

Muscle Dysmorphia in a Young Chinese Male

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Abstract

Introduction: To describe a young Chinese male with muscle dysmorphia, a recently proposed variant of body dysmorphic disorder. **Clinical Picture:** A 24-year-old Chinese male with a morbid fear of weight and muscle loss with associated compulsive weight training, avoidance behaviour, forced eating, depressed mood and disturbed body image. **Treatment:** Antidepressants and cognitive-behavioural psychotherapy. **Outcome:** Preoccupation with muscularity was reduced. **Conclusions:** Muscle dysmorphia has been reported in Western populations, mostly among body builders and anabolic steroid abusers. To our knowledge, this is the first case report originating from a non-Western population. The patient illustrates the nosological difficulty of this recent entity. It is likely to be a culture-bound phenomena associated with a Western concept of an ideal body shape for males.

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Introduction

In 1891, Morselli described “dysmorphophobia” in 78 patients who were severely miserable, preoccupied and distressed by perceived deformities.¹ The word “dysmorphia” in Greek means ugly. Body dysmorphic disorder appeared in DSM-III in 1987. A “reverse” anorexia nervosa syndrome characterised by fears of being too “small” despite being objectively large and muscular was described by Pope et al in 1993.² Phillips, O’Sullivan and Pope³ later termed this entity “muscle dysmorphia”. Clinical features and proposals for diagnostic criteria have been presented.⁴ Various authors have highlighted its under recognition. To date, no reports of this condition in a non-Western population are available.

Case Report

A young Chinese male was referred to our department at the age of 17 years, with complaints of inter-personal difficulties, irritability, palpitations, fear of going out and fears of contracting a terminal disease. Mild depression with obsessional features was diagnosed. He improved on antidepressant treatment and was discharged from outpatient care at the age of 20 years.

Two years later, at the age of 22 years, he presented again complaining of weight loss. He admitted to fears of losing

weight, avoiding situations which he perceived would lead to reduction in muscularity, compulsive weight training, forced eating despite a lack of hunger, fear of negative evaluation and dissatisfaction with his body. Despite weighing 80.1 kg for a height of 1.78 m (BMI 25.2) and appearing well built and muscular, he expressed a fear that he “looked like a twig”. Any real or perceived weight loss would trigger dysphoria and desperate attempts to gain weight/muscle. At times he perceived parts of his body to be shrinking, causing tremendous anxiety, even though he accepted that it was irrational because his weight had increased. He avoided going out at night fearing that inadequate sleep would lead to muscle loss. He described great unease if he was unable to perform his hour workout in the gym every other day. He felt compelled to eat a “minimum amount” each day and consumed protein supplements. He denied abuse of anabolic steroids. He expressed concern that loss of muscularity would result in being “not attractive enough” to other men, risking rejection (“Everything revolves around my muscle mass”).

His symptoms began a year earlier, shortly after beginning a management course. He felt isolated and concluded that it was because he looked “effeminate” and decided to begin body-building. This coincided with his frequenting homosexual meeting places. A relationship break up

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intensified his fears about weight/muscle loss. Though acknowledging that his ex-partner had never commented negatively about his body, he continued to ruminate that the break up was due to his “puny body”. With respect to his personal history, he felt his father never liked him because he was effeminate and favoured his “sportier” younger brother although he admits that his father never vocalised this (“I never lived up to what he wanted in a son.”). He is his mother’s favourite and confides in her. As a child, he preferred playing with girls and hated boys’ games. He remembered his relatives teasing him mercilessly for his effeminacy. His father died suddenly of leukaemia when he was 14. He admitted being conscious of trying to gain his deceased father’s affirmation. He felt isolated and unhappy in junior college. During military service, he developed anxiety and an adjustment disorder. There is no family psychiatric history. His initial exploratory heterosexual behaviour in early adolescence was later replaced by exclusively homosexual preferences and practices.

Mental state examination revealed a well-built, calm, pleasant and articulate young man. His mood was euthymic. He expressed strong dissatisfaction about his appearance and build, but acknowledged these were “irrational”. No psychotic symptoms were elicited. He scored 30 on the Yale-Brown Obsessive Compulsive Scale modified for Body Dysmorphic Disorder.

The patient was treated with sertraline 50 mg and cognitive-behavioural therapy. Using a downward arrow technique, the patient’s catastrophic fears of weight/muscle loss were explored (“I might shrink/lose weight. If I do, I can’t face the outside world because I look disgusting and terrible. I’ll look like a woman. People don’t like men who look like women. People will not like me. I will have no friends, be rejected and betrayed. I am a defective/freak”). Dysfunctional beliefs about appearance and beauty were explored (“beauty is the most important thing in the world”; “I must have a big muscular body for another man to like me”; “slim men are weak and pathetic”). He was encouraged to test these beliefs by observing and enquiring about other’s homosexual relationships.

His preoccupation with muscularity gradually diminished over two years. He admitted seriously doubting his beliefs that significant muscularity was necessary for him to be considered “attractive”. He was able to be more flexible with his workouts and diet. Nevertheless, bouts of dysphoria and associated catastrophic negative cognitions related to lack of attractiveness continued.

Discussion

Muscle dysmorphia lies at the interface of various nosological entities, namely obsessive-compulsive spectrum disorder, body dysmorphic disorder, anxiety disorder, eating

disorder, and impulse control disorder. Pope et al⁴ suggest a family of “affective spectrum disorder” sharing a common physiologic abnormality. Since body image is the predominant focus of the patient’s cognitions and behaviours, it is appropriate to consider muscle dysmorphia as a subtype of body dysmorphic disorder. Phillips⁵ includes weight lifting, aerobics, other forms of exercise, comparing, checking and mirror gazing as possible body dysmorphic disorder behaviours, all of which our patient indulged in. Our patient’s previous diagnoses of depression and anxiety are typical of the comorbidity of body dysmorphic disorder with other psychiatric syndromes. The commonest associated disorders are depression, generalised anxiety, eating disorders, obsessive-compulsive disorder and schizophrenia.⁶ Until prospective studies are completed, it remains unclear whether these conditions predispose to, are caused by or merely coexist with body dysmorphic disorder. Scores of the modified Yale-Brown Obsessive Compulsive Scale for body dysmorphic disorder patients correlate with illness severity.⁷ Our case’s score of 30 indicates moderate severity. Cognitive-behavioural treatments have been described for body dysmorphic disorder⁸ and body image disturbances.⁹ The patient was able to conclude that the belief that he had to be muscular in order to be attractive was faulty. His continued preoccupation with physical appearance suggests prominent appearance schemas. Patients with negative self-image are highly appearance schematic and modification of these schemas are essential for improvement.¹⁰

Although there are no comprehensive studies on the efficacy of medications in muscle dysmorphia, selective serotonin reuptake inhibitors have been found to benefit a proportion of cases of body dysmorphic disorder, which shares many of the features of muscle dysmorphia. In the two small uncontrolled studies available in the literature, about two thirds of the subjects reported improvement on the medications.^{11,12} Such a response would be in keeping with muscle dysmorphia being an “affective”⁴ or “obsessive”¹³ spectrum disorder.

Gender differences reflect prevailing cultural and societal concerns. Women usually express concern with overweight, whereas men are as likely to worry about being too thin.¹⁴ A gender comparison, found women with body dysmorphic disorder more likely to worry about weight and specific body areas being too large, and men more about small body build.¹⁵ Although muscle dysmorphia has been reported to occur frequently in body-builders, it is likely to be common in male homosexuals as a premium on body build is common to both.¹⁶ Our patient’s underlying schemas may have stemmed from his lack of affirmation by his father. His frantic efforts to remain “muscular” can be attributed to a need to be “desirable” and not a “freak” are not unlike

anorexia nervosa, where efforts to lose weight relate to subjective beliefs of desirability and attractiveness. As gross muscularity is not perceived as unhealthy, few with muscle dysmorphia present for treatment.

In conclusion, muscle dysmorphia is rare and previous reports have been mostly among competitive body builders and anabolic steroid abusers from Western populations. Our case is the first to be reported locally and to our knowledge from a non-Western population. Muscle dysmorphia has aspects of a culture-bound phenomena and is possibly beginning to appear in non-Western societies.

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