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Psychosis in body dysmorphic disorder

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Abstract

Body dysmorphic disorder (BDD) has both psychotic and nonpsychotic variants, which are classified as separate disorders in DSM-IV (delusional disorder and a somatoform disorder). Despite their separate classification, available evidence indicates that BDD's delusional and nondelusional forms have many similarities (although the delusional variant appears more severe), suggesting that they may actually be the same disorder, characterized by a spectrum of insight. And contrary to what might be expected, BDD's delusional form, although classified as a psychotic disorder, appears to respond to serotonin-reuptake inhibitors alone. These and other data suggest that a dimensional view of psychosis (in particular, delusions) in these disorders may be more accurate than DSM's current categorical view. A dimensional model might also facilitate more consistent and accurate classification of other disorders that are likely characterized by a spectrum of insight, such as obsessive compulsive disorder, hypochondriasis, and anorexia nervosa. Further research is needed to better understand these classification issues, which likely have treatment implications.

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1. Introduction

Body dysmorphic disorder (BDD) inhabits a place in the psychiatric landscape where psychotic and non-psychotic disorders meet. This disorder has both psychotic and nonpsychotic variants, which are classified as separate disorders in DSM: its nonpsychotic variant as a somatoform disorder, and its delusional variant as a psychotic disorder—a type of delusional disorder, somatic type (American Psychiatric Association, 1994). These two disorders may be double-coded, however; that is, delusional individuals may be diagnosed with both BDD and delusional disorder. While double coding is awkward, and has the drawback of diagnosing the same symptoms as two different disorders, it also reflects the possibility that BDD's delusional and non-delusional variants actually constitute the same disorder rather than being distinct.

Research on BDD, a distressing or impairing pre-occupation with an imagined or slight defect in

appearance, is still in its early stages. Nonetheless, this disorder's psychotic features have been of interest and the focus of research. As discussed below, BDD's delusional and nondelusional forms appear to have many similarities, raising the question of whether these forms of BDD, although classified separately in DSM-IV, may actually be the same disorder, characterized by a spectrum of insight. And contrary to what might be expected, BDD's delusional form, although classified as a psychotic disorder, appears to respond to serotonin-reuptake inhibitors (SRIs) alone. These intriguing data may shed light on psychosis in other nonschizophrenic disorders, such as anorexia nervosa and obsessive compulsive disorder (OCD), about which little is known.

In this paper I will discuss the psychotic symptoms that commonly occur in BDD, similarities and differences between BDD's delusional and nondelusional variants, and their treatment response. I will then discuss a dimensional view of psychosis as an alternative to the current categorical view, as well as DSM-IV's inconsistent classification of BDD and other non-schizophrenic disorders that have psychotic features (delusions being the primary form of psychosis in these disorders). Finally, I will consider some of the research

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needed to better understand these understudied classification issues, which likely have treatment implications.

2. Psychotic symptoms in BDD

The primary psychotic feature of BDD is the delusional conviction with which the core belief about appearance may be held. Despite appearing normal, patients typically think that they look ugly, deformed, or disfigured in some way. In more extreme cases, they may believe that they look like a monster, the Elephant Man, or the wife of Frankenstein (Phillips, 1996). That such beliefs can be held with delusional conviction has long been recognized in the clinical literature (Phillips, 1991). In fact, many earlier authors considered BDD a prodrome or variant of schizophrenia (Zaidens, 1950; Phillips, 1991). In the largest series of patients with BDD ($n=224$), a majority (53%) had held their belief about their appearance “flaws” with delusional conviction for at least several weeks during the course of their illness—that is, they were completely convinced that their belief was true and were unwilling to consider the possibility that it was not true (Phillips et al., 1993, 1994; Phillips KA, unpublished data).

More recent research has further examined delusional thinking in BDD using the Brown Assessment of Beliefs Scale (BABS) (Eisen et al., 1998). This scale was developed to assess delusions in a broad range of disorders because there were no widely used reliable and valid clinician-administered instruments to assess delusions, and available scales were not easily applied to disorders other than schizophrenia (Eisen et al., 1998). The BABS is a reliable and valid 7-item semi-structured clinician-administered scale that assesses current delusionality

both dimensionally and categorically. Scale items were derived primarily from the literature on delusions and a subsequent psychometric study of a longer initial version of the scale. BABS scores for 129 consecutive patients with current DSM-IV BDD are shown in the Figs. 1–8 (Phillips KA, unpublished data). Both the total score and individual item scores indicate that BDD tends to be characterized by a high degree of delusionality (i.e., poor or absent insight). (In this paper I will generally use the terms “delusionality” and “insight”

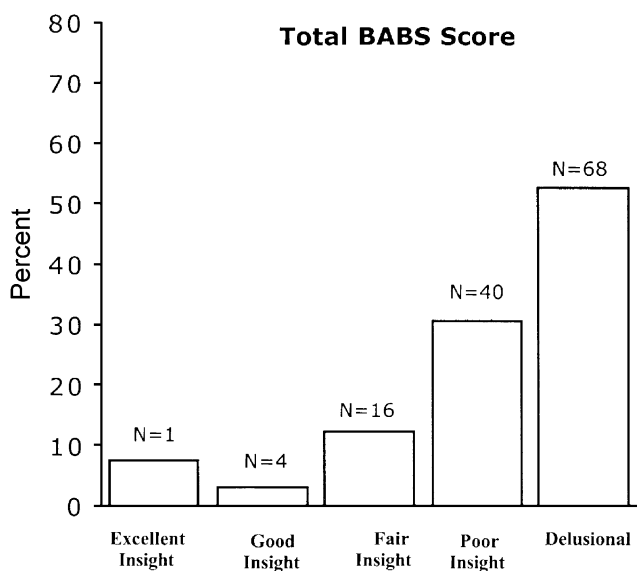


Fig. 1. Total BABS score: delusional: score of 4 on item 1 plus score ≥ 18 on items 1–6.

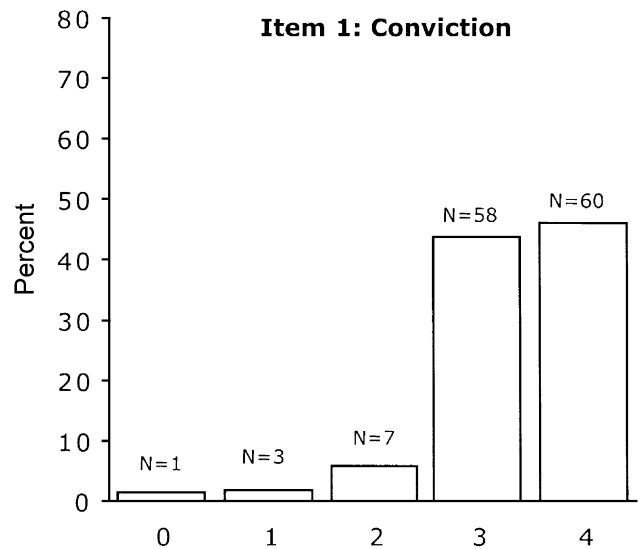


Fig. 2. Conviction (item 1) assesses how convinced the person is that his/her beliefs are accurate: 0 = completely convinced beliefs are false; 1 = beliefs probably not true; 2 = beliefs may or may not be true; 3 = fairly convinced beliefs are true; 4 = completely convinced beliefs are true.

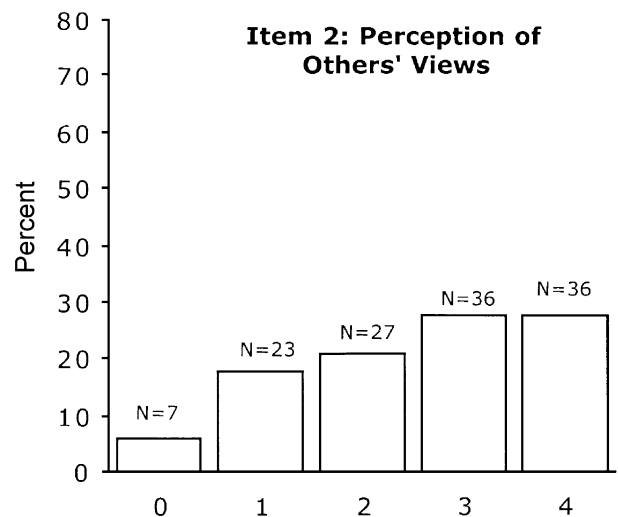


Fig. 3. Perception of others' views (item 2) assesses how certain the person is that most people think beliefs make sense: 0 = completely certain most people think beliefs are unrealistic; 1 = fairly certain most people think beliefs are unrealistic; 2 = uncertain; 3 = fairly certain most people think beliefs are realistic; 4 = completely certain most people think beliefs are realistic.

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