychosis. *Acta Psychiatrica Scandinavica*, **52**, 23–30.

SCHILDER, P. (1935) *The Image and Appearance of the Human Body: Psyche Monographs, No. 4*. London: Kegan Paul.

SHAW, W. C., LEWIS, H. G. & ROBERTSON, N. R. E. (1975) Perception of malocclusion. *British Dental Journal*, **138**, (6), 211–16.

SIMMONS, R. G. & ROSENBERG, F. (1973) Disturbance in the self image at adolescence. *American Sociological Review*, **38**, 553–68.

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