Case report

DOI: https://doi.org/10.4038/sljpsyc.v17i1.8651

Want her to be a doll: A case report on body dysmorphic disorder by proxy

M K T Mohanthi, R B Hapuarachchi

Abstract

Body Dysmorphic Disorder by Proxy (BDDBP) is a rare and under-recognised variant of Body Dysmorphic Disorder (BDD), where an individual's preoccupation is focused on perceived flaws in another person's appearance. We describe an 18-year-old male with persistent preoccupation regarding his partner's skin tone and appearance, driven by an idealised image of a "doll-like" female. His attempts to alter her appearance included cosmetic products, skin-whitening injections, and behavioural restrictions, leading to distress and impaired functioning in both. Differential diagnoses such as psychosis, mood, obsessive-compulsive, and autism spectrum disorders were excluded. The phenomenology was consistent with BDDBP. Treatment with sertraline and cognitive-behavioural strategies led to improvement in insight and reduction in controlling behaviour. This case underscores the need for early recognition and a multimodal therapeutic approach to BDDBP.

Keywords: body dysmorphic disorder, proxy, case report, appearance preoccupation

SL J Psychiatry 2026; 17(1): 68-70

Introduction

In body dysmorphic disorder, the patient has a persistent preoccupation with one or more perceived defects or flaws in appearance, or ugliness in general, that is either unnoticeable or only slightly noticeable to others (1). The presentation is characterized by excessive self-consciousness about perceived defects or flaws, accompanied by any of the following:

Repetitive and excessive behaviours, such as repeated examination of the appearance or severity of the perceived defects or flaws or comparison of the relevant features with those of others. Excessive attempts to camouflage or alter the perceived defects or flaws. Marked avoidance of social or other situations or stimuli that increase distress about the perceived defects or flaws. In the cases where an individual is persistently preoccupied with one or more perceived defects or flaws in appearance, or ugliness in general, of another person (generally a child or a romantic partner), it is diagnosed as "Body Dysmorphic Disorder by Proxy" (1).

First described by Greenberg in 1988, BDDBP remains under-researched, with only a few cases reported worldwide (2). Individuals with BDDBP often project internalised insecurities onto others, sometimes enforcing appearance-modifying behaviours that strain relationships and daily functioning. Here we report a rare case of BDDBP in an adolescent male, illustrating the intersection of perfectionism, attachment difficulties, and socio-cultural ideals of beauty.

Case report

An 18-year-old male presented with persistent preoccupations about his partner's physical appearance, focusing on her skin tone, texture, and overall complexion. He desired her to look "flawless, fair, and doll-like." To achieve this, he encouraged her to use various cosmetic products, undergo skin-whitening injections, and adopt specific hairstyles and clothing. He developed and personally administered a daily skincare routine for her, spending considerable time inspecting her face and body for even the smallest blemishes or scars – many of which were barely noticeable to the partner herself. He meticulously counted minor scars and repeatedly applied products aimed at removing them. He imposed behavioural restrictions, such as prohibiting her from outdoor activities to avoid tanning, discontinuing her office work due to concerns that computer use causing dark circles around eyes, and

insisting she wear gloves while cooking to prevent roughness or discolouration of her hands.

These behaviours caused significant distress and functional impairment in both individuals. His partner experienced anxiety, reduced autonomy, and social withdrawal, while he reported distress when his appearance standards were not met.

Psychosocial history revealed emotional neglect, rejection and bullying during childhood, with comments directed at his darker skin. During adolescence, he developed a marked preference for solitary activities, spending long hours watching animated shows featuring idealised, doll-like female characters. This pattern appeared to emerge partly from boredom and limited emotional engagement within the family, following experiences of social rejection and low self-esteem. There was no history suggestive of psychosis, obsessive-compulsive symptoms, mood episodes, or developmental disorders.

Differential diagnoses considered included autism spectrum disorder, fetishism, obsessive compulsive disorder; however, these did not fully account for the presentation. The clinical picture aligned with BDDBP.
The patient engaged well with outpatient psychiatric care. Considering the severity of symptoms and the impact on their functional level, pharmacotherapy was initiated. Sertraline was commenced and gradually uptitrated to 75 mg daily. Psychotherapeutic management involved psychoeducation and engagement of both the patient and his partner, cognitive restructuring of dysfunctional appearance-related beliefs, and behavioural experiments and modifications aimed at reducing controlling and avoidance behaviours. Both were counselled to avoid engagement in unnecessary or harmful cosmetic procedures intended to enhance skin appearance. The partner was encouraged to adopt a more assertive stance, including learning strategies to set boundaries and avoid reinforcing the patient's maladaptive behaviours. Over six months, he demonstrated gradual improvement in insight and a marked reduction in preoccupation and controlling behaviours, with restoration of healthier interpersonal dynamics and overall functioning.

Discussion

BDDBP is conceptualised as a variant of BDD, differing mainly in the locus of preoccupation – another person rather than oneself. Though phenomenologically similar, the motivational and relational dynamics in BDDBP introduce unique clinical challenges.

Phenomenology and psychodynamics

Our patient's presentation suggests projection of self-critical body image onto his partner. Early experiences of neglect, rejection, bullying, and low self-esteem may have fostered a compensatory desire for external perfection. His focus on achieving a "doll-like" ideal reflects internalised aesthetic standards influenced by media and cultural glorification of fair skin and flawless features – particularly salient in South Asian contexts.

Differential diagnosis

A detailed differential diagnostic assessment was undertaken, including collateral information from the patient't's parents.

Autism spectrum disorder: Developmental history and collateral reports revealed no early childhood deficits in social reciprocity, communication, or restricted stereotyped interests suggestive of autism.

Fetishism: Considered due to his marked preoccupation with his partner's appearance and efforts to make her look and dress like a doll; however, there was no associated sexual gratification or paraphilic drive.

Personality disorders: His behaviour did not reflect pervasive traits of manipulation, entitlement, or identity disturbance, and symptoms were situationally bound to appearance-related preoccupations.

Obsessive-compulsive disorder (OCD): Although repetitive checking and grooming behaviours were noted, they were focused on another person's appearance rather than intrusive, self-directed obsessions.

Management

Evidence-based treatment for BDDBP is limited, but therapeutic strategies mirror those effective in BDD: Pharmacotherapy: SSRIs, particularly fluoxetine and sertraline, reduce preoccupation, anxiety and associated depressive symtoms (3,4).

Cognitive-behavioural therapy (CBT): CBT remains the first-line psychological intervention, focusing on cognitive restructuring of distorted appearance-related beliefs, exposure to avoided situations, and response prevention to reduce reassurance-seeking behaviours (5,6).

Family and Partner Involvement: Psychoeducation and involvement of close others improve understanding of the illness, reduce interpersonal strain, and prevent reinforcement of maladaptive behaviours (7).

In our case, a combined pharmacological and psycho-therapeutic approach led to substantial improvement, consistent with prior reports on BDD management.

Conclusion

This case highlights the complexity of BDDBP; a condition that can profoundly affect both the patient and the proxy, and one that is often concealed behind a façade of care and aesthetic concern. Early detection, comprehensive assessment, and a collaborative treatment approach are essential for functional recovery. Increased clinical awareness can prevent misdiagnosis and unnecessary cosmetic interventions.

Declaration of interest

There are no conflicts of interest

M K T Mohanthi, Registrar in Psychiatry, University Psychiatry Unit, Colombo South Teaching Hospital, Sri Lanka

R B Hapuarachchi, Senior Lecturer, Faculty of Medical Sciences, University of Sri Jayewardenepura, Sri Lanka

Corresponding author: M K T Mohanthi

E-mail: tashimigunthanna@gmail.com

References

1. World Health Organization. International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision). Geneva: World Health Organization; 2019. Available from: https://icd.who.int/
2. Greenberg JL. Body dysmorphic disorder by proxy. Psychosomatics. 1988; 29(1): 45-9.
3. Phillips KA, Albertini RS, Rasmussen SA. A randomized placebo-controlled trial of fluoxetine in body dysmorphic disorder. Arch Gen Psychiatry. 2002; 59(4): 381-8.
4. Hollander E, Allen A, Kwon J, Aronowitz B, Schmeidler J, Wong C, et al. Clomipramine vs desipramine crossover trial in body dysmorphic disorder: selective efficacy of a serotonin reuptake inhibitor in imagined ugliness. Arch Gen Psychiatry. 1999; 56(11): 1033-39.
5. Veale D, Gledhill LJ, Christodoulou P, Hodsoll J. Body dysmorphic disorder: a cognitive behavioural model and pilot randomised controlled trial. Behav Res Ther. 2016; 86: 94-106.
6. Wilhelm S, Phillips KA, Steketee G. Cognitive-Behavioral Therapy for Body Dysmorphic Disorder: A Treatment Manual. New York: Guilford Press; 2013.
7. Veale D, Neziroglu F. Body Dysmorphic Disorder: A Treatment Manual. Chichester: Wiley-Blackwell; 2010.