



A comparison study of body dysmorphic disorder versus social phobia

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ABSTRACT

Body dysmorphic disorder (BDD) shares many characteristics with social phobia (SP), including high levels of social anxiety and avoidance, but to our knowledge no studies have directly compared these disorders' demographic and clinical features. Demographic and clinical features were compared in individuals with BDD ($n=172$), SP ($n=644$), and comorbid BDD/SP ($n=125$). SP participants had a significantly earlier age of onset and lower educational attainment than BDD participants. BDD participants were significantly less likely to ever be married than SP participants, had a greater likelihood of ever being psychiatrically hospitalized, and had significantly lower mean GAF scores than SP participants. The two groups had different comorbidity patterns, which included a greater likelihood for BDD participants to have comorbid obsessive-compulsive disorder (OCD) or an eating disorder, vs. a greater likelihood for SP participants to have a comorbid non-OCD anxiety disorder. The comorbid BDD/SP group had significantly greater morbidity across several domains than the SP only group, but not the BDD only group. In summary, although BDD and SP were similar across many demographic and clinical features, they had important differences. Future studies are needed to confirm these findings and address similarities and differences between these disorders across a broader range of variables.

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1. Introduction

Body dysmorphic disorder (BDD) is an often severe mental disorder that consists of distressing or impairing preoccupations with nonexistent or slight defects in appearance. BDD appears to be closely related to several anxiety disorders, particularly obsessive-compulsive disorder (OCD) and social phobia (SP) (Phillips et al., 1998; Frare et al., 2004; Phillips et al., 2007; Fang and Hofmann, 2010). Much attention has been paid to similarities between BDD and OCD (Phillips et al., 1998; Frare et al., 2004; Phillips and Stout, 2006; Phillips and Kaye, 2007; Phillips et al., 2007; Stewart et al., 2008). Indeed, BDD is often conceptualized as an obsessive-compulsive (OC)-spectrum disorder—i.e., a disorder that shares features with OCD and may be closely related to OCD (Cohen and Hollander, 1997; Goldsmith et al., 1998; Mataix-Cols et al., 2007; Phillips et al., 2010). However, BDD also shares many characteristics with SP (Veale et al., 2003; Pinto and Phillips, 2005; Coles et al., 2006; Kelly et al., 2010), including high levels of social anxiety and social avoidance (Veale et al., 2003; Pinto and Phillips, 2005; Fang and Hofmann, 2010; Kelly et al., 2010). However, to date, no studies

to our knowledge have ever directly compared the demographic and clinical features of BDD to SP.

BDD and SP are both characterized by fear of negative evaluation in social situations (Pinto and Phillips, 2005; Bögels et al., 2010) and avoidance of social interactions (Veale et al., 2003; Stangier et al., 2006; Kelly et al., 2010), although in BDD, social fear and avoidance are largely related to anxiety that the bodily “defects” will be perceived by others and considered unacceptable (Kelly et al., 2010). Indeed, although BDD and SP have not been directly compared, levels of social anxiety in BDD are similar to those reported for SP, with social anxiety symptoms in BDD ranging from 1.3 to 1.7 S.D. units higher than normative samples on the Social Avoidance and Distress Scale (SADS), the Social Phobia Inventory (SPIN) and Social Phobia scales (Veale et al., 2003; Pinto and Phillips, 2005; Kelly et al., 2010). Social avoidance is particularly marked in BDD and in SP (Schneier et al., 2002; Pinto and Phillips, 2005; Stangier et al., 2006; Kelly et al., 2010), contributing to poor social and occupational functioning in both disorders (Schneier et al., 1994; Wittchen et al., 2000; Kessler, 2003; Kelly et al., 2010).

BDD and SP appear to have other features in common. For instance, individuals with BDD and those with SP are more likely than healthy controls to interpret ambiguous social information (e.g., neutral facial expressions or ambiguous social scenarios) as hostile and threatening (Amir et al., 1998; Stopa and Clark, 2000;

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Buhlmann et al., 2002, 2006). Both disorders are characterized by a tendency for negative self-focused thoughts (Hofmann and Barlow, 2002; Veale, 2004; Phillips, 2005; Neziroglu et al., 2008) (although these characteristics are shared by other disorders as well). In addition, there is a high lifetime prevalence of comorbid SP in individuals with BDD, with rates ranging from 12–69 % (Hollander et al., 1993; Veale et al., 1996; Phillips and Diaz, 1997; Zimmerman and Mattia, 1998; Gunstad and Phillips, 2003; Phillips et al., 2005a); in the largest studies that examined comorbidity with a standard assessment measure, 37% of 293 participants and 39% of 200 participants with BDD had comorbid lifetime SP (Gunstad and Phillips, 2003; Phillips et al., 2005a). The prevalence of comorbid BDD in individuals with SP appears lower (5–12%), but to our knowledge has been examined in only two small studies (Brawman-Mintzer et al., 1995; Wilhelm et al., 1997). Furthermore, in some Eastern cultures (e.g., Japan), BDD is considered a type of SP known as *Taijin-kyofu-sho* (TKS) (Kleinknecht et al., 1997; Maeda and Nathan, 1999; Choy et al., 2008). Taken together, these findings suggest that BDD and SP may be related disorders.

However, BDD and SP appear to have important differences. For instance, BDD, but not SP, is characterized by prominent time-consuming repetitive behaviors (e.g., mirror checking, skin picking, excessive grooming) that are aimed at checking, fixing, hiding, or obtaining reassurance about the perceived appearance flaws. Regarding social anxiety specifically, clinical observations indicate that BDD-related social anxiety focuses specifically on concerns that others will judge the person's physical appearance (e.g., skin, hair, nose) negatively (Phillips, 2009). In a recent study, only 14% of individuals with BDD without comorbid SP had clinically significant social anxiety *not* related to appearance concerns, whereas 62% had clinically significant social anxiety due to appearance concerns or other sources (for most participants, BDD was the primary diagnosis) (Kelly et al., 2010). Furthermore, in the only prospective observational study of the course of BDD, examination of time-varying associations between BDD and comorbid SP indicated that change in symptoms of BDD and SP were not closely linked in time (however, statistical power was somewhat limited) (Phillips and Stout, 2006). For participants whose SP symptoms remitted, about half still met full DSM-IV criteria for BDD. Overall, these findings suggest that BDD and SP are similar across a number of clinical features and are highly comorbid, but they have some differences and do not appear to be the same disorder.

Currently, the relationship of BDD to disorders with similar features is an important topic of discussion (Mataix-Cols et al., 2007; Fang and Hofmann, 2010; Phillips et al., 2010). A direct comparison of the demographic and clinical features of BDD vs. SP would provide useful information that could shed light on the relationship between them. In turn, this could be useful for classification and assessment.

This report presents comparisons of demographic and clinical characteristics of BDD vs. SP vs. comorbid BDD and SP. Because to our knowledge there have been no previous comparisons of BDD and SP, and because both disorders are associated with significant morbidity and impairment in psychosocial functioning (Phillips et al., 2005b; Keller, 2006), no specific hypotheses were established for comparisons of morbidity in BDD vs. SP. However, we predicted that the comorbid BDD/SP group would have greater morbidity than the BDD only and SP only groups, given that individuals with more comorbidity, including BDD and anxiety disorders, generally have greater functional impairment (Phillips et al., 1998; Belzer and Schneier, 2004; Frare et al., 2004) and suicidality (Phillips et al., 1998; Frare et al., 2004; Sareen et al., 2005; Pfeiffer et al., 2009). Because BDD has been hypothesized to be an OC-spectrum disorder and has similarities with both OCD

and eating disorders (Grant and Phillips, 2004; Hrabosky et al., 2009; Phillips et al., 2010), we hypothesized that BDD would be more highly comorbid than SP with proposed OC-spectrum disorders (OCD, hypochondriasis, trichotillomania) and eating disorders (which have also been proposed by some to be OC-spectrum disorders) (Hollander et al., 2007). In addition, as SP has high comorbidity with other anxiety disorders and has many similarities with them, we predicted that a significantly higher proportion of individuals with SP would have comorbid anxiety disorder diagnoses (other than OCD) than individuals with BDD (Pollack, 2001; Keller, 2006).

2. Methods

2.1. Participants

Participants were obtained from three different samples: (1) Individuals seeking assessment and/or treatment of BDD from a BDD clinical and research program ($n=141$), (2) participants with BDD from a study investigating the course of BDD ($n=98$; only those individuals who were receiving mental health treatment at the time of the initial assessment are included in this report), and (3) psychiatric outpatients seeking treatment at the Department of Psychiatry at Rhode Island Hospital and who participated in the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project ($n=702$).

All participants met DSM-IV criteria for BDD or its delusional variant, DSM-III-R or DSM-IV criteria for SP (social anxiety disorder), or both comorbid BDD and SP. Across all samples, participants with BDD who had current or past SP were excluded from the SP group, and participants with SP who had current or past BDD were excluded from the BDD group; these excluded individuals were included in the comorbid BDD/SP group ($n=125$). As a result, the BDD group included no individuals with comorbid SP ($n=172$; 55% from the first sample, 35% from the second sample, 10% from the third sample), and the SP group included no individuals with comorbid BDD ($n=644$; 100% from the third sample). The comorbid BDD/SP group ($n=125$) included 38% from the first sample, 30% from the second sample, and 32% from the third sample. All three samples were drawn from studies approved by the hospitals' Institutional Review Boards. Written informed consent was obtained from all participants.

In the first sample (BDD clinical and research program sample), participants were referred from a wide variety of sources for an in-person assessment or treatment of BDD (e.g., self or clinician referral). All participants were age 18 or older. In the second BDD sample, all participants were available for an in-person interview and did not have cognitive impairment (e.g., organic mental disorder) that would interfere with the validity of interview data. The sample in this report included only participants age 18 or older who were receiving mental health treatment, to make them comparable to the other two samples. Participants in the second sample were obtained from mental health professionals (46.0%), advertisements (38.6%), the BDD program's web site and brochures (10.2%), the participant's friends and relatives (3.4%), and nonpsychiatrist physicians (1.7%).

Participants from the Rhode Island MIDAS Project were drawn from a larger sample of 2500 psychiatric outpatients age 18 or older presenting for treatment at the outpatient psychiatry practice of Rhode Island Hospital. This practice is affiliated with the same academic medical center as the BDD practice from which samples 1 and 2 were obtained, and the BDD practice and MIDAS project draw participants from the same geographic area. Participants were most frequently referred from primary care physicians (33.6%), family members/friends (15.1%), and mental health clinicians (14.9%). Individuals with significant cognitive limitations were excluded from the study.

No interrater reliability statistics are available for sample 1, since the last author was the sole rater for all assessments. In the second sample, interrater reliability data is not available for all DSM diagnoses, although Shrout–Fleiss interrater reliabilities for BDD severity ratings over the course of a year ranged from 0.91 to 1.00, with a mean reliability of 0.96, indicating excellent interrater reliability (Phillips et al., 2006b). In the third sample, a kappa derived from 65 interrater reliability evaluations for SP was 0.84. The percentage of BDD diagnoses in sample 3 was too low to derive a kappa from the same sample of 65 interrater reliability evaluations; however, the kappa for somatoform disorders (with which BDD is classified in DSM-IV) was 1.0.

2.2. Measures

All data were obtained by experienced clinical interviewers. This report's last author obtained all data from the first sample. Diagnostic raters for the other two samples included doctoral-level clinical psychologists and research assistants with bachelor's degrees in social or biological sciences. These individuals were extensively trained and closely supervised by each study's respective principal

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