Diagnosis and Treatment of Body Dysmorphic Disorder in Adolescents

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Introduction
The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [1] defines body dysmorphic disorder (BDD) as a somatoform disorder in which the patient is preoccupied with an imagined or slight defect in appearance. (When a slight anomaly is present, the preoccupation is markedly excessive.) The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. A diagnosis of BDD should not be made if the preoccupation is better accounted for by another disorder (such as anorexia nervosa) [1]. As an additional caveat, when BDD patients lack insight into their symptoms, they are also diagnosed as having delusional disorder, somatic type. This article will discuss the clinical features of BDD in children and adolescents, highlight features that differentiate BDD from obsessive-compulsive disorder (OCD), social phobia, depression, and eating disorders, and briefly review current methods for treatment including cognitive behavioral therapy (CBT) and pharmacotherapy.

Normal Development Versus Body Dysmorphic Disorder
Diagnosing BDD is a challenge in the child and adolescent population. In particular, adolescents are notoriously concerned about their appearance and many clinicians may be hesitant to diagnose BDD, thinking that the preoccupations are just part of normal development. A careful history from both adolescents and their parents can reveal normal development has gone awry. For example, adolescents with BDD frequently spend hours in front of a mirror—checking or grooming—usually at the expense of homework and social activities. Some feign medical illness as a way to avoid going to school. Frequently, these adolescents report difficulties focusing on school material because of appearance preoccupations. Others make excuses to go to the bathroom in order to check their appearance in the mirror. These behaviors are usually unsuccessful attempts to relieve anxiety related to appearance concerns. When such appearance preoccupations and associated behaviors cause significant distress and impairment of social, academic or overall functioning, BDD needs to be identified, diagnosed, and treated.

Clinical Features
Any body part can be the focus of preoccupation. In a review of 33 cases of child and adolescent BDD, Albertini and Phillips [2] found that BDD adolescents were most commonly preoccupied with skin (61%) and hair (55%). Some patients with BDD are so ashamed or embarrassed that they avoid describing their "defects" in any detail; instead, they complain of general ugliness. Nonetheless, such preoccupations are often described as uncontrollable and extremely painful and are associated with time consuming ritualistic behaviors such as mirror checking, camouflaging, comparing self with others, and multiple cosmetic surgeries that do not ameliorate the preoccupation. Patients with this disorder notoriously avoid social interaction, fearing shame, humiliation, and embarrassment because of their perceived flaws. Not surprisingly, depression and suicide are frequently complications of the disorder [3]. The prevalence of BDD is 1% to 2% of the US population and 11% to 12% in patients with social anxiety disorder [3]. The prevalence of BDD among children and adolescents is not known for certain, but Mayville et al. [4] reported a 2% prevalence of BDD among a diverse sample.
of 566 adolescents aged 14 to 19. Most studies of adult BDD patients, moreover, report the symptoms frequently began during childhood and adolescent years [2,5,6].

Many BDD patients report shame or embarrassment as reasons for their failure to volunteer BDD symptoms on initial psychiatric presentation. Instead, they volunteer depressive, anxiety or other psychiatric symptoms. Albertini and Phillips [2] reviewed the demographic characteristics of 33 child and adolescent patients with BDD and found that 94% had a significant impairment in functioning that included academic failure, job impairments, and social isolation. They also found 36% of patients had received surgical correction of the perceived flaw, with poor outcomes in all cases. Almost 40% had been psychiatrically hospitalized, and 21% had attempted suicide.

It is critical that clinicians screen for the disorder by asking the patient if they have any concerns about their appearance. Specific screening may lead to the prompt detection and treatment of adolescent BDD necessary to prevent such disastrous consequences. Research has been ongoing to determine the screening tools that are most reliable and valid for detection of BDD. A simple questionnaire such as the body dysmorphic disorder questionnaire (BDDQ) has been found to be reliable and valid for detecting BDD and distinguishing it from eating disorders [7]. Another tool, the BDD modified version of the Yale-Brown Obsessive Compulsive Scale (BDD-YBOCS) [8], is useful for quantifying symptoms (eg, hours per day spent focused on appearance concerns) and rating severity. Once excessive appearance concerns are identified, further evaluation is necessary to distinguish BDD and its delusional variant from OCD, social phobia, depression, and eating disorders.

**Obsessive-Compulsive Disorder and Body Dysmorphic Disorder**

Body dysmorphic disorder patients are preoccupied with worries and "obsessions" about appearance. Ninety percent of these patients' obsessions are associated with time consuming, distressing behaviors that include comparing a body part with the same part of others, questioning or seeking reassurance from others, mirror checking, ritualized grooming, skin picking, and camouflaging the perceived flaw [9]. These obsessive preoccupations, along with compulsive behaviors (which the patient often justifies as being necessary to reduce anxiety), may resemble symptoms of other conditions such as OCD.

The remarkable clinical similarities between OCD and BDD suggest common underlying neural pathophysiologic mechanisms. The preferential response of both BDD and OCD to serotonin reuptake inhibitors (SRIs) implies the existence of a serotonin dysregulation for both disorders. The clinical and neurobiologic similarities between BDD and OCD call into question whether or not these are two distinct disorders or rather different manifestations of the same illness. Several authors [9,10] have noted that OCD and BDD both have an early age of onset (age 17 or earlier) and have a chronic course. Hollander et al. [10] suggested that BDD is one of the obsessive-compulsive spectrum disorders (OCDS) — a disorder with similarities to OCD in multiple domains.

Despite the overlap, Phillips et al. [11] noted important differences, such as higher rates of mood disorders and suicide attempts among BDD patients. Phillips also found that BDD and OCD patients also differ in the quality of their obsessions. Specifically, the content of BDD obsessions usually involves the sense of one's self as ugly and unlovable, whereas OCD obsessions tend to involve the fear of harm and danger. Phillips [12••] concluded that BDD is a more depressed, socially phobic, and psychotic "relative" of OCD.

In practical terms, the DSM-IV [1] is helpful in distinguishing OCD and BDD. If a patient has obsessions and compulsions that are restricted to concerns about appearance, the recommendation is to use the diagnosis of BDD rather than OCD.

**Social Phobia and Body Dysmorphic Disorder**

Body dysmorphic disorder patients tend to avoid situations that could result in attention being drawn to their perceived flaw. In addition, the time involved in behaviors such as mirror checking and grooming leads to more social isolation. Hollander and Aronowitz [3] found that these patients have marked social anxiety that, in severe cases, results in the patient becoming housebound. As a result, BDD patients are sometimes erroneously diagnosed with social phobia. The DSM-IV [1] points out that individuals with avoidant personality disorder or social phobia may worry or feel embarrassed by real defects in appearance; however, these concerns are usually not prominent, persistent, distressing, time consuming and impairing.

**Depression and Body Dysmorphic Disorder**

Many BDD patients develop depressive symptoms as a result of their disorder. However, because of extreme shame or embarrassment these patients may not report BDD symptoms, and, thus, they are easily misdiagnosed as having depression [13]. Among adult BDD studies, major depression is the most commonly occurring comorbid disorder; 60% of BDD patients have current comorbid major depression, and 80% of BDD patients have a lifetime history of major depression [14,15]. Although there are many similarities between depression and BDD, there are important differences. Both BDD and depressed patients often report low self-esteem, shame, and rejection sensitivity, but as depressed patients tend to focus less on or even