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CBT for Body Dysmorphic Disorder by Proxy: A Case Study

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Body dysmorphic disorder (BDD) by proxy is a body image disorder that causes great discomfort to the patient and significant others. Patients suffering from this condition are preoccupied with dissatisfaction about the other person's appearance. There is very little research on the treatment of this disorder. This paper presents a description of the cognitive behavioral treatment of a case of BDD by proxy. The patient is a 36-year-old male who exhibited extreme dissatisfaction with his spouse's appearance. Thirteen sessions of cognitive behavior therapy were supplemented with couple interventions and a trial of pharmacotherapy. Treatment effects were evaluated using an adapted version of the BDD-YBOCS to establish the severity of BDD by proxy, and the Symptom Check List (SCL-90) as a general measure of psychopathology. Visual inspection of the data and the calculation of Reliable Change Indices (RCI) showed that CBT led to a clinically significant reduction in BDD by proxy symptomatology (RCI = 10.6), and in anxiety, depression, and obsessionality. In addition, according to clinical impressions, marital functioning also improved to a considerable extent. This case description is the first to suggest the potential benefits of CBT for BDD by proxy.

Body dysmorphic disorder (BDD; American Psychiatric Association [APA], 2013) refers to the patient's preoccupation with perceived or slight flaws in his or her own appearance, which go unnoticed by other people. This preoccupation yields a marked impairment in social, personal and occupational functioning. Phenomenologically, the clinical picture is characterized by the strong tendency to conceal, inspect, compare, or restore the object of dissatisfaction, which may take many hours a day (Veale & Neziroglu, 2010). In BDD *by proxy,* on the other hand, the focus is on an imagined defect of slight flaw in the appearance of *another individual.* DSM-5 (APA, 2013, p. 244) devotes only one sentence to this condition: "Body dysmorphic disorder by proxy is a form of body dysmorphic disorder in which individuals are preoccupied with defects they perceive in another person's appearance." Patients exhibiting BDD by proxy project their body dissatisfaction upon a significant other (usually a child or partner). Their own psychopathology and need for help goes generally unrecognized, thereby showing poor insight. Moreover, some patients even put a lot of pressure on the other person to conceal, inspect, or modify their imagined appearance flaws, or to seek medical consultations with general practice physicians, cosmetic surgeons, dermatologists, orthodontists, etc. (e.g., Greenberg et al., 2013; Phillips, 2005). The aim of these behaviors is to have the other person improve or beautify their appearance in a way that matches the patient's desired image. Individuals with BDD by proxy are unlikely to seek help because of the conviction that the core of the problem lies with the flawed appearance of the other person. This would suggest that the impairment of BDD by proxy has a much stronger interpersonal component than BDD proper.

Reliable data on the prevalence, assessment, and treatment of BDD by proxy are lacking. Moreover, seminal books on BDD only mention the disorder in one or two sentences, thereby merely acknowledging its existence (Phillips, 2005; Phillips, 2009; Veale & Neziroglu, 2010), or do not mention it at all (Wilhelm, Phillips, & Steketee, 2013). The only empirical study in this area thus far has been reported by Greenberg et al. (2013), describing the phenomenology of BDD by proxy in 11 self-reported cases using an Internet survey. These patients were preoccupied with multiple body parts (predominantly involving the head and face) in significant others. All engaged in comparing, scrutinizing, and checking the other person's appearance, and most of them also persuaded the "person of concern" to perform excessive grooming, changing clothing, and camouflaging. BDD by proxy resulted in serious anxious and depressive symptoms in the sufferers, as well as in psychosocial and relationship consequences. For example, over 80% of this sample avoided or ended an intimate relationship. Although most of them had sought

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psychological treatment, there was a significant gap (9.6 years on average) between onset and finally receiving care. Unfortunately, Greenberg et al. did not investigate the potential consequences experienced by the persons of concern.

BDD by proxy patients present in various ways to health care professionals. Some show up at their general practitioner's office with the aim to convince the doctor that a cosmetic procedure is necessary in order to correct the flaw in the significant other's appearance. Others are sent to the GP by the significant other because the home situation has become unbearable. In still other cases significant others request a procedure themselves while pressured by the patient, making it difficult for the doctor to figure out from whom the request is originating. This is a diagnostic and strategic challenge for any health care professional, who at some point may want to refer the BDD by proxy patient (with or without the significant other) to a mental health care facility. Because BDD by proxy can be regarded as a systemic problem, it is wise to see all who are involved (and who play a maintaining role in the disorder) in order to make an adequate case conceptualization and treatment plan. For example, it can be important to address the behavior of the significant other, as this person plays an important role in the maintenance of the disorder by yielding to the patient's preoccupation in order to prevent or diminish interpersonal turmoil.

When it comes to the cognitive behavioral treatment of BDD proper, the core components are psychoeducation, case formulation, motivational enhancement, cognitive restructuring, and exposure with response prevention (Phillips, 2009; Veale & Neziroglu, 2010; Wilhelm et al., 2013). The efficacy of this approach has found support in a series of treatment outcome studies. A meta-analysis involving a dozen studies showed CBT and pharmacotherapy (in particular SSRIs) to be effective treatments for BDD, with CBT showing stronger results (Williams, Hadjistavropoulos, & Sharpe, 2006). Since then, three additional studies have demonstrated the efficacy of CBT. Wilhelm and her colleagues (2014) found 24 weeks of modular CBT (n = 17) to outperform a wait-list condition (n = 19) at posttreatment and at 6 months follow-up. In another randomized controlled trial, Veale et al. (2014) reported the superiority of CBT over anxiety management training in 46 patients diagnosed with BDD and some of them even with comorbid delusional beliefs or depression. In an uncontrolled trial (n = 23; Enander et al., 2014) a 12-session therapist-guided CBT treatment via the Internet proved to be effective in reducing BDD.

The (treatment) literature on BDD by proxy, on the other hand, is very limited. A systematic search in Medline, Ovid, PsychArticles, PsychInfo, PubMed, and Web of Science as well as a hand search covering the period between 1970 to January 2015, and using the general search term "body dysmorphic disorder by proxy" resulted in five very brief (maximum 1 page) case descriptions in English. Two of these reports merely relate to a clinical description of the disorder, and the other three briefly mention any form of treatment. We summarize the literature in chronological order.

Josephson and Hollander (1997) presented a male (Mr. A; 39 years) and a female patient (Ms. B; 32 years) whose preoccupations concerned their children and partner, respectively. In addition to having features of OCD, both patients had previously been diagnosed with BDD. The authors very briefly describe the treatment as follows: "Mr. A was treated by using behavioral strategies of exposure and response prevention. Examples of in vivo exposure were to look at his children to elicit the anxiety and then turn the lights down to prevent checking" (p. 86). In the second patient, Ms. B's treatment consisted of "…exposure to avoided situations and response prevention (i.e., not checking fiancé's nose and her own jaw)" (p. 87). In addition, various types of SSRIs were tried. Clinical Global Impressions (CGI) on a scale from 1 to 4 showed Mr. A to have reached *much improvement* (CGI = 2) on OCD and his own BDD, but *no improvement* (CGI = 4) on BDD by proxy, whereas Ms. B exhibited *very much improvement* (CGI = 1) on BDD by proxy.

Laugharne, Upex, and Palazidou (1998) reported on BDD by proxy in a female in her mid-20s who had three successive terminations of pregnancies with different partners. She did so for fear of the unborn child inheriting the (according to her) unwanted features of the father (too short, slanted eyes, and a too big mouth). This patient was only seen for psychiatric evaluation, and no treatment was described by the authors.

A case description by Godden (1999) highlighted the morbid preoccupations of a mother who had a number of successful cosmetic and orthodontic procedures carried out on her 17-year-old daughter. Despite the postoperative satisfaction displayed by both her daughter and the medical team, she kept insisting on other corrections. In her mind, she saw her daughter becoming uglier. Her daughter felt pressured by her mother and gave in to having additional procedures performed. No psychological treatment was delivered.

Atiullah and Phillips (2001) presented the case of an overconcerned 63-year-old man who took his daughter from one dermatologist to the other because of an alleged lack of volume in her hair. He was hospitalized for 5 weeks and received (unspecified) inpatient treatment and pharmacotherapy (with several SSRIs and benzodiazepines). The patient was discharged after stating that he was feeling improved, but several weeks later he committed suicide because of the unbearable preoccupation with his daughter's appearance.

Bakhla, Prakriti, and Kumar (2012) discussed the case of a 28-year-old woman diagnosed with BDD herself, who was also obsessed with the shape of her daughter's head. After 12 weeks of pharmacotherapy (venlafaxine and trifluoperazine) and "cognitive behavior therapy" (not further specified) her condition improved considerably. These authors are the first to provide standardized quantitative data by reporting a decrease on the BDD-YBOCS (see below for a more detailed description) from 32 to 12 for her own BDD, and a decrease from 30 to 6 for her preoccupation with her daughter (i.e., BDD by proxy). CGI scores decreased from 5 (*severe symptoms*) to 2 (*much improved*), and the Hamilton Depression Scale scores decreased from 38 to 12.

These case descriptions present only a very sketchy picture of what the authors referred to as BDD by proxy. In three cases, treatment was mentioned in a few sentences, and consisted of CBT interventions combined with SSRIs. Two of the three cases showed considerable improvement on BDD by proxy, and two on the patients' own BDD as well. In conclusion, despite being recognized as a diagnosis according to the DSM-5, little is known about this condition and its treatment. Therefore, the purpose of the present paper is to contribute to the understanding of the clinical picture and to the treatment possibilities of this disorder.

The Patient

Clinical Picture

Alex[1] is a 36-year-old lawyer who was pressured by his wife, Andrea (34 years) to seek help for his "obsession." The couple had been together for over 15 years, with a daughter of 8 and a son of 6. Andrea, who had a job in the fashion industry, reported to her GP with severe symptoms of distress. She described a very tense and unbearable situation at home and was considering a divorce. She told her family doctor that her distress was due to her husband being increasingly preoccupied with her appearance and in particular with her buttocks. In his referral letter to the psychologist, the family doctor mentioned that he had a difficult time convincing Alex that his preoccupation with his wife's buttocks was of a pathological nature. The doctor suspected obsessive-compulsive disorder, as well as memory and concentration problems as a result of his preoccupations. Although Alex did not consider himself to have a reason to seek help, he agreed to the referral in order to save his marriage.

He was referred to a mental health care outpatient facility where he was treated by a senior cognitive behavioral therapist (the second author, T.G.) who had experience with treating BDD. During the individual intake interview Alex presented as a well-groomed, hard-working, intelligent man who was very dedicated to his family. He displayed a good sense of humor and verbal skills, but on the other hand he exhibited a considerable degree of complacency and low introspective ability. He described Andrea as a beautiful woman, with the exception of her too small buttocks. His preoccupations had existed for many years, and by now took several hours a day. Upon the therapist's request, Alex detailed how he persuaded his wife to walk and sit in a particular way and to dress according to his wishes, all with the purpose of concealing her buttocks as much as possible. Activities such as going to restaurants and to the beach or swimming pool were avoided, in order to prevent Alex from being confronted with his wife's small buttocks in public. Alex reported that this preoccupation also occurred in his night-time dreams. During the intake interview, he gradually came to realize the pathological features of his obsessions (as he called them). He nevertheless still persisted that his wife's buttocks were too small.

His nuclear family consisted of a younger brother and two older sisters. He stated that important family values included the ideas that "What's beautiful is good"; "You always have to present yourself in a decent manner"; "It's important to gain appreciation from your environment." He characterized his family as emotionally closed, and without discussing feelings. When he was young, his mother had been suffering from an anxiety disorder, and his sister might have had BDD.

As a young boy, Alex had got along well with girls until he reached puberty. At that time he became very insecure about his appearance, as he wore glasses from a young age onwards and had developed acne. He started feeling like a loser and subsequently stopped pursuing females. He also developed an obsession for sex, as he frequently called sex phone lines, and watched porn on the Internet. He attempted to cover his insecurity with a display of bravado. His self-esteem returned when he started wearing contact lenses and his acne disappeared. From that time onwards, he started dating and reported success in developing romantic relationships.

At the age of 18, he had the experience that his friends commented that the girl he was dating had a flat behind, upon which he broke up with her. When he met Andrea a year later, he found her very beautiful, and at first he was not obsessed with her appearance. Alex suspected his preoccupation had started during an evening out, when he thought (although he admitted not being certain about this) he heard someone say: "Look at that woman; she really has a flat behind!" While initially capable of keeping his preoccupations to himself, he eventually started to express them towards his wife. BDD by proxy developed after a few years of marriage, and gradually

[1] Names and biographical data have been modified to provide anonymity.

grew into an obstacle between the spouses. Andrea became more and more trapped within Alex's preoccupation; she gave in because she wanted to avoid domestic turmoil. Despite other people telling him that his wife is beautiful, he considered these comments as attempts to reassure him. These ruminations led to occasional anxiety and depression, and he started worrying about whether he actually did love his wife.

Both Alex and Andrea described their marriage on the whole as being "good" and without other problems. From the beginning of their relationship there had been mutual love and affection, and that is why they did not want their marriage to fail. The only thing that negatively impacted their marriage was Alex's preoccupation with his wife's buttocks. Interestingly, this did not prevent them from having a satisfactory sexual relationship, even during the most intense periods of his BDD by proxy. They both felt sexually attracted to each other and cherished these moments of intimacy. Although Alex devoted much of his time to his job, he (as well as his wife) considered himself to be a good father for their children. Their request for help pertained to Alex's preoccupation with Andrea's body, rather than to broader marital problems. Considering all this, the therapist concluded there were no major underlying marital issues that required specific therapeutic attention. Finally, the spouses had no individual or common treatment history.

Pretreatment Assessment

The intake phase led to the diagnosis of BDD by proxy, with a history of transient and age-appropriate body dissatisfaction during early adolescence. Making the primary diagnosis, however, required a modification of the DSM-5 criteria A, B and C along the following lines:

A. Preoccupation with one or more perceived deficits or flaws in physical appearance *in another person* that are not observable or appear slight to others.
B. At some point during the course of the disorder, the individual has performed *or has the other person to perform* repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
C. The preoccupation causes clinically significant distress or impairment in *interpersonal,* social, occupational, or other important areas of functioning.

During the initial assessment, the therapist qualified the patient's insight as "poor" but not delusional, although his beliefs were strongly ego-syntonic. Considering comorbidity and differential diagnoses, according to the therapist's initial judgment based upon DSM criteria, Alex did not satisfy criteria for BDD himself, or for disorders suggested by DSM-5 to concur with BDD (notably anxiety, mood, and personality disorders).

Instruments

Symptom severity was assessed at pre- and posttreatment and at 3 months follow-up, using the following two instruments:

The BDD variant of the Yale-Brown Obsessive Compulsive Scale (BDD-YBOCS; Phillips et al., 1997; Phillips, Hart, & Menard, 2014; Dutch version: Van Rood & Bouman, 2007) is the most frequently used semistructured interview quantifying the severity of BDD. For the purpose of this case study it was modified for BDD by proxy by the present authors by replacing *body defect* with *your partner's body defect* in all items. Greenberg et al. (2013) also modified this instrument for BDD by proxy and found a mean of 28.1 (SD = 5.8) in their sample of 11 patients. The interview was administered by the second author.

The Symptom Check List (SCL-90; Derogatis, 1977; Dutch version: Arrindell & Ettema, 2003), a self-report state measure of a number of psychopathological features, possesses high reliability and validity. The Dutch version consists of eight subscales: anxiety, agoraphobia, depression, somatization, obsessionality, interpersonal sensitivity, hostility, and sleep disorder. The total score of all 90 items reflects the general feature of psychoneuroticism.

Formulation, Treatment Rationale, Goal, and Plan

After the first session and in collaboration with Alex, the therapist made a case formulation which they refined over the course of treatment. Alex's cognitions centered on the conviction that his wife's buttocks were too small, which he construed as a sign of imperfection. His core belief related to the importance of perfection ("I am a failure"), from which rules were derived (e.g., "Always stick to the highest norms"; "Don't settle for less than the best"). Some of his conditional beliefs were as follows: "If other people look at my wife, they will judge her flat behind"; "This judgment will be negative"; and "This negative judgment means that I have failed." He was convinced that they would never be able to lead a happy life as long as Andrea's buttocks remained flat. These cognitions led to a mix of emotions, such as distress, anxiety, anger, and low mood. They also increased his selective attention for other people's gazes and remarks, and for Andrea's body.

In order to cope with his negative cognitions and emotions, Alex developed a wide array of checking and avoidance behaviors. Andrea was persuaded to wear specific nonrevealing clothing, and to maintain specific body postures. The two of them avoided social situations

to prevent the potential danger of other people observing and commenting upon Andrea's behind. Additionally, he had become totally immersed in his job in order to prevent him from thinking about his wife's behind. The subtle as well as overt pressure exerted by Alex had led Andrea to increasingly comply with his wishes, thus

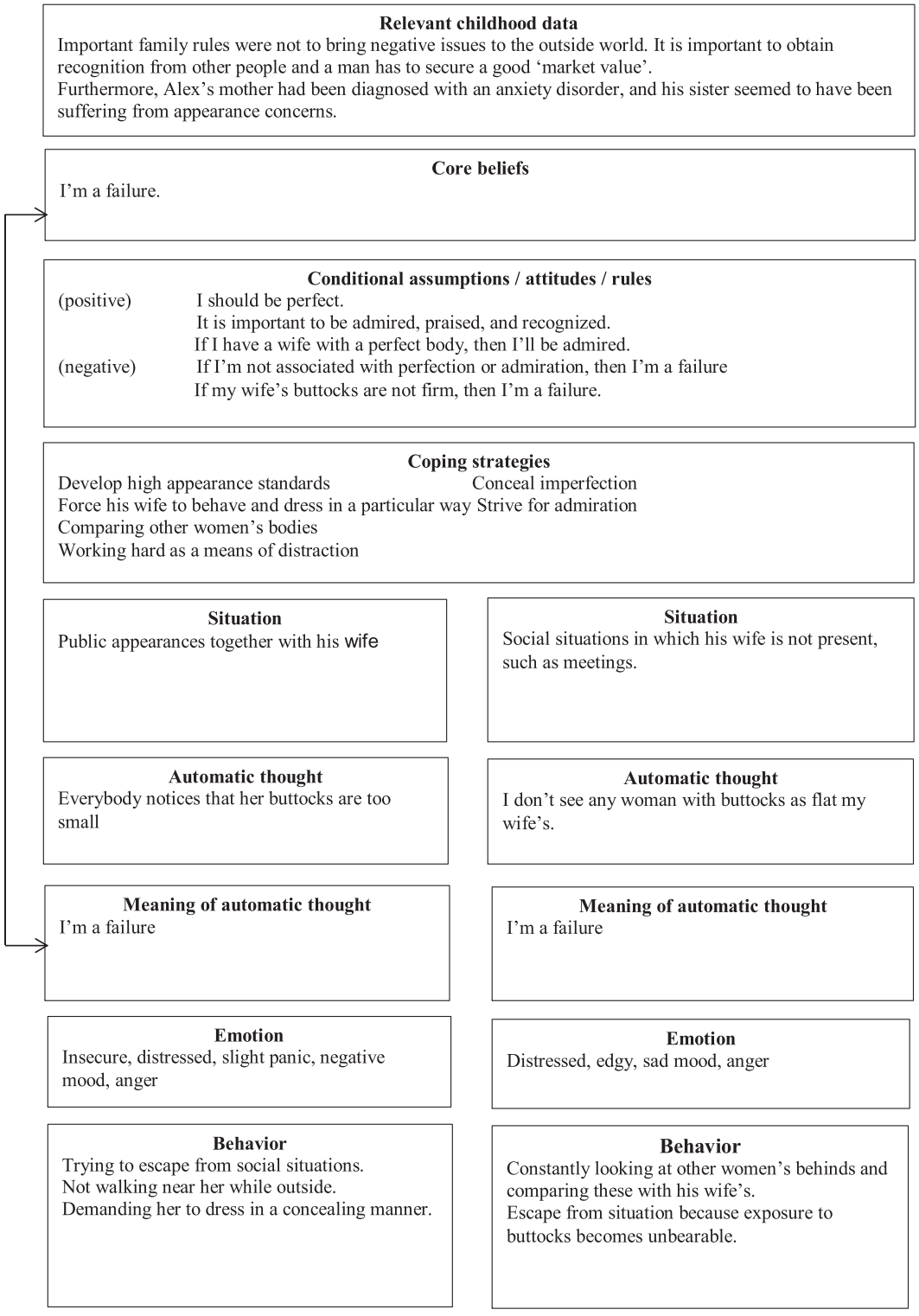

Figure 1. Cognitive case conceptualization.

reinforcing his preoccupation. Initially, she did not consider this compliance to be very harmful, but gradually she became so distressed by his preoccupation that she began to consider a divorce.

The cognitive case conceptualization (cf. Beck, 2011, p. 200) depicted in Figure 1 summarizes the above with the core belief of being a failure as its central component.

Treatment Goal

After the first two sessions Alex and his therapist agreed that the treatment goal was the reduction of Alex's preoccupation with his wife's appearance, in particular her buttocks. It was hypothesized that as a consequence their marital functioning would improve.

Treatment Plan

The initial treatment plan followed the mainstream approach applied to BDD proper (see e.g., Wilhelm et al., 2013) and consisted of subsequent stages, namely, engaging Alex into treatment, psychoeducation, cognitive restructuring, and exposure and response prevention. Because of the interpersonal aspect of the disorder, the therapist decided to involve Andrea at the beginning and end of treatment. Treatment was scheduled for thirteen 45-minutes sessions over a period of 4 months, and took place in a regular outpatient mental health institution with the treatment costs covered by the couple's health care insurance.

Course of Treatment

Alex showed up at all appointments and manifested increasing compliance to the treatment. Over time, he embraced the treatment rationale and showed his willingness to carry out homework assignments both alone and together with his spouse. Over the course of treatment his motivation changed from extrinsic (wanting to save his marriage) to intrinsic (wanting to feel better about himself). The various stages of treatment are depicted in Figure 2 and will be briefly described below.

Engagement

Initially Alex appeared to be only extrinsically motivated for treatment—namely, to save his marriage—rather than seeing his own preoccupation as pathological. The therapist emphasized the discrepancy between the current situation and Alex's desire to have a satisfactory marital relationship. They also discussed the time-consuming and invalidating consequences of Alex's condition, during which the therapist conveyed his understanding of the difficulties Alex was encountering. In order to become motivated for treatment, it was important that Alex embrace his own capabilities to bring about change in his own situation and in his marriage, rather than dwell in guilt and shame. To achieve this, the therapist displayed an empathic and accepting attitude and provided support, structure, and guidance. This made Alex feel recognized and accepted, leading to an increase in his confidence and positive expectations regarding treatment. At the end of this phase, the patient had become aware that is was up to him to make the choice to start treatment.

Psychoeducation

The therapist explained the characteristics and mechanisms of BDD and its much rarer by-proxy variant. Alex was very interested in this topic and browsed the Internet for more information. He regularly sent the therapist what he had found, and was also eager to engage in discussion in which he showed his sense of humor. They also went through the cognitive behavioral formulation of his condition, highlighting the components that were relevant for him.

One of Alex's favorite topics for discussion was his opinion that life is strongly influenced by beauty and aesthetic values. On the one hand, the therapist saw this type of discussion as avoidance of addressing his own problems. On the other hand, Alex and his therapist discussed how ideals of beauty came into existence in order to learn to appreciate beauty and physical appearance in a different and wider perspective. He began to realize that his idealized image of buttocks was just a product of our time. When it came to beauty, Alex

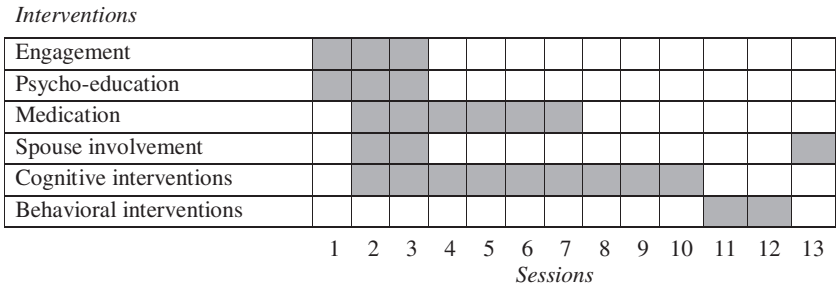

Figure 2. Stages in Alex's treatment.

and his therapist explored the criteria imposed upon women over the past decades. The aim of all this was to bring the message across that beauty is in the eye of the beholder, as well as a product of a specific cultural era.

Pharmacotherapy

After the first session, the therapist judged Alex's initial convictions to be rather severe, and he therefore arranged a consultation with a psychiatrist who confirmed the diagnosis. It was decided to augment CBT with an SSRI (Citalopram; 20 mg daily) because of its potential beneficial effects on BDD proper (Philips, Albertini, & Rasmussen, 2002). This facilitated CBT by reducing Alex's persistent tendency to ruminate, despite side–effects of fatigue and disturbed sleep. However, after 6 weeks the patient decided to terminate the SSRI because he felt that he had to reach his goals without the support of medication.

Cognitive Interventions

Thought record forms were used to investigate Alex's beliefs and their ensuing emotions and behaviors. In addition, the downward-arrow technique and Socratic questioning were applied to gradually uncover his dysfunctional beliefs, and to challenge their validity. Next, treatment worked towards formulating and testing new and more functional beliefs. Topics covered were his beliefs about other people's opinions regarding his spouse's appearance, and about his intolerance for (appearance related) imperfection. Beliefs such as "Beautiful people have all the advantages," "Only what's beautiful is good," "You should not expose your shortcomings," and "You should make every effort in every situation" came to the surface and were scrutinized.

Alex appeared unaware of having developed a number of dysfunctional thinking habits and biased interpretations. He proved to be a selective observer and a negative thinker. For example, he frequently engaged in "mind reading" by stating that he knew exactly what other people thought about his wife's buttocks. The therapist addressed this by explaining the nature of thinking errors and their effects upon Alex's feelings and behaviors. The patient showed a keen understanding of these cognitive distortions and was able to come up with functional alternative thoughts. Challenging his beliefs led to the formulation of more rational alternatives, such as: "You can't be sure what other people are thinking," "I don't necessarily need to find it important what other people's opinions are," and "People are not just ugly or beautiful." Although he admitted to understanding these alternative beliefs on a rational level, he initially found it difficult to feel accordingly. In addition, he exhibited a low frustration tolerance as well as "should" thinking; he couldn't tolerate negative situations and wanted them to change in a specific way.

Although Alex had a handsome appearance, when the therapist explored his core beliefs, these revealed a sense of physical and psychological vulnerability. He strived for perfection that he would never find, thereby uncovering his core belief: "I'm a failure." The therapist's suggestion that he probably used his wife as a vehicle to realize his own desire for perfection initially caused Alex to react defensively. However, he eventually concluded that there was some truth to it. When the therapist asked Alex why he initially recoiled at the idea, Alex responded that it triggered his core belief of being a failure: "When you make this suggestion, I feel bad about myself. I feel like I've failed in this respect as well." This discussion emphasized the impact of his core belief on appearance-related and other areas of functioning. The therapist challenged this by eliciting numerous examples from Alex's life, probing for the validity of his belief about himself. The patient gradually came to the conclusion that he was not an utter failure, but rather that he was more successful in some respects and doing less well in others, resulting in a more nuanced view of himself.

Behavioral Experiments, Exposure, and Response Prevention

Cognitive interventions gradually evolved into behavioral experiments to test his assumptions in real-life situations by means of homework assignments. A few examples follow.

Alex was strongly convinced that other people shared his negative opinion regarding his wife's buttocks. An alternative belief was formulated stating that others might hold different and even positive opinions. In order to test the validity of both beliefs, as an experiment he found a picture of his wife in a bathing suit on the beach and placed it on his desk at the office. Some of his clients, with whom he had close relationships, appeared to feel free to make compliments about the nice shape of the woman in the picture. This finding made him reconsider his belief that other people had a negative evaluation of his wife's buttocks, and, moreover, that they looked at her as a whole person instead.

As another experiment to challenge his dysfunctional belief that other people shared his ideas, Alex was encouraged to ask a few good friends what they thought about his wife's appearance. Initially, he was unwilling to comply with this mini-survey because he was convinced they would only say nice things to please him, despite him being able to see the rationale behind the request. The therapist addressed this issue by focusing on the credibility of the alternative belief, i.e., "My wife's buttocks are okay." In line with the previous experiment, his friends volunteered positive feedback on his wife, thereby again undermining Alex's mind-reading bias. Note that this experiment was not meant to provide him with reassurance (i.e., with a reduction of emotional discomfort), but instead to help

him to further develop alternative beliefs (i.e., a cognitive change) about what other people might think.

A third behavioral experiment focused on the phenomenon of selective attention. The therapist challenged Alex to find out whether paying attention to just one part of his wife, versus attending to her entire body, would make a difference in terms of his preoccupation. At home Alex therefore practiced not only paying attention to the alleged "problematic part" of his wife's body, but to her entire appearance. As a result he learned to describe her appearance in a more balanced way, including positive and negative aspects, and also gradually learned to pay less attention to her buttocks. This further decreased his preoccupation.

Finally, exposure assignments were formulated in which he would appear together with his wife in social situations, such as shopping malls, walking arm in arm on the street, and going to the beach while his wife was wearing a bikini. Initially he found these situations quite distressing, but staying in the situation for quite some time resulted in a decrease of distress and other negative emotions. One of the response prevention interventions implied that Andrea was encouraged to stop wearing the clothes Alex demanded, in particular the ones that covered her behind.

Spouse Involvement

In addition to Alex's individual sessions, three sessions were held with the couple and their respective therapist (Andrea had accepted six individual sessions to boost her self-esteem; see below).Two of the sessions took place after the initial individual intake interview, and a third one at the end of treatment. Apart from gauging her willingness to continue the marriage, the psychoeducational goal was to inform Andrea about her husband's condition, the treatment plan, and her contribution to treatment. To illustrate the latter, a case conceptualization of the couple's dysfunctional interaction was made, focusing on the negative spiral in which they were involved.

A summary of this negative spiral follows: Alex's beliefs about his wife's buttocks (i.e., trigger) prompted him to demand her to wear a concealing dress (i.e., behavior), leading to a sense of control (i.e., consequence) as well as to her compliance. In addition, Andrea perceived her husband's demands (i.e., his behavior being her trigger), resulting in her being compliant (i.e., behavior), leading to consequences such as avoiding marital discord, and at the same time reinforcing Alex's demandingness. At first, Andrea was hesitant to collaborate but she soon realized that she also more or less unknowingly contributed to the maintenance of her husband's problems by having complied with his wishes and demands over the past years.

Over time Alex himself had taken refuge in sporting activities in order to keep a fit and lean body, and was asked to cut these down, and to seek activities together with Andrea. They could be playing tennis together, or having a walk with their children whom he saw too little because of his investment in his job and his sporting. On the one hand, engaging in these activities acted as exposure to be seen with his wife; on the other hand, they also provided an enrichment of their daily functioning by reducing the emphasis on Andrea's bodily appearance.

Andrea's Treatment

Parallel to Alex's treatment, Andrea had six individual sessions with a female therapist in order to address Andrea's insecurity that had developed over the years as a consequence of Alex's condition, and that had undermined her autonomy. No formal Axis I or II diagnosis could be made, apart from the aforementioned disorder–specific relationship distress. Andrea felt much supported by this brief intervention that significantly reduced her own distress, and made her much stronger and more autonomous.

Posttreatment Assessment

Qualitative Results

At the end of treatment Alex did not satisfy the DSM criteria for BDD by proxy because his cognitive and behavioral preoccupation had diminished. This improvement was also to his wife's satisfaction, who no longer saw a reason for divorce, and who felt freer to determine her own life. Based upon clinical information obtained at the exit interview, the quality of their relationship had improved considerably, adding to an increase in marital satisfaction. A 3-month follow-up by telephone brought to light that the individual and relationship improvements had remained. With regard to the effects of advancing age on appearance, both spouses seemed to have a quite realistic view, acknowledging that time would take its toll on their appearance. Both felt the urge to take good care of their health and appearance, for example, by being engaged in sporting activities and a healthy diet. These considerations did not seem to be excessive, but part of their culture and reference group.

Quantitative Results

Reliable change indices (RCI) between pre- and postassessments were calculated according to the formula presented by Jacobson and Truax (1991), namely RCI = $(x_1 - x_2)/S_{diff}$, where X_1 and X_2 are the pre-and postassessments, and S_{diff} the standard error of difference between these two test scores. When the RCI exceeds the value of 1.96, "it is unlikely that the posttest score is not reflecting real change" (Jacobson & Truax, 1991, p. 14). Despite several more sophisticated and innovative approaches, this formula is still considered very useful and widely applied (Wise, 2004).

BDDbp-YBOCS. Table 1 shows a steep decline on the BDDbp-YBOCS scores from pre- to posttreatment, and a

consolidation of this gain at follow-up after 3 months. Interestingly, this is an improvement of a similar magnitude (from 30 to 6) as reported by Bakhla et al. (2012). In comparison with Greenberg et al. (2013) the pretreatment score was in the clinical range (around 28). To calculate the S_{diff} component of the RCI we used the standard deviation from the latter clinical study, and the test-retest reliability on the BDD-YBOCS (r_{xx} = .93; as an estimate for the present instrument) as reported by Phillips et al. (2014). As can be seen in Table 1 the RCI was highly significant, implying that the improvement on this measure is of great clinical significance.

SCL-90. Visual inspection shows a decline between pre- and postassessment on most scales, as well as stabilization between postassessment and follow-up (see Table 1). In order to compute the S_{diff} component of the RCI we used Cronbach's α as estimates of the scales' reliability, and the standard deviations from the Dutch community sample (n = 2,366; Arrindell & Ettema, 2003). As can be seen from the table, six out of nine scales have a significant RCI, implying a clinically significant improvement on these aspects. The three scales that did not show improvement (i.e., agoraphobia, hostility, and sleep problems) started with very low scores at preassessment. These findings converge with the clinical impression of Alex's enhanced functioning on a personal and emotional level.

Discussion

To the best of our knowledge this is the first detailed case description of the cognitive behavioral treatment of BDD by proxy. This disorder is evidently understudied and provides a diagnostic challenge. The treatment took place in a regular mental health outpatient setting, and consisted of the general components advised for the treatment of BDD (Wilhelm et al., 2013) supplemented with spouse involvement and a brief trial of pharmacotherapy. The qualitative and quantitative results show a clinically significant decrease in the severity of BDD by proxy, as well as in anxiety, depression, obsessionality, interpersonal sensitivity, and marital dissatisfaction.

Table 1
Measurements at Pre- and Postassessment and at 3 Months Follow-up

	Pre	Post	Follow-up	RCI $_{Pre\text{-}Post}$
BDDbp-YBOCS	33	10	8	10.60 *
SCL-90				
anxiety	31	11	12	9.28 *
agoraphobia	9	7	7	1.71
depression	42	18	18	7.44 *
somatization	20	12	14	3.08 *
obsessionality	17	11	11	2.47 *
interpersonal sensitivity	28	22	24	1.97 *
hostility	8	8	6	0.00
sleep problems	5	3	3	1.52
psychoneuroticism	179	101	105	4.01 *

Note. RCI $_{Pre\text{-}Post}$ = reliable change index between pre- and post-assessment; *clinically significant change; BDDbp-YBOCS: YBOCS adapted for BDD by proxy; SCL-90: Symptom Check List; Follow-up: at 3 months posttreatment.

Based on our clinical experience with Alex and similar patients, we would like to share some reflections on the assessment and treatment of BDD by proxy. Despite being acknowledged as a DSM diagnosis, the clinical picture of this condition has not received much attention in the literature. Although authors tend to emphasize the preoccupation with another person's appearance, in the cases described in the introduction and based on the present case, it can be deduced that these patients are also preoccupied with their *own* appearance. This may even take the form of full-blown BDD (e.g., Bakhla et al., 2012; Josephson & Hollander, 1997) or subclinical appearance concerns. In our patient the latter was manifest in his devotion to sporting in order to keep a fit and lean body, and his insecurity about his appearance during early adolescence. Comorbidity seems to be high in BDD by proxy, with elevated levels of anxiety and depression in untreated patients (Greenberg et al., 2013). Bakhla et al. reported a decrease in depression and own BDD after treatment, and Josephson and Hollander found a decrease in OCD.

Assessment of BDD by proxy could be improved in several ways. In our case only Alex's condition was assessed using global measures for BDD by proxy and general psychopathology, respectively. Based upon this case we would recommend to assess the spouse (or in general, the person that is the object of BDD by proxy) in more detail. An important first step is collecting quantitative data on the other person's appearance concern, emotional consequences, and the quality of the relationship. In addition, it will also be helpful to obtain a case formulation regarding the other person's contribution to the maintenance of the patient's problem (Persaud, 1998). Dysfunctional personality traits have not been formally assessed in our patient, although these might have colored the patient's idiosyncrasies as well as the therapeutic relationship. In particular, narcissistic traits were apparent in Alex—for example, taking pride in his athletic body and boasting about his professional position and immense income. He also showed the inclination to dominate the conversation during sessions. These features were not addressed directly (as is the case in, for instance, schema therapy) during Alex's treatment, but were more subtly incorporated in the therapeutic relationship by accepting the patient's weaknesses and complimenting him on sharing his vulnerabilities.

Despite the lack of treatment literature, departing from a clear case conceptualization and applying potentially effective interventions for BDD, the core pathology diminished substantially and the quality of the couple's

life had improved. As it appeared, the treatment rationale for BDD could easily be translated to BDD by proxy. However, initially Alex's therapist had to deal with his extrinsic motivation for treatment (i.e., saving his marriage), and had to work towards developing a more intrinsic motivation for change, which is very common in BDD patients in general. For that reason Wilhelm et al. (2013) recommend the application of motivational interviewing as a standard component of CBT for BDD. Despite its clinical benefit in other disorders, the contribution of this particular component has not yet been empirically investigated in BDD (by proxy). Furthermore, the content of Alex's treatment consisted of the core interventions described by Wilhelm et al. (2013) and Veale and Neziroglu (2010), namely, challenging dysfunctional thoughts, applying behavioral experiments, and exposure and response prevention. Some of these interventions partly related to the spouse's bodily features, rather than these of the patient himself. Examples are the modification of our patient's selective attention for his wife's alleged problematic body part, and exposure to appear in public with his wife. Furthermore, the present treatment encompassed 13 sessions, which is rather brief, considering the recommendation by Wilhelm et al. (2013) to devote about 22 sessions in order to reach a substantial amount of improvement. They even go as far as stating that 12 sessions may not be sufficient to treat BDD. In our case, favorable circumstances might have been the relatively high level of the patient's professional and (to a lesser extent) social functioning. It has been found that many patients suffering from BDD proper are virtually housebound (Phillips, 2005), which negatively impacts the prognosis.

In retrospect, the addition of pharmacotherapy in the initial stage of Alex's treatment is debatable, as it might have been a too hasty decision inspired by the therapist's wish to obtain a rapid positive response. The decision to prescribe an SSRI was based on the therapist's estimate of the severity of Alex's conviction after the first session, and took place in consultation with a psychiatrist. However, it might have been more parsimonious to have started with CBT and to establish how this would affect the appearance preoccupation. Based on the relatively low dose of Citalopram and the short treatment duration, no substantial effects should be expected, leaving us with the question whether this SSRI has had any effect.

An interesting point in the present treatment is the involvement of Alex's wife, Andrea. The literature on BDD by proxy does not reveal any do's and don'ts in this respect; the scarce information on the phenomenology and treatment only refers to the patients themselves. Since there is no empirical evidence in favor or against offering couple therapy in a case like ours, it was up to the therapist to make a choice. Clinically, it makes sense to involve the person to whom the preoccupation relates, because he or she is the trigger of the preoccupation, as well as a maintaining factor. The question is how the partner should be involved: as a co-therapist, as part of the dysfunctional system, or as someone in need of individual treatment? Discussing the interaction between intimate relationships and psychopathology, one of the approaches advocated by Whisman and Baucom (2012) consists of *disorder-specific interventions*, in which the emphasis is on the domains that are focal to the patient's disorder. Here, the therapist helps the couple to identify ways to alter their relationship in order to overcome the identified patient's psychological problems. Furthermore, although a couple's perspective on BDD by proxy has not been described, lessons may be learned from a similar approach to OCD. Recently, the interpersonal aspects of the latter disorder have been incorporated in a therapeutic approach (Abramowitz et al., 2013). In OCD as well as in BDD by proxy, the partner may get involved in what these authors call "symptom accommodation." They state that "Accommodation occurs when the partner or spouse of someone with OCD participates in their loved one's rituals, facilitates avoidance strategies, assumes daily responsibilities for the sufferer, or helps to resolve problems that have resulted from the patient's obsessional fears and compulsive urges" (p. 4), and that "The accommodation might occur at the request (or demand) of the individual with OCD, who deliberately tries to involve loved ones to help with controlling his or her anxiety. In other instances, loved ones voluntarily accommodate because they feel the need to show care and concern for their suffering partner and do not wish to see them become highly anxious" (p. 4). The authors describe a number of specific interventions, such as partner-assisted exposure and reducing accommodation. Similarities with our case are obvious. The spouse involvement in the interventions was aimed at the BDD by proxy and not at broad relationship distress. In support of the approach described in our case is (a) the temporal relation between the onset of BDD by proxy and the relationship distress, and (b) the improvement and consolidation of marital satisfaction once the BDD by proxy had been decreased. Future research should focus on the issue of partner (and significant others in general) involvement in BDD, OCD, and other by-proxy variants (e.g., health anxiety and factitious disorder).

In conclusion, theoretical and clinical research is needed to further our hitherto fragmentary knowledge concerning this puzzling disorder and its treatment. Despite the favorable outcome reported above, it remains to be determined how representative this case is for patients suffering from BDD by proxy. Apart from that, our case description underscores the potential benefits of CBT for this understudied group of patients.

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