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Clinical features of body dysmorphic disorder in adolescents and adults

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Abstract

Body dysmorphic disorder (BDD) usually begins during adolescence, but its clinical features have received little investigation in this age group. Two hundred individuals with BDD (36 adolescents; 164 adults) completed interviewer-administered and self-report measures. Adolescents were preoccupied with numerous aspects of their appearance, most often their skin, hair, and stomach. Among the adolescents, 94.3% reported moderate, severe, or extreme distress due to BDD, 80.6% had a history of suicidal ideation, and 44.4% had attempted suicide. Adolescents experienced high rates and levels of impairment in school, work, and other aspects of psychosocial functioning. Adolescents and adults were comparable on most variables, although adolescents had significantly more delusional BDD beliefs and a higher lifetime rate of suicide attempts. Thus, adolescents with BDD have high levels of distress and rates of functional impairment, suicidal ideation, and suicide attempts. BDD's clinical features in adolescents appear largely similar to those in adults.

Keywords: Dysmorphophobia; Body image; Development; Somatoform disorders

1. Introduction

Body dysmorphic disorder (BDD), a distressing or impairing preoccupation with an imagined or slight defect in appearance, usually begins during adolescence (Phillips, 2001; Gunstad and Phillips, 2003). However, very little research has been done on BDD's clinical features in this age group. BDD is an often severe disorder that appears to interfere with normal adolescent development (Phillips, 1996). In addition, body image is important during adolescent development. It may be the most important contributor to adolescents' global self-esteem, and negative body image is associated with depression, anxiety, and fear of negative evaluation in this age group (Harter et al., 1992; Levine and Smolak, 2002).

Adults with BDD have markedly impaired functioning and notably poor quality of life (Phillips et al., 1993; Veale et al., 1996; Phillips and Diaz, 1997). Suicidal ideation and attempts also appear common, with lifetime suicide attempt rates of 22–24% (Veale et al., 1996; Phillips and Diaz, 1997). In a retrospective study of patients in two dermatology practices who

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were known to have committed suicide over 20 years, most had acne or BDD (Cotterill and Cunliffe, 1997).

Retrospective studies of adults indicate that BDD usually begins during adolescence (Phillips, 2001). The largest study ($n=293$) reported a mean age at onset of 16.0 ± 6.9 (range 4–43), with a mode of 13 (Gunstad and Phillips, 2003). However, to our knowledge, published reports on BDD's clinical features in adolescents consist only of case reports and one case series of 33 children and adolescents with BDD (Sondheimer, 1988; El-Khatib and Dickey, 1995; Phillips et al., 1995; Albertini et al., 1996; Heimann, 1997; Albertini and Phillips, 1999; Sobanski and Schmidt, 2000; Horowitz et al., 2002). These reports underscore the severe distress and functional impairment that BDD often causes in this age group. In the study of 33 children and adolescents, for example, 72% reported that their BDD symptoms caused severe or extreme and disabling distress, and 21% had attempted suicide (Albertini and Phillips, 1999). Ninety-four percent had experienced significant impairment in social functioning, and 85% in academic or work functioning, due to BDD. Eighteen percent had dropped out of school primarily because of BDD symptoms.

To our knowledge, no other studies have examined BDD's clinical features in adolescents, and no previous study has compared BDD's clinical features in adolescents and adults. This question is important because psychopathology may meaningfully differ in these age groups. The clinical features of other psychiatric disorders, such as depression, bipolar disorder, obsessive–compulsive disorder, and attention deficit hyperactivity disorder, have been shown to vary in children/adolescents and adults (e.g., Carlson and Kashani, 1988; Dulcan, 1997; Geller and Luby, 1997; Geller et al., 2001). Demonstrating differences–as well as similarities–in these age groups has important clinical implications.

The purposes of this article are to (1) describe BDD's clinical features in middle and late adolescence (age 20 and younger) and (2) compare BDD's clinical features in adolescents ($n=36$) and adults ($n=164$). To our knowledge, this is the first study to compare these age groups and contains a BDD sample that is broader and more diverse than those in most previous samples. Inclusion/exclusion criteria were very broad, and participants were obtained from diverse sources. Unlike the previous study (Albertini and Phillips, 1999), nearly half of adolescents in the present study were not currently seeking or receiving mental health treatment, and a higher proportion were minority group members. (The adolescents in the present report are a different sample from those in previous reports focusing on adolescents with BDD.) Furthermore, we assessed some features of BDD that have not previously been examined in adolescents (for example, depression severity, quality of life, and level of functional impairment using standard measures).

2. Methods

2.1. Participants

Participants were obtained from a study of BDD's course. This report includes only data from the intake (baseline) assessment. All participants met DSM-IV criteria for BDD currently or in the past. Participants were obtained from the following sources: mental health professionals (46.0%), advertisements (38.6%), our program website and brochures (10.2%), participant friends and relatives (3.4%), and nonpsychiatrist physicians (1.7%). Similar methods were used to recruit adolescents and adults, and recruitment sources did not significantly differ between adolescents and adults. We made efforts to overcome possible barriers to adolescent participation in the study (for example, by providing transportation when needed). Parents/guardians were not present during the interview. They were made aware that the interviewer would not share information with them disclosed by their child (including diagnosis), unless the child gave permission for the interviewer to do so or there were safety concerns. In the month before the intake assessment, 89.0% ($n=178$) of the full sample met full BDD criteria, 7.5% ($n=15$) were in partial remission, and 3.5% ($n=7$) were in full remission. Seventy-eight percent of the sample considered BDD their most problematic disorder (compared with any comorbid disorder). (Additional characteristics of this sample have previously been described [Phillips et al., 2005].)

Inclusion criteria were DSM-IV BDD or its delusional variant (delusional disorder, somatic type), age 12 or older (the youngest subject was age 14), and ability to be interviewed in person. The only exclusion criterion was the presence of an organic mental disorder that would interfere with the collection of valid interview data. Of those participants age 20 or younger, 61.1% ($n=22$) were currently receiving mental health treatment (52.8% outpatient, 5.6% inpatient, and 2.8% partial hospital). Of those participants age 21 and older, 68.3% ($n=112$) were currently receiving mental health treatment (64.0% outpatient, 1.8% inpatient, 1.2% partial hospital, and 1.2% residential). All participants signed a statement of informed consent (assent plus parental consent for adolescents).