

Psychosocial functioning and quality of life in body dysmorphic disorder

Katharine A. Phillips^{a,b,*}, William Menard^a, Christina Fay^a, Maria E. Pagano^b

^aButler Hospital, Brown Medical School, Providence, RI 02906, USA

^bDepartment of Psychiatry and Human Behavior, Brown Medical School, Providence, RI 02906, USA

Abstract

Psychosocial functioning and quality of life in body dysmorphic disorder (BDD) have received only limited investigation. We examined these domains in 176 subjects with current *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, BDD using reliable measures, several of which have not been used previously in BDD studies. Scores were compared to published norms. On the Medical Outcomes Study 36-Item Short-Form Health Survey, mental health-related quality of life scores for BDD subjects were approximately 1.8 SD units poorer than US population norms and 0.4 SD units poorer than norms for depression. On the Quality of Life Enjoyment and Satisfaction Questionnaire Short Form, BDD subjects had a mean converted score of $49.9\% \pm 16.4\%$, which was 2.1 SD units poorer than the normative community sample score of $78.1\% \pm 13.7\%$. On the Social Adjustment Scale—Self-Report, BDD subjects had a mean Overall Adjustment total score of 2.37 ± 0.52 , which was 2.4 SD units poorer than the published norm of 1.59 ± 0.33 . Scores on the Range of Impaired Functioning Tool reflected functional impairment in all domains. More severe BDD symptoms were significantly associated with poorer functioning and quality of life on all measures. On all but one measure, functioning and quality of life for subjects who were not currently receiving mental health treatment did not significantly differ from those who were receiving treatment. These findings indicate that individuals with BDD, regardless of treatment status, have markedly poor functioning and quality of life. In addition, they suggest that treatment should aim at improving functioning and quality of life in addition to relieving symptoms.

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1. Introduction

Body dysmorphic disorder (BDD), a distressing or impairing preoccupation with an imagined or slight defect in appearance, is a relatively common disorder [1,2] that is associated with high lifetime rates of psychiatric hospitalization (48%), being housebound (31%), and suicide attempts (22%–24%) [3,4]. Despite these indications that BDD is a severe and impairing illness, psychosocial functioning and quality of life in BDD have received only limited investigation.

In one study ($n = 188$), BDD symptoms had interfered moderately, severely, or extremely with social functioning in 99% of subjects and with occupational/academic functioning in 80% [3]. In a pharmacotherapy study [5], BDD subjects' ($n = 20$) total score on the Schneier Disability

Profile [6] suggested moderate functional impairment. Individuals with BDD also have high levels of perceived stress, with a study of 78 subjects yielding perceived stress scores that were 2.3 SD units higher (ie, worse) than in a large national probability sample [7].

Two studies have investigated quality of life in BDD using standard measures. One study [8] used the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36) [9,10] in 62 consecutive patients with BDD, 85% of whom participated in a placebo-controlled fluoxetine study in BDD [11]. Pretreatment scores on the mental health subscales averaged 1.9 SD units (range, 1.6–2.2) poorer than norms for the general US population, and 0.4 SD units (range, 0.2–0.7) poorer than norms for patients with clinical depression (major depression and/or dysthymia) [8]. In an open-label citalopram study in BDD ($n = 15$), pretreatment SF-36 mental health scores averaged 2.0 SD units (range, 1.8–2.1) poorer than norms for the general US population, and 0.5 SD units (range, 0.5–0.6) poorer than clinical depression norms [12]. To our knowledge, this citalopram

* Corresponding author. Tel.: +1 401 455 6490; fax: +1 401 455 6539.
E-mail address: katharine_phillips@brown.edu (K.A. Phillips).

study [12] and the previously noted fluoxetine study [13] are the only BDD studies that have systematically reported on multiple domains of functioning using a reliable and valid measure. Scores on this measure (the Range of Impaired Functioning Tool [LIFE-RIFT]) [14] reflected impaired functioning in most domains.

To our knowledge, only one previous study has assessed numerous domains of social functioning in BDD [15]. That study used the Social Adjustment Scale—Self-Report (SAS-SR) [16] in an open-label fluoxetine trial in major depression. Depressed patients with comorbid BDD ($n = 28$) had a mean total adjustment score of 2.6 ± 0.6 , which was similar to that of depressed patients without comorbid BDD ($n = 322$) and 3.1 SD units poorer than community norms [15].

Although the above studies indicate that patients with BDD have poor functioning and quality of life, the quality of life studies are limited by a small sample size [8,12]. Another limitation is that the studies that used standard functioning or quality of life measures were pharmacotherapy trials [5,11–13,15] or contained primarily pharmacotherapy trial participants [8], which may have introduced bias. For example, individuals who seek psychiatric treatment may be more severely ill and impaired than those in the community who do not seek treatment. Conversely, the pharmacotherapy studies had standard efficacy study exclusion criteria (eg, subjects could not have a current substance use disorder and or be highly suicidal), which may have excluded more severely ill and impaired individuals. These studies also excluded individuals with a clinically significant or unstable medical illness, which may have affected physical health–related quality of life scores.

In the present study, we examined psychosocial functioning and quality of life with standard measures in the largest sample to date ($n = 176$). To our knowledge, this is also the broadest sample of individuals with BDD that has been studied (eg, subjects were not excluded from the study because of comorbidity, and many were not currently receiving psychiatric treatment). In addition, we used several measures (Social Adjustment Scale [SAS] and Quality of Life Enjoyment and Satisfaction Questionnaire [Q-LES-Q]) that have not been used previously in a sample ascertained for BDD. On the basis of previous studies [5,8,12] and our clinical experience, we hypothesized that compared to community norms, individuals with BDD would have markedly poor quality of life and psychosocial functioning across numerous domains (eg, work, school, social, household, leisure activities, satisfaction, and psychological distress). We also hypothesized that more severe BDD symptoms and more delusional appearance–related beliefs would be associated with poorer functioning and quality of life, as found previously [8]. Because studies to date on this topic have used clinical samples, we also examined whether there were any differences in functioning and quality of life in subjects

currently receiving mental health treatment vs those who were not receiving treatment.

2. Methods

2.1. Subjects

Subjects were 176 consecutive individuals with *DSM-IV* BDD participating in an ongoing naturalistic prospective study of the course of BDD. All 176 subjects currently met full criteria for BDD. Study inclusion criteria were *DSM-IV* BDD or its delusional variant (delusional disorder, somatic type), age 12 years or older, and able to be interviewed in person; the only exclusion criterion was the presence of an organic mental disorder. All subjects were assessed at study intake with reliable interviewer-administered and self-report measures. This report includes only data from the intake interview.

Subjects were referred to the study from a variety of sources, including mental health professionals (46.0%), advertisements (38.6%), our program web site and brochures (10.2%), subject friends and relatives (3.4%), and nonpsychiatrist physicians (1.7%). The sample's mean age was 32.5 ± 12.1 years (range, 14–64), and 65.9% ($n = 116$) were female. One hundred six (63.9%) subjects were single, 42 (25.3%) were married, and 18 (10.8%) were divorced. The average education level was some college. Seventy-nine percent ($n = 122$) considered BDD their most problematic current disorder (compared to any comorbid disorders). One hundred seventeen (66.5%) subjects were currently receiving mental health treatment (63.6% outpatient, 2.8% inpatient), whereas 59 (33.5%) were not receiving treatment. The study was approved by the Butler Hospital Institutional Review Board, and all subjects voluntarily provided written informed consent for study participation.

2.2. Assessments

2.2.1. Medical Outcomes Study 36-Item Short-Form Health Survey

This reliable, valid, and widely used self-report scale measures current mental and physical dimensions of health status and health-related quality of life [9,10]. The Mental Health subscales are (1) Mental Health (psychological distress and well-being), (2) Role Limitations due to Emotional Problems, and (3) Social Functioning. The physical health subscales are (1) Physical Functioning, (2) Role Limitations due to Physical Health Problems, and (3) Bodily Pain. Two additional subscales are sensitive to both mental and physical health status: (1) Vitality (energy vs fatigue) and (2) General Health. Subscale scores range from 0 to 100; lower scores indicate poorer quality of life. SF-36 scores were compared to published norms for the general US population ($n = 2474$), clinical depression (major depression and/or dysthymia [$n = 502$]), a chronic medical condition (type II diabetes [$n = 541$]), and an acute medical condition (recent myocardial infarction [$n = 107$]) [9].

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