International Journal of Community Medicine and Public Health
Patel D et al. Int J Community Med Public Health. 2026 Feb;13(2):958-961
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040
DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20260323

Case Report

Body dysmorphic disorder by proxy: a case report and literature review

Dhruvin Patel[1], Pranati Gudipati[2], Himani Suthar[3], Rithika Narravula[4], Parinda Parikh[5]*

[1]Government Medical College, Surat, Gujarat, India
[2]Jawaharlal Nehru Medical College, Belgaum, Karnataka, India
[3]GMERS Medical College and Civil Hospital, Gandhinagar, Gujarat, India
[4]University of Pittsburg, PA, USA
[5]2nd ARC Associates, White Plains, USA

Received: 30 November 2025
Revised: 20 January 2026
Accepted: 21 January 2026

***Correspondence:**
Dr. Parinda Parikh,
E-mail: dparikh@2ndarc.com

ABSTRACT

Body dysmorphic disorder (BDD) is a distressing and/or impairing preoccupation with a perceived defect in physical appearance which is minimal or unnoticeable to others. It affects approximately 1.6% to 2.4% of the general population. According to DSM-5, BDD is characterized by significant distress and repetitive behaviour. It is sometimes associated with anxiety, obsessive-compulsive disorder (OCD), depression or impaired functioning. BDD by proxy (BDDBP), an overlooked variant, involves obsessive concern with another individual's appearance rather than one's own. It leads to assurance seeking and attempts to correct the flaws. A 23-year-old man presented with anxiety and depressive symptoms due to his concern regarding his wife's protruding chin. The patient's preoccupation began early in the relationship and intensified over the period. The wife's refusal to pursue corrective measures caused marked distress, anxiety and thoughts of divorce. He underwent a mental status examination and psychiatric evaluation for further analysis. Body dysmorphic disorder (BDD) and body dysmorphic disorder by proxy (BDDBP) are serious but often overlooked mental health issues that can lead to significant emotional distress and impairment in daily life. These disorders can strain relationships, cause obsessive behaviors and severely affect quality of life. Effective treatment usually includes cognitive-behavioral therapy (CBT) and SSRIs, along with education and lifestyle changes.

Keywords: Body dysmorphic disorder, Body dysmorphic disorder by proxy, Case report

INTRODUCTION

Body dysmorphic disorder (BDD) is a distressing and/or impairing preoccupation with a perceived defect in physical appearance. It affects approximately 1.6% to 2.4% of the general population.[1] BDD onset typically occurs during adolescence, which makes it critical to identify vulnerable populations with higher risk factors at a younger age.[2]

The psychiatric evaluation for BDD is commonly proposed to be interview question focused to successfully address all diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V-TR).[3] The DSM-V criteria for BDD includes affected patients experiencing preoccupation with one or more perceived defects/flaws in physical appearance that are not/slightly observable to others, thought of preoccupation causes clinically significant distress, affected patients exhibit repetitive behaviors and an eating disorder does not better explain the thought preoccupation.[3] BDD is known to be highly associated with comorbidities such as anxiety or mood disorders and high risk of burden of disease such as impaired psychosocial functioning or risk of suicide.[2]

BDD by proxy (BDDBP) is a significant and less explored aspect of BDD in which the primary preoccupation involves perceived imperfections of another person who

looks normal to others.[4] BDDBP is not recognized as a unique diagnostic entity in the DSM and is thus characterized as a variant of BDD under the current classification system.[4] It is characterized by intrusive, excessive preoccupation with another person's appearance, leading to behaviors such as excessive scrutiny, comparison and attempts to "fix" perceived flaws. This often results in distress, avoidance of social situations, seeking reassurance and performing rituals such as suggesting cosmetic procedures. For example, a woman who worries excessively about her daughter's "crooked" nose and tries "pushing on it to make it straight".[5]

BDD by proxy results from a combination of issues including environmental, psychological and genetic factors.[6] A person will excessively focus on bodily features such as the nose, acne, complexion, facial wrinkles, hair appearance, thinning, baldness, skin and vein appearance, breast size, muscle size and tone and genitalia. Preoccupation with such thoughts leads to distress and time-consuming fixative behaviour, which affects social life, work, school and other aspects of life.[7] It may also contribute to future difficulties, including low self-esteem, social isolation, suicidal thoughts, eating disorders, substance misuse, skin picking, repeated cosmetic or surgical intervention, as well as obsessive-compulsive disorder (OCD), major depressive disorder (MDD) and anxiety disorders.[8-10]

Prevalence studies on BDDBP are limited and the lack of diagnostic criteria and assessment tools for this condition specifically warrant further research efforts.[4] BDD by proxy is an overlooked aspect of anxiety disorders in which only a few documented cases are reported in the database. We present a case of a 23-year-old male expressing dysmorphic thoughts about his wife's chin.

CASE REPORT

A 23-year-old male presented to the clinic with depressive symptoms and significant anxiety. The patient reported persistent preoccupation regarding his wife's mandibular appearance stating that he "felt his wife had a long, protruding, stubborn chin." The patient expressed that his concerns started in the beginning of his relationship. The patient's wife was previously informed by her orthodontist of her jaw misalignment, which the patient persistently requested her to pursue corrective treatment, but she refused. The wife's refusal elicited severe anxiety and emotional distress associated with the inability to tolerate his wife's physical "defect." The patient reported that this preoccupation led to thoughts of divorce, unless his wife underwent surgical, corrective intervention.

The patient's past medical history was notable for his two surgical interventions regarding his deviated septum during adolescence. His psychosocial history consists of childhood bullying around the age of 10 and sexual abuse by an older brother. The patient reported lack of emotional support and minimal physical affection and/or support by his family. The patient describes his relationship with his parents as "moody" and distant.

On the mental status examination (MSE), the patient exhibits a normal thought process but reports feelings of anxiety and sadness, along with intense episodes of crying. The patient reports no history of nightmares, compulsive behaviors, delusions, hallucinations or manic episodes. A history of alcohol abuse is noted. The patient demonstrates fair insight and judgment, with a mood described as euthymic. Behavior is cooperative, though a flat affect is observed, along with standard motor activity. There are no indications of suicidal or homicidal ideation.

The patient was then initiated on Fluoxetine 20 mg for 3 weeks and has been advised to increase the dose to 40 mg until further notice. Fluoxetine is a selective serotonin reuptake inhibitor (SSRI) that is believed to reduce the obsessive thoughts and compulsive behaviors associated with the condition, also in cases relative to another's appearance.

DISCUSSION

BDD is a serious condition marked by an obsessive focus on a minor or imagined flaw in one's physical appearance, impacting approximately 1.8% to 2.4% of the population.[1] The prevalence of BDD was higher among females (16%, 95% CI 11–21%) than among males (11%, 95% CI 7–16%).[12] A significant variation is BDDBP, where the primary concern revolves around alleged imperfections in someone else who typically appears normal to others.[4]

For instance, Phillips in 2005 described a case involving a woman who obsessively worried about her daughter's "crooked" nose and even attempted to "straighten" it by pushing on it.[5] Additionally, Atiullah and Phillips in 2001 reported on a 63-year-old man who was so distressed by his belief that he had caused his daughter's hair to thin, leading him to take his own life. These case studies highlight the severe distress, impairment and potentially fatal consequences of BDDBP, emphasizing the necessity for empirical research into its characteristics and impact.[11]

Additionally, the prevalence of BDD was greater in patients who underwent plastic surgery (24%, 95% CI 15–33%), followed by psychiatric patients (18%, 95% CI 10–26%) and dermatological patients (16%, 95% CI 9–23%).[12] Body dysmorphic disorder can lead to various complications, including low self-esteem and social isolation.

Individuals may also experience severe mood disorders, anxiety disorders, obsessive-compulsive disorder and eating disorders. Additionally, behaviors associated with BDD include skin picking or repeated surgical interventions that can result in physical health issues and increased risk of disfigurement.[7]

There is limited research regarding the origins of BDD, but it appears to stem from a combination of genetic and environmental influences. Some studies indicate that there are both functional and structural differences in the brain compared with control groups, particularly in areas related to visual and emotional processing. Nevertheless, at this point, it is not possible to draw definite conclusions about the disorder's underlying biological mechanisms.[13] The exact causes of BDDBP are not well understood. Similar to various other mental health disorders, it likely stems from a mix of environmental, psychological and genetic influences. According to Judy Lair, licensed professional clinical counselor (LPCC), the rise of social media in recent years has intensified a harmful preoccupation with specific body features and an obsessive urge to address perceived imperfections, driven by fear of social rejection.[6]

To contextualize our discussion, we present several case reports that illustrate the diverse manifestations of this condition and highlight the clinical challenges it may pose. A 36-year-old lawyer was referred to a clinic for obsessive fixation on his wife's buttocks, deemed "too thin." This preoccupation strained their 15-year marriage, prompting his wife to consider divorce. Initially reluctant to seek help, he agreed to treatment to salvage their relationship. He displayed humor but lacked introspection and pressured his wife for changes. His childhood insecurities led to a diagnosis of body dysmorphic disorder by proxy, with symptoms tracing back to adolescence.[14]

Similarly, a 28-year-old woman with a 10-year history of BDD experienced severe preoccupation with her short stature and perceived facial deformity, leading to significant distress and social withdrawal. After marriage, she became critical of her husband's appearance and feared that their daughter might inherit his perceived ugliness, even contemplating abortion. Her symptoms included frequent checking and seeking reassurance about her and her daughter's appearance. Following treatment with venlafaxine, trifluoperazine, and cognitive-behavioural therapy (CBT), she showed significant improvement in her BDD symptoms and depression scores after 12 weeks, although mild dysmorphic ideas persisted. Overall, her condition was classified as much improved.[15]

Treatment for BDD typically involves a combination of CBT and medications. CBT helps individuals understand the interconnectedness of negative thoughts and behaviors, challenge automatic negative beliefs about body image and encourages healthier coping strategies. It also seeks to reduce rituals such as excessive mirror checking and seeking reassurance. Personalizing the treatment plan and including family members can enhance effectiveness, especially for teenagers. While no specific medications are approved for this disorder, certain antidepressants, particularly SSRIs, have proven effective in managing negative thoughts and compulsive behaviors. In severe cases, hospitalization may be necessary, especially if an individual is unable to manage daily responsibilities or poses a risk to themselves.[7]

BDD requires treatment from a mental health professional, but there are additional steps individuals can take to enhance their treatment plan. It is critical for patients to adhere to their treatment plan by not skipping therapy sessions, even on days when there is reduced willingness to participate. Ongoing medication adherence is crucial, as abrupt continuation can lead to withdrawal and/or resurgence of symptoms. Ensuring individuals are staying informed about their BDD experience can promote increased treatment adherence. Monitoring of potential warning signs and collaborative efforts with healthcare providers are warranted to establish an appropriate management plan in cases of recurrence.

Consistent application of therapeutic strategies outside of sessions can help promote long-term habituation. Furthermore, avoidance of drugs and alcohol is critical, as they have the potential to exacerbate symptoms and interfere with medications. Engaging in physical activity, such as walking, jogging, swimming or gardening, can effectively manage symptoms such as depression and anxiety. However, it is important to remain vigilant to avoid excessive exercise aimed at fixing perceived flaws.[7]

BDD and its variant, BDDBP, involve intense preoccupation with perceived physical flaws, leading to significant emotional distress and relationship challenges. For instance, a 23-year-old man became fixated on his wife's "protruding" jaw, resulting in anxiety and marital conflicts. His history of trauma and bullying likely heightened his sensitivity to appearance concerns. This case illustrates the diverse presentations of BDDBP and the critical need for early, individualized treatment to improve outcomes and support healthy relationships.

CONCLUSION

BDD and BDDBP are serious but often overlooked mental health issues that can lead to significant emotional distress and impairment in daily life. These disorders can strain relationships, cause obsessive behaviors and severely affect quality of life. While their exact causes are unclear, they seem to involve a mix of genetic, psychological and environmental factors. Effective treatment usually includes CBT and SSRIs, along with education and lifestyle changes. Increased research and clinical awareness are essential for improving diagnosis and treatment.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Buhlmann U, Glaesmer H, Mewes R, Fama JM, Wilhelm S, Brähler E, et al. Updates on the prevalence of body dysmorphic disorder: a population-based survey. Psychiatry Res. 2010;178(1):171-5.

2. Drüge M, Rafique G, Jäger A, Watzke B. Prevalence of symptoms of body dysmorphic disorder (BDD) and associated features in Swiss military recruits: a self-report survey. BMC Psychiatry. 2021;21(1):294.
3. Nicewicz HR, Torrico TJ, Boutrouille JF. Body Dysmorphic Disorder. In: StatPearls. Treasure Island (FL): StatPearls Publishing. 2025.
4. Greenberg JL, Mothi SS, Wilhelm S. Cognitive-Behavioral Therapy for Body Dysmorphic Disorder by Proxy. Behav Ther. 2016;47(4):515-26.
5. Phillips KA. The broken mirror: Understanding and treating body dysmorphic disorder. New York, NY: Oxford University Press. 2005.
6. Gal K. Understanding Body Dysmorphic Disorder by Proxy (BDD by Proxy). 2024. Available at: https: //www.treatmyocd.com/blog/body-dysmorphic-disorder-by-proxy. Accessed on 05 November 2025.
7. Nicewicz HR, Torrico TJ, Boutrouille JF. Body Dysmorphic Disorder. In: StatPearls. Treasure Island (FL): StatPearls Publishing. 2025.
8. Eskander N, Limbana T, Khan F. Psychiatric Comorbidities and the Risk of Suicide in Obsessive-Compulsive and Body Dysmorphic Disorder. Cureus. 2020;12(8):e9805.
9. Kang WH, Loo MY, Leong XM, Ooi YF, Teo WQ, Neoh TJ, et al. Body dysmorphic disorder and depression among male undergraduate students in a Malaysian University. Front Psychiatry. 2022;13:977238.
10. Hardardottir H, Hauksdottir A, Bjornsson AS. Body dysmorphic disorder: Symptoms, prevalence, assessment and treatment. Laeknabladid. 2019;105(3):125-31.
11. Atiullah N, Phillips KA. Fatal body dysmorphic disorder by proxy. J Clin Psychiatry. 2001;62:204-5.
12. Pérez-Buenfil A, Morales-Sánchez A. Prevalence of Body Dysmorphic Disorder: A Systematic Review and Meta-Analysis. J Cosmet Dermatol. 2025;24(4):e70121.
13. Rück C, Mataix-Cols D, Feusner JD, Shavitt RG, Veale D, Krebs G, et al. Body dysmorphic disorder. Nature Rev Dis Primers. 2024;10(1):92.
14. Gofers T, Verhagen I, Bouman TK. Bespiegelingen over body dysmorphic disorder by proxy: Some reflections on body dysmorphic disorder by proxy. Tijdschr Psychiatry. 2012;54(6):561-5.
15. Bakhla AK, Prakriti S, Kumar PA. A case of body dysmorphic disorder by proxy. Prim Care Companion CNS Disord. 2012;14(4):PCC.12l01347.

Cite this article as: Patel D, Gudipati P, Suthar H, Narravula R, Parikh P. Body dysmorphic disorder by proxy: a case report and literature review. Int J Community Med Public Health 2026;13:958-61.