



# Symmetry concerns as a symptom of body dysmorphic disorder



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## ABSTRACT

Symmetry obsessions are a common symptom of obsessive-compulsive disorder (OCD) and have several demographic and clinical correlates. Appearance-related symmetry concerns appear common in body dysmorphic disorder (BDD); however, no published studies have examined this topic. This study examined the clinical features, prevalence, and correlates of symmetry concerns involving physical appearance in two BDD samples ( $N=160$  and  $N=115$ ). More than 25% of participants in each sample reported symmetry concerns for a body part with which they were preoccupied (total of 18 body parts in sample 1 and 18 in sample 2). In sample 1, BDD participants with appearance-related symmetry concerns were older than those without appearance-related symmetry concerns. In sample 2, those with appearance-related symmetry concerns reported poorer mental health-related quality of life, were more likely to have experienced lifetime suicidal ideation, had better BDD-related insight, and were less likely to have a lifetime eating disorder. In both samples, participants with appearance-related symmetry concerns were more likely to have lifetime OCD but *not* OCD-related symmetry obsessions. Thus, symmetry is a common appearance concern in BDD that is associated with comorbid OCD but not with OCD symmetry concerns specifically, suggesting that symmetry concerns may have a different mechanism/pathophysiology in BDD versus OCD.

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## 1. Introduction

Body dysmorphic disorder (BDD) is defined in *DSM-IV* as a distressing or impairing preoccupation with nonexistent or slight defects in physical appearance (American Psychiatric Association, 1994). In recent years, substantial efforts have been made to better understand the phenomenology of BDD and to identify its clinical features, including body areas of excessive concern, repetitive behaviors such as compulsive grooming and skin picking, and level of insight (e.g., Fontenelle et al., 2006; Grant, Menard, & Phillips, 2006; Phillips, Menard, Fay, & Weisberg, 2005). One feature of BDD that has not received empirical attention is appearance-related symmetry concerns. Our clinical observations suggest that appearance-focused symmetry concerns are common in BDD; for example, patients may report distressing and/or impairing preoccupation with supposedly “uneven” or “asymmetrical” eyebrows, eyes, hair, or other body areas, which appear normal to others. To our knowledge, no published reports have examined preoccupation with appearance-related symmetry as a symptom of BDD.

Whereas symmetry concerns have received virtually no empirical attention in BDD, symmetry obsessions are a well-known and common symptom of obsessive-compulsive disorder (OCD; see Coles & Pietrefesa, 2008), with prevalence rates ranging from 36% to 50% in adult OCD samples (Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999; Pinto, Mancebo, Eisen, Pagano, & Rasmussen, 2006; Pinto et al., 2008). Symmetry obsessions in OCD are commonly accompanied by ordering and arranging compulsions (Radomsky & Rachman, 2004), and a symmetry/ordering factor or cluster has been consistently identified in studies attempting to create symptom-based OCD subgroups using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) Symptom Checklist (Abramowitz, Franklin, Schwartz, & Furr, 2003; Bloch, Landeros-Weisenberger, Rosario, Pittenger, & Leckman, 2008; Calamari et al., 2004; Goodman et al., 1989a,b; Mataix-Cols, Rosario-Campos, & Leckman, 2005).

In OCD, symmetry obsessions have been linked to several notable demographic and clinical features. OCD symmetry symptoms have been found to occur more frequently in men than in women with OCD and to be associated with earlier age at OCD onset (Hasler et al., 2005; Jaisoorya, Reddy, Srinath, & Thennarasu, 2009; Leckman et al., 1997; Lensi et al., 1996; Mataix-Cols et al., 1999; Stein, Anderson, & Overo, 2007; Torresan et al. 2009). OCD symmetry obsessions have also been found to be associated with comorbid obsessive-compulsive personality disorder (OCPD) and tic disorders (Baer, 1994; Jaisoorya, Reddy, Srinath, & Thennarasu, 2008; Labad et al., 2008). In a large outpatient

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OCD sample, Hasler et al. (2005) found that the OC symptom dimension that included symmetry obsessions (as well as repeating, counting, and ordering/arranging compulsions) was significantly related to comorbid diagnoses of panic disorder, agoraphobia, and alcohol and substance abuse/dependence. In a subsequent study of 418 participants from the OCD Collaborative Genetics study, the symmetry, ordering/arranging, repeating, and counting symptom dimension from the Y-BOCS Symptom Checklist was associated with comorbid diagnoses of ADHD, alcohol dependence, and bulimia (Hasler et al., 2007). In a prospective follow-up study of treated OCD patients, symmetry/ordering was the only symptom dimension from the Y-BOCS Symptom Checklist that was more common among those who attempted or committed suicide, and it was independently associated with suicidal behaviors (Alonso et al., 2010).

BDD and OCD have similarities across multiple domains (for a review, see Phillips et al., 2010). Like OCD, BDD is characterized by recurrent, time-consuming, and intrusive thoughts that cause anxiety or distress. To reduce these negative feelings or prevent an unwanted event (e.g., being rejected by others or looking "ugly"), BDD patients engage in repetitive, time-consuming behaviors (e.g., frequent mirror checking, excessive grooming) that resemble OCD compulsions (Phillips, Gunderson, Mallya, McElroy, & Carter, 1998). Three studies that directly compared OCD and BDD across a broad range of clinical features found that the disorders are similar in terms of sex ratio and lifetime comorbidity for many (but not all) associated disorders (Frare, Perugi, Ruffolo, & Toni, 2004; Phillips et al., 1998, 2007). Two of these studies (Phillips et al., 1998, 2007) also found no differences between OCD and BDD with regard to age of onset and illness severity. Family studies have revealed elevated rates of BDD in first-degree relatives of individuals with OCD, suggesting a shared genetic contribution (Bienvenu et al. 2000, 2012). Because of these disorders' shared features, BDD is widely considered an obsessive-compulsive spectrum disorder (e.g., Brady, Austin, & Lydiard, 1990; Hollander & Benzaquen, 1997; Jaisooriya, Reddy, & Srinath, 2003; Phillips, McElroy, Hudson, & Pope, 1995), and BDD will be included in an obsessive-compulsive and related disorders category in DSM-5 (Phillips et al., 2010).

Nonetheless, OCD and BDD have some clinically important dissimilarities. For example, rates of lifetime suicidal ideation and attempts, lifetime major depressive disorder, and lifetime substance use disorders have all been found to be higher in BDD than in OCD (Frare et al., 2004; Phillips et al., 1998, 2007). Insight into disorder-specific beliefs is also poorer in BDD than in OCD (Phillips et al., 2007, 2012). The two disorders also require somewhat different treatment approaches (American Psychiatric Association, 2007; Wilhelm, Phillips, Fama, Greenberg, & Steketee, 2011). Thus, because OCD and BDD appear to be different disorders (Phillips & Kaye, 2007; Phillips et al., 2010), it is important to elucidate their shared versus distinct features.

This study examined the clinical features, prevalence, and demographic and clinical correlates of appearance-related symmetry preoccupations in BDD. Based on clinical experience, we hypothesized that preoccupation with appearance-related symmetry would be reported by a sizable subset of individuals with BDD. Extrapolating from the literature on symmetry obsessions in OCD, we hypothesized that appearance-related symmetry concerns would be significantly more common among men than women with BDD and associated with earlier age at BDD onset. Additionally, we hypothesized that appearance-related symmetry concerns in BDD would be associated with suicidality and with comorbid diagnoses of tic disorders, OCPD, and substance use disorders. Although the above-noted studies by Hasler et al. (2005, 2007) did not find a significant association between the Y-BOCS OCD symptom factor that includes symmetry obsessions and a comorbid diagnosis of BDD, we hypothesized that because

symmetry is a common symptom of OCD, a lifetime diagnosis of OCD would be more common in individuals with BDD-related symmetry concerns than in those without BDD-related symmetry concerns. In addition, we hypothesized that symmetry as a symptom of OCD would be associated with symmetry as a symptom of BDD, based on the theory that such concerns have shared descriptive features and thus may also have shared underlying mechanisms/pathophysiology.

## 2. Methods

### 2.1. Participants

This study examined appearance-related symmetry concerns in two separate samples of individuals with DSM-IV BDD. We chose to analyze the samples separately because they differed in several ways, including how participants were ascertained, use of primarily DSM-III-R versus DSM-IV criteria for comorbid Axis I and II disorders, and number of different body parts assessed as the focus of BDD preoccupation and potentially involving symmetry concerns (see details below). Each of the two samples in this report is a subset of larger, previously described samples because data on appearance-related symmetry concerns were not available for the full samples (questions about appearance-related symmetry concerns were added or removed during the course of the studies). Although other papers have previously reported various characteristics of the larger samples from which the samples in this report were obtained, data pertaining to symmetry concerns in BDD have not previously been reported for either sample. In this report, study participants younger than 18 years of age were included in analyses, as we did not have reason to believe that appearance-related symmetry concerns would differ in children versus adults. The studies from which data for each sample were obtained were approved by the hospital's Institutional Review Board. All participants provided written informed consent (or assent plus parental consent for participants under 18 years of age).

*Sample 1* consisted of 160 individuals with current DSM-IV BDD (41% male, mean age = 28.80 ± 11.04, age range = 11 to 73,  $n = 131$  adults [ $> 18$  years]) who were referred from a variety of sources for clinical evaluation or treatment of BDD in a BDD research and clinical specialty program. Other papers have previously reported on various characteristics of the larger BDD sample from which this sample was derived (e.g., Gunstad & Phillips, 2003; Phillips & Diaz, 1997). They participated in a phenomenology study of the clinical features of BDD that had no exclusion criteria ( $n = 75$ ; Phillips & Diaz, 1997; Phillips, McElroy, Keck, Pope, & Hudson, 1993) or in one of five pharmacotherapy studies of BDD ( $n = 85$ ; Phillips, 2005; Phillips & Menard, 2009; Phillips & Najjar, 2003; Phillips, Albertini, & Rasmussen, 2002; Phillips, Dwight, & McElroy, 1998). The medication studies excluded individuals with a current substance use disorder, past or current bipolar disorder, current clinically significant suicidality, or current inpatient or residential treatment status. Data examined from the five pharmacotherapy studies was obtained from participants prior to initiation of psychotropic medication.

*Sample 2* is a more broadly ascertained sample of 115 individuals (30% male, mean age = 32.93 ± 11.83, age range = 14 to 63,  $n = 108$  adults [ $> 18$  years]) who participated in an observational prospective interview study of the course of BDD. The larger sample from which this subset of participants was derived consisted of 200 BDD participants, and various characteristics of this sample have been previously reported (e.g., Phillips et al., 2005; Phillips, Menard, & Fay, 2006). Recruitment sources consisted of mental health professionals (50%), advertisements (36%), the BDD program's brochures and program website (7.0%), friends and relatives of the participant (3%), nonpsychiatrist physicians (1%), and other sources (3%). Inclusion criteria were DSM-IV BDD or its delusional variant (delusional disorder, somatic type), age 12 or older, and ability to be interviewed in person. The only exclusion criterion was the presence of an organic mental disorder that would interfere with the collection of valid interview data. In the sample of 115 BDD participants used in this report, 87% ( $n = 100$ ) met current criteria (during the past month) for BDD; the rest of the sample met full criteria for BDD at some point in their life (10% were in partial remission, and 3% were in full remission at the time of the intake interview). 65% ( $n = 75$ ) of participants were currently receiving mental health treatment (most in the community). All data reported for this sample are from the initial (intake) interview.

### 2.2. Assessments

In both samples, appearance-related symmetry concerns were assessed with two questions on the *BDD Data Form* (Phillips, KA, unpublished), a semi-structured rater-administered measure used in previous BDD studies (e.g., Phillips & Diaz, 1997; Phillips et al., 1993). Normal-appearing body parts about which participants had excessive, clinically significant concern were first assessed. Participants were then asked whether their preoccupation with any of the identified body parts involved symmetry and if so, which part(s). The studies that constituted sample 1

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