

Cognitive-Behavioral Treatment of Body Dysmorphic Disorder

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ABSTRACT

Cognitive-behavioral therapy (CBT) is an effective treatment for body dysmorphic disorder (BDD). This article reviews the research support for CBT in BDD, describes in detail some of the important considerations when administering CBT in this challenging patient group, and reviews some of the behavioral and cognitive techniques that can be used. In addition, this article identifies three basic principles for clinicians to keep in mind when providing medical treatments for BDD patients. While patients should ordinarily be referred to experienced therapists for CBT, knowledge of the basic principles and techniques can enable medical providers who are not trained in CBT to both make better referrals for treatment and work most effectively with the therapist and BDD patient.

INTRODUCTION

Body dysmorphic disorder (BDD), a serious and undertreated disorder characterized by a preoccupation with an imagined or slight appearance flaw, was first formally recognized as a psychiatric disorder in 1987.¹ Research since that time has identified two effective treatments for BDD, namely serotonin reuptake inhibitors (SRIs; see Hadley in this issue for a review²) and cognitive-behavioral therapy (CBT). This article discusses evidence for the efficacy

Needs Assessment: Patients with body dysmorphic disorder (BDD) often first present to medical professionals other than psychiatrists for correction of their perceived appearance flaw. These patients are very challenging to treat because they characteristically have poor insight. Cognitive-behavioral therapy (CBT) is an effective treatment for this disorder and referral to experienced therapists is recommended. However, understanding some basic learning principles upon which CBT is based enables medical professionals to treat patients with BDD more effectively.

Learning Objectives:

- Present empirical support for and major components of CBT for BDD.
- Identify techniques used to reduce BDD rituals and correct cognitive errors.
- List three CBT principles that are important when prescribing medical treatment for BDD patients.

Target Audience: Primary care physicians and psychiatrists.

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of CBT in BDD and provides a brief overview of how CBT can be conducted with BDD patients. However, it is beyond the scope of this article to serve as a manual for the treatment of BDD patients. Rather, this article serves to familiarize clinicians with some of the basic considerations and behavioral and cognitive techniques that can be employed. It also discusses CBT-based recommendations for working with these patients in medical practice.

EVIDENCE FOR THE EFFICACY OF COGNITIVE-BEHAVIORAL THERAPY IN BODY DYSMORPHIC DISORDER

Only two controlled studies of CBT for BDD are available.^{3,4} However, CBT has emerged as the psychologic treatment of choice based on these studies, consistent findings from case series and uncontrolled studies, and the similarity of BDD to other disorders. One such similar disorder is obsessive-compulsive disorder (OCD), for which the efficacy of CBT is firmly validated.

The first controlled study of CBT in BDD was conducted by Rosen and colleagues,³ who developed and validated a CBT protocol for group treatment of patients with BDD.^{3,5,6} Cognitive techniques were used to modify dysfunctional thoughts; behavioral techniques such as exposure to avoided situations and reduction of checking were used to lessen BDD behavioral symptoms. Compared to a no-treatment control, those who completed eight 2-hour sessions had significantly reduced BDD symptoms. These patients seemed different in several significant ways from those seen at other BDD treatment sites; they had a milder form of BDD, had good insight, and were primarily concerned about their weight (which, notably, was at the lower end of the overweight range in at least one of the studies, with an average body mass index of 26.48).⁶

These studies were built on previous work by Rosen and colleagues^{3,5,6} and on work by Cash and colleagues⁷⁻¹⁰ on the treatment of body image disturbances (including obesity and eating disorders), and represents one of the major research traditions which has contributed to current BDD treatment. A CBT program for patients with body image disturbances was also developed and used to treat patients with weight concerns rather than BDD. This CBT program has been shown to be effective in clinician-conducted individual and group therapy as well as in a largely self-directed individual format.⁷⁻¹⁰

The second successful controlled study was reported by Veale and colleagues.⁴ Nineteen BDD patients were randomly assigned to either a 12-week wait-list control or to 12

sessions of CBT that used cognitive restructuring, exposure to social situations, and reduction of rituals such as mirror checking and seeking reassurance. Seven of the nine patients in the CBT group no longer met the diagnostic criteria for BDD at the end of the trial, but the control patients all remained in the clinical range for BDD. The seven patients in the BDD group scored lower than the control patients on key BDD and depression measures. This work was based on a cognitive-behavioral model of BDD, as well as on theories of and research on social anxiety disorder (SAD), OCD, and other obsessive-compulsive spectrum disorders.

These findings are consistent with case reports and small studies conducted with less scientific rigor in the same tradition. Marks and Mishan¹¹ successfully treated five patients with exposure therapy that included live, fantasy, and paradoxical exposure; they focused on decreasing avoidance of situations that made the patients very anxious about their perceived appearance flaw. Importantly, as their patients' avoidance and anxiety decreased, the certainty about their beliefs decreased as well. This occurred despite the fact that the beliefs were of delusional intensity and no cognitive therapy was conducted to dispute these beliefs. Beary and Cobb¹² used live and imaginal exposure to treat patients with delusional stench. They reported success upon follow-up in two of three cases. Munjack¹³ used relaxation training and systematic desensitization successfully in a male patient diagnosed with dysmorphophobia, as determined through a 1-year follow-up.

CBT was effective in decreasing both BDD obsessions and related behaviors in several uncontrolled studies.¹⁴⁻¹⁷ Typically, treatment consisted of both exposure to distressing situations with prevention of rituals, and cognitive challenges to patients' misperceptions regarding their appearance. Wilhelm and colleagues¹⁸ reported on an open-case series of CBT for BDD conducted in small groups. Their patients improved significantly in both BDD symptoms and depression after 12 weekly 90-minute sessions.

OVERVIEW OF COGNITIVE-BEHAVIORAL TREATMENT OF BODY DYSMORPHIC DISORDER

CBT is a multifaceted treatment that is founded on basic learning principles. Its efficacy has been validated for many disorders. The application of CBT to BDD most resembles techniques used to treat OCD, SAD, eating disorders, and depression. There are several important components to CBT.

Cognitive-behavioral treatment requires determining the thoughts and behaviors that are maintaining the patient's BDD and undermining their functioning, and finding ways to change these thoughts and behaviors. CBT usually also involves relaxation training, such as deep breathing and muscle relaxation. These techniques can be used for BDD. However, the focus of this article is on those elements that apply specifically for BDD symptoms.

BDD patients are characterized by poor insight regarding their perceived appearance flaws and by their overestimation of the importance of physical attractiveness. Clearly, these are major challenges in BDD treatment since they undermine motivation for and cooperation with treatment. A serious and common consequence of the poor insight and overvaluation of attractiveness are patients' beliefs that correcting the physical flaw is the only way to solve their problem, to relieve depression and anxiety, and to allow them to function in the world. Thus, patients often present in medical settings searching for a surgical or dermatologic solution, or perhaps in dental or other treatment settings. For the most part, patients with BDD see their appearance flaw as the primary problem; the thoughts and the feelings that accompany them are the next most disturbing problem. For many patients, the behaviors are not perceived as a problem. However, even if the behaviors limit the patient's life in some way that creates problems, the behaviors are also seen as essential; therefore, no effort is made to eliminate the behaviors. Patients who seriously damage their skin by picking at it generally recognize that their behavior is a problem, but are likely to also consider skin picking essential; they just want to be able to stop sooner.

The strength and rigidity of patients' beliefs in the reality of their perceived appearance flaws will influence the focus of the CBT techniques chosen and how they are applied. Generally, patients will be very interested in talking about their thoughts and feelings. These are important and need to be addressed before treatment is complete. However, focusing on them early in treatment can be counter-productive. It is important to realize that changing BDD behaviors is the key to reducing symptoms, including obsessions. And, given their poor insight, work on BDD patients' thoughts is usually difficult until there has been some improvement. Patients' insight can improve in response to medication or in response to behavioral changes (ie, a reduction in rituals and avoidance). Thus, early in treatment it is valuable to focus on understanding and reducing the BDD behaviors (as explained in the next section of this article), which helps avoid nonproductive discussion of the patient's irrational thoughts. The resulting reductions in BDD behaviors are likely to lead to more flexible thinking.

It is generally important not to give patients feedback about their appearance and essential not to challenge the patient's beliefs about their appearance. Seeking reassurance is a common ritual and it is best that the clinician not get involved in this pattern. It can be helpful for the clinician to state outright that they do not give BDD patients feedback about their appearance; this can be explained in various ways depending on the patient, such as that it is counterproductive or that seeking reassurance becomes a ritual. Additionally, the patient is likely not to believe the reassurance, and anything that is said can be misinterpreted to be negative. It is basically a lose-lose situation. It can take skill to avoid giving feedback. However, if possible, it is important to get a specific description of how patients perceive themselves, beyond descriptions using simple general adjectives.

BEHAVIORS

The core of the behavioral component of CBT is exposure and response prevention, wherein patients are put in situations which arouse their BDD anxiety but are prevented from performing their anxiety reducing rituals or running away (avoidance). Feeling some anxiety is critical to the success of this technique. In order to do the behavioral work it is essential to identify the patient's BDD behaviors; having the patient label all the BDD behaviors and write them down can be a good first assignment.

Exposure and response prevention actually includes a limitless variety of situations. Exposures can be specific planned live events that the therapist leads in session or that are carried out by the patient alone or with a helper between sessions (eg, a patient going out for a walk with the therapist without wearing sunglasses during the session or going out with a friend on a Sunday afternoon without sunglasses). Exposures can also be imaginal, carried out in session, or done between sessions perhaps with the help of a tape or script (eg, a patient imagining what it would be like to go out without sunglasses, including anticipating all that could be distressing in such a situation). Importantly, exposures can also involve changing rituals that are performed in response to naturally occurring BDD arousal situations (eg, not wearing sunglasses when walking the dog late at night, every night). This may be one of the most important tactics in reducing BDD behaviors. Paradoxical exposures can be conducted; in these, the patient is confronted with a situation so outlandish, even the patient can see it does not make sense. For example, when an airplane flies overhead, a patient who thinks his ears are too large might imagine that the passengers are looking out the window and laughing with one another because his ears are so big they can see them.

Often, therapists who do planned exposures begin their work by constructing a hierarchy of situations that evoke BDD-related distress; these situations are rated for the amount of distress they evoked and rank ordered by the distress ratings. Typically, the anxiety is rated using the Subjective Units of Discomfort scale (0 to 100, from the least to the most anxiety).¹⁹ The situations used in the hierarchy would not be exhaustive but would include situations which vary in terms of both the extent to which their perceived flaws are visible and the sensitivity of the situations, so that some would create a low level of stress for the patient and others would be very challenging. A woman with BDD who is concerned about the shape of her eyes and perceives bags or wrinkles around them might be using many methods to avoid having people get a good look at her eyes. She may directly conceal her eyes by wearing sunglasses or may try to camouflage them by artfully applied eyeliner. She may have a hairstyle that allows her hair to fall easily over one eye. She may go out only at night or stay in places with dim lighting, or she may control where she stands in relation to others so they can see her only in profile. Exposure would involve making her eyes more clearly visible to others by modifying these masking and avoiding behaviors. In addition to having degrees of exposure of the flaw, there would also be situational elements that would vary the level of stress. In order of increasing distress, the hierarchy might contain situations such as the patient talking with her parents, talking to female friends, meeting new females, talking to male peers, talking to a male she would like to date, and being on a date with someone of real interest.

BDD patients have many compulsive behaviors or rituals that do not involve hiding their flaws from others. Many of these are listed in the Table. Exposures for these naturally occurring BDD distress situations are extremely valuable. For example, BDD patients are often compelled to look in mirrors and examine their flaws. Exposure and response prevention techniques can be employed by having a patient schedule their mirror checks so that they have the urge to look (the exposure) but resist (prevent their response). While patients cannot just stop looking in the mirror, most can look less often. Depending on the severity of the BDD, the checks can be scheduled a few times a day up to several times an hour. If this technique is used, it is important that the times be scheduled, that there be enough times so the patient is able to do the assignment (ie, resist looking between scheduled checks), and that the patient look at the scheduled time whether they feel the need or not. When designing exposures of this sort, the key is to separate the stimulus (BDD distress) from the response (the compulsive behavior/ritual, such as looking

TABLE
COMPULSIVE BEHAVIORS OF PATIENTS WITH BDD

Behavioral Rituals	Examples
<i>Scrutinizing and comparing</i>	Patients vigilantly observe the body part of concern in others and compare it to their own. For example, a BDD patient with skin concerns would scrutinize the skin of people they see live, in magazines, movies, etc. Commonly and unrealistically, they feel their skin is worse than most of those they see and, if there is someone with bad skin, they imagine that theirs looks that bad or worse. The scrutinizing and comparing may be to themselves at an earlier time. They may have a photo of themselves at an earlier point in time before they developed their perceived problem. They may compulsively take photos of themselves to compare with the older photos to assess deterioration.
<i>Mirror/reflective surface checking</i>	Patients check out the feature of concern in mirrors and reflective surfaces. The majority of patients become transfixed in mirrors for long periods of time, sometimes hours, but will also check out the feature of concern in reflective surfaces briefly throughout the day.
<i>Camouflaging and covering</i>	Patients disguise or cover the feature of concern using make-up, clothing, hats, scarves, or their hand, or by adopting a particular posture or position. For example, a patient concerned about having a weak chin may jut it out continuously, or a male concerned about not being muscular will stand with his arms flexed and in a position to show his muscles to their greatest advantage or least disadvantage.
<i>Seeking consultation and treatments to fix the physical problem</i>	Since patients see the problem as their appearance and not their BDD, the solution is to fix their appearance. Thus, they will make appointments with various specialists (surgery, dermatological, dental) seeking to change their appearance. For example, they may seek hair removal, laser treatments for scars or discolorations of the skin, tooth whitening, tanning, hair straightening, cosmetic dentistry, orthodontia.
<i>Internet and other information searching</i>	Patients will repeatedly seek out information about their appearance problem. They may spend hours on this daily, repeatedly doing the same Internet searches, watching television infomercials or makeover shows, or buying magazines to read articles with the latest fixes for their perceived problem (eg, wrinkles, cellulite, frizzy hair, heaviness).
<i>Lotions and potions</i>	Patients will use creams or other substances on their skin or hair. They may make changes to their diet or take supplements for these or to change their body shape. These include protein shakes and various supplements.
<i>Seeking reassurance or confirmation</i>	Patients compulsively ask those around them if they look okay, or patients sometimes seek confirmation that they look as bad as they think.
<i>Mirror avoidance</i>	Some patients do try to avoid mirrors.
<i>Excessive grooming</i>	Patients spend an inordinate amount of time putting on makeup or doing or redoing their hair. They may try on multiple outfits every day.
<i>Touching the defect</i>	Patients touch the body part of concern in order to assess if it is changing or to try to make it change.
<i>Positioning</i>	Patients manage the view other people have of the perceived defect to ensure they cannot see it clearly or at all, or that they see it from the least disturbing vantage point. For example, patients might keep people on a particular side or at an angle (eg, profile, three-quarters view, or head-on only), stay in dimly lit areas, or keep others at a distance.
<i>Skin picking</i>	Patients compulsively attempt to improve the appearance of the skin by peeling off dry skin, cleaning pores, squeezing pimples or trying to smooth irregularities by removing them. These actions invariably result in damage to the skin, sometimes severe, due to the inability to stop and/or the use of tweezers, pins, or other implements.

BDD=body dysmorphic disorder.

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in the mirror). Therefore, the rituals need to be performed at a preset time that cannot be manipulated by the patient (eg, a specific clock time, during television commercials, when their husband leaves for work). This technique can be applied to many rituals in addition to mirror checking, such as seeking reassurance, touching, applying lotions, and many other behaviors listed in the Table. BDD patients typically have multiple repetitive behaviors that can be targeted in this way. For example, the woman with concerns about her eyes might check them in a mirror from multiple angles, take photos of them and compare current with past photos to assess deterioration, apply wrinkle creams, use treatments for puffiness, consult with specialists for cosmetic surgery and/or dermatologic treatments, and seek reassurance from family and friends. All these behaviors can be targeted for reduction and eventual elimination.

COGNITIVE COMPONENT

The cognitive piece of CBT can be conceptualized as cognitive restructuring. It has several major components, including psychoeducation, identification of problem thoughts, and correction of cognitive errors. All of these components can be very challenging in BDD, and the speed in which the cognitive work can begin depends on the patient's insight. Until the patient's insight has improved and a therapeutic alliance has been formed, it is important to avoid getting into arguments with BDD patients or wasting time on therapeutic attempts that are doomed to fail.

Psychoeducation is generally begun in the initial session with a discussion of what is known about BDD, its characteristics, and how it is maintained, as well as an explanation of CBT. Patients are often very relieved to be speaking to someone who understands BDD and knows what they are talking about and experiencing. Education about the actual importance of physical attractiveness is often beneficial because BDD patients have a greatly exaggerated notion of the significance of attractiveness. However, it is important to accept that physical attractiveness is important and to be careful in challenging patients' beliefs in this regard, taking into account their current level of insight.

The cognitive approach assumes that the interpretation of an event or fact determines the emotional response to it. People who perceive their appearance as flawed may or may not be devastated by their imperfect appearance, depending on how they view it. For example, if the woman who is concerned about her eyes believes that she has to be beautiful in order to be accepted by others, she may be devastated even

if she realizes that her perceived flaw is minimal. Another person who considers appearance less crucial to acceptance may be unaffected by a relatively major imperfection. BDD patients tend both to overestimate the general importance of attractiveness and to incorrectly estimate the reaction others have of their flaw. They have very negative thoughts accompanied by intense feelings of shame and humiliation about their appearance. Their minds move rapidly from thoughts of their perceived flaw to thoughts of how others must be reacting to them, and then to thoughts of how hopeless their lives are. This spiral needs to be stopped. Labeling BDD behaviors and thoughts can be a helpful way to begin making patients more aware of the presence of BDD in their lives and enable them to begin separating from the BDD and getting a better perspective.

An important aspect of cognitive therapy for BDD is the identification of cognitive errors and maladaptive thinking; it includes training the patient to identify these and to, over time, change his or her thinking patterns. Many cognitive errors are usually evident. Commonly, BDD patients use black-and-white thinking. For example, they believe that if they have a flaw, they are ugly, and that their appearance would have to be perfect for them to be attractive. They try to read minds and are adept at interpreting things others do as a reaction to their ugliness. For example, a BDD patient may interpret both people looking at them and people avoiding looking at them, as proof of their ugliness. As therapy continues, patients can monitor their disturbing appearance-related thoughts, and record them and the situations in which they occur. Patients can work on identifying and disputing their distorted thoughts, interpreting situations more accurately, and substituting more realistic thoughts about the significance of their appearance. Note that the focus is not on changing their belief about their physical flaw itself, but rather on the significance of that perceived flaw in their interactions with others.

Patients also need to learn to be more objective and less blatantly negative in their appraisals of their appearance. They can be encouraged to use precise, neutral language to describe their perceived flaw, rather than general, emotion-laden language. For example, a patient would be trained to say "I have two pimples on my chin that are the size of a pencil point," as a substitute for saying "my skin is disgusting." Note that the patient may, in fact, have no visible spots at all on his or her chin. The point here is for the patient to describe what he or she sees in more objective language. The point is not to directly address any misperceptions.

For patients with good insight, discussion of their misperceptions about their appearance might be helpful. However,

correction of misperceptions has not proven to be necessary for treatment success and, in one study, did not add to treatment success.⁶ This is consistent both with the finding that body image can be improved without any bodily change⁸ and with the observation that many patients who are convinced of their defect may readily acknowledge that their level of concern or the amount of time they spend obsessing is excessive. In addition, in some cases when challenging the patient's mistaken beliefs seems helpful, it may simply be serving as reassurance. Such patients may repeatedly seek this reassurance, and, if it continues to be offered, the reassurance can maintain or even increase symptomatic behavior.

IMPORTANT LESSONS FROM BASIC LEARNING THEORY FOR PHYSICIANS

Structured and Automatic Treatment

The more time a patient spends involved in rituals and obsessing about their appearance, the worse the BDD will become. This means that medical treatments are best if they are simple, consistent, can be followed quickly, and involve no examination of the feature of concern and no patient decisions. Therefore, the more structured and automatic the treatment, the better. If, for example, a patient has a mild facial skin condition that a physician decides could benefit from treatment, it is best if the treatment is simple, quick, and done on a consistent basis. One lotion to be applied to the skin daily in the evening after washing the face will be less promoting of BDD than a 3-step process (applied at bedtime if there are no eruptions, but applied both morning and night if there are eruptions, plus something to apply three times a day directly to any problem areas that appear). Not only is the latter treatment more involved and more time consuming, but it has the patient examining his or her skin multiple times a day and deciding if the skin is changing. All this examining and pondering will exacerbate the BDD. While there may be a medical reason to have a different treatment for when the skin is breaking out than when it is not, when treating BDD patients it is important to consider the likelihood that they will not be able to accurately assess the state of their skin even under the best of circumstances. Thus, if it depends on their assessment of the state of the flaw, they may not end up using the proper treatment in any case. If applying a lotion every day is not harmful, it might be preferable to instruct patients to use it every day rather than telling them to decide daily whether to use it or not. In terms of exacerbating the

BDD, telling them to use something for 3 weeks would be preferable to telling them to use it until their skin clears. It is also best to recommend that they not change their routine or products quickly but to change one thing at a time and stick with it for a substantial period of time. Keep in mind that BDD patients can change their skin care routines, exercise routines, or other rituals several times a week, or sometimes several times a day, in response to perceived changes in their skin, hair, weight, shape, or other feature.

Do Not Reinforce Tantrums

The more a patient changes what he or she does in response to BDD distress, the worse the BDD will get. Relevant BDD rituals that involve physicians include medical appointments and treatments. While having many appointments and treatments will be bad for BDD, it is even worse if these are scheduled because the patient is having a bad BDD moment. The author of this article treated one patient who would get laser treatments on a walk-in basis. If the patient got upset about his wrinkles or scars, all of which were minimal, he would run over and get a laser treatment. This was much more detrimental to his BDD than if he had just scheduled laser treatments twice a month (eg, on the 1st and the 15th of every month). Unfortunately, while it is harmful to the patient to schedule appointments due to a BDD crisis, if a physician refuses then the patients are likely to simply find another physician. It is best, of course, if a patient can be prevailed upon to get help from a mental health professional (see Phillips' article in this issue for strategies²⁰) and collaborate with the clinician. If possible, a good strategy is to schedule periodic appointments. A key issue, of course, is whether or not the patient has a problem that could benefit from treatment and how significant the problem is. It can be helpful in the long run to refuse treatment. One patient who went for laser treatments for discoloration and minor scarring resulting from skin picking was told that she should come back to see him after not picking for 3 months because he thought most or all of her concerns would disappear and said he would help her then if any remained. That patient had some insight and was in therapy; the laser specialist's comments motivated her to curtail her skin picking even though she thought scars would remain, and she would return in time for the laser treatments.

Notably, this is one reason self-treatment for BDD can fail. Patients try to change too much and then give in. This proves to them that exposure does not work, and also can exacerbate their BDD. For example, a patient may realize mirror checking is not helpful, so he or she may try to stop all mirror checking.

This is virtually impossible, so the patient will eventually give in when he or she has a really bad BDD attack. This will be interpreted as proof that CBT does not work, plus it may also increase the strength of subsequent BDD attacks.

Avoid Intermittent Reinforcement Schedules

A clinician should be consistent. As bad as it is to reinforce BDD, it is worse to do it inconsistently. One clear finding from basic learning theory is that if a behavior is reinforced intermittently, unpredictably, it will be much more difficult to extinguish than if it is reinforced consistently. This may explain why mirror checking is such a difficult ritual to stop. Patients look in mirrors all the time and occasionally do like what they see. Therefore, they keep looking at their reflections, despite many bad BDD experiences, in hopes for another view that is like the few good ones they have had in the past. These more attractive views come intermittently and unpredictably. Reassurance can also end up being given intermittently, and this is something physicians would do well to keep an eye on. It is important for clinicians to be consistent with these patients, to maintain a consistent tone of interaction with them, to describe their perceived flaws consistently, and to have a treatment plan that does not change frequently.

CONCLUSION

Patients with BDD often first present to medical professionals other than psychiatrists for correction of their perceived appearance flaw. These patients are very challenging to treat because they characteristically have poor insight and may resist referral to a mental health professional. Though additional research is needed to more fully understand the parameters of efficacy, two treatments that have been shown to be effective in reducing BDD symptoms are SRIs and

CBT. Treating BDD patients with CBT is complex. If possible, most patients should be referred to experienced therapists for treatment. However, the techniques outlined should enable physicians to have a better understanding of CBT, and aid physicians in referring their patients to appropriate therapists and in working more effectively with the CBT therapist to provide the coordinated care necessary for optimal treatment of the BDD patient. *PP*

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