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Brief report

The prevalence of body dysmorphic disorder and its clinical correlates in a VA primary care behavioral health clinic

Megan M. Kelly [a,b,c,*], Jinxin Zhang [a,d], Katharine A. Phillips [b,e]

[a] Psychology Service, Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA, USA
[b] Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, Providence, RI, USA
[c] Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA, USA
[d] Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, FL, USA
[e] Rhode Island Hospital, Providence, RI, USA

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ABSTRACT

We examined the prevalence of body dysmorphic disorder (BDD) in a Veterans Affairs (VA) primary care behavioral health clinic. Of 100 Veterans, 11% (95% CI=6.3–18.6%) had current BDD and 12% (95% CI=7.0–19.8%) had lifetime BDD. However, only 8.3% of these Veterans had been diagnosed with BDD. BDD was significantly associated with a substantially elevated rate of suicide attempts, major depression, and obsessive–compulsive disorder. This severe disorder appears to be underdiagnosed in VA settings.

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1. Introduction

Body dysmorphic disorder (BDD) is a severe disorder characterized by distressing or impairing preoccupations with nonexistent or slight defects in one's physical appearance. BDD is also characterized by repetitive behaviors in response to the appearance concerns (e.g., mirror checking, excessive grooming; American Psychiatric Association, 2013). BDD is common, with a prevalence of 1.7–2.4% in nationwide population-based surveys (Rief et al., 2006; Koran et al., 2008; Buhlmann et al., 2010). BDD is also relatively common in various outpatient mental health settings, including among patients with obsessive–compulsive disorder (OCD), social anxiety disorder, and atypical major depressive disorder (MDD; Kelly and Phillips, 2011). Among psychiatric inpatients, 13–16% have BDD (Grant et al., 2001; Conroy et al., 2008), which is more common than many other disorders, including schizophrenia and bipolar disorder (Grant et al., 2001).

A high proportion of individuals with BDD have been psychiatrically hospitalized (48%), often primarily because of BDD. In addition, a high proportion of individuals with BDD have experienced suicidal ideation (78–81%) and attempted suicide (24–28%; Veale et al., 1996; Phillips and Diaz, 1997; Phillips, 2007). BDD is usually associated with substantial impairment across work and social domains (Didie et al., 2008; Phillips, 2009). Despite its severity and prevalence, BDD is usually not diagnosed by clinicians (Grant et al., 2001; Conroy et al., 2008). In two studies of BDD's prevalence in inpatients, only 0–0.6% of patients spontaneously revealed their BDD symptoms to their providers (Grant et al., 2001; Conroy et al., 2008).

Although there have been several studies of BDD's prevalence in community and mental health samples, BDD's prevalence and clinical correlates have never been evaluated in a Veteran population. There are key differences between Veterans and individuals in the general population, including the predominance of men receiving services, a greater prevalence of some psychiatric conditions (e.g., posttraumatic stress disorder, substance use disorders; depression; Hankin et al., 1999; Eisen et al., 2004; Seal et al., 2007; Williams et al., 2013; Wisco et al., 2014), and a higher prevalence of suicide (Blow et al., 2007; McCarthy et al., 2009). Given the high frequency of depression and substance use disorders in Veterans (Hankin et al., 1999; Eisen et al., 2004; Williams et al., 2013), and the high prevalence of these disorders in BDD as well (Gunstad and Phillips, 2003; Phillips et al., 2005), Veterans may also be at higher risk of BDD. Furthermore, given the high prevalence of suicidality in both Veterans and individuals with BDD, it is important to understand whether Veterans with BDD are at increased risk for suicide. In addition, since BDD is often underdiagnosed (Grant et al., 2001; Conroy et al., 2008), and often mistakenly considered by clinicians to be much more prevalent in women than in men, it is unclear how often BDD is diagnosed in a VA psychiatric setting. Finally, information on the specific clinical

* Correspondance to: Edith Nourse Rogers Memorial Veterans Hospital, Psychology Service, 116B, 200 Springs Road, Bedford, MA 01730. Tel.: +1 781 687 3317; fax: +1 781 687 3228.
E-mail address: Megan.Kelly@umassmed.edu (M.M. Kelly).

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correlates of BDD in Veterans would be important to gather in order to develop and tailor services for Veterans with BDD.

The Veterans Health Administration is the largest provider of health care services in the United States, serving an estimated 8.8 million individuals, with 152 medical centers and 1700 sites of care (U.S. Department of Veterans Affairs, 2013). Veterans Affairs (VA) medical centers provide health care services to Veterans of the United States military, including medical, surgical, and quality of life needs. An evaluation of BDD in Veterans seeking services in a VA mental health setting, such as a VA primary care behavioral health clinic, could provide important information on the prevalence, diagnosis, and clinical correlates of BDD for Veterans who are potentially at higher risk of having BDD.

This study's objectives were to (1) examine the prevalence of BDD in a VA primary care behavioral health clinic, and (2) examine the characteristics and clinical correlates of BDD in Veterans (e.g., suicidality, comorbidity, types of body image concerns). It was expected that BDD would be highly prevalent in Veterans presenting to a VA primary care behavioral health clinic, but be underdiagnosed. It was also expected that mental health disorders that are generally common in BDD would also be common for Veterans with BDD [e.g., major depressive disorder (MDD), OCD]. Finally, given the higher rates of suicidality in Veterans and in individuals with BDD, it was expected that suicidality would be particularly elevated in Veterans with BDD compared to those without BDD.

2. Methods

2.1. Participants

Participants were 100 consecutive Veterans (6 women, 94 men; mean age = 54.0 ± 11.0 years) who completed a mental health evaluation in a primary care behavioral health clinic at a VA medical center between 8/2009 and 6/2011. This setting specializes in brief mental health treatment and treatment of health behaviors (e.g., chronic pain, tobacco cessation, weight management) in a primary care setting, as well as triage to other mental health services in the VA system. All Veterans were screened for BDD as part of a routine initial mental health evaluation. There were no exclusion criteria. No Veterans declined to answer questions about BDD as part of their mental health evaluation.

2.2. Measures

The *Body Dysmorphic Disorder Questionnaire* (BDD-Q) is a brief four-item self-report screening measure for DSM-IV BDD (Phillips, 2005). The BDD-Q asks individuals if they worry about their appearance and wished they worried about it less, and to list body areas with which they are excessively concerned. Individuals who respond affirmatively to these questions are then asked whether their appearance concerns are primarily due to weight concerns, and whether appearance concerns cause significant distress, interfere with relationships and activities, or cause them to avoid situations or activities. The BDD-Q also asks individuals how much time they spend thinking about their appearance each day. In order to screen positive for BDD, individuals with BDD had to indicate that (1) they worried about their appearance, (2) their main concerns were not related to weight, (3) appearance concerns caused either significant distress, interference in social or occupational functioning, or significant avoidance, and (4) and the individual thought about appearance concerns for one or more hours each day. The BDD-Q has a sensitivity of 100% in psychiatric inpatient and partial hospital settings, and a specificity of 89–93% (Phillips et al., 1995; Phillips et al., 2000; Grant et al., 2001).

The *Structured Clinical Interview for DSM-IV Patient Version* (SCID-I/P; First et al., 1995, 1996) module for BDD is a semi-structured instrument that was used as a follow-up clinical interview to diagnose BDD.

A *Defect Rating Scale* is a one-item clinician-rated measure used to determine whether the person's perceived appearance concerns were imagined or minimal per DSM-IV criteria (1 = *none*; 2 = *minimally/slight*; 3 = *present/clearly noticeable at conversational distance*; 4 = *moderately severe*; 5 = *severe*). All Veterans had to have been rated as a 1 or 2 in order to meet DSM-IV criteria for BDD. The defect rating scale has high inter-rater reliability (Phillips et al., 2000).

The *Global Assessment of Functioning Scale* (GAF; First et al., 1996) is an interviewer-rated, 100-point scale used by mental health clinicians to rate an individual's overall functioning (including psychological, social, and occupational functioning). Lower GAF scores indicate poorer functioning and greater symptom severity.

2.3. Procedures

Veterans were screened for BDD using the BDD-Q during their mental health evaluation in the clinic. If Veterans had a positive BDD screen, the BDD diagnosis was confirmed with the SCID-I/P BDD module by trained psychology postdoctoral fellows and a staff psychologist. A chart review of Veterans' medical records gathered information on whether BDD was listed as a mental health problem and obtained information on age, gender, race, marital status, psychiatric diagnoses, GAF score, history of suicidal ideation and suicide attempts, and history of psychiatric hospitalizations. The hospital Institutional Review Board approved the study.

2.4. Statistical analyses

Analyses included the proportion of outpatients who met DSM-IV criteria for current and lifetime (past or current) BDD, and a comparison of demographic and clinical correlates for Veterans with and without a diagnosis of BDD, using *t*-tests for continuous variables and Fisher's exact test for categorical variables. All tests were two-tailed with a $p < 0.05$. We calculated effect sizes for comparisons, including Cohen's d for continuous measures and odds ratios for categorical variables.

3. Results

Of all 100 Veterans who were screened on the BDD-Q, 13 initially screened positive. After the SCID interview, 12% of screened Veterans (12/100; 2 women, 10 men; 95% CI = 7.0–19.8%) had a lifetime diagnosis of BDD, and 11% (11/100; 2 women, 9 men; 95% CI = 6.3–18.6%) had a current diagnosis of BDD. For the one positive screen that did not meet BDD criteria, the Veteran had appearance concerns that were above the threshold on the defect rating scale.

For the 12 Veterans who had lifetime BDD, the most common body area of concern was skin (33.3%) (e.g., scarring, blemishes), followed by body build/muscularity (25.0%), teeth (16.7%), eyes (16.7%), nose, (16.7%), hair (16.7%), stomach (8.3%), height (8.3%), fingers (8.3%), and genitals (8.3%). The mean number of body areas of concern per participant was 1.6. Only 8.3% (1/12) of participants with lifetime BDD had the BDD diagnosis documented in their medical record.

Among those with lifetime BDD, 100% were significantly distressed by their perceived appearance defects as rated by the BDD-Q. Similarly, as rated on the BDD-Q, BDD symptoms significantly interfered with social activities for 83.3%, significantly interfered with work activities for 47.1%, and led to avoidance of activities for 91.7%. Among Veterans with BDD, 58.3% spent 1–3 h each day thinking about their appearance concerns, and 41.7% spent more than 3 h each day thinking about their appearance.

Veterans with BDD were more likely to be non-Caucasian than Veterans without BDD; there were no other differences in demographic variables (see Table 1). Among Veterans with BDD, 58.3% had attempted suicide, a markedly higher rate than for Veterans without lifetime BDD (19.3%) (OR = 8.8; p = 0.007). Veterans with lifetime BDD also had higher lifetime rates of suicidal ideation and psychiatric hospitalization than Veterans without BDD, although these differences were not statistically significant. In addition, Veterans with lifetime BDD were significantly more likely to have lifetime MDD, any mood disorder, and OCD than Veterans without BDD.

4. Discussion

These preliminary results suggest that BDD is a prevalent diagnosis in a VA primary care behavior health setting but is underdiagnosed, as has been found in other health care settings (e.g., Grant et al., 2001; Conroy et al., 2008). Contrary to popular belief, Veterans do not appear to be at any lesser risk of developing

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