



Metacognitive therapy for body dysmorphic disorder patients in Iran: Acceptability and proof of concept

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ABSTRACT

The purpose of the present study was to determine the effect of metacognitive therapy (MCT) on symptoms of body dysmorphic disorder (BDD) and on symptoms of thought–fusion, by means of a wait-list controlled clinical trial. Participants were referred from dermatology and cosmetic surgery clinics in the city of Isfahan, Iran, and 20 patients were selected on the basis of DSM-IV-TR diagnostic criteria for BDD. They were randomly assigned to either the experimental or the wait-list control group. The Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS) and the Thought–Fusion Inventory (TFI) were used as the outcome measures. The experimental group received 8 weekly metacognitive intervention sessions. The control group was in the waiting-list until the end of the follow-up. Measures were taken at pre-test, post-test (after 2 months) and follow-up (after 6-months). The results of analysis of variance showed that MCT significantly reduced the symptoms of BDD and of thought–fusion, compared to the wait-list. Effects on both outcome measures were maintained at 6-months follow-up.

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1. Introduction

Body dysmorphic disorder (BDD; previously called dysmorphophobia) is characterized by a preoccupation with an imagined defect in one's appearance or an exaggeration of a slight physical anomaly (American Psychiatric Association, 2000). The largest epidemiological study to date (Rief, Buhlmann, Wilhelm, Borkenhagen, & Brähler, 2006) reported a BDD prevalence rate of 1.7% (95% CI = 1.2%–2.1%) in the community. Prevalence rates are significantly higher when examined in psychiatric populations (e.g., 13%–16%; Conroy et al., 2008; Grant, Kim, & Crow, 2001). A recent Dutch study found 3–8% of the patients in dermatology and plastic surgery clinics of an academic hospital to be suffering from BDD (Vulink et al., 2006).

Surveys of BDD patients attending a psychiatric clinic tend to show an equal sex incidence and sufferers are usually single or separated (Neziroglu & Yaryura-Tobias, 1993; Phillips & Diaz, 1997). BDD shares several common characteristics with OCD, such as similar age of onset, sex ratio, severity of symptoms, persistency,

and high comorbidity with depression and anxiety disorders (Phillips, 2009).

Psychological and pharmacological treatments for BDD have received increasing attention in the past 10 years. Although psychological and pharmacological treatment approaches for BDD have been evaluated, only two RCTs were conducted on CBT and one on medication for BDD in adults. In one study Rosen, Reiter, and Orosan (1995) randomly assigned 54 patients to either group CBT or a no treatment control condition. Groups consisted of four to five patients who attended 8 weekly 2-h CBT sessions. CBT was significantly more effective than no treatment: clinically significant improvement occurred in 82% of the CBT group members at the end of treatment, and in 77% at follow-up 4.5 months later. This study included only females and they were relatively less handicapped than the patients described in other treatment studies. Their concerns were mostly about weight and shape, whereas there was no diagnoseable eating disorder. In the other RCT, Veale et al. (1996), randomly assigned 19 patients to either CBT or a no treatment control condition. Patients attended to 12 weekly individual 1-h sessions. In the CBT condition, 78% had either no BDD anymore or BDD symptoms in the subclinical range after treatment, whereas all 10 waiting-list patients were still in the clinical range of BDD scores at the end of the trial. In an RCT on medication, Phillips, Albertini, and Rasmussen (2002) randomly assigned 67

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individuals to either 12 weeks of Fluoxetine or a placebo. Fluoxetine was superior to placebo. To summarize, evidence of CBT as a favorable treatment for BDD is still scarce and no RCT has directly compared CBT to medication yet.

The present study aims to add knowledge to treatment effectiveness for BDD by conducting an RCT comparing Metacognitive Therapy (MCT; Wells, 2009) with a no treatment control group. Metacognition refers to knowledge or beliefs about thinking and strategies used to regulate and control thinking processes (Moses & Baird, 1998). MCT is based on the idea that metacognitions cause a particular pattern of responding to inner experiences such as worry and rumination that maintains negative emotions and strengthens negative thought. In MCT not the content (per se) of cognitions (e.g., negative, irrational cognitions about the self (and appearance), the world, and other people) is addressed - as is done in cognitive therapy- but merely beliefs about thinking (metacognitive beliefs) and the process itself are the focus of treatment. In other words, CT attempts to modify the content of perseverative thinking, i.e., appraisals, rather than the metacognitive processes which perpetuate the continued maladaptive processing. With respect to content, certain thoughts (eg., about their appearance) and intrusions (urges, images and emotions) are referred to. By the process, the factors that maintain these kinds of intrusions are referred to. For example, the type of attention (eg., self-focused attention) may influence thinking style in such a way that information which comes in through internal feelings and thoughts is especially paid attention to and may increase rumination and worry. This does not mean that BDD patients do not make appraisals of inflated responsibility or overestimate threat but that these occur in the stream of rumination/worry. It follows that modifying the processes and metacognitions that give rise to the stream of worry could be a more effective treatment approach than just focusing on the actual content of thoughts. Evidence of the relationships between metacognitions and OCD symptoms has been demonstrated using non-patient samples (Fisher & Wells, 2008; Myers & Wells, 2005; Wells, Gwilliam, & Cartwright-Hatton, 2001), both in experimental studies (Fisher & Wells, 2005a), and patient group comparisons (Janeck, Calamari, Riemann, & Heffelfinger, 2003).

The metacognitive model of OCD (Wells, 1997) is based on the more generic model, the Self-Regulatory Executive Function Model (S-REF) and proposes that intrusive thoughts activate metacognitive knowledge which in turn guides maladaptive processing. In other words, specific metacognitive beliefs lead to the cognitive attentional syndrome (CAS). The metacognitive beliefs concern the dangerousness and significance of intrusive thoughts/feelings. For example, BDD patients may have so-called 'positive' metacognitive beliefs about the consequences of their body ruminations. They believe that these thoughts lead them to pay much more attention to their appearance and, as a consequence, provide a condition where other people see them as less ugly and which reduces the others' negative beliefs about them. Continuing body rumination, however, causes negative metacognitive beliefs about these persevered negative feelings and thoughts to increase and, eventually, the patient perceives them as dangerous and uncontrollable events. This situation makes them more anxious and irritable.

Cooper and Osman (2007) suggested that patients with BDD do indeed engage in metacognitive processing in relation to their concerns with appearance. They report attempts to control, correct, appraise, and regulate their thinking in relation to images and also in relation to thoughts associated with their illness-related concerns. Thus, as suggested by Veale (2004), metacognition may be an important feature of information processing in BDD and may be one way in which the symptoms of the disorder are maintained. Theoretically, therefore, it may be an important dimension to be

incorporated into a cognitive model of BDD. Further research is needed into the phenomenon of metacognition, including its characteristics, functions, and role in the maintenance of the distressing symptoms of BDD. Imagery has been accorded a particularly important role in the maintenance of BDD, where mental images of the self are thought to be a particularly central feature of a cognitive conceptualization (Veale, 2004, 1996).

Metacognitive therapy has been pilot tested for OCD in a case series (Fisher & Wells, 2008) and as a component of small group treatment (Rees & Van Koesveld, 2008). According to some larger studies it seems that metacognitive therapy is an effective intervention for OCD (Fisher, 2009; Wells, 2000; Fisher & Wells, 2005b). Following the S-REF model the cognitive attentional syndrome (CAS) is a feature of many disorders. There is clear evidence of CAS in BDD (e.g. worry & rumination, threat monitoring, mirror gazing and mirror checking, and coping behaviors that backfire). Thus, a treatment that would decrease CAS and metacognition associated with it should be effective for BDD. The present study investigated the effects of metacognitive therapy on BDD symptoms, as BDD is considered an OCD-spectrum disorder. As a manipulation check, the effect on thought-fusion manifestations was also investigated.

2. Method

2.1. Participants

Patients were drawn from ($n = 100$) consecutive referrals made by general practitioners and psychiatrists to dermatologist and cosmetic surgery clinics in the city of Isfahan, Iran. BDD diagnosis was established using the structured clinical interview for DSM-IV diagnoses (SCID, based on the *Diagnostic and Statistical Manual of Mental Disorders – 4th Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000)*). The diagnoses were made by the first author, holding a master's degree in clinical psychology. Thirty-one individuals met the criteria for diagnosis of BDD set by DSM-IV-TR, of which 20 individuals were willing to participate in our treatment study; their major problem was BDD. See Fig. 1 for a flow chart.

Twenty patients were, thus, recruited (18 females), ages ranging from 16 to 37 years (mean = 25.2; SD = 6.5). Seventeen (85%) of the participants were single and 3 were married. Their socio-economic status was average or above average. Classification of socio-economic status was based on coding of the subjects' income, education and job. Also, they all had some high school diploma and university education. None of the patients were currently taking psychotropic medication (4 patients had previously taken clomipramine and another one fluvoxamine, buspirone and lithium carbonate). The duration of their BDD ranged from 1 to 10 years. Fifty-five percent of the patients had a single diagnosis of BDD, and 45 percent had an additional diagnosis. Two patients met the criteria for additional major depressive disorder. One patient met the criteria for social phobia, and one patient had comorbid OCD. The participants in the experimental group had one or more of the following concerns: facial skin ($n = 3$), hair ($n = 2$), breasts ($n = 1$), eyes ($n = 1$), and shape of the nose ($n = 3$). The participants in the control group had the following concerns: facial skin ($n = 4$), hair ($n = 2$), breasts ($n = 1$), eyes ($n = 1$), and shape of nose ($n = 2$). Table 1 provides general characteristics of the study sample.

2.2. Design

The design of this study was experimental with pre-test, post-test and follow-up. After completion of the baseline assessment, patients who met the entry criteria and agreed to participate in the study were randomly assigned to one of two

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