

Delusional versus nondelusional body dysmorphic disorder: Clinical features and course of illness

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Abstract

DSM-IV's classification of body dysmorphic disorder (BDD) is controversial. Whereas BDD is classified as a somatoform disorder, its delusional variant is classified as a psychotic disorder. However, the relationship between these BDD variants has received little investigation. In this study, we compared BDD's delusional and nondelusional variants in 191 subjects using reliable and valid measures that assessed a variety of domains. Subjects with delusional BDD were similar to those with nondelusional BDD in terms of most variables, including most demographic features, BDD characteristics, most measures of functional impairment and quality of life, comorbidity, and family history. Delusional and nondelusional subjects also had a similar probability of remitting from BDD over 1 year of prospective follow-up. However, delusional subjects had significantly lower educational attainment, were more likely to have attempted suicide, had poorer social functioning on several measures, were more likely to have drug abuse or dependence, were less likely to currently be receiving mental health treatment, and had more severe BDD symptoms. However, when controlling for BDD symptom severity, the two groups differed only in terms of educational attainment. These findings indicate that BDD's delusional and nondelusional forms have many more similarities than differences, although on several measures delusional subjects evidenced greater morbidity, which appeared accounted for by their more severe BDD symptoms. Thus, these findings offer some support for the hypothesis that these two BDD variants may constitute the same disorder. Additional studies are needed to examine this issue, which may have relevance for other disorders with both delusional and nondelusional variants in DSM.

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1. Introduction

DSM-IV's classification of body dysmorphic disorder (BDD) (also known as dysmorphophobia) was debated for DSM-IV (Phillips and Hollander, 1996) and remains controversial. BDD, a distressing or impairing preoccupation with an imagined or slight defect in physical appearance, is classified as a somatoform disorder (American Psychiatric Association, 1994). In contrast, its psychotic (delusional) variant is classified separately

as a psychotic disorder (a type of delusional disorder, somatic type). However, DSM-III-R noted that it is unclear whether BDD and its delusional disorder variant can be distinguished by whether or not the belief is a delusion or "whether they are merely two variants of the same disorder" (American Psychiatric Association, 1987). In recognition of the latter possibility, DSM-IV allows these two variants to be double-coded, so that delusional patients may be diagnosed with both BDD and delusional disorder. While applying two different diagnoses to the same symptoms has drawbacks, double coding has the advantage of implying that BDD's delusional and nondelusional variants may actually constitute the

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same disorder rather than being distinct. However, the relationship between these variants has received little investigation, making it unclear how they should optimally be classified in DSM (Phillips, 2004).

Clinical observations over the past half a century have suggested that these two variants of BDD substantially overlap and in fact may be the same disorder (e.g., Korkina, 1965; Stekel, 1949). For example, de Leon et al. (1989) stated that "...dysmorphophobic ideas are continuous beliefs and it does not seem appropriate to divide them into delusional and nondelusional categories." Subsequently, Phillips and McElroy (1993) suggested that delusional and nondelusional BDD may be variants of the same disorder, based in part on clinical observations that delusional patients (like nondelusional patients) appear to respond to serotonin-reuptake inhibitors (SRIs). These observations suggested that delusionality (i.e., insight) is a dimensional construct that occurs on a continuum, ranging from good through poor to absent (i.e., delusional) (Phillips and McElroy, 1993). The relationship between BDD's delusional and nondelusional variants – and how they should be classified in future editions of DSM – will not be clear until their underlying etiology and pathophysiology are elucidated (Hyman, 2003; Phillips et al., 2003). However, comparisons of their clinical features can shed useful light on their similarities and differences. To our knowledge, the only previous study that has compared delusional to nondelusional BDD across numerous domains ($n = 50$ and 100 in an expanded sample) found that these variants had many more similarities than differences (McElroy et al., 1993; Phillips et al., 1994). Delusional and nondelusional subjects were similar in terms of most variables examined, including demographic characteristics, clinical features, Axis I comorbidity, and response to pharmacotherapy. However, in the expanded sample of 100 subjects, a higher proportion of delusional subjects had experienced interference in work or academic functioning, and they had more severe BDD symptoms (Phillips et al., 1994). Thus, this study suggested that delusional and nondelusional BDD may constitute the same disorder, but that the delusional variant may be associated with greater functional impairment and illness severity. These findings led to suggestions that consideration be given to classifying BDD's delusional and nondelusional variants together in DSM, perhaps using a psychotic subtype designation, similar to how psychotic depression is classified. This debate touches on the complex issue of how a categorical classification system such as DSM can accommodate what may be a dimensional construct, such as delusionality, and it has relevance to other "nonpsychotic" disorders with separate psychotic disorder variants in DSM-IV (e.g., hypochondriasis and obsessive compulsive disorder [OCD]).

In the present study, we examined this topic in a larger ($n = 191$) and more diverse BDD sample than

previously studied (for example, one third of subjects were not seeking or receiving mental health treatment at the time of the intake evaluation, unlike those in the previous study). The present study also differs from the previous study in several additional ways: (1) we examined some new variables (e.g., quality of life and additional functioning variables), (2) we classified subjects as delusional or nondelusional using a reliable and valid measure that is suitable for assessing delusionality in BDD (the Brown Assessment of Beliefs Scale [Eisen et al., 1998]), which had not been developed when the previous study was done; and (3) we present prospective longitudinal data on the course of delusional versus nondelusional BDD; to our knowledge, this is the first prospective course of illness study in BDD. We hypothesized that delusional subjects would have a more chronic course of BDD than nondelusional subjects based on previous findings suggesting that delusional BDD may be a more severe variant of the illness (Phillips et al., 1994), as well as findings on other disorders suggesting that the presence of psychotic features may denote a more chronic course of illness (Coryell et al., 1996).

2. Methods

2.1. Subjects

Subjects were 191 participants with DSM-IV BDD from an ongoing prospective study of the course of BDD. This report includes data from both the baseline (intake) assessment and 1-year course data. Study inclusion criteria were very broad: DSM-IV BDD or its delusional variant (delusional disorder, somatic type), age 12 or older, and able to be interviewed in person. The presence of an organic mental disorder was the only exclusion criterion. The sample's age range was 14–64, and 8.4% ($n = 16$) of the sample were adolescents (age 14–17). Forty eight percent of subjects were referred by professionals, and 52% were self-referred. At the time of the intake assessment, 89.0% ($n = 178$) of subjects currently met full DSM-IV criteria for BDD (i.e., during the past month), 7.5% ($n = 15$) were currently in partial remission, and 3.5% ($n = 7$) were currently in full remission (subjects in the latter two groups had met full BDD criteria in the past). Seventy eight percent of the sample considered BDD their most problematic disorder (compared to any comorbid disorder). The study was carried out in accordance with the latest version of the Declaration of Helsinki, the study design was approved by the hospital Institutional Review Board, and all subjects signed statements of informed consent after the procedures had been fully explained (assent plus parental consent for adolescents).

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