Volume 3, Issue 3, March - 2025 **ISSN (E):** 2938-3811

Web of Scientists and Scholars: Journal of Multidisciplinary Research

THE ROLE OF PATIENT PSYCHOLOGY IN THE CHOICE OF AESTHETIC PROCEDURES

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Abstract
The article examines the influence of psychological factors on patients' choice of aesthetic procedures. Key aspects are analyzed: level of self-esteem, age perception, social pressure, emotional state and expectations of treatment results. The importance of psychodiagnostics and an interdisciplinary approach in planning aesthetic therapy is emphasized. A conclusion is made about the need to individualize the strategy of interaction with the patient to improve the effectiveness and safety of the procedures.

Keywords: Aesthetic medicine, patient psychology, choice of procedures, self-esteem, expectations, psychodiagnostics.

Introduction

The scientific novelty of the study lies in the emphasis on the key role of psychological factors in the choice and outcomes of aesthetic procedures, the systematization of validated psychodiagnostic tools (RSES, BDDQ, COPS, PHQ-9, G AD-7) and the justification of their use as a mandatory stage of clinical practice to improve safety and patient satisfaction.

Modern aesthetic medicine offers a wide range of procedures, but the choice of a specific intervention is rarely based solely on medical indications. Psychological factors such as self-esteem, perception of one's own age, and social expectations play a key role.

Research shows that up to 70% of patients seek aesthetic procedures not so much because of objective defects, but because of the desire to improve their quality of life, increase their self-confidence and meet generally accepted standards of attractiveness [1]. At the same time, the degree of satisfaction with the result directly correlates with the adequacy of expectations.

The phenomenon of «inner and outer age discrepancy» deserves special attention, when a person feels significantly younger than their age. This often becomes a strong motivator for turning to rejuvenating procedures. At the same time, some patients may suffer from dysmorphophobia (BDD). In such cases, even an objectively successful result does not bring satisfaction, which can lead to conflicts and repeated visits [2].

Social media also has a significant impact on motivation. Research shows a direct correlation between the active use of platforms such as Instagram and TikTok and the increase in requests for minimally invasive procedures, especially among young women [3]. Thus, aesthetic medicine is becoming not only a clinical, but also a socio-psychological practice.

In this regard, understanding the role of psychological factors is of particular relevance. Effective psychodiagnostics and well-established communication between the doctor and the patient help reduce the risk of dissatisfaction, optimize the choice of procedures and increase the long-term effectiveness of therapy.

The choice of an aesthetic procedure is rarely determined solely by medical indications. Psychological factors play a key role, directly affecting satisfaction with the result and the long-term success of the therapy:

1. Motivation is the main factor determining the choice and outcome of the procedure. Most patients are motivated by the desire to increase self-esteem, improve social adaptation, or meet aesthetic standards. It is important that the patient's expectations are realistic. Unrealistic expectations often lead to dissatisfaction even with a technically perfect result [4].

Practical recommendation: during the initial consultation, it is necessary to thoroughly clarify the motivation, including hidden motives (e.g., «saving the relationship»). Discuss with the patient possible and realistic results.

2. Low self-esteem is often accompanied by excessive concern about appearance and may lead to adverse psychological consequences after the procedure. Objective assessment of self-esteem, for example, using the Rosenberg Self-Esteem Scale, may be useful in clinical practice [5].

Practical recommendation: if self-esteem indicators are low, more time should be spent on consultation, and in case of pronounced psychopathologies, the patient should be referred to a psychologist or psychiatrist.

3. Dysmorphophobia is a key diagnosis that must be excluded before any aesthetic procedures. Patients with BDD are rarely satisfied with the results and often complain or require repeated interventions. Validated questionnaires such as the BDD - Q or COPS can be used for screening [6].

BDD screening is mandatory at the initial appointment. If the result is positive, a consultation with a psychiatrist should be recommended.

4. High levels of depression or anxiety may distort the perception of results and increase the risk of dissatisfaction. The short scales PHQ -9 (for depression) and GAD -7 (for anxiety) can be used for screening [7].

Practice recommendation: inclusion of these scales in the standard initial assessment will help identify patients who require additional consultation or procedure delay.

5. Social networks and media exert significant pressure on patients, especially young ones, increasing their desire for aesthetic changes. It is important to distinguish internal, mature motivation from external, social [8].

Practical tip: find out where the patient gets their inspiration (real people or doctored photos) and discuss the realistic nature of expectations.

6. Traits such as narcissism and perfectionism may increase the risk of repeated procedures and dissatisfaction. Evaluation of these personality traits is part of in-depth psychodiagnostics [9] .

Practical recommendation: if severe personality disorders are suspected, an interdisciplinary discussion with a psychologist or psychiatrist is recommended.

Taking these factors into account, integrating psychological screening into the initial consultation can significantly improve the safety and effectiveness of aesthetic procedures.

Table 1 - Psychological factors: assessment, influence on the choice of procedures and clinical actions

Psychological factor	**Tools**	**Influence on the choice of procedures**	**Recommended actions by the physician**
Motivation/Expectations	Clinical interview; expectations questionnaire	Defines the goal: cosmetic vs. functional request; unrealistic expectations - risk of dissatisfaction	Detailed consultation, visualization of real results, documentation; refusal in case of unrealistic goals.
Self-esteem	Rosenberg Self-Esteem Scale (RSES).	Low self-esteem - tendency to frequent corrections, less subjective benefit	Enhanced preoperative discussion; psychological support; postponement if necessary.
Body dysmorphic disorder (BDD)	BDD-Q, COPS (screening).	Frequent requests to correct "deficiencies", high probability of dissatisfaction	Mandatory psychiatric/psychological evaluation; refusal of procedure prior to treatment of BDD.
Depression	PHQ-9.	Depressive symptoms reduce satisfaction, increase risk of complications in quality of life	Screening; if positive, referral to a psychiatrist/psychologist; deferment in case of severe depression.
Anxiety	GAD-7.	Anxiety increases the risk of dissatisfaction and somatization	Screening; brief psychoeducation, in case of severe anxiety - therapeutic assistance before intervention.
Social media influence/external pressure	Interview, questions about motivation	The motive «because of social networks» is often associated with impulsive requests	Discuss sources of motivation, show real examples; prevent impulsive decisions.
Personality traits (perfectionism, narcissism)	Clinical assessment; personality scales if needed	May lead to repeated interventions and complaints	Consultation with a psychologist; caution when agreeing to procedures

Integration of psychological screening into the routine practice of a cosmetologist can significantly improve the safety and effectiveness of aesthetic procedures. Below is an algorithm for implementing psychological assessment:

1. Initial consultation. Begin with a detailed clinical interview to understand the patient's motivation, expectations, and perception of their appearance. Visual aids (such as before and after photos with a discussion of actual results) can be used to illustrate the point. Be sure to document all information obtained.

2. Rapid screening. Introduce standardized questionnaires into practice that will take only 4-10 minutes. It is recommended to use the Rosenberg Self-Esteem Scale (RSES) to assess the level of self-esteem, the Dysmorphophobia Questionnaire (BDD-Q) to identify signs of BDD, the

Patient Health Questionnaire (PHQ-9) to assess the level of depression, the GAD-7 questionnaire to identify anxiety disorders.

3. Interpretation of results. In case of positive screening results that indicate high risk, conduct an in-depth interview or refer the patient to a psychologist or psychiatrist. This will help to avoid undesirable outcomes and conflicts.

4. Shared decision making. If no contraindications are identified, discuss the procedure plan, possible limitations, and alternatives with the patient. Prepare an informed consent that describes not only the medical but also the psychological aspects.

5. Post-procedure monitoring. Monitor the patient's satisfaction and psycho-emotional state 1–3 months after the procedure. If you detect signs of dissatisfaction or a deterioration in emotional state, offer psychological assistance.

Table 2 - Clinical instruments of psychodiagnostics in aesthetic medicine

Tool	**Purpose**	**Questions / Time**	**Criteria / Notes**	**Practical action with positivity**
Rosenberg Self-Esteem Scale (RSES)	Global Self-Esteem Assessment	10 points, ~3–5 min	Below average → low self-esteem (interpret in context)	In-depth conversation, psychological support; in case of pronounced problems - referral
BDDQ/BDD Q-DV	Body Screening Dysmorphic Disorder	Short questionnaire (yes/no) ~2–4 min	Positive answer to key questions → high chance of BDD (high sensitive and specific)	Deferral/refusal; referral to psychiatrist/psychologist; document
COPS (Cosmetics Procedure Screening)	Specialized screening of BDD in cosmetology practice	9 points, ~3–5 min	Elevated scores indicate risk of BDD	As for BDDQ - do not conduct the procedure before the assessment
PHQ-9	Screening for depression	9 points, ~2–4 min	Threshold ≥10 - moderate/ class significant depression	Consider deferment; refer to psychotherapist/psychiatrist
GAD-7	Screening for generalized anxiety	7 points, ~2–3 min	Threshold ≥10 - moderate anxiety	Psychopsychological assessment; deferment in case of severe anxiety

The introduction of psychological assessment into the practice of aesthetic medicine is a necessary step towards improving the safety and effectiveness of procedures. The use of simple screening tools and careful attention to psychological factors allows us to identify patients with increased risk, promptly adjust the treatment plan and, ultimately, ensure their long-term satisfaction.

In aesthetic medicine, the success of a procedure largely depends on competent communication between the doctor and the patient. It should be built on several key principles:

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1. Setting realistic expectations. The doctor must clearly and understandably explain what results can be achieved and what cannot. This helps to avoid disappointments and conflicts in the future.
2. Discussing risks and limitations. Openly communicating possible risks and limitations of the procedure (such as temporary side effects) builds trust and demonstrates the doctor's professionalism.
3. Identifying hidden motives. It is important to understand what really drives the patient. Often, the desire to change appearance hides deeper problems, such as the desire to «save a relationship» or «start a new life».
4. Ability to refuse. The doctor must have the skills to tactfully but firmly refuse a procedure if the patient has signs of dysmorphophobia or serious psycho-emotional instability. Refusal in such cases is a manifestation of professional ethics and concern for the patient's well-being.

Thus, psychological factors play a decisive role in the choice and outcome of aesthetic procedures. The level of self-esteem, emotional state, social influences and expectations of the patient directly affect their satisfaction with the achieved result. The introduction of psychodiagnostics and a personalized approach allows for a significant increase in the effectiveness and safety of aesthetic procedures. This approach helps to strengthen trust between the doctor and the patient, ensuring a more predictable and favorable outcome of therapy.

REFERENCES

1. Patel RA, Malhotra R., Sharma S. Cosmetic procedures: patient motivations and satisfaction // Value in Health . – 2013. – Vol. 16, No. 3. – P. A171. – URL: https://www.valueinhealthjournal.com/article/S1098-3015(13)01398-3/fulltext (date accessed: 01.09.2025).
2. Veale D., Gledhill LJ, Christodoulou P., Hodsoll J. Body dysmorphic disorder in different settings: A systematic review and estimated weighted prevalence // Body Image . – 2016. – Vol. 18. – P. 168–186.
3. Walker CE, Krumhuber EG, Dayan S., Furnham A. Effects of social media use on young women's body image concerns and cosmetic surgery attitudes // Journal of Social and Clinical Psychology . – 2019. – Vol. 38(4). – P. 318–335.
4. Phillips KA Body dysmorphic disorder: recognition and treatment // Journal of Psychiatric Practice . – 2001. – Vol. 7 (3). – P. 125–132. – URL: https://pmc.ncbi.nlm.nih.gov/articles/PMC1762095/ (date accessed: 02.09.2025).
5. Rosenberg M. Society and the adolescent self-image. – Princeton, NJ: Princeton University Press, 1965. – 326 p. – URL: https://www.yorku.ca/rokada/psyctest/rosenbrg.pdf (date accessed: 03.09.2025).
6. Musa R., Musa MA, Azmi AN Evidence-based review: Screening body dysmorphic disorder in aesthetic clinical settings. – 2023. – URL: https://www.researchgate.net/publication/368844872_Evidence-

based_review_Screening_body_dysmorphic_disorder_in_aesthetic_clinical_settings (date accessed: 03.09.2025).
7. Spitzer RL, Kroenke K., Williams JB Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study // JAMA Internal Medicine . – 1999. – Vol. 159 (20). – P. 2466–2476. – URL: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326 (date accessed: 03.09.2025).
8. Honigman RJ, Phillips KA, Castle DJ A review of psychosocial outcomes for patients seeking cosmetic surgery // Plastic and Reconstructive Surgery . – 2004. – Vol. 113(4). – P. 1229–1237. – URL: https://www.researchgate.net/publication/8620273_A_Review_of_Psychosocial_Outcomes_for_Patients_Seeking_Cosmetic_Surgery (date accessed: 04.09.2025).
9. Phillips KA Body dysmorphic disorder: recognition and treatment // Journal of Psychiatric Practice . – 2001. – Vol. 7 (3). – P. 125–132. – URL: https://pmc.ncbi.nlm.nih.gov/articles/PMC1762095/ (date accessed: 04.09.2025).

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