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Status of body dysmorphic disorder in Argentina

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ABSTRACT

Although body dysmorphic disorder (BDD) has received recent attention, it remains misunderstood and under-studied. The Argentine population seeks out plastic surgery at a disproportionate rate and exhibits high rates of preoccupation with bodily dissatisfaction, yet BDD is unrecognized and research is limited. The current study describes the prevalence, quality of life, and presentation style of BDD in depressed adolescents, as depression is the most common symptom for which adolescents seek treatment in Argentina. Twenty-five depressed adolescents and 85 non-depressed students were initially assessed for depression and BDD and subdivided depending on BDD status. Participants were assessed on various constructs including obsessions and compulsions, overvalued ideas, and overall level of impairment. A 2×2 factorial design was employed, and multivariate analysis of variance (MANOVA) was used to analyze the data. Significant main effects were observed for all dependent measures (BDI, OVIS, YBOCS, and Sheehan Disability Scale) for depressed vs. non-depressed participants and BDD status; significant interactions were observed between independent variables for all dependent measures. Depressed adolescents had significantly higher scores on the YBOCS-BDD, OVIS, BDI, and the Sheehan Disability Scale compared to non-depressed participants; furthermore, individuals reporting BDD symptoms reported significantly higher scores on the YBOCS-BDD, OVIS, BDI, and Sheehan Disability Scale. Significant interactions are discussed according to BDD status and depression on dependent measures. Patients with BDD have poor quality of life and present with anxiety and depression, yet it still remains underdiagnosed.

1. Introduction

Body dysmorphic disorder (BDD) is an underrecognized and underdiagnosed problem that is relatively common among adolescents with an age of onset during adolescence and young adulthood (Neziroglu & Yaryura-Tobias, 1993; Phillips, 1991). Body dysmorphic disorder (BDD) is a disorder characterized by distress about an imagined defect in appearance. According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision) (DSM-IV-TR), BDD is an excessive preoccupation with an imaginary and/or a slight defect in one's appearance that is not accounted for by another disorder (e.g., anorexia nervosa). Preoccupation must cause marked distress and/or result in a significant decrease in functioning within major life domains (e.g., social, occupational or academic functioning) (American Psychiatric Association, 2000). BDD can be quite severe and potentially disabling, causing marked distress, severe social and occupational impairment and high rates of comorbid mood disorders, suicide attempts and hospitalization (Phillips et al., 2005; Veale et al., 1996). Common comorbid disorders which present with BDD are major depressive disorder, substance use disorders, obsessive–compulsive disorder (OCD), and social phobia (Phillips et al., 2005).

BDD is under-diagnosed and under-studied within the United States, and even less information exists about the disorder within other countries. Argentina, for example, is one of the world capitals of plastic surgery, ranking 13th among the top 25 countries for total number of surgical procedures (International Society of Aesthetic and Plastic Surgery, 2009), yet BDD is hardly diagnosed nor researched (Borda & Perez Rivera, 2006; Yaryura-Tobias, Perez Rivera, Neziroglu, & Borda, 2003). Although onset of the disorder occurs in adolescence, BDD research in child and adolescent psychiatry is relatively limited and can be chronic if not treated appropriately (Phillips, 2005a). Adolescents in societies with disproportionate rates of plastic surgery and body dissatisfaction, such as Argentina, may be at higher risk for development of BDD. Likewise due to the comorbid nature of BDD, presentation and course of treatment may differ in depressed adolescents with BDD compared to depressed adolescents without BDD.

There has been only one epidemiologic study in the US indicating a prevalence rate of 2.4%, exceeding prevalence rates of schizophrenia and bipolar disorder type I (Koran, Abujaoude, Large,

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& Serpe, 2008). Prior studies indicated prevalence data of 0.7% (Faravelli et al., 1997) to 13% (Biby, 1998). Prevalence studies that exclusively investigated adolescents of similar age to the population used in this study (14–19 years old) reported a BDD rate of 2.2% (Mayville, Katz, Gipson, & Cabral, 1999).

Otto, Wilhelm, Cohen, and Harlow (2001) conducted a survey of women ages 36–44 years old in the USA and found a prevalence rate of 0.7%. A nationwide survey of over 3,000 participants in Germany estimated a prevalence rate of 1.7% (Rief, Buhlmann, Wilhelm, Borkenhagen, & Brahler, 2006). Vinkers, van Rood, and van der Wee (2008) used a validated screening questionnaire to estimate the prevalence of BDD in a Dutch population ($n = 892$). The estimate was 0.7% (C.I. 0.2–1.2), which is remarkably similar to the prevalence studies of Faravelli et al. (1997) and Otto et al. (2001). Vinker's sample consisted of 55% females, with an average age of 32.8 years, and 49.3% were married or living with another person. No further analysis is provided on those identified as having BDD.

Biby (1998) screened undergraduate psychology students. The original sample included 83 females and 25 males ($n = 108$), however, 6 students with eating disorders were excluded. A questionnaire specifically devised for the study was used, and a BDD prevalence rate of 13% was reported. Bohne et al. (2002) found the prevalence rate of BDD in a nonclinical sample of German college students (average age 21) to be 5.3%. According to another study (Dufresne, Phillips, Vittorio, & Wilkel, 2001), poor body image is associated with poor self-esteem and symptoms of depression and obsessive–compulsive disorder. Lastly, Cansever, Uzun, Donmez, and Ozsahin (2003) surveyed 420 female nursing college students in Turkey. A self-report questionnaire was used to screen for dissatisfaction with appearance and 43.8% reported dissatisfaction. Those dissatisfied students were then interviewed by a psychiatrist who diagnosed BDD in 4.8% of them. Head/face areas and hips were the most common areas of concern.

Additionally, Fontenelle et al. (2006) conducted a sociodemographic, phenomenological, and long-term study of patients with BDD in Brazil. The prevalence rate of BDD in this clinical Brazilian population who was seeking treatment at a facility specializing in obsessive–compulsive spectrum disorders was 12% ($N = 20$). Six patients (30%) indicated complete lack of insight on the YBOCS while only four patients (20%) demonstrated full insight regarding their dysmorphic beliefs. Comorbidity included obsessive–compulsive disorder (70%), major depressive disorder (55%), eating disorders (25%), and co-occurrence of OCD and MDD (30%). There was a prevalence of females with the following body parts affected: overall appearance, size or shape of their face, skin, hair, nose, body build, and weight. All patients displayed compulsive behaviors such as mirror checking, camouflaging, seeking reassurance, and cosmetic use.

The mental representation of body image occurs early during psycho-emotional and cognitive development. Commonly, BDD appears during adolescence, and some traits may already be present during childhood and puberty (Neziroglu & Yaryura-Tobias, 1993). This is not surprising because body appearance changes substantially during the developmental process. The developmental literature underscores the role of body image during adolescence as a factor which influences and is impacted by adolescent transitions, including development, peer relationships, dating, and sexuality. BDD appears to become less common with increasing age (Borda & Perez Rivera, 2003). Exceptions may be late onset BDD associated with a life crisis and a belief about the consequences of an aging appearance, or the appearance after cosmetic surgery.

Although BDD develops during adolescence the time between the onset of BDD and the time that individuals seek treatment it is about 10 years (Yaryura-Tobias et al., 2003). Because of the severity of BDD and the length of time of time prior to seeking treatment the individual's quality of life is affected. In fact, BDD patients have a poorer quality of life as compared to other psychiatric and physical illnesses such as diabetes and cardiovascular problems (Phillips, 2000). In addition, BDD is not only associated with high rates of functional impairment, but it is also complicated by depressive symptoms, high rates of hospitalization, and suicidal ideation and attempts (Hollander, Cohen, & Simeon, 1993; Phillips, McElroy, Keck, Pope, & Hudson, 1993; Phillips, 1991; Veale et al., 1996).

Though categorized as a somatoform disorder, BDD shares psychopathological similarities with anxiety and mood disorders such as social phobia (e.g., fear of negative evaluation), obsessive–compulsive disorder (e.g., intrusive thoughts and compulsive behaviors) and depression (e.g., suicidal ideas). In addition, it appears that a majority of BDD patients have at least one comorbid disorder, and are more likely than other psychiatric outpatients to have three or more comorbid Axis I disorders (Gunstad & Phillips, 2003) and Axis II disorder (Neziroglu, McKay, Todaro, & Yaryura-Tobias, 1996). With different assessment methods, BDD outpatients met criteria for a mood disorder in 88% of cases and for an anxiety disorder in 60% of cases (Phillips & Diaz, 1997). The most common Axis I disorders were major depression (82%), social phobia (38%), substance use disorders (36%), and obsessive–compulsive disorder (30%) (Gunstad & Phillips, 2003).

Because BDD individuals demonstrate a high rate of incidence with depression – rates from 36% to 76% (Phillips & Diaz, 1997) – it seems important to determine rate of BDD in individuals seeking treatment for depression. This seems even more crucial given that very few individuals in Argentina seek treatment for BDD. It is noteworthy that within an inpatient and outpatient population of more than 500 patients, none had received a diagnosis of BDD (Alfredo Cia personal communication, 2009).

Proper assessment of BDD is crucial in improving the underdiagnosis of BDD especially among adolescents during which its onset occurs. Assessment instruments with acceptable psychometric properties have been developed to specifically to assess BDD (e.g., the Body Dysmorphic Disorder Examination; Rosen & Reiter, 1996 and the Yale-Brown Obsessive Compulsive Scale modified for body dysmorphic disorder; Phillips et al., 1997). Another area of diagnostic importance is the degree to which individuals hold their obsessional beliefs to be true. Overvalued ideas have been shown to predict treatment outcome in OCD and BDD (Neziroglu, Stevens, McKay, & Yaryura-Tobias, 2001).

Estimation of the exact prevalence of BDD appears to be a difficult task, not only because patients with BDD primarily do not go to psychologists or psychiatrists, but also because of the rate of subclinical conditions (i.e., conditions in which the core symptoms of BDD are present but are not inducing a significant impairment in functioning) (Altamura, Paluello, Mundo, Medda, & Mannu, 2001).

The aim of the current study is to describe the prevalence, quality of life, and presentation style of BDD in an Argentine adolescent population, where there is a disproportionate rate of body dissatisfaction. Due to high rates of surgery and body preoccupation in Argentina, this study sought to explore obsessive body concerns in a clinical and nonclinical sample of adolescents diagnosed with BDD. A nonclinical sample was compared to a clinical sample of adolescents with depression in order to assess the general level of body dissatisfaction in a sample of Argentine college students. We hypothesized that depressed patients with BDD would have greater severity of depressive symptoms and poorer overall functioning than depressed patients without BDD. In addition, it was hypothesized that the student population would demonstrate a high rate of body dysatisfaction but not necessarily BDD. Specifically, the goal of this study was to emphasize the importance of assessing for the presence of BDD in adolescents seeking treatment for depression. Symptoms of BDD in adolescents may go undiagnosed and lead to misdiagnosis due to comorbid symptoms of depression.