



Subthreshold body dysmorphic disorder in adolescents: Prevalence and impact



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ABSTRACT

The aim of the current study was to establish the prevalence of subthreshold body dysmorphic disorder (subthreshold-BDD) in a community sample of adolescents, and to compare disorder correlates in individuals with subthreshold-BDD to those with probable full-syndrome BDD (probable-BDD) and those without BDD (non-BDD). Self-report questionnaires assessing *DSM-IV* BDD criteria, past mental health service use, and symptoms of body dysmorphic disorder, anxiety, depression, obsessive-compulsive disorder and eating disorders, were completed by 3149 Australian high school students (mean age =14.6 years, 63.5% male). Male participants also completed measures assessing quality of life, muscularity concerns, emotional symptoms, conduct problems, hyperactivity, and peer problems. The prevalence of subthreshold-BDD was 3.4%, and probable-BDD was 1.7%. Compared to the non-BDD group, subthreshold-BDD was associated with elevated symptoms of comorbid psychopathology and greater past mental health service use, and in male-only measures, with poorer quality of life and elevated muscularity concerns. Subthreshold-BDD participants reported significantly lower mental health service use, and fewer symptoms of depression, eating disorders, and hyperactivity than probable-BDD participants, however, other comorbid symptoms did not differ significantly between these groups. These findings indicate that subthreshold-BDD is associated with substantial difficulties for adolescents in the general community. BDD screening should include subthreshold presentations, as these may be an important target for early intervention programs.

1. Introduction

Body dysmorphic disorder (BDD) is an obsessive-compulsive spectrum disorder involving preoccupation with perceived defects in appearance (American Psychiatric Association, 2013). BDD typically begins in the adolescent years (Phillips et al., 2005); it affects 1.7–2.3% of adolescents, prevalence does not appear to differ between adolescent males and females, but is higher in older adolescents than younger adolescents (Mayville et al., 1999; Rief et al., 2006; Schneider et al., 2016). In clinical samples, adolescent BDD is associated with high rates of suicidality, functional impairment, and comorbid psychopathology, particularly depression, anxiety, and obsessive-compulsive disorder (Albertini and Phillips, 1999; Phillips et al., 2006). Recent community studies have also linked probable cases of adolescent BDD to elevated comorbidity, impaired quality of life, and deficits in social and emotional functioning (Mastro et al., 2016; Schneider et al., 2016).

Although BDD appears to be a potentially severe disorder in adolescence, little is known about the prevalence and relative severity of subthreshold-BDD. There is no established definition of subthreshold-BDD, but subthreshold disorders involve the presence of core disorder symptoms and associated distress or impairment that do not meet full diagnostic criteria (Pincus et al., 1999). In adolescents, subthreshold mental disorders are approximately twice as common as full-syndrome disorders, and constitute a substantial disease burden (Roberts et al., 2015). For example, adolescent subthreshold depression, anxiety, and obsessive-compulsive disorder are linked to increased comorbidity, greater functional impairment, and higher risk of later full-syndrome disorders (Balázs et al., 2013; Haller et al., 2014; Shankman et al., 2009; Wesselhoeft et al., 2013; Wolitzky-Taylor et al., 2014). No study has systematically examined subthreshold BDD in adolescence. However, one recent study found that those at moderate risk for BDD reported depression symptoms, self-worth, and appearance-related rejection sensitivity at levels intermediate between high-

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risk and low-risk groups (Mastro et al., 2016). There were similar numbers of adolescents in the high and moderate risk groups (9% vs 8% of the sample). However, as the study did not directly identify those with full syndrome and subthreshold BDD presentations, the prevalence of subthreshold-BDD in adolescents thus remains uncertain.

The current study aimed to establish the prevalence of subthreshold-BDD in a large community sample of adolescents. It also sought to examine the relative severity of subthreshold-BDD by comparing disorder correlates both to those with probable full-syndrome BDD (referred to as probable-BDD), and those without BDD (non-BDD). It was hypothesized that subthreshold-BDD prevalence would be elevated in older adolescents compared to younger adolescents, and that no significant sex difference in prevalence would be observed. Further, it was hypothesized that the subthreshold-BDD group would report higher symptoms of anxiety, depression, obsessive-compulsive disorder, and eating disorders, and greater past mental health service use, when compared with the non-BDD group. It was also hypothesized that the subthreshold-BDD group would report lower levels of anxiety, depression, obsessive-compulsive disorder, and eating disorder symptoms, and lower past mental health service use, than those with probable-BDD. Due to the nature of the recruitment methods, outlined below, a number of measures were administered to male participants only, and therefore the final hypotheses are specific to male participants. It was hypothesized that adolescent males with subthreshold-BDD would report higher quality of life impairment, muscularity concerns, emotional symptoms, peer problems, conduct problems, and hyperactivity, than non-BDD males, and lower scores on these measures than probable-BDD males.

2. Methods

2.1. Participants and procedure

Participants were recruited from seven high schools in New South Wales, Australia. Male participants were recruited from four single-sex Catholic boys' schools participating in a study about the utilization of an online treatment program for anxiety and depression. Female participants were recruited from two independent schools and one government girls' high school participating in a study of the development and prevention of anxiety and depression. All schools were located in the Greater Sydney area of New South Wales, Australia. School-level information was collected about socio-educational advantage (ICSEA; Australian Curriculum and Assessment Reporting Authority, 2013). This index is a standardized score ($M = 1000.0$, $SD = 100.0$) indicating socio-educational advantage relative to other schools in Australia. ICSEA of the participating schools ranged from 1002.0 to 1201.0 ($M = 1092.5$, $SD = 70.8$), indicating that schools ranged from average to high ICSEA.

Of 5005 eligible students, 3149 (62.9%) consented and took part in the current study; 2000 (63.5%) male, mean age 14.58 years ($SD = 1.4$, range = 12–18). Full information about study participants and procedures are available elsewhere (Schneider et al., 2016). Briefly, assessment sessions took place in class or year groups during school time, supervised by members of the research team, and teachers where available. Responses were collected confidentially using de-identified alphanumeric codes and participants were informed that the breaking of confidentiality would be considered only if their questionnaire responses indicated serious risk of harm, such as current suicidal ideation or evidence of abuse. The research was approved by the Human Research Ethics Committee of Macquarie University. Approval was also granted by each school and their relevant governing body. Information about the study was provided directly to parents and students, and informed consent and assent were obtained.

2.2. Measures

2.2.1. All participants

The Body Dysmorphic Disorder Questionnaire-Adolescent Version (BDDQ-A; Phillips, 2005) assesses DSM-IV criteria for BDD in a series of yes/no questions assessing appearance preoccupation, distress, and impairment (American Psychiatric Association, 1994). For example, preoccupation is assessed with the item 'Do you think about your appearance problems a lot and wish you could think about them less?' Participants are excluded if they report that their primary appearance concern is related to their weight, or concerns about not being thin enough. Participants also describe the body areas of concern and the nature of any associated impairment. Time spent thinking about appearance per day is also assessed, with a duration of at least one hour required to indicate BDD. Although the BDDQ-A has not been validated in adolescent samples, it is highly similar to the adult BDDQ, which has good sensitivity (100%) and specificity (89–93%) in adult psychiatric samples (Grant et al., 2001; Phillips et al., 1995).

BDDQ-A responses were used to determine BDD group membership. Individuals who were preoccupied with their appearance, experienced related distress or impairment, and were not primarily concerned about weight were classified as *probable-BDD* if they thought about their appearance for at least one hour per day, or *subthreshold-BDD* if they spent less than one hour per day thinking about appearance. All remaining participants were classified as *non-BDD*.

The Body Image Questionnaire, Child and Adolescent Version (BIQ-C; Veale, 2009) examines BDD symptoms including appearance checking, distress, avoidance, and impairment. The questionnaire begins with a screening item asking about the presence of any appearance concerns. If the participant does not report any concerns, they are given a total score of 0 and do not answer further items. Those with appearance concerns rank up to five body areas from most to least concerning. Twelve items then assess the nature and severity of appearance concerns, with varying response options scored 0–8. Current study internal consistency of the 12 symptom items $\alpha = 0.88$.

The child version of the 26-item Eating Attitudes Test (ChEAT-26; Maloney et al., 1988) measures disordered eating attitudes and behaviors. The least problematic responses (*never, rarely, sometimes*) are scored 0, the remaining responses scored as 1 (*often*), 2 (*very often*), or 3 (*always*). In the current study, internal consistency was $\alpha = 0.87$.

The Spence Children's Anxiety Scale (SCAS; Spence, 1998) contains 38 items assessing social anxiety, separation anxiety, generalized anxiety, panic-agoraphobia, obsessive-compulsive disorder, and physical injury fears, scored 0 (*never*) to 3 (*always*). Current study total scale internal consistency $\alpha = 0.93$.

The Short Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995) assesses depression symptoms over the past two weeks. This 13 item measure is scored from 0 (*not true*) to 2 (*true*). Current study $\alpha = 0.92$.

A screening item was included to assess whether participants had ever received assessment or treatment for any mental health concerns. If so, they were asked to indicate the type of mental health professionals consulted (psychologist/psychiatrist/school counselor/other), and to briefly describe their reasons for seeking treatment.

2.2.2. Male participants

The drive for muscularity scale (DMS; McCreary and Sasse, 2000) is a 15 item measure of muscularity-driven behaviors and body image concerns from 1 (*never*) to 6 (*always*), the total score is the mean of all items. The item assessing anabolic steroid use was omitted. As muscularity concerns are linked primarily to body image dissatisfaction in males (McCreary, 2007), the DMS was administered to male participants only. Current study internal consistency $\alpha = 0.93$.

Due to differences in the design of the two larger studies, two additional measures were administered only at boys' schools. The

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