Available online at www.sciencedirect.com
ScienceDirect
Cognitive and Behavioral Practice 17 (2010) 241–247
Cognitive and Behavioral Practice
www.elsevier.com/locate/cabp

A Cognitive-Behavioral Treatment Approach for Body Dysmorphic Disorder

Sabine Wilhelm, *Massachusetts General Hospital and Harvard Medical School*
Ulrike Buhlmann, *Humboldt University Berlin*
Laura C. Hayward, *Binghampton*
Jennifer L. Greenberg and Ruta Dimaite, *Massachusetts General Hospital and Harvard Medical School*

Although body dysmorphic disorder (BDD) has been described in the literature for more than a century, there has been only a limited focus on the development of cognitive behavioral treatments for BDD. Our case report provides a detailed description of a course of cognitive behavioral treatment (CBT) for an individual with BDD. The patient was treated for 10 weekly 50-minute individual sessions. The treatment focused on psychoeducation, cognitive restructuring, exposure and response prevention, and perceptual retraining exercises. The patient's BDD symptoms significantly improved over the course of the treatment. This case study illustrates several clinical strategies and provides further support for CBT as a promising treatment for individuals suffering from BDD.

DESPITE the recent increase in public awareness regarding body dysmorphic disorder (BDD), effective treatment options are underutilized and require further elucidation. Classified as a somatoform disorder in the *DSM-IV*, BDD is characterized by a preoccupation with imagined or slight defects in physical appearance (American Psychiatric Association [APA], 1994), which leads to significant distress and/or social or occupational impairment. Patients with BDD are reluctant to discuss appearance concerns, and subsequently live alone in shame and despair with their symptoms. Although individuals may eventually seek treatment for comorbid psychiatric disorders, they often do not disclose BDD symptoms to clinicians. It is critical for health providers to specifically screen patients for appearance-related concerns to prevent BDD symptoms from continuing to go unnoticed and untreated.

Clinicians can start screening for BDD by asking patients about potential worries they may experience about any part of their appearance. The most common preoccupations involve the face or head, including the skin (e.g., scarring), hair (e.g., thinning hair), or nose (e.g., shape or size), but any body part may be the focus of concern (e.g., Phillips, McElroy, Keck, Pope, & Hudson, 1993). Although shape and weight concerns are common among BDD patients, if concerns are exclusively related to weight/shape, an eating disorder assessment may be warranted. Intrusive appearance- related thoughts are time-consuming and upsetting, and lead individuals to engage in compulsive behaviors (i.e., mirror checking, comparing themselves to others, camouflaging, excessive grooming, skin picking)—which often take up several hours a day—in an attempt to alleviate distress (e.g., Phillips et al., 1993). Individuals often go out of their way to avoid certain situations, people, or places. Avoidance can be so severe that patients become nearly or completely housebound. Insight is often very limited, and the appearance-related beliefs of nearly half of patients are delusional (Phillips, 2004; Phillips, Menard, Fay, & Weisberg, 2005). In a recent examination of clinical features in 164 adults with BDD (Phillips, Didie et al., 2006), current delusionality was reported in about one-third of the sample (33.1%, n=45) and 75.6% (n=124) reported lifetime delusionality. Almost half of the sample (45.7%, n=75) reported delusional ideas of reference, for example, being convinced that others are laughing about or staring at their perceived flaw (Phillips, Didie, et al., 2006). More than 60% of patients with BDD (Gunstad & Phillips, 2003; Phillips & Menard, 2006) suffer from comorbid depression and are at high risk of suicide. A recent 4-year prospective study of 185 BDD patients (Phillips & Menard, 2006) found annual rates of suicidal ideation (57.8%) and attempts (2.6%) to be markedly high; the annual completed suicide rate among BDD (0.3%) patients is approximately 45 times higher than that in the general U.S. population (Phillips & Menard, 2006).

1077-7229/10/241–247$1.00/0
© 2010 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd. All rights reserved.

BDD is a relatively common disorder, which affects approximately 0.7% to 2.4% of the population (Bienvenu et al., 2000; Faravelli et al., 1997; Koran, Abujaoude, Large, & Serpe, 2008; Otto et al., 2001; Rief, Buhlmann, Wilhelm, Borkenhagen, & Brahler, 2006). The largest epidemiological study to date (Rief et al., 2006) reported a BDD prevalence rate of 1.7% (95% CI=1.2%–2.1%). Prevalence rates are significantly higher when examined in psychiatric (e.g., 13%–16%; Conroy et al., 2008; Grant, Kim & Crow, 2001) and appearance-enhancing medical settings (e.g., 7%–8% in studies of cosmetic surgery patients; Sarwer, Wadden, Pertshuk, & Whitaker, 1998; and 8.5–15% in dermatological samples; Bowe, Leyden, Crerand, Sarwer, & Margolis, 2007; Dufresne, Phillips, Vittorio, & Wilkel, 2001; Phillips, Dufresne, Wilkel & Vittorio, 2000; Vulink et al., 2006). Studies yield somewhat variable findings on gender ratio, although most studies suggest that BDD may be slightly more common among females than males (Koran et al., 2008; Phillips & Diaz, 1997; Phillips, Menard, & Fay, 2006; Phillips, Menard, Fay, & Weisberg, 2005; Rief et al., 2006). Phenomenological differences between the genders reflect those reported in the general population; for example, men are more likely to be preoccupied by their genitals, musculature, and thinning hair, and women with their skin, stomach, general shape/weight and excessive body/facial hair (Phillips, Menard, et al., 2006).

Two empirically based treatments are available for BDD: serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT). Of the SRIs, clomipramine (Hollander, Allen, & Kwon, et al., 1999), fluvoxamine (Perugi et al., 1996; Phillips, Dwight, & McElroy, 1998), fluoxetine (Phillips, Albertini, & Rasmussen, 2002), citalopram (Phillips & Najjar, 2003), escitalopram (Phillips, 2006), and venlafaxine (Allen et al., 2008) have been shown to be effective (response rates ranging from 53% to 73%) when used at their optimal dose for at least 12 weeks. Evidence for the effectiveness of non-SRI antidepressants (e.g., tricyclics) or neuroleptics in treating BDD symptoms has not been adequately demonstrated. Our clinical experiences suggests that combination treatments of SRIs and CBT may prove helpful in cases of severe comorbid depression, suicidality or delusionality, however, more research in this area is needed.

Cognitive-behavioral models of BDD (e.g., Veale, 2004; Wilhelm & Neziroglu, 2002; Wilhelm, 2006) have driven the development of new cognitive behavioral treatments for BDD. The first step in our CBT model proposes that individuals with BDD are likely to overfocus on perceived appearance flaws and attach significant meaning to them or consider them very important. Our model is informed by clinical observations and neurobiological research findings, which indicate a selective attention among BDD patients to small details, including specific aspects of appearance or minor appearance flaws. A study based on the Rey Osterrieth Complex Figure Test (Deckersbach et al., 2000) and an fMRI study conducted while processing faces of high, normal and low spatial frequency (Feusner, Townsend, Bystritsky, & Bookheimer, 2007) demonstrate a bias toward detailed information processing rather than a focus on global, organizational features. Our research also shows the presence of other information processing biases in BDD—for example, threatening interpretations for nonthreatening scenarios, and overestimation of the attractiveness of others' faces (Buhlmann, Etcoff, Wilhelm, 2008; Buhlmann et al., 2002). Our model proposes that these maladaptive processing strategies and interpretations trigger shame, depression, anxiety, and further increased attention to perceived appearance defects, which in turn fuel self-defeating ritualistic behaviors (e.g., mirror checking, excessive grooming) and avoidance of situations (e.g., social situations) that trigger these emotions. Rituals and avoidance behaviors are negatively reinforced because they may temporarily decrease unpleasant emotions, thereby maintaining dysfunctional BDD-related beliefs. CBT targets these maladaptive thought and behavior patterns.

CBT for BDD typically begins with psychoeducation, during which the therapist explains and individualizes the cognitive-behavioral model of BDD. In addition, CBT usually includes techniques such as self-monitoring one's automatic negative thoughts and behaviors, cognitive restructuring, exposure and response prevention, and relapse prevention. Some CBT for BDD treatment studies have also included mirror or perceptual retraining (described below). The efficacy of CBT for BDD has only rarely been examined. A recent meta-analysis comparing pharmacotherapy to CBT, BT, and CT showed all treatments to be effective in improving BDD and depressive symptoms (Williams, Hadjistavropoulos, & Sharpe, 2006). CBT, but not BT alone, yielded larger effect sizes than pharmacotherapy. Additional support for the benefits of CBT comes from case reports; however, only a few case descriptions illustrating the application of different treatment strategies in BDD have been published (e.g., Munjack, 1978; Phillips et al., 1993; Schmidt & Harrington, 1995). The current paper will provide a case description to illustrate state-of-the-art clinical strategies and clinical decision-making in BDD.

Case Example

Case History

Paul[1], an attractive 33-year-old Caucasian physical therapist, sought treatment at an outpatient clinic specializing in BDD at Massachusetts General Hospital

[1] The name and identifying details of the case have been altered to protect patient anonymity.

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات