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# Insight in body dysmorphic disorder (BDD) relative to obsessive-compulsive disorder (OCD) and psychotic disorders: Revisiting this issue in light of DSM-5

Wei Lin Toh[a,b,c,*], David J. Castle[c,d], Rachel L. Mountjoy[e,f,g], Ben Buchanan[b], John Farhall[g], Susan L. Rossell[a,b,c,d]

[a]*Centre for Mental Health, Swinburne University, Australia*
[b]*Cognitive Neuropsychiatry, Monash Alfred Psychiatry Research Centre, Alfred Hospital and Monash University School of Psychology and Psychiatry, Australia*
[c]*Departments of Psychological Sciences and Psychiatry, University of Melbourne, Australia*
[d]*Department of Psychiatry, St. Vincent's Mental Health, Australia*
[e]*Mental Health Clinical Services Unit, Austin Health, Australia*
[f]*The Melbourne Clinic, Australia*
[g]*Department of Psychology and Counselling, La Trobe University, Australia*

**Abstract**

**Introduction:** In DSM-5, body dysmorphic disorder (BDD) was reclassified under the *obsessive-compulsive and related disorders* (OCRDs), but little is known about the nature of BDD beliefs. This study aimed to compare level of insight in BDD and consider related implications for DSM-5 classification.
**Method:** Participants were 27 BDD, 19 obsessive-compulsive disorder (OCD), and 20 psychosis (SZ) participants as well as 42 non-clinical controls (NC), who completed the Brown Assessment of Beliefs Scale (BABS) and Peters Delusions Inventory (PDI).
**Results:** For total (and most individual) BABS items, BDD and SZ participants scored significantly higher than OCD and NC participants. On the PDI, there were significant group differences in number of questions endorsed, with clinical groups scoring significantly higher than the NC group on dimensions of *distress* and *preoccupation*, but not *conviction*.
**Conclusion:** These findings suggest appearance-related concerns in BDD somewhat resemble delusions seen in psychosis (and not OCD), and convey important nosological and therapeutic implications.
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## 1. Introduction

Body dysmorphic disorder (BDD) is characterised by (i) excessive preoccupation with an imagined defect in appearance, along with (ii) repetitive behaviours and/or mental acts that occur in response to the preoccupation [1]. Frequent complaints relate to perceived flaws in facial features (e.g. shape or size of nose) as well as other body parts (e.g. proportion of limbs; [2]). Afflicted individuals typically engage in elaborate avoidance strategies (e.g. camouflage with make-up) and/or repetitive safety behaviours (e.g. excessive grooming). Persons with BDD have reported markedly impaired psychosocial functioning and quality of life [3,4]. Adverse long-term outcomes include needless cosmetic procedures, acts of self-mutilation, severe social isolation, or even suicide [3,5].

### 1.1. Delusionality/insight

A prominent clinical aspect of BDD relates to the notion of delusionality or impaired insight, often used interchangeably in the literature. These distinct but related constructs are of particular interest, especially in light of recent nosological changes. A delusion refers to a ‘false belief based on incorrect inference about external reality that is firmly

* Corresponding author at: Centre for Mental Health, Swinburne University, PO Box 218, Hawthorn, VIC 3122, Australia
*E-mail address:* wtoh@swin.edu.au (W.L. Toh).

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sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary' [1]. Insight may be theorised as comprising three multidimensional facets involving (i) recognition that one has a mental illness, (ii) correct attribution of unusual mental events as pathological, and (iii) treatment adherence [6]. Focus was placed on the second facet in this study. It is important to note that insight in BDD (and other disorders) tends to vary across individuals, and even within individuals at differing time points. Furthermore, it exists along a continuum, with patients often moving along this spectrum in line with treatment status. A key distinction delineating poor insight from a true delusion is ultimately the latter's 'un-understandability', involving profound psychopathological alteration of one's reality, not amenable to logic or reasoned perception [7].

Existing research in the area has largely compared BDD to two other clinical populations, namely obsessive-compulsive disorder (OCD) and anorexia nervosa (AN). Comparative studies have reported multidimensional insight in BDD as significantly poorer relative to OCD [8,9]. From a categorical perspective, the majority of BDD participants in each of these studies was classed as exhibiting poor or absent insight, and this tended to be associated with disorder severity. Two other studies examined insight in relation to comorbidity, where insight was significantly impaired in BDD with comorbid OCD [10] as well as OCD with comorbid BDD [11], relative to individuals with a single diagnosis. In a study directly comparing body image disorders, poorer insight (using categorical and dimensional criteria) was found in BDD relative to AN, and this was associated with increased symptom severity [12]. In a separate sample of AN patients, 39% were diagnosed with comorbid BDD [13]. Relative to the rest of the AN cohort, this subset of patients had lower insight and greater overall illness severity. Despite these studies, there has been little direct comparison of how and whether (if at all) appearance-related preoccupations in BDD differ from delusions typically encountered in primary psychotic disorders, such as schizophrenia.

### *1.2. BDD in DSM-5*

In DSM-IV-TR [14], BDD was classified as a somatoform disorder, but was moved under the *obsessive-compulsive and related disorders* (OCRDs) in DSM-5 [1]. A key criterion was added, emphasising the clinical significance of repetitive behaviours and/or mental acts in BDD, akin to those observed in OCD. Double coding of its delusional variant (i.e. delusional disorder, somatic subtype; DDST), as stipulated in DSM-IV-TR [14], was also replaced by a new *absent/delusional beliefs* specifier. This latter move seemed largely prompted by several studies directly comparing delusional and nondelusional variants of BDD [15–18], where up to 60% of BDD cohorts held their beliefs with delusional conviction. There were moreover, broad similarities between the two variants, including clinical characteristics, familial history, psychosocial functioning, and pharmacotherapy response. Notable differences mainly related to BDD symptom severity and associated levels of insight. This led to the inference that these variants represent a single disorder differentiated along the spectrum of insight, with a subsequent recommendation for the insight specifier in DSM-5 [19].

Though the double-coding approach in DSM-IV-TR received considerable censure for a range of reasons [20], such as lack of consideration of the multidimensional nature of insight, criticisms of the current DSM-5 stance also exist [21]. For instance, some authors have argued that a diagnosis of DDST is a wider construct than delusional BDD, with DDST not fitting neatly within the OCRD grouping [22]. On the whole, reclassification of BDD as an OCRD in DSM-5 seems primarily justified by the shared presence of repetitive behaviours and/or mental acts in both disorders. However, this approach does not explicitly consider similarities and differences between preoccupations in BDD versus obsessions in OCD. Though both disorders may be given an *absent/delusional beliefs* specifier, up to 60% of those with BDD tend to be affected [15–18], compared with only 4% or less of those with OCD [1].

### *1.3. Aims & hypotheses*

Given BDD is frequently associated with low insight, especially relative to OCD (and its DSM-IV-TR conceptualisation allowed for a *delusional beliefs* specifier), further examination of its relationship to psychosis is warranted. On the whole, there remains a lack of convincing empirical evidence, especially with regards to phenomenological examinations of ideas/delusions of body image in BDD, supporting an outright dissociation from the psychotic disorders. The current study therefore aimed to compare level of insight in BDD with other clinical and non-clinical (NC) cohorts, as well as consider related implications for DSM-5 classification. The two clinical groups comprised participants with i) OCD, or ii) psychotic disorders (SZ; i.e. schizophrenia or schizoaffective disorder). Delusionality and insight were assessed using both the Brown Assessment of Beliefs Scale (BABS) and Peters Delusions Inventory (PDI).

Accordingly, two sets of opposing hypotheses were put forward. In support of the DSM-5 nosology, it was hypothesised that: i) On the BABS, the BDD and OCD groups would perform at similar levels, but would be significantly less impaired that the SZ group, and significantly more impaired than the NC group (i.e. SZ > BDD = OCD > NC). On the PDI, the BDD and OCD groups would perform at similar levels to each other and the NC group, but would be significantly less impaired that the SZ group (i.e. SZ > BDD = OCD = NC). In support of the DSM-IV-TR nosology, it was hypothesised that: ii) On the BABS, the BDD and SZ groups would perform at similar levels, but would be significantly more impaired than the

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