Insight in Obsessive Compulsive Disorder and Body Dysmorphic Disorder

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Similarities between obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD) have been described in terms of clinical presentation, comorbidity rates, treatment response profiles, and other features. This is the first study to compare insight in OCD and BDD measuring global insight and numerous components of insight. We compared insight in 64 adult outpatients with DSM-IV OCD and 85 adult outpatients with DSM-IV BDD using a reliable and valid measure (the Brown Assessment of Beliefs Scale [BABS]). BDD patients had significantly poorer global insight than OCD patients. BDD patients also had significantly poorer insight on the following components of insight: conviction that the belief is accurate, perception of other's views of the belief, explanation for differing views, willingness to consider that the belief is wrong, and recognition that the belief has a psychiatric/psychological cause. Poorer insight was significantly positively correlated with more severe symptoms of the disorder only in the BDD group.

OBSESSIVE-COMPULSIVE disorder (OCD) is characterized by persistent intrusive thoughts, ideas, or images (obsessions), and subsequent behaviors or rituals that one feels driven to perform (compulsions). Body dysmorphic disorder (BDD) is characterized by a distressing or impairing preoccupation with an imagined or slight defect in appearance (e.g., a "large" nose, or facial "scarring"). There is increasing interest in the relationship between OCD and BDD. Case studies have described similarities in these disorders,[1,2] and a growing body of empirical literature supports a link between them. Indeed, BDD is widely considered an "OCD-spectrum disorder."[3-5] The disorders' clinical presentations are similar, with both characterized by intrusive thoughts and compulsive behaviors.[6,7] The two disorders have similar sex ratios, demographic characteristics, and illness severity.[7-9] In addition, OCD and BDD often co-occur. Simeon et al. found that 12% of patients with OCD had lifetime comorbid BDD.[10] Conversely, in the largest series of patients with BDD (N = 293), Gunstad and Phillips found that 33% had lifetime comorbid OCD (although rates in other studies have varied from as low as 6% to as high as 78%).[11] Additional evidence for a link between OCD and BDD is their apparent similarities in treatment response. Both disorders appear to respond selectively to serotonin reuptake inhibitors (SRIs).[12-17] In addition, behavioral interventions also appear efficacious for both disorders.[18-21]

However, differences between these disorders have also been reported. In a direct comparison of OCD and BDD subjects (N = 139), Phillips et al. found that BDD patients were younger, less likely to be married, more likely to report suicidal ideation or a suicide attempt because of their disorder, and had higher lifetime rates of major depression and social phobia.[8] Saxena et al. (N = 107) found that BDD subjects had higher levels of clinician-rated depressive symptoms and trait anxiety symptoms,[7] although McKay et al. failed to find group differences between OCD and BDD subjects (N = 45) in self-reported levels of depressive symptoms and trait anxiety.[9]

Another possible difference between OCD and BDD is degree of insight (delusionality). Some authors, on the basis of clinical observations, have noted that BDD preoccupations are held with greater conviction than OCD obsessions.[22-24] One study found that patients with both OCD and comorbid BDD had less insight regarding their BDD than their OCD,[10] although it is unclear how insight was measured. Furthermore, in that study, although insight and symptom severity were not significantly correlated for OCD, they were strongly related for BDD. In their comparison of OCD and BDD (N = 45), McKay et al. found that BDD patients had higher scores than OCD patients on a measure of overvalued ideation.[9] Finally, in a comparison of OCD subjects without BDD versus

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BDD subjects without OCD, Phillips et al. found that significantly more BDD subjects received a psychotic disorder diagnosis.[8] In nearly all cases, the psychotic disorder diagnosis was entirely attributable to delusional BDD.

While these studies suggest that insight is poorer in BDD than in OCD, they reported a global measure of insight, which may be limited given that there is consensus in the literature that delusionality is a multidimensional construct.[25-27] Although there is not complete agreement on what these dimensions are, they have been proposed to consist of constructs such as conviction, bizarreness, and extension,[25-28] as well as reasonableness and accuracy of beliefs.[29]

The current study is the first to compare insight in OCD and BDD measuring global insight and numerous components of insight. It is also the first study to compare insight in these disorders using a reliable and valid clinician-administered measure of insight (the Brown Assessment of Beliefs Scale [BABS][25]). In addition, this study consists of a larger sample than previous studies, thereby improving the reliability of group scores and increasing the ability to detect differences between groups. Based on the literature and our clinical experience, we hypothesized that BDD subjects would have poorer global insight than OCD subjects and that a higher percentage of BDD subjects would be classified as delusional. Regarding specific components of insight, we hypothesized that BDD subjects would have higher conviction that their belief is accurate, since this component is probably most similar to constructs of global insight used in previous studies. We had no specific hypotheses regarding other components of insight. Finally, we hypothesized that poorer insight would be associated with more severe BDD symptoms. This hypothesis was based on the literature and a previous study in a different BDD sample in which we found that delusional subjects had more severe BDD symptoms than nondelusional subjects.[30]

METHOD

Subjects and Procedure

Subjects were 64 adult outpatients meeting both DSM-III-R and DSM-IV criteria for OCD and 85 adult outpatients meeting DSM-IV criteria for BDD.[31,32] Subjects were not excluded if their OCD or BDD preoccupations were delusional. They were referred to BDD and OCD pharmacotherapy studies at the same site; these studies included baseline assessments of symptom severity and insight (see below) prior to initiation of treatment. OCD subjects were recruited from an open-label study of relapse following discontinuation of sertraline.[28] BDD subjects were recruited from an open-label study of fluvoxamine[33] and a placebo-controlled study of fluoxetine.[13] All subjects were treatment free at the time insight was assessed. After a complete description of the study to the subjects, written informed consent was obtained.

The OCD group consisted of 31 males (48%) and 33 females (52%), and the BDD group consisted of 29 males (34%) and 56 females (66%) (Fisher's exact $P = .09$). The mean age for the OCD subjects was 36.13 $\pm$ 10.00 years and for the BDD subjects was 32.18 $\pm$ 10.14 years [t (147) = 2.37, $P = .02$].

Assessments

Insight was assessed using the BABS.[25] The BABS is a seven-item clinician-administered scale designed to assess degree of insight (delusionality) during the past week in a variety of psychiatric disorders. The BABS assesses degree of insight dimensionally and also provides a cutpoint to differentiate delusional from nondelusional beliefs (see below). The patient's main disorder-related belief is determined, and specific probes and anchors are used to rate various components of this belief. In BDD, a typical belief might be "I am hideous looking" or "I look like a monster." In OCD, a typical belief might be "If I touch this faucet, I will get terribly ill and end up in the hospital" or "If I don't check the stove over and over, the house will burn down." The BABS's individual items assess the following components of insight: (1) conviction (how convinced the person is that his/her belief is accurate); (2) perception of others' views (how certain the person is that most people think the belief makes sense); (3) explanation of differing views (the person's explanation for the difference between his/her and others' views of the belief); (4) fixity (whether the person could be convinced that the belief is wrong); (5) attempt to disprove beliefs (how actively the person tries to disprove his/her belief); (6) insight (whether the person recognizes that the belief has a psychiatric/psychological cause); and (7) referential thinking (an optional item that assesses ideas/delusions of reference). (While BABS item 6 is called "insight" and refers to whether the person is aware that the belief has a psychiatric cause, herein we also use the term "insight" globally to capture all the components of insight, as reflected by the BABS total score.) Each item is rated from 0 to 4, with higher scores indicating poorer insight; a score of 0 on each item indicates excellent insight, and a score of 4 indicates absence of insight. The first six items are summed to create a total score (range, 0 to 24). (The seventh item is not included in the total score because referential thinking is characteristic of some disorders but not others.) In addition, beliefs can be classified as delusional or nondelusional: a total score $\geq$ 18 plus a score of 4 on the first item (conviction) classifies a belief as delusional. Previous sensitivity and specificity calculations showed that use of this cutpoint resulted in 100% sensitivity and 86% specificity.[23]

The BABS has strong internal consistency ($\alpha = .87$), and interrater and test-retest reliability (intraclass correlation coefficients for total score = .96 and .95, respectively). The BABS also has good convergent and discriminant validity. The BABS has been used to study treatment-related changes in insight in individuals with OCD[28] and BDD.[13] For the current study, all BABS interviewers were trained according to the criteria de-