The Efficacy of Cognitive-Behavioral Therapy in the Treatment of Body Dysmorphic Disorder

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Abstract

Body dysmorphic disorder (BDD) is described as the preoccupations with one's looks to the point of severe impairment and poor quality of life. Nearly 2% of the population is affected by BDD with a purported equal number of men and women falling into some subcategory of the disorder. BDD contains both a delusional and non-delusional variant as well as comorbidity several other disorders. This paper outlines whether CBT is an effective and/or long term method of treatment along with the benefits and drawbacks.

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Steve Maraboli writes in Unapologetically You: Reflections on Life and the Human Experience, "There is nothing more rare, nor more beautiful, than a woman being unapologetically herself; comfortable in her perfect imperfection. To me, that is the true essence of beauty." As humans, we may notice our imperfections and perhaps compare ourselves to other people, wishing our imperfect body parts looked more like theirs; however, at some point there is a line that is crossed where constant notice and comparison of imperfections or flaws can cause significant distress in life. According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), the crossing of that line can result in a diagnosis of Body Dysmorphic Disorder (BDD). Characterized as "a preoccupation with one or more perceived defects or flaws in physical appearance that are not observed or appear to be slight to others", those who suffer with BDD feel compelled to perform repetitive actions in response to said preoccupation. As such, these individuals cannot be comfortable in their imperfections and deal with impairment in social, academic, and occupational functioning. Additionally, co-occurring mental health disorders such as depressive and anxiety disorders are commonly seen (American Psychological Association [APA], 2013).

Though classified in the DSM-5 under Obsessive and Compulsive Disorders, BDD diagnostic features overlap with another cluster of disorders. BDD, anxiety and depressive disorders have the common thread of maladaptive cognitions or negative automatic thoughts as triggers for the behaviors that lead to the resulting clinical impairment (APA, 2013; Phillips, 2014). As such, first-line treatment approaches for BDD may often align with the approach taken to treat anxiety or depression (Hong, Nezgovorovam & Hollander, 2018). In this paper, the author posits that successful treatment of BDD encompasses addressing the distorted thinking at the root of the disorder and such an approach involves the use of Cognitive-Behavioral Therapy (CBT). The reader will be provided with an overview of BDD including the evolution, onset, and impact of the disorder; a description of CBT including the premise, applications, and evidence of efficacy; and finally, a summation of the strengths, limitations, and future research needed to advance treatment of BDD with this modality.

Body Dysmorphic Disorder

The origins of BDD

The core epithets of BDD are reported to have been first discussed over 100 years ago by Italian psychiatrist Enrico Morelli in 1886 (Veale, 2001; Phillips, 2004). He coined the term "dysmorphophobia" to define the feelings of the individual consumed by an unrelenting fear of some form of deformity in their features, to the point in which they are likely to develop extreme sadness and impairment to their overall livelihood (Phillips, 2004). Over time, there has been a goal to develop and understand this level of impairment and fear as more than just a feeling of ugliness

due to vanity. The contemporary term of "BDD" has become slightly more stringent in its definition but is generally recognized as a somatoform disorder in the DSM, with secondary designations of as a hypochondriacal disorder (Veale, 2004), or a psychological disorder with delusional variants (Prazeres, 2013).

Comorbidity with Other Disorders

Recent studies have established a comorbid/co-occurrence factor between BDD and other psychological disorders. There is most commonly an overlap with OCD when examining the nature of the excessive repetitive behaviors resting in a fear of contamination and/or an inherent need to camouflage oneself such as constant mirror checking, over-grooming, skin picking (excoriation disorder), and hair pulling (trichotillomania) (Phillips, 2014; Krebs, 2017). There has also been established overlap with major depressive disorder (MDD), eating disorders, and social anxiety/social phobias (Krebs, 2017). Some studies found that MDD was the greatest comorbid disorder (Phillips, 2004) while others focused more on OCD. There has also been established comorbidity with bipolar disorder, schizophrenia, and panic disorder (Bjornsson, 2013).

Brain Function

The Yale-Brown Obsessive-Compulsive Scale (YBOBC) exists to measure the symptoms of OCD and the Yale-Brown Obsessive-Compulsive Scale Modified for BDD (BDD-YOBCS) was devised to examine the cross-over between the two disorders. When performing a clinical study of BDD, one, if not both, of these scales are typically used (Krebs, 2017). The overlap between OCD and BDD has been linked to the similarities in the way the brain processes information in both

disorders. The brains of those with BDD tend to place emphasis on specific features–both facial and non-facial instead of a "big picture" or top down perspective. (Phillips, 2014). This is thought to be because of an increase of white matter in the brain that is noted as having a compromising effect on the white matter fibers in the surrounding area coupled with insufficient connections to areas vital to organizational processing (Phillips, 2014). Those who suffer with BDD are thought to view themselves as objects that are meant to be characteristically perfect (Veale, 2001). The age of onset is also applicable to the comorbidity, as those with an early onset of BDD experience increased severity of symptoms, something prevalent in OCD (Bjornsson, 2013).

Onset and Prevalence

Adolescence (16-17) is the most widely agreed upon age of onset due to not only studies and research conducted with individuals in that age group, but also with those with later onset BDD; in addition to those groups, there is a need for research in populations under the age of twelve where cases of BDD have been identified (Bjornsson, 2013). Patients with an early onset of BDD potentially experience a lifetime of symptoms of comorbid disorders as well as an increase in suicidality and social phobias, etc. (Bjornsson, 2013). BDD has a point-prevalence of about 2% of the reported population (Phillips, 2014) with 1.7%-2.2% being adolescent sufferers (Krebs, 2017). According to some studies, there is little discrepancy between men and women who suffer with BDD; however, some biases in reporting are believed to be the reason behind the prevalence rates in one group over the other (Phillips, 2004). There are different subgroups of BDD which appear to affect the genders differently. The Muscle dysmorphic subgroup tends to affect men more as they are more focused on the muscular build of their bodies and whether they are too big or too small

and the insight subgroup is designed to measure the severity of one's BDD and aims to understand if the sufferer's beliefs are based in delusion (Phillips, 2014).

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) is a commonly used treatment approach for anxiety, depressive, and obsessive-compulsive disorders (DeRubeis, Siegle, & Hollon, 2008; Foa, 2010). Often used in conjunction with psychotropic treatment, CBT is an evidence-based approach that has roots in psychoanalysis and has paved the way for other models such as Dialectical Behavior Therapy (DBT), and Rational Emotive Behavior Therapy (REBT; Fenn & Bryne, 2013; Kalodner, 2011). CBT interventions can be adapted to fit the patient and can be employed in the treatment of culturally diverse populations (Fenn & Bryne, 2013; Hinton & Patel, 2017).

The Theory and Application of Cognitive-Behavioral Therapy

Background

A combined theoretical approach from the cognitive and behavioral schools of thought regarding mental illness, cognitive-behavioral therapy (CBT) was devised by Dr. Aaron Beck in the 1960s (Fenn & Bryne, 2013; Kalodner, 2011). Freud is credited with providing a foundation for many of the models of psychotherapy; however, behaviorists focus on learned behavior's impact on the presentation of mental illness in contrast to Freud's focus on the unconscious. Cognitive

theorists take this focus a step further by examining how defective thinking can lead to the emotional and behavioral impact on said presentations (Kalodner, 2011). Thus, the core premise of CBT is that the patient's world (life experiences, cultural influences, developmental stage/normalcy, trauma, etc.) has instilled beliefs or schemas that influence how the individual feels. As a result of these misguided emotions, the individual has established patterns of ineffective behaviors or coping skills that can cause distress on a clinical level (Fenn & Bryne, 2013; Kalodner, 2011). To demonstrate this premise, an example of the cognitive-emotive-behavioral loop is provided using the mock patient "Mia". Mia has the core belief that she hideous and the ugliest girl at school. She describes feeling worthless, unlovable, and inferior. Mia also worries a lot about being out in public because she is afraid that people will see how hideous she is and call her names. In response, Mia has broken all the mirrors in her home, pulls her eyelashes out when she worries, has been missing school for the past few weeks, and has contemplated suicide because "the world would be better without her hideousness". As a result of Mia's distorted cognitions, she is experiencing significant distress and impaired functioning on several levels. Additionally, Mia has contemplated taking her life to prevent the punishment of other people observing her perceived "hideousness". This may seem like an extreme example, but such a symptom profile can often be seen in a clinical setting relevant to BDD and co-occurring disorders such as social anxiety (APA, 2013; Butcher, Hooley, & Mineka, 2013; Phillips, 2007).

Goals of Treatment

As with most therapy models, treatment goals are defined based on the individual patient and symptom profile, with consideration of level of functioning and commitment (Kalodner, 2011).

In addition to reducing/eliminating distress and impaired functioning, ultimately CBT is aimed at the patient reaching what is termed as self-efficacy – the ability to use the new skills taught/modeled in therapy to identify and change the faulty thinking that is causing their emotional reasoning and maladaptive behaviors (Fenn & Bryne, 2013). At the close of therapy, it is intended for the patient to be equipped with the tools/coping strategies necessary to allow them to better counter negative self-talk and manage distress (Fenn & Bryne, 2013; Kalodner, 2011). In treatment, the clinician and patient work together to discover distorted thoughts/assumptions the patient holds of him/herself and misperceptions about situations/events. Homework assignments, such as journaling or worksheets, are often provided to reinforce what was discussed in session, as well as independent learning/processing (Fenn & Bryne, 2013; Kalodner, 2011). Socratic questioning is utilized to gain understanding of the patient's thought processes while fostering insight (Fenn & Bryne, 2013; Kalodner, 2011). Cognitive restructuring is commonly used to evaluate an identified thought/assumptions/perception by jointly testing its truth and replacing it with a more effective belief (Fenn & Bryne, 2013; Kalodner, 2011). Exposure is another technique that may be introduced in session to reduce a patient's fear of a person, place, and/or situation (Fenn & Bryne, 2013; Kalodner, 2011). Continuing with the example of "Mia" to describe sample CBT treatment goals, desired treatment outcomes based on this model can include: Mia being aware of distorted cognitions – "I am hideous", emotional reasoning – "I am worried about others seeing how ugly I am", and maladaptive behaviors – "I will avoid all social interactions"; ultimately, Mia will learn to identify and adjust cognitive distortions on her own. Furthermore, Mia will become aware of ineffective coping skills when she is anxious (i.e., pulling out eyelashes); ultimately, Mia will learn new coping skills to utilize when anxious (Fenn & Bryne, 2013; Kalodner, 2011).

Evidence-Based Approach

Researchers have conducted numerous studies examining the efficacy of CBT in treating myriad mental health disorders; however, there is debate in the field as to whether this model can be considered the "gold standard" of treatment (David, Cristea, & Hofmann, 2018; Leichsenring et al., 2018). Hoffmann et al., (2012) reviewed a sample of meta-analytic studies (n=106) examining the efficacy of CBT in treatment of disorder clusters including anxiety, depressive, eating, obsessive-compulsive, traumatic, and personality disorders. The results indicate that CBT is efficacious in the treatment of these clusters when compared to other treatment modalities (Hoffmann et al., 2012). There is significant empirical support for CBT efficacy in treating depression and anxiety – noted comorbid disorders with BDD; however, when compared to psychotropic treatment, efficacy rates are lower (Cuijpers et al., 2016). The combination of drug (selective serotonin reuptake inhibitors (SSRIs)) and cognitive-behavioral therapy appears to be most efficacious in moderate to severe presentations (Cuijpers et al., 2016; Hoffmann et al., 2012).

Cognitive-Behavioral Therapy and Body Dysmorphic Disorder

As demonstrated throughout this paper, there is noted cognitive distortion evident in the symptom profile of an individual suffering with BDD (Butcher, Hooley, Mineka, 2013; Phillips, 2014). Elements of shame and delusions are noted in the clinical presentations of these patients with varying severity (Hong, Nezgovorova, & Hollander, 2018). For milder presentations, it appears that treatment with CBT can yield positive short-term outcomes (Krebs et al., 2017) and more severe cases can benefit from medication and CBT (Hong, Nezgovorova, & Hollander, 2018). As CBT has been shown efficacious in the treatment of co-occurring disorders such as MDD and social anxiety, it is likely that patients with such diagnoses would benefit from therapy inclusive of CBT

interventions as this approach can help challenge the shame and delusional thinking described (Hong, Nezgovorova, & Hollander, 2018; Weingarden, Renshaw, Davidson, & Wilhelm, 2017). This evidence-based approach is not the end-all-be-all of treatments but is often noted as clinicians' primary choice when treating these clusters of disorders (David, Cristea, & Hofmann, 2018).

Discussion

The research discussed throughout this paper describes a link between the cognitive impairment involved in BDD and the cognitive repair possible with treatment involving CBT. While there is some evidence to support use of this modality in the treatment of BDD, the author notes that the available evidence only supports a positive short-term outcome (Krebs et al., 2017). As such, future research should examine long-term outcomes of the same treatment. Additionally, the correlation between early onset and increased symptom severity raises subsequent research questions in unstudied populations of patients under the age of twelve. Lastly, diagnosis criteria have become more clearly defined over time yet there are still a number of patients that are misdiagnosed or diagnosed too late for reasons that still remain unclear so continued research to garner deeper understanding of BDD presentations is needed (Phillips, 2014).

Conclusion

BDD is a complex mental health disorder that can have crippling effects on those suffering with it. It has been shown that CBT can be an effective element of treatment and may need to be integrated with other modalities based on a patient's symptom profile. Further

research is recommended to explore symptomology, understudied populations, and long-term treatment outcomes.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bjornsson, A. S., Didie, E. R., Grant, J. E., Menard, W., Stalker, E., & Phillips, K. A. (2013). Age at onset and clinical correlates in body dysmorphic disorder. *Comprehensive psychiatry*, *54*(7), 893–903. doi:10.1016/j.comppsych.2013.03.019

Butcher, J. N., Hooley, J. M., & Mineka, S. (2013). *Abnormal psychology* (16th ed.). Boston, MA: Pearson.

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. *World Psychiatry*,*15*(3), 245-258. doi:10.1002/wps.20346

David, D., Cristea, I., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. *Frontiers in psychiatry*, *9*, 4. doi:10.3389/fpsyt.2018.00004

DeRubeis, R. J., Siegle, G. J., & Hollon, S. D. (2008). Cognitive therapy versus medication for depression: treatment outcomes and neural mechanisms. *Nature reviews. Neuroscience*, *9*(10), 788–796. doi:10.1038/nrn2345

Foa E. B. (2010). Cognitive behavioral therapy of obsessive-compulsive disorder. *Dialogues in clinical neuroscience*, *12*(2), 199–207.

Hinton, D. E., & Patel, A. (2017). Cultural Adaptations of Cognitive Behavioral Therapy. *The Psychiatric Clinics Of North America*, *40*(4), 701–714. https://doi:10.1016/j.psc.2017.08.006

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive therapy and research*, *36*(5), 427–440. doi:10.1007/s10608-012-9476-1

Hong, K., Nezgovorova, V., & Hollander, E. (2018). New perspectives in the treatment of body dysmorphic disorder. F1000Research, 7, 361. doi:10.12688/f1000research.13700.1

Kalodner, C. R. (2011). Cognitive-behavioral theories. In D. Capuzzi & D. R. Gross (Eds.), *Counseling and psychotherapy: Theories and interventions* (5th ed., pp. 193-213). Alexandria, VA: American Counseling Association.

Krebs, G. (2017). Long-Term Outcomes of Cognitive-Behavioral Therapy for Adolescent Body Dysmorphic Disorder. Behavior Therapy, (4), 462. https://doi-org.ezp.waldenulibrary.org/10.1016/j.beth.2017.01.001

Krebs, G., Cruz, L. F., Monzani, B., Bowyer, L., Anson, M., Cadman, J., . . . Mataix-Cols, D. (2017). Long-Term Outcomes of Cognitive-Behavioral Therapy for Adolescent Body Dysmorphic Disorder. *Behavior Therapy*,*48*(4), 462-473. doi:10.1016/j.beth.2017.01.001

Leichsenring, F., Abbass, A., Hilsenroth, M. J., Luyten, P., Munder, T., Rabung, S., & Steinert, C. (2018). "Gold Standards," Plurality and Monocultures: The Need for Diversity in Psychotherapy. *Frontiers in psychiatry*, *9*, 159. doi:10.3389/fpsyt.2018.00159

Li, W., Arienzo, D., & Feusner, J. D. (2013). Body Dysmorphic Disorder: Neurobiological Features and an Updated Model. *Zeitschrift fur klinische Psychologie und Psychotherapie (Gottingen, Germany)*, *42*(3), 184–191. doi:10.1026/1616-3443/a000213

Phillips K. A. (2004). Body dysmorphic disorder: recognizing and treating imagined ugliness. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *3*(1), 12–17.

Phillips K. A. (2007). Suicidality in Body Dysmorphic Disorder. *Primary psychiatry*, *14*(12), 58–66.

Phillips, K. A. (2014). Body Dysmorphic Disorder: Common, Severe and in Need of Treatment Research. *Psychotherapy and Psychosomatics*,*83*(6), 325-329. doi:10.1159/000366035

Prazeres, A. M., Nascimento, A. L., & Fontenelle, L. F. (2013). Cognitive-behavioral therapy for body dysmorphic disorder: a review of its efficacy. *Neuropsychiatric disease and treatment*, *9*, 307–316. doi:10.2147/NDT.S41074

Weingarden, H., Renshaw, K. D., Davidson, E., & Wilhelm, S. (2017). Relative relationships of general shame and body shame with body dysmorphic phenomenology and psychosocial outcomes. *Journal of obsessive-compulsive and related disorders*, *14*, 1–6. doi:10.1016/j.jocrd.2017.04.003