

Functional impairment in body dysmorphic disorder: A prospective, follow-up study

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Abstract

Cross-sectional/retrospective studies indicate that individuals with body dysmorphic disorder (BDD) have markedly impaired psychosocial functioning. However, no study has prospectively examined functioning in BDD. In this study, which is to our knowledge the first prospective study of the course of BDD, psychosocial functioning was assessed at baseline and over 1–3 years (mean = 2.7 ± 0.9 years) of follow-up with the Global Assessment of Functioning scale (GAF), Social and Occupational Functioning Scale (SOFAS), and LIFE-RIFT (Range of Impaired Functioning Tool). Psychosocial functioning was poor during the follow-up period. Functioning remained stably poor over time on the SOFAS and LIFE-RIFT, although there was a trend for a gradual and slight improvement on the GAF over time. The cumulative probability of attaining functional remission on the GAF (score > 70 for at least 2 consecutive months) during the follow-up period was only 5.7%. On the SOFAS, the cumulative probability of attaining functional remission (score > 70 for at least 2 consecutive months) was 10.6%. BDD severity significantly predicted functioning on the GAF ($p = 0.0012$), SOFAS ($p = 0.0017$), and LIFE-RIFT ($p = 0.0015$). A trend for a time-by-BDD severity interaction was found on the GAF ($p = 0.033$) but not the SOFAS or LIFE-RIFT. More delusional BDD symptoms also predicted poorer functioning on all measures, although this finding was no longer significant when controlling for BDD severity. Functioning was not predicted, however, by age, gender, BDD duration, or a personality disorder. In conclusion, psychosocial functioning was poor over time, and few subjects attained functional remission. Greater BDD severity predicted poorer functioning.

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1. Introduction

Body dysmorphic disorder, a distressing or impairing preoccupation with an imagined or slight defect in one's physical appearance (e.g., "scarred" skin or a "deformed" nose), is a relatively common disorder (Bienvenu et al., 2000; Rief et al., 2006). Descriptions of BDD during the past century have emphasized these individuals' poor psy-

chosocial functioning (Morselli, 1891; Phillips, 1991). However, functioning in BDD has received only limited investigation.

In an early study, 97% of 30 subjects with BDD reported a history of avoiding usual social or occupational activities because of embarrassment over their perceived appearance defects (Phillips et al., 1993). Subsequent studies which used standard functioning measures reported impairment in psychosocial functioning. In a BDD pharmacotherapy study ($n = 20$), Schneier Disability Profile scores reflected moderate functional impairment (Hollander et al., 1999). In a study of 62 patients with BDD (85% of whom participated in a placebo-controlled pharmacotherapy study,

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Phillips et al., 2002), scores on the Medical Outcomes Study 36-Item Short Form Health Survey (SF-36) (Ware, 1993) were markedly poor in all mental health domains. For example, on the SF-36 subscale that assesses role limitations due to emotional problems, BDD subjects' scores were 1.6 standard deviation units poorer than US population norms; on the social functioning subscale, their scores were 2.2 standard deviation units poorer (Phillips, 2000). Similarly poor SF-36 scores were reported in two small open-label pharmacotherapy studies (Phillips, 2006; Phillips and Najjar, 2003). Mental health-related SF-36 subscale scores in all three studies were poorer than norms for clinical depression (Ware, 1993). These studies also found impaired functioning on the Global Assessment of Functioning scale (GAF), Social and Occupational Functioning Scale (SOFAS), and Longitudinal Interval Follow-Up Evaluation (LIFE) (American Psychiatric Association, 1994; Keller et al., 1987). However, these studies are limited by relatively small sample sizes. In addition, studies which used standard functioning measures consisted entirely or largely of pharmacotherapy trial participants, which may have introduced bias.

The present study examined the following aspects of psychosocial functioning in BDD over 1–3 years (mean = 2.7 ± 0.9 years) of follow-up: level of psychosocial functioning, stability of functional impairment, the probability of attaining “functional remission”, and predictors of psychosocial functioning. To our knowledge, this is the first report of prospectively assessed psychosocial functioning in BDD. (We have previously reported on this sample's cross-sectional/retrospectively assessed functioning from the intake interview, Phillips et al., 2005a.) The present study had a larger sample and broader inclusion criteria than previous studies, which may increase the generalizability of the findings. We hypothesized that (1) psychosocial functioning would be poor and remain poor over time; (2) few subjects would “functionally remit” over time; and (3) more severe BDD symptoms would predict poorer functioning over time. We were also interested in whether delusional BDD appearance beliefs would predict poorer functioning. In a previous cross-sectional study, delusional BDD beliefs were associated with poorer functioning/quality of life on two of three SF-36 mental health subscales (Phillips, 2000). A report from the present sample found that at the time of intake into the study, greater delusional BDD beliefs were significantly, although modestly, associated with poorer scores on three of seven functioning/quality of life scales/subscales (Phillips et al., 2005a). This question is of clinical interest, as it is useful for clinicians to know whether more delusional patients function more poorly over time. This question also has some relevance for DSM-V. In DSM-IV, non-delusional BDD and delusional BDD are classified separately (BDD as a somatoform disorder and delusional BDD as a psychotic disorder). However, the nature of the relationship between these BDD variants is unclear (Phillips, 2004), and data are needed on delusional BDD. In addition, delusional-

ty/insight may be conceptualized as a dimension that characterizes a number of disorders (Eisen et al., 2004; Phillips, 2004), yet little is known about the relationship between delusional BDD and functional impairment.

2. Methods

2.1. Subjects

Participants were recruited from a variety of sources into this single-site longitudinal observational study of the course of BDD. All subjects met full criteria for lifetime (i.e., current or past) DSM-IV BDD or its delusional variant. Subjects were required to be age 12 or older and able to be interviewed in person. The only exclusion criterion was the presence of a mental disorder (e.g., an organic mental disorder) that would interfere with the collection of valid interview data. Forty six percent of the subjects were referred by mental health professionals, 38.6% were obtained from advertisements, 10.2% from our program website and brochures, 3.4% from subject friends and relatives, and 1.7% from non-psychiatrist physicians. (For a detailed description of the full sample of 200 subjects at the time of intake into the study, see Phillips et al., 2005b.) The investigation was carried out in accordance with the latest version of the Declaration of Helsinki. The study was approved by the Hospital Institutional Review Board, and written informed consent was obtained (assent plus parental consent for adolescents) after the procedures had been fully explained.

The current report is based on the 176 subjects who met full DSM-IV criteria for BDD during the week before the intake interview (the remaining 24 subjects had met full DSM-IV BDD criteria in the past). Of these 176 subjects, 163 (92.6%) completed a one-year follow-up interview. This report also includes all two-year and three-year interview data presently available for analysis (for 141 subjects and 78 subjects, respectively). Two-year and three-year interview data are not available for all subjects because subjects were enrolled over a period of 2.4 years and therefore currently have varying follow-up durations; for example, most subjects had not come due for their year 3 interview at the time these data were analyzed. For all 176 subjects, the mean age at intake was 32.5 ± 12.3 years (range = 14–64), 71.0% ($n = 125$) were female, and 76.1% ($n = 134$) were single. At study intake, the mean score on the 48-point Yale-Brown Obsessive Compulsive Scale Modified for BDD (Phillips et al., 1997), a measure of current BDD severity, was 30.4 ± 6.6 .

2.2. Assessments

Subjects were interviewed at intake and re-interviewed annually following the intake interview. At each annual interview, psychosocial functioning scores were obtained for the past month and for each month during the preceding year. Interviews were conducted by experienced inter-

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