Cognitive–Behavioral Body Image Therapy for Body Dysmorphic Disorder

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Body dysmorphic disorder (BDD) is a distressing body image disorder that involves excessive preoccupation with physical appearance in a normal appearing person. Prior case reports of behavior therapy were encouraging, but no controlled evaluation of behavior therapy or any other type of treatment had been conducted. In the present study, 54 BDD subjects were randomly assigned to cognitive behavior therapy or no treatment. Patients were treated in small groups for eight 2-hour sessions. Therapy involved modification of intrusive thoughts of body dissatisfaction and overvalued beliefs about physical appearance, exposure to avoided body image situations, and elimination of body checking. Body dysmorphic disorder symptoms were significantly decreased in therapy subjects and the disorder was eliminated in 82% of cases at posttreatment and 77% at follow-up. Overall psychological symptoms and self-esteem also improved in therapy subjects.

Although body dissatisfaction seems almost normal today, concern with physical appearance is truly distressing and disabling for a significant number of people. The category of the body dysmorphic disorder (BDD). The prevalence of BDD is approximately 4% in women and less than 1% in men (Rich, Rosen, Orosan, & Reiter, 1992). Although it is not a rare disorder, only a few case studies of BDD treatment have been reported. Some treatments appear promising, but none has been subjected to an experimentally controlled evaluation using standardized measures. That was the objective of the present study.

BDD patients can be distressed about virtually any aspect of their physical appearance (Phillips, 1991), though they are normal appearing. Complaints about the size, shape, or symmetry of facial features are common. Some patients report concerns about skin blemishes, breast size or symmetry, thinning hair or excessive body hair, teeth, and genitals. Others have more vague complaints such as being “ugly.” Dislike of body weight or shape is common today, but these complaints can reach the level of BDD if accompanied by distressing and disabling preoccupation (Crisp, 1988). Like other somatoform disorders, the essence of BDD is not where in the body the patient sees the defect, but the fact that the patient is preoccupied with it.

Appearance preoccupation occurs mostly in social situations in which the person feels self-conscious and expects to be scrutinized by other people. This attention makes the patient feel ashamed because he or she believes the defect reveals some personal inadequacy. Body image beliefs in BDD patients are characterized as strong irrational convictions or overvalued ideas (Hay, 1970; Thomas, 1984). However, some patients with nothing visible are completely convinced their defects are real, and some have ideas of reference without insight into the fact that their thoughts are distorted. Thus, body image beliefs in BDD can seem delusional, although this is debated (de Leon, Bott, & Simpson, 1989).

Most body dysmorphic disorder patients engage in some avoidance of social situations they believe might call attention to their appearance. A small portion become housebound (Phillips, McElroy, Keck, Pope, & Hudson, 1993). However, most patients are capable of at least limited social and vocational functioning, using ways to avoid full exposure of their appearance in public by wearing clothes, grooming, or contorting body posture and movements in such a way as to hide the defect. Various kinds of body checking behaviors are common, such as inspecting the defect in the mirror, performing grooming rituals, comparing one's appearance to others, and asking others for reassurance. Like compulsions, these behaviors are difficult to resist and in some extreme cases body checking can last hours each day. Finally, body dysmorphic disorder patients are convinced the only way to improve their self-esteem is to improve the way they look. Thus, most BDD patients undertake beauty remedies such as weight reduction, skin or hair treatments, cosmetic surgery, and other measures to eliminate the defect that usually are unnecessary and ineffective for BDD symptoms.

Although little is known about the etiology of BDD, we proposed a cognitive–behavioral model for body image disorder that is the basis for the treatment we will present here (Rosen, 1992). The BDD patient's preoccupation with physical appearance is likely to begin during adolescence when concerns regarding physical and social development peak. Many adoles-
cents have observable physical differences that provoke added attention from other people. The risk for developing a body image problem is even greater if this attention is coupled with more traumatic incidents such as being teased or humiliated for one's looks or being physically or sexually assaulted. These experiences can trigger dysfunctional assumptions in the person about the normality of his or her physical appearance and its implication for personality, self-worth, and acceptance.

Several mechanisms maintain the preoccupation with appearance. The patient rehearses negative and distorted self-statements about physical appearance to such an extent that they become automatic and believable. Avoidance behavior prevents the patient from habituating to the sight of his or her appearance, especially in social situations where there is the possibility of attention from other people. Finally, checking behavior may provide immediate relief, but in the long run keeps the person's attention focused on aspects of appearance that elicit anxiety.

Various treatments for BDD have been proposed, but no definite conclusion can be made because all reports are based on uncontrolled case studies without appropriate objective measures of body image. A few cases of BDD have responded well to medication (Phillips, 1991). The most promising medication is serotonin reuptake inhibitors (clomipramine and fluoxetine), which were effective in all 5 of Hollander's cases (Hollander, Liebowitz, Winchel, Klumer, & Klein, 1989) but ineffective in 12 other cases (Neziroglu & Yaryura-Tobias, 1993a; Thomas, 1984; Vitiello & de Leon, 1990).

In regard to psychotherapy, Bloch and Glue (1988) reported reduced BDD symptoms in one case through psychodynamic therapy, whereas two reports of other nonbehavioral therapies were unsuccessful (Braddock, 1982; Philippopoulos, 1979). Systematic desensitization was effective in two cases (Giles, 1988; Munjack, 1978). Marks and Mishan (1988) reported exposure plus response prevention was successful in four of five cases, although only two of their cases were treated purely with behavior therapy and no medication. In comparison, Neziroglu and Yaryura-Tobias (1993b) reported the use of exposure plus response prevention alone that resulted in decreased BDD symptoms in four of five cases. In conclusion, the results of behavior therapy for BDD are the most encouraging, and a controlled evaluation seems warranted.

There have been five controlled studies of cognitive behavior therapy for treatment of body dissatisfaction (Butters & Cash, 1987; Dworkin & Kerr, 1987; Grant & Cash, in press; Rosen, Cado, Silberg, Srebnik, & Wendt, 1990; Rosen, Saltzberg, & Srebnik, 1989). Cognitive behavior therapy proved to be more effective than no treatment and control treatment in improving body image and overall psychological adjustment. However, it is unknown how many of the subjects met criteria for the BDD; none of the studies screened for the disorder, and four of them were begun prior to the introduction of BDD into the DSM. Also the study samples were college women who were selected from screening questionnaires in class surveys. Thus, one cannot generalize the good results from these studies to a clinical sample of BDD patients. The present investigation was designed to evaluate cognitive behavior therapy compared with a no-treatment control with a clinical sample of body dysmorphic disorder.

Method

Participants

Participants were 54 women who met the DSM third edition, revised, and fourth edition (American Psychiatric Association, 1987, 1993) criteria for body dysmorphic disorder. Briefly, the key features for the diagnosis were (a) normal physical appearance, (b) physical appearance overemphasized in self-evaluation, (c) negative self-esteem attributed to physical appearance, (d) distressing dissatisfaction and preoccupation with appearance, (e) extreme self-consciousness in or avoidance of social or public situations, and (f) no anorexia or bulimia nervosa. The diagnosis of BDD was made with a semistructured clinical interview, the Body Dysmorphic Disorder Examination (BDE; Rosen & Reiter, 1994). The criteria on the BDE were a minimum of moderately severe symptom ratings on the items related to features b to e (above) plus a total score in excess of 1.25 standard deviations above the community norm for adult women (z = 62). Normality of appearance also was rated on the BDE; however, likely eligible subjects were subjected to a second, independent rating of appearance. Only subjects rated as normally appearing by both raters were included. (The BDE and exact BDD criteria are available on request.)

Potential subjects were 156 patients referred to an outpatient clinic for treatment of BDD and body image complaints. Referring professionals included mental health therapists, general physicians, plastic surgeons, orthopedists, and dermatologists. Patients were also recruited with newspaper announcements of a "body image therapy" program. Ninety-four patients were excluded for the following reasons (more than one reason possible for each patient): (a) BDD symptoms not severe enough (58), (b) significant physical abnormality (38 severe overweight, 1 severe scars, 1 leg amputation, 1 hemiparesis, 1 breast abnormality); (c) anorexia or bulimia nervosa (11 screened out with the Eating Disorder Examination, Cooper & Fairburn, 1987); (d) psychosis (3), (e) severe depression with suicidal behavior (1); and (f) male patients (15), in order to make the therapy groups more homogeneous (treatment of male BDD patients will be reported elsewhere). Eight eligible patients refused treatment or were not available.

The subjects' ages ranged from 20 to 61 years (M = 36.5, SD = 9.5). Education was college graduate (34%), some college (28%), and high school degree (18%). Twenty-one percent were unemployed. Marital status was married (52%), never married (36%), divorced (10%), and widowed (2%). The mean body mass index (wt/ht²) was 26.48 (SD = 3.48). Other treatment included previous psychotherapy (48%), cosmetic surgery (11%), repeated dermatology consultations (11%), and cosmetic dentistry (4%). All subjects with weight complaints had a history of repeated dieting.

There seems to be some variation in BDD samples between research centers (Hollander, Neziroglu, Phillips, & Rosen, 1992), which may result from differences in clinical specialty of the investigators and their referrals or the fact that BDD still is not a clearly agreed upon disorder. Therefore, for clarification purposes, we want to highlight some features of our patients that may differ from other reports. First, with respect to compulsions, our patients all engaged in repetitive body checking and grooming behavior, 78% on a daily basis. However, only a couple of patients had extremely high-frequency, day-long grooming rituals coupled with social isolation. By comparison, Neziroglu and Yaryura-Tobias (1993a, 1993b) had several patients with debilitating compulsions in their small case series. Although body checking behavior seems to be a major symptom of BDD, presently it is not a diagnostic criterion.

Second, with respect to the normality of physical appearance, we
screened out persons with definite physical abnormalities but included subjects with distinctive features who nonetheless were within normal limits (e.g., a large but normally shaped nose). This is consistent with the DSM and BDD literature. We also included mildly overweight but not severely overweight subjects (a body mass index between 27.3 and 32.3), reasoning that this degree of overweight is common enough (24% of American women according to the NHANESII study; Najjar & Rowland, 1987) to consider these subjects normal-looking. Thus, some subjects complained of defects that were not completely imagined. However, none had true physical abnormalities and they all perceived their appearance as being more anomalous and important than was realistic—that is, they had overvalued ideas.

Third, the types of appearance complaints in order of frequency, beginning with the most frequent, were thighs (38%), abdomen (35%), breast size or shape (20%), skin blemishes (17%), buttocks (15%), facial features (12%), overall weight (9%), scars (8%), aging (7%), height (6%), hips (5%), teeth (4%), and arms (3%). Thirty-eight percent of subjects presented body weight or shape complaints only, 44% presented both weight/shape and other complaints, and 17% presented non-weight/shape complaints only. By comparison, fewer subjects in the case series of Phillips et al. (1993) presented weight or shape complaints, although half of her cases were men and weight complaints are less common in men. The significance of the type of appearance complaint in BDD is unknown. So far, we have not found any difference in body image and psychological symptoms between BDD patients when grouped according to type of appearance complaint, nor is any difference reported in the BDD literature.

Experimental Design and Treatment

Subjects signed a consent to participate prior to the initial evaluation and were randomly assigned to cognitive therapy or no-treatment control. They were assessed again 2 weeks after the treatment versus no-treatment phase. Subjects in the no-treatment condition subsequently were offered therapy, limiting the experimentally controlled portion of the study from pre- to posttreatment. Treatment subjects were assessed a third time at 4.5 months after treatment. Assessments were performed by BA-level research assistants. Eligibility at the initial evaluation was checked by a clinical psychologist. Research assistants were uninformed of the subjects' experimental condition at posttreatment or follow-up evaluations.

No-treatment control. These subjects were promised therapy after a minimum 10-week waiting period.

Cognitive-behavior therapy. Treatment was provided in groups of four or five patients and one therapist and was scheduled as eight weekly 2-hour sessions. If any member of the group was unable to attend a session, the session was canceled and rescheduled. Consequently, the groups varied in the spacing of treatment sessions, which lasted from 8 to 12 weeks. Therapists were the three authors: a clinical psychologist and two post-masters-level graduate students in clinical psychology. Subjects were charged for therapy at standard rates.

Therapy was modeled after the cognitive behavioral body image therapy of Rosen et al. (1989, 1990) but was modified to meet the needs of a BDD population (the treatment manual is available from the authors). Subjects were provided with an audiotape program on body image therapy by Thomas Cash (1991) that supported the cognitive-behavioral principles used in therapy sessions and structured the homework assignments.

1. Therapy began with an explanation of our model of BDD causation and treatment. Subjects were helped to identify the developmental antecedents of their body image problem, sociocultural and familial factors, and the immediate sources of body image distress.

2. Subjects explained concretely the distressing aspects of their appearance to the other members of the group. As much as possible, they were provided more objective feedback about the appearance of the perceived defect. For example, subjects with exaggerated complaints of excessively large thighs or facial features estimated the size or shape of the distressing part with drawings or moveable markers. These subjective perceptions were compared with actual size or shape using anthropometric calipers or silhouettes drawn by other group members. Subjects then rehearsed more accurate representations of their appearance defects.

3. Subjects constructed a hierarchy of distressing aspects of their appearance. Exposure therapy, thought stopping, and relaxation were used to extinguish subjective distress at the sight of these features. This was practiced first in therapy sessions when subjects stood in the group and explained the hierarchy they had constructed while other members studied the relevant features of their appearance (subjects did not remove their clothing). Subjects were taught to refrain from critical self-talk and to substitute more objective sensory descriptions of the body parts (e.g., "round nose" instead of "horse face"). Then at home, subjects progressed through the hierarchy by exposing themselves first imaginally and then in front of the mirror, clothed and unclothed. Negative body talk was to be interrupted with nonjudgmental sensory self-description.

4. In support of the cognitive therapy, subjects kept a body image diary throughout treatment in which they recorded relevant situations, the body image thoughts or beliefs they had in these situations, and the effect of these on mood and behavior. Eventually, subjects were taught to recognize maladaptive thoughts and to record disputing thoughts in the diary. We encouraged subjects as much as possible to interrupt intrusive negative self-statements about the aesthetics of their appearance such as, "Oh, my breasts are so limp and shapeless." Ultimately, these thoughts are difficult to extinguish completely, some degree of body dissatisfaction is normal, and in many cases their self-statements were accurate to some extent. Therefore, we focused mainly on helping subjects to correct the more damaging beliefs related to the implications of physical appearance for self-worth and relationships, especially those beliefs that caused them to feel ashamed or embarrassed around other people. Typically, subjects believed their looks proved they were unlovable, foolish, stupid, slutty, immoral, disgusting, freakish, alien, and so forth.

5. Exposure therapy was used to overcome distressing self-consciousness and avoidance of feared body image situations. Example exposure assignments were wearing a form-fitting outfit instead of baggy clothes, undressing in front of spouse, not hiding facial features with hands or combed-down hair, dressing to reveal scars, exercising in public wearing work-out clothes, drawing attention to appearance with more trendy clothes, accentuating a distressing feature (e.g., lips) with make-up or not wearing make-up at all, standing closer to people, and trying on clothes or make-up in stores and then asking sales clerks for feedback on their looks. Exposure was carried out first in the therapy session, then prescribed as homework. The difficulty of assignments was increased by varying the exposure situations with respect to familiarity of people, physical proximity to others, and type of social interaction (e.g., giving a talk in front of a group vs. speaking individually to a colleague; speaking to a superior at work vs. speaking to a friend).

6. Response prevention was used to decrease body checking behaviors. Examples are stopping weighing, inspecting in the mirror, or measuring body size with measuring tapes or certain special clothes. Some subjects were instructed to set a fixed time for dressing or to refrain from multiple changes of clothes. Some subjects were instructed to first accentuate their desire to check, by messing hair for instance, and then to refrain from self-inspection in the mirror. Repeatedly asking other people for reassurance and comparing oneself with other people are other forms of body checking that were targeted.

7. Finally, subjects were instructed in the principles of relapse pre-
viation and were asked to identify and prepare themselves for impending high-risk situations.

Measures

Body Dysmorphic Disorder Examination (Version 3.1). This is a 32-item semistructured clinical interview designed to measure the cognitive and behavioral symptoms of body dysmorphic disorder (Rosen & Reiter, 1994). It taps into self-consciousness and preoccupation with physical appearance, overvalued ideas about the importance of appearance in self-evaluation, avoidance of social situations or exposure of the appearance defects, and body camouflaging and body checking behavior. The BDDE had acceptable test–retest reliability ($r = .94$), internal consistency ($r = .95$), and concurrent validity with other body image questionnaires ($r_s = .68$ to $.83$). The interrater reliability for the total score of independent interviews was $r = .89$, and the kappa measure of independent diagnostic agreement with the BDDE was .81.

For the present study, the BDDE was scored for the total severity of BDD symptoms and for the presence or absence of BDD according to the recommended set of cutoff scores.

Body Shape Questionnaire. This is a body image questionnaire (Cooper, Taylor, Cooper, & Fairburn, 1987) that measures desire to lose weight, body dissatisfaction, and feelings of low self-worth in connection with weight and shape. The coefficients of internal consistency, test–retest reliability, and concurrent validity with other measures of body satisfaction are adequate: $r_s = .97$, .88, and .66, respectively.

Multidimensional Body Self-Relations Questionnaire (MBSRQ) Appearance Evaluation scale (Brown, Cash, & Mikulka, 1990). Of the seven MBSRQ scales, only the Appearance Evaluation scale was administered. Appearance Evaluation consists of 7 ratings of feelings of physical attractiveness or unattractiveness and satisfaction or dissatisfaction with one’s looks. The $r_s$ for test–retest reliability and internal consistency are .91 and .88. Concurrent validity with another measure of body satisfaction is .66.

Brief Symptom Inventory (Derogatis & Spencer, 1982). We calculated the Global Severity Index, which is an index of overall psychological distress. Test–retest reliability is .90 and internal consistency ranges from .71 to .85. Validity coefficients with the Minnesota Multiphasic Personality Inventory are above .30.

Rosenberg Self-Esteem Scale. This is a measure of global self-esteem (Rosenberg, 1979) involving ratings of attitudes regarding general self-worth. The measure has acceptable test–retest reliability (.77) and internal consistency (.89). The scale is significantly correlated with peer ratings ($r = .32$; Demo, 1985).

Results

Pretreatment

Statistical tests performed on values of age, education, body mass index, marital status, body image measures, psychological symptoms, and self-esteem revealed no significant differences between the experimental conditions at baseline.

Adherence, Credibility, and Satisfaction

No subject dropped out of treatment. The cancellation policy proved successful as treatment subjects attended all eight sessions, (i.e., there was 100% attendance). The only deviation from the planned format was that two subjects received one individual session each because the remainder of group participants were unable to agree on an alternative meeting time. At each session subjects returned a homework completion checklist and the therapists reviewed each assignment. Of the 41 homework assignments, subjects completed an average of 86% ($SD = 15$). Twenty-two percent completed less than 80% of assignments, but none completed less than half. All subjects completed the posttreatment (or postwaiting) evaluation. One treatment subject refused to return for the follow-up evaluation. No treatment subject began psychological treatment outside of the program during the treatment or follow-up phase. One no-treatment subject started psychotherapy elsewhere 2 weeks prior to the posttreatment assessment.

In the second therapy session, we asked subjects to rate on a scale of 1 to 7 their expectation to benefit from this therapy; the mean was 5.46 ($SD = .90$). After treatment ended, their rating of satisfaction with treatment was 5.73 ($SD = 1.22$) and the degree to which they would recommend this program to others was 6.27 ($SD = 1.31$). Eighty percent said they would recommend the program. These ratings and the percent of homework completion were not significantly correlated with changes on the body image measures.

To assist therapist adherence to the treatment protocol, therapists followed a detailed session-by-session manual. Conformity also was simplified by the fact that a main focus of each session was debriefing and preparing for the homework assignments, which were fairly standard for all subjects. Finally, the three therapists met weekly to review each case and ensure adherence to the protocol.

Differences Between Conditions at Posttreatment

The difference between the treatment and no-treatment conditions at posttreatment on the five measures of body image and psychological adjustment (see Table 1) was examined in a between-groups multivariate analysis of covariance, controlling for pretreatment scores. The main effect for group was significant, $F(5, 43) = 20.01, p < .001$, indicating that the subjects who received treatment were much improved compared with the no-treatment subjects.

Differences between groups at posttreatment on individual dependent variables controlling for pretreatment were examined using the univariate analyses of covariance derived from the multivariate analysis. Cognitive behavior therapy subjects were significantly improved on all measures at posttreatment compared with the no-treatment subjects: Body Dysorphic Disorder Examination, $F(1, 47) = 65.80, p = .000$; MBSRQ Appearance Evaluation scale, $F(1, 47) = 45.57, p = .000$; Body Shape Questionnaire, $F(1, 47) = 81.61, p = .000$; psychological symptoms, $F(1, 47) = 13.53, p = .001$; and self-esteem, $F(1, 47) = 12.61, p = .001$.
Table 1
Means and Standard Deviations of Dependent Variables by Treatment Phase

<table>
<thead>
<tr>
<th>Measure</th>
<th>Cognitive-behavior therapy (n = 27)*</th>
<th>No treatment (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Body Dysmorphic Disorder Exam</td>
<td></td>
<td></td>
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<tr>
<td>Pretreatment</td>
<td>83.9</td>
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<tr>
<td>Posttreatment</td>
<td>41.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Follow-up</td>
<td>39.9</td>
<td>21.3</td>
</tr>
<tr>
<td>MBSRQ Appearance Evaluation Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretreatment</td>
<td>1.97</td>
<td>.42</td>
</tr>
<tr>
<td>Posttreatment</td>
<td>3.08</td>
<td>.59</td>
</tr>
<tr>
<td>Follow-up</td>
<td>2.99</td>
<td>.82</td>
</tr>
<tr>
<td>Body Shape Questionnaire</td>
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<td></td>
</tr>
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<td>Pretreatment</td>
<td>133.5</td>
<td>19.2</td>
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<tr>
<td>Posttreatment</td>
<td>87.5</td>
<td>20.4</td>
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<tr>
<td>Follow-up</td>
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<tr>
<td>Brief Symptom Inventory</td>
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<td></td>
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<tr>
<td>Pretreatment</td>
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<td>.48</td>
</tr>
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<td>Posttreatment</td>
<td>.57</td>
<td>.46</td>
</tr>
<tr>
<td>Follow-up</td>
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<td>.40</td>
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<tr>
<td>Rosenberg Self-Esteem Scale</td>
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<tr>
<td>Pretreatment</td>
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<tr>
<td>Posttreatment</td>
<td>29.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Follow-up</td>
<td>30.0</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Note. MBSRQ = Multidimensional Body Self-Relations Questionnaire.
* At follow-up, N = 26.

Significant main effects for time for each variable (df = 2,49; p = .000): Body Dysmorphic Disorder Examination, \( F(2, 49) = 69.02, p = .000 \); MBSRQ Appearance Evaluation Scale, \( F(2, 49) = 31.89, p = .000 \); Body Shape Questionnaire, \( F(2, 49) = 57.55, p = .000 \); psychological symptoms, \( F(2, 49) = 17.59, p = .000 \); and self-esteem, \( F(2, 49) = 28.23, p = .000 \).

Post hoc paired comparisons controlling for family-wise error indicated that treatment subjects improved significantly on all measures from pre- to posttreatment and pretreatment to follow-up at \( p = .000 \), except that the pre- to posttreatment change in psychological symptoms was significant at \( p = .003 \). There were no significant differences between posttreatment and follow-up.

Rates of Clinically Significant Improvement

To be considered clinically improved, a subject had to (a) no longer meet the diagnostic criteria on the Body Dysmorphic Disorder Examination and (b) have a score lower on the BDDE after treatment than her pretreatment score minus 2 standard errors of measurement. Using Speer’s recommendation for calculating clinically significant change (1992), we centered this confidence interval on an estimate of the subject’s “true” pretreatment score, which adjusted for regression to the mean. Two subjects in the no-treatment condition (7.4%) met these criteria for improvement after the waiting period. Of the 27 cognitive therapy subjects, 22 were clinically improved at posttreatment (81.5%) and 20 of 26 were improved at follow-up (76.9%). Three of the five unimproved treatment subjects at posttreatment were clinically improved at follow-up, and four “relapsed,” that is, no longer scored in the clinically improved range at follow-up.

Discussion

Cognitive behavioral body image therapy proved to be an effective treatment for body dysmorphic disorder. The total severity of BDD symptoms of therapy subjects decreased to the normal range on the Body Dysmorphic Disorder Examination (.4 SD above the mean for a community sample, Rosen & Reiter, 1993) and the majority of patients no longer met the diagnostic criteria for BDD. Preoccupation with appearance and body dissatisfaction were improved on the other two measures of body image, the Body Shape Questionnaire and MBSRQ Appearance Evaluation scale. The means on these scales decreased from the clinically severe range to the normal range. Although other psychological symptoms were not targeted in therapy, on average the total severity of symptoms and global self-esteem improved to the normal range.

Treatment was not uniformly effective; a significant minority of subjects still had BDD at the follow-up. We were unable to identify any subject characteristics that distinguished these patients from others. They did not differ in demographics or severity of body image and psychological symptoms at baseline. However, in regard to the therapy format, our impression was that some patients might have benefitted from longer treatment and more intensive, supervised exposure response prevention outside of the clinic. Also, it is possible that some subjects might
have benefitted from more individual attention than allowed in group therapy. On the other hand, none of the subjects complained of this, and actually, there seemed to be advantages of the group format. Our impression was that the patients inspired each other to complete homework and invest themselves in therapy at times when they felt like dropping out. Moreover, it seemed therapeutic for the subjects to observe other women conquer the same type of maladaptive beliefs about appearance and self-worth that they held themselves.

The successful outcome is consistent with previous reports of cognitive behavior therapy for BDD (Marks & Mishan, 1988; Neziroglu & Yaryura-Tobias, 1993b). The additional contributions of this study were that a larger series of patients was studied, subjects received no treatment for BDD other than cognitive behavior therapy, therapy was more effective than a control condition of repeated assessment, more subjects with weight and shape complaints were included, and outcome was evaluated with standardized measures of body image and BDD symptoms. The effectiveness of this body image therapy also is similar to the results we obtained earlier with women who reported less severely disturbed body image than BDD (Rosen et al., 1989, 1990). Thus, it seems that cognitive behavioral body image therapy is appropriate for persons with different degrees of body image disorder.

Although this study was very encouraging, we hope it will be just a beginning to more systematic controlled treatment trials for BDD, a disorder that has been surprisingly neglected. There are several limitations and new questions in this project that could be addressed in future research. One research design limitation was the lack of experimental control carried out to a follow-up period. Thus, the longer term effect of treatment versus no treatment remains to be evaluated. The length of our follow-up was short and because there was some deterioration in the improvement after treatment; a much longer follow-up is needed. The experimental design controlled for treatment but not for attention and nonspecific aspects of therapy. Thus, a placebo control in BDD treatment research might be worth evaluating, although we have found this type of intervention to be ineffective for people with body image problems (Rosen et al., 1989). The encouraging results in this study cannot necessarily be generalized to male BDD patients. Also the effectiveness of this type of cognitive behavioral body image therapy for strictly non-weight or shape complaints is unknown. Although we could find no difference in treatment outcome based on type of appearance complaint, our sample of non-weight/shape complainers was too low to give a definitive answer to this question. Finally, the only other treatment for BDD that has been recommended is pharmacotherapy, especially the use of serotonin reuptake blockers (Phillips, 1991). Thus, it would be useful to compare these two modalities in a single study and to evaluate the use of combined treatment.

References


Cognitive behavior therapy with and without size perception training for women with body image disturbance. Behavior Therapy, 21, 481-498.

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