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Cognitive-Behavioral Therapy for Adolescent Body Dysmorphic Disorder

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The onset of appearance-related concerns associated with body dysmorphic disorder (BDD) typically occurs in adolescence, and these concerns are often severe enough to interfere with normal development and psychosocial functioning. Cognitive behavioral therapy (CBT) is an effective treatment for adults with BDD. However, no treatment studies focusing on adolescents with BDD have been conducted. The need for an effective treatment in this population led to the development of a brief CBT protocol with family involvement. The treatment focuses on enhancing an adolescent's quality of life through the reduction of maladaptive thoughts and behaviors, and incorporates skills training and parent training. Similar treatment packages have already been shown to be efficacious for children and adolescents with similar disorders, such as obsessive-compulsive disorder and social phobia. The following case illustrates the application of this brief CBT protocol for BDD in an adolescent, and highlights clinical considerations needed when adapting CBT for a pediatric population. Treatment was associated with clinically significant improvement in symptoms of BDD, self-esteem, depression, and quality of life. This report extends extant literature by suggesting that CBT may be a helpful treatment for adolescents with BDD.

Adolescence is characterized by concurrent physical changes of puberty and increased significance of body image as a determinant of psychosocial worth (Rudiger, Cash, Roehrig, & Thompson, 2007). Negative body image is associated with poor self-esteem, and is a risk factor for depression, anxiety, and body image disorders, including eating disorders and body dysmorphic disorder (BDD) (e.g., Cash, Morrow, Hrabosky, & Perry, 2004; see Greenberg et al., 2010). Indeed, BDD, which has been hypothesized to be a pathological response to the physical, psychological, and social changes that occur around puberty (Phillips, 2005; Zaidens, 1950), typically develops during adolescence (Gunstad & Phillips, 2003; Phillips et al., 2005).

The prominence of appearance concerns during adolescence may help to explain how pathological body image dissatisfaction goes overlooked by parents and health providers. However, in contrast to typical adolescent concerns, adolescents with BDD are more severely distressed and impaired by nonexistent or very minor appearance flaws. The appearance defects are usually related to the skin (e.g., acne or scarring), hair (e.g., thinning or frizzy hair, excessive body hair), or stomach (American Psychiatric Association [APA], 2000; Phillips, Didie, et al., 2006). Excessive concern with muscle shape and size, *muscle dysmorphia*, may be more common among boys and men with BDD. Although the "flaw" is not usually visible to others, adolescents with BDD misinterpret the importance and magnitude ("I'm disgusting looking") of minor or perceived imperfections ("Others are staring at me"; "No one will ever want to date a zit face like me"), which causes them to think about their appearance for several hours a day. As compared to youth with "normal" appearance concerns, adolescents with BDD spend an inordinate amount of time (e.g., more than 1 hour, often 3 to 8 hours) in front of the mirror—checking or grooming—and otherwise engaged in appearance-enhancing (e.g., applying makeup, skin picking, changing clothing, tanning) or distress-reducing (e.g., reassurance seeking, comparing with others) activities. These behaviors often occur at the expense of homework, school, and social activities, and can lead to social isolation (Hadley, Greenberg, & Hollander, 2002). Feelings of frustration, hopelessness or shame resulting from engagement in or disruption of rituals can also lead to anger outbursts, and may involve physical aggression. Further, the onset of BDD during adolescence can lead to a disruption of age-appropriate task development,

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including the development of a stable self-concept, social skills, and increased autonomy and independence.

Cognitive information and perceptual processing biases are identified and addressed by cognitive-behavioral models of BDD. Recent findings from information processing (e.g., Buhlmann et al., 2004) and neuroimaging (e.g., Feusner, Townsend, Bystritsky, & Bookheimer, 2007) studies provide an empirical framework for understanding the bias toward negative misinterpretations of ambiguous stimuli and detailed (versus global) information processing in BDD patients (for a full review of the CBT model see Wilhelm, 2006, or Wilhelm et al., 2010-this issue, in the current series). CBT for BDD addresses these perceptual and attentional biases, teaching patients to evaluate and modify self-defeating beliefs, perceptions, and behaviors, and enhancing their abilities to see "the big picture." CBT has been effective in group (Rosen, Reiter, & Orosan, 1995; Wilhelm, Otto, Lohr, & Deckersbach, 1999) and individual (McKay et al., 1997; Veale et al., 1996) formats of various durations, and is generally comprised of cognitive restructuring, exposure with response prevention, and may include perceptual retraining, habit reversal (e.g., for skin picking), and activity scheduling. CBT, cognitive therapy (cognitive restructuring alone), and behavior therapy (exposure-response prevention alone) have been shown to be effective in treating BDD and related symptomatology, such as depression, insight, body image, self-esteem, and social anxiety in adults (Hadley et al., 2002; McKay, 1999; McKay et al., 1997; Neziroglu & Yaryura-Tobias, 1993; Phillips, 2005; Rosen et al., 1995; Sarwer, Gibbons, & Crerand, 2004; Veale et al., 1996, Wilhelm et al. 1999; Williams, Hadjistavropoulos, & Sharpe, 2006). In a recent meta-analysis of treatments for BDD (Williams et al., 2006), CBT yielded slightly larger effect sizes than medication; however, no significant differences were found between CBT and BT.

So far, no treatment studies focusing on adolescents with BDD have been conducted. BDD is a chronic disorder associated with severe psychosocial disturbances and morbidity. In the absence of accurate diagnosis and treatment, adolescents with BDD are at increased risk for severe academic, social, and functional impairment, compromised quality of life, the development of additional psychopathology, hospitalization, and suicide (Albertini & Phillips, 1999; Hadley et al. 2002; Phillips, Didie, et al., 2006; Sobanski & Schmidt, 2000). An effective CBT treatment for adolescents with BDD would be beneficial in reducing current and future psychopathology. CBT has also been used effectively to treat similar pediatric populations, including obsessive-compulsive disorder and social phobia (e.g., Albano & Barlow, 1996; Kendall et al., 2005; March & Mulle, 1998).

The current paper describes clinical strategies and decision making involved in developing a CBT protocol for adolescents with BDD and provides a case description to illustrate its application.

Adapting CBT for BDD for Adolescents

Although CBT for adolescent BDD shares the same overarching goals with the adult treatment, modifications are necessary to ensure a developmentally appropriate treatment. In particular, adapting a CBT approach for youth with BDD requires taking into account theories of human development and psychological change. Unique psychosocial challenges that adolescents face through various stages of their development must be addressed throughout treatment.

Adolescence is characterized by significant physical changes, identity development, issues around sexuality and increased peer influence and pressures. Adolescents are moving toward acquisition of self-directed skills and autonomy; however, this normative trajectory is typically disrupted by BDD. Indeed, BDD can lead to skills deficits and, during a time in which social pressures are increasingly grounded in independence-based activities, teens with BDD may become increasingly dependent on parents. Thus, acknowledging and addressing potential developmental challenges at each step of treatment is critical.

The extent of family involvement in CBT for adolescent BDD will vary based on the developmental level of the child and his/her specific treatment goals. Findings from studies in pediatric anxiety populations comparing individual CBT to CBT plus family involvement have been mixed. However, CBT plus family involvement has shown some advantage over purely individual treatments (Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall et al., 1997; March & Mulle, 1998; Storch et al., 2007). Targeting parent behaviors associated with the maintenance of BDD symptoms, such as family accommodations of rituals, may facilitate symptom improvement and maintenance of gains.

Assessment

As with any good treatment, CBT for adolescent BDD begins with a good assessment. Here, a thorough assessment can help to discriminate normative vs. pathological concerns. It is not uncommon for BDD to first come under attention as a child's "inattentiveness" at school, anxiety, depression and social withdrawal, or school refusal. Thus, specific queries about appearance and body areas are important; therapists may uncover concerns that adolescents might otherwise be embarrassed or ashamed to disclose. The therapist also needs to evaluate the adolescent's concerns within a greater context, assessing for potential interference in daily life, including home, school (both behavioral and academic), and social settings. Younger adolescents often leave it to