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# COGNITIVE–BEHAVIORAL TREATMENT OF BODY DYSMORPHIC DISORDER: A CASE REPORT

NORMAN B. SCHMIDT

Uniformed Services University of the Health Sciences

PATRICK HARRINGTON

The University of Texas at Austin

**Summary** — Body dysmorphic disorder (BDD) refers to preoccupation with an imagined physical defect or the exaggeration of a slight physical anomaly. Since BDD's inclusion in the DSM-III-R, there have been only a handful of reports of its cognitive–behavioral treatment. We describe one successful short-term cognitive–behavioral therapy treatment of a BDD patient whose presenting concern was small hand size. After nine sessions of therapy, the patient evidenced substantial change on indices measuring affective, cognitive, and behavioral facets of BDD. There was also clinically meaningful improvement in overall levels of depression and anxiety. It is suggested that cognitive–behavioral treatment programs for BDD should take into account comorbid conditions such as social phobia, and avoidant personality disorder.

Relatively little is known about the nature, causes, and treatment of dysmorphophobia, or body dysmorphic disorder (BDD). BDD is defined by the DSM-IV (APA, 1994) as the preoccupation with some imagined defect in physical appearance or a gross exaggeration of some slight physical anomaly. Individuals with BDD are typically preoccupied with facial appearance or, more rarely, with the appearance of genitals (Hollander, Liebowitz, Winchel, Klumker, & Klein, 1989), breasts (Olley, 1974), skin (de Leon, Bott, & Simpson, 1989) or other body parts. Individuals with BDD may be preoccupied with multiple body parts simultaneously (Andreason & Bardach, 1977) and these body parts may shift over time (Hollander et al., 1989).

The functional impairment created by BDD can be considerable. Not only do individuals with BDD spend an inordinate amount of time worrying about and attempting to conceal the perceived defect, their worry can create significant avoidance of social activities (Hay, 1970), work (de Leon et al., 1989) and school (Braddock, 1982). A substantial proportion of BDD patients become completely housebound (Cotterill, 1981; Philips, McElroy, Keck, Pope, & Hudson, 1993). Not surprisingly, many individuals with BDD seek out medical treatment and plastic surgery (Andreasen & Bardach, 1977; Hay, 1970). Individuals with BDD also appear to be at risk for suicide attempts (Braddock, 1982; Philips et al., 1993).

Since BDD's inclusion in the DSM-III-R (APA, 1987), there have been relatively few

Requests for reprints should be addressed to Norman B. Schmidt, Ph.D., Department of Medical and Clinical Psychology, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814-4799, U.S.A.
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reports describing its treatment. Phillips (1991) in a review of pharmacological treatments, reports that serotonin-reuptake blockers have shown the greatest effectiveness. However, there has been little or no efficacy demonstrated in studies using tricyclics (Hollander et al., 1989; Thomas, 1984), MAO inhibitors (Vitello & de Leon, 1990), benzodiazepines (Hollander et al., 1989), or antipsychotics (de Leon, Bott, & Simpson, 1989). ECT has also been ineffective (Hay, 1970; Hollander et al., 1989).

Several reports have examined the combination of pharmacological and behavioral or cognitive-behavioral treatments for BDD. Although these combined treatments show some effectiveness (Marks & Mishan, 1988; Solyom, DiNicola, Phil, Sookman, & Luchins, 1985; Vitello & de Leon, 1990), there is no clear evidence indicating that specific combinations of pharmacological and psychological treatments are especially effective.

Only one report has examined the effectiveness of cognitive–behavioral treatment for unmedicated BDD patients. Neziroglu and Yaryura-Tobias (1993) used exposure plus response prevention in treating five BDD patients who were preoccupied with some aspect of their face or head. Patients received some cognitive therapy but the treatment focused on exposure of the perceived physical anomaly along with the prevention of related avoidance behaviors (e.g., keeping hands from covering the face). Successful outcome was reported in four of the five cases. Interestingly, all five cases in this study also met diagnostic criteria for obsessive–compulsive disorder (OCD). This is consistent with other reports which have suggested a relationship between BDD and OCD (Hollander et al., 1989; Solyom, DiNicola, Phil, Sookman, & Luchins, 1985).

This report describes a short-term cognitive–behavioral therapy treatment of one BDD patient. There are several unique aspects of the case and its treatment. Unlike patients in the Neziroglu and Yaryura-Tobias (1993) study, this individual exhibited no obsessive–compulsive traits. In addition, the patient's area of worry, a preoccupation with hand size, is an uncommon BDD concern. For example, one recent report on a fairly large sample of BDD patients found no patients with hand size concerns (Philips et al., 1993). The cognitive–behavioral therapy method was based on a collaborative-empiricist approach and, unlike previous work, involved no therapist assisted exposure.

## Method

### *Subject*

The patient was self-referred to a psychology department clinic due to distress which resulted from preoccupation and worry regarding his hand size. Assessment using the SCID and SCID-II (Spitzer, Williams, & Gibbon, 1987) revealed a primary diagnosis of BDD as well as diagnoses of Alcohol Abuse and Benzodiazepine Abuse. The patient did not meet diagnostic criteria for any Axis II personality disorder.

*Case history.* The patient is a 24-year-old Caucasian male in his senior year of college. He presented at intake by stating "I've got a physical deformity (small hands) and it makes me very uncomfortable, especially around women with hands bigger than mine. I see my deformity as a sign of weakness; it's like I'm a cripple."

The patient reported that his BDD-concerns began when he was 18 years old and was working as a landscaping assistant with a large firm. After receiving instructions to plant some shrubs three hand-widths apart, the patient reported that his boss angrily reviewed his work, saying to the patient, "You have the smallest hands I've ever seen! You need to replant the shrubs five hand-widths apart!" After this incident, the patient began comparing his hand size with others and also become increasingly anxious when exposing his hands to others. He spent considerable time researching hand sizes for different populations and stated at intake that his middle finger is one and one-fourth inches smaller than the average size for a male in the United States.

The patient reported that he viewed his small hands as a sign of weakness and inferiority. He