

Body Dysmorphic Disorder in Psychiatric Outpatients: Recognition, Prevalence, Comorbidity, Demographic, and Clinical Correlates

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The prevalence of Body Dysmorphic Disorder (BDD), based on structured and unstructured clinical interviews, was compared in two samples of psychiatric outpatients drawn from the same practice setting. In the first sample, 500 patients were diagnosed according to a routine, unstructured clinical interview. In the second sample, 500 subjects were diagnosed according to information obtained by the Structured Clinical Interview for DSM-IV (SCID). No patient was diagnosed with BDD in the clinical sample, whereas 16 (3.2%) patients were diagnosed with BDD in the SCID sample. Compared with patients without BDD, patients with BDD received significantly more current

axis I diagnoses, and were more likely to be diagnosed with current obsessive-compulsive disorder (OCD) and social phobia. Both groups were diagnosed with major depression at similar rates. Patients with BDD, versus those without, tended to be sicker and more functionally impaired. It appears that BDD is an infrequent disorder in an outpatient setting, which is rarely recognized when clinicians conduct their routine diagnostic interview. Although it was not usually a patient's principal reason for seeking treatment, the majority of patients with BDD in this sample wanted their treatment to address these symptoms.

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BODY DYSMORPHIC DISORDER (BDD) is a distressing and impairing preoccupation with an imagined or slight defect in appearance.¹ In a large case series of patients with BDD, Phillips et al.^{2,3} reported that the disorder was associated with significant impairment in academic, occupational, and social functioning. BDD was also associated with a risk of suicidal behavior (29% of patients had attempted suicide). Despite its associated suicidal risk and psychosocial impairment, many individuals are so humiliated or ashamed of their BDD symptoms that they keep their concerns secret even from clinicians who have been treating them for years.⁴ The underdiagnosis of BDD has been consistently described in case series and research reports.⁴⁻⁶

Studies of the prevalence of BDD in psychiatric patients suggest that the disorder is not rare. In the DSM-IV field trial for obsessive-compulsive disorder (OCD), 12% of 442 patients with OCD had comorbid BDD.⁷ Two other studies found BDD rates of 15%⁸ and 8%⁹ in series of patients with OCD. In a study of 80 outpatients with atypical major depression, a similar percentage (13.8%) was diagnosed with BDD.⁶ Other studies have found that 11% of 53 patients with social phobia⁹ and 23% of 62 patients with trichotillomania had comorbid BDD.¹⁰ These studies were limited to patients with selected axis I disorders. We are unaware of any studies that assessed the presence of BDD in an unselected sample of patients presenting for treatment in an outpatient psychiatric setting.

In the present study, a large series of outpatients

were evaluated as part of the Rhode Island Methods to Improve Diagnosis and Services (MIDAS) project. The MIDAS project was designed to examine and develop procedures to improve diagnostic practice in routine clinical settings. Patients who did and did not have BDD were compared on clinical and demographic characteristics. In addition, we examined whether BDD might be underdiagnosed in routine clinical practice by comparing the prevalence rates in two sequentially ascertained samples—one in of which BDD diagnoses were based on unstructured clinical interviews, and one in which diagnoses were made with a semistructured diagnostic interview.

METHOD

Five hundred patients were evaluated in the Rhode Island Hospital Department of Psychiatry outpatient practice. This private-practice group predominantly treats individuals who have medical insurance (including Medicare, but not Medicaid) on a fee-for-service basis, and is distinct from the hospital's outpatient residency training clinic, which predominantly serves lower income, uninsured, and medical assistance patients.

Before the initial evaluation, all patients were asked to complete a 102-item self-administered symptom questionnaire (the Psychiatric Diagnostic Screening Questionnaire [PDSQ]) as part of their initial paperwork. The clinical sample consists of 500 patients who successfully completed this questionnaire. Another 58 patients were excluded because they did not satisfactorily complete the scale (37 patients omitted >10% of

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0010-440X/98/3905-0008\$03.00/0*

the items, nine patients refused, two did not speak English, one was mentally retarded, seven had visual or other physical limitations, and two were too confused or mentally ill to complete the scale).

Almost all (96%, $n = 480$) diagnostic evaluations were conducted by board-certified or board-eligible psychiatrists. The other evaluations were conducted by clinical nurse specialists or master's level social workers. Clinicians completed a standardized intake form modeled on the Initial Evaluation Form of Mezzich et al.¹¹ Diagnoses were based on DSM-IV criteria.¹ Patients' charts were reviewed by research assistants who recorded demographic information, axis I diagnoses, and Global Assessment of Functioning (GAF) ratings. Only definite axis I diagnoses were recorded as present; rule-out diagnoses were counted as absent.

Subsequent to the completion of the aforementioned study, the method of conducting initial diagnostic evaluations was changed. Five hundred patients were interviewed by a trained diagnostic rater who administered the Structured Clinical Interview for DSM-IV (SCID),¹² and the results of this interview were presented to a psychiatrist who finished the evaluation. All patients provided informed consent for participation in the study. During the course of the study, joint-interview diagnostic reliability information was collected on 17 patients. For disorders diagnosed at least two times, the kappa coefficients were as follows: major depressive disorder (MDD) ($\kappa = 1.0$); dysthymic disorder ($\kappa = 1.0$); bipolar disorder ($\kappa = 1.0$); depressive disorder, not otherwise specified (NOS) ($\kappa = .45$); adjustment disorder ($\kappa = .45$); panic disorder ($\kappa = 1.0$); social phobia ($\kappa = .87$); OCD ($\kappa = 1.0$); specific phobia ($\kappa = 1.0$); generalized anxiety disorder (GAD) ($\kappa = .64$); posttraumatic stress disorder (PTSD) ($\kappa = 1.0$); and anxiety disorder NOS ($\kappa = .19$). None of the 17 patients was diagnosed with BDD.

Towards the end of the clinical study, and throughout the SCID study, patients were given a booklet of questionnaires to complete at home and return by mail. Fifty-one patients in the clinical sample and 275 patients in the SCID sample returned the booklet of questionnaires. To examine the clinical similarity of the clinical and SCID samples, the two groups of patients were compared on self-report symptom measures of bulimia (Eating Disorder Inventory Bulimia Subscale)¹³; social phobia (Brief Fear of Negative Evaluation Scale,¹⁴ Fear Questionnaire-Social Phobia Subscale)¹⁵; agoraphobic fears (Fear Questionnaire-Agoraphobia Subscale,¹⁵ Social Phobia and Anxiety Inventory Agoraphobia Subscale)¹⁶; posttraumatic stress (Posttraumatic Stress Disorder Scale)¹⁷; obsessive-compulsive behavior (Obsessive Compulsive Scale)¹⁸; cognitions common in generalized anxiety (Penn State Worry Scale)¹⁹; anxiety symptoms common in panic attacks (Beck Anxiety Inventory)²⁰; alcohol use (Michigan Alcohol Screening Test)²¹; drug use (Drug Abuse Screening Test)²²; hypochondriasis (Whitely Index)²³; and somatization (Somatic Symptom Index).^{24,25} These scales have been commonly used in research, and their reliability and validity have been well established.

The core of the diagnostic evaluation was the January 1995 DSM-IV patient version of the SCID.¹² The axis I version of the SCID covers seven DSM-IV sections: (1) mood disorders (MDD, bipolar disorder, dysthymia, depressive disorder NOS, mood disorder due to a general medical condition, and substance-induced mood disorder); (2) psychotic disorders (schizophrenia, schizophreniform disorder, delusional disorder, schizoaffective

disorder, brief psychotic disorder, and psychotic disorder NOS); (3) substance use disorders (abuse and dependence of alcohol, sedative-hypnotics, cannabis, stimulants, opioids, cocaine, hallucinogens, inhalants, phenylcyclidine, and polydrug); (4) anxiety disorders (panic disorder with and without agoraphobia, agoraphobia without history of panic disorder, social phobia, specific phobia, OCD, PTSD, acute stress disorder, GAD, and anxiety disorder NOS); (5) somatoform disorders (somatization disorder, pain disorder, undifferentiated somatoform disorder, hypochondriasis, and body dysmorphic disorder); (6) adjustment disorders; and (7) eating disorders (anorexia nervosa, bulimia nervosa, and binge-eating disorder). The SCID does not cover childhood, cognitive, factitious, dissociative, sexual and gender identity, sleep, and impulse-control disorders, or other conditions that may be the focus of clinical attention. However, information from the overview at the beginning of the interview could be used to diagnose these other disorders.

The DSM-IV version of the SCID includes a BDD module in the somatoform disorders section. In the overview of this section, BDD is screened for by the question "Some people are very bothered by the way they look. Is this a problem for you?" The BDD module assesses the level of preoccupation with appearance, and the impairment and/or distress caused by the preoccupation. For patients with BDD, we inquired whether the BDD symptoms were a reason for currently seeking treatment. Whether BDD was the principal or additional diagnosis was based on the patients' primary reason for seeking treatment.

In the present report, the prevalence rates of current DSM-IV disorders were compared for patients with and without the diagnosis of BDD. Although DSM-IV includes a partial remission specifier only for the mood and substance use disorders, we adopted this specifier for all disorders. For example, someone who met DSM-IV criteria for PTSD 5 years ago but at the time of the evaluation was bothered by a subthreshold number of criteria, or someone who was bingeing and purging only once per week during the past 6 months but who met criteria for bulimia nervosa 6 months before the evaluation, would be diagnosed with the disorder in partial remission. In the present analyses, partial remissions were considered as present.

Supplementing the SCID interview, were items from the Schedule for Affective Disorders and Schizophrenia (SADS)²⁶ on current and adolescent social functioning, and the amount of time employed during the past 5 years. The Clinical Global Index of depression severity²⁷ was rated on all patients.

For continuously distributed variables, t tests were used to compare patients who did and did not have BDD. Pooled variance estimates were used when the variances in the BDD-positive and BDD-negative groups significantly differed, otherwise separate variance estimates were used. Categorical variables were compared by χ^2 analysis, or Fisher's exact test if the expected value in any cell of a 2×2 table was less than 5.

RESULTS

The demographic characteristics of the two samples were similar (Table 1). The majority of both samples were white, female, high school graduates, and married or single. There were no significant differences between the two samples in their demographic characteristics. Patients in the

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