



A comparison of insight in body dysmorphic disorder and obsessive–compulsive disorder

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ABSTRACT

Insight/delusional of beliefs is an important dimension of psychopathology across psychiatric disorders. This construct is of increasing interest in obsessive–compulsive and related disorders, including obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD). Even though OCD and BDD are considered closely related, no prior study has compared these disorders across a range of categories of global insight (excellent, good, fair, poor, absent/delusional), and only one study has compared these disorders on individual components of insight. Using the reliable and valid Brown Assessment of Beliefs Scale (BABS), this study examined insight/delusional of OCD- or BDD-related beliefs in 211 individuals with primary OCD versus 68 individuals with primary BDD. In both disorders, levels of insight spanned the full range, from excellent to absent (i.e., delusional beliefs). However, the distribution of BABS scores across insight categories differed significantly by disorder, with the majority of OCD subjects showing excellent or good insight, and the majority of BDD subjects showing poor or absent insight. Compared to OCD subjects, BDD subjects had significantly poorer insight both overall (total BABS score) and on all individual BABS items. BABS score was significantly correlated with BDD and OCD severity, but in regressions it accounted for only 21% of the variance in OCD and 28% in BDD. In summary, both global insight and its individual components are poorer in BDD than in OCD, which has implications for research and clinical care, as well as understanding of the relationship between these disorders. Disorder severity is associated with but not equivalent to insight/delusional.

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1. Introduction

Insight/delusional of beliefs is an important dimension of psychopathology across psychiatric disorders. This construct is important not only in psychotic disorders (Kaplan et al., 2006; Lincoln et al., 2007) but also in mood disorders (Keller et al., 2007) and eating disorders (Konstantakopoulos et al., 2011; Steinglass et al., 2007), as well as obsessive–compulsive disorder (OCD) (Eisen et al., 2001; Kozak and Foa, 1994) and related disorders like body dysmorphic disorder (BDD), a distressing or impairing

preoccupation with nonexistent or slight defects in appearance (Phillips, 2004). For example, in DSM-IV, OCD has a “poor insight” specifier, and for the upcoming DSM-5 a broader “insight specifier” is proposed for inclusion within the diagnostic criteria of OCD, BDD, and several other disorders (Feusner et al., 2010b; Leckman et al., 2010; Mataix-Cols et al., 2010; Phillips et al., 2010b). Research on insight in OCD and BDD, in particular, has increased in recent years (Aigner et al., 2005; Alonso et al., 2008; Bellino et al., 2005; Catapano et al., 2010; Mancuso et al., 2010; Matsunaga et al., 2002; Phillips et al., 2006). However, no study has compared these disorders across categories of global insight/delusional (excellent, good, fair, poor, absent/delusional), and only one study has compared them on individual components of insight/delusional (Eisen et al., 2004).

For the upcoming DSM-5, it is proposed that BDD and OCD both be categorized as obsessive–compulsive and related disorders (also

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known as obsessive–compulsive-spectrum disorders) (Hollander et al., 2005; Phillips et al., 2010a). BDD and OCD have similarities in a number of domains, such as symptoms, many aspects of treatment response, and perhaps underlying neurobiology (although data on the latter are still limited for BDD [Feusner et al., 2010a; Phillips et al., 2010b]). Furthermore, there are elevated rates of comorbidity between BDD and OCD (see Neziroglu and Khemlani-Patel, 2005 for a review) and elevated rates of BDD in first-degree relatives of individuals with OCD (Bienvenu et al., 2000, 2012).

Despite these similarities, OCD and BDD also appear to have some clinically important differences, one of which may be insight. Among obsessive–compulsive and related disorders, “insight” – also often referred to as degree of “delusional” – is often defined as a person’s conviction that their disorder-relevant belief is accurate (for example, in BDD that one looks deformed, or in OCD that the house will actually burn down if the stove is not checked 30 times). Insight is a multidimensional construct (Eisen et al., 1998; Kessler et al., 1983; Kozak and Foa, 1994), which includes components such as recognition that the belief has a psychological/psychiatric cause, and willingness to consider that the belief may be false (Amador et al., 1993; Eisen et al., 1998; Garety and Hemsley, 1987; Kessler et al., 1983). Clinical observations have suggested that BDD is characterized by poorer insight than OCD (de Leon et al., 1989; McKenna, 1984; Vitiello & de Leon, 1990). Supporting these early observations, studies that compared OCD to BDD found that patients with BDD had greater overvalued ideation (a construct similar to poor insight; McKay et al., 1997) and were more likely to receive a psychotic disorder diagnosis due to BDD- or OCD-related delusional beliefs (Phillips et al., 1998).

More recently, Eisen et al. (2004), using the reliable and valid Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998), found that patients with BDD ($n = 85$) had poorer global insight (higher total BABS score), and were more likely to have their disorder-related beliefs classified as delusional, than patients with OCD ($n = 64$). Reese et al. (2011) similarly found poorer global insight on the BABS (higher total score) in BDD ($n = 20$) than in OCD ($n = 20$). Furthermore, Eisen et al. (2004) found large between-group differences for most individual components of insight on the BABS, with BDD characterized by greater conviction that the disorder-related belief is accurate, greater certainty that other people think the belief is accurate, greater certainty that their own view is more accurate than the view of others, greater reluctance to accept the possibility that the belief is not accurate, and poorer insight into the psychological/psychiatric cause of the belief. Only two components of insight/delusional did not significantly differ between BDD and OCD (attempts to disprove the belief and ideas/delusions of reference).

In this report, we compare insight in OCD and BDD using the BABS. This report extends a prior report from a broadly ascertained sample of treated individuals with OCD or BDD in which we compared these disorders across a broad range of demographic and clinical features (Phillips et al., 2007). That report noted that BDD subjects had poorer global insight/delusional than OCD subjects (BABS total score) and that a higher proportion of BDD than OCD beliefs were classified as delusional. However, examination of insight/delusional was limited to these two items. The present report examines and compares additional aspects of insight – a range of global insight categories (i.e., excellent, good, fair, poor, delusional), components of insight, and the relationship between insight and illness severity – which were not previously reported from this sample. We hypothesized that BDD subjects would have poorer global insight across a range of insight categories as well as poorer insight across all individual components of insight. Based on our clinical experience, we hypothesized, contrary to Eisen et al.’s

(2004) prior findings, that BDD subjects would be less likely to try to disprove their belief and more likely to have disorder-related ideas or delusions of reference. Referential thinking is a prominent clinical feature of BDD (Phillips, 2004; Phillips et al., 1994), with many individuals believing that others take special notice of their perceived appearance defects in a negative way – for example, stare at, talk about, or laugh at the perceived deformities. In contrast, referential thinking is not considered typical of OCD (Kozak and Foa, 1994).

2. Methods

2.1. Subjects

Subjects were obtained from two larger samples that have previously been described (e.g., Phillips et al., 2005; Pinto et al., 2006). The sample selection process for the present report is described in Phillips et al. (2007). In brief, subjects were obtained from two very similar longitudinal studies of the course of BDD and OCD conducted at the same site (Phillips et al., 2005; Pinto et al., 2006). Although some inclusion criteria differed between the two studies, a similar subset of both samples was selected; each subset included broadly ascertained adults with a primary diagnosis of DSM-IV OCD or DSM-IV BDD who were receiving mental health treatment at the time of the intake interview. In both samples, the primary diagnosis was defined as the disorder that subjects considered their biggest problem overall across their lifetime. The selection process yielded 225 participants with primary OCD, 211 of whom were evaluated with the BABS and are therefore included in this report. The BABS was not administered to eight participants due to rater error, and it could not be administered to six others because their primary symptom was not associated with a feared consequence that involved a belief. The BDD group consisted of 70 individuals with primary BDD, 68 of whom could be evaluated with the BABS and are thus included in this report. Two subjects could not be evaluated with the BABS because they had severely damaged skin from BDD-related skin picking (thus, their belief about perceived skin defects was accurate). Thirteen of the 211 OCD participants (6.2%) had comorbid BDD, and 24 of the 68 BDD participants (35.3%) had comorbid OCD. These individuals are included in this report to increase the generalizability of the results. These subjects were not put in a separate “comorbid” group ($N = 37$) because BABS scores were available only for the primary disorder; thus, BABS scores in a separate comorbid group would be for BDD in some cases and OCD in others, making results difficult to interpret. (Because comorbid individuals are included in the primary OCD and BDD groups in this report, unlike in our prior report (Phillips et al., 2007), some aspects of these two reports slightly differ.) The most common additional current comorbid diagnoses for the OCD and BDD groups, respectively, were social phobia (17% and 34%), major depressive disorder (15% and 46%), specific phobia (13% and 16%), and panic disorder (9% and 16%). The study was performed in compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) and approved by the sites’ hospital Institutional Review Board. All participants signed statements of informed consent after procedures were fully explained.

2.2. Assessments

All data were obtained in person by experienced interviewers who were closely supervised by senior study staff. Both studies used the same careful and rigorous interviewer training and monitoring procedures (see Phillips and Stout, 2006; Pinto et al., 2006). Interviewer training included viewing and discussing

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