

Reality Monitoring in Patients With Body Dysmorphic Disorder

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Patients with body dysmorphic disorder (BDD) typically have very poor insight into their disorder. Their conviction in their ugliness is often of delusional intensity. Reality monitoring is the ability to distinguish in memory between things that one has imagined and things that one has perceived. Deficits in reality monitoring have been associated with the development of other delusional beliefs. Therefore, in the present study we investigated whether individuals with BDD ($n=20$) demonstrate impairments in reality monitoring relative to individuals with obsessive-compulsive disorder (OCD; $n=20$) and healthy controls ($n=20$). This hypothesized impairment might predispose people with BDD to confuse memories of how they imagine themselves to appear (i.e., ugly) with memories of how they actually appear (i.e., normal). All participants completed a memory task assessing reality-monitoring ability for verbal stimuli. The BDD patients did not exhibit a reality-monitoring deficit despite elevated levels

of focal delusional. The results suggest that impairments in reality monitoring do not contribute to the development or maintenance of appearance-related beliefs in BDD.

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BODY DYSMORPHIC DISORDER (BDD) is characterized by a preoccupation with imagined or very slight defects in physical appearance (*American Psychiatric Association, 2000*). The most frequent areas of concern are the skin, hair, and nose (*Phillips, Menard, Fay, & Weisberg, 2005*) although the focus of concern may be any body part. Individuals with BDD are often consumed by intrusive thoughts and images related to their appearance. In response to these concerns, they will often spend hours each day performing ritualistic behaviors to reduce their distress. Excessive grooming, mirror checking, repetitive touching, excessive application of makeup, and camouflaging one's appearance with clothing or jewelry are common rituals. The disorder may affect nearly 2% of the general population (*Buhlmann et al., 2010; Koran, Abujaoude, Large, & Serpe, 2008; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brähler, 2006*). It typically causes marked social, educational, and occupational impairment. For example, in a study of 200 individuals with BDD, 36% missed a week or more of work in the prior month and 11% dropped out of school because of BDD (*Phillips et al., 2005*). Perhaps most alarmingly, more than 25% reported at least one prior suicide

attempt. Clearly, we need to deepen our understanding of the factors contributing to the development and maintenance of such a severe disorder.

One striking feature of individuals with BDD is a lack of insight into their disorder. They often do not see themselves as suffering from a psychological problem requiring mental health care, but rather suffering from a defect in appearance remediable only by cosmetic procedures. For example, an examination of 129 patients with BDD revealed that 84% were classified as either delusional ($n=68$) or having poor insight ($n=40$) into their primary disorder-related belief (Phillips, 2004). Similarly, in a larger study of 191 individuals with BDD, approximately one third of the sample ($n=68$) was classified as delusional (Phillips, Menard, Pagano, Fay, & Stout, 2006). The remaining participants, although not delusional, were characterized by poor insight into their primary disorder-related belief.

In recent years, researchers have developed a number of cognitive-behavioral models of BDD (Veale, 2004; Wilhelm, 2006; Wilhelm, Buhlmann, Hayward, Greenberg, & Dimaite, 2010). One central hypothesis common to these models is that certain biases or deficits in information processing contribute to the development and maintenance of BDD. Indeed, researchers have identified abnormalities in interpretation (Buhlmann, Wilhelm, et al., 2002), attention (Buhlmann, McNally, Wilhelm, & Florin, 2002), visual processing (Feusner, Townsend, Bystritsky, & Bookheimer, 2007; Feusner et al., 2010), emotion recognition (Buhlmann, Etcoff, & Wilhelm, 2006), and memory (Deckersbach et al., 2000). In the present study, we investigated whether patients with BDD exhibit deficits in a specific type of memory: reality monitoring.

Reality monitoring is the ability to distinguish in memory between things that one has imagined and things that one has perceived (Johnson & Raye, 1981). For both clinical and theoretical reasons, we hypothesized that individuals with BDD might be characterized by deficits in reality monitoring. Clinically, patients often report that they actually *appear* ugly or deformed, not just that they *feel* ugly or deformed. Individuals with BDD report frequent, intrusive, negative appearance-related images of themselves (Osman, Cooper, Hackmann, & Veale, 2004). If they also have a tendency to mistake self-generated images with percepts, they may then accept those images as evidence of their actual appearance. In other words, deficits in reality monitoring could lead the individual to mistakenly conclude that he or she is, in fact, ugly. Theoretically, reality-monitoring deficits could account for the high levels of delusionalism observed in BDD. Indeed, reality-monitoring

deficits feature prominently in cognitive models of delusion formation within other disorders (for review, see Bell, Halligan, & Ellis, 2006). Relative to healthy controls, individuals with schizophrenia demonstrate reality-monitoring deficits (for review, see Achim & Weiss, 2008). They are not only less accurate in making reality-monitoring judgments but also more confident in the accuracy of their judgments, even when incorrect (Moritz & Woodward, 2002, 2006; Moritz, Woodward, & Chen, 2006; Moritz, Woodward, & Ruff, 2003; Moritz, Woodward, Whitman, & Cuttler, 2005). Researchers argue that when individuals with delusional beliefs mistakenly attribute internally generated phenomena (e.g., thoughts or images) to external sources (e.g. voices, percepts) they may then develop unusual beliefs about the world. Therefore, if reality-monitoring deficits contribute to the development and maintenance of other delusional beliefs, it is reasonable to hypothesize that they might contribute to the development of appearance-related delusional beliefs.

For comparison, we also tested individuals with obsessive-compulsive disorder (OCD) and healthy controls. Although BDD and OCD are similar in many ways (for reviews, see Chosak et al., 2008; Phillips et al., 2007; Simeon, Hollander, Stein, Cohen, & Aronowitz, 1995) they do differ with regard to level of insight. For example, in a study comparing level of insight in patients with BDD to those with OCD, 39% of the BDD patients were delusional, whereas only 2% of the OCD patients met such criteria (Eisen, Phillips, Coles, & Rasmussen, 2004). Thus, it seemed reasonable to hypothesize that individuals with BDD might be uniquely impaired in reality monitoring. Additionally, individuals with OCD have not demonstrated impairments on previous tests of reality monitoring (e.g., McNally & Kohlbeck, 1993; for review, see Woods, Vevea, Chambless, & Bayen, 2002); rather, they are characterized by decreased confidence in all memory judgments whether correct or incorrect.

We also assessed reality-monitoring ability for four types of information: neutral stimuli, negative stimuli, BDD-related stimuli, and OCD-related stimuli. This enabled us to assess whether any observed abnormalities in performance were deficits that affected the processing of all stimuli or biases specific to the content of the material being processed. For example, it is possible that individuals with BDD exhibit a reality-monitoring impairment only when processing BDD-related information but not when processing other stimuli.

Our primary hypothesis was that individuals with BDD would exhibit impairments in reality-monitoring ability relative to the individuals with

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