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+15878858911
editorial-office@sciformat.ca

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FROM FILTERED SKIN TO COSMETIC PROCEDURE REQUESTS: A NARRATIVE EVIDENCE REVIEW AND CLINICAL SCREENING FRAMEWORK FOR DERMATOLOGY AND AESTHETIC MEDICINE

Olena Abramchuk *(Corresponding Author, Email: abramchuk19el@gmail.com)*
Centrum Medyczne Unimed, ul. Młodej Polski 7, Kraków, Poland
ORCID ID: 0009-0000-2604-0287

Liliia Koshlak
Wojewódzki Szpital Zespolony w Kielcach, Poland
ORCID ID: 0009-0000-0761-5890

Yaryna Manila
University Clinical Hospital in Krakow, ul. Marii Orwid 1130-688 Kraków Poland
ORCID ID: 0009-0008-2002-3863

Lesia Slobozheniuk
Central Clinical Hospital in Warsaw Banacha 1a Street, 02-097 Warszawa, Poland
ORCID ID: 0009-0006-8432-568X

Artem Shchebetun
Zespół Opieki Zdrowotnej, Kościuszki 74, 62-100 Wągrowiec, Poland
ORCID ID: 0009-0004-3044-4793

Yuliia Fomenko
Centrum Medyczne "Twój lekarz w Poznaniu" ul. Święty Marcin, 46/50, Poznań , Poland
ORCID ID: 0009-0009-2350-4221

Alina Biletska
Wojewódzki Szpital Specjalistyczny im. Janusza Korczaka w Słupsku, Hubalczyków 1, 76-200 Słupsk, Poland
ORCID ID: 0009-0009-9090-2721

Olena Chiernobaievska
Lux Med Jaśkowa Dolina 132, Gdańsk, 80-286, Poland
ORCID ID: 0009-0003-7016-1061

Katsiaryna Miliuk
Szpital Matki Bożej Nieustającej Pomocy w Wołominie, Poland
ORCID ID: 0009-0004-7283-1871

Anastasiia Plakhotniuk
Szpital Matki Bożej Nieustającej Pomocy w Wołominie, Poland
ORCID ID: 0009-0005-1529-4472

Maryna Postolaki
SPZOZ w Lubartowie, Poland
ORCID ID: 0009-0001-0629-1246

Ingrida Zamoyska
Szpital Uniwersytecki w Krakowie, Macieja Jakubowskiego 2, 30-688 Kraków, Poland
ORCID ID: 0000-0001-9290-1946

ABSTRACT

Background. Image-centered social media have changed how patients observe, edit, compare, and evaluate their appearance [1, 2]. Beauty filters can erase acne, pores, pigment variation, erythema, scars, and lines while also altering facial proportions, creating a continuously available idealized version of the user's own skin and face [3]. Dermatologists and aesthetic clinicians increasingly encounter procedure requests framed by filtered selfies, influencer content, and videoconferencing images [4, 15]. The popular expression "Snapchat dysmorphia" describes part of this phenomenon but is not a recognized diagnosis and should not be used interchangeably with body dysmorphic disorder (BDD) [1, 2, 37].

Aim. To synthesize evidence along the pathway from digital modification of skin and facial appearance to appearance anxiety and cosmetic procedure requests, and to develop an evidence-informed clinical screening framework for dermatology and aesthetic medicine.

Methods. A structured narrative search of PubMed/Google Scholar was conducted through 4 October 2026 using combinations of terms related to social media, filters, selfies, photo editing, skin and facial appearance, appearance anxiety, BDD, cosmetic dermatology, cosmetic surgery, screening, and aesthetic procedures. Reference lists of relevant systematic reviews, meta-analyses, clinical reviews, and professional guidance were examined. Evidence was organized by its position in the proposed clinical pathway: digital exposure and self-editing, appearance comparison and anxiety, procedure consideration, dysmorphic symptoms, and consultation outcomes. Priority was given to systematic reviews and meta-analyses, experimental and longitudinal studies, validated screening research, and clinical guidance.

Results. Systematic reviews and experiments indicate that exposure to idealized appearance content can worsen short-term body or facial satisfaction and increase appearance comparison. Active behaviors, including repeated selfie editing and filter use, show more consistent associations with cosmetic procedure acceptance than total social media time. The evidence supports a plausible but not fully established pathway from digital self-modification to self-discrepancy, appearance surveillance, anxiety, and procedure requests. Effect sizes vary, most studies involve young women, and evidence linking filter exposure to completed procedures or long-term psychiatric outcomes remains limited. BDD is substantially overrepresented in dermatology and cosmetic settings. The proposed framework combines assessment of the objective dermatologic finding, digital appearance behaviors, preoccupation and impairment, validated BDD screening, expectations, prior procedures, and mental health risk to guide treatment, extended assessment, deferral, or referral.

Conclusions. Filtered skin and facial images should be treated as clinically relevant sources of comparison and procedure expectations rather than as diagnostic entities. The proposed framework translates heterogeneous evidence into a reproducible consultation process. A positive BDD screen does not establish a diagnosis, but probable BDD, an anatomically impossible target, marked functional impairment, acute psychological distress, or self-harm risk should lead to postponement of elective treatment and appropriate mental health assessment.

KEYWORDS

Filtered Skin, Social Media, Beauty Filters, Selfie Editing, Appearance Anxiety, Body Dysmorphic Disorder, Cosmetic Dermatology, Aesthetic Medicine, Clinical Screening, Cosmetic Procedures

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1. Introduction

Visual social media have made facial appearance unusually observable and modifiable. A user can capture dozens of images, compare them immediately, alter skin texture or facial proportions, and publish only the selected result. The edited image then returns through comments, likes, algorithmic recommendations, advertising, and repeated self-viewing. This process differs from exposure to conventional beauty advertising because the object being optimized is often the user's own face. The comparison is therefore not only with models or celebrities but also with an idealized digital version of the self.

Early clinical commentary described requests to resemble filtered selfies as "Snapchat dysmorphia" [1,2]. More recent dermatology reviews place the phenomenon within the broader relationship between digital beauty culture, appearance concern, and BDD [36,37]. The phrase remains useful as a cultural description, but it can create diagnostic confusion. Neither Snapchat dysmorphia, Instagram face, social media dysmorphia, nor Zoom dysmorphia is a formal disorder in current psychiatric classification. These terms may describe transient dissatisfaction, socially reinforced appearance anxiety, dysmorphic concern below the diagnostic threshold, or established BDD. The clinical response depends on which of these is present.

The distinction matters in dermatology. Skin texture, acne, scars, pigment variation, erythema, pores, and signs of aging are common targets of digital correction. They are also legitimate reasons for medical or cosmetic consultation. A request influenced by an edited image is not automatically pathological, and a patient with a real dermatologic condition may also have BDD. The clinician must judge whether the proposed intervention addresses a stable, proportionate concern and whether the expected benefit is achievable.

The available evidence supports concern but requires careful interpretation. Cross-sectional studies repeatedly associate appearance-focused social media behaviors with lower body satisfaction, greater social appearance anxiety, and higher acceptance of cosmetic procedures [3-6]. Experimental studies show that exposure to idealized or altered images can produce short-term worsening in appearance satisfaction [7-10]. Meta-analytic evidence supports a small adverse effect of appearance-focused social media exposure on body image, but associations vary according to content, platform behaviors, baseline vulnerability, age, and study design [11,12]. The evidence is much weaker for a direct pathway from filter use to a clinical diagnosis of BDD or to completed cosmetic treatment.

Existing publications have established several parts of this problem but have usually examined them separately. Studies of edited selfies have focused on body image or immediate cosmetic procedure interest; reviews have addressed social media and cosmetic surgery consideration; dermatology commentaries have emphasized digital beauty culture; and facial aesthetic pathways have concentrated on BDD screening [4,36-38]. Less attention has been given to the specifically dermatologic transition from digitally perfected skin to a concrete request for treatment, or to the way clinicians can integrate digital behaviors, objective skin findings, functional impairment, expectations, screening results, and safety risk within one consultation.

This review therefore follows the patient journey from filtered skin to a cosmetic procedure request. It separates established findings from plausible mechanisms, distinguishes informal alteration labels from BDD, and proposes an evidence-informed clinical screening framework for dermatology and aesthetic medicine. The framework is not presented as a validated diagnostic instrument. It is a structured synthesis intended to improve consistency, documentation, and decisions about treatment, extended assessment, deferral, and referral.

2. Methods

This article was designed as a structured narrative review. PubMed/MEDLINE was searched from database inception through 4 October 2026. Search concepts included "social media," "Instagram," "TikTok," "Snapchat," "selfie," "photo editing," "beauty filter," "digital manipulation," "appearance comparison," "appearance anxiety," "body image," "facial dissatisfaction," "cosmetic surgery acceptance," "cosmetic procedures," "dermatology," "aesthetic medicine," "body dysmorphic disorder," "dysmorphic concern," "BDDQ," "BDDQ-DV," "BDDQ-AS," and "COPS." Boolean combinations were adapted to the topic being examined. Reference lists of relevant reviews and guidance were used to identify additional studies.

Evidence was selected for clinical relevance and methodological value. Systematic reviews, meta-analyses, randomized or controlled experiments, longitudinal studies, and studies validating BDD screening instruments were prioritized. Cross-sectional studies were included when they directly evaluated photo editing, filter use, appearance comparison, or cosmetic procedure attitudes. Narrative reviews and professional guidance were used for terminology, ethical analysis, and clinical pathways. Reports based exclusively on

anecdote, promotional material, or unvalidated online surveys were not used to support quantitative conclusions.

The evidence was interpreted by design. Meta-analyses and systematic reviews informed the overall direction and consistency of associations. Experiments informed short-term causal effects of exposure or editing tasks. Longitudinal evidence was used to assess temporal relationships. Cross-sectional findings were treated as associations and not as proof that social media caused appearance dissatisfaction, BDD, or treatment seeking. Screening studies were evaluated separately from diagnostic studies because a positive screening result requires clinical confirmation. Findings were then mapped to five clinically relevant transitions: exposure to modified appearance, comparison with the edited self or others, appearance anxiety and repetitive behavior, interest in or requests for procedures, and the consultation decision.

This approach has limitations. The search was not registered, formal dual-reviewer screening was not undertaken, and no new risk-of-bias score or meta-analysis was produced. The proposed framework has not undergone prospective validation and should not be interpreted as a substitute for a diagnostic interview or local clinical guidance. The literature is heterogeneous in exposure definitions, outcome instruments, platforms, and populations. Many studies rely on self-report and convenience samples of young women. Platform features also change faster than conventional publication cycles. The conclusions therefore emphasize replicated patterns and clinically actionable safeguards rather than precise estimates of a single filter effect.

3. Concepts and Clinical Boundaries

3.1 Body image concern and appearance anxiety

Body image is a multidimensional construct that includes perception, thoughts, emotions, and behavior related to the body or specific features. Dissatisfaction is common and does not itself indicate psychiatric illness. Social appearance anxiety refers to fear that one's appearance will be negatively evaluated. It can increase checking, concealment, avoidance, reassurance seeking, and interest in appearance modification without meeting the criteria for BDD.

Dysmorphic concern is also dimensional. At lower levels it may reflect persistent dissatisfaction or overvaluation of appearance. At higher levels it overlaps with BDD symptoms, including intrusive preoccupation, repetitive behaviors, impaired functioning, and poor insight. Studies that use dysmorphic concern scales cannot be assumed to measure diagnosed BDD.

3.2 Body dysmorphic disorder

BDD is characterized by preoccupation with one or more perceived defects or flaws in appearance that are not observable or appear slight to others. At some point, the individual performs repetitive behaviors or mental acts in response, such as mirror checking, excessive grooming, comparing appearance, camouflaging, seeking reassurance, skin picking, or repeatedly reviewing photographs. The preoccupation causes clinically significant distress or impairment and is not better explained by concerns about body fat or weight in an eating disorder [13]. Insight varies from good to absent or delusional.

BDD must be distinguished from reasonable concern about acne, scarring, pigmentary disease, hair loss, vascular lesions, or aging. Objective pathology and BDD can coexist. The relevant questions are whether the concern is disproportionate to the finding, how much time it occupies, what behaviors it drives, and how it affects daily function. A clinician should avoid dismissing genuine disease because a patient also reports distress.

3.3 Social media dysmorphia and related labels

"Snapchat dysmorphia" originally referred to patients asking clinicians to reproduce features seen in filtered selfies [1,2]. "Instagram face" describes a culturally recognizable cluster of features promoted by influencers, filters, editing, and aesthetic procedures. "Zoom dysmorphia" describes appearance concern arising during prolonged video conferencing, where close camera distance, wide-angle distortion, lighting, gaze position, and continuous self-view can change perceived facial proportions [14,15].

These labels describe exposures or contexts. They do not replace a psychiatric assessment. The safest formulation is to document the observable phenomenon: for example, "the patient compares her unedited appearance with a routinely filtered image and expects complete removal of normal skin texture." This is more clinically useful than assigning an informal label.

4. How Digital Platforms May Influence Appearance Concern

4.1 Continuous upward comparison

Image-centered feeds provide a dense stream of selected and often enhanced faces and bodies. Users may compare their unedited appearance with content that has passed through makeup, lighting, posing, lens selection, editing, filters, and professional procedures. Because the production process is often invisible, the comparison target may be interpreted as ordinary appearance rather than constructed media.

Meta-analytic and systematic-review evidence links appearance-focused social media exposure and social comparison with body image concerns [11,12]. The important exposure appears to be what users do and view rather than total screen time alone. Passive viewing of idealized content, following appearance-focused accounts, comparing oneself with others, and investing heavily in feedback on personal images are more consistently associated with adverse outcomes than general communication or non-appearance content.

4.2 Self-objectification and appearance surveillance

Social media allow the user to adopt an observer's perspective toward the self. Repeated posing, checking, cropping, and editing can shift attention from bodily function and lived experience toward how the body appears to an audience. This appearance surveillance may increase sensitivity to small variations in skin texture, symmetry, lighting, or facial proportions. A three-level meta-analysis published in 2025 found a relationship between social media use and self-objectification, although heterogeneity and the predominance of observational data limit causal conclusions [16].

The clinical consequence is not simply dissatisfaction. Attention becomes narrowly allocated. Normal features that were previously background details can become repeatedly inspected targets. In susceptible patients, short-term relief after editing or receiving positive feedback may reinforce the checking and editing cycle.

4.3 The editable self-discrepancy

Beauty filters create a personalized comparison target. Unlike a celebrity photograph, the altered image preserves the user's identity while modifying selected features. This may increase the perceived attainability of the result. The patient may reason that the filtered version is the "real me" with a few correctable defects rather than a synthetic image.

Common modifications overlap with aesthetic procedures: uniform skin, narrowed nose, enlarged eyes, increased lip volume, elevated brows, reduced facial width, sharper jawline, and reduced under-eye shadow. Some changes cannot be produced safely or simultaneously in a real three-dimensional face. Filters may also alter spatial relationships in ways that are difficult to recognize without direct comparison.

4.4 Reinforcement by feedback and commercial content

Likes and approving comments can reward images that most closely match platform beauty norms. Algorithms may then supply more of the content with which the user already engages. Observational evidence cannot fully separate personal vulnerability from algorithmic exposure, but the feedback structure plausibly maintains appearance monitoring.

The boundary between peer content, influencer marketing, and medical advertising is often unclear. Before-and-after images may be selected, lit, posed, or retouched. Complications, repeat treatments, maintenance costs, and neutral outcomes receive less attention than dramatic transformations. Aesthetic clinicians also participate in this environment when they publish patient images, trend-based procedure content, or digitally enhanced results. The clinician is therefore both an interpreter of social media effects and a potential contributor to them.

5. Evidence Linking Social Media to Cosmetic Procedure Interest

5.1 Cross-sectional and observational findings

The direct literature on cosmetic procedure interest is dominated by cross-sectional surveys. Chen and colleagues studied 252 adults and found that greater investment in social media was positively associated with consideration of cosmetic surgery. Users of Snapchat filters showed higher overall acceptance of cosmetic surgery, while users of Instagram filters and VSCO showed greater consideration of surgery than non-users [3]. The study adjusted relationships using structural equation modeling, but the design could not determine direction. People already interested in cosmetic treatment may be more likely to use editing applications.

A 2024 systematic review included 25 studies and 13,731 participants and concluded that appearance-focused social media use was generally associated with body dissatisfaction and consideration of cosmetic surgery [4]. The review included heterogeneous designs and measures, and some component studies had convenience samples or limited control for confounding. Its value lies in the consistency of the direction of findings rather than a single pooled causal estimate.

Several studies refine the exposure. Hermans and colleagues found that passive appearance-focused social media use and perceived normalization of cosmetic procedures were related to procedure intention and acceptance among young adults, whereas posting frequency alone was generally not a consistent predictor [5]. Studies in women have linked Instagram image activities, appearance comparison, and body dissatisfaction with cosmetic surgery acceptance [6]. Research in men is smaller but suggests that self-consciousness, muscularity or facial ideals, and appearance comparison may also contribute; the phenomenon should not be framed as exclusive to women.

Photo editing has dermatologic relevance. In a survey of university students, editing was common, and acne or acne scars were frequent targets. Among respondents who edited photographs, 63.6% reported editing a skin lesion [17]. Such behavior may indicate ordinary impression management, but frequent lesion removal can also signal shame, concealment, or an increasing gap between online and offline appearance.

5.2 Experimental evidence

Experiments provide stronger evidence for immediate effects. Kleemans and colleagues found that viewing manipulated Instagram images adversely affected body image in adolescent girls, particularly among those with stronger social comparison tendencies [7]. Mills and colleagues reported that taking and posting selfies could worsen mood and facial satisfaction in young women, including when participants could retake or edit images [8]. Tiggemann and colleagues found associations between the selfie-editing process and body dissatisfaction, supporting the view that producing an optimized image can be psychologically relevant rather than neutral [9].

A small prospective study asked 20 participants to use a digital appearance manipulation application. Cosmetic surgery consideration increased after the editing task, while some self-perception outcomes also changed [10]. The experimental direction is informative, but the sample was too small to provide a stable estimate or establish long-term behavior.

More recent controlled research has compared filtered and unfiltered short-form video. Exposure to filtered TikTok videos can reduce mood and facial or body satisfaction and increase immediate cosmetic surgery interest relative to unfiltered content, although results depend on baseline appearance concern and the content used [18]. These studies measure state outcomes immediately after exposure. They do not show that a brief exposure produces persistent BDD or that participants proceed to treatment.

5.3 What meta-analyses add

Meta-analyses of experimental and longitudinal evidence indicate that appearance-ideal social media images have a small but reliable adverse effect on body image compared with non-appearance content [11].

Contextual elements such as captions and comments may modify effects, but they do not eliminate the impact of the image itself. Longitudinal associations are generally smaller than cross-sectional associations, which suggests both selection and bidirectionality: vulnerable users may seek more appearance-focused content, and repeated exposure may also maintain dissatisfaction.

The evidence base has several recurring weaknesses. Samples frequently consist of young women in high-income countries. Measures of body satisfaction, facial satisfaction, appearance anxiety, and cosmetic surgery acceptance are not interchangeable. Platform use is often self-reported. “Filter use” may mean color correction, skin smoothing, facial reshaping, or augmented reality. Studies rarely quantify the intensity of modification or verify actual exposure histories. Completed procedures, complications, regret, and long-term psychiatric outcomes are seldom measured.

5.4 Videoconferencing and camera distortion

Videoconferencing introduced a related exposure: prolonged, live self-observation. In the “Zoom Effect” study, greater appearance focus during video calls was associated with dysmorphic concern and interest in aesthetic treatments [14]. Surveys of dermatologists during the COVID-19 period also reported patients attributing new cosmetic concerns to video calls [15].

Front-facing cameras can distort facial proportions, particularly at short distances. Lighting, screen position, image mirroring, and wide-angle lenses may emphasize the nose or alter facial width. These technical effects should be explained before interpreting a video image as a reliable representation of anatomy. Videoconferencing concern can persist beyond pandemic restrictions because self-view and appearance-enhancing filters remain embedded in communication software.

6. Body Dysmorphic Disorder in Dermatology and Aesthetic Practice

6.1 Prevalence

BDD is uncommon enough in the general population to be missed but common enough in aesthetic settings to require routine attention. A systematic review by Veale and colleagues estimated weighted prevalence at 1.9% in community adults, 11.3% in dermatology outpatients, 9.2% in cosmetic dermatology outpatients, 13.2% in general cosmetic surgery, and 20.1% in rhinoplasty settings [19]. A later meta-analysis estimated a pooled prevalence of approximately 20% across cosmetic and dermatology settings, although heterogeneity between studies and instruments was substantial [20].

The figures should not be interpreted as the probability that an individual patient has BDD. They vary according to setting, procedure, country, sampling method, and whether a screening questionnaire or diagnostic interview was used. They do show that relying on clinical intuition alone will miss cases. In one dermatology study, prevalence was 14.0% in cosmetic patients and 6.7% in general dermatology patients, compared with 2.0% in community controls [21].

6.2 Why cosmetic treatment is a poor treatment for BDD

Patients with BDD frequently seek dermatologic, dental, or surgical correction because the perceived defect appears to be the cause of their distress. The treatment request can therefore be coherent from the patient’s perspective even when the defect is minimal. If the procedure changes the feature without changing the underlying attentional and interpretive process, concern may persist, shift to another feature, or become focused on the result.

A critical review of cosmetic treatment outcomes in BDD found little evidence that procedures reliably improve the disorder [22]. Many reports describe persistent symptoms, dissatisfaction, repeated consultations, or requests for revision. Evidence quality is limited by retrospective designs and selection bias, but it does not support cosmetic treatment as therapy for BDD. Current consensus favors evidence-based psychiatric treatment, particularly cognitive behavioral therapy adapted for BDD and selective serotonin reuptake inhibitors when indicated [23,24].

This does not mean that every screen-positive patient must be permanently excluded from all dermatologic care. Active acne, scarring, rosacea, pigmentary disease, or alopecia still warrants appropriate medical treatment. The immediate question is whether an elective appearance-changing procedure is likely to reduce distress safely and whether BDD has been assessed and treated. A mental health professional with relevant expertise should participate when BDD is suspected.

6.3 Risk and comorbidity

BDD commonly coexists with depression, anxiety disorders, obsessive-compulsive symptoms, eating disorders, and substance misuse [23,24]. Suicidal ideation and attempts occur at clinically important rates. NICE recommends that clinicians consider BDD in people with minor blemishes seeking cosmetic or dermatologic procedures, arrange specialist mental health assessment when BDD is suspected, and assess self-harm and suicide risk, especially when depression is present [24].

Risk assessment cannot be reduced to a questionnaire score. Direct questions about hopelessness, self-harm, suicidal thoughts, plans, means, and immediate safety are required when distress or risk cues are present. Urgent pathways should follow local mental health and emergency procedures.

7. Clinical Screening Framework From Filtered Image to Treatment Decision

The proposed framework organizes the consultation into six linked stages. It is intended for patients requesting cosmetic dermatologic, laser, injectable, or surgical treatment, particularly when the request is illustrated by an edited image or shaped by social media. It does not assign a psychiatric diagnosis and has not yet been prospectively validated. Its purpose is to ensure that the clinician evaluates the physical finding, digital context, psychological burden, expectations, and risk before deciding whether to treat.

7.1 Stage 1 Define the target and document the dermatologic finding

The consultation should begin with the patient's own description of the concern and desired change. The clinician should identify whether the target is a disease, a sequela of disease, a normal anatomical feature, an age-related change, or an image-dependent feature that is difficult to reproduce during examination. Acne, scars, rosacea, pigmentary change, hair loss, and vascular lesions require appropriate medical assessment even when appearance anxiety is also present.

Standardized unfiltered photographs can help establish a shared baseline. The clinician should document lesion severity, distribution, lighting-dependent variation, facial movement, asymmetry, and the difference between what is visible clinically and what appears in the presented image. This stage prevents two opposite errors: dismissing genuine dermatologic disease as psychological and treating a digitally generated target as if it were a stable physical abnormality.

7.2 Stage 2 Map the digital pathway behind the request

The next task is to establish how the request developed. Ask when the concern began and whether it followed the use of a particular filter, repeated selfie editing, influencer content, online comments, videoconferencing, targeted advertising, bullying, or a stressful life event. Determine whether the same feature is concerning in the mirror, in standardized photographs, and during ordinary social contact, or mainly in front-facing camera images.

Digital appearance behaviors should be described rather than labeled. Relevant questions include how often the patient applies skin smoothing or facial reshaping, how much time is spent taking and retaking images, whether unedited photographs are deleted or avoided, whether the patient compares the unfiltered face with an edited version, and whether distress increases after viewing procedure content. A filtered selfie can be used as a communication prompt, but it should not become the procedural target.

7.3 Stage 3 Assess preoccupation repetitive behaviors and function

The clinician should estimate how much time the concern occupies and what the patient does in response. Repetitive behaviors can include mirror checking, camera checking, comparing images, seeking reassurance, concealing the feature, excessive grooming, skin picking, and repeatedly consulting clinicians. Avoidance of photographs, work, education, intimacy, exercise, or social contact indicates that the issue extends beyond ordinary dissatisfaction.

Disproportion between the observable finding and the level of distress is clinically important, but it should be assessed respectfully. The patient's distress can be genuine even when the physical feature is slight.

Normalizing language may improve disclosure: appearance concerns are common among people seeking treatment, so questions about time, checking, avoidance, and daily function form part of a safe consultation. Telling a patient that they "have dysmorphia" without adequate assessment is both unhelpful and diagnostically unjustified.

7.4 Stage 4 Use a validated BDD screen and interpret it correctly

The Body Dysmorphic Disorder Questionnaire Dermatology Version (BDDQ-DV) was designed for dermatologic settings. In its original cosmetic dermatology validation, the brief questionnaire showed high sensitivity and specificity compared with a clinician-administered diagnostic interview [25].

Later reviews have supported the diagnostic accuracy of the BDDQ family while noting variation across settings and more limited evidence for some newer tools [26,27]. A validated Polish-language BDDQ-DV is available [28].

The BDDQ-AS adapts screening to aesthetic surgery, and the Cosmetic Procedure Screening Questionnaire (COPS) evaluates symptoms and functional impact in people seeking cosmetic treatment. Reviews identify these among the better-supported tools in aesthetic settings [26,29]. The Dysmorphic Concern Questionnaire measures a broader dimension of concern and does not map directly onto every diagnostic criterion.

The selected instrument should be used and scored in its validated form. Informal shortening, unvalidated translation, or selecting only convenient questions changes its performance. A positive screen indicates the need for focused clinical or mental health assessment; it does not establish BDD. Conversely, a negative result should not override marked impairment, compulsive behaviors, multiple unsuccessful procedures, fixed impossible expectations, or safety concerns.

7.5 Stage 5 Test expectations treatment history and mental health risk

The patient should define a successful result in specific and observable terms. The clinician should determine whether partial improvement is acceptable and whether normal pores, texture, pigment variation, asymmetry, folds, or movement can be tolerated after treatment. Completely poreless skin, perfectly uniform pigmentation, or a two-dimensional filtered facial proportion may be biologically or anatomically impossible. Explaining the precise limitation is more respectful and useful than simply calling the expectation unrealistic.

Previous consultations and procedures provide important prognostic information. Document the number and type of treatments, duration of satisfaction, requests for correction, changes in the target feature, conflict with previous clinicians, and whether technically adequate results were experienced as failures. Explore whether the patient expects treatment to restore a relationship, secure employment, eliminate social anxiety, or transform self-worth. These expectations exceed what a cosmetic intervention can reliably provide.

Mental health assessment should include depression, anxiety, obsessive-compulsive symptoms, eating concerns, substance use, current treatment, self-harm, and suicidal ideation. When distress or risk cues are present, direct questions about thoughts, plans, means, and immediate safety are required. Acute risk should be managed through local urgent mental health or emergency pathways rather than through elective treatment planning.

7.6 Stage 6 Classify the consultation outcome and act

The assessment should lead to one of four documented outcomes. Proceed when a stable objective target is present, impairment is limited, expectations are achievable, consent is informed, and no significant psychological risk is identified. Proceed with safeguards when concern is elevated but proportionate: consider additional education, standardized photographs, a cooling-off period, a conservative treatment plan, and planned follow-up. Defer and assess further when goals are unstable, digital behaviors are escalating, screening is positive, or the clinician cannot yet determine whether treatment is likely to help. Decline and refer when probable untreated BDD, an anatomically impossible target, severe functional impairment, coercion, impaired decision-making, repeated dissatisfaction, active self-harm risk, or threats toward clinicians are present.

Referral should be framed as care for the distress rather than rejection of the patient. Medical treatment of active acne, rosacea, pigmentary disease, scarring, or alopecia may continue when clinically appropriate, while elective appearance-changing procedures are paused. A mental health professional with experience in BDD is preferable when available.

Digital morphing used by clinics can support communication but may also intensify fixation.

Simulations should be described as illustrations rather than predictions, and the unaltered standardized image should remain the clinical record. Practices should not use beauty filters, skin smoothing, perspective changes, or inconsistent lighting in before-and-after photographs.

In 2023, Australian professional regulation introduced mandatory use of a validated BDD screening tool for patients seeking cosmetic surgery, illustrating a broader move toward standardized assessment [30]. Universal screening remains debated because it creates responsibilities for interpretation and referral, and evidence that screening improves long-term procedural outcomes is still developing. In a setting where BDD is substantially overrepresented, a brief validated instrument embedded within the six-stage interview is a proportionate safeguard.

8. Communication Ethics and Professional Responsibility

8.1 Respectful risk communication

Patient autonomy requires accurate information and freedom from coercion; it does not require a clinician to provide a procedure that is unlikely to help or may cause harm. The consultation should separate the validity of the patient's distress from the suitability of the requested intervention. A useful formulation is: "I can see that this feature causes significant distress. The degree of distress is greater than the physical change I can safely produce, so I recommend that we assess the appearance concern before considering treatment."

The clinician should provide realistic ranges rather than idealized promises. Discussion should cover the expected magnitude and duration of benefit, normal residual asymmetry or texture, maintenance, complications, recovery, cost, and the possibility that satisfaction may not improve. Consent obtained while a patient is pursuing a digitally impossible result is not adequately informed.

8.2 Ethical social media use by clinicians

Professional accounts can normalize procedures and shape perceived need. Ethical communication requires consistent photography, disclosure of relevant adjunctive treatments, representative outcomes, and clear separation between education and advertising. Before-and-after images should use comparable lighting, distance, lens, angle, expression, and makeup. Retouching that changes the treatment area should not be used. If an image has been altered for privacy or another nonclinical reason, the alteration should be stated.

Clinicians should avoid humiliating descriptions of normal features, trend-based urgency, and messages that equate treatment with social success. Paid partnerships and conflicts should be transparent. Complications and limitations should be visible enough to counter an impression of guaranteed transformation. Patient consent for publication must be specific and separate from consent for treatment; patients should understand that withdrawal may not remove copies already redistributed by other users.

8.3 Limits of alteration labels

Labeling altered images appears intuitive, but evidence does not show that a simple disclaimer reliably protects body image. A systematic review and meta-analysis of 22 studies found little support for disclaimer or warning labels and suggested that labels may sometimes increase appearance comparison [31]. Labels may direct attention to the manipulated feature without changing the underlying ideal.

Transparency remains ethically necessary. Its purpose is to prevent deception, even if it is not a sufficient psychological intervention. More effective prevention is likely to require reduced use of appearance-altering images, broader representation, media literacy, and changes to recommendation systems and advertising practices.

9. Prevention and Intervention

9.1 Patient-level strategies

For patients with mild or moderate filter-related dissatisfaction who do not have BDD, practical changes may reduce exposure and checking. These include removing beauty filters from routine camera settings, limiting repeated selfie capture, hiding self-view during video calls, increasing camera distance, placing the camera at eye level, using neutral lighting, and curating feeds away from highly appearance-focused accounts. The aim is to interrupt repeated comparison and checking, not to impose complete abstinence.

A randomized study in youth with emotional distress found that reducing social media use improved appearance and weight esteem over several weeks [35]. The result is encouraging but should not be generalized to every user or treated as evidence that screen reduction alone treats BDD. The clinically useful lesson is that a time-limited behavioral experiment can help determine whether appearance distress changes when exposure changes.

Body-positive and appearance-neutral content may offer modest benefits. A 2025 systematic review and meta-analysis found small improvements in body satisfaction and body appreciation, with substantial heterogeneity and less consistent effects on body dissatisfaction or surveillance [32]. Trials of following body-positive or appearance-neutral accounts also suggest short-term improvement in some outcomes [33]. Appearance-neutral content may be preferable for patients who find that body-positive content still keeps attention fixed on appearance.

Media-literacy programs teach users to identify selection, commercial incentives, editing, and algorithmic reinforcement. A cluster randomized trial of the SoMe program demonstrated that structured social media literacy can improve some body-image-related outcomes in adolescents, although effects were not uniform [34]. Such interventions are preventive tools. Patients with probable BDD require evidence-based mental health care.

9.2 Treatment of body dysmorphic disorder

For BDD, current guidance supports cognitive behavioral therapy adapted to the disorder, including exposure and response prevention, and selective serotonin reuptake inhibitors according to severity, preference, comorbidity, and specialist assessment [23,24]. Therapy addresses distorted interpretation, attentional bias, avoidance, reassurance seeking, checking, camouflage, and other rituals. The goal is not to persuade the patient that appearance never matters but to reduce preoccupation and restore function.

Dermatologists should continue medically necessary care while coordinating with mental health professionals. Treatment of active inflammatory disease can be appropriate even when BDD is present, provided expectations and risk are managed. Elective procedural decisions should be revisited after psychiatric assessment and clinical stabilization rather than promised in advance as a reward for treatment.

9.3 Clinic-level systems

A safe clinic pathway includes a standard psychosocial history, validated BDD screening, documented expectations, a cooling-off period for major or irreversible interventions, and an established referral relationship with a psychologist or psychiatrist familiar with BDD. A systematic review of facial aesthetic practice similarly supports a pathway that links screening results to focused assessment, deferral when indicated, and mental health referral [38]. Staff should know how to respond to a positive screen and to acute self-harm risk. Screening without a referral pathway identifies vulnerability without providing care.

Standardized photography and advertising policies should apply to all clinicians and marketing staff. Clinics should audit whether images are retouched, whether results are representative, whether complications are described, and whether influencer partnerships create undisclosed incentives. These measures also improve informed consent and the credibility of clinical records.

9.4 Platform and policy options

Potential platform-level measures include default disclosure of facial reshaping, easy access to unfiltered camera modes, limits on targeted advertising of invasive procedures to minors, searchable advertising archives, and friction before applying extreme appearance changes. The effectiveness of these measures is uncertain. Evidence on simple disclaimers suggests that transparency alone will not correct the psychological effect of idealized content [31].

Research should test system-level changes against meaningful outcomes such as appearance comparison, distress, help seeking, completed procedures, and adverse events. Engagement metrics are not adequate safety outcomes.

10 Research Gaps

The most urgent gap is longitudinal evidence. Studies should determine whether frequent filter use predicts persistent dysmorphic concern after baseline symptoms, depression, anxiety, and pre-existing cosmetic interest are considered. Repeated assessments and objective platform-use data would improve exposure measurement.

More research is needed in men, gender-diverse populations, older adults, adolescents, and culturally diverse samples. Filters may promote gendered and racialized ideals, including skin lightening, narrow facial proportions, and Eurocentric features. These effects cannot be assumed to be identical across populations.

Clinical studies should move beyond procedure intention. Relevant outcomes include consultations, completed treatments, repeat procedures, dissatisfaction, complications, regret, clinician conflict, and mental health trajectories. Screening research should test whether routine tools plus defined referral pathways improve these outcomes. The six-stage framework proposed in this review requires prospective validation for feasibility, interclinician consistency, patient acceptability, referral completion, and procedural outcomes. Comparative studies are also needed to determine which instrument performs best in dermatology, nonsurgical aesthetic medicine, and surgery.

Platform research should specify what the filter changes. Color correction, temporary makeup, skin smoothing, and structural facial reshaping are different exposures. Studies should quantify modification intensity and distinguish viewing altered others from repeatedly editing one’s own image. The latter may create a stronger personalized self-discrepancy.

Finally, the relationship may be bidirectional. Appearance-vulnerable individuals may engage more with filters and cosmetic content, while the content may maintain or intensify the vulnerability. Future models should test this reciprocal pathway instead of treating social media as a single external cause.

11 Conclusions

The movement from filtered skin to a cosmetic procedure request is best understood as a pathway rather than a new diagnosis. Digital modification can create a personalized ideal, direct attention toward minor skin or facial features, intensify appearance comparison, and normalize procedural correction. Evidence supports associations with short-term dissatisfaction, appearance anxiety, and greater acceptance or consideration of cosmetic procedures. Experimental studies strengthen the case for immediate effects, but current research does not establish that filters alone cause BDD or lead inevitably to treatment.

BDD is sufficiently overrepresented in dermatology and aesthetic settings to require systematic attention. Brief validated tools can support detection, but neither a filter habit nor a positive questionnaire establishes the diagnosis. Cosmetic procedures rarely resolve established BDD symptoms and may reinforce preoccupation or repeated treatment seeking.

The proposed six-stage framework translates the evidence into a consultation sequence: define the dermatologic target, map the digital pathway, assess preoccupation and function, use a validated BDD screen, test expectations and mental health risk, and document a decision to proceed, add safeguards, defer, or refer. Filtered images may support discussion but should not define the procedural endpoint. When the target is digitally impossible, goals are unstable, functional impairment is marked, or BDD and safety risk are suspected, elective treatment should be postponed and appropriate mental health assessment arranged. Prospective evaluation is now needed to determine whether this framework improves identification, referral, patient experience, and procedural outcomes.

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