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A Cognitive-Behavioral Treatment Approach for Body Dysmorphic Disorder

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Abstract

Although body dysmorphic disorder (BDD) has been described in the literature for more than a century, there has been only a limited focus on the development of cognitive behavioral treatments for BDD. Our case report provides a detailed description of a course of cognitive behavioral treatment (CBT) for an individual with BDD. The patient was treated for 10 weekly 50-minute individual sessions. The treatment focused on psychoeducation, cognitive restructuring, exposure and response prevention, and perceptual retraining exercises. The patient’s BDD symptoms significantly improved over the course of the treatment. This case study illustrates several clinical strategies and provides further support for CBT as a promising treatment for individuals suffering from BDD.
Despite the recent increase in public awareness regarding body dysmorphic disorder (BDD), effective treatment options are underutilized and require further elucidation. Classified as a somatoform disorder in the *DSM-IV*, BDD is characterized by a preoccupation with imagined or slight defects in physical appearance (American Psychiatric Association [APA], 1994), which leads to significant distress and/or social or occupational impairment. Patients with BDD are reluctant to discuss appearance concerns, and subsequently live alone in shame and despair with their symptoms. Although individuals may eventually seek treatment for comorbid psychiatric disorders, they often do not disclose BDD symptoms to clinicians. It is critical for health providers to specifically screen patients for appearance-related concerns to prevent BDD symptoms from continuing to go unnoticed and untreated.

Clinicians can start screening for BDD by asking patients about potential worries they may experience about any part of their appearance. The most common preoccupations involve the face or head, including the skin (e.g., scarring), hair (e.g., thinning hair), or nose (e.g., shape or size), but any body part may be the focus of concern (e.g., Phillips, McElroy, Keck, Pope, & Hudson, 1993). Although shape and weight concerns are common among BDD patients, if concerns are exclusively related to weight/shape, an eating disorder assessment may be warranted. Intrusive appearance-related thoughts are time-consuming and upsetting, and lead individuals to engage in compulsive behaviors (i.e., mirror checking, comparing themselves to others, camouflaging, excessive grooming, skin picking)—which often take up several hours a day—in an attempt to alleviate distress (e.g., Phillips et al., 1993). Individuals often go out of their way to avoid certain situations, people, or places. Avoidance can be so severe that
patients become nearly or completely housebound. Insight is often very limited, and the appearance-related beliefs of nearly half of patients are delusional (Phillips, 2004; Phillips, Menard, Fay, & Weisberg, 2005). In a recent examination of clinical features in 164 adults with BDD (Phillips, Didie et al., 2006), current delusionality was reported in about one-third of the sample (33.1%, \(n = 45\)) and 75.6% (\(n = 124\)) reported lifetime delusionality. Almost half of the sample (45.7%, \(n = 75\)) reported delusional ideas of reference, for example, being convinced that others are laughing about or staring at their perceived flaw (Phillips, Didie, et al., 2006). More than 60% of patients with BDD (Gunstad & Phillips, 2003; Phillips & Menard, 2006) suffer from comorbid depression and are at high risk of suicide. A recent 4-year prospective study of 185 BDD patients (Phillips & Menard, 2006) found annual rates of suicidal ideation (57.8%) and attempts (2.6%) to be markedly high; the annual completed suicide rate among BDD (0.3%) patients is approximately 45 times higher than that in the general U.S. population (Phillips & Menard, 2006).

BDD is a relatively common disorder, which affects approximately 0.7% to 2.4% of the population (Bienvenu et al., 2000; Faravelli et al., 1997; Koran, Abujaoude, Large, & Serpe, 2008; Otto et al., 2001; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brahler, 2006). The largest epidemiological study to date (Rief et al., 2006) reported a BDD prevalence rate of 1.7% (95% CI = 1.2%–2.1%). Prevalence rates are significantly higher when examined in psychiatric (e.g., 13%–16%; Conroy et al., 2008; Grant, Kim & Crow, 2001) and appearance-enhancing medical settings (e.g., 7%–8% in studies of cosmetic surgery patients; Sarwer, Wadden, Pertshuk, & Whitaker, 1998; and 8.5–15% in dermatological samples; Bowe, Leyden, Crerand, Sarwer, & Margolis, 2007; Dufresne,
Phillips, Vittorio, & Wilkel, 2001; Phillips, Dufresne, Wilkel & Vittorio, 2000; Vulink et al., 2006). Studies yield somewhat variable findings on gender ratio, although most studies suggest that BDD may be slightly more common among females than males (Koran et al., 2008; Phillips & Diaz, 1997; Phillips, Menard, & Fay, 2006; Phillips, Menard, Fay, & Weisberg, 2005; Rief et al., 2006). Phenomenological differences between the genders reflect those reported in the general population; for example, men are more likely to be preoccupied by their genitals, musculature, and thinning hair, and women with their skin, stomach, general shape/weight and excessive body/facial hair (Phillips, Menard, et al., 2006).

Two empirically based treatments are available for the treatment of BDD: serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT). Of the SRIs, clomipramine (Hollander, Allen, & Kwon, et al., 1999), fluvoxamine (Perugi et al., 1996; Phillips, Dwight, & McElroy, 1998), fluoxetine (Phillips, Albertini, & Rasmussen, 2002), citalopram (Phillips & Najjar, 2003), escitalopram (Phillips, 2006), and venlafaxine (Allen et al., 2008) have been shown to be effective (response rates ranging from 53% to 73%) when used at their optimal dose for at least 12 weeks. Evidence for the effectiveness of non-SRI antidepressants (e.g., tricyclics) or neuroleptics in treating BDD symptoms has not been adequately demonstrated. Our clinical experiences suggests that combination treatments of SRIs and CBT may prove helpful in cases of severe comorbid depression, suicidality or delusionality, however, more research in this area is needed.

Cognitive-behavioral models of BDD (e.g., Veale, 2004; Wilhelm & Neziroglu,
CBT for BDD

2002; Wilhelm, 2006) have driven the development of new cognitive behavioral treatments for BDD. The first step in our CBT model proposes that individuals with BDD are likely to overfocus on perceived appearance flaws and attach significant meaning to them or consider them very important. Our model is informed by clinical observations and neurobiological research findings, which indicate a selective attention among BDD patients to small details, including specific aspects of appearance or minor appearance flaws. A study based on the Rey Osterrieth Complex Figure Test (Deckersbach et al., 2000) and an fMRI study conducted while processing faces of high and low spatial frequency (Feusner, Townsend, Bystritsky, & Bookheimer, 2007) demonstrate a bias toward detailed information processing rather than a focus on global, organizational features. Our research also shows the presence of other information processing biases in BDD—for example, threatening interpretations for nonthreatening scenarios, and overestimation of the attractiveness of others’ faces (Buhlmann, Etcoff, Wilhelm, 2008; Buhlmann et al., 2002). Our model proposes that these maladaptive processing strategies and interpretations trigger shame, depression, anxiety, and further increased attention to perceived appearance defects, which in turn fuel self-defeating ritualistic behaviors (e.g., mirror checking, excessive grooming) and avoidance of situations (e.g., social situations) that trigger these emotions. Rituals and avoidance behaviors are negatively reinforced because they may temporarily decrease unpleasant emotions, thereby maintaining dysfunctional BDD-related beliefs. CBT targets these maladaptive thought and behavior patterns.

CBT for BDD typically begins with psychoeducation, during which the therapist explains and individualizes the cognitive-behavioral model of BDD. In addition, CBT
CBT for BDD usually includes techniques such as self-monitoring one’s automatic negative thoughts and behaviors, cognitive restructuring, exposure and response prevention, and relapse prevention. Some CBT for BDD treatment studies have also included mirror or perceptual retraining (described below). The efficacy of CBT for BDD has only rarely been examined. A recent meta-analysis comparing pharmacotherapy to CBT, BT, and CT showed all treatments to be effective in improving BDD and depressive symptoms (Williams, Hadjistavropoulos, & Sharpe, 2006). CBT, but not BT alone, yielded larger effect sizes than pharmacotherapy. Additional support for the benefits of CBT comes from case reports; however, only a few case descriptions illustrating the application of different treatment strategies in BDD have been published (e.g., Munjack, 1978; Phillips et al., 1993; Schmidt & Harrington, 1995). The current paper will provide a case description to illustrate state-of-the-art clinical strategies and clinical decision-making in BDD.

Case Example

Case History

Paul, an attractive 33-year-old Caucasian physical therapist, sought treatment at an outpatient clinic specializing in BDD at Massachusetts General Hospital because he felt that he “no longer had control of his life” as a result of his preoccupation with the appearance of his nose and jaw line. He thought his “nose was too long, and bumpy” and that the overall line and proportion of his jaw made him look “feminine, scrawny and distorted.” As he described, “mirror checking just completely conquers my life—even in my dreams… [my obsession with my nose and jaw] takes over every aspect of my life.”
In his late 20s, Paul had sought treatment for depression when he noticed that he had difficulties getting out of bed in the morning. His depression had been treated successfully with an SRI. At the time Paul presented for BDD treatment, he was unmedicated and his depressive symptoms were minimal.

Paul reported being shy as a younger child, but that his appearance concerns were relatively minor until adolescence. When he was 14 years old, he remembers seeing his reflection in store mirrors and windows and being “horrified” by what he had seen. Around this time, he had experienced a growth spurt and felt that his nose had suddenly grown disproportionate to the rest of his body. He described that his friends had developed more “squared” jaw lines, but that his remained “scrawny and young looking.” He maintained a close group of friends through high school and college but he avoided dating due to his appearance concerns. He remembers feeling awkward around even his closest friends at times, wondering “if they were noticing how hideous his large nose was and how it totally dominated the rest of his face.” He recalls getting so distracted by thoughts of his nose or how “scrawny [his] jaw looked” that his friends would joke about having to “pull [him] back into reality.” Paul, however, never told his family or friends that he so was preoccupied with his nose and jaw; keeping his concerns to himself prevented family members from suspecting that anything was wrong.

Paul eventually started a career as physical therapist. However, as he neared his 30th birthday, he experienced increased doubts about his ability to help clients. Paul found himself worrying that his clients weren’t concentrating on the techniques he was teaching them but rather on the appearance of his “grotesquely large” nose or “scrawny jaw.”
By the time he sought treatment for BDD, he often spent 4 to 5 hours per day thinking about his face. He would find himself at home staring for hours at his reflection in any reflective surface he could find, including mirrors, CDs, or going out to sit in the car to scrutinize his nose in the rearview mirror. Occasionally he measured the size of his nose with a ruler, and he would have to touch it over and over again to get a sense of how long or bumpy it felt. He engaged in facial exercises that he hoped would “increase” the muscles around his jaw so it would “bulk up” the area. Paul spent 2 to 3 hours online each day researching surgeons and looking for examples of the “perfect” nose and “chiseled” jaw lines. In his most recent consultation with a surgeon, the doctor did not agree to set a surgery date because she could not see the facial flaws over which Paul was so distressed.

Despite the fact that his friends and colleagues often invited him to go out, he frequently spent the entire weekend alone in his apartment. When Paul did end up going out with friends, “within the first 5 minutes, [he would] use the restroom, and then probably get up 3, 4, 5 other times throughout the night to use the restroom just for the mirror’s sake.” He also found it difficult to stay engaged in conversation; his attention often drifted to sneaking glimpses of his face in windows or other reflective surfaces around the bar. Paul often tried to hide his nose or jaw with his hand, and sometimes even pretended to have a cold in order to hide his nose behind a tissue or handkerchief. Although he expressed an interest in meeting women when he went out, he became so absorbed in thinking about others’ perceptions of him that he had difficulty maintaining conversations. As he described, “Sometimes I am pretty convinced that they are thinking about my face. At other times I am not sure. I realize they may not be thinking anything,
but it’s still there. As I’m talking to someone I just met, I’m looking at them noticing my face…it hurts my confidence, kills my self-esteem, and I feel the unattractiveness.”

When Paul presented for treatment, he reported extreme distress related to preoccupation with his nose and jaw, and his concerns had caused moderate interference with his social life. He was particularly worried about the impact BDD had on his work and friendships as he occasionally had called in sick or cancelled appointments in the last minute because his symptoms became overwhelming. When Paul presented for treatment, he reported that the way BDD dominated his life was very inconsistent with his life goals and values. He wanted to be more focused on developing his career, and he desired healthy friendships, and perhaps ultimately an intimate relationship with a woman. He realized that in order to reach these goals, he needed to learn skills to help him overcome his appearance preoccupation and decrease his avoidance behaviors and rituals.

Assessment

Paul’s structured clinical interview (SCID; First, Spitzer, Gibbon, & Williams, 1995) revealed a primary diagnosis of BDD with a past diagnosis of a major depression. Paul was also assessed with the Body Dysmorphic Disorder modification of the Yale-Brown Obsessive Compulsive Scale (BDD-YBOCS; Phillips et al., 1997) prior to the beginning of treatment. The BDD-YBOCS measures the severity (time occupied, interference, distress, resistance against, degree of control over) of appearance-related thoughts and behaviors. The BDD-YBOCS also assesses insight and the degree of avoidance behavior. At his initial visit, Paul scored 29 out of a possible 48 on the BDD-YBOCS (moderate severity) and reported the amount of distress he experienced related to his nose and jaw to be “severe and very disturbing.” The therapist rated Paul’s overall
severity of symptoms at baseline as moderately ill on the Clinical Global Impression scale (CGI; Guy, 1976).

**Procedure**

*Treatment Overview*

Treatment for Paul consisted of ten 50-minute weekly individual sessions with a doctoral-level psychologist (S.W.). At the time of Paul’s treatment, no treatment manual was available; however, much of the information regarding the treatment structure and strategies can now be found in the manual by Wilhelm, Phillips, and Steketee (2009). The initial session involved psychoeducation during which Paul learned more about BDD. The therapist and Paul also discussed how Paul’s BDD might have developed. Paul mentioned that appearance standards had always been very high in his family. He described that his mother often dieted, and talked regularly about her appearance. He also suspected that his father suffered from obsessive-compulsive disorder, which manifested itself by checking certain tasks over and over again to ensure that they had been done perfectly. Paul felt that for his entire life, he had struggled to live up to his parents’ high expectations both in terms of appearance as well as other aspects of his life, such as academic success. He also identified cognitive and behavioral factors involved in the maintenance of his symptoms. For example, Paul often assumed that others were focused on and judging him negatively based on his face. These thoughts made Paul self-conscious, anxious, and disgusted with himself. To alleviate or avoid these distressing feelings, Paul often stayed home from work, declined offers to go out, or engaged in BDD rituals (e.g., camouflaging, mirror checking, measuring) to try to fix, hide, or check on his appearance. The therapist explained how rituals and avoidance behaviors
reinforce and maintain BDD symptoms. Over the course of this case conceptualization session, Paul realized that his distress (anxiety or shame) would have likely subsided on its own and feared situations would have been manageable even if he would not have avoided or ritualized. Paul and his therapist also discussed that treatment would focus on modifying his negative thoughts, decreasing maladaptive coping behaviors, and increasing adaptive behaviors (e.g., hobbies, increased social support and activities).

After the psychoeducation session, each following treatment session began with a brief review of the past week with regard to symptoms and homework. Next, the therapist and Paul set an agenda to determine which strategies to cover during the session. Sessions ended with a review and discussion of an assignment to be completed for homework during the week. The review allowed time for Paul to provide feedback and for the therapist to address any potential questions or concerns about the session or homework.

In his second treatment session, the therapist and Paul reviewed a list of common thinking errors and Paul was asked to monitor his self-defeating thoughts to help him identify and eventually modify them using cognitive restructuring techniques. For example, at work when Paul had the thought, “My client isn’t even paying attention to me. She must be so distracted by my bumpy, hideous nose,” he was encouraged to write it on a thought record and label the thinking error (i.e., mind reading). Through self-monitoring, Paul learned to identify his most common cognitive errors, including black-and-white thinking (“Any flaw means I’m ugly”), mind reading (“I know my client is thinking about how ugly my nose is”), fortune telling/catastrophizing (“If I ask a woman out on a date, she will reject me because I’m not attractive enough”), emotional reasoning
(“I know I’m ugly because I feel disgusting”), and discounting the positives (“People only talk to me because they feel bad for me”). Paul learned to question his self-defeating thoughts, for example, by looking at the evidence. He asked himself if there was any evidence that his thoughts were really true, and whether there was actually evidence that the original thoughts might have been false. These questions helped Paul to evaluate the accuracy and utility of such self-defeating thoughts so that he could respond over time with more balanced, rational responses, such as, “It’s more likely that my client is having difficulty paying attention because she is in physical pain than because she is repulsed by my nose,” or “The client is concentrating more on making it to their next appointment on time than on my jaw line.”

Behavioral techniques were introduced to address Paul’s maladaptive coping behaviors. Avoidance behaviors (e.g., minimal eye contact, avoidance of mirrors, bright lights, social events) were addressed with exposure, and rituals (e.g., checking, camouflaging, grooming, websurfing to read about surgery, and comparing himself to others) were reduced with response prevention. The therapist reviewed with Paul how rituals and avoidance have played a role in the maintenance of his BDD and developed hierarchies for gradually increasing exposure to anxiety-provoking situations and for decreasing ritualistic behaviors. Paul noted that although he often engaged in rituals or avoidance to reduce anxiety related to thoughts about the appearance of his nose and jaw (e.g., thinking about going to work), over the years his anxiety and distress related to rituals and avoidance had actually worsened. In therapy, Paul started with less challenging tasks, such as going to meet with a family member despite feeling self-conscious about his appearance (exposure) and not going to the bathroom to check his
nose (response prevention). He gradually embarked on more difficult tasks such as
meeting his friends at a bar and refraining from mirror checking or camouflaging.
Exposure and response prevention tasks were often set up as behavioral experiments,
which helped Paul to test his BDD beliefs and predictions for accuracy.

Paul’s hierarchy included many items directly aimed at reaching the goals he had
set at the beginning of treatment. For instance, one of his goals had been to work on his
friendships. Therefore, instead of avoiding his friends on days when he thought his face
looked really “bad,” Paul was encouraged to go out twice per week with friends for
dinner, regardless of how he thought his face looked and despite feeling somewhat
anxious. Also included on Paul’s hierarchy were assignments to reenter previously
avoided situations and places, such as areas with bright lighting or many mirrors. For
example, Paul’s homework assignments routinely involved exercising at his health club
(i.e., bright lighting and mirrors) and entering stores with the goal of initiating
conversations with others. Over the course of treatment Paul was able reduce his
appearance-related rituals substantially; however, he and the therapist were very careful
to “fill” the time that had been freed up from rituals with healthy behaviors such as
engaging in various hobbies (for example, kayaking) as well as social activities (that
often also served a dual purpose as exposure exercises).

Next, after about five sessions of treatment, the therapist introduced a perceptual
retraining technique, to help Paul observe and describe his body in objective,
nonjudgmental terms as opposed to selectively attending to his perceived flaws. As part
of this exercise, Paul stood in front of a full-length mirror and described every part of his
body, starting with his hair and ending with his feet. In the process of this exercise he
also described his nose and jaw, in objective, nonjudgmental terms. Paul was asked to refrain from negative labeling and from engaging in rituals or avoidance behaviors (e.g., avoiding looking at his nose, touching it, or measuring it). Initially this was very anxiety provoking, but after he had repeated the exercises daily for a week, he actually began liking them. He even remarked that he had previously never noticed his “nice eyes.”

Perceptual retraining helped Paul with one of the overall treatment goals: namely, to learn to see “the big picture” rather than only attending to details. Paul was able to look at himself more wholly rather than only viewing himself with regard to his nose or jaw.

Paul had a general tendency to self-focus his attention not only on his perceived appearance flaws, but also on his negative internal attributions and negative affect. Over the course of the treatment, Paul learned to decrease self-focused attention by increasing attention to external stimuli. For example, when he went out for dinner with a friend, Paul learned to pay attention to things like the sound of the friend’s voice or the taste of the food instead of thinking about his nose.

As the treatment progressed, it became clear that many of Paul’s negative automatic thoughts, interpretations, and assumptions were rooted in deeper, more global ideas about himself (i.e., core beliefs). Using the downward arrow technique (Beck, 1995), the therapist helped to elicit core beliefs by asking Paul to consider the ultimate (“worst-case”) ramifications of his thoughts. Paul was asked to continue elaborating on the feared consequences of his beliefs (e.g., “. . . and if that were true, what would that mean?”) until he reached his core belief. For example, Paul was able to describe that his core belief, “I’m unlovable,” was triggered by and maintained his BDD thoughts and behaviors in work and socially related situations. Paul could then test these errant beliefs.
with similar strategies that he had used for his more situation-specific beliefs (especially evaluating the evidence for and against his original belief).

While working on core beliefs, it quickly became evident how much Paul’s feelings of self-worth and appearance-related beliefs were intertwined. Paul based his self-worth almost entirely on his appearance, and as he considered his appearance flawed, his perceived self-worth was very low. The “self-esteem pie” strategy was used to help Paul determine which other traits might be of value to him in determining his self-worth. A pie was drawn on the middle of a page and Paul was asked to cut the pie into slices that represent what characteristics one might value about him. With the therapist’s help, Paul was able to recognize that he was a caring friend, loving uncle, loyal brother, reliable coworker, etc. Each of those traits was assigned a slice in the pie. Paul was amazed how many non-appearance-based slices he was able to generate as a basis for his self-worth. He liked the pie chart technique so much that he kept a picture of his “self-worth pie” on his refrigerator for the remainder of his treatment.

Taken together, the mindfulness-based mirror work, the retraining to an external focus, and the pie chart technique helped Paul to shift his attention from a selective focus on his appearance flaws to other aspects of himself and the world around him.

Finally, during the last session, Paul and the therapist initiated relapse prevention strategies. They reviewed Paul’s improvement in therapy and which techniques had been most helpful for him. Paul was prepared for possible symptom recurrence in future challenging situations and a coping plan was developed (e.g., reviewing his thought records, conducting exposure exercises etc) to help him manage his symptoms. Paul was
also instructed to set aside some time for “self-sessions” during which he reviewed the progress that he had made and assigned himself new homework.

Results

Through the course of treatment, Paul demonstrated significant improvements in his ability to modify maladaptive thoughts and with the respect to the distress caused by his appearance concerns. Paul’s initial pretreatment score of a 29 on the BDD-YBOCS was reduced at posttreatment by 75.86% to a score of 7; a 30% or greater decrease in total BDD-YBOCS is an empirically derived cut-point that reflects clinically significant improvement (Phillips et al., 1998). The distress associated with thoughts about his nose and jaw, which he had reported at pretreatment to be “severe, very disturbing,” was reported at posttreatment to be “none.” Additionally, by posttreatment, he no longer endorsed his initial BDD-related beliefs, such as “I believe others are thinking of my appearance,” “If my appearance is defective, I am worthless…I will end up alone and isolated…I am helpless.”

Although Paul noted that the mirror exercises were the most difficult aspect of treatment for him, he described them to be the most beneficial. He reported, “I had forgotten what I looked like,” and that the perceptual retraining exercises forced him to see himself as a whole person after years of being fixated solely on his nose and jaw. Paul also found the attention on exposure and increased adaptive behaviors (e.g., being encouraged to go to the store, the gym, or to socialize) were helpful in improving his quality of life. He commented on the continuous daily struggle he faces with his preoccupation (“it’s still not easy”) but how he managed to take advantage of opportunities to challenge himself to not allow the obsession about his nose or jaw to
dominate his life once again. Finally, Paul reported a significant improvement in self-esteem over the course of treatment.

**Discussion**

The treatment presented in this case study illustrates the effective use of CBT in a single case of BDD. The treatment utilized a cognitive-behavioral model of BDD (e.g., Wilhelm, 2006) to target Paul’s maladaptive thought and behavior patterns over 10 sessions. Over the course of treatment, Paul experienced a significant improvement in BDD symptom severity and associated distress (as measured by the BDD-YBOCS). In addition, poor self-esteem was improved by posttreatment. At the end of 10 sessions, Paul reported increased functioning at work (e.g., less days absent, increased pleasure working with clients) and in his social life (e.g., improved friendships, and starting to date), which led to increased optimism about his future. The improvement in quality-of-life symptoms that Paul experienced over the course of treatment is consonant with extant findings on the amelioration of secondary symptoms in the treatment of BDD (Phillips, 2005).

This treatment adds to existing support for the use of CBT in the treatment of adult BDD. However, the treatment presented was atypical in length due to external constraints (i.e., the patient moved to another state). Furthermore, the patient was highly motivated, which is not always the case in BDD. Although controlled research is needed to determine optimal treatment length and components, CBT for BDD usually consists of 18 to 22 sessions, and includes psychoeducation, motivational enhancement, cognitive techniques, behavioral techniques (e.g., exposure/response prevention, perceptual
retaining) and relapse prevention. Individuals with severe depression and delusionality may require a longer course of treatment.
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1 The name and identifying details of the case have been altered to protect patient anonymity.