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# Body Dysmorphic Disorder in Pregnant Mothers Who Choose Cesarean Section

**Nozhan Alimi[1], Zahra Hamidi Madani[2], Rohollah Saranjam[3], Seyedeh Shahed Shoarishoar[2], Ali Massoudifar[1], Zeinab Haghighi Fini[1], Misa Naghdipour Mirsadeghi[2*]**

1. *Department of Psychiatry, School of Medicine, Hormozgan University of Medical Sciences, Bandar Abbas, Iran*
2. *Department of Gynecology Oncology, School of Medicine, Reproductive Health Research Center, Alzahra Hospital, Guilan University of Medical Sciences, Rasht, Iran*
3. *Department of Health Psychology, Kish International Campus, University of Tehran, Tehran, Iran*

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**Corresponding Information:**
**Misa Naghdipour Mirsadeghi,**
Department of Gynecology Oncology, School of Medicine, Reproductive Health Research Center, Alzahra Hospital, Guilan University of Medical Sciences, Rasht, Iran

**Email:** Misa.naghdipour@gums.ac.ir

**ABSTRACT**

**Background & Objective:** Body Dysmorphic Disorder (BDD) is a psychiatric condition characterized by perceived defects in physical appearance leading to distress and significant impairment in daily functioning. This study was conducted with aim of investigating the prevalence and severity of BDD in pregnant mothers who choose C-section due to concerns about their body image.

**Materials & Methods:** This cross-sectional study was conducted on 149 pregnant mothers who were candidates for cesarean section. Demographic information, surgical history, and previous deliveries were comprehensively collected, and participants were asked to complete the BDD-YBOCS questionnaire to examine their BDD status. Data were analyzed using IBM-SPSS software (version 23). $P<0.05$ was regarded as statistically significant.

**Results:** Among the participants, 55% had a history of surgery, 24.8% had plastic surgery, and 45.6% had given birth once. About 16.8% of the total patients obtained the maximum score for diagnosis of BDD. The history of plastic surgery was significantly higher in BDD patients. BDD scores, including obsessive thoughts, compulsion, avoidance, and insight, were higher in those who had undergone plastic surgery. Obsession scores and BMI were significantly different between patients with and without a history of childbirth. Only the avoidance dimension of the BDD questionnaire had a positive and significant correlation with age and the scores of different dimensions of BDD questionnaire were notably higher in individuals with a history of plastic surgery.

**Conclusion:** The findings underscore the significant impact of plastic surgery history on BDD. The correlation results further highlight the influence of age on the dimension of avoidance.

**Keywords:** Body dysmorphic disorder (BDD), Pregnancy, Cesarean section, YBOCS questionnaire

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## 1. Introduction

Body Dysmorphic Disorder (BDD) is a prevalent but often overlooked mental health condition, affecting 1.7-2.4% of the population according to DSM-5 **(1,2)**. It is characterized by an obsessive preoccupation with perceived flaws in physical appearance, which can be minor or even invisible to others **(3,4)**. The disorder can lead to significant disruption in daily functioning. Common areas of concern include facial features, skin imperfections, and body size. Individuals with BDD often experience accompanying conditions such as depression, anxiety, and suicidal thoughts **(5,6)**. This distorted self-image can lead to excessive grooming, avoidance of social situations, and a diminished quality of life **(7)**. People with BDD often engage in repetitive behaviors such as checking mirrors, seeking reassurance, and undergoing unnecessary cosmetic procedures to correct their perceived defects **(8)**.

Pregnancy can significantly exacerbate the symptoms of BDD. The body undergoes substantial changes to accommodate the growing fetus, including changes in posture, weight distribution, and overall body shape. Enlargement of the abdomen and alterations in the size and shape of the breasts are natural and expected parts of pregnancy. However, they can provoke anxiety and uncertainty in pregnant women, particularly nulliparous mothers. Concerns

about body image, discomfort, and perception of changing physical appearance may arise, affecting the mother's self-esteem. Women with BDD may experience intense preoccupation with perceived defects related to weight gain, skin changes, or other physical changes associated with pregnancy **(9,10)**. The mother's mental health during pregnancy is closely linked to the growth of the fetus and the subsequent consequences for the child. Research shows that the mother's stress and anxiety can affect the growth of the fetus and contribute to children's developmental and behavioral problems. Therefore, specialized care for pregnant women with BDD is crucial for the well-being of both the mother and the child **(11,12)**.

Studies have been conducted on facial nerve syndrome with synkinesis, facial acne, breast hypertrophy, and women who are candidates for labiaplasty surgery, showing that a person's perception of their appearance and disfigurement disorders are crucial factors in improving their quality of life **(13-17)**. However, despite the numerous effects of childbirth and pregnancy on people's metacognition, no study has been conducted in this area. Cesarean section has been associated with an increase in OCD complaints in the postpartum period compared to vaginal delivery **(18,19)**. Therefore, given the context of OCD in pregnant mothers, awareness of the prevalence of BDD in this population can significantly improve their quality of life. Healthcare providers play a vital role in reducing concerns and creating a positive experience of pregnancy **(20,21)**. Therefore, this study was conducted with aim to investigate the prevalence and severity of BDD in pregnant women candidates for cesarean section, highlighting the importance of healthcare providers in addressing BDD in pregnant women.

## 2. Materials and Methods

This cross-sectional study was conducted on 149 pregnant women candidates for cesarean delivery who referred to Shariati Hospital Clinic, BandarAbbas, Iran, in December 2023-April 2024. All pregnant women candidates for cesarean delivery, referring to Shariati Hospital Obstetrics and Gynecology Clinic, were included in the study. Lack of interest in completing the questionnaire or participating in the survey was considered an exclusion criteria. The census method was used to prepare the sample size, and all eligible patients were invited to participate in this study.

The patients were invited to complete the questionnaire. Women's demographics characteristics (age) and other variables (history of surgery, history of plastic surgery, number of previous births and their BDD status) were recorded. Then, a 12-question BDD-YBOCS questionnaire was completed. The Yale-Brown Obsessive-Compulsive Scale for Body Dysmorphic Disorder (BDD-YBOCS-Revised) **(19)** is a 12-item, semi-structured, rater-administered scale that assesses BDD severity and the intensity of obsessive thoughts and obsessive behaviors related to BDD. This scale was adapted from the Yale-Brown Obsessive-Compulsive Disorder Scale (BOCS), the most widely used measure of Obsessive-Compulsive Disorder (OCD) severity **(22,23)**. This questionnaire includes four factors: metacognitive control strategies (about appearance), objectification (mixing of thoughts), positive and negative metacognitive beliefs, and safety behaviors about body deformity. Each question contains five options, and the scoring of the respondents' questionnaire showed their agreement with each of the items on a Likert scale ranging from (completely disagree=score 0) to (completely agree=score 4), the higher scores indicating more severe symptoms. The questions 1 to 5 measure obsessive thoughts and 5 to 10 compulsions, question 11 measures avoidance and question 12 measures insight and a total score above 20 indicates the diagnosis of BDD. The questionnaire includes questions about the frequency of obsessive thoughts, the duration of their influence, the degree of control over them, as well as the impact of obsessive behaviors on daily life. Doctors and therapists, empowered with this tool, can effectively evaluate the progress of treatment and help diagnose the severity of the disorder in patients **(12,23,24)**. The questions of this questionnaire, which are related to obsessions and compulsions, include: 1. The amount of time spent on obsessive thoughts and behaviors. 2. Interference in daily life. 3. Discomfort caused by obsessive thoughts and behaviors. 4. Resistance and control over obsessive thoughts and behaviors. This information helped mental health professionals to diagnose the severity of the body deformity disorder and determine the appropriate treatment plan.

**Data analysis**

Data was analyzed by descriptive and analytical statistical analysis using IBM-SPSS 23 software. Quantitative variables were reported as mean±SD and qualitative variables as percentages. Chi-square, student t, ANOVA, and correlation coefficient tests were used to ensure a thorough analysis. $P<0.05$ was regarded as statistically significant.

## 3. Results

Among the 149 pregnant women studied, most patients were in the two groups of 20 to 28 years (40.9%) and 29 to 38 years (34.9%). More than half of them (55%) mentioned a history of previous surgery, and 24.8% also mentioned the history of plastic surgery. The highest frequency of the number of previous births was one birth (45.6%), and the lowest was three births (10.1%). Based on the questionnaire, 16.8% of all patients obtained the score for BDD (Table 1).

The quantitative variables studied are shown in Table 2. The mean Body Mass Index (BMI) of the studied

patients was 26.90±1.63 kg/m$^2$, and the mean score of the BDD score of the questionnaire was 16.80±6.85.

The results of the Chi-square test showed no significant difference between patients with BDD and those without BDD in terms of age groups (P=0.19) and surgical history (P=0.11). However, the chi-square test results to compare the frequency of plastic surgery history separately from disfigurement showed that the frequency of positive history of plastic surgery was significantly higher in patients suffering from disfigurement (80% vs. 13.7%, P<0.01). The results of the chi-square test to compare the frequency of previous births by different types of dyspareunia also showed that the frequency of previous births was significantly higher in patients with dyspareunia than in the other group. For example, the frequency of patients with two and three births in the group suffering from dyspareunia was 48% and 12%, respectively. In contrast, these cases in the group without dyspareunia were 28.2% and 9.7%, respectively (P=0.04) (Table 3).

Table 4 shows the results of independent t-test to compare the scores of different dimensions of disfigurement by history of plastic surgery. In all dimensions, the mean scores of patients with a history of plastic surgery were significantly higher than those of the other group.

Also, the results of the independent t-test, which was studied and compared the average body mass index between the two groups, showed that there was a significant difference between the two groups in terms of BMI, so that BMI was significantly higher in patients with dystopia than other nodes (P<0.01) (Table 5).

Mwan BMI in BDD group was 27.86±1.52 and in the group without BDD was 26.81±1.59 (P-value<0.01)

The results of the ANOVA test to compare quantitative variables according to the number of previous births are shown in Table 6. The results showed that compulsion score (P=0.73), avoidance score (P=0.99), insight score (P=0.10), and the total score of the BDD questionnaire (P=0.23) had no significant difference according to the number of previous births. However, BMI (P=0.01) and obsession (P<0.01) had significant differences between patients with different births. The post-hoc test results for BMI revealed that between each group, there was a significant difference between patients without a history of childbirth and those with a previous childbirth (25.76±1.68 and 27.12±1.51, respectively, P=0.15). Also, post-hoc test was conducted to compare the average obsession score between different groups, which showed that the average score of obsessions was significantly different in nulliparous patients and patients with one previous delivery (8.63±3.98 and 5.83±2.14, respectively, P<0.01).

The correlation between age and the scores of the deviance questionnaire is shown in Table 6. According to the findings, age has no significant correlation with items such as obsessive thoughts, practical obsessions, insight, and the total score of the BDD questionnaire (P>0.05 in all cases). Only the dimension of avoidance had a significant positive correlation with age, so with increasing age, we would expect an increase in the score of the dimension of avoidance.

**Table 1. Qualitative characteristics of the participants**

| | Variable | Number | Frequency (percentage) |
|---|---|---|---|
| **Age** | 20-28 years | 61 | 40.9 |
| | 29-38 years | 52 | 34.9 |
| | 39 years and more | 36 | 24.2 |
| **History of surgery** | No | 67 | 45.0 |
| | Yes | 82 | 55.0 |
| **History of plastic surgery** | No | 112 | 75.2 |
| | Yes | 37 | 24.8 |
| **Number of previous births** | 0 | 19 | 12.8 |
| | 1 | 68 | 45.6 |
| | 2 | 47 | 31.5 |
| | 3 | 15 | 10.1 |
| **The state of BDD** | Negative | 124 | 83.2 |
| | Positive | 25 | 16.8 |

**Table 2.** Quantitative characteristics of the participants

| Variable | Mean | Standard deviation |
|---|---|---|
| BMI | 26.90 | 1.63 |
| Obsession | 6.71 | 2.93 |
| Compulsion | 7.18 | 3.45 |
| Avoidance | 1.41 | 0.92 |
| Insight | 1.49 | 0.81 |
| The total score of the BDD questionnaire | 16.80 | 6.85 |

**Table 3.** Frequency of age groups, history of surgery, history of plastic surgery and number of previous births according to the status of BDD

| Age | With BDD | | Without BDD | | P-value |
|---|---|---|---|---|---|
| | Number | Abundance (percentage) | Number | Abundance (percentage) | |
| 20-28 | 10 | 40.0 | 51 | 41.1 | 0.19 |
| 29-38 | 12 | 48.0 | 40 | 32.3 | |
| 39< | 3 | 12.0 | 33 | 26.6 | |
| History of surgery | With BDD | | Without BDD | | P-value |
| | Number | Abundance (percentage) | Number | Abundance (percentage) | |
| Positive | 17 | 68.0 | 65 | 52.4 | 0.11 |
| Negative | 8 | 32.0 | 59 | 47.6 | |
| | | | | | |
| History of plastic surgery | With BDD | | Without BDD | | P-value |
| | Number | Abundance (percentage) | Number | Abundance (percentage) | |
| Positive | 20 | 80.0 | 17 | 13.7 | <0.01 |
| Negative | 5 | 20.0 | 107 | 83.3 | |
| Number of previous births | With BDD | | Without BDD | | P-value |
| | Number | Abundance (percentage) | Number | Abundance (percentage) | |
| 0 | 5 | 20.0 | 14 | 11.3 | |
| 1 | 5 | 20.0 | 63 | 50.8 | |
| 2 | 12 | 48.0 | 35 | 28.2 | 0.04 |
| 3 | 3 | 12.0 | 12 | 9.7 | |

**Table 4.** The scores of different dimensions of the BDD questionnaire according to the history of plastic surgery

| Variable | With a history of surgery | | Without a history of surgery | | P-value |
|---|---|---|---|---|---|
| | Mean | Standard deviation | Mean | Standard deviation | <0.01 |
| Obsession | 9.02 | 3.19 | 5.94 | 2.41 | <0.01 |
| Compulsion | 9.83 | 3.16 | 6.30 | 3.08 | <0.01 |
| Avoidance | 2.00 | 1.08 | 1.22 | 0.77 | <0.01 |
| Insight | 2.02 | 0.83 | 1.32 | 0.72 | <0.01 |
| The total score of the BDD questionnaire | 22.89 | 6.10 | 14.79 | 5.83 | <0.01 |

**Table 5.** The quantitative variables according to the number of births

| Variable | without childbirth | | 1 birth | | 2 births | | 3 births | | P-value |
|---|---|---|---|---|---|---|---|---|---|
| | Mean | Standard deviation | Mean | Standard deviation | Mean | Standard deviation | Mean | Standard deviation | |
| BMI | 25.76 | 1.68 | 27.12 | 1.51 | 26.98 | 1.67 | 27.16 | 1.52 | 0.01 |
| Obsession | 8.63 | 3.98 | 5.83 | 2.14 | 6.93 | 2.70 | 7.53 | 3.88 | <0.01 |
| Compulsion | 7.10 | 4.86 | 6.89 | 2.85 | 7.63 | 3.79 | 7.13 | 2.82 | 0.73 |
| Avoidance | 1.47 | 0.96 | 1.39 | 0.88 | 1.42 | 0.97 | 1.40 | 0.98 | 0.99 |
| Insight | 1.26 | 0.45 | 1.45 | 0.76 | 1.51 | 0.97 | 1.93 | 0.70 | 0.10 |
| The total score of the BDD questionnaire | 18.47 | 9.37 | 15.58 | 5.47 | 17.51 | 7.22 | 18.00 | 7.34 | 0.23 |

**Table 6.** Correlation of age and scores of BDD questionnaire

| Variable | Age | |
|---|---|---|
| | Correlation | P-value |
| Obsession | -0.12 | 0.11 |
| Compulsion | -0.14 | 0.56 |
| Avoidance | 0.19 | 0.01 |
| Insight | -0.09 | 0.27 |
| The total score of the BDD questionnaire | -0.06 | 0.44 |

## 4. Discussion

Body Dysmorphic Disorder (BDD) is characterized by an obsessive preoccupation with perceived defects in appearance often leading to repetitive behaviors **(8)**. It causes a significant disturbance in psychosocial functioning and increases the risk of suicide **(5,19)**. The purpose of the present study was to assess BDD in pregnant women who choose cesarean delivery using the BDD-YBOCS questionnaire. In our study, most participants aged 20 to 28 years, 55% mentioned previous surgical experience, and 45.6% mentioned the history of plastic surgery. Nearly half of the patients had a history of giving birth once. Moreover, 16.8% of the total patients obtained the maximum score for the application of rectification. The mean body mass index of the participants was about 27, and the mean score on the BDD questionnaire was about 17. According to the results, the frequency of age groups in people with and without BDD was similar. Also, the history of surgery did not show a significant difference in the two groups. However, the history of plastic surgery was significantly higher in patients with BDD. The scores of different dimensions of the BDD questionnaire, including obsession, compulsion, avoidance, and insight, as well as the total score of the BDD questionnaire in patients who had a history of plastic surgery, were significantly higher than the other group. Also, the frequency of previous birth was significantly higher in patients with BDD compared to the opposite group. In addition, BMI was significantly higher in

people with BDD than in other groups. The compulsion score, avoidance score, insight score, and total score of the BDD questionnaire showed no significant difference in the number of times of previous childbirth. However, BMI and obsession showed a significant difference in patients with varying times of childbirth. So, BMI in patients without a history of childbirth was significantly lower than in patients with a previous order of childbirth, and obsession was considerably higher in patients without a history of childbirth. Among the dimensions of the BDD questionnaire, only the avoidance dimension had a significant positive correlation with age, so the score of the avoidance dimension increases with age.

The study by House et al., in 2016 regarding obsessive-compulsive disorder in pregnancy and the postpartum period, in which the researchers examined the course of OCD during pregnancy and its impact on childbirth and newborns. Fifty-six pregnant women with OCD were followed up from early pregnancy up to 52 weeks after delivery. Maternal age showed an inverse correlation with the severity of OCD over time. Cesarean section was associated with higher OCD symptoms after delivery compared to vaginal delivery. However, no direct relationship was found between OCD severity and specific obstetric or neonatal complications **(18)**. In the present study, the frequency of previous birth was significantly higher in patients with BDD compared to the group without BDD. Therefore, there is a relationship between BDD and the birth records of the patients. Thus, these two studies are somewhat similar. However, in our study, age did not have a significant correlation with items such as obsessions, compulsion, insight, and the total score of the BDD questionnaire, and only the dimension of avoidance had a significant positive correlation with age. In this study, the mother's age over time showed an inverse correlation with the severity of OCD.

Mehta et al., in their study examined how body image is related to pregnancy weight gain. Their results showed a complex relationship between body image and pregnancy weight gain, which is very important in addressing health issues related to pregnancy **(25)**. In the current study, BMI was significantly lower in patients without a history of childbirth than in patients with a previous history of childbirth, and BMI was significantly higher in patients with BDD than in the other group. Therefore, our study also showed the effect of pregnancy changes on the prevalence of BDD, and their study was in accordance with the present study.

Brito et al., conducted a study in 2016 to measure BDD symptoms in abdominoplasty candidates. Among 90 patients, 57% showed symptoms of BDD. These symptoms are related to body dissatisfaction, appearance obsession, and avoidance behaviors. Severe BDD symptoms were associated with more significant concerns about weight and body shape. Patients who had distorted self-perceptions were more likely to show severe BDD symptoms. Abdominoplasty candidates often have BDD symptoms, which exacerbate the body's concerns **(3)**. In the present study, the history of plastic surgery was significantly higher in patients with BDD. Also, the scores of various dimensions of the BDD questionnaire, including obsession, compulsion, avoidance, and insight, as well as the total score of the BDD questionnaire in patients who had a history of plastic surgery, were significantly higher than the other group. Therefore, there is a relationship between BDD and the history of plastic surgery.

One of the limitations of this study is the lack of a control group that may be challenging to establish a causal relationship between BDD and choosing cesarean section. The other limitation is a small sample size, potentially affecting the findings' generalizability. Also, the assessment of Body Dysmorphic Disorder (BDD) in our study relies on self-reported symptoms, which can introduce bias or inaccuracy. Therefore, to increase the validity of the diagnosis of BDD, objective measures, such as clinical assessments or diagnostic tools, should be included in addition to participant-reported symptoms. Expanding the number of participants can also help to include pregnant mothers with different demographic backgrounds and obtain a more representative sample. A longitudinal study to track the progression of BDD symptoms during pregnancy and postpartum could also provide a more comprehensive understanding of its impact on cesarean delivery.

## 5. Conclusion

As evidenced by the results of the present study, the history of plastic surgery was significantly higher in patients with BDD and the symptoms of different dimensions of BDD can be higher in people who had plastic surgery. Also, in people with BDD, the frequency of previous childbirth and BMI were higher. Obsession scores and BMI can be significantly different between patients with and without a history of childbirth, and with increasing age, the score of the avoidance dimension in the BDD questionnaire increases.

## 6. Declarations

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## Ethical Considerations

Consent for publication was obtained from all participants. Hormozgan University of Medical Sciences Ethical Committee approved the study (ethical code: IR.HUMS.REC.1401.061).

## Authors' Contributions

Conceptualization: NA, ZHM, Methodology: RS, SSS, AM, MNM, Investigation: ZHF, MNM, MNM, NA, Writing- Original Draft Preparation: RS, SSS, Writing- Review and Editing: AM, MNM.

## Conflict of Interest

The authors declare no conflict of interest.

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## Ethics approval and consent to participate

The study was approved by the Ethics Committee of Hormozgan University of Medical Sciences (ethical code IR.HUMS.REC.1401.061.)

## Consent for publication

Consent for publication was obtained from all participants.

## Availability of Data and Materials

The data sets used during the current study are available from the corresponding author upon reasonable request.

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