

Original Research Reports

Demographic Characteristics, Phenomenology, Comorbidity, and Family History in 200 Individuals With Body Dysmorphic Disorder

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The authors examined characteristics of body dysmorphic disorder in the largest sample for which a wide range of clinical features has been reported. The authors also compared psychiatrically treated and untreated subjects. Body dysmorphic disorder usually began during adolescence, involved numerous body areas and behaviors, and was characterized by poor insight, high comorbidity rates, and high rates of functional impairment, suicidal ideation, and suicide attempts. There were far more similarities than differences between the currently treated and untreated subjects, although the treated subjects displayed better insight and had more comorbidity.

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Body dysmorphic disorder, a distressing or impairing preoccupation with an imagined or slight defect in appearance, is a relatively common somatoform disorder that often is seen by psychiatrists and other mental health professionals. Studies indicate that body dysmorphic disorder occurs in 0.7%–1.1% of community samples, 2%–13% of nonclinical student samples, and 13% of psychiatric inpatients.¹ Individuals with body dysmorphic disorder also present frequently to dermatologists and plastic surgeons. Studies have found that 9%–12% of patients seen by dermatologists and 6%–15% of patients seeking cosmetic surgery have body dysmorphic disorder.¹ Because cosmetic procedures are on the rise,² it is likely that individuals with body dysmorphic disorder will increasingly present to dermatologists and surgeons, and therefore they may also increasingly be seen by psychiatrists in consultation-liaison settings. In 1997, plastic surgeons, dermatologists, and otolaryngologists in the United States performed about 2 million cosmetic procedures (surgical and nonsurgical); by 2003, that number had risen to nearly 8.3 million.²

Case reports spanning more than a century have described the disorder's clinical features, including the severe

morbidity it can cause.³ However, systematic studies have been done for little more than a decade, and there are still very few reports on a broad range of the clinical features of body dysmorphic disorder. Most studies of a broad range of features have had fairly small samples: 30 subjects in our 1993 study,⁴ 50–60 in studies by Hollander et al.,⁵ Veale et al.,⁶ and Perugi et al.,⁷ and 100 in our 1994 investigation.⁸ The largest investigation to date (N = 188) focused on gender differences.⁹ Nearly all of these studies^{4,5,7–9} were done in clinical populations, which can introduce bias.^{10,11} For example, studies in clinical settings tend to show higher comorbidity rates than those in nonclinical settings (because of Berkson's bias and clinical bias).¹⁰ Some subjects in the largest study⁹ participated in pharmacotherapy trials, which can also introduce bias. For example, individuals who seek treatment might be more symptomatic than those who do not; on the other hand, the

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pharmacotherapy studies excluded severely ill individuals who were actively suicidal or needed inpatient care and those with certain comorbid disorders (e.g., bipolar disorder or a current substance use disorder).

In the present study, we examined the clinical features of body dysmorphic disorder in a new sample of 200 subjects, which we believe to be the largest group for which a wide range of clinical features has been reported. To our knowledge, this sample is also more diverse than most samples that have been studied. The inclusion/exclusion criteria (described in the following) were very broad, and unlike the subjects in most previous studies, these people were not currently seeking or receiving treatment in a specialty setting for body dysmorphic disorder; one third were receiving no mental health treatment at all. To address the biases we have noted, we compared individuals with body dysmorphic disorder who were currently receiving mental health treatment to those who were not, which we believe has not previously been done. We also assessed characteristics that have been examined only in relatively small studies of body dysmorphic disorder, e.g., scores on scales for depression and obsessive-compulsive disorder (OCD), or that we have not seen in previous reports—for example, age at onset of subclinical body dysmorphic disorder, rates of certain comorbid disorders, certain behaviors associated with body dysmorphic disorder, and days of work or school missed because of body dysmorphic disorder.

METHOD

Subjects

The subjects were 200 people with DSM-IV body dysmorphic disorder who were participating in an ongoing prospective study of the course of the disorder. This report includes only data from the intake (baseline) assessment. The inclusion criteria were as follows: DSM-IV body dysmorphic disorder or its delusional variant (delusional disorder, somatic type), age 12 or older, and ability to be interviewed in person. The only exclusion criterion was the presence of an organic mental disorder. Subjects were obtained from mental health professionals (46.0%), advertisements (38.6%), our program web site and brochures (10.2%), the subject's friends and relatives (3.4%), and nonpsychiatrist physicians (1.7%). Most of them, 89.0% (N = 178), currently met the full DSM-IV criteria for body dysmorphic disorder. The remaining 11.0% had met the full criteria in the past; 7.5% (N = 15) were currently in partial remission, and 3.5% (N = 7) were currently in full

remission. Body dysmorphic disorder was considered the most problematic disorder (compared to any comorbid disorder) by 78.0% of the sample. Sixty-seven percent (N = 134) were currently receiving mental health treatment (62.0% outpatient, 2.5% inpatient, 1.5% partial hospital, and 1.0% residential). Fifty-three subjects (26.5% of the sample) were currently receiving psychotropic medication only, 33 (16.5%) were receiving psychotherapy only, and an additional 48 (24.0%) were receiving both medication and psychotherapy. Of the 33.0% (N = 66) of the sample not currently receiving mental health treatment, 86.4% had received such treatment in the past. The study was approved by the Butler Hospital institutional review board, and all subjects signed statements of informed consent (assent plus parental consent for adolescents).

Assessments

The Structured Clinical Interview for DSM-IV Axis I Disorders, Non-Patient Edition (SCID-NP)¹² and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)¹³ were used at intake. (The SCID-II was used only in adults.) The psychosis section was modified such that a psychotic disorder, but not individual psychotic disorders, was diagnosed if present. Except for eating disorders, "not otherwise specified" diagnoses were not made because of their subjective nature. Rates of tic disorder, trichotillomania, and olfactory reference syndrome, which are not in the SCID, were assessed by using SCID-like modules based on DSM-IV criteria. The BDD Form, an unpublished semistructured instrument used in previous studies,^{4,8,9} was used to obtain data on demographic characteristics, clinical features of body dysmorphic disorder (e.g., body areas of concern, associated behaviors, functional impairment), and treatment history. Employment and school status in the past month were assessed with the Range of Impaired Functioning Tool.¹⁴ Current employment (excluding employed subjects who were primarily students) was assessed with the Hollingshead Occupational Index, two-factor version; the scores range from 1 to 9.¹⁵

The current severity of body dysmorphic disorder was assessed with the Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder,¹⁶ a reliable and valid 12-item semistructured measure; the scores range from 0 to 48. The Body Dysmorphic Disorder Examination¹⁷ was used to assess symptoms of body dysmorphic disorder and severely negative body image in the first 98 subjects, with eating disorder symptoms excluded; the scores ranged from 0 to 168. The current delusional quality of

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