Body Dysmorphic Symptom Among Psychiatric Illnesses

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Abstract

Body dysmorphic symptoms can be manifested in various psychiatric illnesses. It is classified in DSM IV as a somatoform disorder (body dysmorphic disorder). The aim of this work is to study and find out the rate of distribution of body dysmorphic symptoms in patients with psychiatric illnesses. Twenty patients (1.7%) with these symptoms were found out of 1200 psychiatric patients, their mean age was 32.5 years " 9.29. Most of them were single and not working. Body dysmorphic symptoms were present in 12 cases (60%) with non psychotic disorders (OCD, social phobia) and 8 cases (40%) with psychotic disorders (delusional disorder, and schizophrenia). The BD symptoms were found mainly in the face area and head. Depressive traits were found in 95% of cases as shown by Guilford battery scale. Tailor anxiety scale showed 50% of cases had high scores and 45% had severe scores. Yale Brown obsessive compulsive scale showed high score in 30% of cases and by Eysenck Personality Questionnaire 90% of patients had high score on neuroticism scale.

Introduction

Body dysmorphic disorder (BDD) is a feeling of intense shame associated with imagined physical defect or dissatisfaction with some aspects of body appearance. The core of the disorder is the person's strong belief or fear that he or she is unattractive or even repulsive. That fear is rarely assuaged by reassurance or compliments. Yet the typical patient with the disorder is quite normal in appearance. Although a minority of the patients with the disorder have a minor defect.

It is a poorly studied condition, because the patients are more likely to go to dermatologists, internists, or plastic surgeons than to psychiatrists.

Body dysmorphic disorder (BDD) may be present as a separate disorder or commonly coexists with other mental disorders,) several studies found that more than 90% of BDD patients had experienced a major depressive episode in their life times, about 70% had had anxiety disorder (in particular obsessive compulsive disorder and social phobia) and about 30% had had psychotic disorder. However, it is classified in DSM IV as a type of somatoform disorder and it has a delusional variants in the same classification under a delusional disorder, somatic subtype.

The objective of this study was to describe and find out the rate of distribution of body dysmorphic symptom in patients with different psychiatric illnesses.

Material and Method

The study included twenty patients with body dysmorphic symptoms out of 1200 patients with different psychiatric illnesses, diagnosed according to the DSM IV criteria, attended to the psychiatric outpatient clinic of Alexandria University Hospital over a period of 6 months.

They have been assessed by :

- Full psychiatric examination and evaluation using DSM IV diagnostic criteria.
- Psychometric assessment which included

Guilford battery scale for depression.

Tailor scale for anxiety.

Yale Brown obsessive compulsive scale.

Eysenck personality questionnaire.

RESULTS

From the recruited 1200 psychiatric patients, it was found that only 20 patients (1.7%) having a complaint of body dysmorphic symptoms, their ages ranged from 18 years to 55 years with a mean age of 32.5 " 9.29. They were 11 males (55%) and 9 females (45%). Four males and six females of these patients were presented in the age group between 26-35 years.

Twelve cases (60%) were not working with equal percentages in both sexes (30% of each) and only one female patient (5%) was a student. Seventeen patients (85%) were single (9 males; 45% and 8 females; 40%). Two patients (10%) were married (one male and one female) while one male patient only (5%) was divorced (Table 1-A, 1-B).

Table (2) revealed the clinical presentation of patients with body dysmorphic symptoms : Most of the patients has an "imagined defect" in more than one location. The main presentations were on the face area in 16 patients (80%) then the genitalia 2 patients (10%) then the breast in one patient (5%). Different parts of the face are included in the complaint of the patients e.g. nose in 9 cases (45%), skin of the face in 10 patients (50%), hear of face 11 patients (55%), eyes in 6 patients (30%), lips in 3 patients (15%), teeth in 3 patients (15%), ears in 3 patients (15%) and forehead in one patient (5%).

The comorbidity of body dysmorphic symptoms among psychiatric illnesses were divided into non psychotic illnesses (12 patients, 60%) and psychotic illnesses (8 patients, 40%). The non psychotic 12 patients were subdivided into obsessive compulsive disorders 6 patients (30%), social phobia 4 patients (20%), panic disorder 1 patient (5%), and psychoactive substance abuse disorder 1 patient (5%) whereas the psychotic disorders 8 patients (40%) were subdivided into delusional disorder 1 patient (5%) and schizophrenia 7 patients (35%) (Table 3).

Table (4) shows that there were thought disorders of body dysmorphic symptoms in the form of obsessive thought disorders in 12 (60%) of cases and delusional thought disorders in 8 (40%) of cases. There were thought disorders associated with body dysmorphic symptoms in the form of ideas of reference in 12 cases (60%) and delusion of reference in 8 cases (40%). There were thought disorders not related to body dysmorphic symptoms in the form of classical obsessive thought disorders in 6 (30%) of cases and delusional thought disorders as delusion of persecution, delusion of grandeur and delusion of influence in 8 cases (40%).

The associated common and frequent compulsive behaviors in patients with body dysmorphic symptoms were frequent mirror checking behavior in 15 cases (75%), and avoidance of mirror checking in 5 cases (25%) while repeated questioning of others was present in 8 cases (40%), these patients were included under the 15 patients (75%) with frequent mirror checking (Table 5).

The mean scores of the studied psychometric tests in non psychotic and psychotic patients presented with body dysmorphic symptoms were as follows (Table 6):

Guilford battery depressive scale: There were a statistical significant difference between the mean score of patients with non psychotic (69.5+/-2.98) and psychotic illnesses (55.9+/- 10.38) (t=6.18, p<0.05).

Tailor anxiety scale: The mean score on this scale in patients with non psychotic illnesses was 39.91+/-6.09 while it was 27.88 " 1.96 in psychotic patients. The difference was statistically significant (t=6.18, p<0.05).

Yale Brown Obsessive Compulsive Scale: The difference in the mean scores between the non psychotic patients and the psychotic group with associated body dysmorphic symptoms was not statistically significant (39.91+/-6.04, 16.38+/-6.89 respectively) (t=1.08, p=0.294).

Eysenck personality questionnaire:

a. The mean score on psychoticism scale in patients with non psychotic illnesses were 5.72+/-2.37, where as it was 9.25+/- 1.49 in the psychotic patients. The difference of comparison was statistically significant (t=4.48, p<0.05).

b. The mean scores on extraversion scale in patients with non psychotic illnesses and psychotic illnesses were 4.45+/- 2.73 and 8.25 +/-2.82 respectively. The difference was statistically significant (t=2.95, p=0.09).

c. There was a statistically significant difference of the mean scores on neuroticism scale between the two groups of patients (non psychotic and psychotic) (17.64 +/-1.86, and 15.38+/-1.60;respectively) (t=2.77, p=0.013).

d. The mean scores on lie scale were 12.09+/-3.67 and 9.50+/-2.98 in non psychotic and psychotic patients without a statistical significant difference (t=1.64, p=0.120).

It was found that 12 patients (60%) had a family history of first degree relatives of mood disorder, also 2 patients (10%) had a family history of obsessive compulsive disorder and 2 patients (10%) had family history of schizophrenia while 4 patients had no family history of any psychiatric illnesses (Table 7)

Table (1-A) : Sex and age of patients with body dysmorphic symptoms and their relation to occupation

Job	Co (n=20)	%	Male n (%)	Female n (%)	Age			
					18-25	26-35	36-45	46-55
Not working	2	60	6 (30%)	6 (30%)	3 (15%)	4 (20%)	3 (15%)	2 (10%)
Part time	3	15	2 (10%)	1 (5%)		2 (10%)	1 (5%)	
Full time	4	20	3 (15%)	1 (5%)		3 (15%)		1 (5%)
Student t	1	5		1 (5%)				

Table (1-B) : The marital status of patients with body dysmorphic symptoms and their relation to age and sex

Marital status	Count (n=20)	%	Male n (%)	Female n (%)	Age			
					18-25	26-35	36-45	46-55
Single	17	85	8 (40%)	9 (45%)	3 (15%)	9 (45%)	2 (10%)	3 (15%)
Married	2	10	1	1		1	1	
Divorced	1	5		1			1	

Table (2) : The clinical presentation of patients with body dysmorphic symptoms and the locations of these symptoms in the face parts

Clinical presentation of body dysmorphic symptoms	Count (n=20)	%
Face	16	80
Genitalia	2	10
Breast	1	5
Hair of head	1	5
Location of body dysmorphic symptoms in the face parts	**Count (n=20)**	**%**
Nose	9	45
Eye	6	30
Lips	3	15
Teeth	3	15
Ears	3	15
Fore head	1	5
Skin of face	10	5
Hear of face	11	55

Table (3) : Comorbidity of body dysmorphic symptoms and other psychiatric illnesses

Body dysmorphic symptoms among psychiatric illnesses	Count (n=20)	%
A. Non psychotic disorders	12	60
1. Obsessive-compulsive disorders	6	30
2. Social phobia	4	20
3. Panic disorder	1	5
4. Psychoactive substance abuse disorder	1	5

Table (IV) : Thought disorders in patients with body dysmorphic symptoms

Thought disorder	Thought disorders of body dysmorphic symptoms		Thought disorders associated with body dysmorphic symptoms		Thought disorders not related to body dysmorphic symptoms	
	Obsessive thought disorder	Delusional thought disorder	Ideas of references	Delusion of reference	Classical obsessive thought	Delusional thought disorders
Count (n=20)	12	8	12	8	6	8
%	60	40	60	40	30	40

Table (V) : Associated compulsive behavior in patients with body dysmorphic symptoms

Associated compulsive behaviour	Count (n=20)	%
Frequent mirror checking	15	75
Avoidance of mirror checking	5	25
Repeated questioning of the others	8	40

Table (6) : The mean scores of the studied psychometric tests in non psychotic and psychotic patients presented with body dysmorphic symptoms (No. 20)

Psychometric tests in patients with body dysmorphic symptoms	Non Psychotic illnesses (No. 12) Mean +/- S.D.	Psychotic illnesses (No. 8) Mean +/- S.D.	t
Guilford Battery depressive scale	69.5 +/- 2.98	55.8 +/- 10.38	6.52**
Tailor anxiety scale	39.91 +/- 6.09	27.88 +/- 1.96	6.18**
Yale Brown Obsessive Compulsive scale	39.91 +/- 6.04	16.38 +/- 6.89	1.08
Eysenck personality questionnaire	5.27 +/- 2.37	9.25 +/- 1.49	4.48**
- Psychoticism scale	4.45 +/- 2.73	8.25 +/- 2.82	2.95**
- Extroversion scale	17.64 +/- 1.86	15.38 +/- 1.60	2.77**
- Neuroticism Scale	12.09 +/- 3.67	9.50 +/- 2.98	1.64
- Lie scale			

Table (7): Family history of first degree relatives of patientswith body dysmorphic symptoms

Family history of first degree relatives	Count (n=20)	%
Mood disorder	12	60
Obsessive-compulsive disorder	2	10
Schizophrenia	2	10
No family history	4	20

Discussion

Body dysmorphic symptom has a rich tradition in European psychiatry, but it is of little interest in Egypt. This little known symptom or disorder, however may be more common that cause severe distress and impairment, and also may be treatable.

In this study, out of 1200 patients suffering from different psychiatric disorders only 20 patients (1.7%) complained of body dysmorphic symptoms; 60% were non psychotic patients while 40% were psychotic ones. The age of onset of the symptoms usually started at adolescence period with approximately equal frequency in both male and female. This was in agreement with almost other studies. The majority of the studied patients were single and not working which may be due to the distress and the disturbance of the disease on the occupational and social aspects of life because of the embarrassment over imagined defects in appearance.

The present study revealed a high association between body dysmorphic symptoms and anxiety disorders (55%) (mainly OCD and social phobia). Similar associations were found in the study of Phillips (1994) and Hollander et al (1933. Eric Hollander (1989) reported that the comorbidity between body dysmorphic disorder and OCD, in conjunction with similarity in phenomenology, family history and treatment response to serotonin reuptake inhibitors has conceptualized body dysmorphic disorder as an obsessive compulsive spectrum disorder, so the considerable association between BDD and OCD suggested that the two disorders are strongly related to each other.

On the other hand, social avoidance was frequently observed in the studied patients similar to the results reported by Phillips et al (1933).

The exact relationship between psychoactive substance abuse disorder and body dysmorphic symptoms is not yet known. This study showed one case of heroin addiction and there have been other reports of exacerbation of body dysmorphic symptoms of delusional intensity with Marijuana smoking.

Body dysmorphic symptoms had delusional variants in the DSM IV which were classified as a delusional disorder, somatic subtype. Birtchnell similarly noted that dysmorphophobia may be variously expressed as an obsessive, overvalued ideas or frank delusion.[1] This was obviously manifested in this study when body dysmorphic symptoms of delusional intensity were present in psychotic patients (delusions of reference related to body dysmorphic somatic delusion and another delusions not related to somatic delusions as persecutory and grandiosity delusions), also there were body dysmorphic symptoms of obsessional intensity in non psychotic patients (as ideas of reference related to body dysmorphic symptoms and obsessive thoughts not related to body dysmorphic symptoms). Other studies found a similar results.

It can be said that the delusional and non delusional variants of body dysmorphic symptoms are the same disorder, characterized by a range of insight from good to absent, so the individual patient may exist on a continuum with regard to insight and thus at a different courses of patient illnesses having true obsessions, overvalued ideas or frank delusions.

Clinically body dysmorphic symptoms may be distributed all over the external appearance of the body, but mainly concentrated on the face and head that is already present in this study and nearly all the patients had imagined defects in more than one locations and this goes with other reports.

The studied patients were represented with certain compulsive behaviors as frequent mirror checking, avoidance mirror checking or repeated questioning to the others about "the defect" and this was in agreement with other studies.

From previous reports and studies, it was observed that patients with body dysmorphic symptoms were more depressed, more anxious and more introverted. The majority of the patient of this study (95%) had depressive traits as shown by the higher scores on Guilford battery scale, this means that these patients were liable to develop depression along their course of illness. The statistically significant high scores of the non psychotic patients compared to the psychotics on this scale may be explained by the fact that the psychopathology of OCD, social phobia, body dysmorphic symptoms and depression are the same. Dr. Phillips in 1993 reported 28 cases (93%) of BDD with depressive episodes which tend to be long and persistent.

Tailor anxiety scale was applied to the studied patients, and it revealed that the severest scores were mainly found in patients having body dysmorphic symptoms associated with OCD and social phobia, these results may be due to the presence of the symptoms itself or due to the associated illnesses as anxiety disorders, in addition that the patients had insight the illness or collectively. On the other hand the high scores on the Tailor anxiety scale were mainly found in psychotic patients with the dysmorphic symptoms and this denotes that they had some degree of anxiety which may be arise from the body dysmorphic symptoms of delusional intensity. Phillips et al reported that 14 cases with primary diagnosis of anxiety disorders had an additional anxiety apparently secondary to body dysmorphic disorder, while Eric Holander et al stated that patients with OCD and comorbid BDD had more anxious, impulsive and schizotypal features than patients without comorbid BDD.

Several authors, have suggested that a variety of personality traits may predispose to body dysmorphic disorders. This commonly cited are obsessional, schzoid,) narcissistic, or a mix of these, but it was actually observed that it is difficult to focus on the differentiation of premorbid from comorbid features. Eysenck personality questionnaire was applied to all the studied patients and it was found that 90% of cases had high scores on neuroticism scale, 80% had low scores on extraversion scale (i.e. introverted) this may explain the social avoidance and introversion of most of the patients. Also there were a high scores of 50% of cases on psychoticism scale and high score of 55% of cases on lie scale. This may explain impuslivity and the schizotypal features in these patients. Christopher S. Thomas noted that the most frequently observed personality traits in these patients were introversion, neuroticism, schizoidness, obsessionalism and narcissism.

There may be a significant relationship between family history of first degree relatives of patients with BD symptoms and psychotic disorders. This appears clearly in this study in which the family history of the first degree relatives of 60% of cases had mood disorders. This may indicate that there was a comorbidity between body dysmorphic

symptoms and mood disorders, but the exact relationship is not yet known and this goes with similar studies.

The conclusion of this study was that body dysmorphic symptoms are usually chronic persistent disabling symptoms and may cause difficulties in social, marital and occupational functioning to the point where the patient's life can be disrupted. The distress of the body dysmorphic symptoms can be so severe that causing suicidal ideations or suicidal attempts, and unnecessary plastic surgery. So training programs for these symptoms or disorders for early detection are important.

The symptoms can occur in a wide variety of psychiatric illnesses. As these symptoms are non specific they should be called body dysmorphic symptoms while the term body dysmorphic disorder (BDD) should be used to describe a discrete syndrome and applied to patients whose symptoms are personality based.

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رهبة التشوه الجسدي كعرض في الأمراض النفسية المختلفة

أعراض رهبة التشوه الجسدي - أعراض عادة ما تكون مزمنة ومستمرة وتعرض المريض لجراحات تجميلية غير ضرورية.وقد أجرى هذا البحث بهدف دراسة هذه الأعراض المرضية ومعدل حدوثها بين الأمراض النفسية المختلفة. وقد وجد أن ٢٠ حالة مرضية (١,٧٪) من بين ١٢٠٠ حالة اضطرابات نفسية تعاني من رهبة التشوه الجسدي وكان متوسط أعمارهم ٣٢,٥ ± ٩,٢٩، ٥٥٪ ذكور، ٤٥٪ إناث وأن ٦٠٪ منهم لا يعملون إطلاقا و ٨٥٪ غير متزوجين مما يدل على ان المرض له تأثير بالغ على الحياة الاجتماعية والزوجية.كما أظهرت الدراسة أن هذه الأعراض مرتبطة بأمراض نفسية مختلفة وهي ٦٠٪ حالات عصابية وخاصة الوسواس القهري والرهاب الاجتماعي و ٤٠٪ حالات يعانون من أمراض نفسية عقلية مثل الفصام والاضطرابات الضلالية.

وبتطبيق القياسات النفسية مثل مقياس جيلفرد للاكتئاب، مقياس تيلور للقلق ومقياس يل بروان للوسواس القهرى ومقياس أيزنك لسمات الشخصية ثبت أن ٩٥٪ يعانون من اكتئاب، ٥٥٪ يعانون من قلق، ٨٠٪ لديهم ميول عالية للإنطوائية و٩٠٪ لديهم درجات عالية من العصابية.كما أظهرت الدراسة أن هناك علاقة بين أعراض رهبة التشوه الجسدي في المرضى ومرضى اضطراب المزاج لدى عائلة المرضى والقرابة من الدرجة الأولى حيث أن ٦٠٪ من الحالات لديهم في التاريخ المرضى للعائلة اضطراب في المزاج في الأقارب من الدرجة الأولى وخصوصا الاكتئاب.