



Acceptance-Based Exposure Therapy for Body Dysmorphic Disorder: A Pilot Study

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Body dysmorphic disorder (BDD) is an often severe, chronic, and disabling disorder, and although some controlled trials of cognitive behavior therapy (CBT) have shown efficacy, the body of evidence is still limited. The condition is generally considered difficult to treat, and further research to determine the effectiveness of psychological treatments for BDD is needed. The present study is the first to evaluate an acceptance-based therapy for BDD. In total, 21 patients received a 12-week group treatment consisting of weekly sessions of psychoeducation, acceptance and defusion practice, and exposure exercises to foster acceptance of internal discomfort and to strengthen the patients' committed purposeful actions. The primary outcome was BDD symptomatology (measured on the BDD-YBOCS) assessed by a psychiatrist before and after treatment and at 6 months follow-up. The secondary outcomes were self-rated BDD symptoms, psychological flexibility, depressive symptoms, quality of life, and disability. Reductions in BDD symptomatology from pre-

to posttreatment were significant and showed a large effect size, $d = 1.93$ (95% CI 0.82–3.04). At posttreatment, 68% of the participants showed clinically significant improvement in the primary outcome variable. Treatment gains were maintained at 6 months follow-up. The treatment also resulted in significant improvements in all secondary outcomes. The dropout rate was low; 90.5% of the participants completed treatment. This study suggests that acceptance-based exposure therapy may be an efficacious and acceptable treatment for BDD that warrants further investigation in larger controlled trials.

Keywords: body dysmorphic disorder; BDD; acceptance-based; exposure; psychological flexibility

BODY DYSMORPHIC DISORDER (BDD) is a severe, chronic, and disabling disorder characterized by a preoccupation with one or more perceived defects in appearance that are not observable or appear only slight to others (American Psychiatric Association, 2013). The disorder is marked by intrusive thoughts concerning these perceived flaws in appearance and feelings of anxiety, disgust, or shame, particularly in situations where the body parts can be viewed (Veale & Neziroglu, 2010). In attempts to reduce internal

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discomfort, those afflicted by the disorder engage in ritualistic behaviors aimed at checking, concealing, or improving the perceived flaws (Phillips, Gunderson, Mallya, McElroy, & Carter, 1998). Insight is usually poor or absent. More than one-third of patients have delusional appearance beliefs (Phillips, Menard, Pagano, Fay, & Stout, 2006), i.e., a complete conviction that they appear disfigured.

The prevalence of BDD in the general population has been estimated to be between 1.7 % and 2.4 %, and the rate of spontaneous remission appears to be low (Buhlmann et al., 2010; Koran, Abujaoude, Large, & Serpe, 2008; Phillips, Pagano, Menard, & Stout, 2006; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brähler, 2006). BDD is associated with decreased quality of life (Phillips, 2000) and impairment in interpersonal and social functioning (Rabinowitz, Neziroglu, & Roberts, 2007). Additionally, lifetime incidence rates of undergoing psychiatric hospitalization, being suicidal, or becoming housebound are high (Phillips, Coles, et al., 2005; Phillips & Menard, 2006). Comorbidity with other disorders, particularly depression, social phobia, obsessive-compulsive disorder, and personality disorders, is high (Gunstad & Phillips, 2003; Phillips & McElroy, 2000; Phillips, Menard, Fay, & Weisberg, 2005).

Even though BDD is associated with high prevalence and impairment, research on BDD treatment remains limited. The small existing body of research, which consists of case reports, case series, and a few studies using waitlist control groups, shows preliminary support for the effectiveness of cognitive behavioral therapy (CBT) for BDD, with effect sizes ranging from $d = 1.01$ to 2.18 (Enander et al., 2014; Iper, Sander, & Stein, 2009; Wilhelm et al., 2013; Williams, Hadjistavropoulos, & Sharpe, 2006). Moreover, pharmacological treatment appears to be effective (Williams et al., 2006), but no studies comparing pharmacological treatments with psychological treatments have been conducted. Most studies of CBT for BDD have included both cognitive and behavioral interventions. However, a number of studies indicate that exposure and response prevention (ERP) in itself is effective for treating BDD (Campisi, 1995; Gomez-Perez, Marks, & Gutierrez-Fisac, 1994; McKay et al., 1997). Furthermore, a small randomized controlled trial conducted by Khemlani-Patel, Neziroglu, and Mancusi (2011) indicated that ERP was equally effective alone as when combined with cognitive therapy, suggesting that ERP is a core component of BDD treatment.

Although there is evidence for the effectiveness of ERP in the treatment of BDD, ERP seems to be associated with a substantial dropout rate (Campisi, 1995, 56%; Gomez-Perez et al., 1994, 30%; Khemlani-Patel et al., 2011, 33%). Furthermore,

Folke, Von Bahr, Assadi, and Ramnerö (2012) reported that all participants in a case series expressed initial skepticism to the ERP treatment approach to BDD.

One of the problematic clinical features of the disorder is that patients generally perceive the credibility of psychological treatments to be limited. As a result of poor insight, many individuals with BDD perceive the problem as physical rather than psychological. Persons with BDD therefore frequently seek cosmetic treatments, including surgery, rather than psychiatric care (Phillips, Grant, Siniscalchi, & Albertini, 2001). Moreover, this group of patients is considered difficult to treat. Because of the delusional nature of BDD beliefs, challenging the veracity of patients' thoughts about physical appearance can be difficult. Thus, in order for them to engage and remain in treatment, a pivotal task is to develop treatments that are viewed as acceptable to these patients.

Exposure with and without response prevention is a treatment that targets conditioned emotional responses and the meaning that an individual has ascribed to both stimuli and responses. This approach has traditionally been presented with decreased emotional responding to stimuli or falsification of fearful interpretations as an overarching aim (Neudeck & Wittchen, 2012). However, in the wake of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), exposure has instead been conceptualized as a route to fostering acceptance of inner experiences, increased behavioral flexibility and the pursuit of valued goal-directed behavior in the presence of aversive internal responses (Gloster, Hummel, Lyudmirskaya, Hauke, & Sonntag, 2012). In ACT, a primary goal of exposure is to increase *psychological flexibility*, i.e., broadening the individual's effective repertoire in the presence of feared events (Hayes, 2004). Prior studies indicate that acceptance-based interventions have the potential to increase the willingness to engage in activities while experiencing difficult emotions (Eifert & Heffner, 2003; Levitt, Brown, Orsillo, & Barlow, 2004), which highlights a critical challenge in BDD treatment. Such an approach may in turn help decrease the dropout problems that are commonly experienced with traditional exposure methods. Thus, it seems theoretically plausible that an acceptance-based approach might be useful in treatment for BDD.

Controlled studies have demonstrated the effectiveness of ACT for related disorders such as obsessive-compulsive disorder (OCD), skin picking, and trichotillomania (Twohig et al., 2010; Twohig, Hayes, & Masuda, 2006; Woods, Wetterneck, & Flessner, 2006). Furthermore, considering anxiety

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