

The Nature of Body Dysmorphic Disorder and Treatment With Cognitive Behavior Therapy

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Body Dysmorphic Disorder (BDD) is a distressing and disabling body image disorder that involves excessive preoccupation with physical appearance in a normal appearing person. Persons with BDD exhibit fears of being noticed, feelings of shame and embarrassment, thought processes that can range from repetitive thinking to delusions, avoidance of social situations and exposure of physical appearance, compulsive rituals, somatic preoccupation, medical and cosmetic treatment seeking, and resistance to psychological intervention. BDD overlaps diagnostically with other disorders and presents unique challenges for the mental health practitioner. The purpose of this paper is to describe the pathology of BDD and its development and treatment, although empirical information on these topics is very limited at the present time. Detailed recommendations are given for cognitive behavior therapy. Intervention consists of cognitive restructuring of private body talk and undue importance given to physical appearance, exposure to avoided body image situations, and response prevention of body checking and grooming behaviors.

Body dissatisfaction is so common today, it is a normal sign of living in a society that glorifies beauty, youth, and health. Yet some people develop an excessive preoccupation with their physical appearance to the point it causes them significant distress or disability. The diagnostic category that can accommodate such people is body dysmorphic disorder (BDD).

The concept of pathologic concerns about physical appearance has a long history, although BDD is new to the diagnostic nomenclature. Dysmorphophobia, the original term for BDD, was introduced by Morselli in 1886 (Morselli, 1886).

The phobia in Morselli's cases was not described clearly, but the term he coined literally meant fear of ugliness. In Janet's description (1903), he referred to an "obsession de la honte de corps" (obsession with shame of the body) that involved distressing fears of being viewed as ridiculous. The first English language paper on dysmorphophobia was not published until 1970 (Hay, 1970a). The essence of the disorder was eventually clarified as not a fear of *becoming* deformed, but an irrational conviction of already being abnormal and fear of other people's reactions. Accordingly, the "phobia" suffix was removed from the DSM terminology when body dysmorphic disorder was introduced as a diagnosis in that system (APA; American Psychiatric Association, 1987). Cases of dysmorphophobic complaints were also described under the term, monosymptomatic hypochondriacal psychosis (MHP; Munro, 1980, 1988), a disorder involving an encapsulated somatic delusion that currently is diagnosed as delusional disorder, somatic subtype (APA, 1994). BDD is classified as a somatoform disorder, but its features overlap with obsessive compulsive disorder, social phobia, and eating disorders.

Clinical Features of Body Dysmorphic Disorder

The essential feature of BDD is: "Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive" (APA, 1994, p. 468). Unlike normal concerns about appearance, the preoccupation with appearance in BDD is excessively time consuming and causes significant distress or impairment in social situations.

This definition implies two facets of BDD. One is a perceptual disturbance of body image evident by the absence of a real physical defect. The other is a preoccupation with the defect, which is manifested in maladaptive affective/cognitive or behavioral reactions. Both are required for a patient to be considered BDD. A person concerned with a true physical deformity, such as an amputated limb or morbid obesity, cannot be diagnosed BDD even if that concern is excessive and pathologic¹. On the other hand, a person who complains of a minimal flaw is not necessarily BDD. For example, some people who seek cosmetic nasal surgery for trivial imperfections are realistic about the importance of their appearance and are not overly self-conscious or compelled to hide their "flaw." Like other somatoform disorders, the body image perception and concern in BDD are out of proportion to the actual physical condition.

¹ Although the physical defect of such a person might not be imagined or exaggerated, he or she can still have a body image problem in the cognitive or behavioral sense if concern about the defect is excessively distressing or impairs activity. For example, a man with an upper limb amputation might feel worthless and avoid outings in public due to fear of embarrassing attention to his missing arm. Treatment for his appearance concern might be warranted, however, the symptoms would have to be diagnosed under a different category than BDD; such as an anxiety, mood, or adjustment disorder.

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