This belief, even though it may be extreme, is not of delusional proportion. The majority of people with BDD have very little insight into the origins of their symptoms. In fact, the greater the perceived defects, the lower the degree of insight (Marazzita et al., 2006). See the following DSM-IV-TR Diagnostic Criteria feature for a description of the diagnostic criteria for BDD.

People with BDD often use avoidance, such as Joanna does, to cope with their perceived defect(s). Such avoidance may result in extreme social isolation. For example, a man who tries to camouflage his “defect” of imaginary hair loss may leave his home only at night, and then only with a hat covering the “defective” part. The preoccupation with one’s appearance is very time consuming; thus, it restricts activities. In some cases, clients seek out cosmetic surgery to “cure” the imagined defect. In some people, BDD “interferes with their judgment and can lead them to make poor choices when considering cosmetic procedures” (Ritvo, Melnick, Marcus, & Glick, 2006, p. 194). This is a major reason why plastic and cosmetic surgeons should do careful screenings before performing cosmetic or reconstructive surgery.

**Diagnostic Criteria for Hypochondriasis**

A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms.

B. The preoccupation persists despite appropriate medical evaluation and reassurance.

C. The belief in Criterion A is not of delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic Disorder).

D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration of the disturbance is at least 6 months.

F. The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder.

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**Clinical Example**

Joanna is very worried about the size of her nose despite reassurances that her nose is normal. She spends an inordinate amount of time in front of the mirror using cosmetics designed to shadow or minimize her nose. Joanna recently turned down a job promotion that would have put her in charge of the entire human resources department at the company at which she works. The job involves training human resources staff at locations in ten other cities. Joanna cannot bear the thought that trainees will have to look at her nose all day.

This belief, even though it may be extreme, is not of delusional proportion. The majority of people with BDD have very little insight into the origins of their symptoms. In fact, the greater the perceived defects, the lower the degree of insight (Marazzita et al., 2006). See the following DSM-IV-TR Diagnostic Criteria feature for a description of the diagnostic criteria for BDD.

Health care providers often use language unfamiliar to clients and family members. In terms that clients and family members can readily understand, explain how an individual can misinterpret his or her bodily symptoms.

**Diagnostic Criteria for Body Dysmorphic Disorder**

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

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**Using DSM-IV-TR**

Health care providers often use language unfamiliar to clients and their families. Explain what it means to be preoccupied with an imaginary defect in such a way that clients and family members can understand the basis for body dysmorphic disorder.