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Classification of body dysmorphic disorder — What is the advantage of the new DSM-5 criteria?☆

Katharina Schieber [a,*], Ines Kollei [b], Martina de Zwaan [c], Alexandra Martin [d]

[a] Department of Psychosomatic Medicine and Psychotherapy, University Hospital of Erlangen, University of Erlangen-Nuernberg, Schwabachanlage 6, 91054 Erlangen, Germany
[b] Department of Clinical Psychology and Psychotherapy, University of Erlangen-Nuernberg, Nägelsbachstr. 25a, 91052 Erlangen, Germany
[c] Department of Psychosomatic Medicine and Psychotherapy, Hannover Medical School, Carl-Neuberg-Str. 1, 30625 Hannover, Germany
[d] Department of Clinical Psychology and Psychotherapy, University of Wuppertal, Max-Horkheimer-Str. 20, 42097 Wuppertal, Germany

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ABSTRACT

Objective: In DSM-5 the diagnosis of body dysmorphic disorder (BDD) has been subjected to two important changes: Firstly, BDD has been assigned to the category of obsessive–compulsive and related disorders. Secondly, a new criterion has been defined requiring the presence of repetitive behaviors or mental acts in response to appearance concerns. The aims of this study were to report the prevalence rates of BDD based on a DSM-5 diagnosis, and to evaluate the impact of the recently introduced DSM-5 criteria for BDD by comparing the prevalence rates (DSM-5 vs. DSM-IV).
Methods: BDD-criteria (DSM-IV/DSM-5), dysmorphic concerns, and depressive symptoms, were assessed in a representative sample of the German general population (N = 2129, aged 18–65 years).
Results: The association between BDD case identification based on DSM-IV and DSM-5 was strong (Phi = .95, $p < .001$), although point prevalence of BDD according to DSM-5 was slightly lower (2.9%, n = 62 vs. 3.2%, n = 68). Approximately one third of the identified BDD (DSM-5) cases reported time-consuming behavioral acts in response to appearance concerns. In detail, 0.8% of the German general population fulfilled the BDD criteria and reported repetitive acts of at least one hour/day.
Conclusions: The revised criteria of BDD in DSM-5 do not seem to have an impact on prevalence rates. However, the recently added B-criterion reflects more precisely the clinical symptoms of BDD, and may be useful for distinguishing between various severity levels related to repetitive behaviors/mental acts.

Introduction

Body dysmorphic disorder (BDD) is characterized by a severe preoccupation with a defect in physical appearance that is objectively slight or may even be unobservable, resulting in distress and impairment in social and/or occupational functioning [1]. Two epidemiological surveys among the German general population revealed a point prevalence of 1.7–1.8% [2,3], and a prevalence rate of 2.4% was found among the general population of the United States of America [4].

BDD was first included in DSM-III as an example of an atypical somatoform disorder called "dysmorphophobia" [5]. In the course of subsequent DSM-editions, BDD was classified in the somatoform section as a self-contained disorder. In DSM-IV (and DSM-IV-TR) the BDD diagnosis was based on three criteria [6,7]: preoccupation with appearance, distress and impairment, and appearance concerns that are not better accounted for by any other mental disorder. The recently published DSM-5 has experienced two important changes concerning the classification of BDD [8]: a relocation of the diagnosis and an extension of the diagnostic criteria. In DSM-5, BDD is now classified under the new category "obsessive–compulsive and related disorders", along with obsessive–compulsive disorder, trichotillomania, hoarding disorder, and excoriation disorder. In addition, a new criterion has been defined requiring that "at some point during the course of the disorder, the person has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking), or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns" (p. 242, DSM-5 [8]). Furthermore, a specifier for muscle dysmorphia was added as well as a specifier that indicates the degree of insight regarding BDD beliefs. Apart from that, some minor revisions have been made such as more precise phrasing and changes in the wording.

The classification of BDD as a somatoform disorder has often been questioned and similarities between BDD and obsessive–compulsive disorder, social phobia, eating disorders, and affective disorders, have been discussed. Most research has focused on the relationship between

☆ The work was conducted at the Department of Psychosomatic Medicine and Psychotherapy, University Hospital of Erlangen and University of Erlangen-Nuernberg, Schwabachanlage 6, 91054 Erlangen, Germany.

* Corresponding author at: Department of Psychosomatic Medicine and Psychotherapy, University Hospital of Erlangen, University of Erlangen-Nuernberg, Schwabachanlage 6, 91054 Erlangen, Germany. Tel.: +49 8544542; fax: +49 8535952.
E-mail address: katharina.schieber@uk-erlangen.de (K. Schieber).

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BDD and obsessive–compulsive disorder, with empirical evidence underpinning the inclusion of BDD among the obsessive–compulsive and related disorders [9–13]. The high comorbidity between BDD and obsessive–compulsive disorder [10,14,15] as well as similar characteristics [16,17] such as repetitive thoughts and behaviors, an early onset and a chronic course of the disease [18,19], shared genetic factors [20], and neurobiological features [21,22], indicate that BDD and obsessive–compulsive disorder are related disorders. Because of these similarities, classification of BDD among the obsessive–compulsive and related disorders has been widely supported [9]. Nonetheless, BDD and obsessive–compulsive disorder represent distinct disorders [23–25] and therefore merit independent diagnoses.

The new DSM-5 criterion for a BDD diagnosis, which requires the presence of repetitive behaviors or mental acts (at some point during the course of the disorder), reflects the likely relatedness of BDD to obsessive–compulsive and related disorders [11] and may help to differentiate BDD from other disorders such as major depression or social phobia [11]. Furthermore, repetitive behaviors and thoughts are considered to be key aspects of the clinical picture of BDD. For example, grooming, camouflaging, and mirror checking, are common acts [15] performed by individuals with BDD, with the aim to correct, hide, or distract from perceived defective body parts. Focusing on unattractive body parts, rumination, mental rituals or other mental acts are also often reported by individuals with BDD [15,26]. They suffer from these symptoms as they are time-consuming and can last several hours or the entire day [27]. However, BDD prevalence has not yet been established using the newly added criterion requiring repetitive behaviors and cognitive processes.

Some diagnostic concepts and assessment procedures [2,28,29] suggested the use of a time-criterion to differ between degrees of BDD severity. The Structured Clinical Interview for DSM-IV [29] adds a time-requirement to BDD criterion A and specifies that preoccupation with appearance should last for at least one hour/day. The same procedure was used in a German general population survey [2]. However, the Yale-Brown Obsessive–Compulsive Scale, modified for BDD [28], proposed degrees of severity based on the average time an individual is occupied with thoughts as well as behaviors regarding appearance concerns. A proposal for BDD severity was also made during the DSM-5 development process (www.dsm5.org update nov-8-2010) including the daily amount of time spent on concerns and repetitive behaviors related to physical appearance.

However, the time-specification has not been included in the new DSM-5 classification of BDD. Furthermore, a specific cut-off value for the amount of time that an individual engages in mental acts or behaviors has also not yet been validated, so to our knowledge no evidence-based guideline exists for severity degrees in BDD.

In this study, using a large representative general population sample, we wanted to illustrate any differences that occur as a result of revisions to the criteria of BDD in DSM-5. The aims of this study were therefore, firstly, to report the prevalence rate of BDD based on DSM-5 criteria; secondly, to examine the impact of the recently introduced DSM-5 criteria. To do this we compared prevalence rates based on DSM-5 criteria with prevalence rates based on DSM-IV criteria, in order to assess whether BDD groups identified by DSM-5 and DSM-IV were comparable. We also reported DSM-5 prevalence rates of BDD according to the amount of time spent on repetitive behaviors. Furthermore, we compared individuals diagnosed with BDD according to DSM-5 with individuals without BDD, in terms of socio-demographic and clinical variables.

Methods

Design

The design of the study provides a cross-sectional survey of a representative German general population sample. With the assistance of an independent demographic consulting agency (USUMA, Berlin, Germany) a random sample of households was chosen in proportion to the population density of the region. Following this, a target subject of each household was randomly identified with the Kish selection grid. The selected sample was representative of the general German population in relation to age, gender and living area (www.destatis.de). Subjects from all over Germany were contacted from May to June in 2011 and underwent a computer assisted telephone interview. Afterwards participants completed questionnaires about symptoms of BDD, depression, and dysmorphic concerns, either online or in written form. Written informed consent was obtained from all participants. The survey was conducted in accordance with the Helsinki Declaration as revised 2008 and met the ethical guidelines of the international Code of Marketing and Social Research Practice, by the International Chamber of Commerce and the European Society for Opinion and Marketing Research.

Subjects

A total of 4212 people aged between 18 and 65 years were approached by telephone, whereof 2286 subjects (56%) agreed to participate in the survey. Of these, 157 had to be excluded from the present analysis due to missing data regarding the main assessment tool of BDD diagnosis, thereby resulting in a final sample of 2129 participants. Similar participation rates were reported by prior German general population surveys [2,3]. The mean age of the final sample was 45.3 years (SD = 13.0). Overall 54% were women, and 53.5% reported to be married, 46.6% had either graduated from high school or reached a higher educational level. Apart from a high educational level, the final sample corresponded approximately to the general German population (www.destatis.de).

Measurements

All participants completed a form to assess gender, age, family status, and level of education. Participants were also required to complete the following questionnaires:

BDD diagnosis

The assessment of BDD was based on self-report instruments previously used in epidemiologic studies [2,3,30] with adaptations allowing case definitions for BDD according to the diagnostic criteria of DSM-IV and DSM-5. As data collection started before the release of the DSM-5 the BDD DSM-5 items were based on drafts published on the website "DSM-5 Development" of the American Psychiatry Association (www.dsm5.org). Final analyses were computed according to the DSM-5 published in May 2013. Table 1 displays the items assessing current BDD criteria. To exclude the presence of an eating disorder, all subjects were screened specifically for the symptoms of anorexia nervosa and bulimia nervosa on the basis of the Eating-Disorder-Examination-Questionnaire [31]. An additional item differentiated between symptoms related to BDD and concerns about shape and body weight in the context of an eating disorder. Subjects who fulfilled the criteria for an eating disorder or reported that their perceived deficits were related to concerns about shape and weight (n = 14) were excluded from the BDD group.

To analyze the data, the sample was classified into the following diagnostic groups:

- No BDD: No agreement with the diagnostic criteria of BDD (DSM-IV/DSM-5).
- BDD (DSM-IV): Endorsement of preoccupation with flaw in appearance and presence of daily thoughts regarding appearance, agreement to distress *or* impairment while eating disorders were not present.
- BDD (DSM-5): Endorsement of preoccupation with flaw in appearance and presence of daily thoughts regarding the appearance, agreement to distress *or* impairment. The presence of daily repetitive behaviors was reported, while eating disorders were not present. In