

Modular Cognitive–Behavioral Therapy for Body Dysmorphic Disorder

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This study pilot tested a newly developed modular cognitive–behavioral therapy (CBT) treatment manual for body dysmorphic disorder (BDD). We tested feasibility, acceptability, and treatment outcome in a sample of 12 adults with primary BDD. Treatment was delivered in weekly individual sessions over 18 or 22 weeks. Standardized clinician ratings and self-report measures were used to assess BDD and related symptoms pre- and posttreatment and at 3- and 6-month follow-ups. At posttreatment, BDD

and related symptoms (e.g., mood) were significantly improved. Treatment gains were maintained at follow-up. A relatively low drop-out rate, high patient satisfaction ratings, and patient feedback indicated that the treatment was highly acceptable to patients. To our knowledge, this represents the first test of a broadly applicable, individual psychosocial treatment for BDD.

Keywords: body dysmorphic disorder; BDD; cognitive-behavioral therapy; body image; treatment

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Body dysmorphic disorder (BDD) is a severe body image disorder consisting of an often-delusional preoccupation with an imagined or slight defect in appearance (American Psychological Association, 1994). This preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, and it is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa). BDD is a common disorder; nationwide surveys have found a point prevalence of 1.7 to 2.4%

(Buhlmann et al., 2010; Koran, Abujaoude, Large, & Serpe, 2008; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brähler, 2006). BDD usually begins during early adolescence (Phillips & Diaz, 1997; Phillips, Didie, et al., 2006) and, when untreated, the disorder is often chronic and unremitting (Phillips, Pagano, Menard, & Stout, 2006). BDD is associated with high lifetime rates of psychiatric hospitalization (48%), being housebound (31%; Phillips & Diaz, 1997), and high rates of suicidality. In cross-sectional studies, lifetime suicidal ideation rates are 78–81%, and lifetime suicide attempt rates are 24–28% (Perugi et al., 1997; Phillips, Coles, et al., 2005; Phillips & Diaz, 1997; Phillips & Menard, 2006; Veale, Boocock, et al., 1996). This suicide attempt rate is 6–23 times higher than in the U.S. population. Completed suicide has been reported (Atiullah & Phillips, 2001; Cotterill, 1981; Cotterill & Cunliffe, 1997; Phillips & Menard, 2006; Veale, Boocock, et al., 1996; Yamada, Kobashi, Shigemoto, & Ota, 1978). When controlling for age, gender, and geographic region, the standardized mortality ratio is markedly elevated (American Psychological Association, 2003; Harris & Barraclough, 1997). Despite BDD's relatively high prevalence and substantial morbidity, no widely applicable manualized psychosocial treatment has been tested for this complex disorder.

Treatments for other disorders are not applicable to BDD because there are important differences between symptoms of BDD and those of other disorders (Phillips, 2005). Differences include the content of the preoccupation (appearance), specific repetitive and avoidance behaviors (e.g., surgery seeking, mirror checking, skin picking, compulsive grooming), perceptual distortions, and poor insight, which are typically present in BDD but not disorders such as obsessive-compulsive disorder (Eisen, Phillips, Coles, & Rasmussen, 2004). Thus, a treatment that specifically targets BDD's unique symptoms is greatly needed.

Preliminary research suggests that cognitive-behavioral therapy (CBT) specially developed to address the unique features of BDD is promising for this severe disorder. A growing literature—consisting of case reports, case series, and two studies using wait-list control groups (for review see Ipser, Sander, & Stein, 2009)—suggests the effectiveness of cognitive and behavioral techniques, such as cognitive restructuring and exposure and ritual prevention exercises, in reducing BDD symptoms when delivered individually (McKay et al., 1997; Neziroglu, 1996; Veale, Gournay, et al., 1996) or in a group-therapy format (Rosen, Reiter, & Orosan, 1995; Wilhelm, Otto, Lohr, & Deckersbach, 1999). In Wilhelm et al.'s (1999) study of group CBT for BDD,

BDD symptoms and depressive symptoms significantly improved. These preliminary findings are encouraging; however, limitations of these early studies raise questions about the generalizability and replicability of their results. For example, some individual treatments (McKay et al., 1997; Neziroglu, 1996) used lengthy (e.g., 2 hours) and frequent (e.g., daily) sessions that are difficult to employ in clinical settings, given third-party reimbursement policies. In addition, most studies had restrictive inclusion criteria that reduced sample representativeness, some studies included patients who appeared to have mild or even subclinical BDD, and few studies included men, even though about 40% of those with BDD are male (Koran et al., 2008; Rief et al., 2006). One study excluded delusional patients, even though more than one-third of patients currently have delusional BDD beliefs (Phillips, Menard, Pagano, Fay, & Stout, 2006). Thus, it is unclear whether the treatment is suitable for such patients.

Only two prior studies used a treatment manual. Rosen et al.'s (1995) brief group treatment manual focuses mostly on weight and shape concerns, whereas BDD patients usually focus on other body areas, such as skin, hair, or facial features (Phillips & Diaz, 1997; Phillips, Menard, Fay, & Weisberg, 2005). Thus, Rosen et al.'s manual does not apply to the large majority of BDD patients. This manual remains unpublished. Wilhelm et al. (1999; a case series) employed a very preliminary version of the manual used in the study described in this report; however, this manual was also developed for a group treatment. Neither Rosen et al.'s nor Wilhelm et al.'s manual were developed for individualized treatment, nor were they very detailed or personalized to address all of the heterogeneous symptoms of BDD. The lack of a widely applicable CBT manual for clinical and research use has been a major limitation for the field.

Thus, we (Wilhelm, Phillips, & Steketee, in press) developed a broadly applicable treatment manual that focuses specifically on BDD symptoms and is based on our BDD model, which has been informed by prior theories of BDD (e.g., Veale, Gournay, et al., 1996; Wilhelm & Neziroglu, 2002). Our CBT model (e.g., Wilhelm, Buhlmann, Cook, Greenberg, & Dimaite, 2010) is based on the premise that individuals with BDD misinterpret visual input of normal appearance features or minor appearance flaws in biased ways that result in negative cognitive, emotional, and behavioral consequences of BDD. Our cognitive-behavioral model proposes that individuals with BDD selectively attend to specific aspects of appearance or minor appearance flaws. This theory is informed by clinical observations and neurocognitive findings (Deckersbach et al., 2000; Feusner, Moody, et al., 2010; Feusner, Townsend,

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