



Insight impairment in body image disorders: Delusionality and overvalued ideas in anorexia nervosa versus body dysmorphic disorder

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ABSTRACT

The two body image disorders anorexia nervosa (AN) and body dysmorphic disorder (BDD) share many similarities. Delusionality in BDD has recently gained increased attention, as the new DSM-5 criteria for BDD include an insight specifier. However, delusionality in AN has rarely been examined. We evaluated the delusionality of appearance-related beliefs in AN ($n=19$) vs. BDD ($n=22$) via structured interview. Participants also completed measures of disorder-specific psychopathology and body image. Compared to those with AN, individuals with BDD exhibited significantly greater delusionality on a dimensional scale ($p=0.0014$, $d=1.07$), and were more likely to meet dichotomous criteria for delusional beliefs ($p=0.021$, $V=0.36$). In AN, delusionality was associated specifically with shape concerns and drive for thinness; in BDD, delusionality was related to the severity of BDD symptoms (all $p < 0.05$). Delusionality of appearance beliefs is present in individuals with AN, but is less pronounced than in BDD. Nevertheless, as high delusionality might predict poor treatment outcome in AN, treatment strategies that were originally developed to address delusionality in BDD might be modified for AN.

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1. Introduction

Both anorexia nervosa (AN) and body dysmorphic disorder (BDD) are characterized by severe body image concerns (Hrabosky et al., 2009), which, in turn are associated with other behaviors characteristic of the respective disorder such as fixing (dieting, purging [AN] vs. applying make-up, surgical procedures [BDD]), checking (the mirror or by pinching oneself), and avoidance (wearing wide clothing, not going to the beach or not leaving the house) (for an overview see Buhlmann and Winter, 2011; Kachani et al., 2013). While individuals with BDD may have appearance concerns with regard to their face, skin or other specific body areas, individuals with AN typically think that they or parts of their body are too fat despite being dangerously underweight. The level of delusionality of these appearance-related beliefs in BDD has been shown to positively predict symptom severity and suicidal ideation (Phillips et al., 2005). Therefore, the DSM-5 Obsessive-Compulsive and Related Disorders Work Group added an insight specifier to characterize the delusionality of such beliefs in BDD (Phillips et al., 2012). Recent research indicates that appearance beliefs in AN are often delusional as well (Konstantakopoulos et al., 2012). No previous study has directly compared the degree of

delusionality in BDD vs. AN. Such comparisons might help to better understand similarities and differences between the two disorders. This in turn might inform classification, treatment, and research.

Insight seems to be a key aspect of various disorders, i.e., AN (Konstantakopoulos et al., 2012), psychosis (McCormack et al., 2013), and BDD (Phillips and Hollander, 2008). Insight is thought to be a dimensional (rather than categorical) construct, ranging from more general insight into having a disorder at all, to a more disorder-specific belief (e.g., body image beliefs in AN and BDD). Delusionality of body image beliefs can also be viewed dimensionally – ranging from completely delusional, to having overvalued ideas (“unreasonable and sustained beliefs that are maintained with less than delusional intensity”), to being completely insightful.

The specific types of delusionality observed in each psychiatric disorder may be outward manifestations of more general deficits in theory of mind (ToM), emotion recognition, or metacognitive functioning. A recent literature review confirmed deficits in emotion regulation and other cognitive abilities, in particular executive functions, in both disorders (Hartmann et al., 2013), and ToM deficits in AN. ToM studies in BDD have not yet been conducted. In addition, research showed that metacognitive abilities (i.e., the person's awareness of her/his cognitive abilities) might be a moderator between poor cognitive abilities and insight (Arbel et al., in press). Again, comparable studies in BDD are lacking.

In BDD, about one third of individuals report delusional beliefs, and are thus convinced that their perception of their appearance flaws is accurate (Phillips and Hollander, 2008). Up to 73% of

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individuals with BDD also show ideas/delusions of reference; that is, they are certain that people take special notice of them because of these perceived flaws (Phillips et al., 1993). In DSM-IV-TR, delusional BDD was either diagnosed as a delusional disorder of the somatic type or as a comorbid diagnosis of both BDD and delusional disorder (APA, 2000). However, studies suggest that delusional and non-delusional variants of BDD differ in degree rather than in kind, and share more similarities than differences with regard to demographics, phenomenology, course, comorbidity, and treatment response (McElroy et al., 1993; Phillips et al., 1994; Mancuso et al., 2010). Indeed, available data suggest that the delusional variant may simply be associated with greater BDD-symptom severity and impairment (Phillips et al., 1993, 1994, 2006; Mancuso et al., 2010). Therefore, as Phillips et al. (2010) proposed, DSM-5 BDD now includes an insight specifier that characterizes accompanying appearance beliefs on a continuum of good insight to delusionality (APA, 2013).

Much less is known about the delusionality of appearance beliefs in AN. Steinglass et al. (2007) identified 24% of individuals with AN as having delusional body image beliefs using the Brown Assessment of Beliefs Scale (BABS; Eisen et al., 1998), which measures both delusionality of appearance-related beliefs and ideas/delusions of reference. In a more recent study using the BABS, 29% of participants with AN reported delusional body image beliefs. Of note, only 6% of participants with binge/purge-type AN held delusional beliefs, compared to nearly half (46%) of those with restrictive-type AN (Steinglass et al., 2007; Konstantakopoulos et al., 2011). Furthermore, Steinglass and colleagues found no significant correlations with more general measures of AN severity such as body mass index (BMI), lowest lifetime BMI, and duration of illness. Similarly, one of Konstantakopoulos' studies found that delusionality was associated with body dissatisfaction, but not with BMI (Konstantakopoulos et al., 2012). In line with research in BDD, preliminary results also suggest that delusionality in AN occurs along a continuum ranging from fair or even excellent insight, to overvalued ideas (in which insight is poor, but not absent), to delusional (Konstantakopoulos et al., 2012). In DSM-IV-TR (APA, 2000), body image disturbance (criterion C) is characterized as “disturbance in which one’s body, weight or shape is experienced”, “undue influence of body weight and shape”, or “denial of seriousness of the current low body weight” (p. 589). While the descriptors already represent a range of intensity of beliefs and conviction, different authors, based on literature reviews, have proposed a clear classification of appearance beliefs in AN as “with good insight”, “with poor insight”, and “with delusional (or psychotic) features” (Phillips et al., 1995; Van Der Zwaard et al., 2006). However, DSM-5 AN does not include an insight specifier similar to that of DSM-5 BDD (APA, 2013).

One study investigating insight into appearance-related beliefs that were not further specified among individuals with eating disorders (Grant et al., 2002) revealed that a comorbid BDD diagnosis was associated with higher delusionality in AN. In contrast, a study by Ruffolo et al. (2006) comparing BDD with and without a lifetime comorbid eating disorder showed that an eating disorder comorbidity in BDD did not influence delusionality of bodily image beliefs, irrespective of focus of the belief. However, to our knowledge, no studies have directly compared delusionality, overvalued ideas, and ideas/delusions of reference in both body image disorders. Such direct comparisons could provide insight into the utility of a delusionality specifier in AN, as well as insight into new clinical and research directions (e.g., development and testing of new clinical strategies to reduce delusionality).

Our primary aims of the present study were to assess the extent of delusionality in AN and BDD and to determine and compare the number of individuals in the AN and BDD groups who could be classified as having delusional appearance beliefs. We also examined correlations of delusionality with clinical

variables, body image measures, and disorder severity. Based on the extensive literature on delusionality in BDD in contrast to the relative dearth in AN, we hypothesized that individuals with BDD would have higher levels of delusionality and be more likely to report delusional or overvalued ideas. Additionally, we expected significant correlations between delusionality and measures of body image in both groups, overall disorder severity in BDD but not AN, and disorder specific symptoms in AN (i.e., drive for thinness).

2. Methods

2.1. Subjects

Participants were recruited through advertisements and flyers (AN: $n=5$; BDD: $n=7$). We also asked prospective patients who inquired about treatment options at the Eating Disorder Program ($n=4$) at Massachusetts General Hospital (MGH) or the Obsessive-Compulsive Disorder (OCD) and Related Disorders Clinic at Massachusetts General Hospital ($n=15$) if they were interested in participating. Finally, we recruited research participants from a residential treatment facility for eating disorders at McLean Hospital ($n=10$).

Individuals aged 18 years or older who had a diagnosis of either AN or BDD according to DSM-IV-TR (APA, 2000) were eligible to participate. Only BDD patients with a score on the Yale-Brown Obsessive Compulsive Scale modified for BDD (Phillips et al., 1997) ≥ 20 (Deckersbach et al., 1998) were included in the study. Amenorrhea was not required for AN patients (Attia and Roberto, 2009), but the participant's weight needed to be below the 85th percentile according to the medium frame weight for height and gender on the 1959 Metropolitan Life Insurance Tables. We used the Eating Disorder Examination (see measures) to assess the diagnostic criteria for AN (Item “maintain low weight” = 1, Items “fear of weight gain” ≥ 4 , and “importance of weight or shape” or “feeling fat” ≥ 4 , all for the past 3 months). Exclusion criteria included a diagnosis of substance abuse or dependence, psychotic or bipolar disorder in the past 3 months, homicidality, current clinically significant suicidality, significant CBT treatment experience for either disorder (> 10 CBT sessions in the last 10 years²), and self-identified English language difficulties. Because the purpose of the study was to compare the two patient groups, we excluded individuals with comorbid AN and BDD.

Out of 77 potential participants (AN: $n=33$, BDD: $n=44$), 31 were deemed ineligible after the phone screening/initial contact at the residential facility (AN: $n=16$; BDD: $n=15$). Reasons for exclusion were: not meeting diagnostic criteria (weight criterion in AN: $n=5$; severity of appearance concerns in BDD: $n=7$), having too much CBT experience (AN: $n=6$; BDD: $n=5$), or meeting criteria for both disorders (AN: $n=5$; BDD: $n=3$). After the in person interviews, another three participants (AN: $n=1$; BDD: $n=2$) were excluded as they did not meet diagnostic criteria, and two participants from the AN group withdrew from the study mid-way through the assessments. Ultimately, 41 individuals (AN: $n=19$, BDD: $n=22$) took part in the study.

2.2. Procedures

After providing informed consent, participants were interviewed by a clinical psychologist and completed self-report measures in REDCap, an electronic data capturing system (Harris et al., 2009). The Partners Human Research Committee at Massachusetts General Hospital (MGH) approved the study protocol and the Institutional Review Board at McLean Hospital ceded review to MGH.

2.2.1. Clinical interviews

The *Structured Clinical Interview for DSM-IV* (SCID; First et al., 2002) is a semi-structured clinical interview used to diagnose Axis I disorders, which we used to confirm participants' AN or BDD and associated comorbidity. Inter-rater reliability in previous studies was satisfactory to good across diagnoses ($0.61 \leq r_{icc} \leq 0.83$; Lobbstaal et al., 2011).

The *Brown Assessment of Beliefs Scale* (BABS; Eisen et al., 1998) is a 7-item semi-structured clinician-administered interview that assesses current delusional thinking, both categorically and dimensionally. The BABS first assesses the dominant belief about appearance/perceived flaws. Then, the clinician rates six items to assess insight into the veracity of the spontaneously reported appearance belief, as well as the corresponding level of delusion. An additional item (item 7) assessing ideas/delusions of reference (“Does it ever seem that people are talking about you or taking special notice of you because of (fill in belief)?” or “What about receiving special messages from your environment because of (fill in belief)?”) is not

² This exclusion criterion was relevant for another study conducted with the current subjects.

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