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Culturally Adapted Cognitive Behavioral Therapy for Body Dysmorphic Disorder: Case Examples

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Abstract

Individuals with Body Dysmorphic Disorder (BDD) have distressing or impairing preoccupations with imagined or slight defects in their appearance (e.g., nose too big). BDD is a severe psychiatric disorder often associated with high rates of suicidality as well as social and occupational impairment (Phillips, Coles et al., 2005). Researchers have only recently begun to investigate psychological treatments for BDD, with available data suggesting that cognitive behavioral therapy (CBT) appears efficacious for BDD (Williams, Hadjistavropoulos, & Sharpe, 2006). To our knowledge, however, there are no reports of whether CBT for BDD can be effectively generalized to ethnic minority and other special populations. The current report suggests specific modifications within the CBT for BDD framework that might improve the effectiveness and retention rates of CBT among ethnic minority patients with BDD. Specifically, the present study describes the cases of Ben*, a 40-year-old, Jewish, married male, and John, a 30-year-old, African American, single male, both with a primary diagnosis of BDD. Various treatment techniques were used to make the course of CBT more culturally responsive. This case report illustrates the challenges and benefits of integrating cultural variables into a CBT framework for BDD, and it highlights the need for more work in this area.

Keywords

Body Dysmorphic Disorder; BDD; cognitive behavioral therapy; treatment; Cultural Adaptation

Body Dysmorphic Disorder (BDD) consists of a distressing or impairing preoccupation with an imagined or very minor defect in appearance (APA, 2000). BDD is a common, impairing, and often chronic disorder (Phillips, Pagano, Menard, & Stout, 2006). Nationwide

*Ben and John are fictional names used to protect the patients' anonymity.

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epidemiologic studies have found that BDD occurs in 1.7% – 2.4% of the population (Buhlmann et al., 2010; Koran, Abujaoude, Large, & Serpe, 2008; Rief, Buhlmann, Wilhelm, Brähler, & Borkenhagen, 2006). Research has demonstrated that 24 – 27.6% of individuals with BDD have a history of suicide attempts (Phillips & Menard, 2006; Veale, Boocock, Gournay, & Dryden, 1996) and one study found that 0.3% of individuals with BDD complete suicide per year, a markedly high rate (Phillips & Menard, 2006).

Individuals with BDD are often concerned about a wide range of body parts, such as their face, skin, nose, body shape, and hair (Phillips, Menard, Fay, & Weisberg, 2005). In response to appearance concerns, people with BDD commonly spend many hours a day engaging in checking and/or camouflaging behaviors, such as hiding the perceived flaw with baggy clothes, hats, or make-up. Appearance concerns may also manifest as other time-consuming repetitive behaviors, such as excessive grooming, making comparisons about one's appearance, changing or selecting clothing, and touching or measuring body parts (Phillips, Menard et al., 2005). Additionally, people with BDD may involve romantic partners and family members in their ritualistic behaviors and seek excessive reassurance about their appearance, which in turn generates interpersonal difficulties for these patients (Phillips, Menard et al., 2005).

Despite its longstanding recognition in the literature, BDD has not been studied systematically until recently. In part, this is due to the shame that individuals with BDD experience, which frequently causes them to suffer in silence rather than to seek help (Phillips, 2005). Although treatment research is still very limited, available research suggests that cognitive behavioral therapy (CBT) appears to be an efficacious intervention for BDD (For a review, see Greenberg & Wilhelm, this issue; Lovell & Bee, 2008). CBT techniques must be specifically tailored to BDD's unique symptoms; indeed, BDD differs from other disorders in important ways (Phillips et al., 2010). CBT techniques that can be utilized in the treatment of BDD include psycho-education, motivational enhancement, cognitive restructuring, exposure and response prevention, mirror retraining, and relapse prevention (Wilhelm, Phillips, Fama, Greenberg, & Steketee, Accepted for Publication; Wilhelm, Phillips, & Steketee, In Press). These techniques are presented in a modular treatment approach by Wilhelm, Phillips, and Steketee (Wilhelm et al., Accepted for Publication; Wilhelm et al., In Press) that is tailored for the individual needs and appearance concerns of the patient (e.g., weight, shape and muscularity module for patients with muscle dysmorphia, who are concerned that they are too small or not muscular enough).

Despite research suggesting that CBT is efficacious for BDD (Neziroglu & Yaryura-Tobias, 1993; Rosen, Orosan, & Reiter, 1995; Veale et al., 1996; Wilhelm et al., Accepted for Publication), we are unaware of any prior reports on how CBT for BDD might be adapted for ethnic minority individuals. While this is a limitation of empirically supported treatments for many psychological disorders, it may be especially salient with regard to treatment for BDD because body image and beauty ideals are shaped by one's cultural and ethnic identity. For instance, in the general population African Americans are more satisfied overall with their bodies compared to Caucasians and Latino Americans (Altabe, 1998). Latina women have been shown to be least satisfied with their breasts compared to women of other ethnic groups (Altabe, 1998), while Asian American females strive for Western beauty ideals, such

as thin figures, as well as Asian beauty ideals, such as pale skin (Hall, 1995; Kawamura, 2002; Mintz & Kashubeck, 1999).

Just as beauty ideals in the general population are influenced by one's ethnicity, body image concerns in BDD are also likely to be shaped by one's ethnicity, and this may be important to address in treatment. There is preliminary evidence that body parts of concern in an Internet sample of individuals who reported BDD symptoms differed by ethnicity. For example, Asian American participants were more worried about their skin being too dark and their hair being too straight, compared to Caucasian participants (Marques et al., 2011). Furthermore, in a large college sample of self-reported BDD, Caucasian and Latina women reported more BDD symptoms compared to African American women (Boroughs, Krawczyk, & Thompson, 2010), a finding which mirrors the pattern in the population at large (Altabe, 1998).

Our clinical experience also suggests that ethnic identity influences BDD symptoms and that CBT treatment must address ethnic identity in order to be effective for some individuals. The current paper discusses two such cases. Our aim is to demonstrate how CBT can be culturally adapted for the treatment of BDD by describing the cases of Ben* and John*, for whom addressing ethnic identity as part of CBT seemed necessary in order to achieve the desired treatment outcome.

As described by several investigators, the theoretical underpinnings of CBT permit its modification, to incorporate cultural adaptations and tailor the treatment to be culturally-sensitive (Hays & Iwamasa, 2006). In fact, several researchers have developed culturally-adapted CBT for other psychological disorders. For instance, some studies have examined adaptations to CBT when treating Cambodian refugees with PTSD and panic attacks, in order to incorporate somatic and culturally bound symptoms, as well as specific cultural beliefs (Hinton et al., 2005; Hinton & Otto, 2006; Hinton et al., 2004).

Overview of CBT for BDD

Cognitive-behavioral therapy for BDD involves using cognitive and behavioral techniques to help patients identify, test, and modify dysfunctional thoughts and behaviors related to their BDD symptoms (for a detailed description of approaches used in these cases, see (Wilhelm et al., Accepted for Publication). Briefly, CBT for BDD begins with psycho-education, which is designed to help the patient learn more about the disorder as well as begin to develop a conceptual model of his or her BDD. At this stage, the patient will be asked to consider sociocultural, biological, and psychological factors that may have contributed to his or her BDD symptoms. In addition, patients learn to distinguish between "physical appearance" and "body image."

Treatment then turns to cognitive restructuring, in which the patient is taught to evaluate distorted thoughts in a more rational and empirical manner, through a Socratic approach. For example, BDD patients may report the cognitive distortion "Everyone looks away because they think I am so ugly." The therapist helps the patient identify the specific cognitive distortion related to this thought (i.e., mind reading). In addition, the therapist encourages the patient to consider alternative explanations for his or her beliefs (e.g., people are

avoiding eye contact because it is not socially appropriate to maintain eye contact with a stranger for extended periods of time, not because they think I'm ugly) and to find evidence to support or contradict such alternative beliefs. Modified cognitive approaches are used for patients with delusional BDD beliefs.

The next step is to introduce in vivo exposure and response prevention exercises, or behavioral experiments, both in and out of session. Exposures are designed to aid the patient in engaging in situations they would typically avoid, and response prevention exercises help the patients reduce or eliminate appearance-related rituals and safety behaviors. Exposure and response prevention exercises are typically combined (e.g., go outside on a sunny day without applying any makeup and don't check your appearance) and are designed hierarchically so that less distress-provoking exercises are attempted earlier in treatment. Concurrently, the patient learns to identify and modify BDD-related core beliefs, such as "I am defective" or "I am worthless." This aspect of the intervention tends to be emphasized later in treatment, as the patient often needs additional practice with cognitive restructuring prior to being able to identify and modify core beliefs.

For mirror, or "perceptual," retraining, the therapist teaches the patient to describe his or her appearance in a non-judgmental and holistic way while looking in the mirror. Patients are asked to stand at a distance from the mirror and to describe themselves in neutral terms, rather than negative terms, from their head to feet (e.g., I have brown hair, my skin is light brown). Mirror retraining allows patients to develop more control over their mirror checking rituals by developing a different relationship with the mirror. To that end, a hierarchy of mirror checking rituals can be developed to slowly aid the patient in decreasing mirror checking. In the present cases, there was not a need to culturally adapt mirror retraining.

Treatment concludes with relapse prevention techniques to teach the patient skills to maintain gains after therapy. Depending on the patients' specific BDD concerns and comorbidity, additional modular components are included in the treatment. For example, if a patient presents with comorbid depression that warrants concurrent treatment, an emotion regulation module might be implemented (for a detailed description, see Wilhelm et al., Accepted for Publication).

This treatment protocol was modified for the cases presented in this report because of issues of ethnic identity that appeared early in treatment and which required the therapist to adapt the standard treatment to be more culturally-sensitive.

Method

The Structured Clinical Interview for the DSM-IV (First, Spitzer, Gibbon, & Williams, 1995) was administered to both patients at baseline, in order to assess for BDD as well as any comorbid diagnoses. At intake, BDD symptom severity was assessed using the Yale-Brown Obsessive Compulsive Scale modified for BDD (BDD-YBOCS: Phillips, Hollander, Rasmussen, & Aronowitz, 1997). The BDD-YBOCS is a 12-item semi-structured clinician-administered measure, which was adapted from the Y-BOCS for OCD (Goodman, Price, Rasmussen, & Mazure, 1989). The BDD-YBOCS rates current severity of BDD symptoms

(Phillips et al., 1997) and has demonstrated excellent test-retest and inter-rater reliability (ICC for total score = .88 and .99, respectively), internal consistency (Cronbach's α = .80), convergent validity (*r* = .55 with the CGI), and sensitivity to change with treatment (Phillips et al., 1997). Scores range from 0 to 48.

Delusionality of BDD beliefs was assessed with the Brown Assessment of Beliefs Scale (BABS; Eisen, 1998), which is a 7-item semi-structured clinician-administered interview that assesses current delusional thinking categorically and dimensionally (Eisen, 1998). Excellent test-retest and inter-rater reliability (ICC for total score = .95 and .96), internal consistency (Cronbach's α = .87), convergent validity (*r*'s = .56–.85 with measures of delusionality), and divergent validity (*r* = .20 with the BDD-YBOCS) have been demonstrated (Eisen, 1998). The cut-off score (18) for the presence of delusional thinking in BDD had a sensitivity of 100% and a specificity of 86%, and it correctly identified 90% of 20 participants with BDD as delusional or non-delusional (Eisen, 1998). It is also sensitive to treatment change (Phillips et al., 1997). Scores range from 0–24.

Finally, the patients' current level of depressive symptomatology was assessed by the administration of the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), which is a 21-item self-report inventory measuring depression severity with items that reflect DSM-IV criteria for major depression (Beck et al., 1996). It has good internal consistency (α = .92) and construct validity (Beck et al., 1996).

Case Descriptions

Relevant History and Presenting Problems

Ben.*—Ben was a 40-year-old, married, Caucasian accountant who sought treatment at an outpatient clinic that specialized in BDD. Ben presented with body image concerns related to his hair being messy and lacking volume, although later in treatment it was discovered that these hair concerns were actually secondary to his nose concerns. Ben explained that he meticulously styled his hair in order to distract people from noticing his "Jewish" nose, which he believed was "deformed" and led people to immediately notice that he was Jewish. Later in treatment, it was discovered that Ben held many negative associations with his Jewish ethnicity, believing others would assume he was self-centered, disrespectful to others, loud and obnoxious. Ben engaged in repetitive behaviors to decrease anxiety caused by his perceived appearance flaw (i.e., his nose and hair), such as ritualistic mirror checking, taking multiple showers each day in order to style and restyle his hair, applying products such as hairspray to his hair and moisturizers to his nose, arranging and rearranging his hair to disguise the size and shape of his nose, avoiding the outdoors on windy days to prevent his hair from getting messy, which in turn would call attention to his nose, and wearing scarves to cover his nose. At his intake assessment, Ben's appearance-related thoughts consumed three to eight hours per day, and related ritualistic behaviors took at least two hours per day. In addition, Ben had not gotten parts of his hair cut (e.g., front part of his hair) for the past several years for fear that cutting his hair would make his nose more noticeable. At the time of treatment, Ben's hair had grown long in the front and he styled it by combing it back over his head, using hairspray to create as much volume as possible. He was often late for work because of the time-consuming morning rituals that he performed,

and he avoided many enjoyable outdoor activities such as bike riding because he worried that the wind would alter his hairstyle, which in turn might lead to people noticing his nose. Furthermore, Ben's appearance concerns caused him daily distress with regard to both family and work relationships; he commonly second-guessed other people's intentions toward him, thinking that they were reacting negatively to his appearance.

When exploring beliefs related to his primary body image concern, Ben reported that his nose was a "typical Jewish nose," which he feared would lead others to identify his Jewish ethnicity. Ben was raised in a Reform Jewish household by two Jewish parents. Ben felt very uncomfortable with his Jewish background and described that his parents "embodied many of the negative stereotypes of Jews;" he described them as "pushy, loud, and self-centered," and he often felt very embarrassed by them as a child. As a result, Ben disassociated himself from his Jewish background entirely in his adulthood. Ben noted that his hair might distract people from his nose, but if he were to ever go bald, he would consider getting a nose job, as he was terrified by the implications of people being able to identify him as Jewish.

At the baseline assessment, Ben had a primary diagnosis of BDD, as well as a history of cued panic attacks related to his BDD. He had no comorbid disorders. He had no family history of BDD. Ben's BDD-YBOCS score was a 27, indicating clinically significant BDD symptoms in the moderate range of severity. His BABS score was 13, suggesting poor insight regarding his BDD beliefs, and his BDI score was a 2, indicating no depressive symptoms. He reported having taken 200 mg of sertraline for the past five years for BDD symptoms.

John.*—John was a 30-year-old, single, African American medical student seeking treatment at an outpatient BDD clinic. John presented with concerns about short height, a protruding stomach, his body build, which he felt was not sufficiently muscular, and his skin color, which he believed was too dark. He reported spending 1–3 hours per day thinking about these appearance concerns. To decrease anxiety about these concerns, John spent two to three hours per day, six days per week, at the gym (formerly, he had spent as many as four hours a day at the gym). He took prohormones, a legal alternative to anabolic-androgenic steroids, to increase muscular growth. He also compared his body to others', measured his body parts of concern, and compulsively checked his appearance in mirrors. Due to his BDD symptoms, John also avoided leaving home and socializing with friends, did not have a romantic partner, and had increasing academic difficulties.

John discussed early in treatment that he grew up as "one of the few Black kids in a predominately White neighborhood." He reported that as a child his parents had encouraged him to associate with his White classmates, but not his Black classmates. In high school, he was involved in extracurricular activities, such as the speech and debate team, in which he was the only Black member, while the majority of his Black classmates participated on the football team. However, he reported that he was frequently the target of teasing from his White peers. By avoiding associating with his Black classmates and being teased by his White classmates, John felt that he did not fit in with either group, and therefore did not develop a strong personal identity as an adolescent.

John also described a preoccupation with exercising and building muscle starting in early adulthood, as an attempt to fit in with the African American community in a way he was not able to in middle school and high school. However, because John believed that society viewed African American males as inherently unattractive, he felt he had to become extremely physically fit in order to be regarded as merely acceptably attractive. Thus, John's exercise served two purposes: to help him establish a place in the African American community and to overcompensate for what he believed was society's opinion of him, as inherently unattractive because of his race.

At his baseline assessment, John received a diagnosis of BDD with comorbid severe Major Depressive Disorder (MDD), which was secondary to his BDD. He had no family history of BDD and was not taking any psychiatric medications. John's baseline BDD-YBOCS score was a 37, indicating severe BDD symptoms. His BABS score was a 17, which indicates poor insight of BDD-related beliefs, and his BDI-II score was a 20, indicating moderate depressive symptoms.

Treatment Process

Both patients received 22 50-minute individual sessions of CBT, 20 of which were weekly sessions; the two final individual sessions were held two weeks apart. The treatment protocol followed that as described in Wilhelm et al. (Accepted for Publication). Throughout the treatment, several culturally sensitive strategies were incorporated. These will be highlighted as we discuss the treatment process for the patients. As treatment shifted between modules, the patients continued to work on previously learned skills.

Sessions 1–3: Psycho-Education and Individual CBT Model Construction

During the initial stage of treatment, the patients were educated about the cognitive and behavioral components of BDD, and specific treatment goals were set to incorporate the patient's values. Each patient and therapist collaboratively created a CBT model specific to the patient's BDD symptoms (see Figures 1 and 2).

At the beginning of therapy, Ben attributed some of his appearance concerns to his ethnic identity. He disclosed to the therapist that his parents were obnoxious and loud, which he attributed to their being Jewish. Ben explained how witnessing his parents' pushy behavior led him to avoid being associated with Judaism. However, he explained that his nose was one permanent marker of his ethnicity that he could not hide from others. If others noticed his nose, Ben feared that they would also assume that he was obnoxious and loud, like his parents. Finally, Ben discussed how he used his hair in order to distract others from noticing his nose.

Similarly, in sessions 1–3 John discussed childhood experiences related to race that he felt were integral in his development of BDD. He discussed being taught by his parents to disassociate from the Black community; he talked about growing up in a primarily White neighborhood and only participating in extracurricular activities with the White students. He also mentioned being teased relentlessly by both his White classmates and his parents about his appearance.

A valuable technique at this stage was for the therapists to remain open to the patients' cultural experiences and to discuss them in a non-judgmental way. Because John and his therapist were of different ethnicities, at the end of sessions in which race had been an important topic of discussion, John's therapist always asked whether she had said anything that misrepresented John's experiences or felt offensive to him in any way. This was an effort to maintain an open dialogue between the patient and therapist and to work toward cultural sensitivity in therapy. In addition, for both patients it was helpful for the therapist to incorporate the patient's cultural or ethnic interpretations into their case formulations (see Figures 1 and 2).

Sessions 4–8: Cognitive Restructuring and Behavioral Experiments

To identify cognitive distortions, Ben was asked to keep thought records and to evaluate his thoughts with respect to their utility and accuracy, helping him to move toward a more rational way of thinking. Below are several of the cognitive distortions endorsed by Ben through thought records:

I am beyond hope these days (Catastrophizing).

My co-workers will not want to look at me because I look terrible (Mind reading and fortune telling).

My hair should look like it has volume (Should statements).

Either my hair has to be perfect, or people will notice my nose and judge me because I look Jewish (Labeling, all or nothing thinking).

John endorsed similar cognitive distortions:

I'm a worthless person (Labeling).

I will always be alone (All or nothing thinking, fortune telling, catastrophizing).

People won't like me and will reject me (Mind reading, fortune telling).

Black is not beautiful (Labeling, all or nothing thinking).

It is important to note that for some patients there might be evidence to support their cognitive distortions (e.g., racial discrimination or being ostracized or teased because of one's race), which in turn makes it more difficult for the patient to use thought records to evaluate the veracity of their thoughts in a balanced way. As described by Kelly (2006), in these situations, therapists have to be careful not to invalidate the patient's experiences of discrimination, while also supporting the patient in exploring ambiguous data in a more objective and scientific manner (Kelly, Hays, & Iwamasa, 2006). A particular challenge when treating patients with BDD is that many experience BDD-related ideas or delusions of reference (referential thinking; Phillips, 2004). That is, they misperceive the behavior of others, assuming that others are taking special notice of them in a negative way (e.g., staring at them or mocking them) because of their "defects," when this is not actually the case. Therapists need to carefully listen to the patient's experience in an attempt to determine the accuracy of their perceptions. Perceptions that appear to be inaccurate (for example, "your receptionist was laughing at me in the waiting room because of my skin color") are more amenable to standard cognitive restructuring. Thus, when working with minority patients, it

is important for the therapist to validate the patient's experience within the context of their culture, while not validating any distortions in thinking.

This issue was pertinent in John's treatment. John's therapist validated John's experiences, telling him "There is a real, historical reason for your concerns." However, the therapist also encouraged John to generate rational responses to his cognitions. For instance, she suggested that those individuals who made fun of him for his appearance were discriminatory or racist; their reactions were a reflection of their imperfections, rather than his own.

Sessions 9–13: Exposure and Response Prevention

Ben participated in frequent in-session and out-of-session exposure and ritual prevention exercises that involved engaging in activities he believed would bring attention to his hair and nose (i.e., walking outside in the wind, wearing a hat) while refraining from engaging in mirror checking or grooming rituals. John's exposures focused on decreasing the amount of time spent exercising, as well as pushing out his stomach around others in order to experience the anxiety of appearing unfit.

Additionally, both patients were asked to perform exposure exercises connected with their ethnic identities and beliefs about what it meant to be Jewish or Black. For example, Ben was assigned to visit Jewish neighborhoods, which created an opportunity for him to challenge his beliefs about the stereotypical negative traits of Jews as well as to begin exploring what it meant to be associated with other Jews. For instance, through these exposures Ben discovered that his predictions of witnessing loud, obnoxious behavior were not met, and he also learned that others did not seem to treat him differently when he was in Jewish neighborhoods. Additionally, Ben was encouraged by his therapist to ask friends if they knew he was Jewish, and if so, whether they thought the negative stereotypes applied to him.

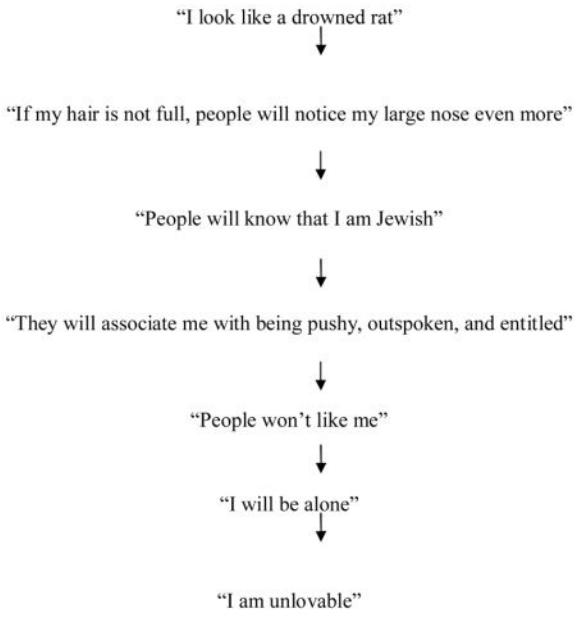
Similarly, John was encouraged through homework to think about successful and respected African American acquaintances and public figures. The goal of this exercise was to challenge John's belief that society views African American men as inherently unattractive, and that as a result, physical appearance is particularly important to the success of African American men. John believed that for Black men to be successful they must overcompensate by being *highly* physically attractive. When reviewing this homework assignment, John's therapist pointed out that none of the characteristics John listed as defining these individuals was related to their physical appearance. The therapist emphasized that although John felt that others judged his self-worth primarily by his appearance, John valued other people's personal characteristics. This assignment helped John to better identify and modify some of his cognitive distortions.

Sessions 14 and 15: Mirror Retraining

The main goal of mirror retraining is to help the patient learn to look at himself in a holistic way, rather than focusing on specific perceived defects (See above for description). In the present cases, there was not a need to culturally adapt mirror retraining.

Sessions 16–18: Core Beliefs

The next step in therapy is to identify and challenge core beliefs, which are considered the deepest level of beliefs people hold about themselves (Beck, 1995). Although Ben's BDD symptom severity had decreased significantly by session 16 (his BDD-YBOCS score had decreased from 27 at session 1 to 10 at session 16), he was still struggling to incorporate data that disputed his previously held BDD beliefs that were associated with his ethnic identity. Techniques such as the downward arrow are often used when identifying core beliefs (Beck, 1995). For Ben, this work revealed his belief that he was unlovable because of his appearance.



Once a core belief is identified, the therapist must aid the patient in disputing the belief. One technique often used in treating BDD is the self-esteem pie (Wilhelm, 2006). According to this technique, the therapist aids the patient in identifying sources of his or her self-worth by considering components of self-worth other than appearance. As highlighted in Figure 3, at the outset Ben's self-worth was entirely shaped by his view of being Jewish, which in turn signified to him at a core level that he was unlovable. One way to target such a belief is to help patients identify alternative parts of their self-worth that they or others value, and to list them with appropriate percentages in a cultural identity pie (see Figure 4). The cultural identity pie (Cox, 1994) aids the patient in creating a broader view of himself or herself than just his or her appearance or ethnicity, which is a goal consistent with treatment for BDD. After cognitive restructuring and developing a list of other important personal attributes, such as being a good father and being a kind and generous person, Ben decreased the importance of being Jewish from 100% of his identity to 10% and included other components that comprised his identity and self-esteem (see Figure 4). Therefore, he began to address the positive aspects of his identity, which he had previously discounted.

At this point in the treatment, John's BDD Y-BOCS score had decreased from 37 at session 1 to 25 at session 16. John's father, with whom he had a close relationship, became very ill

during treatment. Furthermore, John encountered legal trouble for which he felt he was discriminated against based on race. These stressors led to an increase in drinking behavior (from two or three drinks a week prior to therapy to five or six drinks nightly at this point in the therapy). He lost interest in social activities and his schoolwork suffered. Furthermore, John's belief that he was racially discriminated against in the legal proceedings likely hindered the treatment goal of viewing his self-worth as based on more than just race and appearance. A major focus of John's treatment at this time, therefore, was to decrease his drinking behavior and identify other activities to look forward to at the end of the day.

However, John and his therapist also addressed core beliefs. John identified as his core belief "I am defective." Similar to Ben, John's core belief stemmed from his narrowly defining his self-worth by his race and appearance (see Figure 3), which he viewed negatively. Therefore, John's therapist used the cultural identity pie to identify additional important characteristics that contributed to John's self-worth, beyond his race. They succeeded in creating a more holistic picture of John's self-worth, including that he was a hard-working student, a loyal friend, and an intelligent person (see Figure 5). The cultural identity pie helped John view his self-worth in a broad manner, rather than merely defining it by his ethnicity and appearance.

Sessions 20–22: Integration and Relapse Prevention

The final sessions focus on summarizing the treatment and helping the patients fine-tune techniques learned in treatment, as well as identifying ways to prevent future relapses. Ben and John continued to work on challenging their negative ethnic identities and appearance concerns during these sessions. John also continued to focus on decreasing his drinking during these final sessions.

Summary of Treatment

Throughout his course of CBT, Ben described the sessions as "very helpful," and he described himself as heading in the right direction. By the end of his treatment, his BDD-YBOCS score had dropped to 0, indicating no BDD symptoms, his BABS score had decreased to 2, indicating excellent insight, and his BDI-II score had decreased to 0, indicating no depressive symptoms.

John's BDD-YBOCS score had dropped to 15 at the end of treatment, indicating that his symptoms decreased to a sub-clinical level, and his BABS score decreased to 12, indicating fair insight. However, John's BDI-II score increased to 50, indicating severe depression at the end of treatment. This increase in depression appeared to be due to his father's illness, as well as his legal trouble and increased drinking behavior. In response to his increased depressive symptoms and problematic drinking, John was referred for additional treatment that focused on these symptoms after his BDD treatment ended.

Discussion

Ben and John both improved substantially with CBT that was specifically tailored to their BDD symptoms. Both treatments were modified in an attempt to make them culturally

sensitive, which we believe helped make the treatment more acceptable to the patients and more effective for their symptoms.

There are several factors that may have made John's case more challenging than Ben's. First, to the best of our knowledge, John's personal history included many instances of actual discrimination, which made it more difficult for him to challenge his beliefs about how he was viewed by others as an African American male. John's father's illness, his legal trouble, and his resulting alcohol use and comorbid depression made his treatment more complex. However, we believe that adapting CBT to incorporate examination of John's beliefs about his ethnic identity was an integral part of the improvements that he did achieve in treatment.

The cases described in this report demonstrate the utility of addressing ethnicity and BDD together for some BDD patients. Consistent with previous CBT adaptation studies for other psychological disorders (Hinton et al., 2005; Hinton & Otto, 2006; Hinton et al., 2004; Munoz et al., 2006; Zane, Enomoto, & Chun, 1994), this report indicates that CBT can be effectively adapted for minority populations with BDD. In BDD treatment, this approach begins with creating a culturally informed case-conceptualization. It also involves using cognitive restructuring techniques to address both the patient's appearance concerns as well as his or her negative ethnic stereotypes, in order to refute maladaptive beliefs about his or her ethnic background that are related to the BDD symptoms. Finally, creating a culturally sensitive treatment for BDD includes using self-esteem pie techniques and core belief work in order to help the patient see the bigger picture (e.g., my identity is more than just my race/ethnicity and appearance).

In our clinical experience, many patients have reported similar culturally related appearance concerns. For example, Eastern Asian patients may report specific concerns about the shape of their eyes or eyelids while Southeast Asian patients, like African American patients, may be concerned about the color of their skin. Thus, examining efficacious interventions that focus on ethnic minorities with culturally influenced appearance concerns is an important area for future research.

The current report should be interpreted in light of its limitations. Most importantly, the current study is a case report of two individuals, which limits the generalizability of our findings. Secondly, our report could not control for confounding variables such as clinician and participant expectations, minority or majority status of the therapist, or the therapeutic relationship and empathy, which may influence treatment outcomes (Martin, Garske, & Davis, 2000).

Conclusion

Although our results represent only two cases, this report supports the integration of cognitive behavioral techniques with culturally sensitive adaptations for the treatment of individuals with BDD from diverse backgrounds. Additional research examining the role of ethnicity in BDD and the utility of incorporating ethnic identity into BDD treatment is needed.

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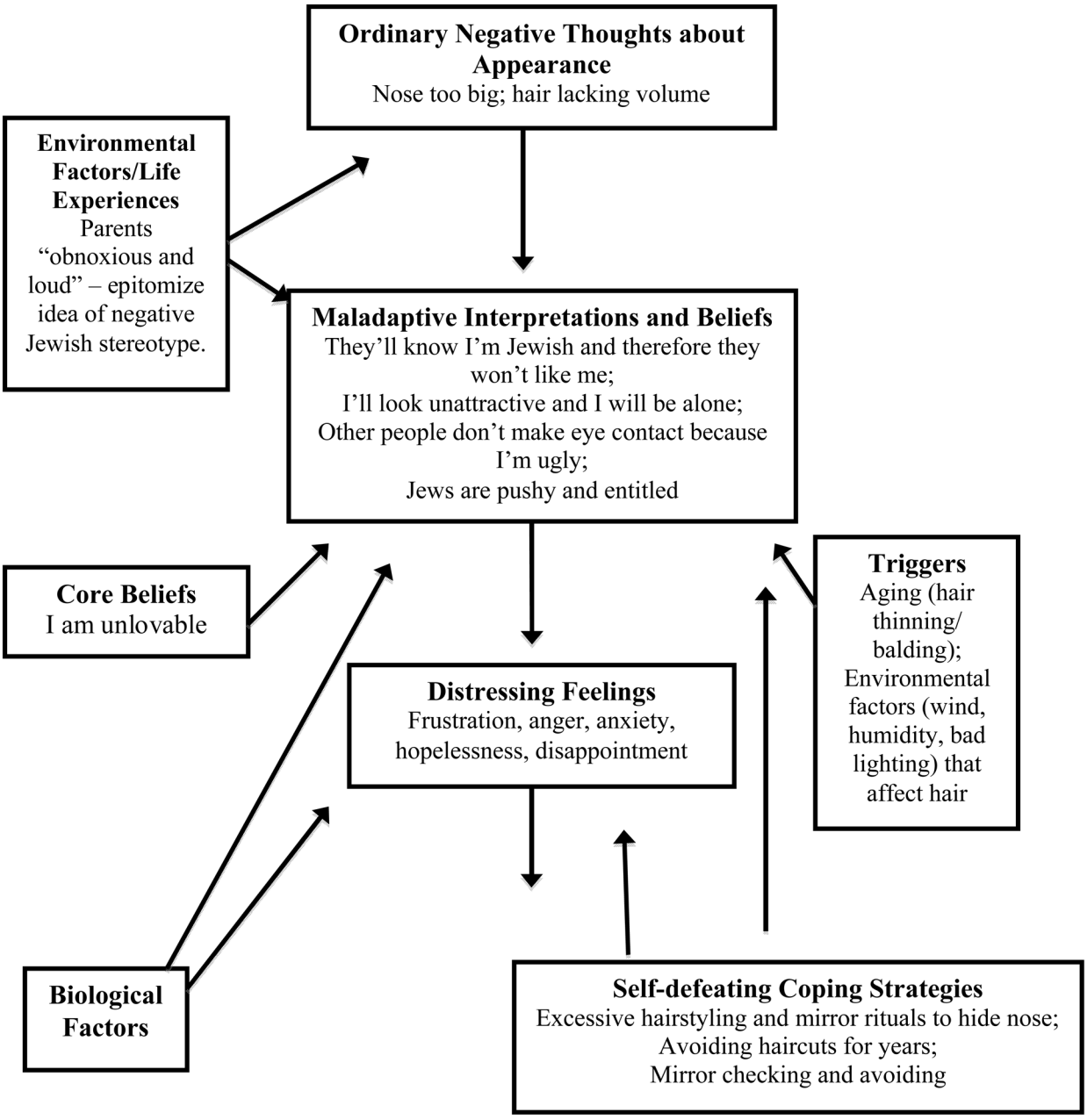

Figure 1.
CBT Model of BDD: Ben.*

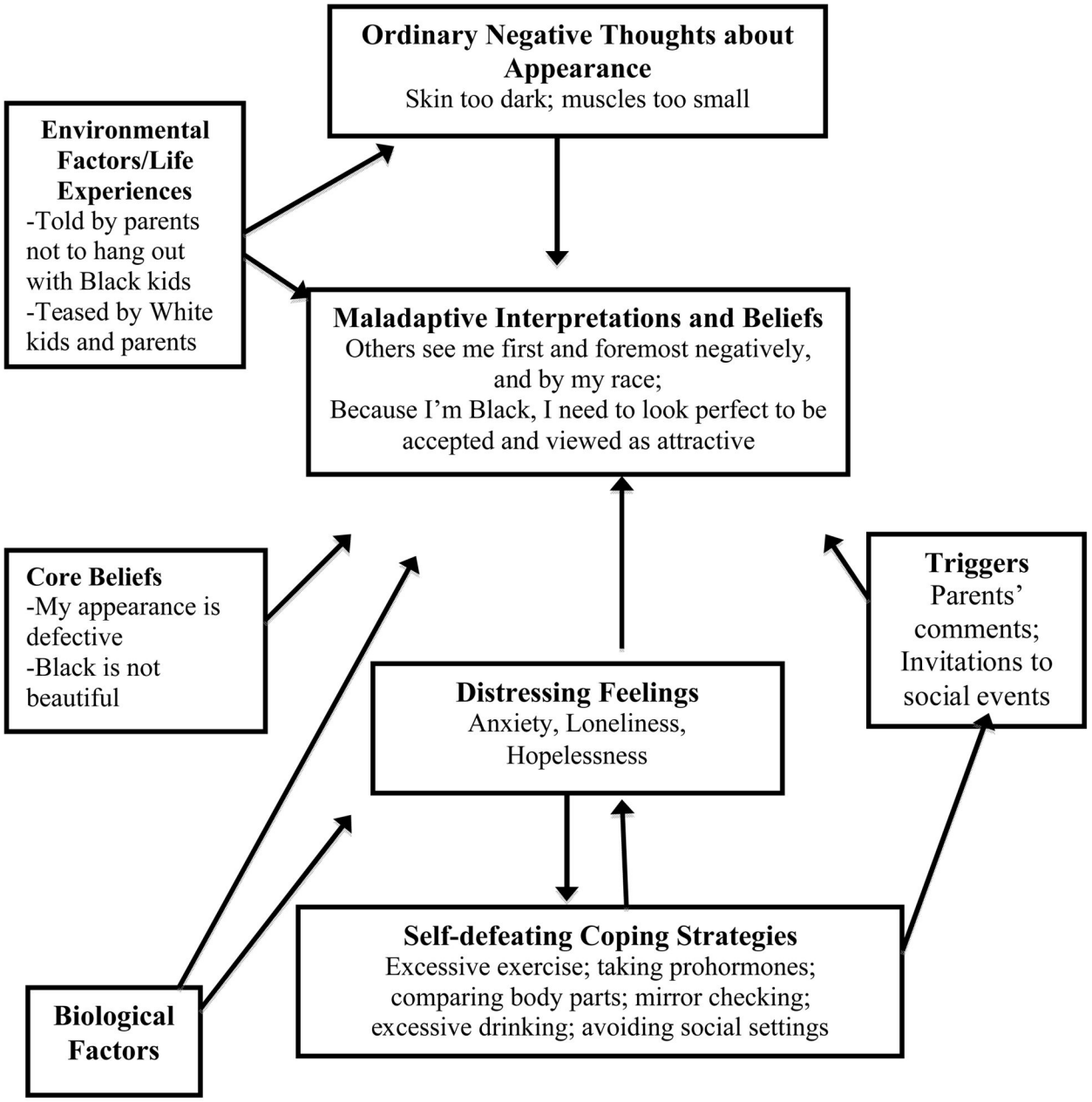

Figure 2.
CBT Model of BDD: John.*

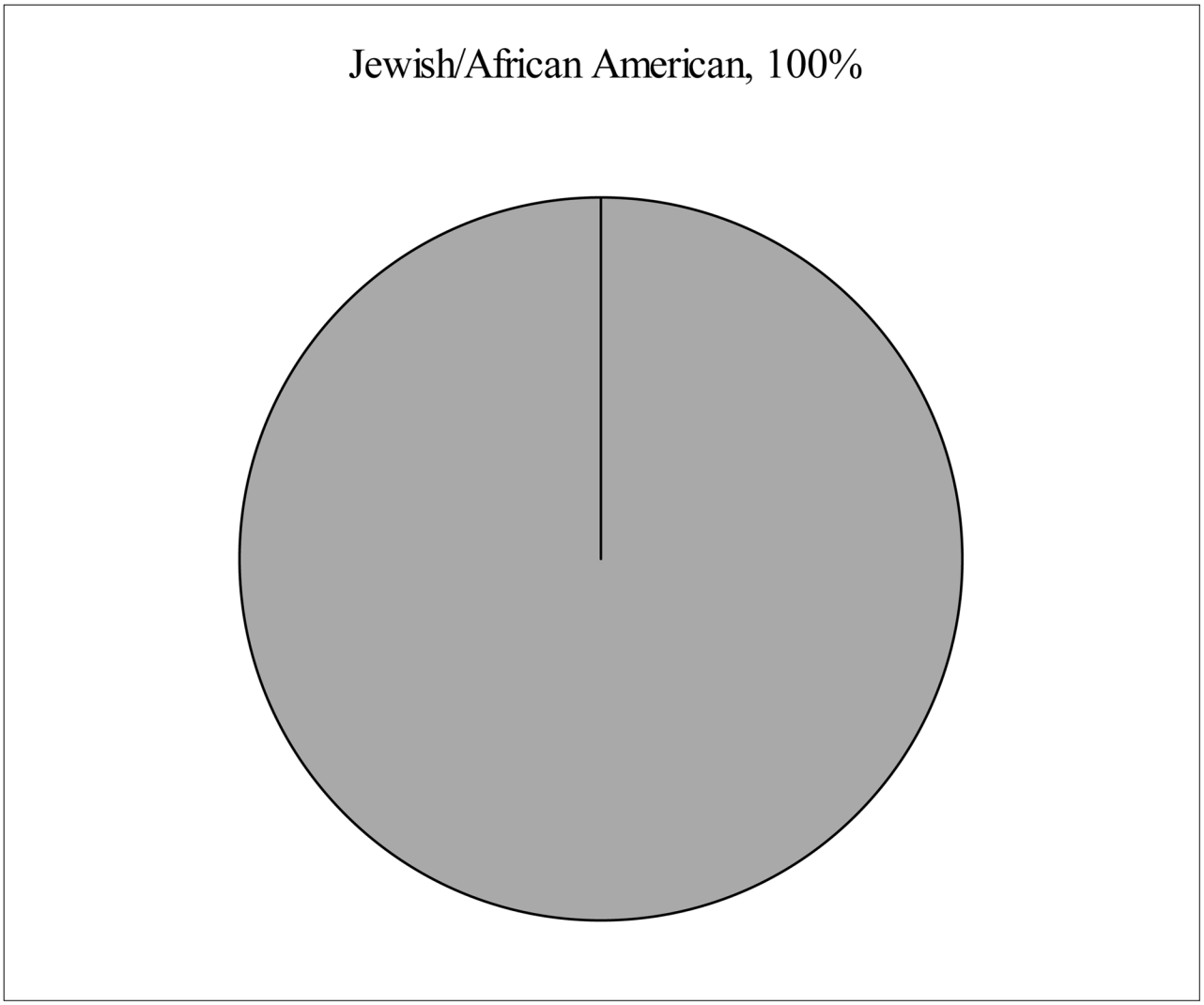

Figure 3.
Self-Identity Pie 1 for Ben/John

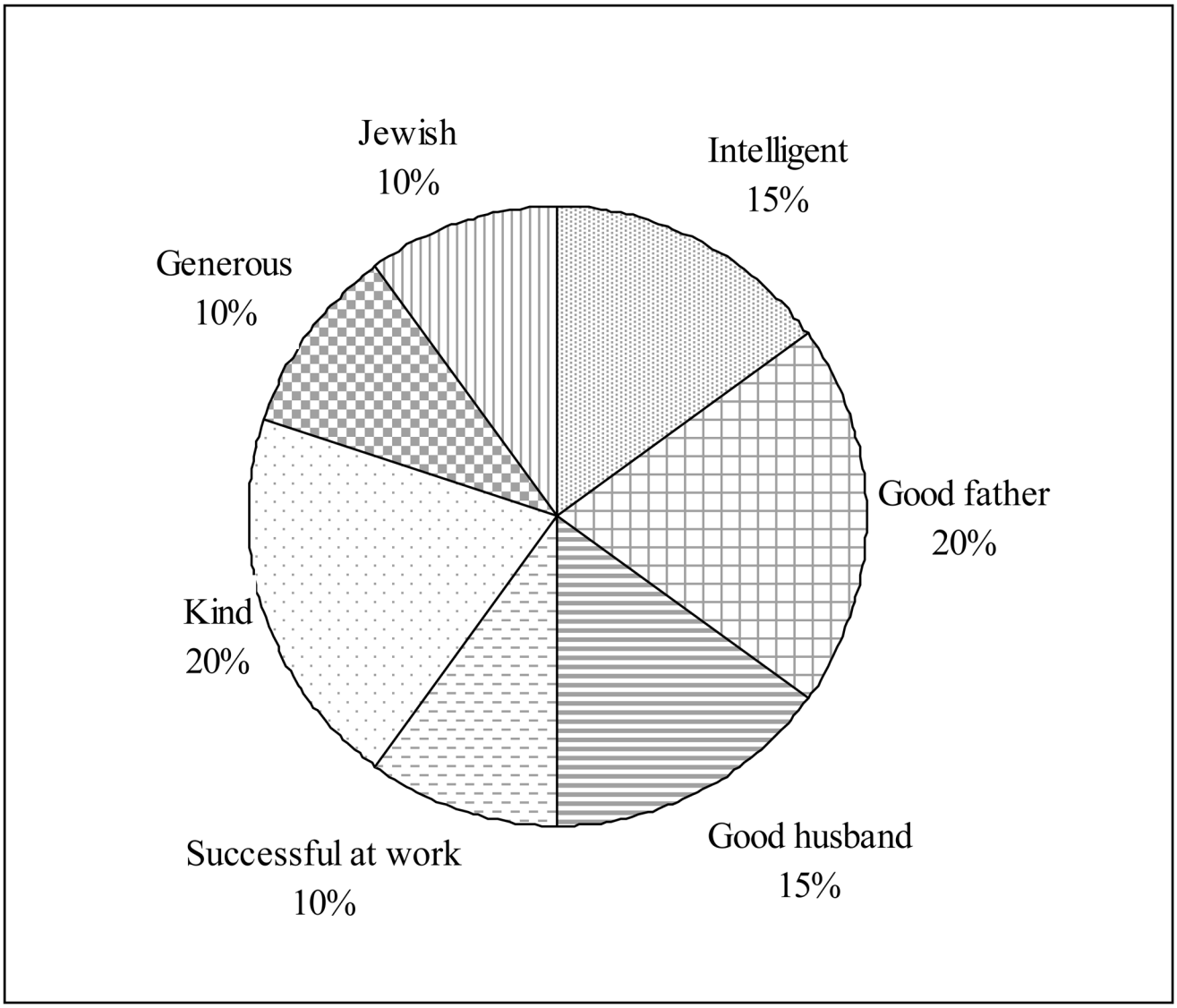

Figure 4.
Self-identity pie 2: Ben.

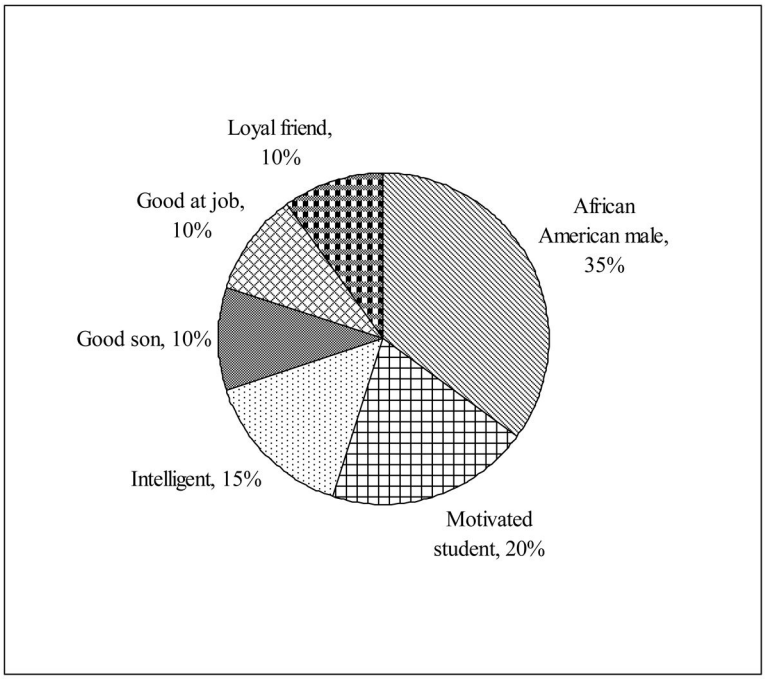

Figure 5.
Self-identity pie 2: John.