Published in final edited form as:

J Am Acad Child Adolesc Psychiatry. 2002 December ; 41(12): 1503–1509.

Body Dysmorphic Disorder in an Adolescent Girl

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Identification

L.G. is a 16-year-old female who attends high school in a regular education 11th-grade classroom. After a series of referrals following presentation to a plastic surgeon for a breast surgery consultation, she eventually came to our outpatient psychiatric treatment center in the winter of 2000. I have seen her weekly since that time and have had collateral family sessions as well.

Chief Complaint

L.G.: “I want to have surgery soon to remove my breasts, because they don’t look like breasts, they look like flaps of skin hanging.”

History of Present Illness

L.G. has been binding her breasts since the age of 11. According to L.G., she began developing breasts as early as age 9. At age 11 she started wearing two leotards during dance class, in an attempt to hide them, and by the time she was 12 she was binding her breasts with bandages under her clothing. She was extremely self-conscious of her breasts and felt that they were “too large and [she] was too young to have them.” Her breast-binding led to a physical deformity for which she sought a bilateral mastectomy. At no time did she convey her wishes to become a boy, exhibit cross-gender play or roles, or prefer to spend time with boys. Rather, she wanted to remain a little girl.

According to her mother, L.G. exhibited a variety of other unusual behaviors as well. At age 12 L.G. cut off her dolls’ hair or removed their heads. She cleaned them frequently with rubbing alcohol and placed them individually into Ziploc bags in a particular order, which she did not want to be disturbed. At age 13 she began washing her hands frequently and spent up to 2 hours a day in the bathroom. She also restricted her food intake but from her history did not meet criteria for an eating disorder. Eventually, she began to apply creams and bleaches to her face,

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The parents and child provided verbal consent to the publication of this paper.

hair, eyelashes, and eyebrows; would cut her own hair on occasion; washed her face several times a day; and at times engaged in skin-picking. Her academic performance suffered because the rituals kept her in the bathroom or looking at the mirror during class and before school. She became oppositional with her parents and sometimes took money from them to buy face creams. Her worries about her breasts intensified, and she sometimes kept the shades drawn in her home because she believed that people outside were looking at her face and her breasts. She became socially isolated, but denied other symptoms of social phobia or panic attacks.

L.G. reported that for approximately a year before intake she was irritable, was anhedonic, and had difficulty falling asleep and a low energy level. She had a normal appetite and no psychomotor agitation or retardation. She also reported feeling unloved by her mother and criticized by her father. At times L.G. would tell her parents, "If I were gone you would be better off." L.G. denied active suicidal ideation or a plan, however, and has never made a suicide attempt or engaged in self-injurious behavior. L.G. has no history of manic symptoms. L.G. had poor insight. At times her beliefs about her body approached delusional proportions. She was guarded about these beliefs and expressed paranoid ideation outdoors and in school. She believed that most people looked at her and scrutinized her body. She denied auditory or visual hallucinations.

Psychiatric History

L.G. had two psychiatric evaluations in the year prior to starting treatment. She has no history of substance abuse and no history of physical or sexual abuse or neglect.

Medical History

L.G. has a history of asthma, with no medications required for the past 3 years. She has had no major surgeries or illnesses. She refused a pediatric examination for 3 years. Upon eventual physical examination in 2001, it was found that she had attempted to remove all evidence of secondary sexual characteristics and denied entering menarche. Laboratory results were normal for complete blood cell count, Chem-20, thyroid function test, anti-streptolysin O titer, vitamin B₁₂/folate, and rapid plasma reagin test. A magnetic resonance imaging scan and a neurological evaluation performed by a neurologist were showed no abnormalities.

Developmental History

L.G. was a planned pregnancy. Her mother reported a normal spontaneous vaginal delivery after 2 hours of labor without complications. Her mother described L.G. as a "healthy lovely" infant and said that she met all of her milestones at normal ages.

Social History

Although her family lived together until L.G. was 5 years old, at that age her mother moved to another state to live with her own mother and L.G. was left to live with her paternal grandparents. L.G.'s father soon followed her mother, but L.G. did not join them permanently until she was 12 years old. Although L.G. enjoyed having her own bedroom in her grandparents' home, she did not enjoy being separated from her parents. At the age of 12 she asked her parents, "Why don't you send my little sister instead of me [to live with the grandparents]?" Because of her distress with this separation, the parents then brought L.G. to live with them. She was a fair student, but she had minimal peer interaction during and after school. L.G. reported enjoying ballet dancing and playing dress-up and dolls with her sister and grandmother as a younger girl. She currently enjoys going to the bookstore, spending time

with her dog, reading, surfing the Web, listening to music, playing guitar, and playing computer games.

Family Psychiatric History

L.G.'s mother is the primary financial provider for the family. She has a history of early abuse with resulting posttraumatic stress disorder symptoms. She reports episodes of dissociation, nightmares, panic attacks, and multiple somatic complaints. L.G.'s father has not worked for several years because of multiple somatic complaints; he currently suffers from depression and anxiety symptoms. Her grandmother has multiple phobias, social anxiety, and depression. The family lives in a one-bedroom apartment because of their limited financial means.

Mental Status Examination on Admission

L.G. is a light-skinned adolescent female who appears younger than her stated age. She has long dark hair with bleached areas near her temples and bleached eyelashes and eyebrows. She often wears a large jacket and a knit hat or baseball cap during sessions. She walks hunched over and shuffles her feet "like a penguin," according to L.G., her father, and her peers. L.G. generally has good eye contact and is able to sit still in sessions. She speaks fluent English and has a loud, childlike voice, but normal rate and prosody. She is generally cooperative but is guarded and superficial at times. She usually reports that her mood is "fine," but her affect is often constricted although she is able to laugh and smile appropriately. Her thought process is logical and linear, although at times she is concrete and demonstrates thought patterns more appropriate for a younger child. For example, she says things like, "I crossed my fingers in the assembly and that is why they didn't call my name." She has overvalued ideas about others looking at her but no hallucinations. According to psychological testing, her memory and intelligence are in the average range.

Diagnostic Impression on Admission

Diagnoses at the time of admission were as follows:

- Axis I: Body dysmorphic disorder; major depressive disorder, single episode, moderate; rule out delusional disorder, somatic type
- Axis II: Deferred
- Axis III: Breast deformity, asthma
- Axis IV: Conflict with parents, poor school performance, history of multiple separations from parents
- Axis V: 55

Course of Treatment

During the initial phase of treatment the major focus was on establishing an alliance with L.G. and her parents. Initially, there was a discrepancy between L.G.'s agenda for therapy and my own. L.G. believed that she was coming to therapy to convince me that she needed a bilateral mastectomy. I believed that therapy would help L.G. to understand better her psychiatric symptoms and to develop more healthy ways of resolving her anxieties about her body and growing up. During the engagement phase of the treatment, we spent time together looking at magazines, discussing journals, walking outside of the office, and taking a fuller history.

L.G.'s ensuing treatment has included multiple treatment modalities including psychodynamic psychotherapy, cognitive-behavioral therapy (CBT), psychopharmacotherapy, consultations

with other medical specialists, and family sessions. Briefly, I will go through each of the modalities utilized in her treatment.

Psychodynamics

L.G.'s psychodynamic issues arose quickly, and clearly, in our work together. Themes of conflict with sexuality and her relationship with her parents, as well as struggles over growing up and remaining young, were present from the onset of our work. In one of our early sessions L.G. shared a journal passage with me which clearly illustrates these issues:

The one reason I want to have this surgery is because I'm sick and tired of everyone laughing at me at school.... I believe that at age 9 the breasts (I don't wanna say "my") were big.... I remember Momma buying me bras. I think that I was pretty naive because I actually liked the bras then as I grew older I hated them real badly. At age 11 I started wearing a wraparound. I wished that I didn't have any breasts. I believe that I was the only girl in the ballet school with breasts. I hated that. I hate this.... The big main reason I want this surgery is because after all these years I have been happy but not really happy. I have had tons of beautiful toys, but then when it's time to go to the doctor, I panic. My heart beats really fast and this is because I don't want the doctors to examine me because of my problem.... After all these years of suffering, I think that my mind is 100% made up. If the reduction is done [to restore the breasts to a normal shape] then I can't be a kid cause I'll look like a woman and it wouldn't make up for the lost years of sorrow. And I would hate it.

This excerpt and our initial sessions together emphasized L.G.'s wish to remain a little girl. When she was allowed to openly explore her struggle between growing up and staying young, she began to resolve some of her unconscious fears about developing into a woman. She began to experiment with adolescent interests such as rock stars, nail polish, funky jewelry, and shoes, and she became more interested in learning about the female body.

Her ambivalence about growing up translated into general ambivalence about therapy and her relationship to me. As the work progressed, many reasons for her reluctance to grow up became clear. Her mother, who had suffered abuse as a child, transmitted her own ambivalence about the dangers of becoming sexual. At an unconscious level, L.G. realized that her mother did not want her to grow up, because of a fear for her safety and a fear of her own relationship with sexuality. I also came to see how her father encouraged L.G. to remain a little girl. Perhaps because of the platonic relationship with his wife, the discomfort of having a pubescent adolescent in their apartment provoked his anxiety. As a result, L.G. understood that she would be more tolerable to both of her parents if she remained a little girl and did not become a sexual woman. This translated transferentially into a reluctance to attend therapy sessions, discuss certain topics, and a conscious wariness of becoming healthy. Although I did not directly interpret these sexual issues and the way that they interfered with her health, it helped me to understand her, her relationship with me, her relationship with her parents, and the obstacles to attaining psychological health as represented by an age-appropriate developmental stage.

Cognitive-Behavioral Therapy

Although CBT is the evidence-based treatment for body dysmorphic disorder (BDD), L.G. was initially unwilling to accept a diagnosis or to work on changing her ego-syntonic symptoms. She reported boredom with cognitive restructuring or exposure/response prevention efforts. However, we made some progress in this regard over time. Perhaps a turning point was an event that happened on one of her class trips. She became extremely panicked while on a horse, but before anyone could help, she noticed her anxiety dissipate. Noticing that her anxiety could rise and fall, she became willing to discuss ways of coping with her anxiety in therapy. We subsequently came up with a hierarchy of activities for exposure therapy for

being outdoors, and we used some of our therapy time for walking outside of the hospital and having her go short distances by herself. We also have developed response prevention for looking in the mirror and going outdoors, and we had an in-session component of placing spots on her face and walking around the hospital while resisting looking in the mirror or washing them off. Although she will not participate in these efforts outside of our sessions or in an ongoing way, she has begun to contemplate her diagnosis and jokingly renamed BDD to FDD (face dysmorphic disorder) as she believes that her worries about her face are her biggest problem.

Psychopharmacology

BDD, including severe forms such as delusional disorder, somatic type, have been found to respond better to high doses of selective serotonin reuptake inhibitors (SSRIs) than to antipsychotics. If the patient is refractory, an atypical antipsychotic or buspirone may be helpful. Because of L.G.'s ego-dystonic symptoms of "worrying about everything," wanting more friends, and fearing the outdoors, she agreed to begin taking medication. She was initiated on fluvoxamine 25 mg b.i.d., which has been titrated up over the course of her treatment to 400 mg most recently. I chose this medication because it has been cited in the literature as an effective SSRI for BDD, would treat her symptoms of depression, and has been proven safe and efficacious for children with anxiety disorders. On this medication L.G.'s depression went into remission as evidenced by her improved mood, decreased irritability, decreased hopelessness, and improved sleep.

After approximately 6 months of treatment with fluvoxamine, a decision was made to add an atypical antipsychotic to target L.G.'s intense paranoia and micropsychotic episodes related to her worries about her face and leaving her home. At times she hid under the bed or in the closet out of concern that others were looking at her face and body; at school she would sometimes hide in the bathroom or walk the hallway pressed up against the walls (to hide). Initially, quetiapine fumarate was added but she had significant sedation with 25 mg once-daily dosing. We then initiated risperidone up to a total of 1.5 mg/day. On this medication L.G. initiated leaving her home and felt less paranoid outdoors. Unfortunately, within a few weeks hyperprolactinemia (86.2 ng/mL [3.5–31 normal]) with galactorrhea developed as a side effect, so risperidone was discontinued. More recently, on olanzapine 2.5 mg at bedtime she reported increased comfort outdoors and around peers at school. However, over the course of approximately 2 months she gained 35 pounds and this medication was discontinued. Because her QTc is 0.45 ms and she would not tolerate regular electrocardiograms, ziprasidone was not initiated. At present her fluvoxamine dose has been increased to 400 mg, and we are considering haloperidol if her severe paranoia with agitation, insomnia, school refusal, or refusal to go outdoors returns while we wait for her to reach an effective dose.

Consultation

During treatment L.G. had consultations with her pediatrician, plastic surgeon, and neurologist. Most poignant to our work was the two times I accompanied L.G. to the plastic surgeon. In preparation and during the meetings, L.G. and I were allies in her problem of how to deal with her breasts. Fortunately, we found a plastic surgeon who had informed herself about BDD. The plastic surgeon and I agreed that the following criteria must be met prior to L.G.'s undergoing surgery for her breast deformity: (1) L.G. must be at least 17 years of age to complete her physical maturation prior to any surgery; (2) L.G. must be prepared not to bind her breasts or put restrictive garments across her chest for at least 1 year because of possible irritation of surgical scars; and (3) L.G. will need to demonstrate an attitude of acceptance regarding her surgery outcome (barring any complications) such that she will be expected to tolerate her breasts regardless of their exact size or shape. This may be determined by having her practice

wearing a minimizing bra that will return her breasts to their appropriate location and allow for them to be a round shape. L.G. understands these criteria, but does not currently believe she could tolerate them. At this time, the surgery will remain an active psychotherapy issue.

Family Therapy

The family work focused on psychoeducation about BDD, parenting skills, and improving communication. L.G. and I set out parameters for her parents to intervene with L.G.'s behaviors only in dangerous situations, in order to decrease their anxiety and to decrease the amount of time they spent preoccupied with L.G. I promoted the family work together to contain their anxieties about this illness. This intervention was more successful with the mother, who has educated herself about BDD, joined a parent support group, and is able to foster age-appropriate behaviors in L.G. Her father, on the other hand, because of his struggle with his own anxiety and depression, does not abstain from scrutinizing L.G. and continues to inadvertently support her in the sick role without promoting her attainment of adolescent behavior. Of note, although L.G. was the identified patient in this family system, as some of her symptoms improved her parents demonstrated increased psychiatric symptoms.

Conclusion

Working with L.G. and her family has presented many challenges. Chief among these are the intransigence of her symptoms and the necessity to create an individual multimodal treatment. Although she recently told me that she wishes she were in her early teens, she remains physically, psychologically, and socially delayed. She continues to bind her breasts and deny her menarche. Although she agrees that she has BDD, she has not yet fully embraced participating in CBT and continues to have fears about going outside, not using lotions, avoiding the mirror, and becoming a woman. She isolates herself at home and fears contact with other children, even if they are younger. If treatment is to be successful, she will eventually learn techniques to decrease her physically and socially debilitating BDD behaviors and will have the confidence to proceed through development out of childhood and eventually into womanhood.

BDD and Psychopharmacology Discussion: *Katharine Phillips, M.D*

This intriguing case presentation richly illustrates many of the classic features of BDD while also highlighting that each patient presents with a unique history and symptoms requiring an individualized formulation and treatment approach. L.G. met criteria for BDD, a *DSM-IV* somatoform disorder (American Psychiatric Association, 1994) that usually begins during adolescence, because she was excessively preoccupied with minimal or nonexistent appearance flaws that caused clinically significant distress and functional impairment. BDD is relatively common in adolescents, with a reported rate of 2.3% in a community sample (Mayville et al., 1999).

Skin concerns (e.g., facial acne, scarring, lines) appear most common in both adolescents and adults, although the preoccupations can focus on any body area (Albertini and Phillips, 1999; Phillips and Diaz, 1997). L.G.'s excessive and time-consuming mirror checking, facial routines, hair dying, skin picking, and camouflaging (e.g., wearing a baseball cap) are typical BDD behaviors (Phillips et al., 1993). It is ironic that L.G.'s attempts to camouflage her breasts by binding them caused an actual physical deformity. "Self-mutilation" in BDD can take many forms. Occasionally patients hate their appearance so intensely that they purposely mutilate the body part (e.g., slash their face with a razor blade) (Phillips, 1996). More often, however, the damage is an unintentional byproduct of misguided attempts to improve the perceived flaw. For example, about one third of BDD patients compulsively pick their skin to remove minor

imperfections such as blemishes (Phillips and Diaz, 1997). However, because they typically pick for hours a day and may use implements such as pins or razor blades, this behavior can cause notable lesions or scarring and even dangerous outcomes (e.g., exposing major blood vessels and requiring emergency surgery). Occasionally patients, in a desperate attempt to remove a perceived deformity, do self-surgery (e.g., attempt a facelift with a staple gun or cut off their nipples) (Phillips, 1996; Veale, 2000).

Functional impairment caused by BDD can reach debilitating proportions in both adults and adolescents (Albertini and Phillips, 1999; Phillips et al., 1993). L.G.'s academic impairment and social isolation and avoidance are typical complications of this disorder. In the largest series of children and adolescents with BDD ($n = 33$), BDD led to social impairment (e.g., avoidance) in 94% and school or work impairment in 85% (Albertini and Phillips, 1999). In addition, 39% of patients had a history of psychiatric hospitalization, 67% a history of suicidal ideation, and 21% a history of suicide attempts.

Such symptoms and complications clearly require treatment and should not be considered a normal "phase" of childhood or adolescence. Essential groundwork for successful treatment includes obtaining a comprehensive history, providing psychoeducation about BDD, and establishing a good treatment alliance. The latter can be difficult to accomplish because individuals with BDD are usually ashamed of their symptoms and reluctant to reveal or discuss them. In addition, like L.G., many patients want surgery or dermatological treatment rather than psychiatric treatment, most have poor insight or are delusional in their belief that they look abnormal, and relatively few can acknowledge that their appearance-related beliefs are due to a psychiatric illness (Cotterill, 1996; Phillips et al., 1993). Engagement in treatment may be facilitated by emphasizing its potential to improve functioning and diminish distress and time-consuming preoccupations.

L.G. received excellent treatment, and a multimodality approach was highly appropriate in her case. SSRIs are often effective for BDD in children and adolescents, although data are limited to a small number of case reports, case series, and a retrospective chart review study that included adolescents (Phillips, in press). SSRI efficacy in adults is supported by more methodologically rigorous studies, consisting of three open-label trials (two with fluvoxamine and one with citalopram), a double-blind crossover trial (clomipramine versus desipramine), and a placebo-controlled trial (fluoxetine) (Hollander et al., 1999; Phillips, in press; Phillips et al., 2002). Of note, SSRIs appear as effective for patients with delusional beliefs about their appearance as for nondelusional patients (Phillips, in press). Although dose-finding studies have not been done, clinical experience with adults and adolescents suggests that relatively high SSRI doses are often needed and that some patients benefit from a dose exceeding the maximum recommended dose. A 12- to 16-week trial may be necessary for response to occur. While the efficacy of antipsychotics has received very little investigation, it is reasonable to add one to an SSRI, especially when insight is lacking or referential thinking is prominent.

CBT also appears effective for BDD, although no studies of this modality have been done in children or adolescents. In adults, case series and two waitlist control studies (Rosen et al., 1995; Veale et al., 1996) suggest that response prevention (e.g., stopping excessive mirror checking), exposure (e.g., to social situations), and cognitive restructuring are effective for a majority of patients. Unfortunately, some patients, like L.G., refuse to participate in CBT, although may agree to do so at a later stage of treatment—for example, after the therapeutic alliance has been strengthened or symptoms have partially responded to medication.

While the histories of patients with BDD may be rich with meaning, it appears that psychodynamic psychotherapy alone is unlikely to be effective for BDD symptoms per se, although data on this important question are very limited (Phillips et al., 1993). Nonetheless,

a psychodynamically informed understanding of the case can be helpful, and psychodynamic psychotherapy may be beneficial—even necessary—in addition to an SSRI or CBT to address other problems the patient may have, such as relationship conflicts, life stressors, or identity issues. Surgery and dermatological treatment, which a majority of BDD patients receive (Phillips et al., 2001), usually appear ineffective for this disorder. However, for occasional patients such as L.G., such treatment may be reasonable, in which case it is important for the psychiatrist and nonpsychiatric physician to collaborate. Research on BDD's treatment, clinical features, and other characteristics in adolescents is very limited and greatly needed, so that patients like L.G. can be helped to overcome this distressing and sometimes disabling disorder.

Psychoanalytic Discussion: Owen Lewis, M.D

Modern psychoanalytic psychotherapy with children is pluralistic in theory and integrative in technique. Because neither its theories nor techniques are fixed or formatted, its practitioners, working from what is known about specific treatments for specific diagnoses and from general guidelines pertaining to specific developmental stages, are in the position to create anew each treatment for each child. Thus both theory and technique evolve. This case presentation offers excellent illustrations of these considerations.

While psychoanalytic theory may be used to explain specific psychopathology (in this case, BDD and an arrested psychosexual development), it is first and foremost a mode of inquiry. It is about making the mind (and the behaviors the mind elaborates) intelligible to itself; it is, as Donald Spence has described, about creating a plausible life narrative; it is about finding meaning. Even when there is incontrovertible evidence of a specific disorder, the disorder exists in a human being who may or may not accept its presence. Thus the starting point of every treatment is the engagement of the patient with the therapist in a process of looking for meaning, even when the patient tenaciously adheres to his formulations.

L.G., at the start of treatment, sees her therapist merely as the gatekeeper to the plastic surgeon. She does not accept that she has a psychological disorder, let alone any concept of arrested development. When initial denial is of sufficient magnitude, the patient will reject all attempts to cure. Psychopharmacological or cognitive-behavioral interventions pertain to disorders. Short of conducting oneself in a benign physicianly manner, these interventions essentially provide no theory to guide the approach when the patient rejects the idea of a disorder. What are therapists to do when the patient does not want the help they have to offer? To insist on initiating either medication or a behavioral approach at this point is essentially to tell patients that they are wrong in their views, or to tell them simply to stop the behaviors which brought them to treatment.

Central to all psychoanalytic theories, however, is the concept of complex, multideterministic symptom-formation. Such concepts allow the therapist to be guided by some theory when there is not clear agreement of therapeutic purpose and to formulate questions that will be answered over the course of the treatment. L.G.'s rejection of her breasts is patently a signal that she is not ready to assume a maturing feminine identity. Why this girl has presented with this developmental impasse is one such question to be answered. One can hypothesize that the separation from her parents at age 5 played an etiological role, yet this too frames other questions. An important piece of information is obtained many months after treatment has begun; namely, that L.G.'s mother was abused at about the same age that she abandoned L.G. One then understands both the mother's fears about L.G.'s potential sexuality as well as the mother's inability to shepherd her daughter toward a comfortable adult sexuality.

As stated, modern psychoanalytic psychotherapy is pluralistic in theory. Three differing theories—drive, object relations, and interpersonal—will be used to illustrate. There is perhaps not yet enough information to spell out fully the formulation in terms of drive theory, yet such a formulation would posit unusual anxiety around genital sexual impulses, denial of these impulses, regression to a pregenital state, and the conflict between genital sexual impulses and pregenital needs. Interpretation, per se, would not be any more helpful than premature involvement in a CBT program. Object relations theory would look at the lacunae in the internalized mother figure and offer the therapeutic relationship as a forum in which to examine these. The therapist's role thus becomes clear, especially considering that all child psychoanalytic theories of technique hold that the therapist serves both as transference object as well as real object offering new possibilities for identification, if not internalization. In the middle phase of this treatment, Dr. Horowitz was able to share books and magazines with L.G. that dealt with issues of feminine beauty and health. There was simultaneously offered a corrective emotional experience and an examination of the deficits of L.G.'s upbringing. Finally, the interpersonal approach looks transactionally at the array of interactions occurring between patient and therapist (with therapist as participant observer) and considers, as well, those classes of interactions not occurring. Dr. Horowitz notes, in the first phase of treatment, that a discrepancy existed between L.G.'s agenda for therapy and her own. Even when there is apparent agreement between patient and therapist, there is always, on some level, a divergence of agenda between patient and therapist initially, just as there is a divergence of language. Therapy, from an interpersonal perspective, initially aims to achieve convergent language and clarify the divergences of agenda. Ultimately, therapy succeeds through a process of what Harold Bloom (in literary criticism) called a "theory of mutual influence." In the interpersonal psychoanalytic perspective, patients come to see themselves from the therapists' perspective, and the therapists come to understand the how's and why's of the patients' perspective and, usually, there is a change of stance toward each other. L.G. came to accept that she was afraid to grow up (Dr. Horowitz's perspective), and Dr. Horowitz came to facilitate the consultations with the plastic surgeon (L.G.'s perspective).

It is important to note that Bloom's theory of mutual influence pertained, as well, to cultural influences. This applies, of course, to the culture of therapeutics. It is impossible to practice a pure therapy, even if it be a manual-based one. Psychoanalysts today, by guiding their patients to address the realities of their lives, and in stages to reduce the attendant anxieties, are, in fact, incorporating cognitive-behavioral techniques. By allowing for these influences, child therapists of all affiliations are able to practice a more comprehensive and competent psychotherapy.

Cognitive-Behavioral Therapy Discussion: *Kenneth Gorfinkle, Ph.D*

L.G. is a resistant patient with undeveloped insight into the fact and nature of body dysmorphism. This, however, need not be a major obstacle to effecting change through cognitive-behavioral methods. The preferred approach to BDD is based on a three-part technique used with obsessive-compulsive spectrum disorders. Principally, the patient must:

1. Reduce avoidance of symptom-producing stimuli, thereby increasing the experience of anxiety, stimulating compulsive urges. In L.G.'s case this means attending therapy sessions knowing that her body image will be discussed realistically. As long as she lived "as if" she were a little girl and avoided all the ramifications of being a socialized American teenager, she was protected from much of the emotional stress that drives her compulsive scrutiny of her skin and body.
2. Engage in response prevention. For L.G. compulsive responses must include taping her breasts, walking with hunched posture, contemplation of and seeking mastectomy as a "permanent solution," seeking application of skin creams, checking mirrors for

skin irregularities, bleaching and tweezing body hair and eyelashes, and thinking or talking about all of the above.

3. Practice exposure to intentionally trigger the above urges as intensely as feasible. Exposure guarantees that the patient will experience compulsive urges. However, because the patient plans and executes exposure by herself, she may paradoxically perceive her self-induced anxiety and resultant urges to be under her control. Examples of exposure for L.G. might include painting blemishes on her face and walking in public, or walking with freer posture vis-à-vis her breasts with the intention of being looked at. Contemplating appropriately shaped outcomes of breast reconstructive surgery and intentional emphasis on femininity might function both to reduce avoidance and increase the discomforts associated with being perceived as physically mature. When the time comes for the surgery itself, every phase of that process is likely to be anxiety-inducing and therefore potentially useful to L.G. if used in such a way as to provide repeated sequences of anxiety followed by successful response prevention. It will be crucial for L.G. to take as much control and initiative as possible with regard to the surgery, while maintaining realistic expectations of its outcome.

Clinical experience has shown that a piecemeal approach to symptom control hampers overall success of CBT. The patient's fear of appearing like a grown woman functions as an underlying theme for most of her BDD symptoms.

Insofar as L.G. continues to cling to her conviction that she must not look physically mature, it will be crucial that she attack the broad spectrum of her symptoms with equal vigor. Thus, to ensure success, not only should she refrain from tweezing and bleaching facial hair, but she then could be guided to create the much exaggerated "hyperfeminine" look that she perhaps had feared in the first place.

Dr. Horowitz need not try to accomplish such intense treatment without support from L.G.'s family, friends, plastic surgeon, and any others whom L.G. can recruit to support her through a difficult and challenging treatment. Change occurs equally within the therapist's office and in the patient's daily life. The therapeutic fulcrum for exposure/response prevention is the moment when anxiety triggered by self-exposure is tolerated long enough for it to dissipate while compulsive urges are successfully resisted. For L.G. such a pivotal moment may have to await breast reconstructive surgery, after which she will have the opportunity to face herself in a new way—with no turning back.

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