Long-Term Outcomes of Cognitive-Behavioral Therapy for Adolescent Body Dysmorphic Disorder

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Emerging evidence suggests that cognitive-behavioral therapy (CBT) is an efficacious treatment for adolescent body dysmorphic disorder (BDD) in the short term, but longer-term outcomes remain unknown. The current study aimed to follow up a group of adolescents who had
originally participated in a randomized controlled trial of CBT for BDD to determine whether treatment gains were maintained. Twenty-six adolescents (mean age = 16.2, SD = 1.6) with a primary diagnosis of BDD received a course of developmentally tailored CBT and were followed up over 12 months. Participants were assessed at baseline, midtreatment, posttreatment, 2-, 6-, and 12-month follow-up. The primary outcome measure was the clinician-rated Yale-Brown Obsessive-Compulsive Scale Modified for BDD. Secondary outcomes included measures of insight, depression, quality of life, and global functioning. BDD symptoms decreased significantly from pre- to posttreatment and remained stable over the 12-month follow-up. At this time point, 50% of participants were classified as responders and 23% as remitters. Participants remained significantly improved on all secondary outcomes at 12-month follow-up. Neither baseline insight nor baseline depression predicted long-term outcomes. The positive effects of CBT appear to be durable up to 12-month follow-up. However, the majority of patients remained symptomatic and vulnerable to a range of risks at 12-month follow-up, indicating that longer-term monitoring is advisable in this population. Future research should focus on enhancing the efficacy of CBT in order to improve long-term outcomes.

Keywords: body dysmorphic disorder; children; adolescents; cognitive-behavioral therapy

Body Dysmorphic Disorder (BDD) is characterized by an excessive preoccupation with perceived defects in appearance, causing significant distress and/or impairment in functioning (American Psychiatric Association, 2013). The disorder is relatively common, with an estimated prevalence of 1.7–2.4% in community samples of adults (Koran, Abujamoude, Large, & Serpe, 2008; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brähler, 2006; Veale, Gledhill, Christodoulou, & Hodsoll, 2016). BDD typically has its onset during adolescence, where it can have a devastating impact on emotional, educational, and social functioning (Albertini & Phillips, 1999; Phillips et al., 2006). Moreover, adolescent-onset BDD is associated with the development of more severe symptoms, greater lifetime comorbidity, and higher rates of attempted suicide, compared with adult-onset BDD (Bjornsson et al., 2013). This highlights the urgent need for effective treatments for BDD in youth.

In adult populations, six randomized controlled trials (RCTs) have demonstrated cognitive-behavioral therapy (CBT) to be efficacious in reducing BDD severity compared with no treatment or wait-list control conditions (Rabiei, Mulkens, Kalantari, Molavi, & Bahrami, 2012; Rosen, Reiter, & Orosan, 1995; Veale et al., 1996; Wilhelm et al., 2014), supportive therapy (Enander et al., 2016), and anxiety management (Veale, Anson, et al., 2014). To date, only one RCT has evaluated CBT for BDD in youth (Mataix-Cols et al., 2015). Encouragingly, this study found that developmentally tailored CBT was efficacious compared with a control condition. The between-group effect size was 1.13, 95% CI [0.31, 1.96] at posttreatment and 0.85, 95% CI [0.02, 1.69] at 2-month follow-up, favoring the CBT intervention, which is broadly in line with the results of adult trials. Furthermore, CBT was found to be associated with significant improvements in depressive symptoms, insight, quality of life, and global functioning.

Although it is well established that CBT for BDD is associated with significant symptom relief in the short term, longer-term outcomes are less clear. A recent meta-analysis of CBT for BDD concluded that gains are likely to be maintained for a least 2–4 months following treatment (Harrison, Fernández de la Cruz, Enander, Radua, & Mataix-Cols, 2016). Existing RCTs in adults have included follow-up periods ranging from 1 (Veale, Anson, et al., 2014) to 6 months (Rabiei et al., 2012; Wilhelm et al., 2014), and have shown preservation of gains over this period. To our knowledge, only two studies have examined longer-term outcomes (McKay, 1999; Veale, Miles, & Anson, 2015). McKay (1999) found that gains were maintained at 2-year follow-up among 10 patients who had received behavior therapy with or without an additional relapse prevention program. In a larger study, Veale et al. (2015) examined outcomes among 30 patients 1–4 years after completing CBT. Overall, symptoms remained stable and the relapse rate was relatively low (n = 4, 13.3%).
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