Comorbid Personality Impairment in Body Dysmorphic Disorder

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Personality impairment was evaluated in 17 body dysmorphic disorder (BDD) patients undergoing a treatment study of clomipramine versus desipramine. Semistructured interviews were administered using both categorical (Structured Clinical Interview for DSM [SCID II]) and dimensional (Dimensional Assessment of Personality Impairment [DAPI]) methods. Personality measures were also correlated with a range of clinical variables (severity of BDD and depressive symptoms, age, duration of illness, and response to treatment). A secondary aim of the study was to provide preliminary validation for the DAPI. Consistent with previous studies, BDD patients showed considerable personality pathology. By SCID II, patients met criteria for a mean of 2.53 personality disorder diagnoses; 87% of patients met criteria for at least 1 diagnosis and 53% for more than 1. Cluster C diagnoses were the most common. Mean scores for the DAPI were 2.63 (3 = mild impairment) to 6.41 (7 = severe impairment), averaging 5.26 (5 = moderate). With regard to the DAPI, the results provided preliminary evidence of good reliability and validity. Moreover, both personality measures were highly intercorrelated. Although SCID II diagnoses correlated with baseline depression (Hamilton Rating Scale for Depression [HRSD]) scores, there were few other significant correlations between personality and other clinical variables. Of note, however, treatment responders demonstrated less personality impairment than nonresponders. The finding that personality measures were highly intercorrelated but, on the whole, not well correlated with other clinical measures supports the distinct and dissociable nature of personality phenomena in BDD. Despite the small sample size, these results suggest that personality impairment appears to be significant factor in BDD and may even play a role in treatment response.

BODY DYSMORPHIC DISORDER (BDD), classified in DSM-IV as a somatoform disorder, is characterized by excessive concern with imagined or overvalued defects in bodily appearance. Areas of concern focus on the face and head but can include the hands, feet, torso, and sexual body parts. Behaviors related to BDD include mirror-checking, ritualized make-up application, avoidance of social and occupational situations, and multiple cosmetic surgeries.[1,2]

Numerous similarities with obsessive-compulsive disorder (OCD), such as family history, clinical symptoms, and response to serotonin reuptake inhibitors, support the inclusion of BDD in an obsessive-compulsive spectrum of disorders (OCSDs), a proposed group of disorders that includes OCD, trichotillomania, Tourette's syndrome, pathological gambling, and other disorders of repetitive behaviors.[3-5] As a large body of literature supports the neurobiological etiology of OCD, there is reason to believe that BDD and other OCSDs may have a biological origin.[3,6]

BDD has also been associated with considerable comorbidity. Most studies of BDD indicate high rates of comorbid axis I disorders, including major depression, OCD, and social phobia.[1,2,7]

Axis II pathology has also been found to be prevalent in BDD patients. Evidence of comorbid axis II pathology is found in both case reports and controlled studies. In a study of 50 BDD patients evaluated by the Structured Clinical Interview for DSM-III-R (SCID II), Veale et al.[8] found that 72% met criteria for 1 personality disorder, 48% for 2, and 26% for 3. Avoidant and paranoid personality disorders were the most common (38%), followed by OCD (28%), passive-aggressive (16%), dependent (12%), histrionic (8%), narcissistic (6%), and borderline (6%). Also, 36% of these patients reported past depressive episodes and 24% had attempted suicide.

In a study of 17 BDD patients assessed with the SCID II, 13 (76.5%) had 4 or more axis II diagnoses, with a mean of 6 diagnoses. The most prevalent diagnoses were avoidant, OCD, borderline, self-defeating, and dependent. Ninety-four percent met criteria for a cluster C disorder.[7] Similarly, a study by Hollander et al.[2] produced retrospective information on 50 BDD patients' comorbidity and family history with first- and

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second-degree relatives. Thirty-nine (78%) had OCD (17 family members with OCD), 34 (68%) had major depression (14 family members), and 19 (38%) were diagnosed with personality disorders (5 family members). Axis II disorders included 5 cluster A, 6 cluster B, and 8 cluster C disorders.

Systematic assessments of personality dimensions are also of use. Administration of the Neuroticism, Extraversion, Openness (NEO) Five Factor Index (NEO-FFI) to 123 BDD patients, 33 of whom were also skin-pickers, yielded scores in the very high range for neuroticism and the low to very low range for extroversion and conscientiousness. Scores for openness and agreeableness were in the average or low-average range. Skin-pickers showed significantly greater impairment than nonpickers on all scales.[9] In a prior study of 17 patients with dysmorphophobia, Hay[10] found elevated hostility, intropunitive hostility, neuroticism, and obsessoid traits as compared with a control group.

Finally, there are numerous case reports supporting the presence of personality disorders or dysfunctional personality traits in BDD patients, dating back even to Janet's initial reports.[10-12] There are a number of case reports suggesting that premorbid personality features, including obsessive-compulsive, schizoid, and narcissistic traits, may be involved in BDD patients.[13]

Thus, there is fairly solid evidence of a relationship between personality impairment and BDD. However, the nature of that relationship is not well understood. To what extent is personality impairment in BDD patients dissociable from the clinical features and psychosocial sequelae of BDD? How does personality impairment affect the clinical presentation and treatment response of BDD? Ultimately, we can ask if particular personality traits predispose patients to BDD. Alternatively, to what degree does personality impairment arise as a result of BDD or of the neurobiological vulnerabilities associated with it? Given the absence of longitudinal and prospective studies, investigation of the relationship between personality impairment and the clinical features of BDD is of particular interest.

The present study aims to evaluate personality dysfunction both categorically (by diagnostic interview) and dimensionally (by assessment of specific personality functions) in 17 BDD patients undergoing a controlled treatment study of clomipramine versus desipramine. The relationships between personality impairment and a range of clinical variables (severity of BDD and depressive symptoms, age, duration of illness, and response to treatment) are also investigated.

A secondary aim of this study is to provide preliminary validation for the Dimensional Assessment of Personality Impairment (DAPI), a semistructured interview developed by the first author (L.J.C.) that measures personality from a dimensional as opposed to a categorical approach. The DAPI is based on an emergent systems model of personality, in which personality is seen as a hierarchically organized system of psychological functions.[14] Personality impairment is seen to reflect dysregulation of relevant psychological subsystems, specifically those involved in affective, conceptual, and interpersonal functioning (L.J. Cohen, unpublished manuscript, December 1998).

METHOD

Subjects

Seventeen BDD patients (12 males and 5 females) were evaluated consecutively as part of a treatment study at Mount Sinai School of Medicine. Patients were recruited through the media for the 16-week double-blind crossover study comparing clomipramine and desipramine in BDD. As assessed by the SCID I and psychiatric interview, all subjects met DSM-III-R criteria for BDD or for delusional disorder, somatic type if BDD ideation was of delusional intensity. Patients with comorbid organic mental syndrome, schizophrenia, schizoaffective and bipolar disorders, and current substance abuse were excluded. The mean age was 36.6 ± 10.9 years (range, 19 to 55). Eight subjects (47%) were employed at the time of the study, 6 were unemployed (35%), 1 was a homemaker (6%), and 2 were students (12%). The mean Hollingshead socioeconomic status score was 3.47 ± 1.28 (range, 1 to 5). The mean educational level was 14.13 ± 2.55 years (range, 11 to 18). Other current axis I disorders included major depressive disorder, recurrent (n = 2), dysthymia (n = 6), social phobia (n = 6), generalized anxiety disorder (n = 2), agoraphobia without panic disorder (n = 2), OCD (n = 2), trichotillomania (n = 1), somatoform disorder, undifferentiated (n = 1), and hypochondriasis (n = 1).

Instruments

Subjects were administered 2 semistructured interviews (SCID II and DAPI) and 2 clinician-administered questionnaires (Yale Brown Obsessive-Compulsive Body Dysmorphic Disorder Scale [BDD-YBOCS] and Hamilton Rating Scale for Depression [HRSD]). The SCID-II is a well-established diagnostic interview for DSM axis II disorders. All but 3 subjects were administered the SCID II for DSM-III-R.[15] The remaining 3 subjects were administered the SCID II for DSM-IV.[16] The HRSD is a clinician-administered questionnaire measuring the severity of depression.[17] The 24-item version was used. The BDD-YBOCS is a modified version[18] of the original YBOCS,[19] designed to measure the severity of BDD symptoms. Ten questions assess the amount of time spent, degree of distress and