

Insight in Body Dysmorphic Disorder with and Without Comorbid Obsessive-Compulsive Disorder

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ABSTRACT

Introduction: The aim of this study was to compare the level of insight in patients with body dysmorphic disorder (BDD) with and without comorbid obsessive-compulsive disorder (OCD), and to measure its possible relationships with clinical features.

Methods: Thirty outpatients affected by BDD, according to *Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition* criteria, of whom 18 were also suffering from OCD, were included in the study. Clinical assessment was carried out by means of the Yale-Brown Obsessive-Compulsive Scale modified for BDD and a specially designed OCD Questionnaire. The level of insight was measured by means of the score at item 11 of the Yale-Brown Obsessive-Compulsive Scale modified for BDD.

Results: The insight resulted to be excellent in four cases, good in four, fair in five, poor in 15 and absent in two. Significant and positive correlations were observed between the level

FOCUS POINTS

- The relationship between body dysmorphic disorder (BDD) and obsessive-compulsive disorder (OCD) is complex, in particular the impact on insight.
- The analysis of the different levels of insight in BDD patients with and without comorbid OCD may be helpful.
- BDD patients with comorbid OCD are characterized by a lower degree of insight than those with OCD only.
- This may suggest that the OCD comorbidity may influence the level of insight in the sense that it seems to worsen the overall clinical picture with a shift toward the psychotic end of the spectrum.

of insight and the following items: resistance to thoughts and to activities as well as to time spent on activities and control on activities related to the defect. The insight was significantly lower in patients affected by both BDD and OCD.

Conclusion: The findings indicate that the majority of BDD patients in this study, and especially

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those with comorbid OCD, have a low degree of insight that is significantly correlated to symptoms specific of the disorder.

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INTRODUCTION

Body dysmorphic disorder (BDD), already known as “dysmorphophobia” for more than a century, only recently has been recognized as an autonomous disorder by international classification systems. It is defined in the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV)*¹ as the preoccupation with an imagined or minimal defect in appearance. Patients may focus on either single or multiple aspects of their body image and their complaint is often specific and only sometimes described in a vague way difficult to understand. Common associated features include ideas or delusions of reference and repetitive behaviors such as mirror checking, skin picking, persistent requests for reassurance about the supposed defect, and attempts to camouflage it with make-up and clothing. The disorder provokes significant impairment in occupational and social functioning due to onset during adolescence and its chronic course² and may be severe enough to require psychiatric hospitalization or to induce suicidal acts.^{3,4}

BDD preoccupations resemble obsessions in that they are persistent thoughts difficult to resist or control. In addition, repetitive behaviors, such as mirror checking are similar to compulsions. Nearly a century ago, Janet⁵ underlined these characteristics and classified BDD symptoms within a class of syndromes similar to obsessive-compulsive disorder (OCD), a concept widely accepted even currently, since BDD is often considered to belong to the so-called obsessive-compulsive spectrum disorders.⁶⁻⁸

In the past, the term “dysmorphophobia” has been used to describe a preoccupation of delusional intensity and, therefore, it would suggest a psychotic component to the disorder.^{9,10}; subsequently, although researchers^{1,12} noted that dysmorphophobia may be alternatively expressed as an obsession, an overvalued idea or a clear delusion,¹ recent diagnostic criteria maintain the dichotomy between non-psychotic and psychotic thinking: in particular, *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised*¹³ distinguishes BDD from the delusional disorder, somatic type. Subsequent studies¹⁴⁻¹⁸

have reported that BDD and its delusional variant do not differ significantly in terms of most variables and suggested that these two diagnostic entities may actually be the same disorder, the psychotic variant representing a more severe form. Most of the available observations, therefore, would indicate that the degree of insight may indeed fluctuate over time in the same patient, while ranging between “good” and “absent”.

The issues of delusional versus non-delusional thinking and their relationships are present in other disorders (ie, a delusional subtype for OCD has been recognized).^{19,20} On this basis, it has been hypothesized that OCD may be also located along the insight/no insight dimension: this notion has been accepted by *DSM-IV*¹ that recognizes the existence of the so-called “OCD with poor insight” for individuals who do not realize for most of the time that obsessions and compulsions are excessive or unreasonable.

Although different observations have highlighted the relationships between BDD and OCD,^{6,19,21} it is still unclear whether the co-occurrence of the two disorders may or may not have an impact at clinical level, particularly on insight.

The aim of the present study was to explore the possible relationships between clinical features and different degrees of insight in a group of patients suffering from BDD, as well as the possible differences between patients with or without comorbid OCD.

METHODS

Thirty patients with a *DSM-IV*¹ diagnosis of BDD, consecutively recruited at the out-patient unit of the Department of Psychiatry, Neurobiology, Pharmacology and Biotechnology in the Section of Psychiatry at the University of Pisa in Italy, were included in the study. Diagnoses were made by psychiatrists with at least 10 years’ clinical experience and supervised by senior psychiatrists. The primary selection criterion was a diagnosis of BDD at the Structured Clinical Interview for *DSM-IV*- Patient Version.²² The clinical assessment was carried out by means of the Yale-Brown Obsessive-Compulsive Scale modified for BDD (BDD-YBOCS),²³ an 18-items scale that permits assessment and measure of the presence and severity of symptoms specific of the disorder (the total score ranges between 0 and 48, with a cut-off of 16) and the OCD-Questionnaire,²⁴ a semi-structured in-depth interview, which collates relevant demographic

data, family history, psychopathological features (symptoms checklist), course of the illness and lifetime and intra-episodic comorbidity. The level of insight was evaluated by means of the score on item 11 of the BDD-YBOCS.

Most patients were drug-free: three were taking benzodiazepines, one had been treated previously with haloperidol by his physician, and two had undergone supportive psychotherapy.

This study was approved by the Ethics Committee at the University of Pisa and informed written consent was obtained by all patients.

Statistical Analysis

For categorical variables, the χ^2 values were used, comparing the number of observed events with those expected. For continuous variables, summary statistics (mean, standard deviation) were applied, while the correlations between demographic, clinical features, and level of insight were assessed using Pearson's analysis, all with personal computer programs, using the SPSS, version 4.0.²⁵

RESULTS

Twenty-five (83%) of the 30 participants, were male and 5 (17%) were female. The mean age was 24 ± 6 years (range: 15–40), the age at onset was 17 ± 3 years (range: 12–25), and the duration of illness was 8 ± 3 years (range: 1–20). Twelve (40%) patients had completed primary school, 16 (53%) had completed high school, and two (7%) had a doctorate degree. With regards to patients' occupation, 11 (37%) were white collar workers, 11 (37%) were unemployed, seven (23%) were students and one (3%) was a specialized worker.

The BDD-YBOCS total score of the whole sample was 30 ± 7 . Therefore, the symptoms of the disorder ranged between "moderate" and "severe". The score on BDD-YBOCS was 0 (excellent) in four (13%) patients, 1 (good) in four (13%), 2 (fair) in five (17%), 3 (poor) in 15 (50%), and 4 (absent) in two (17%) patients.

Statistically significant and positive correlations were observed between the level of insight and resistance to thoughts related to the defect ($r=0.4$, $P=.02$), time spent in activities related to the defect ($r=0.4$, $P=.004$), resistance to activities related to the defect ($r=0.5$, $P=.007$), control on activities related to the defect ($r=0.4$, $P=.04$); this means that the higher the score on the BDD-YBOCS, that is the poorer the insight, the more severe these symptoms.

Eighteen patients (60%) out of 30 were also affected by OCD. The YBOCS total score was 29 ± 6 . Apart from somatic obsessions present in the whole sample, the main obsessions were those of order/symmetry (47%), aggression and sex (both 23%), and contamination (20%). The most frequent compulsions were those of washing and ordering (both 30%) and those of checking and somatic (both 27%).

No difference between patients with and without OCD was observed in terms of age, sex, age at onset, duration of illness, or symptom severity. However, the degree of insight was poorer in the patients with OCD ($P<.0001$). The score on item 11 of the BDD-YBOCS in these patients was 2 (fair) in three (17%), 3 (poor) in 13 (72%), and 4 (absent) in two (11%) (Table).

DISCUSSION

The present study compared the degree of insight in a group of 30 patients affected by BDD with and without comorbid OCD and explored the possible correlations with clinical features; however, it presents a number of limitations. Its main bias is the small sample size that might affect the possibility of detecting important differences between the groups. However, compared with available studies,^{17,26,27} it was carried out in rather homogenous patients, all within a limited age range and similar age at onset. In addition, our sample was rather atypical in terms of gender distribution, because it was constituted mainly of male subjects (83%), while BDD seems about equally common in men and women or some-

TABLE.
BDD-YBOCS Score on Item 11 in BDD Patients with and Without Comorbid OCD

<i>Score</i>	<i>BDD</i>	<i>BDD+OCD</i>
0 (excellent)	4	0
1 (good)	4	0
2 (fair)	2	3
3 (poor)	2	13
4 (absent)	0	2

BDD-YBOCS=Yale-Brown Obsessive-Compulsive Scale modified for body dysmorphic disorder; BDD=body dysmorphic disorder; OCD=obsessive-compulsive disorder.

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what more common in women.^{20,29} Furthermore, our patients had a low educational level, a feature that, according to some studies,¹⁸ may be related to delusional BDD. Finally, the insight was measured only by item 11 of the BDD-YBOCS.

The majority of our patients had a score of 3 (poor) or 4 (absent) on item 11 of the BDD-YBOCS and felt that they had little or no control over the thoughts about their supposed defect. This is in agreement with previous reports underlining that subjects with BDD tend to have poor insight.^{9,18} Nevertheless, none of the patients had ever shown overt psychotic symptoms, such as hallucinations or delusions, in line with other studies, indicating that classical schizophrenic symptoms may be usually absent in BDD.^{3,6,31,32}

The concept that BDD may be a variant of schizophrenia is really challenged by the wide use of the diagnosis of "schizophrenia" in the past in the presence of even isolated psychotic symptoms. In fact, while reviewing most of the studies on this topic,^{9,33-35} it clearly emerges that the analyzed samples included patients who might now receive a diagnosis of OCD, mood, or multiple anxiety disorders. In addition, it is now well-recognized that in BDD patients the certainty of the defect may change over time, impair the awareness of the illness and fluctuate at the border between non-delusional and delusional thinking.³⁶

No difference between patients affected by BDD and those affected also by OCD was observed in terms of sex distribution, age, age of onset, course, clinical characteristics: this might suggest that the two disorders may be strongly related, but not identical, as already reported.^{4,21,37-39}

Previously, Marazziti and colleagues⁴⁰ found that a sample of OCD patients showed no correlation between degree of insight and clinical features. On the contrary, in the BDD patients included in the present study, the level of insight resulted to be significantly linked to symptoms specific of the disorder, such as resistance to thoughts related to the defect, time spent in activities related to the defect, and resistance to activities related to the defect. This is in line with the results of another study⁴¹ investigating the characteristics of a BDD in a large sample of OCD patients and concluding that poor insight is associated with more severe BDD symptoms.

Moreover, our patients affected by both OCD and BDD presented a significantly lower level of insight than the patients suffering from BDD only. This could suggest that the OCD comorbidity may

influence the level of insight in the sense that it seems to worsen the overall clinical picture with a shift toward the psychotic side.^{10,37,41}

CONCLUSION

Based on the findings of this study, our opinion is that insight may indeed be considered a primary dimension that may vary by different degrees and fluctuate over time, as already proposed.^{20,36,43} However, as most of the patients in this study were male and the obsessions they reported were not the most common, future studies should ascertain whether these findings can be generalized to more typical patients as well as to women. **CNS**

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