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Occupational functioning and impairment in adults with body dysmorphic disorder

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Abstract

Objective: Body dysmorphic disorder (BDD) is relatively common and appears to be associated with marked impairment in psychosocial functioning. Previous reports, however, did not investigate occupational functioning in detail, assess impairment specifically in occupational functioning using standardized measures in a nontreatment seeking sample, or examine correlates of occupational impairment.
Methods: Occupational functioning and other clinical variables were assessed in 141 adults with BDD. Measures included the Range of Impaired Functioning Tool and other reliable and valid self-report and interviewer-administered measures.
Results: Fewer than half of subjects were working full-time, and 22.7% were receiving disability pay. Thirty-nine percent of the sample reported not working in the past month because of psychopathology. Of those subjects who worked in the past month, 79.7% reported impairment in work functioning because of psychopathology. Adults with BDD who were not working because of psychopathology were comparable to subjects who were working in most demographic variables, delusionality of BDD beliefs, and duration of BDD. However, compared to subjects who worked in the past month, those not currently working because of psychopathology had more severe BDD and more chronic BDD. They also were more likely to be male, had less education, and had more severe depressive symptoms, a higher rate of certain comorbid disorders, poorer current social functioning and quality of life, a higher rate of lifetime suicidality, and were more likely to have been psychiatrically hospitalized.
Conclusions: A high proportion of individuals with BDD were unable to work because of psychopathology; most who worked reported impairment in occupational functioning. Certain clinical variables, including more severe and chronic BDD, were associated with not working.

1. Introduction

Body dysmorphic disorder (BDD) is defined in the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV) as a distressing or impairing preoccupation with an imagined or slight defect in appearance. This disorder appears to be relatively common, with a reported prevalence of 0.7% to 1.7% in community or general population samples [1-4]. Body dysmorphic disorder is associated with high lifetime rates of psychiatric hospitalization, suicidal ideation and suicide attempts, and markedly poor social functioning and quality of life [5-10]. Impairment in occupational functioning also appears common. In a study of 188 subjects with BDD from the United States, 38% were currently unemployed, and 77% reported that their BDD symptoms had interfered moderately, severely, or extremely with occupational, academic, or role functioning over the course of their illness [7]. In a study from England [8], 50% of 50 subjects with BDD were currently unemployed; in 2 studies from Italy, 53% of 58 subjects with BDD and 47% of 34 subjects with BDD were currently unemployed [11,12]; and in a study from Brazil, 85% of 20 subjects with BDD were currently unemployed [13]. Despite these unemployment rates and indications of occupational impairment, these studies did not specifically assess problems in occupational functioning using standardized measures that examine this domain specifically, nor did they examine correlates of occupational impairment.

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There are only limited data on occupational functioning in BDD using standard measures. Several studies reported poor global functioning on the Global Assessment of Functioning Scale (GAF), the Social and Occupational Functioning Assessment Scale (SOFAS), and the Schneier Disability Profile [14]; these measures incorporate occupational functioning but do not report on this domain specifically. Scores on these measures suggest moderate functional impairment [15-18]. Several studies reported specifically on the Medical Outcomes Study 36-item Short-Form Health Survey (SF-36) role-emotional domain [19], which assesses problems with work or other daily activities as a result of emotional problems. Scores for BDD patients (n = 62) were 1.62 SD units poorer than published US population norms [6]. In 3 BDD pharmacotherapy studies (n = 15, n = 15, and n = 60), SF-36 role-emotional scores were 1.47 SD units, 2.12 SD units, and 1.58 SD units poorer than US population norms, respectively [16,18,20]. These studies are limited, however, by relatively small samples and by assessment of functioning in individuals who sought consultation or treatment in a BDD specialty setting or who participated in pharmacotherapy trials, which may limit the generalizability of the findings. In addition, little is known about the characteristics of individuals with BDD who do not work and correlates of occupational impairment.

It is important to assess functional impairment [21], as functional impairment may warrant interventions and research efforts that differ from those needed for psychiatric symptoms [21,22]. Furthermore, occupational impairment—including days missed from work, unemployment, and consequences such as collection of disability pay—may have serious economic consequences [23].

The present report has several aims. We previously reported that a high proportion of the present sample was unemployed, was not working because of psychopathology, and had poor scores on several quality of life measures, including work-related subscales [5]. However, our previous report did not examine occupational status and functioning in further detail, and it did not examine clinical correlates of not working because of psychopathology. Therefore, the aim of the present report is to (1) further examine occupational status and functioning in a more broadly ascertained sample of adults with BDD and (2) examine clinical correlates of being unable to work because of psychopathology in this sample. On the basis of variables associated with occupational impairment in depressive and anxiety disorders [24-26], we hypothesized that subjects who were not currently working because of psychopathology would have more severe depressive symptoms. On the basis of our clinical impressions, we also predicted that subjects not currently working because of psychopathology would have greater lifetime impairment because of BDD symptoms specifically.

The present study expands upon earlier studies of impairment in individuals with BDD in that it is the first study to focus on work impairment in a broadly ascertained BDD sample. Previous studies have been conducted with patients seeking clinical consultation or treatment at a BDD specialty clinic, or in patients participating in pharmacotherapy efficacy studies, which may limit the generalizability of the findings. Our subjects were broadly ascertained, and one third was receiving no mental health treatment at all. This study also assessed occupational functioning and impairment with standardized measures. To our knowledge, no previous studies have examined clinical correlates of not working because of psychopathology in individuals with BDD. Furthermore, this is the first study to specifically examine the above hypotheses related to occupational impairment and functioning in BDD.

2. Methods

2.1. Subjects

Subjects were 141 adults age 21 and older who currently met full criteria for DSM-IV BDD and were participating in an observational study of the course of BDD (68.8% female; mean age, 36.1 ± 10.9 years). Adolescents (≤20 years) were excluded from this report because its primary focus is on impairment in occupational functioning, and adolescents were not expected to be employed. This report includes data only from the study's intake (baseline) assessment. Study inclusion criteria were current DSM-IV BDD or its delusional variant (delusional disorder, somatic type), age 12 or older, and ability to be interviewed in person and provide a valid interview. The only exclusion criterion was an organic mental disorder (eg, delirium), although no potential subjects were actually excluded for this reason.

Subjects were recruited from a wide variety of sources. Referrals from mental health professionals and other physicians yielded 48.9% of the sample, and advertisements (eg, radio, newspaper) generated 47.5% of the sample. The remaining 3.5% of participants came from other sources that included friends, family members, and self-referrals. All subjects were compensated $50 for the intake interview. Skin (78.7%), hair (61.7%), and nose (41.1%) concerns were the 3 most common body areas of concern. A more comprehensive description of our sample's body areas of concern and other phenomenologic features (eg, associated compulsive behaviors) has been reported elsewhere [27]. Two thirds (66.7%) of the sample were receiving mental health treatment at the time of their intake interview (61.7% outpatient; 5.0% inpatient, partial hospital, or residential). We did not collect data on how many subjects were currently receiving treatment for BDD specifically; however, 81.0% of the sample in this report considered BDD their most problematic disorder currently. Most subjects (93.8%) had received mental health treatment for any reason in their lifetime. The study was