

Imagery Rescripting for Body Dysmorphic Disorder: A Multiple-Baseline Single-Case Experimental Design

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Individuals with body dysmorphic disorder (BDD) often experience negative distorted images of their appearance, and research suggests these may be linked to memories of adverse events such as bullying or teasing. This study evaluates imagery rescripting (ImR) as an intervention for BDD. In this article, we present a multiple-baseline single-case experimental design testing imagery rescripting as a brief, stand-alone intervention, with six individuals with BDD that related to aversive memories. The impact of the intervention was assessed by self-reported daily measures of symptom severity (preoccupation with appearance, appearance-related checking behaviors, appearance-related distress, and strength of belief that their main problem is their appearance) and standardized clinician ratings of BDD severity (Yale–Brown Obsessive Compulsive Scale modified for BDD). Four out of six of the participants responded positively to the intervention, with clinically meaningful improvement in symptomatology. Overall response was rapid; improvements began within the first week post-ImR intervention. From a small sample it is cautiously concluded that imagery rescripting may show promise as a module in cognitive-behavioral therapy for BDD, and is worthy of further investigation.

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INDIVIDUALS WITH BODY DYSMORPHIC disorder (BDD) are preoccupied with a perceived defect or flaw in their physical appearance that is not observable to others or appears only slight. To fulfill the diagnostic criteria, they must also experience clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013). The prevalence of BDD is reported to be up to 2.4% in the U.S. population (Koran, Abujaoude, Large, & Serpe, 2008). BDD is a chronic condition that usually develops during adolescence (Veale, Boocock, et al., 1996) and has significant negative impact on quality of life (Phillips, 2000). Suicide rates in individuals with BDD are high, with as many as 80% reporting lifetime suicidal ideation and up to 28% attempting suicide (Phillips et al., 2006; Veale, Boocock, et al., 1996).

Cognitive-behavioral therapy (CBT) for BDD has traditionally focused on cognitive restructuring and exposure and response prevention or behavioral experiments (Veale & Neziroglu, 2010; Wilhelm, Phillips, & Steketee, 2013). There are only four randomized controlled trials (RCTs) testing CBT versus a wait-list as a treatment for people with BDD (Rabiei, Mulkens, Kalantari, Molavi, & Bahrami, 2012; Rosen, Reiter, & Orosan, 1995; Veale, Gournay, et al., 1996; Wilhelm et al., 2014). All studies reported a significant reduction in symptoms associated with BDD compared with the wait-list.

Last, [Veale et al. \(2014\)](#) have shown CBT to be superior to anxiety management for BDD. In clinical practice, individuals with BDD are frequently regarded as difficult to treat, and a significant number fail to respond or to make a full recovery.

A distorted body image and excessive self-focused attention are central features of a model of “the self as an aesthetic object,” which is characteristic of people with BDD ([Veale, 2004](#); [Veale, Boocock, et al., 1996](#)). Evidence for the experience of distorted imagery in BDD comes from a descriptive study that compared 18 participants with BDD with 18 healthy controls using a semi-structured interview and questionnaires ([Osman, Cooper, Hackmann, & Veale, 2004](#)). The BDD and control groups were equally likely to experience spontaneous images of their appearance. However, people with BDD were found to have appearance-related images that were significantly more negative, more recurrent, and viewed more from an observer perspective (seeing themselves in their mind’s eye from another person’s viewpoint) than were those of the control participants. These images were more vivid, detailed, and distorted, and typically involved bodily sensations. The content of the images was frequently related to early aversive memories from childhood or adolescence. The most common memories were of bullying or teasing.

These findings were confirmed by [Buhlmann, Cook, Fama, and Wilhelm \(2007\)](#) and [Buhlmann et al. \(2011\)](#), who also found that people with BDD reported memories of more appearance and competency-related teasing than did mentally healthy control participants. [Kosslyn, Ganis, and Thompson \(2001\)](#) note that while mental images often take a visual form, they may include other sensory modalities as well, such as the auditory, olfactory, or kinesthetic. People with BDD are frequently comparing or scrutinizing their area of concern within their mind’s eye, and imagining how their feature appears to others ([Veale, 2004](#)).

The prevalence of imagery linked to aversive experiences in BDD could indicate that imagery-based techniques might be worthy of investigation. Imagery rescripting (ImR) has received increasing interest as an intervention for people who experience distressing images ([Holmes, Arntz, & Smucker, 2007](#)). ImR was originally developed for posttraumatic stress disorder (PTSD; [Smucker & Dancu, 1999](#)) and personality disorder ([Arntz & Weertman, 1999](#)) and involves techniques that transform distressing mental images into more benign entities or construct new positive images. [Holmes et al. \(2007\)](#) demonstrated that imagery has greater power to affect emotion than verbal processing, and that emotional memories are far more likely to be represented as

images than as verbal thoughts. ImR was not typically used as a stand-alone intervention in the four RCTs for CBT for BDD ([Rabiei et al., 2012](#); [Rosen et al., 1995](#); [Veale, Gournay, et al., 1996](#); [Wilhelm et al., 2014](#)), but was used as an optional module in a treatment protocol for one RCT ([Veale et al., 2014](#)). Thus it would be helpful to determine if a module using ImR has any efficacy for people with BDD who report images and so would strengthen the rationale for its inclusion in CBT packages. The evidence to date for ImR in other disorders has been dominated by case studies and pilot RCTs with small sample sizes. For example, [Nilsson, Lundh, and Viborg \(2012\)](#) conducted a small RCT ($n = 14$) comparing ImR with a reading task in participants with social phobia. They found a significant reduction in symptoms of social phobia across a number of measures. ImR has demonstrated some efficacy, mainly in people suffering from a range of conditions such as social phobia ([Nilsson et al., 2012](#); [Wild & Clark, 2011](#); [Wild, Hackmann, & Clark, 2008](#)), PTSD ([Hackmann, 2011](#)), depression ([Wheatley & Hackmann, 2011](#)), personality disorder ([Arntz & Weertman, 1999](#)), simple phobia ([Hunt & Fenton, 2007](#)), and obsessive-compulsive disorder (OCD; [Veale, Page, Woodward, & Salkovskis, 2015](#)).

In a recent review of the ImR literature, [Arntz \(2012\)](#) concluded that the results are encouraging in terms of efficacy of the technique, but that the RCTs or case series that have been carried out have been underpowered or with inadequate control conditions. There may be a number of possible mechanisms that account for the effects of ImR. They typically focus on imagining that an aversive memory has changed so that the outcome is more desirable, or at least less aversive ([Arntz, 2012](#))—for example, through emotional processing, changing memory representation, counterconditioning (such as adding a soothing image), changing the meaning of the imagery, and changing the sense of “nowness” or context of the imagery. However, these putative mechanisms have not been fully investigated.

Because people with BDD have a distorted body image and share a number of features with OCD and social phobia ([Coles et al., 2006](#); [Wilhelm & Neziroglu, 2002](#)), interventions that have been of benefit for OCD and social phobia are of particular interest to those trying to help people with BDD. ImR has not previously been evaluated for BDD but it seems to be a logical choice given the central nature of imagery in BDD and the frequent emotional links to aversive early memories. It also offers the opportunity to develop an alternative understanding and context for their body image, while avoiding verbal debate about whether the person has a perceived or “real” defect, or whether

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