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The British Journal of Psychiatry

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*The British Journal of Psychiatry* 1982 140: 199-201  
Access the most recent version at doi:[10.1192/bjp.140.2.199](https://doi.org/10.1192/bjp.140.2.199)

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## Dysmorphophobia in Adolescence: A Case Report

LOUISE E. BRADDOCK

A distinction is made (*British Medical Journal*, 1978; Munro, 1980) between an excessive preoccupation with minor bodily defect, dysmorphophobia, and monosymptomatic psychosis in which a delusion of bodily change may be the sole symptom of an underlying schizophrenic or depressive illness. Hay (1981) has argued for careful distinction between the over-valued idea of dysmorphophobia and the delusion of depressive or schizophrenic illness. But in the absence of any features suggesting psychosis, scrutiny of the abnormal belief in isolation may fail to detect which sort it is. Riding and Munro (1975) hold the distinction to depend upon assessment of the abnormal belief as being of 'neurotic' versus 'delusional' intensity and of the degree of personality involvement. Andreasen and Bardach (1977) have proposed formal diagnostic criteria incorporating similar features: the dysmorphophobic symptom of excessive concern with appearance, the desire for surgery or underlying presence of personality disorder, and the absence of psychotic symptomatology. However, judgements of 'neurotic' versus 'delusional' intensity, of absence of psychotic symptomatology and of personality involvement may be particularly difficult against a background of developing personality and in adolescence the problem may be further compounded by the cumulative and recursive effects upon personality development of psychological disturbance.

### The Case

C.R., 17 years, was referred to the adolescent unit outpatients with a 13 month history of complaint of abnormal facial features for which she was convinced she required surgery. Her parents were fairly strict, working-class people and her mother had received ECT for puerperal depressive episodes following the birth by caesarean section of both her two children. The older, a sister, was outgoing, ebullient and assertive. C.R. was a slower developer, clinging to her mother long after she could walk and slow to toilet train through being afraid of the noise the cistern made. At primary school her parents reported she took a year before she would answer the register in an audible voice. However, she happily attended a small middle school locally before moving at age 13 to a large upper school where she settled poorly. Her

parents described her as always quiet and shy with few friends.

At age 16 she complained her nose was 'funny and crinkly', did not respond to reassurance, and refused to go out shopping at weekends on two or three occasions. She also complained of shortness of breath and was taken to her GP but no treatment was given. There were no further complaints for two months but she then began to say her forehead was lined and wrinkled and again refused to go out, ostensibly in case the wind blew her fringe off her forehead. One month later she took a small overdose and subsequently received some assertiveness training from the local clinical psychology service. However, she gradually lapsed from school attendance saying she felt people looked at her on her way to school so that she was obliged to cross the road to avoid them. Seven months after her initial complaint she was completely house-bound; her mother described her then as unhappy, depressed and unable to enjoy herself. She felt life was not worth living. She was then admitted to an adult psychiatric ward, and was treated with imipramine, trifluoperazine and ECT with no improvement. She was referred thence to the adolescent unit 8 months later.

Mental state examination showed her to be a quiet, mousy, expressionless girl, wearing a heavy fringe over a normal-appearing forehead and avoiding the interviewer's eyes. She did not talk spontaneously, and answered questions after a long (30–60 seconds) pause in a quiet, indistinct voice. Her mood was subdued but not depressed or anxious. However, she described herself as indecisive and a worrier, being especially frightened of needles and of having the plastic surgery she wished for.

The belief that her forehead was abnormal had come on gradually and had later been accompanied by a feeling of stiffness in the forehead. She was unable to stop thinking about this and about having plastic surgery which she was convinced she needed. However, there was no subjective resistance to these thoughts, which were not regarded as senseless. She said she also looked in the mirror whenever she could and was unable to stop herself doing this although it only made her feel her forehead was getting worse. Reassurance or disagreement from others made her

think about her forehead more, but not change her mind. She had no explanation for the failure of others to perceive the abnormality than that "perhaps they could not see it properly".

There were no other abnormal beliefs, there had been no abnormal experiences, and first rank symptoms of schizophrenia were absent. Cognition was normal. Using the classification scheme prepared by Rutter, Shaffer and Sturge, the diagnosis was formulated as a disturbance of emotions specific to childhood and adolescence with sensitivity, shyness and social withdrawal (313.2) developing into dysmorphophobia in an adolescent of sensitive, anxious personality.

Family interviews showed that her parents could not resist being drawn into discussion of the forehead and its abnormality. A behavioural approach was used in her management, in which all reference to her forehead and its possible abnormality was eschewed. She was encouraged to develop her social skills and assertiveness and to move towards independence from her family. During her four months' admission she did not relinquish her belief in the abnormality of her forehead or in her need for surgery, and she continued to be passive and shy with no initiative. However, she was noted to be more assertive with her peer group and at home on leave. She formed friendships, enjoyed sharing her sister's social life at weekends, and showed abilities in typing and in crafts. She was discharged to out-patient care on a work experience placement in which she experienced anxiety on being forced into learning new albeit simple skills.

### Comment

There are no estimates of the prevalence of dysmorphophobia in the general population although the demand for plastic surgery in the private sector suggests that subclinical forms may be common. Early onset was noted by Andreasen and Bardach (1977) who state that "the onset of dysmorphophobia usually occurs in adolescence in the setting of a pre-morbid personality with obsessional and schizoid traits". Their description resembles that of Olley (1974) who described young female patients presenting for plastic surgery with minimal deformities, as shy, retiring and self-conscious. It is not surprising that in adolescence, a time of increasing preoccupation with the self-image and with relationships to others, exaggerated perceptions of and concentration on idiosyncratic physical features may be incorporated into the psychological defences being employed at this time.

The development of such beliefs into dysmorphophobic symptoms must depend upon both personality and environmental factors. The dependence of

the growing personality in adolescence upon exposure to a varied and stimulating environment renders it peculiarly vulnerable to developments which reduce this exposure, such as social withdrawal. In younger children, school refusal occurs with various somatic complaints or often with no reason given. As a manifestation of the transition which occurs during adolescence from childlike, non-verbal and often physical symptoms of emotional disturbance to more 'adult type' symptoms, verbally expressed, the adolescent who develops a preoccupation with an imagined physical abnormality may then happen upon a more sophisticated route to the benefits of the sick role. A preoccupation which in most cases would be transient may then become an established dysmorphophobic symptom maintained by the responses of family, by medical attention and intervention, and by the further avoidance of the anxiety-laden experiences with which adolescent development is fraught. Consequences for further personality development if this process is not reversed may be severe.

Of the course of dysmorphophobia once established, little is known. According to Olley's description the early stages are characterized by a gradual increase in self-consciousness with attempts to conceal the feature, withdrawal and poor work performance, and the persistent conviction that plastic surgery will help. However, the prognosis for those who receive surgery appears unfavourable. Connolly and Gipson (1978) found significantly more neurosis and schizophrenia in former adult cosmetic rhinoplasty patients than in those who had had reparative rhinoplasty for trauma or disease though detailed information on the mental state at the time of operation was not available. However, 'severely disturbed patients' were not operated upon and the number of early monosymptomatic psychoses in the group at the time of operation cannot therefore be ascertained.

The uncommon occurrence of dysmorphophobia and its relatively recent distinction from monosymptomatic psychosis have meant that little systematic attention has been paid to its treatment. Drug treatment has emerged as having application in monosymptomatic psychosis. Riding and Munro (1975) have reported improvement with pimozide of monosymptomatic psychosis but not of dysmorphophobia. However, good drug response appears to have acted as a diagnostic weighting affecting final diagnosis in at least two of the six cases described. Beary and Cobb (1981) report successful treatment with behavioural psychotherapy of two out of three patients with monosymptomatic delusion of alimentary stench but from the information available the correct diagnosis of these three patients is not clear.

The theoretical view of the genesis of the dys-

morphophobic symptom outlined above would suggest that early intervention to reduce secondary gain is indicated and that behavioural techniques may be appropriate. The evidence to date does not exclude a trial of pimozide. Further and more systematic study is required, however.

#### Acknowledgements

Thanks are due to Dr D. Batten, Dr C. P. Oppenheimer and Dr W. Ll. Parry-Jones of Highfield Adolescent Unit, Warneford Hospital, Oxford, for helpful comments, and to Dr Parry-Jones for permission to report on a patient under his care.

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Louise Elaine Braddock, M.A., M.B., B.Chir., M.R.C.Psych., Registrar in Psychiatry, Highfield Family and Adolescent Unit, The Warneford Hospital, Warneford Lane, Headington, Oxford OX3 7JX

(Received 11 September 1981)