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South West Yorkshire Partnership NHS
NHS Foundation Trust

Mental Health and Learning Disabilities
Research and Practice

Volume 7 Number 1
Spring 2010

Mental Health and Learning Disabilities Research and Practice, 2010, 7, 29 -42

Developing a Small Specialised Body Dysmorphic Disorder Service in Leeds

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Abstract

Aims and Method

A specialist service was developed to treat patients with body dysmorphic disorder within a liaison psychiatry service.

Case notes were reviewed with the aid of an audit tool to capture demographic information, and scores on psychometric measures pre and post intervention by the service.

Results

Twenty per cent of patients who were given the intervention no longer met caseness for BDD at the end of treatment. Standardised measures also indicated improvements in anxiety and depressive symptoms. There were statistically significant improvements in symptoms. However, caution is necessary in interpreting these findings, because of the small sample size and the absence of a control group.

Clinical Implications

It is feasible to run a small specialised service for BDD patients with minimal resource. Our data demonstrate some preliminary evidence that the service is effective.

Introduction

Body dysmorphic disorder (BDD) is defined according to DSM-IV (American Psychiatric Association 1994) as a preoccupation with some imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive. The preoccupation must cause clinically significant distress or impairment in functioning and must not be better accounted by another mental disorder. BDD has a prevalence of 0.7% and is associated with high rates of other mental disorders including depression, social phobia, and obsessive compulsive disorder and high rates of self harm (National Institute for Clinical Excellence, 2005).

BDD has been described as extremely difficult to treat (Phillips and Castle 2002). A meta-analysis of fifteen treatment trials on BDD patients reported that psychological interventions such as cognitive behavioural therapy and SSRIs were both effective but concluded that the available evidence slightly favoured psychological interventions (Williams et al 2006). The fifteen trials included a total of only 314 patients and only three randomised controlled trials.

The NICE guidelines recommend a step wise approach starting with brief individual or group CBT. Those with more severe functional impairment should be offered a course of an SSRI antidepressant or more intensive CBT. A further course of CBT

and an SSRI at higher doses than usually prescribed for depression is recommended for those who do not respond.

The authors work in a well-developed multidisciplinary liaison psychiatry service in an area which does not have a recognised body dysmorphic disorder service. The liaison psychiatry service was receiving an increasing number of patients with body dysmorphic disorder and we were struggling to meet their needs.

In 2005 we visited a small BDD service in Warrington, researched the limited literature and changed our approach accordingly. Our clinical impression was that existing patients started to progress. In the same year NICE guidelines for OCD and BDD (National Institute for Clinical Excellence, 2005) were published and this supported and directed our practice.

In 2006 we agreed with our managers that a session of CBT time and half a session of consultant liaison psychiatrist time could be devoted to seeing BDD patients. The consultant time was later increased to one session. The service was publicised to GPs, dermatologists and community mental health teams. Over time teaching sessions were provided to various groups of mental health professionals and general hospital professionals. We were not able to offer a stepwise approach according to NICE guidance due to the small nature of our service.

The aim of the paper is to present a service evaluation of a new specialised service which was developed with minimal resource. We describe medical and CBT management of BDD. We describe the clinical characteristics of the patients seen and treatment strategies employed. We present some outcome data and three clinical vignettes.

We report routinely collected self report questionnaire data which was anonymised before analysis. We contacted the chair of the Leeds West Research Ethics Committee who confirmed that as this was a service evaluation project ethics approval was not necessary.

The Medical Component of the Service

The liaison psychiatrist (DP) provided a medical assessment, detailed explanation of the clinical diagnosis of BDD (American Psychiatric Association, 1994) and any co-morbid diagnoses and treatments, risk assessment, simple family interventions and prescription of medication if indicated. All patients were routinely invited to fill out self-report rating scales on assessment and again every six months and on discharge from the service.

All patients were encouraged to obtain and read a book about BDD written for patients, carers and health professionals (Phillips 2005). In addition, having experience and training and clinical supervision in CBT DP learned to present the CBT model for BDD, socialise the patient to the model, and encourage the patient to identify, record and change problem behaviours. Later on this extended to simple attentional exercises (Wells 1997). A small number of patients who were willing to address their problems in a more formal, specialised and intensive CBT approach were referred to the CBT practitioner (ME). The service was recognised as not being ideal but the best that could be offered with limited resource.

The CBT Treatment Model of BDD

Veale's CBT model of BDD (Veale et al 1996; Veale 2004) builds upon existing models for social phobia (Clark and Wells 1995), OCD (Salkovskis 1999) and health anxiety (Warwick and Salkovskis 1990). A distinct difference from these models is his emphasis on the importance of the relationship with reflective surfaces, for example mirrors, which act as a trigger for symptoms of BDD. Key elements within the model are the role of selective attention and viewing oneself from an observer perspective. This perspective appears to lend increased authority to the negative appraisal made of appearance. Rumination is also identified as playing an important role in the maintenance of distress, leading to an increased use of safety behaviours (e.g. camouflage, compulsive checking), which are defined as behaviours that are intended to be helpful in reducing concerns, but which have the paradoxical effect of maintaining them (Wells 1997). Veale (2004) hypotheses that these behaviours increase self-consciousness, exacerbate distress, and maintain the cycle of BDD.

In order to engage people with BDD in a CBT approach, it is important to spend time socialising and engaging them with the CBT model. Treatment then involves some form of attentional training to address the issue of self-focusing, as well as some behavioural interventions to address safety behaviours, for example mirror checking. Cognitive restructuring is used, not to challenge the specific cognitions relating to a perceived defect in appearance, but rather, it is aimed at working with beliefs about appearance. A number of steps are involved in this process, including work with continuums, as well as developing alternative beliefs, and testing these out.

High levels of shame and self disgust are common in BDD (Veale et al 1996; Veale 2004) these emotions are not always responsive to standard cognitive restructuring (Gilbert 1997). Compassionate mind training (CMT) was developed specifically for people with high levels of shame and self criticism (Gilbert and Irons 2005). Gilbert (1997) describes shame as having two key components, the first being to do with thoughts and feelings relating to how one exists in the minds of others (external shame), the second relating to an individual's own self evaluation, (internal shame) or view of themselves as bad, which leads to high levels of self criticism.

This is highly relevant in BDD, where the individual's self appraisal or distorted mental image, seen from an observer perspective provides both an internal and external appraisal, activating idealised values about the importance of appearance, leading to a sense of failure, worthlessness and shame (Veale 2004).

CMT, as part of compassion focused therapy (CFT) (Gilbert 2007), provides the individual with a framework to explore their relationship with themselves, in order to understand how they have developed safety behaviours related to their deep sense of shame, and to help them to gradually replace their self attacking response style, with one that is more caring and self compassionate. CFT builds on a standard CBT approach, as well as dialectical behaviour therapy (Lynch et al 2006) through guided discovery (Padesky 1993) decentring and acceptance. Gilbert hypothesises that the therapist's ability to develop a therapeutic relationship is key to this approach (Gilbert, 2007).

In clinical practice, incorporating a CFT approach into standard treatment for BDD appears to be helpful. Through this approach it is possible to address and challenge not only the behaviours associated with BDD, but also the underlying processes and patterns of thinking involved in shame. This entails working with the content of

thoughts as well as empowering the individual to understand and change unhelpful patterns of self criticism.

Method

Sample

All patients who had been seen at least once in the BDD clinic were identified from the hospital database. Thirty-seven patients were seen in the clinical service at least once, twenty-seven of whom met DSM-IV diagnostic criteria for BDD (American Psychiatric Association 1994). The remainder (N = 10) had a range of understandable body image concerns relating to appearance features that seemed according to others to be significantly abnormal or outside the normal range (see Table 1).

Measures

Patients who met criteria for BDD were asked to complete the Depression Anxiety and Stress Scale (Lovibond and Lovibond 1995) and the Yale-Brown Obsessive Compulsive Scale modified for Body Dysmorphic Disorder (Phillips et al 1997) at pre- and post-treatment. The DASS is a 42-item self-report scale designed to measure three separate negative emotional states (depression, anxiety, stress/tension) in the current study only the depression and anxiety subscales were used. Each item is rated on a four-point severity/frequency scale; scores on each subscale can range between 0 and 42. Total scores on each subscale can be classified into one of five ranges: normal, mild, moderate, severe, and extremely severe (Lovibond and Lovibond 1995). The DASS has well-established psychometric properties (Brown et al 1997; Antony et al 1998; Phillips 2005). The BDD-YBOCS is a modified version of the original YBOCS and is designed to measure severity of BDD (Phillips 1997). It does not have an empirically derived cut off but Phillips recommends a cut off of 20/21 as a threshold for BDD caseness (Phillips 2005). Those patients who were not diagnosed with BDD did not fill in the standardised measures.

Procedure

Relevant clinical information (demographic details, scores on standardised measures) was gathered from case notes using a structured instrument developed for this study.

Data Analysis

The change in scores from pre-treatment to post-treatment on the standardised measures was examined using the Wilcoxon Signed Ranks Test rather than a paired t test, because the distribution of scores was substantially non-normal. Changes in the proportion of people scoring in different ranges of the DASS subscales and above the BDD cut-off point on the BDD-YBOCS were also calculated. For the ranges and cut-off point, where post-treatment scores were not available, pre-treatment scores were entered as post-treatment scores to provide a more conservative estimate of the effectiveness of the intervention.

Table 1. Characteristics of the Patients Assessed in the Clinic

		BDD (n=27)	Not BDD (n=10)
Source of referral	General practitioner	12	4
	Primary care mental health worker	1	1
	General hospital consultant	4	4
	Self harm clinic	3	0
	Other mental health	7	1
Gender	Male	12	1
	Female	15	9
Age	17-25	9	4
	26-35	11	2
	36-45	4	4
	46-55	2	0
	56-65	1	0
Assessed/treated by	Liaison psychiatrist only	18	10
	Liaison psychiatrist and CBT therapist	9	0
Co morbidity	Depression	23	4
	Generalised anxiety disorder	15	4
	Social anxiety disorder	24	9
	Obsessive-compulsive disorder	4	1
Taking serotonin specific reuptake inhibitor (SSRI) referral		13	3
Past contact with secondary care Mental health services		16	1
Number of sites of body image concern	1	9	6
	2-5	11	4
	6-10	5	0
	11+	2	0
Main site of appearance	Nose	6	0
concern	Skin	5	1
	Other facial features	9	3
	Breast	2	4
	Genitalia	2	0
	Other	3	2
Past cosmetic procedure		10	0
Wanting cosmetic procedure		17	5

Results

Of the BDD group sixteen (59.3%) reported past contact with secondary care mental health services. Twenty-three (85.2%) were clinically diagnosed by DP with depression and 24 (88.9%) were clinically diagnosed with social anxiety disorder. Seventeen (63.0%) wanted a cosmetic surgical or medical procedure and ten patients (37.0%) had already received a cosmetic procedure.

Interventions

A summary of the main treatment strategies employed in the clinic is shown in Table 2. Three patients attended once and a few more attended only twice. Of the nine patients seen at least once for CBT, seven were considered suitable for formal CBT and offered therapy. The remaining BDD patients who engaged received psycho-education, CBT formulation of their problems and some CBT from the liaison psychiatrist. Most patients were seen with a significant other on at least one occasion.

Table 2. Treatment Strategies Employed

		BDD (n=27)	Not BDD (n=10)
No of liaison psychiatrist appointments	1	3	3
	2-5	9	7
	6-10	12	0
	11-15	3	0
Number of CBT appointments	1-5	2	0
	6-10	2	0
	11-15	3	0
	16-20	1	0
	20+	1	0
Medication	SSRI prescribed	18	2
	British national Formulary SSRI upper dose limit reached	6	0
	Buspirone prescribed	8	0
	Other drug strategies used	4	0

Eighteen (66.7%) of the BDD patients were prescribed an SSRI antidepressant often at a higher dose than that usually used for depression alone. The British National Formulary (BNF) upper limit was reached, usually for a brief period, in six (22.2%) patients. The BNF limit was not breached in any patient. Buspirone was prescribed for eight (29.6%) patients who were taking antidepressants.

Those that did not receive an SSRI antidepressant comprised those who did not want medication, those with mild BDD who did not require it and those who did not engage with the service.

Progress of the Patients

Pre-treatment DASS anxiety and depression scores were available on 26 patients and the BDD-YBOCS on 25 out of the 27 patients who were diagnosed with BDD. Post treatment scores were available on between 16 and 18 patients because of drop out from the clinic, patient refusal to complete questionnaires and clinician error. As summarised in table 3, scores indicated a statistically significant improvement from pre- to post-treatment on the DASS depression scale (Z= -3.096, p=0.002) and the BDD-YBOCS (Z= -3.625, p<0.0001); the DASS anxiety score showed a trend towards significance (z = -1.94, p= 0.052).

Table 3. Pre and Post Treatment Self Rating Scores for the BDD Group

Measure	Median pre-treatment score	Median post-treatment score	Statistic
DASS[1] Depression subscale	27 (n=26)	14.5 (n=16)	Z= -3.096, p=0.002
DASS[1] Anxiety subscale	12 (n=26)	6.5 (n=16)	Z= -1.942, p= 0.052
BDD-YBOCS[2]	33 (n=25)	23 (n=18)	Z= -3.625, p<0.0001

[1] Depression Anxiety and Stress Scale
[2] Yale-Brown Obsessive Compulsive Scale modified for Body Dysmorphic Disorder

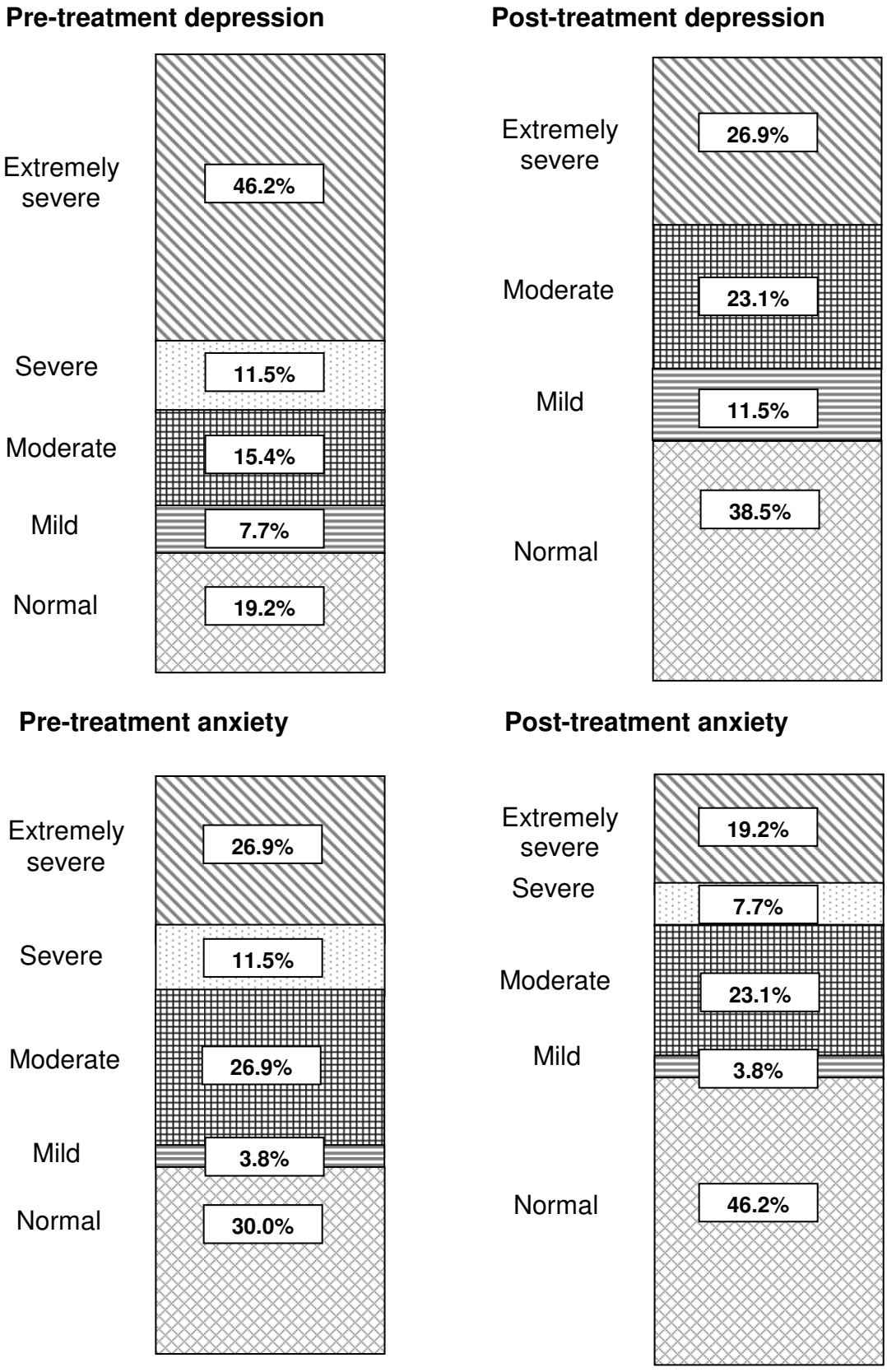
Twenty per cent of the patients who scored above the BDD-YBOCS cut-off point for caseness no longer did so at the end of treatment. The changes in the proportion of patients scoring in the different ranges on the DASS subscale also broadly suggest an improvement in symptoms (see figure 1).

Some patients with BDD were ambivalent about the diagnosis or about receiving psychological or psychiatric help. They may have viewed the service as a potential route to obtaining a cosmetic procedure and disengaged when they realised that this is not going to happen. On referral most families appreciated that the patient was suffering from some kind of psychological problem even if they could not name it. Most family members did not think that a cosmetic procedure was necessary or desirable. However a few families were trying to support the sufferer by arranging and paying for cosmetic procedures.

Most patients were seen with a partner or family member sometimes on a regular basis. Simple couple interventions based on explaining the diagnosis and providing information seemed beneficial in most cases. Some family members later became quite involved in therapeutic interventions such as behavioural experiments.

Ten patients who were seen in the clinic were not diagnosed with BDD. Some of these patients had significant medical problems such as eczema affecting the face and were referred for assessment and emotional support. Others were understandably distressed about more significant cosmetic problems such as markedly ptotic (sagging) breasts.

Figure 1. Pre-treatment and post-treatment ranges for the depression and anxiety subscales of the Depression Anxiety and Stress Scale



Clinical Vignettes

Vignette A

Jo 43 year old divorced mother of two children was referred from an acute day hospital setting with a possible diagnosis of body dysmorphic disorder. She had been attending there because of suicidal ideas and depression three months after a rhinoplasty. Although the operation had been surgically successful it had not lived up to her expectations. She felt that her appearance had been permanently ruined by surgery.

Jo felt angry with the surgeon whom she thought should have paid more attention to her past history of depression and should not have operated. She was diagnosed by the liaison psychiatrist as suffering from BDD, a recurrent depressive episode and marked social phobia.

The liaison psychiatrist spent several sessions formulating her problems with her. They identified that the BDD had been present for many years and that a relationship break up two years previously had precipitated the increased body image concerns.

The fluoxetine started in the day hospital was increased gradually to 60mg a day. No CBT was available. The psychiatrist introduced the Veale model of BDD (Veale 2004) and encouraged her to record and subsequently attempt to reduce her checking behaviours. She was also taught simple attentional exercises (Wells 1990) designed to re-focus her attention away from her appearance and from her perception that other people were continually appraising her appearance. Her beliefs that success is dependent upon appearance and that her appearance was more important than other personal values were also successfully challenged.

Vignette B

Louise a 23 year old single woman was referred by her general practitioner, whom she had approached for a referral to a surgeon. Now in her early twenties, she had for a number of years, been hugely preoccupied with the appearance of her jaw. At point of referral she had a very low level of functioning, was isolated from friends and family, and unable to see any resolution to their problems beyond surgery. She was engaged in extensive avoidance and safety behaviours including camouflaging her self with her hair and a scarf.

She was assessed by the liaison psychiatrist who spent some time in engaging and socialising her to a psychological model of BDD. She was also prescribed Fluoxetine 20mg to help with low mood and the obsessional nature of her body image concerns. This was soon increased to 60mg a day but eventually decreased to 40mg.

Louise agreed to try CBT, and was assessed by the CBT therapist, together an initial formulation and goals were agreed, primarily around changing safety behaviours to begin with, in particular, her relationship with reflective surfaces. Extensive work was done to change behaviour with mirrors, in order to challenge selective attention and cognitive distortions. In addition she was encouraged to gradually reduce safety behaviours. A range of behavioural experiments were undertaken, for example changing camouflage behaviours and talking to people in public places. This took place over 12-14 sessions, and led into cognitive

restructuring which focused on exploring the value she placed on the importance of her appearance.

At this point, CFT was incorporated to address high levels of self criticism and shame which were key to how she viewed herself, and how she expected to be appraised by others. This related to previous bullying and unfavourable comparisons with others, which had reinforced the beliefs about the importance of attractiveness. Through a CFT approach, it was possible for her to understand her shame, and to begin to learn how to interact in a more compassion focused way. Through this shift in affect and reappraisal of beliefs, it was then possible to begin to develop an alternative view of the value of appearance, and begin to re engage in previously avoided activities.

At the end of therapy, although acknowledging she still did not think that her primary area of concern was entirely attractive, there was a reduction in its overall importance in terms of how she evaluated herself as a person (i.e. she was able to rate her value on more than just appearance). Lesser areas of concern, such as weight and body shame had reduced substantially. At the end of treatment she was able to socialize fully, and had resumed employment.

Vignette C

Jake was a 22 year old man referred by his dermatologist because of perceived hair loss relating to his beard and arms. The dermatologist could not identify any areas of hair loss and did not feel that there was any treatment he could offer him. Jake did not think he should be seeing a psychiatrist but came as he thought that it was a necessary formality before the dermatologist would give him the medical treatment he felt he required.

Jake was angry and frustrated that neither the psychiatrist, his general practitioner nor the dermatologist could see what he thought was obvious namely that his hair was thinning at an alarming rate. Further enquiry revealed that he had been tentatively diagnosed as having a personality disorder by another psychiatrist some years previously and that there were no significant risks.

It was not possible to engage Jake and despite two rather lengthy sessions it was agreed that further appointments would not be helpful to him. He did agree that the liaison psychiatrist could communicate the diagnosis of body dysmorphic disorder to the referrer and the general practitioner so long as the patient's own view about his problems was included in the letter with similar prominence.

Discussion

The data suggest that patients who engaged with the service showed some improvements in their symptoms. Caution is necessary in interpreting these results, because of the absence of a control group and the small sample size, but they do offer some preliminary indication that a service for BDD may be effective for at least some patients.

Patients suffering from BDD form a very variable group (Phillips 2005.) Many do not view themselves as suffering from a psychological problem and view cosmetic medical and surgical procedures as the only solution to their body image concerns. The condition is often unrecognised and patients may not receive appropriate help or may be seen elsewhere with other co-morbid diagnoses such as depression or

obsessive compulsive disorder (Phillips 2005). We suspect that the patients seen in our service are not representative of BDD sufferers in the community and it is thus not possible to extrapolate our results to them.

As time went on we became more confident about communicating with the patients and dealing with the issues that they and their families brought to the sessions. Some patients with more complex needs were seen by the liaison psychiatrist and their community mental health team worker as care coordinator according to the care programme approach. We believe that many more of the BDD patients seen in the service would have benefited from CBT if more clinical sessions had been available.

We think that it is possible to provide a service to BDD patients with limited resources. Clinicians working in general hospital specialities such as dermatology are very aware of the diagnosis of BDD but struggle to identify cases and the presence of the service in an adjacent clinic area may have heightened awareness amongst physicians. We think that many patients preferred to be seen in a general hospital based specialist service as many had previously attended general hospital clinics there. We think that it would also be appropriate to base a BDD service in a mental health setting and focus on developing links with community mental health teams and primary care.

BDD, although not an uncommon disorder, is under researched. Further randomised controlled studies are required to establish which interventions are most acceptable and beneficial to patients and which components of psychological interventions such as CBT and CFT are most effective.

Note

The patient vignettes each comprise altered clinical details components of two or three patients and are unidentifiable from the information provided.

Declaration of Interest

None

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