BRAIN. Broad Research in Artificial Intelligence and Neuroscience
e-ISSN: 2067-3957 | p-ISSN: 2068-0473
Covered in: Web of Science (ESCI); EBSCO; JERIH PLUS (hkdir.no); IndexCopernicus; Google Scholar; SHERPA/RoMEO; ArticleReach Direct; WorldCat; CrossRef; Peeref; Bridge of Knowledge (mostwiedzy.pl); abcdindex.com; Editage; Ingenta Connect Publication; OALib; scite.ai; Scholar9; Scientific and Technical Information Portal; FID Move; ADVANCED SCIENCES INDEX (European Science Evaluation Centre, neredataltics.org); ivySCI; exaly.com; Journal Selector Tool (letpub.com); Citefactor.org; fatcat!; ZDB catalogue; Catalogue SUDOC (abes.fr); OpenAlex; Wikidata; The ISSN Portal; Socolar; KVK-Volltitel (kit.edu)
2026, Volume 17, Issue 2, pages: 458-469
Submitted: December 30th, 2025 | *Accepted for publication:* April 21st, 2026

Problematic Aesthetic Procedure Seeking Behaviour: A Review of Body Dysmorphic Symptoms, Emotional Regulation, and Compulsive Patterns

Adriana Olaru
Department of Psychiatry, Socola Institute of Psychiatry, Iasi, Romania; Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania.
adriana23olaru@gmail.com

Alexandra Boloș
Department of Psychiatry, Socola Institute of Psychiatry, Iasi, Romania; Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania.
alex_andra_bolos@yahoo.com,
https://orcid.org/0009-0007-1247-0383

George Cătălin Moroșan
Department of Psychiatry, Socola Institute of Psychiatry, Iasi, Romania; Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania.
morosangeorgecatalin@yahoo.com,
https://orcid.org/0009-0002-4025-3304

Andreea-Cătălina Moroșan
Department of Psychiatry, Socola Institute of Psychiatry, Iasi, Romania; Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania.
andreeearus@yahoo.com,
https://orcid.org/0009-0001-7794-9842

Florin Ștefan Olaru
Department of Plastic Surgery, Galati County Emergency Clinical Hospital, Galati, Romania

Marius Cocu
Doctoral School, Dunarea de Jos University of Galati, Galati, Romania. https://orcid.org/0009-0009-5322-8539

Abstract: *The exponential growth of the aesthetic medical industry has precipitated a parallel increase in patients presenting with problematic cosmetic procedure seeking (PCPS). While aesthetic interventions generally yield high satisfaction rates for the normative population, a discernible subset of patients engages in a relentless, maladaptive pursuit of physical alteration. This narrative review synthesises current literature to examine the triadic relationship between body dysmorphic symptoms, emotion dysregulation, and compulsive behavioural patterns in the context of PCPS. We explore how perceived physical defects are often somatic manifestations of underlying affective distress; wherein cosmetic interventions are erroneously utilised as an externalising coping mechanism for internal emotional dysregulation. Furthermore, we conceptualise repeated procedure seeking through the lens of the obsessive-compulsive spectrum, highlighting the transient nature of postoperative relief and the cyclical escalation of interventions. By delineating these psychological underpinnings, this review underscores the critical need for integrated psychiatric screening within aesthetic practice and advocates for a paradigm shift from purely surgical or dermatological solutions towards comprehensive, multidisciplinary patient care.*

Keywords: *problematic cosmetic procedure seeking; body dysmorphic disorder; emotion dysregulation; compulsive behavioural patterns; aesthetic psychiatry; psychiatric screening; neurobiology; body image perception; cosmetic surgery addiction; psycho-aesthetic model.*

How to cite: Olaru, A., Boloș, A., Moroșan, G.-C., Moroșan, A.-C., Olaru, F. Ș., Cocu, M., Nedelcu, C., Chirică, V. A., Olaru, I., & Szalontay, S. A. (2026). *Problematic aesthetic procedure seeking behaviour: A review of body dysmorphic symptoms, emotional regulation, and compulsive patterns*. BRAIN. Broad Research in Artificial Intelligence and Neuroscience, 17(2), 458-469. https://doi.org/10.70594/brain/17.2/29

Cristina Nedelcu
Department of Psychiatry, Socola Institute of Psychiatry, Iasi, Romania. celenanedelcu@gmail.com

Valeriu Aurelian Chirică
Department of Preventive Medicine and Interdisciplinarity, Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania. https://orcid.org/0009-0000-3958-1090

Iulia Olaru*
Department of Plastic Surgery, Galati County Emergency Clinical Hospital, Galati, Romania; Faculty of Medicine, Dunarea de Jos University of Galati, Galati, Romania. iulia_dabija@yahoo.com, https://orcid.org/0009-0005-5673-7639

Silvana Andreea Szalontay
Department of Psychiatry, Socola Institute of Psychiatry, Iasi, Romania; Grigore T. Popa University of Medicine and Pharmacy, Iasi, Romania. https://orcid.org/0000-0002-9272-1379

* *Corresponding author*

©2026 Published by EduSoft Publishing. This is an open-access article under the CC BY-NC-ND license

1. Introduction

The contemporary democratisation of aesthetic medicine has fundamentally altered the landscape of cosmetic interventions. Propelled by rapid advancements in minimally invasive techniques coupled with the pervasive and normative influence of digital media, global demand for aesthetic procedures has grown exponentially. For the vast majority of individuals, these interventions yield high satisfaction rates, objectively enhancing psychosocial functioning, self-esteem, and subjective well-being. However, clinical observation and emerging psychiatric literature increasingly point towards a distinct, highly vulnerable cohort of patients for whom cosmetic interventions do not resolve aesthetic distress. Instead, for these individuals, a single procedure frequently acts as a catalyst, perpetuating a chronic cycle of profound dissatisfaction and repeated procedure seeking (Mulkens et al., 2012).

Colloquially referred to in popular culture as “plastic surgery addiction,” this clinical phenomenon is better conceptualised within academic psychiatry as Problematic Cosmetic Procedure Seeking (PCPS) (Suissa, 2008; Grant et al., 2010). PCPS is not yet codified as an independent diagnostic entity in the DSM-5 or ICD-11; rather, it represents a complex behavioural manifestation characterised by the persistent, distress-driven pursuit of aesthetic alteration. Crucially, this pursuit continues despite objective medical risks, diminishing aesthetic returns, subjective dissatisfaction with previous outcomes, or direct contraindications from medical professionals (Bouman et al., 2017).

Understanding the aetiology of PCPS requires a paradigm shift: practitioners must look beyond the superficial articulation of a patient’s desire for aesthetic enhancement and examine the underlying cognitive and emotional architecture. The literature suggests that the unrelenting drive for surgical or dermatological intervention is rarely rooted in objective physical disfigurement. Instead, it is frequently underpinned by Body Dysmorphic Disorder (BDD) symptomatology. Epidemiological data highlight a stark contrast in prevalence: while BDD affects approximately 1.7% to 2.4% of the general community, its prevalence soars to between 14% and 21% among populations actively seeking cosmetic dermatology or rhinoplasty, respectively (Bouman et al., 2017; Conrado et al., 2010).

Furthermore, the compulsion to alter one’s physical appearance is increasingly understood as a somatised manifestation of profound emotion dysregulation. Recent psychological investigations indicate that patients grappling with high dysmorphic concerns often exhibit severe deficits in emotional regulation and heightened states of hopelessness (Boullion et al., 2021). In this context, the physical body becomes a canvas upon which internal psychological chaos is projected. The aesthetic intervention is thus erroneously used as an externalising, maladaptive coping mechanism aimed at modulating intolerable affective states, such as shame, social anxiety, or trauma-related distress (Fang & Wilhelm, 2015).

Consequently, the cyclical escalation of procedure seeking behaviour mirrors the obsessive-compulsive spectrum and behavioural addiction models. The perceived physical defect functions as the obsession, while the attainment of cosmetic surgery serves as the compulsive ritual. Unfortunately, surgical alteration rarely treats psychiatric pathology. Procedures typically provide only transient, unsustainable relief before the fundamental psychological distress resurfaces or shifts to a new anatomical site (Phillips et al., 2001).

Therefore, this narrative review aims to critically examine the current psychiatric and dermatological literature surrounding PCPS. By deconstructing this phenomenon into a triadic interplay of body dysmorphic symptomatology, emotion dysregulation, and compulsive behavioural patterns, this paper argues for the urgent integration of robust psychometric screening within aesthetic practice. Recognising these insidious psychological mechanisms is not merely an academic exercise but a clinical imperative to prevent iatrogenic harm and to safeguard a deeply vulnerable patient population.

June 2026
Volume 17, Issue 2

2. Materials and Methods

As a narrative review, this paper synthesises current theoretical frameworks and empirical data to demonstrate not only the complex psychopathology driving PCPS, but also to highlight how simple, easily administered, and cost-effective standardised screening methods can reveal crucial psychological insights and effectively mitigate iatrogenic risks in daily aesthetic practice. The literature search was conducted using PubMed, Scopus, and Google Scholar databases between January 2000 and March 2026. Search strategies combined Medical Subject Headings (MeSH) and free-text keywords related to cosmetic procedures, body dysmorphic disorder, emotion regulation, compulsive behaviours, and aesthetic medicine. The initial search identified 312 records. Following duplicate removal and title and abstract screening, 86 articles were assessed for eligibility, with 44 publications ultimately included in the final narrative synthesis. The study selection process followed a structured review approach inspired by PRISMA recommendations, adapted for the purposes of a narrative review. To achieve this, the search syntax was constructed using a combination of Medical Subject Headings (MeSH) and free-text keywords, organised into three primary conceptual domains: aesthetic and cosmetic procedures (e.g., “cosmetic surgery,” “dermatological surgery”), psychopathology (e.g., “body dysmorphic disorder,” “body image dissatisfaction”), and emotion or behavioural patterns (e.g., “emotion regulation,” “behavioural addiction”). These domains were combined using the Boolean operator “AND” to isolate literature specifically residing at the intersection of aesthetic intervention and psychological vulnerability. Furthermore, the reference lists of highly relevant articles and previous reviews were manually searched to identify any seminal publications not captured by the initial database queries.

To ensure the rigour and relevance of the synthesised data, inclusion and exclusion criteria were established *a priori* to capture a comprehensive clinical and theoretical perspective. Eligible literature included peer-reviewed original research (cross-sectional and longitudinal studies), systematic reviews, and foundational clinical overviews published in English. The primary inclusion criterion was that the articles had to explore the theoretical, clinical, or empirical links between aesthetic interventions and psychological constructs, specifically body dysmorphia, emotion dysregulation, or compulsive behaviours. Importantly, inclusion was not restricted exclusively to empirical studies utilising standardised psychometric measurements. Theoretical frameworks and psychiatric reviews were purposefully included to construct a robust conceptual model of PCPS.

Conversely, non-peer-reviewed literature, opinion pieces, and isolated case reports lacking generalisable clinical data were excluded. Surgical or dermatological technique papers reporting solely on physical outcomes without any psychosocial or behavioural discussion were also omitted. Finally, studies focusing exclusively on reconstructive surgery (e.g., post-oncological reconstruction, severe congenital anomalies, or gender affirming surgeries) were excluded, as the psychological motivations and affective baseline in these cohorts fundamentally differ from those driving purely elective aesthetic alterations.

3. Body Dysmorphic Symptomatology in the Aesthetic Patient: Beyond Normative Body Dissatisfaction

3.1. The Blurring Threshold of Normativity

In contemporary society, mild to moderate body dissatisfaction has become statistically normative, frequently driving the initial consultation in an aesthetic clinic. However, the critical distinction between a normative desire for aesthetic optimisation and pathological preoccupation is often blurred in clinical practice (Sarwer & Polonsky, 2016). For patients with PCPS, the motivation is rarely rooted in a healthy desire for enhancement but rather in the debilitating symptomatology of BDD.

BDD is defined by an intense, time-consuming preoccupation with a slight or entirely imagined defect in physical appearance, accompanied by repetitive behaviours (e.g., mirror

checking, reassurance seeking) and significant psychosocial impairment (Phillips, 2005). Systematic reviews indicate that while the prevalence of BDD in the general population hovers around 2%, its prevalence in cosmetic surgery and dermatological settings is strikingly amplified, ranging from 13% to 20% (Veale et al., 2016; Higgins & Wysong, 2018). This disproportionate concentration dictates that aesthetic practitioners are frequently operating on a psychiatrically vulnerable demographic.

3.2. Neurocognitive Architecture of Dysmorphia

To comprehend the futility of treating PCPS with aesthetic interventions, it is necessary to examine the neurobiological mechanisms underlying dysmorphic symptomatology. The patient's relentless pursuit of physical correction is not a product of vanity but a manifestation of profoundly altered visual and cognitive processing.

Functional magnetic resonance imaging (fMRI) and neuropsychological studies have demonstrated that individuals with BDD exhibit distinct abnormalities in visual processing. Specifically, these patients demonstrate a bias towards local, detail-oriented processing over holistic, gestalt perception (Feusner et al., 2010). When observing a face, the BDD-afflicted brain exhibits hyperactivity in the left hemisphere and aberrant connectivity in the visual cortex, leading the patient to fixate exclusively on minor, isolated features, such as a single pore, slight asymmetry, or a specific cutaneous lesion, while failing to integrate these details into a cohesive overall appearance (Feusner et al., 2007; Rück et al., 2024). Consequently, when these patients demand surgical or dermatological correction, they are asking the practitioner to fix a neuroperceptual distortion rather than an anatomical reality. More recent neuroimaging investigations have further expanded this model by demonstrating abnormalities not only in visual processing pathways but also in neural networks involved in salience attribution, emotion regulation, and self-referential processing. Contemporary functional MRI studies suggest that patients with BDD exhibit dysfunctional connectivity between frontostriatal circuits, the amygdala, and visual association cortices, contributing to the excessive emotional significance assigned to minor perceived defects. Emerging evidence from electroencephalographic and connectivity-based research additionally supports the hypothesis that BDD is characterised by altered integration of perceptual and affective information, reinforcing distorted body image representations and maladaptive self-focused attention (Rück et al., 2024; Kaleeny & Janis, 2024).

To fully comprehend this perceptual dichotomy, it is useful to visualise the dynamics of a routine aesthetic consultation. While the physician evaluates the patient's facial structure from a macroscopic perspective, assessing overall proportions, harmony, and symmetry according to anatomical standards, the patient experiences a fundamentally divergent visual reality. Driven by hyperactivity in the left hemisphere and aberrant connectivity within the visual processing networks, the patient is virtually blind to their holistic image (Deshpande, 2014; Feusner et al., 2010). Instead, they exhibit a profound deficit in global organisational processing, approaching the mirror only to obsessively isolate a singular, minor feature (Feusner et al., 2007; Feusner et al., 2011). This localised, detail-oriented bias amplifies the perceived flaw until it entirely monopolises their self-perception (Gorven, 2026). Thus, the patient's request for surgical intervention is not an aesthetic caprice but a desperate attempt to surgically correct a neurobiological error in visual processing, a task that a scalpel or syringe is inherently incapable of accomplishing (Deshpande, 2014).

3.3. The Fallacy of Surgical Efficacy in BDD

The intersection of altered visual processing and cosmetic surgery yields predictably catastrophic outcomes. A robust body of psychiatric literature unequivocally demonstrates that aesthetic procedures are ineffective, and often detrimental, for patients harbouring dysmorphic symptoms.

Retrospective analyses and longitudinal outcome studies reveal that only a negligible fraction of BDD patients report long-term improvement in their symptoms following a cosmetic intervention (Crerand et al., 2006). More frequently, the clinical trajectory follows one of three maladaptive pathways. First, the patient may experience immediate, profound dissatisfaction with the procedure, insisting that the "defect" was worsened by the practitioner. Second, the patient may experience transient relief, only for the intense preoccupation to shift to an entirely different anatomical site, a phenomenon recognised as "symptom substitution" (Laughter et al., 2023). Third, the failure of the surgical intervention to resolve the underlying internal distress can precipitate a severe exacerbation of comorbid psychiatric conditions, notably major depressive disorder and suicidal ideation (Phillips & Menard, 2006).

Therefore, treating a patient with unrecognised BDD symptoms not only violates the core medical tenet of *primum non nocere* but also places the aesthetic practitioner at significant legal and physical risk. Research indicates an alarming rate of hostility, threats, and even violence directed towards surgeons by dysmorphic patients following perceived surgical failures (Pavan et al., 2008). In this paradigm, PCPS must be recognised not as an indication for further aesthetic refinement but as a rigid contraindication requiring immediate psychiatric triage.

4. Aesthetic Alteration as a Maladaptive Emotion Regulation Strategy

4.1. The Conceptual Framework of Emotion Dysregulation

While body dysmorphic symptomatology accounts for the perceptual distortions seen in PCPS, it does not fully explain the intense affective drive that compels patients to undergo repeated, invasive interventions. To deconstruct this drive, PCPS must be evaluated through the lens of emotion regulation.

Emotion regulation, as delineated in foundational psychological models, encompasses the intrinsic and extrinsic processes by which individuals monitor, evaluate, and modify their emotional reactions to achieve homeostasis (Gross, 2015). In the context of psychopathology, profound deficits in these regulatory mechanisms, termed emotion dysregulation, force individuals to heavily rely on maladaptive coping strategies to navigate daily stressors (Aldao et al., 2010). For the problematic aesthetic patient, emerging literature suggests that the physical body becomes the primary vehicle for processing and externalising these intolerable affective states.

4.2. Somatization and the Illusion of Agency

When internal emotional distress, such as profound shame, chronic interpersonal anxiety, low self-worth, or unresolved trauma, surpasses an individual's psychological tolerance threshold, these nebulous feelings are frequently somatised. The distress is subconsciously projected away from the fragile ego and localised onto a tangible, perceived physical defect (Honigman et al., 2004).

This externalisation provides a powerful, albeit pathological, cognitive anchor. By attributing generalised psychosocial misery to a specific anatomical feature (e.g., operating under the core belief: "I am unhappy and socially isolated solely because of my ageing skin or asymmetric facial structure"), the patient effectively transforms an insurmountable emotional deficit into a concrete, medically correctable problem. The pursuit of cosmetic alteration functions less as a desire for beauty and more as a desperate emotion regulation strategy. Longitudinal psychological profiling reveals that patients with high baseline distress seek aesthetic interventions as a means to assert control and agency over their internal chaos (von Soest et al., 2012). The structured environment of the aesthetic clinic, the procedural planning, and the financial investment all serve to temporarily bind the patient's free-floating anxiety, offering the illusion of a definitive, surgical "cure" for psychological pain.

This psychological defence mechanism is remarkably effective in the short term because it transmutes amorphous, overwhelming emotional trauma into a tangible issue with clearly delineated

physical boundaries. The human psyche struggles profoundly to tolerate internal, abstract distress for which solutions remain uncertain and demand sustained emotional effort. By externalising this suffering onto a perceived physical defect, the patient is instantly provided with a concrete roadmap towards "healing" (Hampel, 2018; Honigman et al., 2004). The hyper-structured clinical environment in which these procedures occur acts as a temporary psychological sedative. The rigid sequence of appointments, preoperative assessments, the sterile environment, and the meticulous planning of the surgery provide the patient with a comforting, albeit false, sense of predictability and control (Sansone & Sansone, 2007). For an individual whose internal emotional landscape is defined by chaos and a profound lack of agency, this Faustian illusion of a definitive, calculable medical cure becomes irresistible, effectively explaining why the surgical intervention itself evolves into their primary coping mechanism (Frasier et al., 2026; Suissa, 2008).

4.3. The Transience of Surgical Relief

The clinical paradox of PCPS lies in the physiological reality that altering tissue cannot repair an intrinsic affective deficit. While cosmetic procedures are highly effective in modifying anatomy, they are blunt and entirely ineffective instruments for treating emotion dysregulation.

Following an intervention, patients often experience a transient psychological "honeymoon phase". This brief period of relief is rarely due to the aesthetic outcome itself but rather stems from the intense distraction of the physical recovery process, the placebo effect of having taken decisive action, and the temporary psychological scaffolding provided by the attentive medical staff (Sarwer et al., 2005). However, as the acute postoperative phase wanes and the new physical appearance normalises, the fundamental emotion dysregulation inevitably re-emerges.

Because the maladaptive coping mechanism (the surgery) has been exhausted without addressing the root affective pathology, the patient experiences a severe emotional relapse. They are left psychologically exactly where they began, yet physically altered, and often financially depleted (Sansone & Sansone, 2007). This predictable failure to achieve sustained emotional homeostasis through external modification is the catalyst that drives the patient back to the practitioner, transitioning the behaviour from a singular coping attempt into a chronic, compulsive trajectory.

5. The Compulsive Trajectory: PCPS as a Behavioural Loop

5.1. The Obsessive-Compulsive Paradigm and Collaborative Rituals

The recurrent nature of PCPS cannot be fully articulated without positioning it within the obsessive-compulsive spectrum. In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), BDD was explicitly reclassified into the "Obsessive-Compulsive and Related Disorders" category, acknowledging the profound phenomenological overlap between these conditions (Ravindran et al., 2009).

Within this framework, the patient's perceived aesthetic defect operates as the intrusive obsession, generating severe ego-dystonic anxiety. To neutralise this anxiety, the individual must engage in compulsive behaviours. While typical BDD compulsions are self-executed (e.g., compulsive mirror checking, dermatillomania/skin picking, or excessive camouflaging with makeup), the pursuit of cosmetic surgery represents a uniquely complex, "collaborative compulsion" (Prazeres et al., 2013). It is a macro-ritual that requires the active participation and facilitation of a licensed medical professional. By performing the surgery or administering the injectable, the aesthetic practitioner inadvertently validates the somatic obsession and participates in the execution of the compulsive act, thereby reinforcing the pathological cycle rather than dismantling it.

5.2. PCPS as a Behavioural Addiction

Beyond the obsessive-compulsive model, emerging psychiatric discourse increasingly evaluates PCPS through the paradigm of behavioural addiction. Historically termed "plastic surgery

addiction", this phenomenon meets several core criteria of addictive disorders, including salience, mood modification, tolerance, and withdrawal (Grant et al., 2010).

For the problematic aesthetic patient, the pursuit of procedures becomes the salient, organising principle of their life, often eclipsing occupational and social functioning. The "mood modification" occurs during the consultation and acute postoperative phase, providing a transient neurochemical reward, a dopamine-driven relief from the baseline affective dysregulation discussed previously. However, much like substance dependence, patients exhibit "tolerance" (Suissa, 2008). Over time, minor non-invasive interventions fail to deliver the requisite psychological relief, driving the patient to seek increasingly invasive, multiple, or anatomically extreme surgical procedures.

Furthermore, a form of psychological "withdrawal" is frequently observed when these patients are denied further interventions by ethical practitioners. This denial does not lead to acceptance but rather precipitates severe depressive episodes, acute anxiety, and intense "doctor-shopping" behaviour, wherein the patient sequentially navigates through clinics until they locate a practitioner willing to perform the requested procedure (Kaleeny & Janis, 2024).

5.3. Escalation and Iatrogenic Consequences

The culmination of this compulsive-addictive trajectory is severe iatrogenic harm. Driven by an insatiable psychological need rather than an objective aesthetic goal, the patient progressively accumulates surgical alterations. Because the underlying dysmorphia dictates that the outcome is never "perfect", the patient frequently demands revisions on previously operated areas, severely compromising tissue viability and leading to genuine, objective disfigurement (Crerand et al., 2009).

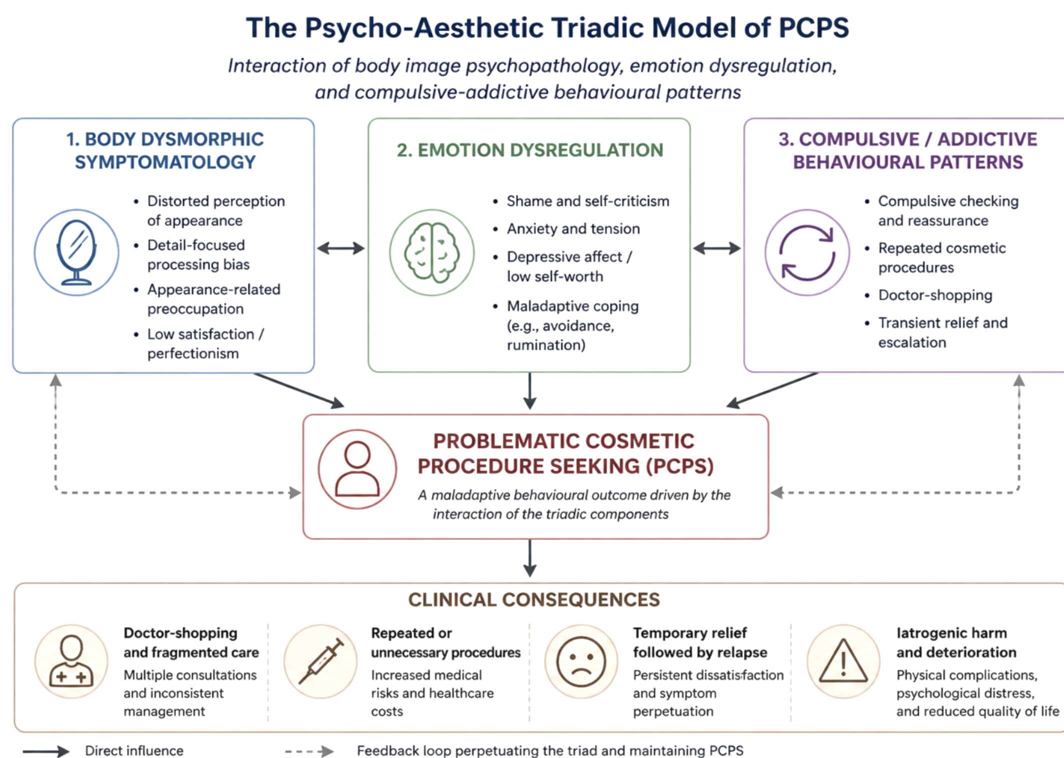

Figure 1. Conceptual representation of the proposed Psycho-Aesthetic Triadic Model underlying Problematic Cosmetic Procedure Seeking (PCPS), illustrating the interaction between body dysmorphic symptomatology, emotion dysregulation, and compulsive-addictive behavioural patterns and their clinical consequences

In this late stage of the PCPS loop, the boundary between cosmetic enhancement and self-mutilation becomes dangerously indistinct (Sansone & Sansone, 2007). The patient is trapped in an escalating cycle of diminishing aesthetic returns and compounding physical risks. Consequently, treating this cohort with aesthetic interventions fundamentally violates medical ethics, as it exploits a psychiatric vulnerability under the guise of elective self-improvement,

ultimately deepening the patient's psychological pathology and physical morbidity (as shown in Figure 1).

6. Clinical Implications and Future Directions: Towards a Psycho-Aesthetic Paradigm

6.1. The Empirical Mandate for Standardized Screening

The synthesis of body dysmorphic symptomatology, emotion dysregulation, and compulsive behavioural loops unequivocally demonstrates that PCPS is fundamentally a psychiatric presentation masquerading as an aesthetic request. Consequently, the reliance on a practitioner's "gut feeling" or unstructured clinical intuition to identify at-risk patients is entirely insufficient and empirically flawed (Sarwer, 2019).

The primary clinical implication derived from this review is the absolute necessity of integrating standardised psychometric screening into routine aesthetic practice. Brief, validated instruments, such as the Cosmetic Procedure Screening Questionnaire (COPS) or the Body Dysmorphic Disorder Questionnaire (BDDQ), must become as routine as taking a patient's medical history or evaluating blood coagulation profiles prior to surgery (Veale et al., 2012). By proactively identifying perceptual distortions and elevated affective distress, practitioners can preemptively disrupt the compulsive loop before surgical intervention occurs.

Transitioning towards this proactive clinical practice does not necessitate a massive restructuring of the clinic's operational flow but rather a strategic shift in patient management. It is crucial to emphasise how highly cost-effective, concise, and accessible these psychometric evaluation tools genuinely are (Yurtsever et al., 2021). Implementing a brief self-report measure, such as the COPS or BDDQ, in the waiting room, distributed alongside standard consent forms and medical history questionnaires, consumes merely minutes of the patient's time and incurs no additional financial burden on the practice (Veale et al., 2012; Yurtsever et al., 2021). Despite their logistical simplicity, these instruments possess the capacity to reveal an extraordinary amount of hidden data regarding the patient's cognitive architecture and psychological impairment (Gorven, 2026). They function as a highly efficient early warning system, providing the practitioner with an immediate snapshot of affective vulnerabilities and perceptual distortions, thereby preventing disastrous surgical interventions before they are even scheduled (Veale et al., 2012).

The fundamental differences between the conventional aesthetic approach and the proposed Psycho-Aesthetic paradigm are synthesised in ***Table 1***, highlighting the clinical and methodological superiority of the latter.

Table 1. Comparative Analysis of Traditional Aesthetic Approaches versus the Proposed Psycho-Aesthetic Paradigm

Clinical Dimension	Traditional Aesthetic Paradigm	Proposed Psycho-Aesthetic Paradigm
Risk Identification	Reliance on unstructured clinical intuition or "gut feeling".	Integration of standardised psychometric screening (e.g., COPS, BDDQ).
Operational Efficiency	High risk of iatrogenic harm and escalating physical morbidity.	Cost-effective, brief, and easily administrable screening tools.
Intervention Target	Anatomical correction of perceived physical defects.	Modulation of neuro-perceptual distortions and affective distress.
Coping Strategy	Maladaptive externalisation via surgical rituals.	Development of internal emotional regulation and cognitive opening.
Patient Trajectory	Compulsive escalation and chronic "doctor-shopping" behaviour.	Interdisciplinary triage and collaborative models.

6.2. Interdisciplinary Triage and the Management of Refusal

When screening indicates a high probability of PCPS, the clinical pathway must shift from aesthetic execution to interdisciplinary triage. The aesthetic practitioner is not expected to act as a psychiatrist. However, they possess an ethical obligation to act as a critical gatekeeper.

Managing the refusal of cosmetic interventions for these vulnerable patients requires immense clinical tact, as abrupt dismissal frequently triggers acute psychological withdrawal, hostility, and the aforementioned “doctor-shopping” behaviour (Bascarane et al., 2021). The refusal must be reframed not as a rejection of the patient but as a medical contraindication. Aesthetic clinics must cultivate robust referral networks with mental health professionals, establishing a “Psycho-Aesthetic” collaborative care model. In this model, psychiatric consultation is presented to the patient as a prerequisite for ensuring long-term surgical satisfaction rather than a punitive measure for presumed “insanity” (Kaleeny & Janis, 2024). From an ethical and medicolegal perspective, practitioners must carefully balance respect for patient autonomy with the principle of non-maleficence. Thorough documentation of psychiatric concerns, informed refusal of procedures, and appropriate referral pathways may additionally reduce medico-legal vulnerability in cases involving severe dysmorphic symptomatology or unrealistic procedural expectations.

6.3. Future Directions in Translational Research

While the conceptualisation of PCPS as a triadic intersection of dysmorphia, emotion dysregulation, and compulsivity offers a robust theoretical framework, significant gaps in empirical research remain. Future investigations must prioritise longitudinal, prospective cohort studies that track the psychological trajectories of two distinct groups: at-risk patients who are ethically denied aesthetic procedures versus those who manage to receive them. Such data are crucial to definitively quantify the iatrogenic harm of operating on dysmorphic patients.

Furthermore, there is a critical need for the development and validation of targeted psychotherapeutic interventions specifically adapted for the aesthetic clinic environment. While standard Cognitive Behavioural Therapy (CBT) is highly effective for classic BDD (Wilhelm et al., 2014), patients exhibiting PCPS often lack the insight required for traditional psychiatric engagement. Future translational research should focus on “bridge therapies”, brief, motivational interviewing-based interventions delivered within the dermatology or plastic surgery clinic setting, designed to gently shift the patient’s focus from external somatic correction to internal emotional regulation.

The conceptualisation of these “bridge therapies” addresses one of the most significant practical hurdles in aesthetic medicine: the patient’s profound resistance to psychiatric care (Bascarane et al., 2021). When an individual enters a cosmetic clinic with the unwavering conviction that the root of their suffering is a physical defect, an abrupt referral to a psychotherapist is frequently interpreted as a deep invalidation of their reality, often resulting in treatment abandonment and an escalation of their compulsive “doctor-shopping” behaviour (Kaleeny & Janis, 2024). These bridge interventions must be explicitly designed for administration within the trusted, non-stigmatising environment of the aesthetic clinic. Utilising techniques derived from motivational interviewing, these brief collaborative sessions do not directly challenge the objective reality of the perceived defect. Rather, they gently explore the unrealistic emotional expectations the patient has tethered to the procedure (Prazeres et al., 2013; Wilhelm et al., 2014). The primary objective is not to provide comprehensive psychiatric therapy but to create a cognitive opening, facilitating a gradual shift in the patient’s focus from external somatic modification towards the recognition of their intrinsic need for emotional regulation (Aldao et al., 2010; Boullion et al., 2021).

Potential bridge interventions may include brief motivational interviewing sessions, structured psychoeducation regarding body dysmorphic symptomatology, collaborative psychiatric consultation models, and staged referral approaches designed to reduce resistance to mental health referral within aesthetic settings.

7. Conclusions

PCPS represents a critical and escalating intersection between modern aesthetic capabilities and underlying psychopathology. As this review has demonstrated, the unrelenting pursuit of repeated physical alteration is rarely driven by an objective cosmetic deficit or normative vanity. Instead, it is fundamentally propelled by a complex, synergistic triad: the altered visual processing

of body dysmorphic symptomatology, profound intrinsic deficits in emotion regulation, and the escalation of compulsive behavioural loops. By externalising intolerable affective distress onto perceived somatic flaws, these patients are subconsciously attempting to surgically excise psychological pain.

The inherent danger of this clinical phenomenon lies in the illusion of a surgical cure. Aesthetic interventions, while highly effective for enhancing the well-being of the normative population, are entirely unequipped to repair cognitive distortions or restore emotional homeostasis. Consequently, providing cosmetic procedures to this vulnerable cohort does not alleviate their distress. Rather, it validates the somatic obsession, reinforces the pathological compulsion, and traps the patient in a dangerous cycle of diminishing aesthetic returns, significantly amplifying the risk of irreversible iatrogenic harm.

Ultimately, the aesthetic medical community must embrace a profound paradigm shift. The contemporary practitioner can no longer operate in a purely surgical or dermatological silo. Rigorous psychiatric vigilance must be integrated into routine care. Implementing validated screening protocols and fostering interdisciplinary collaborative models with mental health professionals are not merely optional administrative tasks but absolute ethical imperatives. By transitioning towards a proactive, "Psycho-Aesthetic" framework, practitioners can fulfil their paramount duty of *primum non nocere*, safeguarding both the psychological well-being of their patients and the medical integrity of the aesthetic field.

References

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review, 30*(2), 217–237. https://doi.org/10.1016/j.cpr.2009.11.004

Bascarane, S., Kuppili, P. P., & Menon, V. (2021). Psychiatric assessment and management of clients undergoing cosmetic surgery: Overview and need for an integrated approach. *Indian Journal of Plastic Surgery, 54*(1), 8–19. https://doi.org/10.1055/s-0040-1721868

Boullion, G. Q., Witcraft, S. M., Schadegg, M. J., Perry, M. M., & Dixon, L. J. (2021). Emotion regulation difficulties and depression among individuals with dermatological and body dysmorphic concerns. *The Journal of Nervous and Mental Disease, 209*(9), 650–655. https://doi.org/10.1097/NMD.0000000000001355

Bouman, T. K., Mulkens, S., & van der Lei, B. (2017). Cosmetic professionals' awareness of body dysmorphic disorder. *Plastic and Reconstructive Surgery, 139*(2), 336–342. https://doi.org/10.1097/PRS.0000000000002962

Conrado, L. A., Hounie, A. G., Diniz, J. B., Fossaluza, V., Torres, A. R., Miguel, E. C., & Rivitti, E. A. (2010). Body dysmorphic disorder among dermatologic patients: Prevalence and clinical features. *Journal of the American Academy of Dermatology, 63*(2), 235–243. https://doi.org/10.1016/j.jaad.2009.09.017

Crerand, C. E., Franklin, M. E., & Sarwer, D. B. (2006). Body dysmorphic disorder and cosmetic surgery. *Plastic and Reconstructive Surgery, 118*(7), 167e–180e. https://doi.org/10.1097/01.prs.0000242500.28431.24

Crerand, C. E., Infield, A. L., & Sarwer, D. B. (2009). Psychological considerations in cosmetic breast augmentation. *Plastic Surgical Nursing, 29*(1), 49–57. https://doi.org/10.1097/01.PSN.0000347725.13404.5f

Deshpande, R. (2014). *The neurobiology of body dysmorphic disorder (BDD)*. BDD Foundation.

Fang, A., & Wilhelm, S. (2015). Clinical features, cognitive biases, and treatment of body dysmorphic disorder. *Annual Review of Clinical Psychology, 11*, 187–212. https://doi.org/10.1146/annurev-clinpsy-032814-112849

Feusner, J. D., Hembacher, E., Moller, H., & Moody, T. D. (2011). Abnormalities of object visual processing in body dysmorphic disorder. *Psychological Medicine, 41*(11), 2385–2397. https://doi.org/10.1017/S0033291711000572

Feusner, J. D., Moody, T., Hembacher, E., Townsend, J., McKinley, M., Moller, H., & Bookheimer, S. (2010). Abnormalities of visual processing and frontostriatal systems in body dysmorphic disorder. *Archives of General Psychiatry, 67*(2), 197–205. https://doi.org/10.1001/archgenpsychiatry.2009.190

Feusner, J. D., Townsend, J., Bystritsky, A., & Bookheimer, S. (2007). Visual information processing of faces in body dysmorphic disorder. *Archives of General Psychiatry, 64*(12), 1417–1425. https://doi.org/10.1001/archpsyc.64.12.1417

Frasier, K., Werpachowski, N., Hash, M. G., & Madan, R. (2026). Chasing digital perfection in a filtered world: The role of dermatologists in addressing social media dysmorphia. *Journal of Cosmetic Dermatology, 25*(1), e70672. https://doi.org/10.1111/jocd.70672

Gorven, S. (2026). *Body dysmorphic disorder (BDD): Symptoms, causes, and treatment*. Time-To-Change.org.uk.

Grant, J. E., Potenza, M. N., Weinstein, A., & Gorelick, D. A. (2010). Introduction to behavioral addictions. *The American Journal of Drug and Alcohol Abuse, 36*(5), 233–241. https://doi.org/10.3109/00952990.2010.491884

Gross, J. J. (2015). Emotion regulation: Current status and future prospects. *Psychological Inquiry, 26*(1), 1–26. https://doi.org/10.1080/1047840X.2014.940781

Hampel, A. (2018). *From mask to mirror: Self as object in Chinese popular psychology* [Doctoral dissertation, University of Chicago]. https://doi.org/10.6082/M1H41PK4

Higgins, S., & Wysong, A. (2018). Cosmetic surgery and body dysmorphic disorder—An update. *International Journal of Women's Dermatology, 4*(1), 43–48. https://doi.org/10.1016/j.ijwd.2017.09.007

Honigman, R. J., Phillips, K. A., & Castle, D. J. (2004). A review of psychosocial outcomes for patients seeking cosmetic surgery. *Plastic and Reconstructive Surgery, 113*(4), 1229–1237. https://doi.org/10.1097/01.PRS.0000110214.88868.CA

Kaleeny, J. D., & Janis, J. E. (2024). Body dysmorphic disorder in aesthetic and reconstructive plastic surgery—A systematic review and meta-analysis. *Healthcare, 12*(13), 1333. https://doi.org/10.3390/healthcare12131333

Laughter, M. R., Anderson, J. B., Maymone, M. B. C., & Kroumpouzos, G. (2023). Psychology of aesthetics: Beauty, social media, and body dysmorphic disorder. *Clinics in Dermatology, 41*(1), 28–32. https://doi.org/10.1016/j.clindermatol.2023.03.002

Mulkens, S., Bos, A. E., Uleman, R., Muris, P., Mayer, B., & Velthuis, P. (2012). Psychopathology symptoms in a sample of female cosmetic surgery patients. *Journal of Plastic, Reconstructive & Aesthetic Surgery, 65*(3), 321–327. https://doi.org/10.1016/j.bjps.2011.09.038

Pavan, C., Simonato, P., Marini, M., Mazzoleni, F., Pavan, L., & Vindigni, V. (2008). Psychopathologic aspects of body dysmorphic disorder: A literature review. *Aesthetic Plastic Surgery, 32*(3), 473–484. https://doi.org/10.1007/s00266-008-9113-2

Phillips, K. A. (2005). *The broken mirror: Understanding and treating body dysmorphic disorder* (Rev. & expanded ed.). Oxford University Press.

Phillips, K. A., & Menard, W. (2006). Suicidality in body dysmorphic disorder: A prospective study. *The American Journal of Psychiatry, 163*(7), 1280–1282. https://doi.org/10.1176/ajp.2006.163.7.1280

Phillips, K. A., Grant, J., Siniscalchi, J., & Albertini, R. S. (2001). Surgical and nonpsychiatric medical treatment of patients with body dysmorphic disorder. *Psychosomatics, 42*(6), 504–510. https://doi.org/10.1176/appi.psy.42.6.504

Prazeres, A. M., Nascimento, A. L., & Fontenelle, L. F. (2013). Cognitive-behavioral therapy for body dysmorphic disorder: A review of its efficacy. *Neuropsychiatric Disease and Treatment, 9*, 307–316. https://doi.org/10.2147/NDT.S41074

Ravindran, A. V., da Silva, T. L., Ravindran, L. N., Richter, M. A., & Rector, N. A. (2009). Obsessive-compulsive spectrum disorders: A review of the evidence-based treatments.

Canadian Journal of Psychiatry, 54(5), 331–343. https://doi.org/10.1177/070674370905400507

Rück, C., Mataix-Cols, D., Feusner, J. D., Shavitt, R. G., Veale, D., Krebs, G., & Fernández de la Cruz, L. (2024). Body dysmorphic disorder. *Nature Reviews Disease Primers, 10*(1), 92. https://doi.org/10.1038/s41572-024-00577-z

Sansone, R. A., & Sansone, L. A. (2007). Cosmetic surgery and psychological issues. *Psychiatry (Edgmont), 4*(12), 65–68.

Sarwer, D. B. (2019). Body image, cosmetic surgery, and minimally invasive treatments. *Body Image, 31*, 302–308. https://doi.org/10.1016/j.bodyim.2019.01.009

Sarwer, D. B., & Polonsky, H. M. (2016). Body image and body contouring procedures. *Aesthetic Surgery Journal, 36*(9), 1039–1047. https://doi.org/10.1093/asj/sjw127

Sarwer, D. B., Wadden, T. A., & Fabricatore, A. N. (2005). Psychosocial and behavioral aspects of bariatric surgery. *Obesity Research, 13*(4), 639–648. https://doi.org/10.1038/oby.2005.71

Suissa, A. J. (2008). Addiction to cosmetic surgery: Representations and medicalization of the body. *International Journal of Mental Health and Addiction, 6*(4), 619–630. https://doi.org/10.1007/s11469-008-9164-2

Veale, D., Ellison, N., Werner, T. G., Dodhia, R., Serfaty, M. A., & Clarke, A. (2012). Development of a Cosmetic Procedure Screening Questionnaire (COPS) for body dysmorphic disorder. *Journal of Plastic, Reconstructive & Aesthetic Surgery, 65*(4), 530–532. https://doi.org/10.1016/j.bjps.2011.09.007

Veale, D., Gledhill, L. J., Christodoulou, P., & Hodsoll, J. (2016). Body dysmorphic disorder in different settings: A systematic review and estimated weighted prevalence. *Body Image, 18*, 168–186. https://doi.org/10.1016/j.bodyim.2016.07.003

von Soest, T., Kvalem, I. L., & Wichstrøm, L. (2012). Predictors of cosmetic surgery and its effects on psychological factors and mental health: A population-based follow-up study among Norwegian females. *Psychological Medicine, 42*(3), 617–626. https://doi.org/10.1017/S0033291711001267

Wilhelm, S., Phillips, K. A., Didie, E., Buhlmann, U., Greenberg, J. L., Fama, J. M., Keshaviah, A., & Steketee, G. (2014). Modular cognitive-behavioral therapy for body dysmorphic disorder: A randomized controlled trial. *Behavior Therapy, 45*(3), 314–327. https://doi.org/10.1016/j.beth.2013.12.007

Yurtsever, I., Matusiak, Ł., Szepietowska, M., Wójcik, E., Veale, D., & Szepietowski, J. C. (2021). Cosmetic Procedure Screening Questionnaire (COPS): Creation and validation of the Polish language version. *Advances in Dermatology and Allergology/Postępy Dermatologii i Alergologii, 38*(5), 881–886. https://doi.org/10.5114/ada.2020.96704