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Overvalued ideas: psychopathologic issues

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The position attributed in recent years to overvalued ideas between delusion and obsession and that are derived from the reduction of the construct per se to one of its characteristics, that is, insight, has undergone a critical review. Using a case with dysmorphophobic ideas, the difficulties to define it and differentiate it from delusion are proposed and different psychopathological approaches are outlined that make it possible to reconstruct the case differently.

Key words:

Dysmorphophobia, overvalued ideas, obsession, delusion, psychopathology, values.

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Ideas sobrevaloradas: cuestiones psicopatológicas

Se revisa críticamente la posición atribuida en los últimos años a las ideas sobrevaloradas entre el delirio y la obsesión, y que deriva de la reducción del constructo mismo a una de sus características, el insight. A través de un caso con ideas dismorfofóbicas se plantearán las dificultades para delimitarlo y diferenciarlo del delirio y se esbozarán distintas aproximaciones psicopatológicas que permitan reconstruir el caso de modo distinto.

Palabras clave:

Dismorfofobia, ideas sobrevaloradas, obsesión, delirio, psicopatología, valores.

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INTRODUCTION

In our clinical practice, it is not unusual to find individuals who have ideas whose content is more or less normal for the rest of individuals of their community, but that significantly determine their behavior and affective state in a much greater way than usual in the others. Differentiating if these can be classified from a psychiatric point of view as delusional ideas or overvalued ideas is not always easy. This can be seen by the definition given by the international scientific community for delusional ideas in the diagnostic manual of DSM-IV-TR¹ which mentions the strength with which such an idea is maintained to distinguish between these two constructs.

The same problem can be observed in the core of some disorders whose nuclear symptom is the overvalued idea. These are cases of body dysmorphic disorder, hypochondria or anorexia nervosa.² Furthermore, there are other conditions in which the same problem occurs, although they are not clearly explained in the diagnostic manuals. This is the case of pathological jealousy. In other cases, see affective psychoses and schizophrenic psychoses, overvalued ideas are presented as precursor symptoms to delusions.³ The point in which this step is established is a question that needs to be elucidated. The question that arises from all of this is: when can we speak about an overvalued idea and when can we speak about a delusional idea? This question has been approached in recent years, above all in relationship to the body dysmorphic disorder. To briefly summarize this, the idea proposed is that of the existence of this symptomatic *continuum* that would allow for a bidirectional step between obsessions, overvalued idea and delusion based on the *insight* of the idea in question.⁴⁻⁶ In this way, we would speak of dysmorphophobia and delusional dysmorphophobia, and in the same way, we could make this extendable to hypochondria, obsessive-compulsive disorder and anorexia.⁷

In our opinion, to make this step workable, a critical review must be made of the definitions of obsession, overvalued idea and delusion. And since obsession and

dilution have been widely studied, we will focus on overvalued ideas, that although they have remained on a second conceptual level, these concepts are often up-dated within the clinical practice. However, during this article, mention will be made to the delusion and obsession constructs, since the definitions have historically been defined by opposition among them.⁸

OBSESSION-OVERVALUED IDEA-DELUSION CONTINUUM

Wernicke was the first to coin the term of overvalued idea in order to define those solitary beliefs firmly supported and related with the personality of the individual and that differentiated it from obsessions and delusions.

Jaspers⁹ considers that delusion is qualitatively different from a normal or overvalued belief. Certainty and incorrigibility are evident. There is a radical transformation of the individual and his/her experience. Overvalued idea deals with a belief sustained with greater conviction than normal, but that is in consonance with the personality and affect of the individual. For Fish,¹⁰ on the other hand, what is essential is the discrepancy observed in the delusions between the sustained conviction and repercussion in the actions. The overvalued idea would repeatedly determine the behavior. This does not occur with delusions.

In his article in 1984, McKenna¹¹ reviewed the disorders in which overvalued ideas are the central symptom. He made the distinction between obsessions based on the grade of *insight* and bizarreness in regards to the Self, with phobias, since in the overvalued ideas fear and anguish do not increase in direct relationship with a stimulus or idea, and with the delusions based on a "distinct quality, difficult to define, but easily recognizable," but without specifying anything more.

Kozak and Foa¹² analyzed obsessions, overvalued ideas and delusions in patients with OCD. After reviewing the articles that refer to transition from obsessions to overvalued ideas and delusions, they concluded that the distinction between these three constructs is not sufficiently clear. They also state that *insight* is not a dichotomic construction, that transition is possible and has therapeutic implications (worse response to SSRI) and prognoses (schizophrenic spectrum symptoms may lead to worse prognosis) and that the continuity model seems more satisfactory.

David Veale¹³ reviewed this concept in the year 2002, listing different characteristics historically attributed from continental psychiatry to the overvalued idea. Veale mentioned that it deals with a firmly maintained egosyntonic belief (without reaching delusional intensity), that concerns

the individual, which is often developed from an abnormal personality, that is normally understood within the past experience and the personality of the individual, that the content is abnormal for the general population (but not bizarre), that it alters functioning and causes distress to the individual and others, then it is highly associated to affect, that it leads to repeated and justified actions by the individual, that may progress to delusional idea, for which the patient normally does not request help and that they are similar to political or religious beliefs. From a cognitive perspective, Veale distinguishes between beliefs and values and defines the overvalued idea as beliefs associated with specific idealized, rigid values that are excessively identified with the *self*. The historic characteristics that Veale reviews cannot be translated in the strict definition found in the diagnostic manuals.

CLINICAL CASE

A 48-year-old male who consulted due to a depressive picture of 2-months evolution with intense, recurrent and anxiogenic ideas that his right hip was getting wider. The Traumatology Service performed complimentary tests that ruled out organic disease. As previous psychiatric background, standing out were hospital admission at 17 years of age due to a picture consistent with restrictive type anorexia nervosa that was resolved in 2 weeks without pharmacological treatment and that has remained stable up to date. He had no apparent maladaptive personality traits. Overweight in childhood. Elevated physical activity during 15 years prior to the consultation (he ran several kilometers a day and participated frequently in marathons). Before coming to our consultation, he had initiated treatment with fluoxetine up to doses of 40 mg/days and neuroleptic treatment with perphenazine had been added that was poorly tolerated at a dose of 4 mg/day. When he came to the medical consultation, he was sad, with social withdrawal, apathy, anxiety that increased in social situations, significant decrease in self-care and the idea that his hip was continuously becoming thicker. Verifications were made in front of the mirror of the size of his hip and complementary examinations were requested to observe this objective sensation. Analyses and brain CT scan were performed, which were normal.

The fluoxetine dose was increased up to 60 mg/day with improvement of the depressive syndrome and treatment was initiated with olanzapine with significant global improvement and less recurrence and emotional repercussion (decrease of anxiety and worry) and behavior repercussion (withdrawal and checking behaviors) of ideas on his hip. With the progressive increase of olanzapine (up to 20 mg/day), he has had progressive objective improvement (sadness, communication, anxiety, worry) and subjective improvement. After, and given that complete remission was not obtained

and he had significant weight gain, olanzapine was substituted with pimozide with poor tolerability (increased restlessness and nervousness) so that it was decided to maintain the olanzapine. However, he persisted in the belief that his hip was growing every day. He states that the same as bones grow in length in childhood, they grow in thickness when an age is reached. He stated that the others did not notice it because they did not look at it as much as he did and that the growth is very slow. And he reports noticing a "sensation" in the zone "that is difficult to define, as a pressure." Even though he continues with this idea and these perceptions, he is not anguished nor does he think so much about the idea. On repeated occasions, he classifies this idea as "ridiculous," but states that he believes it to be true.

DISCUSSION

The case presented takes us to the already proposed problem on the differentiation of overvalued idea and delusion as well as its nosological analogues, dysmorphophobia and monosymptomatic hypochondriacal psychosis, and their diagnostic and therapeutic implications.¹⁴⁻²³

Both in Wenicke and in Jaspers, and later, in the continental tradition,²⁴ mention is made of a predisposing personality on which overvalued ideas are developed. The same is stated for paranoid delusions, thus admitting the special nosological status of paranoia. Furthermore, as Fish states, the repercussions of overvalued ideas on behavior are elevated. However, it occurs the same way in paranoid delusions. The position of Fish would correspond more with schizophrenic or paraphrenic delusions and the double accountability described by Bleuler.

The subsequent proposals reviewed do not offer an easy solution to the difficulty to distinguish both constructs. Most do it based on *insight* or grade of certainty that the affected individual has on the specific idea. The basic proposal of this *continuum*, which has largely been assumed in Anglo-Saxon psychopathology, is not successful in differentiating overvalued ideas from delusions more than the grade of *insight*, a construct that entails conceptual complexities as has been studied by Markova and Berrios.^{2, 26} The problem is suggested that it is very possible that we are not evaluating the same thing when we evaluate *insight* of an obsessive symptom and *insight* of a psychotic symptom. As a consequence of the continuity approach, scales have been constructed that attempt to show the grade of conviction of a specific belief. Examples of this are the Brown Assessments of Belief Scale (BABS)²⁷ or the more recently made Overvalued Ideas Scale (OVIS).²⁸ We believe that the dimensional models that have occupied a large part of scientific interest in recent years are the consequence of an attempt to take into account this information that is not

included within the diagnostic systems or the strict definitions of the symptoms, something that occurs more in symptoms that are difficult to define such as overvalued ideas (and thus, the OVIS scale carefully evaluates the strengths, reasonableness, extension, incorrigibility, etc. of the idea, and the attitude that the patient adapts towards the specific idea, whether cognitions or behaviors or motions). In our case, the *insight* varied during the same interview and between successive interviews, as had already been reported by Insel and Akiskal²⁹ in their analyses of OCD patients with psychotic symptoms. They also characterized overvalued ideas based on a hiatus between intellectual and emotional *insight*, that is, that they intellectually described their obsessions as meaningless, but behaviorally they seem to adopt them without any resistance. All of this significantly approaches our patient. In the delusion, supposedly, this intellectual distancing would not occur. However, the vision that compares delusion with null *insight* is not exempt of criticisms. Luchelli et al.³⁰ demonstrated this problems with the presentation of four cases that were diagnosed of body dysmorphic disorder and that had different grades of *insight* without strict relationship with the severity of the patient's disorder and the psychiatric symptoms they had. Based on that presented, they finally proposed maintaining a categorial vision that differentiated Body Dysmorphic Disorder and Monosymptomatic Hypochondriacal Psychosis, mentioning the globalness of the clinical picture and not exclusively to the grade of *insight* of a specific idea, that may be variable. On the other hand, a recent study³¹ that compared 2 groups of patients, one with delusions and another with overvalued ideas, found that the grade of conviction and *insight* was not differentiated between the 2 groups and did not allow for discrimination between both symptoms. However, they concluded that there are differences between the two symptoms based on other variables investigated such as plausibility, extension, worry, awareness of idiosyncrasy, displeasure, among others, and they support the view of Jaspers of delusion as an experience occurring against a developed one in the overvalued idea.

To our understanding, the proposal of Veale provides something more, as he took interest in compiling other characteristics associated to the overvalued idea that surpass the strict definitions and proposed a hypothesis that opens new possibilities, since an attempt is made to make it possible to pass one belief to an overvalued idea or delusion through idealization, rigidity and introjection of certain values, and not only naming a series of characteristics observed in the overvalued ideas or in delusions. In this way, Veale can, for example, understand the specific case of dysmorphophobia through the rigidity and excessive introjection of the esthetic value of beauty. Already in the past, some authors³² had differentiated the idea focused on appearance (esthetics) of the body and the concern focused on the active transformation of the body in order to distinguish between nosologically different disorders. However, in the distinction

in question herein, the article of Veale continues suggesting, in other terms, the same, the *continuum* overvalued idea-delusion through *insight*, since the affect, the abnormal personality (generic term that gives little information), the understandability in the biography, the character of the individual and his/her behavior influence are not decisive in such distinction. For him, the transition between both constructs would depend on the grade of intensity acquired by the value. We do not want to miss mentioning the complexity of the intensity when applying it to an idea. The analysis that Lakoff and Johnson³³ make of the role of the metaphors in the formation of the concept of the mental helps us to consider the mistakes that language may introduce when we speak of the intensity of an idea, as if it were dealing with a quantitatively measurable physical magnitude. Our opinion is that speaking of the intensity of an idea is a metaphoric concept that should be shown and explained in different aspects, which is already being done, as we have mentioned above in relationship to the OVIS scale. In our patient, there are data that indicate a possible idealization of the esthetic value of beauty (importance of the overweightness in childhood and its subsequent influence in the anorexic picture, significant physical activity for years that his wife attributed his care about appearance, an attribution of great importance to the external aspect of the persons he knows.). However, we believe that it is important in order to obtain more training in examination and recognition of values in the patient that provide us fundamental information when understanding the picture where have in front of us and to help us organize the symptoms present.

Based on all the above, we warn that the differentiation between overvalued idea and delusion presents many problems, especially with paranoid delusion. It seems more that it presents a fluid transition, even though there are no controlled clinical trials that reliably support this. Veale provides something original regarding the previous approaches to overvalued ideas. That is, he provides us with a theory that helps us to understand the formation of different pictures with overvalued ideas as central symptom. This interpretation is made through the concept of value. However, it is still an interpretation that has to be empirically compared and to do so, we need to obtain better training for the examination and recognition of values in our patients. Furthermore, it does not tell us anything about the relationship of some symptoms of the picture with others. We understand psychopathology as a tool that helps us to provide intelligibility to that which is generated in the meeting between the psychiatrist and the patient. The symptoms are registered on a changing totality, explaining the information obtained in the psychiatric meeting, then schematizing and reconstructing it to give it meaning. An open and non-determined meaning.³⁴ The proposal of Veale does not help us to organize coherently the symptoms that the patient brings to the medical consultation. It provides us

with a causal hypothesis. However, there are other ways of approaching the case. This would be the case of that proposed by Thomas Fuchs in regards to Body Dysmorphic Disorder, and that uses shame as a psychopathological organizer around which the symptoms are organized coherently and understandably.³⁵

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