BEHAVIOR THERAPY 27, 67-77, 1996

Effect of Cognitive Behavior Therapy on Persons With Body Dysmorphic Disorder and Comorbid Axis II Diagnoses

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A study was conducted to determine the effect of intensive cognitive behavior therapy on body dysmorphic disorder (BDD) and to investigate the presence of comorbid personality disorders in this population. Seventeen patients diagnosed with BDD participated. They all received 4 weeks of daily 90-min sessions of cognitive behavior therapy. During treatment they were exposed to their perceived physical defect and prevented from engaging in behaviors that reduce their discomfort. The majority of the patients were preoccupied with their nose and complexion, and, consequently, they frequently checked their defective body parts, looked in the mirror, and avoided social interaction. At the end of treatment there was a significant decrease in their preoccupation and time engaged in the above behaviors. As for the personality disorders, the mean number of personality disorders was 6. The most common personality disorders were avoidant, obsessive compulsive, borderline, self defeating, and dependent.

In the past few years there has been growing interest in the obsessive compulsive spectrum disorders. One of the spectrum disorders to receive attention is body dysmorphic disorder (BDD), which is characterized by an excessive preoccupation with an imagined bodily defect. Symptoms of BDD are present in a variety of disorders. It is reported in depression (Cotterill, 1981; Hardy & Cotterill, 1982), psychosis (Connolly & Gibson, 1978; Crisp, 1981; Hay, 1970; Korkina, 1959; Stekel, 1950), obsessional states (Hardy & Cotterill; Janet, 1908; Morselli, 1886; Stekel), obsessive compulsive disorder (OCD;

Portions of this data were presented at the 28th Annual Convention of the Association for Advancement of Behavior Therapy, San Diego, CA.

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0005-7894/96/0067-0077$1.00/0

Hollander, Leibowitz, Winchel, Klumker, & Klein, 1989; Jenike & Baer, 1990; Neziroglu & Yaryura-Tobias, 1991, 1993a, 1993b), and anorexia nervosa (Jerome, 1987; Thomas, 1984).

Several researchers suggest that individuals with BDD have various personality disorders (Andreason & Bardach, 1977; Braddock, 1982; Edgerton, Jacobson, & Meyer, 1960; Hay, 1970). As early as 1908, Janet described BDD as being rooted in the personality, resembling hysterics and obsessives. Dietrich (1962) believed that, although BDD may occur in a variety of illnesses, the syndrome usually arises out of neurotic conditions or crises of personality development. Hay compared patients with BDD to a control group and found that patients were more "obsessoid, introverted, intropunitive, highly neurotic and hostile" (p. 401) as compared to the control group. He concluded that BDD occurs in insecure and sensitive personalities. Andreasen and Bardach concurred with Hay in concluding that the underlying factor of BDD is a moderate to severe disturbance in personality, typically schizoid or obsessional in nature. Personality disorders have been reported in adolescents as young as 13 years of age (Korenblum, Marton, Golombek, & Stein, 1990).

The literature suggests that there is a relationship between BDD and personality disorders. Whether BDD is a symptom often seen in personality disorders or a separate entity, as in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM III-R*; American Psychiatric Association, 1987) and *DSM IV* with accompanying personality disorders, is still undecided.

It has been proposed that BDD is a variant of OCD (Hollander & Phillips, 1993; Neziroglu & Yaryura-Tobias, 1993a, 1993b). Comparisons between OCD and BDD patients reveal similar MMPI profiles, and similar behavioral and pharmacological approaches are reported to be effective (Neziroglu & Yaryura-Tobias, 1993a). However, BDD patients seem to have significantly more depression and higher levels of overvalued ideas (Neziroglu, McKay, & Yaryura-Tobias, 1993) and may be delusional.

The few case reports suggest that behavior therapy may be effective in reducing BDD symptoms (Braddock, 1982; Jerome, 1987; Marks & Mishan, 1988; Neziroglu & Yaryura-Tobias, 1993b). In most of these studies, exposure and response prevention (ERP) was used, whereby patients were exposed to their perceived physical "defects" and prevented from engaging in their compulsions, i.e., exposing BDD patients to others without camouflaging their "defects" and preventing them from checking their faces in the mirror or seeking reassurance. However, most of these studies were limited in number of patients, and duration of treatment varied from patient to patient.

Since the advent of *DSM III-R*, when BDD was first included as a diagnostic category, the presence of Axis II diagnoses in this population has not been assessed. The purpose of this pilot study is to investigate the efficacy of cognitive behavior therapy among patients with BDD and to identify the frequency of personality disorders in this population.