Available online at www.sciencedirect.com
ScienceDirect
Comprehensive Psychiatry 51 (2010) 177–182
Comprehensive PSYCHIATRY
www.elsevier.com/locate/comppsych

Delusional versus nondelusional body dysmorphic disorder

Serafino G. Mancuso[a,b], Natalie P. Knoesen[a], David J. Castle[a,c,*]

[a]St Vincent's Mental Health, Melbourne, Australia
[b]Swin-PsyCHE Research Unit, Swinburne University of Technology, Melbourne, Australia
[c]Department of Psychiatry, St Vincent's Hospital, Melbourne, Australia

Abstract

This study assessed demographic and clinical features in 65 subjects with body dysmorphic disorder (BDD) and compared the 39 (60%) with the delusional form (receiving an additional diagnosis of delusional disorder, somatic type) with those who did not meet delusionality criteria. Delusional and nondelusional patients did not statistically differ on most demographic and clinical variables. Delusional patients, however, had significantly more severe BDD symptoms at both baseline and follow-up assessments than those of nondelusional patients. Furthermore, poorer insight was significantly associated with more severe BDD symptoms at both baseline and follow-up. Overall improvement in BDD symptom severity was similar for the 2 groups. Our results support other studies in the view that BDD and its delusional variant have more similarities than differences and that the delusional variant may be simply a more severe form of BDD. Implications for the diagnostic classification of BDD and future research directions are discussed.

1. Introduction

Individuals with body dysmorphic disorder (BDD) are preoccupied with a perceived or minor defect in 1 or more aspects of their appearance [1]. The most common preoccupations concern the hair, nose, and skin, but any body part can be the focus of concern [2,3]. The preoccupations are typically difficult to resist or control and, on average, consume 3 to 8 hours daily [2]. Although not a diagnostic criterion, almost all people with BDD perform compulsive behaviors to examine, improve, or hide their perceived defect [2,3].

Insight into the appearance preoccupations is often impaired such that BDD patients hold their beliefs about the perceived defects with strong conviction [2,4]. Case reports suggest that patients fluctuate between obsessional thoughts, overvalued ideation, and delusionality [5]. Those patients who maintain their beliefs with delusional intensity qualify for an additional diagnosis of delusional disorder, somatic type [1].

Body dysmorphic disorder tends to begin in late adolescence, with the mean age of onset between 16 and 18 years [3]. There are similar prevalence rates for males and females in adult clinical samples [6]. Studies within the general population have reported prevalence rates ranging from 0.7% [7] to 1.7% [8]. Higher rates have been reported in clinical samples, ranging from 3.2% [9] to 16% [10] in psychiatric settings, 11.9% in dermatologic settings [11], and 7% [12] to 17% [13] in cosmetic surgery settings. Individuals with moderate to severe symptoms tend to follow a deteriorating course and experience BDD for an average of 15 to 16 years [6]. Almost all BDD patients experience impairment in social, occupational, and/or academic functioning because of their appearance concerns [14].

Major depressive disorder, social anxiety disorder, and obsessive-compulsive disorder are often comorbid with BDD [15,16]. Patients with BDD are also often diagnosed with comorbid personality disorders, the most common of which are avoidant, paranoid, and obsessive-compulsive personality disorders [16,17].

Psychological and pharmacological treatments for BDD have received increased attention. Psychological treatment studies have focused on cognitive-behavioral therapy (CBT), whereas pharmacological treatment studies have concentrated on selective serotonin reuptake inhibitors (SSRIs). Cognitive-behavioral therapy approaches comprise cognitive restructuring for maladaptive beliefs about appearance and exposure and response prevention for appearance-related behaviors [18]. Cognitive interventions incorporating

* Corresponding author. St. Vincent's Hospital, The University of Melbourne, Fitzroy, Victoria 3065, Australia.
E-mail address: david.castle@svhm.org.au (D.J. Castle).

0010-440X/$ – see front matter.
doi:10.1016/j.comppsych.2009.05.001

exposure and response prevention seem efficacious in reducing symptom severity and overvalued ideation [19]. Pharmacotherapy trials consistently indicate that SSRIs, including fluoxetine [20], fluvoxamine [21], clomipramine [22], citalopram [23], and escitalopram [24], are often efficacious in treating both delusional and nondelusional variants of BDD.

1.1. Classification

According to *Diagnostic and Statistical Manual of Mental Disorders, Revised Fourth Edition* (DSM-IV-R), BDD is classified as a somatoform disorder and its delusional variant as a psychotic disorder [1]. However, Phillips and McElroy [5] have contended that both delusional and nondelusional variants of BDD may reflect 1 single disorder, with the degree of insight varying along a continuum, ranging from good through poor to absent. Unpublished data [25] using the Brown Assessment of Beliefs Scale [26] in 129 BDD patients highlights this varying degree of insight, with only 0.78% having excellent insight, 3.1% good insight, 12.4% fair insight, 31% poor insight, and 52.7% absent insight (ie, delusional). Phillips et al [4] also compared 52 delusional to 48 nondelusional patients and found that the 2 groups did not differ in relation to demographics, phenomenology, course, comorbidity, and treatment response. Delusional patients, however, had more severe BDD symptoms and greater impairment in occupational or academic functioning than those of nondelusional patients.

Comparable results were reported by Phillips et al [27], who found that delusional (n = 68) and nondelusional (n = 123) BDD patients were similar in terms of demographics, clinical characteristics, course of illness, and probability of remitting from BDD. Although delusional patients were found to have more severe symptoms, greater functional impairment, poorer quality of life, higher suicidality, and greater substance abuse than those of nondelusional patients, these differences were accounted for by their more severe BDD symptoms. These data taken together suggest that although insight in BDD is often impaired, BDD and its delusional variant have many more similarities than differences.

However, there remains debate about the delusional and nondelusional classification of BDD. We present here a naturalistic study of an Australian sample of BDD patients and compare demographics, clinical features, and treatment response between patients classified as delusional and nondelusional. We hypothesized that delusional patients would differ from nondelusional ones in terms of symptom severity but that, overall, there would be more similarities than differences between the groups.

2. Method

Potential participants were all consecutive BDD patients seen at the St Vincent's Health Body Image Disorder Service, a statewide outpatient service specializing in the evaluation and treatment of people with BDD. Treatment is free and comprises a standardized pharmacological approach (see Section 2.3), standardized psychoeducation (which includes written information about the nature of BDD and the fundamentals of CBT for BDD), and on-referral to a clinical psychologist for more intensive CBT when required.

2.1. Participants

Of the 72 eligible BDD patients, 7 refused to participate or did not attend follow-up appointments; thus, we here report on 65 patients. Referral sources comprised self-referrals, general practitioners, psychiatrists, psychologists, cosmetic surgeons, and various medical specialists. Participants provided written informed consent to participate in a phenomenological study, which was later amended to include treatment data. The phenomenological study was approved by the University of Melbourne Human Research Ethics Committee (Project 040629X) as was the amendment to obtain treatment data (Project 040629X.2).

2.2. Measures

2.2.1. Body Dysmorphic Disorder Questionnaire

The Body Dysmorphic Disorder Questionnaire [28] is a 10-item self-report measure that screens for BDD. For BDD diagnosis, the Body Dysmorphic Disorder Questionnaire has been shown to have a sensitivity of 100% and a specificity of 89% in an outpatient psychiatric setting [29] and a sensitivity of 100% and a specificity of 93% in a dermatologic setting [30]. Items 7, 8, and 9 were used to assess social impairment, occupational impairment, and avoidance, respectively.

2.2.2. Dysmorphic Concern Questionnaire

The Dysmorphic Concern Questionnaire (DCQ) [31] is a 7-item self-report measure that assesses cognitive and behavioral symptoms of overconcern with an imagined or slight physical defect. The score for each item ranges from 0 (not at all) to 3 (much more than most people). The DCQ is scored by summing all items, with a score of 11 and above indicative of probable BDD. A cutoff score of 11 has been shown to have a sensitivity of 100% and a specificity of 79% in a dermatologic outpatient setting [32]. In the present study, the reliability coefficient (Cronbach α) was .73.

2.2.3. Self-rating Depression Scale

The Self-rating Depression Scale (SDS) [33] is a 20-item self-report measure that assesses cognitive, behavioral, affective, and somatic symptoms of depression on a 4-point scale, from 1 (a little of the time) to 4 (most of the time). The SDS is scored by summing all the items, with total raw scores ranging from 20 to 80. In the present study, the reliability coefficient was .78.

2.2.4. Social Interaction Anxiety Scale

The Social Interaction Anxiety Scale (SIAS) [34] is a 20-item self-report scale that measures cognitive, behavioral, and affective aspects of social anxiety as experienced in