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Delusions of Body Image in the Prodrome

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To the Editor:

Imagine an adolescent presenting to a treatment clinic with the belief that the features of his face are deformed, although nothing is apparent to others. The belief is so pervasive that he thinks people take special notice of him, and begins to withdraw socially. According to the DSM-IV-TR, the individual may currently meet criteria for Body Dysmorphic Disorder (BDD) and delusional disorder- somatic subtype. However, there is also a possibility that the hypothetical patient is experiencing attenuated psychosis syndrome (APS; i.e., moderate levels of positive symptoms and/or a decline in global functioning accompanying the presence of schizotypal personality disorder and/or a family history of schizophrenia; Miller et al., 2002) and is at high-risk for developing schizophrenia.

There are several similarities between the psychosis prodrome and BDD: symptoms begin in adolescence, and patients experience impairment in academic/occupational/interpersonal functioning, show poor insight, and often exhibit ideas of reference (Phillips et al., 2008). Within a clinical framework, the diagnostic confusion becomes significantly amplified when considering the plans for DSM-5. The workgroup has suggested combining BDD delusional and non-delusional variants into a single disorder based on evidence that there is no real distinction between BDD patients with and without delusions (e.g., up to 39% of BDD patients show delusional symptoms and individuals diagnosed with either delusional and non-delusional BDD respond to monotherapy with selective serotonin reuptake inhibitors and not antipsychotic medications) (Phillips et al., 2010). The suggested change was made in part to discourage treatment with antipsychotics for patients with BDD who show delusional thinking/poor insight (Phillips et al., 2010).

Although these revisions make sense for BDD, the classification issue for APS (which will not be included as a formal disorder in DSM-5) becomes increasingly confused. DSM-5 will employ the use of insight/delusion dimension for BDD based on the level of conviction. . While a patient with symptoms centered primarily around somatic issues could have been given both BDD and delusional disorder in the current system, with DSM-5, regardless of the level of conviction shown (e.g., ranging from a case where the person can acknowledge the possibility that he or she may be exaggerating the extent of the perceived defect or that there may be no defect at all to complete conviction that the defect is real) they will be classified as BDD alone. While this stands to prevent true BDD cases from being treated as psychotic, there is also a possibility that an individual at-risk for developing a psychotic disorder will be missed as it is difficult to ascertain whether these symptoms will remain specific to physical appearance, or will manifest in other ways with time. Further, there is no clear diagnostic pathway for cases of conversion (in the APS conception, changes in

conviction level indicate increasing severity and contribute toward a conversion diagnosis but with BDD, they have no effect on category shift).

In addition, the upcoming changes to delusional disorder in DSM-5, which will now only consider delusions of medical conditions (and no longer perceived body irregularities), limits the likelihood of an adolescent with APS being viewed within a psychotic disorder framework entirely (especially by practitioners outside of specialized clinics, who rely primarily on the DSM for guidance), as these patients often have vague and unformed unusual thoughts which may further develop during conversion to psychosis (e.g., a preoccupation with an imagined ugliness of the nose may formalize into a medical condition delusion). With regard to clinical care, correct identification is particularly important for adolescents who are actually “prodromal”, who may otherwise be classified into a category that would not receive potential treatment options for APS, such as cognitive therapy (Morrison, et al., 2004) or pharmaceutical options, such as neuroleptics (McGlashan et al., 2006). However, it should be noted that this remains a very tricky issue as false-positives have serious consequences; misclassifying someone as prodromal and subsequently initiating the use of neuroleptics in a pediatric patient is also concerning due to serious side effects (Haroun et al., 2006).

Overall, it is important to carefully assess the delusional quality of an adolescent presenting with BDD-like symptoms, and evaluate whether any additional information hints at APS (e.g., family history, other categories of positive symptom as well as negative and disorganized symptomatology, cognitive impairment). One potential solution would be to systematically assess all patients on a psychosis dimension, regardless of their diagnosis (Phillips, Kim, & Hudson, 1995; Phillips et al., 2010). A more thorough evaluation of psychotic symptoms and risk factors (e.g., family history) would encourage clinicians to become more familiar with psychosis, and dissuade quickly diagnosing BDD with poor insight instead. Additionally, psychosocial and low side-effect treatments (e.g., long chain ω -3s polysaturated acids) (Amminger et al., 2010) could be implemented until more information is gathered: as the insight/delusional qualities decrease with treatment in BDD (Phillips et al., 2008) but symptom severity and conviction likely escalate in truly “prodromal” cases (Cannon et al., 2008); changes in presentation or new information gathered over time should help to clarify the issue.

To date, the data on somatic symptoms in the psychosis prodrome and risk for conversion to psychosis is limited (for example, measures of psychosis prodromal symptoms assess somatic complaints, but that information is averaged with other data into a global score of unusual thought content). However, one study examined abnormal bodily experiences in first-episode acute schizophrenia patients and reported that 18% of their sample reported dysmorphic experiences (Stanghellini et al., 2012). Although researchers have argued that within BDD, both persons with and without delusional variants are more similar than different, more research is needed to determine the relevance of BDD symptoms within the context of psychotic disorders. The field needs to reach a consensus regarding the assessment, and inclusion, of individuals with primary BDD presentations in studies of the prodrome. It is our hope that this letter will generate conversation, and help to galvanize efforts to collect more systematic data on somatic symptoms.

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References

- Amminger GP, Schäfer MR, Papageorgiou K, Klier CM, Cotton SM, Harrigan SM, Mackinnon A, McGorry PD, Berger GE. Long-chain omega-3 fatty acids for indicated prevention of psychotic disorders: A randomized, placebo-controlled trial. *Archives General Psychiatry*. 2010; 67(2):146–154.
- Cannon TD, Cadenhead K, Cornblatt B, Woods SW, Addington J, Walker E, Seidman LJ, Perkins D, Tsuang M, McGlashan T, Heinssen R. Prediction of Psychosis in youth at high clinical risk. *Archives General Psychiatry*. 2008; 65(1):28–37.
- Haroun N, Dunn L, Haroun A, Cadenhead KS. Risk and protection in prodromal schizophrenia: ethical implications for clinical practice and future research. *Schizophrenia Bulletin*. 2006; 32(1):166–178. [PubMed: 16207892]
- McGlashan TH, Zipursky RB, Perkins D, Addington J, Miller T, Woods SW, Hawkins KA, Hoffman RE, Preda A, Epstein I, Addington D, Lindborg S, Trzaskoma Q, Tohen M, Breier A. Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis. *American Journal Psychiatry*. 2006; 163(5):790–79.
- Miller T, McGlashan TH, Rosen JL, Somjee L, Markovich PJ, Stein K, Woods SW. Prospective diagnosis of the initial prodrome for schizophrenia based on the Structured Interview for Prodromal Syndromes: Preliminary evidence of interrater reliability and predictive validity. *American Journal Psychiatry*. 2002; 159(5):863–865.
- Morrison AP, French P, Walford L, Lewis SW, Kilcommons A, Green J, Parker S, Bentall RP. Cognitive therapy for the prevention of psychosis in people at ultra-high risk: Randomised controlled trial. *British Journal of Psychiatry*. 2004; 185:291–297. [PubMed: 15458988]
- Phillips KA, Kim JM, Hudson JI. Body image disturbance in body dysmorphic disorder and eating disorders. Obsessions or delusions? *Psychiatric Clinics of North America*. 1995; 18(2):317–334. [PubMed: 7659601]
- Phillips K, Didie ER, Feusner J, Wilhelm S. Body Dysmorphic Disorder: Treating an underrecognized disorder. *American Journal Psychiatry*. 2008; 166(9):111–118.
- Phillips KA, Wilhelm S, Koran LM, Didie ER, Fallon BA, Feusner J, Stein DJ. Body Dysmorphic Disorder: Some key issues for DVM-V. *Depression and Anxiety*. 2010; 27:573–591. [PubMed: 20533368]
- Stanghellini G, Ballerini M, Fusar Poli P, Cutting J. Abnormal bodily experiences may be a marker of early schizophrenia? *Current Pharmaceutical Design*. 2012; 18:392–398. [PubMed: 22239570]