

Multiple choice questions

1. Over-concern with physical appearance may be a symptom of:
 - a body dysmorphic disorder
 - b anorexia nervosa
 - c depression
 - d schizophrenia
 - e borderline personality disorder.
2. 'Delusional' body dysmorphic disorder:
 - a is categorised in DSM-IV with the psychotic disorders
 - b is phenomenologically quite distinct from the non-delusional form
 - c responds well to antipsychotic medication
 - d often responds to SSRIs
 - e might be considered a severe form of non-delusional body dysmorphic disorder.
3. Body dysmorphic disorder and obsessive-compulsive disorder:
 - a show many phenomenological similarities
 - b have distinct underlying pathogenic mechanisms
 - c both respond to exposure/response prevention treatment
 - d both respond to SSRIs
 - e there is no familial aggregation of OCD cases in individuals with BDD.
4. Regarding treatments for BDD:
 - a psychodynamic psychotherapy is the most successful treatment
 - b exposure/response prevention is successful in a proportion of cases
 - c cognitive therapy has no place in treatment
 - d treatment requires antipsychotics if beliefs are held with delusional intensity
 - e MAOIs might be successful where other treatments have failed.
5. Regarding epidemiology of BDD:
 - a rates are elevated in those seeking plastic surgery
 - b BDD usually begins abruptly in adolescence
 - c girls are more commonly affected than boys
 - d BDD is usually short-lived
 - e the diagnosis of BDD cannot be made in individuals with anorexia nervosa.

MCQ answers

1	2	3	4	5
a T	a T	a T	a F	a T
b T	b F	b F	b T	b F
c T	c F	c T	c F	c F
d T	d T	d T	d F	d F
e T	e T	e F	e T	e F

Commentary

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As Castle & Harrison note in their fine review, imagined ugliness is a not uncommon problem presenting to psychiatrists. The "considerable lag before the disorder comes to the attention of health professionals" was a mean of seven years in the 30 cases of Gomez-Perez *et al* (1994). Whether the problem is called dysmorphophobia, body dysmorphic disorder (BDD) or something else, its coherence of features resembles that of other psychiatric syndromes.

Diagnostic systems dwell on one's belief that one *looks* ugly, but an otherwise similar clinical picture is seen in many patients who believe that they *smell* bad (Marks, 1987, p. 371; Gomez-Perez, *et al* 1994). Like other patients with dysmorphophobia (cases of BDD), those who complain that they smell may have surgery to remove axillary glands, avoid social contact, conceal the perceived problem (by washing a lot and using vast amounts of deodorants) and may improve with treatment by exposure, and

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prevention of washing and of deodorant use. A related picture is seen in patients who think that they sweat too much.

Differences between various clusters in which imagined ugliness predominates have been a topic of much taxonomic debate, but their import for treatment is even more debatable. An example is whether the belief is fixed enough to amount to a delusion. As Castle & Harrison note, something similar is seen regarding the beliefs held by patients with obsessive-compulsive disorder (OCD) which can become delusional in their intensity (Lelliott & Marks, 1987; Lelliott *et al.*, 1988). Abnormal beliefs in dysmorphophobia and OCD are not an either/or phenomenon; rather, they are dimensional on a continuum (Gomez-Perez *et al.*, 1994). They may fluctuate in intensity over time from being mildly overvalued ideas to fixed delusions and, after successful treatment by exposure and response prevention, weaken to non-delusional proportions or no beliefs at all as the patient improves with lessening social avoidance and other symptoms. This casts some doubt on the importance of distinguishing delusional from non-delusional dysmorphophobia (delusional disorder, somatic subtype from BDD). Improvement in beliefs might take longer to appear (cognitive lag) than does improvement in other features (Gomez-Perez *et al.*, 1994).

The same fluctuation in intensity from delusional to non-delusional intensity and back again may appear in the beliefs about being fat that are prominent in anorexia nervosa. The fact that the beliefs concern the body, and that they may fluctuate in intensity, is similar to the situation in transsexualism (gender dysphoria, gender identity disorder) in which patients believe that their 'real' gender identity is opposite to that of their physical body. 'I'm a woman trapped in a man's body' (or vice versa) is a common way of expressing the problem. Gender dysphoric beliefs need not be fixed and can change markedly over the years; complete remission has been documented for up to 10 years with or without treatment (Marks & Mataix-Cols, 1997).

In common with OCD, BDD shares not only the fluctuations of intensity of associated beliefs and the frequent rituals which are present, but a high prevalence of comorbid depression, as noted by Castle & Harrison.

In BDD, social avoidance can become so prominent that social phobia seems to be the main feature. It is worth adding that patients may take pains to

hide whatever aspect of their appearance they are sensitive about. They may grow their hair long to conceal their ears or face, wear loose clothes and a long coat to hide their body shape, avoid being seen in a swimsuit, avoid going out by day, and hide as hermits in their room with the blinds drawn. Such avoidances are obvious issues to deal with in an exposure and ritual prevention programme.

Castle & Harrison note the success of behavioural and cognitive treatments in several studies. To their comprehensive survey can be added the results of a further randomised controlled trial, in which cognitive-behavioural therapy was more effective than being on a waiting list in 50 cases of BDD (Gournay *et al.*, 1997; Veale *et al.*, 1996). One might also add three patients who improved with rational role-play. Two refused exposure therapy until they did role-play requiring them to research and debate beliefs contrary to their overvalued ideas, after which they had exposure therapy and improved markedly in a 12- to 18-month follow-up (Newell & Shrubb, 1994). The third patient had, after exposure therapy, improved in many ways but his/her dysmorphic belief only resolved after brief rational role-play; gains continued in an 18-month follow-up (Cromarty & Marks 1995). Rational role-play awaits a randomised controlled trial.

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