Psychological Assessment Of Skin Dysmorphophobia And Response To Drug Therapy

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ABSTRACT

A group of 20 skin dysmorphophobic patients (16 females and 4 males) complaining of hair fall, big sore tongue, excessive facial hair, wide pores of sebaceous glands, and 2 plastic surgical nose problems , were subjected to full psychiatric sheet Middle sex Hospital Questionnaire . Another group of 20 non - dysmorphophobic skin patients was studied as a control. Therapeutic evaluation of pimozide alone in comparison to an antidepressant (Amitriptyline) alone and in combination with the first was performed. The dysmorphophobic patients scored higher in depression, and obsession than the control group.

Marital disharmony was found to be commoner in dysmorphophobic patients than in the control group.

Also we found that dysmorphophobia is commoner in females than males in the age group ranging from 30-40 years.

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. Cotterill (1981) described dysmorphophobia as follows:A complaint of some physical defect which the patient thinks is noticeable to others but in reality there are no objective changes on examination. The definition of dysmorphophobia in Hay's concept (1970b) was more or less the same as that of Morselli (1886) and Corterill (1981) who stated that patients are seen whose concern is for some external

physical defect which is noticeable to other people whereas objectively they have no cause at all for the complaint; their appearance being well within normal limits. Stedman's Medical Dictionary (1972) uses the term "dysmorphophobia" to describe a morbid fear of deformity .This term has been critisized by Schachter (1973) saying that only some of the cases can be regarded as phobic, and this view was supported by Dietrich (1962), who said that the term phobia is used because the patients present with fear of upsetting other members of the society. The dysmorphophobic group of Coterill complained of symptomatology confined to the face, scalp and perineum. The symptoms related to face included hirsuties, intense burning , itching, redness and swelling of the face or any part of it, while scalp symptoms included hair loss; in the genital area intense itching, discomfort, swelling and redness were the common symptoms. Hay (1970b) on 17 dysmorphophobic patients described their symptomatology as folows: small penis, thin arms , disfigured mouth, lines under the eyes, receding chin and small breasts.

Many authors stress the difficulty in the diagnosis, differentiation of dysmorphophobia and similar cases, e.g. monosymptomatic hypochondriacal psychosis, which in Hay's concept (1970a) meant a single hypochondriacal complaint which appeared to reach delusional intensity and which was sustained for a very long period. In other respects, the personality is well retained, though the individual life style may be more or less affected by his response to the complaint and differentiated from dysmorphophobia by neurotically determined factors. Schachter (1963) distinguished between dysmorphic neurosis and dysmorphic delusions. Walters (1965) contrasted the hypochondriac with dysmorphophobic as the former wanting to draw attention to himself by saying that he is not normal; the latter wishing to appear normal but feeling that others notice that he is not.

Patients are of interest in psychiatry as dysmorphophobia has often been considered an ominous symptom in the sense that the patient may be an early schizophrenic (Hay, 1970b). (Stekel 1950) mentioned dysmorphophobia to illustrate a discussion as to whether obsessions can develop into delusions; there are people who occupy themselves continuously with a specific part of

the body. Thoughts can be very tormenting and frequently connected with feelings of inferiority. They can be elaborated into a whole compulsive system. The initial diagnosis may be obsessive compulsive neurosis but few years later the patient is found to be suffering from schizophrenia.

Anderson (1964) although stressing the diagnostic difficulty in such patients felt that the majority were probably mild cases of schizophrenia.

There is thus abundant evidence for considering dysmorphophobia as 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 (Hay, 1970b) . Yet, from the classical writers onwards, it has been realized that certain deviant and sensitive personalities may have superficially similar complaints and be preoccupied with and complain of their appearance for no apparent reason. Morselli (1886) described it along with phobic and obsessional state. Janet (1908) described numerous patients who had an unwarranted feeling of dissatisfaction with their physical appearance . He thought that these patients were neurotic and although they resembled hystericals, in some way there were important differences and he stressed the obsessional side of their symptomatology.

Management of dysmorphophobia is extraordinarily difficult. A complete failure to respond to any medication, whether placebo or more specific, is sadly the rule rather than the exception (Cotterill, 1981). The use of the drug "Pimozide"has revolutionised the case in the majority of patients (Gould and Gragg, 1976). Munro(1980) found that 60% of a group of dysmorphophobia and monosymptomatic hypochondriacal delusion had a more or less complete disappearance of symptoms with satisfactory return to their normal social existence.

The aim of this work is to assess the psychiatric condition of skin dysmorphophobic patients in comparison with control group of non-dysmorphophobic skin diseased patients . Also , the experience with pimozide and some antidepressants was tried for the management of this group.

SUBJECT AND METHOD :

All the 20 patients (16 females and 4 males)were referred from the dermatology clinic, except two cases which were from the plastic surgery clinic.

The twenty cases fitted the research criteria, their complaints were feelings of :

- Hair fall	7 patients
- Big sore tongue	1 patient
- Excessive facial hair (Hirsutism)	5 patients
- Nose problems	2 patients
- Wide pores of sebaceous glands	3 patients
- Scrotal penile abnormality	2 patients

All subjects of the group were examined fully to exclude any physical dermatological defects.

- Another 20 non-dysmorphophobic patients with actual skin lesions were taken as the control group. Both the dysmorphophobic and the control groups were matched in age, sex and marital status. Both the dysmorphophobic group and the control group were subjected to the following:

1. A full psychiatric history was taken, and full psychiatric sheet was done.
2. Middlesex Hospital Questionnaire was applied for both groups.
3. We divided the dysmorphophobic group randomly into 3 subgroups, Pimozide alone was given to the first group, the dose varied from 2-4 mg daily, antidepressants (Tricyclic) amitriptyline were given to the second subgroup in a dose of 25-75 mg, and antidepressant in combination with Pimozide were given to the third subgroup. All such medication was applied for two months. Psychiatric assessment was done by two senior psychiatrists at the end of each month, the number of "improved" patients in each group was compared by the other.

RESULTS

Table 1 (A & B) showing the classification of the dysmorphophobic group and the control group-(regarding the diagnosis).

Dysmorphophobia (A)

Diagnosis Feeling and complaining of	No.of patients	%
Hair fall	7	35
Hirsuties	5	25
Sore big tongue	1	5
Wide pores of gland	3	15
Nose problems	2	10
Penile scrota abnormalities	2	10
Total	20	100

Control (B)

Diagnosis	No.	%
Warts	1	60
Herpes simplex	5	25
Impetigo	3	15
Total	20	100

Table 2 (A&B) showing the age classification of a dysmorphophobic group and the control group.

Dysmorphophobia (A)

	20-30	30 40	40 - 50	Total
No.	6	12	2	20
%	30%	60%	10%	100

Control(B)

	20 - 30	30 - 40	40 - 50	Total
No.	8	8	4	20
%	40%	40%	20%	100

$X^2 = 0.239$ df= 2 P>0.10(n.s)

Table 3 (A&B) showing the different sex in dysmorphophobia group and the control group.

Dysmorphophobia (A)

Sex	Female		Male		Total	
	N	%	N	%	N	%
	16	80%	4	20%	20	100%

Control (B)

Sex	Female		Male		Total	
	N	%	N	%	N	%
	8	40%	12	60%	20	100%

X^2=3.169; df=1; P>0.05 (n.s.)

Table 4 (A&B) showing the marital status in both dysmorphophobic group and control group.

Dysmorphophobic (A)

Marital status	N	%
Single	6	30%
Married	10	50%
Divorced	2	10%
Widow	1	5%
Separated	1	5%
Total	20	100%

Control (B)

Marital status	N	%
Single	4	20%
Married	16	80%
Divorced	-	
Widow -		
Separated	-	
Total	20	100%

Corrected for continuity :

$X^2 = 0.891$; df = 4; P>0.10(n.s.)

married vs non married

$X^2 = 1.406$; df = 1; P>0.10(n.s.)From table (2),(3),(4) we can conclude that no statistical difference between the two group as regard the age, sex, marital status is shown.

Table 5(A&B) showing the marital relation in the married group of both dysmorphophobia patients and the control (as judged by the senior psychiatrist in clinical interview).

Dysmorphophobia (A)			Control		
Marital harmony 87.5%	2	20%	Marital harmony	14	
Marital dysharmony	2	19.5%	Marital dysharmony	8	80%

$\chi 2 = 5\ 5.625; df = 1;$ $P<0.02$(sig.)

From table (5) we can conclude the marital dysharmony was signifiantly higher in the dysmorphophobic group than the control group ;80% in the first and 12.5% in the second at $P<0.02$.

Table (6) showing the anxiety scale of Middlesex Questionnaire for both the dysmorphophobic group and the control group.(Morbidity score from 9 - 16).

	Dysmorphophobic gp N	%	Control N	%	t
0 - 8	2	10	3	15	
9 - 16	18	90	17	85	
Total	20	100			
Mean	9.85		9.50		
S.D	±1.69		±2.59		±0.37

From table (6) we can observe that the difference between both groups on the anxiety scale was non significant.

Table (7) showing the phobia scale of Middlesex Questionnaire for both the dysmorphophobic group and the control group.

	Dysmorphophobic group		Control group		t
	N	%	N	%	
0 - 8	8	40	11	55	
9 - 16	12	60	3	45	
Total	20	100	20	100	
Mean	8.70		8.10		±0.645
S.D	±1.78		±2.51		

From table (7) we can observe that, although the dysmorphophobic group showed higher percentage on the pathological scale (9 - 12) than the control group, 60% and 45% respectively, the difference was not statistically significant.

Table (8) showing the obsessive scale of Middlesex Questionnaire for both the dysmorphophobic group and the control group.

	Dysmorphophobic group		Control group		t
	N	%	N	%	
0 - 8	3	15	16	80	
9 - 16	17	85	4	20	
Total	20	100	20	100	
Mean	11.9		6.50		
					±5.179*
S.D	±2.95		±2.42		

*P<0.001 highly significant

From table (8) we can observe that the dysmorphophobic group scored higher than the control group on the obsessive scale, this result was highly significant (P<0.001).

Table (9) showing the somatization scale for both the dysmorphophobic group and the control group.

	Dysmorphophobic group		Control group		t
	N	%	N	%	
0 - 8	15	75	14	70	
9 - 16	5	25	6	30	
Total	20	100	20	100	
Mwan	8.20		7.6		
S.D	±2.04		±2.74		

From Table (9) we can see that there was no significant difference between the two groups on somatization scale.

Table (10) showing the depression scale of Middlesex Questionnaire for both the dysmorphophobic group and the control group.

	Dysmorphophobic group		Control group		t
	N	%	N	%	
0 - 8	2	10	14	70	
9 - 16	18	90	6	30	
Total	20	100	20	100	
Mean	13.65		7.30		±7.023*
S.D	±1.93		±2.31		

*P <0.001 highly significant.

From table (10) we can conclude that the dysmorphophobic group scored higher on depression scale, than the control group, this result was statistically significant (P<0.001).

Table (II) showing the hysteria scale of Middlesex Questionnaire for both the dysmorphophobic group and the control group.

	Dysmorphophobic group		Control group		t
	N	%	N	%	
0 - 8	16	80	14	70	
9 - 16	4	20	6	30	
Total	20	100	20	100	
Mean	5.6		76.7		±1.04
S.D	±2.09		±2.83		

From table (11) we can observe that both groups scored high, non pathological group between (0 - 8), and the difference between the two groups was non significant.

Table (12) showing the management of dysmorphophobic patients.

	Pimozide (2 -8mg)		Pimozide(2- -8mg)+ Amitriptyline(25 - 75mg)		Amitriptyline (25-75mg)	
	No.	%	No.	%	No.	%
No.of Patients	6	33.33	6	33.3	6	33.3

From table (12) we can see that the total number of the patients receiving medication are (18). The two schizophrenic patients were excluded as they discontinued the drug 2 days after taking it.

Table (13) showing the rate of recovery after one and two months periods, in the three dysmorphophobic groups of patients.

	Pimozide		Pimozide + Amitriptyline		t	Pimozide		Amitrip-tyline		t	Pimozide + Amitriptyline		Amitrip-tyline		t
	No.	%	No.	%		No.	%	No.	%		No.	%	No.	%	
One month	3	50	3	50	0	3	50	2	33.3	±0.595	3	50	2	33.3	±0.595
Two months	4	66.6	5	83.3	±0.680	4	66.3	2	33.3	±1.223	5	83.3	2	33.3	±2.038*

*P <0.05 significant.

From the above table we can see that the combination of pimozide with amitripyline gave the best result in the treatment of dysmorphophobia after two months from the beginning of the treatment , this result was statistically significant (P<0.05).

DISCUSSION

In our findings, most of the patients were females (80%) and their ages ranged between (30-40) years old (60%), followed by age group between (20-30)(30%). This result was in agreement with that of Cotterill (1981) who found that most of his patients were females in their 30's, 40's around 80% of his dysmorphophobic patients. France (1978) in his study on dysmorphophobia recorded that the mean age was 32 years.

We observed that 80% of our group of patients were unsatisfied in their marriage (marital dysharmony) in contrast to 20% of the married group who were in harmony in their marriage. This was almost the reverse in the control group in which 87.2% were in marital harmony contrasted with 12.7% who were not in good relations with their partners. This result between the dysmorphophobic group and control group was statistically significant at $P<0.02$. Eckert(1975) found that marital dysharmony was 70% in his dysmorphophobic group. However, we cannot conclude that such a disorder is the cause of the dysharmony. Perhaps both dysmorphophobia and marital dysharmony are two aspects of personality difficulty to adapt at different levels (self and object relational level).To a lesser extent the dysharmony could be secondary to the nagging of the dysmorphophobic spouse.

Most of our patients were severely psychologically disturbed and in fact two were psychotics. The presented complaint of the twenty dysmorphophobic patients appeared as overvalued ideas. The two cases referred from plastic surgery department as possible candidates for rhinoplasty, proved to be psychotics. This agrees with Connelly and Gipson (1978) who suggested that nose concern is a schizophrenic symptom. This result was obtained from their study in which Hay (1970a) found a high incidence of schizophrenia in patients who had undergone rhinoplasty for cosmetic reasons compared with control group who had undergone cosmetic surgery on the nose following trauma. However, this does not necessitate generalization that dysmorphophobia is more psychotic than neurotic. The remaining 18, in our study, were clinically equivalent to some neurosis or another. This agrees with Morselli (1886), Janet (1908), Dietrish (1962) and Walters (1965), who

considered that dysmorphophobia as a neurotic illness and disagrees with Bychowski (1943), Stekel (1950) and Gillies (1958) who considered dysmorphophobia as a psychotic illness. We can conclude that dysmorphophobia should be considered as a symptom in whatever diagnostic category that is justified to exist.

Eighteen patients in our study showed depression as assessed by our research tool (Middlesex questionnaire) . Seventeen scored morbidly high on obsession scale, the difference was statistically significant from the control group at $P<0.001$ in both. This result was in some ways with and in other ways contradicting with similar research in dysmorphophobia studied by Hay (1970a) who found that the patients were more"obsessoid"and introverted and tended to be intropunitive with highly significant findings. Hay (1970a) in his 17 cases did not find affective disorder (depression) except in one case. Our 15"depressed" cases (out of twenty) look much more than could be expected. However, this could be explained by the fact that we are dealing with depression as a symptom elicited by a specific self questionnaire rather than a diagnosis. Also most of our group of patients were skin dysmorphophobia , which differed from that heterogenous group of Hay (1970b) . The interesting finding is that the only patient in Hay's group complained of skin dysmorphophobia (line under the eyes and feeling of fullness in the eyes) was diagnosed as depression. Feeling of disfigured hair fall or wide sebaceous glands or hirsuties seemed to have arisen in the setting of severe depersonalization, self devaluation and disfigurement , which are prominent features of depression. Lastly the concept of how others perceive this disfigurement may explain such depression. Our result parallels that of Eckert (1975) who found that the most common psychological illness in his dysmorphophobic group was a high incidence of successful suicide and attempted suicide present in patients with facial pathology. The high score of depression was found in many other studies (Morselli 1886, Stekel 1950 and many others).

As regards the significantly higher incidence of obsessive score, this could favour the opinion that dysmorphophobia is of a more obsessive nature (on intellectual level) than phobic reaction (on affective level). This is reaffirmed

by the non significant difference between both groups (dysmorphophobic group and the control group), on phobic scale as compared with the obsessive. Free floating anxiety is again more an affective experience than intellectual preoccupation. Thus it agrees with the phobic reaction more than with obsessive phobias. The same argument fits the non significant difference in anxiety as in phobia.

As regards the non significant results on both hysteria and somatization score, this could be some indication that dysmorphophobia as an outlet pathological mechanism is occupying a wide area of defence , so much so that it dispenses with any more conversion or somatization defences.

In our results, the use of pimozide in dysmorphophobic patients gave a good result after months of treatment (66.6%) and the result was much better when we combined it with the antidepressant (amitriptyline). Pimozide did not prove to be superior alone in treating such group of patients than the antidepressant alone. There are other successful reports of the treatment with pimozide by Rielley et al(1978) and Haman and Avnstrop (1982). The superiority of combination of pimozide and amitriptyline over either alone should be considered as a step further after the successful trial mentioned with pimozide alone. We do not believe that amitriptyine is dealing simply with the possible secondary depression. Perhaps such response favours the assumption that dysmorphophobia is both a depressive equivalent and impending disorganization controlled by this defensive intellectual phobia.

REFERENCES

1. Abdel Gawad, M.S.; Guirguis, W. and Rakhawy, Y.T.(1972): Middlesex Hospital Questionnaire.(Arabic version).

2. Anderson, W.W.(1964): Psychiatry, Bailliere, Tindall & Cox, London.

3. Bychowski, C.(1943): Disorders of the body image in clinical pictures of the psychoses. J.Nerv.Ment.Dis.,97,310-334.

4. Connolly, F.H.and Gipson, M.(1978):Dysmorphophobia:A long -term study.British Journal of Psychiatry 132:568-570.

5. Cotterill, J.A.(1981):Dermatological non disease :A common and potentially fatal disturbances of cutaneous body image. British Journal of Dermatology 104:611-619.

6. Dietrich, H. (1962):Uber Dysmorphophobia:Arch Psychiatry.Nervenkr., 20 3/5 511-518. after Hay, G.G.(1970a) (See below).

7. Eckert, G.(1975):Diffuse hair loss and psychiatric disturbance.Acta Dermato-venerologica. Stockholm 55,147-149.

8. Gillies, H.(958):The clinical diagnosis of early schizophrenia. In Topics of Psychiatry (ed.Rodger, Mowbray and Roy) .47-56 London, Gasel.

9. Hamman, K. and Avnstrop, C.(1982):Delusions of infestation treated by pimozide:A double-blind cross-over clinical study. Acta Dermatol. venereal., 62:55, 1982.

10. Gould, W.M. and Gragg, T.M. (1976):Delusions of infestation treated by pimozide :A double blind crossover clinical study. Acta Dermatovenero logica, Stockholm 62:55-58.

11. Hay, G/G. (1970a):Psychiatric aspects of cosmetic nasal operations.British Journal of Psychiatry, 116,85.

12. Hay, G.G.(1970b):Dysmorphophobia. British Journal of Psychiatry, 16,399.

13. Janet, P.(1980) :Obession de la honte du corps.In les Obessions et la Psychasthenie, Chapter 5, 2nd ed . Paris.

14 Jaspers, K.(1913):Experience of body distortion. in General Psychopathology. Translated 1963 by S. Hoenig and M. Hamilton, p, 91.University of Chicago Press.

15. Morselli, E.(1886):Si sulla dismorfofobia e sulla tafefobia. Bulletion Acedemia delle Scienze Mediche di Genova.VI, 110 (After Connelly, F.H. and Gipson, M.,1978) (see above).

16. Reilley, T.M. Jobling, W.H.; Beard, A.W.(1978):Successful treatment with pimozide of delusional parasitosis.British Journal of Dermatology.

17. Schachter, M.(1973):Dysmorphic neurosis(ugliness complexes) and delusion or delusional conviction of ugliness. Ann. Med. Psychol., 129, 723-745.

18. Shuster.S.; Fisherm G.H.; Harris, E. and Binnell, D.(1978):The effect of skin disease on self-image. British Journal of Dermatology 99:Suppl.16,18-19.

20. Stedman's Medical Dictionary(1973) 22 ed . Williams & Wilkins. Baltimore.

21. Stekel, W.(1950):Compulsion and Doubt. Vol.II.London:Peter Nevill.

22. Walter, K. (1965): Uber das"Phobische Beziehungs Syndrome".Nervenarzi, 36/1,7-11.(After Hay, 1970b) (See above).

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EVALUATION PSYCHOLOGIQUE ET PHARMACO THÉRAPEUTIQUE DE LA DYSMORPHOPHOBIE DERMALE.

ABSTRAIT

Une controverse a toujours éxisté à propos de la définition et du diagnostique de la dysmorphophobie. Le dictionnaire médicale de Stedman (1972) l'a définit comme étant une peur morbide de déformité , Morselli (1986), Hay (1970b) et Corterill (1981) mentionnent que le souci des malades se rapportait à une défectuosité physique externe pour laquelle ils n'avaient , objectivement , acune cause , leur apparence étant à la limite normale .

Nous avons assujetit 20 patients (16 femmes et 4 hommes) souffrant de dysmorphophobie dermale , (chute de cheveux , grosse et douleureuse langue , cheveux éxcéssifs au visage, pores larges des glandes sebacées) ainsi que deux malades avec des problèmes de nez dûe à une chirurgie plastique, a une évaluation psychiatrique compléte qui comprenait le quéstionnaire de l'hôpital de Middlesex .Un autre groupe de 20 patients non-dysmorphophobes a servit comme groupe contrôle. Nous avons ainsi évalué l'éfficacité thérapeutique du Pimozide comparé à l'amitriptyline ainsi qu' à la combinaison des deux agents.

Les patients dysmorphophobes ont marqué un résultat plus élevé sur l'échélle de depression suivit par celle de l'obssession du quéstionnaire de Middlesex comparé au groupe contrôle. Les résultats étaient statistiquement significatifs ($P<0,01$ et $P<0,001$ respectivement). La malentente maritale, chez les malades dysmorphophobes , était présenté à un point statistiquement

significatif. Nous avons aussi trouvé que la dysmorphophobie était plus fréquente chez les femmes plutôt que les hommes , dans le groupe d'age 30 à 40 ans.

الموجز

أتفق كثير من الباحثين علي أعتبار كلمة " خوف التشويه" أنه شكوى المريض من اختلال عضوى يلاحظه الاخرون على الرغم من أنه ليس هناك ما يدل بالفحص على هذا الاختلال.

وقد تم هذا البحث على مجموعة من الذين يشكون من أعراض جلدية ليست موجودة بالكشف عليهم (كالصلع – الشعر الغزير – ذوائد انفية تشوه شكل الأنف – ورم والتهابات فى اللسان – ورم وزوائد في الخصية . وقد طبق استبار "الميدل سكس" على هذه المجموعة . وتم مقارنتها بمجموعة أخرى أخذت كعينة ضابطة من مرضى الجلدية الذين يعانون فعلاً من وجود مرض عضوى وقد تم تطبيق استبار "الميدل سكس" على العينة الضابطة ايضاً . وقد وجد أن هناك ارتفاعاً له دلاله اخصائية فى المجموعة الأولى عن المجموعة الضابطة فى مستوى (الأكتئاب – والوسواس) كما وجد أن أغلبية مرضى المجموعة الأولى يعانون من الأضطرابات الزوجية وأن اعمارهم تتراوح بين (٣٠ – ٤٠ سنة) وأن الغالبية العظمى منهم من النساء.

كما أوضح البحث أن علاج (البيموزايد) قد يكون له تأثيراً فعالاً فى علاج هذة المجموعة خاصاً اذا أعطى معة مضادات الأكتئاب.