

Change in Psychosocial Functioning and Quality of Life of Patients With Body Dysmorphic Disorder Treated With Fluoxetine: A Placebo-Controlled Study

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In a 12-week placebo-controlled study of fluoxetine in the treatment of body dysmorphic disorder, the authors investigated change in psychosocial functioning and mental health-related quality of life in 60 subjects. The subjects were assessed with the LIFE-RIFT (a measure of impaired functioning), Social and Occupational Functioning Scale (SOFAS), and Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36) before and after receiving fluoxetine or placebo. At baseline, the patients had impaired psychosocial functioning and markedly poor mental health-related quality of life. Compared to placebo, fluoxetine was associated with significantly greater improvement in LIFE-RIFT and SOFAS scores and with improvement on the mental health subscale of the SF-36 that approached significance. Decrease in the severity of body dysmorphic disorder, as measured by the Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder, was significantly correlated with improvement in functioning and quality of life.

(Psychosomatics 2004; 45:438-444)

Body dysmorphic disorder, also known as dysmorphophobia, consists of a distressing or impairing preoccupation with a nonexistent or slight defect in appearance (e.g., “thinning” hair, a “large” nose, or “severe” acne). Body dysmorphic disorder is relatively common and is associated with significant impairment in social and occupational/academic functioning.¹⁻³ Patients with body dysmorphic disorder have high lifetime rates of psychiatric hospitalization (48%), suicidal ideation (45%–82%), and suicide attempts (22%–24%).^{4,5} Death by suicide of patients with body dysmorphic disorder has been reported in both psychiatric⁶ and dermatology^{7,8} settings.

Although a majority of patients with body dysmorphic

disorder receive surgery and other nonpsychiatric medical treatment (e.g., dermatologic treatment), such treatments usually appear to be ineffective and may even make body dysmorphic disorder symptoms worse.^{4,9} In contrast, emerging research indicates that serotonin-reuptake inhibitors¹⁰ and cognitive behavior therapy¹¹ are often effective for treatment of body dysmorphic disorder. However, most treatment research has focused on change in body dysmorphic disorder symptoms, and the important question of whether quality of life and psychosocial functioning improve with treatment has received little investigation. In a randomized, double-blind crossover trial (N = 29 patients), clomipramine was associated with significantly greater improvement on the Schneier Disability Profile, compared with desipramine.¹² In a small open-label study of citalopram in treatment of body dysmorphic disorder (N = 15), improvement was found in psychosocial functioning and quality of life, as assessed by the LIFE-RIFT (Range of Impaired Functioning Tool) and the Medical Outcomes

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Study 36-Item Short-Form Health Survey (SF-36).¹³ To our knowledge, no other studies have investigated treatment-related change in psychosocial functioning and quality of life in body dysmorphic disorder.

Evaluating the effects of treatment on functioning and quality of life is increasingly considered to be as important as evaluation of symptom reduction.¹⁴ We investigated medication treatment effects on functioning and quality of life in what is to our knowledge the only placebo-controlled study of patients with body dysmorphic disorder to date.¹⁵ We hypothesized that, compared with placebo, fluoxetine would be associated with greater improvement in psychosocial functioning and mental health-related quality of life.

METHOD

The study's methods are described in detail elsewhere.¹⁵ In brief, 67 outpatients with DSM-IV body dysmorphic disorder or its delusional variant (delusional disorder, somatic type) were randomly assigned to the placebo group or the fluoxetine group in a 12-week double-blind, parallel-group study. Psychosocial functioning and mental health-related quality of life (see definitions later in this section) were assessed at study baseline and endpoint. Results are presented for the 60 subjects for whom both baseline and endpoint data on functioning and quality of life were available (41 [68.3%] female patients; mean age = 32.2 years [SD = 10.5]).

The study inclusion and exclusion criteria were standard for a pharmacotherapy efficacy trial and are reported in detail elsewhere.¹⁵ In brief, inclusion criteria were the presence of DSM-IV body dysmorphic disorder or its delusional variant currently and for at least 6 months, age 18–65 years, score of ≥ 24 on the Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS),¹⁶ and a score of at least moderate on the Clinical Global Impression Scale for body dysmorphic disorder. Exclusion criteria included current or lifetime bipolar disorder or psychotic disorder (other than delusional body dysmorphic disorder), alcohol or other substance dependence or abuse in the past 6 months, a recent suicide attempt or clinically significant suicidal ideation, use of psychoactive medication within 2 weeks of the 1-week placebo lead-in period or initiation of psychotherapy within 4 months of placebo lead-in, and significant or unstable medical illness. An institutional review board approved the study and the informed consent documents. After a thor-

ough description of the study, voluntary written informed consent was obtained from the patients.

Subjects received fluoxetine or pill placebo equivalent for 12 weeks starting at 20 mg/day and reaching a maximum dose of 80 mg/day if tolerated. The mean fluoxetine dose at study endpoint was 77.7 mg/day (SD = 8.0, range = 40–80); the fluoxetine equivalent in the placebo group was 76.0 mg/day (SD = 13.1, range = 20–80). No other psychotropic medications were taken except 0.5–2.0 gm/day of chloral hydrate up to three times a week, if needed, for insomnia. Psychotherapy of any type was not initiated during the study. The primary outcome measure was the BDD-YBOCS, a reliable and valid 12-item, semistructured, clinician-rated measure of current severity of body dysmorphic disorder.¹⁶ The 17-item Hamilton Depression Rating Scale¹⁷ was used to assess current severity of depressive symptoms. Psychosocial functioning and quality of life were assessed at baseline and endpoint with the following scales:

1. Social and Occupational Functioning Scale (SO-FAS),¹⁸ a global clinician-rated measure of functioning. Scores range from 0 to 100, with lower scores denoting poorer functioning.
2. LIFE-RIFT (Range of Impaired Functioning Tool),¹⁹ a reliable and valid semistructured clinician-rated measure of functional impairment. The LIFE-RIFT consists of items from the Longitudinal Interval Follow-up Evaluation (LIFE).^{20,21} The LIFE-RIFT has a total score and individual domain scores for the following areas of functioning: household duties, work, recreation, relationships with family, relationships with friends, schoolwork, and global life satisfaction (the satisfaction item is patient rated). Scores in each domain range from 1 to 6, with higher scores indicating poorer functioning; scores ≥ 2 reflect impaired functioning. We report results for the total score, which is based on all individual domain scores, and for each individual domain except school functioning (because only 13 subjects were in school). Ratings were done for the average level of functioning during the previous 2 weeks.
3. SF-36,²² a reliable, valid, and widely used self-report measure of mental and physical health-related quality of life. The subscales that best assess mental health-related quality of life are: 1) mental health (a measure of psychological distress and well-being that is the most valid SF-36 measure of mental health-related quality of life), 2) social functioning, and 3) role (e.g., work) limitations due to emotional problems. The mental health subscale primarily assesses subjective sense of well-being, whereas the social

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