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Beyond Aesthetic Expectations: Body Dysmorphic Disorder, Psychiatric Vulnerability, and Preoperative Patient Selection in Cosmetic Surgery

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ABSTRACT

Body dysmorphic disorder (BDD) represents a significant challenge in aesthetic surgery because of its association with psychological distress, psychiatric comorbidity, unrealistic treatment

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expectations, and variable postoperative satisfaction. This narrative review aimed to critically examine international and Latin American scientific evidence regarding preoperative detection, psychiatric vulnerability, surgical outcomes, and safe patient selection among individuals seeking elective cosmetic procedures. A descriptive and analytical approach was adopted to synthesize 20 scientific publications, including observational studies, systematic reviews, meta-analyses, and clinical investigations addressing psychological assessment in aesthetic surgical settings. The reviewed evidence demonstrated considerable variability in BDD prevalence, with a meta-analysis reporting a pooled prevalence of 32.7% among rhinoplasty candidates and individual studies identifying higher proportions of dysmorphic symptoms in selected surgical populations. Preoperative screening instruments, including the Body Dysmorphic Disorder Questionnaire and its aesthetic adaptations, demonstrated clinical utility for identifying patients requiring additional psychological or psychiatric evaluation, although differences in diagnostic performance and population characteristics limited direct comparisons. Psychiatric comorbidity emerged as a relevant dimension, particularly regarding depressive disorders, obsessive-compulsive manifestations, and suicidality. Evidence concerning postoperative outcomes remained heterogeneous: while greater preoperative symptom severity was frequently associated with lower satisfaction, selected patients with mild to moderate dysmorphic symptoms experienced improvements following aesthetic procedures. Brazilian investigations provided relevant Latin American evidence concerning prevalence, functional characteristics, and postoperative evolution, although geographical representation remained limited. Overall, the findings support the integration of psychological screening, individualized psychiatric assessment, and multidisciplinary collaboration into aesthetic surgical decision-making. Further prospective and multicenter investigations are necessary to establish standardized assessment strategies, clarify predictors of postoperative psychological outcomes, and strengthen evidence-based criteria for safe patient selection.

KEYWORDS

Body dysmorphic disorder, Aesthetic surgery, Plastic surgery, Preoperative screening, Psychiatric comorbidity, Body image, Patient selection, Postoperative satisfaction, Psychological assessment, Multidisciplinary care

INTRODUCTION

The increasing demand for aesthetic surgical procedures has highlighted the importance of psychological assessment in patients seeking modifications to their physical appearance. Although cosmetic surgery may improve body satisfaction and perceived quality of life, psychological factors can substantially influence treatment expectations, postoperative satisfaction, and long-term outcomes. Among these factors, body dysmorphic disorder (BDD) represents a significant clinical concern because it involves persistent preoccupation with perceived physical imperfections that are minimal or unobservable to others. This condition is frequently associated with emotional distress, repetitive appearance-related behaviors, and impairment in social, occupational, or interpersonal functioning. Its identification is particularly relevant in aesthetic surgery, where patients may seek anatomical corrections as a means of alleviating psychological suffering [1], [4], [5].

The prevalence of BDD among individuals requesting cosmetic procedures has attracted considerable research attention. Nabavizadeh et al. [3], in a systematic review and meta-analysis involving 2,132 rhinoplasty candidates, reported a pooled BDD prevalence of 32.7%, although substantial heterogeneity was observed across studies. Similarly, Joseph et al. [8] identified positive screening results in a relevant proportion of patients attending facial plastic and oculoplastic surgery clinics, while also documenting limitations in surgeons' ability to recognize the disorder through routine clinical evaluation. These findings underscore the potential underrecognition of dysmorphic symptoms during preoperative consultations and support the incorporation of structured psychological screening into aesthetic surgical practice.

Preoperative detection remains challenging because dissatisfaction with physical appearance is not necessarily indicative of psychiatric pathology. Distinguishing ordinary aesthetic concerns from clinically significant dysmorphic preoccupation requires an evaluation of symptom intensity, repetitive behaviors, functional impairment, and the expectations associated with surgery. Several screening instruments have been investigated, including the Body

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Dysmorphic Disorder Questionnaire and tools specifically adapted for aesthetic populations. Studies by Picavet et al. [6] and Lekakis et al. [7] have contributed to the development and evaluation of these approaches, while Pereira et al. [1] emphasized the importance of selecting appropriate instruments and recognizing that screening results cannot replace comprehensive psychiatric assessment.

Psychiatric comorbidity constitutes an additional dimension of clinical relevance. Patients with BDD may present depressive disorders, anxiety symptoms, obsessive-compulsive manifestations, and other psychological difficulties that influence their perception of appearance and expectations of surgical correction. Phillips et al. [19], [20] documented the clinical complexity of BDD and its association with major depressive disorder, while Angelakis et al. [18] identified a significant relationship between BDD and suicidal ideation and behavior. These findings demonstrate the importance of evaluating emotional stability, psychiatric history, and potential psychological risk before elective aesthetic interventions, particularly when patients express disproportionate distress or unrealistic expectations concerning postoperative changes.

Evidence regarding surgical outcomes in patients with BDD remains heterogeneous. Picavet et al. [10] reported an association between preoperative dysmorphic symptoms and postoperative satisfaction following aesthetic rhinoplasty, whereas Bowyer et al. [11] highlighted the limitations of cosmetic interventions in achieving sustained psychological improvement among affected individuals. Nevertheless, selected patients with milder symptoms may experience favorable outcomes, suggesting that surgical eligibility should not be determined solely through a screening result. Instead, clinical decisions should consider symptom severity, psychiatric stability, functional impairment, treatment expectations, and the potential benefits and limitations of the proposed intervention [12], [14].

Latin American contributions, particularly those originating from Brazil, have strengthened the available evidence concerning BDD in aesthetic surgery. De Brito et al. [13] investigated dysmorphic symptoms among candidates for abdominoplasty, rhinoplasty, and rhytidectomy, while Ramos et al. [15] and de Souza et al. [17] examined their prevalence and clinical characteristics in rhinoplasty populations. Additionally, Rabaioli et al. [16] evaluated postoperative satisfaction among patients presenting dysmorphic symptoms. These investigations provide a regional perspective on the relationship between psychiatric vulnerability and aesthetic interventions, although differences in study design, assessment methods, and patient characteristics limit direct comparisons between populations.

Despite growing scientific interest, important uncertainties persist regarding the most appropriate preoperative screening strategies, the influence of psychiatric comorbidity on surgical outcomes, and the criteria required for safe patient selection. Variability in diagnostic instruments, symptom severity, follow-up periods, and surgical specialties complicates the development of universally applicable recommendations. Furthermore, distinguishing patients who may benefit from aesthetic intervention from those requiring psychiatric or psychological treatment before surgery remains a central challenge in multidisciplinary practice [1], [2], [4].

Accordingly, this review aims to examine the available international and Latin American evidence concerning body dysmorphic disorder in aesthetic surgery, focusing on preoperative detection, psychiatric comorbidity, postoperative outcomes, and safe patient selection. The review is guided by three principal questions: which clinical and screening strategies facilitate the recognition of BDD before surgery, how psychiatric comorbidity influences risk assessment and postoperative satisfaction, and which factors should inform multidisciplinary decisions regarding surgical eligibility. To address these questions, the article adopts a narrative review approach, integrating relevant clinical studies, systematic reviews, and investigations of psychological screening and surgical outcomes. Through this framework, the study seeks to provide a clinically applicable synthesis that supports early recognition of psychological vulnerability, appropriate referral to mental health specialists, and individualized surgical decision-making.

DEVELOPMENT

Clinical Relevance of Body Dysmorphic Disorder in Aesthetic Surgery

Body dysmorphic disorder (BDD) represents a significant challenge in aesthetic surgical practice because of the complex relationship between perceived physical imperfections, psychological distress, and expectations of surgical correction. Although dissatisfaction with appearance is a common motivation for cosmetic procedures, individuals with BDD experience persistent and disproportionate concerns that extend beyond ordinary aesthetic preferences.

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These concerns frequently involve repetitive checking behaviors, excessive comparison with others, avoidance of social interactions, and emotional distress that interferes with everyday functioning. Consequently, the presence of BDD may influence treatment decisions and compromise postoperative satisfaction, even when the surgical intervention achieves technically satisfactory results [5], [12].

The clinical relevance of this disorder is supported by epidemiological evidence indicating a substantial prevalence of dysmorphic symptoms among aesthetic surgery candidates. Nabavizadeh et al. [3] reported a pooled prevalence of 32.7% among rhinoplasty candidates, although considerable heterogeneity existed between studies. This finding should be interpreted cautiously because screening-positive cases do not necessarily represent confirmed psychiatric diagnoses. Nevertheless, the available evidence demonstrates the importance of incorporating psychological considerations into preoperative evaluation rather than relying exclusively on anatomical findings or the patient's expressed desire for physical modification.

Preoperative Detection and Psychological Screening

Early recognition of BDD is essential for identifying individuals who may require additional psychiatric or psychological assessment before elective surgery. Conventional preoperative consultations generally emphasize medical history, anatomical evaluation, surgical feasibility, and anticipated aesthetic outcomes. However, these approaches may be insufficient to identify distorted body-image perceptions, excessive emotional investment in surgical results, or unrealistic expectations regarding postoperative psychological improvement.

Joseph et al. [8] demonstrated that surgeons frequently fail to identify patients presenting symptoms compatible with BDD during routine consultations. This observation supports the use of structured screening strategies that complement clinical judgment. Instruments such as the Body Dysmorphic Disorder Questionnaire and tools adapted for aesthetic populations have been investigated as methods for recognizing dysmorphic symptoms. Picavet et al. [6] and Lekakis et al. [7] contributed evidence regarding the clinical applicability of these instruments, while Pereira et al. [1] emphasized the importance of their appropriate selection and interpretation.

A positive screening result should not be considered sufficient to establish a definitive diagnosis or automatically exclude a patient from surgery. Instead, it should prompt further evaluation of the severity and duration of appearance-related concerns, repetitive behaviors, functional impairment, psychiatric history, and anticipated surgical benefits. This distinction is essential to avoid both underrecognition of clinically significant psychopathology and unnecessary exclusion of patients whose concerns do not meet diagnostic criteria for BDD [1], [2].

Psychiatric Comorbidity and Psychological Vulnerability

The psychiatric complexity of BDD extends beyond dissatisfaction with physical appearance. Individuals affected by the disorder frequently present additional psychological symptoms, particularly depression, anxiety, and obsessive-compulsive manifestations. These conditions may influence emotional stability, the interpretation of bodily characteristics, and the expectations associated with aesthetic interventions.

Phillips et al. [19] documented substantial psychiatric comorbidity among individuals with BDD, while subsequent research highlighted the relationship between dysmorphic symptoms and major depressive disorder [20]. The coexistence of these conditions may complicate clinical assessment because patients can attribute psychological suffering to an isolated anatomical feature, expecting surgical correction to resolve broader emotional difficulties.

Suicidality represents another important consideration. Angelakis et al. [18] identified a significant association between BDD and suicidal thoughts and behaviors, indicating the importance of evaluating psychiatric risk in patients presenting severe distress or hopelessness. These findings do not imply that every patient with dysmorphic concerns is at imminent risk; rather, they reinforce the need for individualized assessment and appropriate referral when clinically indicated.

Consequently, psychiatric evaluation should be regarded as an integral component of safe surgical planning when psychological vulnerability is suspected. Collaboration between plastic surgeons, psychiatrists, and psychologists may facilitate diagnostic clarification, identification of treatable psychiatric symptoms, and informed decisions regarding the suitability and timing of elective procedures [4].

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Postoperative Satisfaction and Surgical Outcomes

Postoperative satisfaction is a multidimensional outcome influenced by anatomical results, patient expectations, emotional functioning, and subjective body-image perception. In patients with BDD, improvements in physical appearance do not necessarily produce corresponding improvements in psychological well-being because the underlying preoccupation may persist or become focused on other perceived imperfections.

Picavet et al. [10] identified an association between preoperative dysmorphic symptoms and postoperative satisfaction following rhinoplasty, supporting the relevance of psychological characteristics in predicting patient-reported outcomes. Similarly, Bowyer et al. [11] found that cosmetic interventions frequently provide limited improvement in the broader psychopathology associated with BDD, although the available evidence presents important methodological limitations.

Nevertheless, surgical outcomes are not uniformly unfavorable among individuals reporting dysmorphic symptoms. Felix et al. [14], in a Brazilian investigation, reported favorable postoperative changes among selected patients with mild to moderate BDD symptoms. Rabaioli et al. [16] also documented improvements in postoperative measures among rhinoseptoplasty patients presenting dysmorphic characteristics.

These findings highlight the importance of distinguishing symptom severity, psychiatric stability, and individual expectations when considering surgical eligibility. Favorable outcomes in selected populations should not be generalized to patients with severe or untreated BDD, nor should aesthetic surgery be considered a primary psychiatric treatment for the disorder.

Latin American Evidence and International Perspectives

International investigations have demonstrated that BDD-related concerns occur across different aesthetic specialties and healthcare environments. However, variations in diagnostic methods, cultural expectations, and patient populations complicate the comparison of prevalence estimates and treatment outcomes.

Latin American research has contributed valuable findings, particularly through Brazilian investigations. De Brito et al. [13] examined BDD among patients seeking abdominoplasty, rhinoplasty, and rhytidectomy, demonstrating that dysmorphic concerns are not restricted to facial procedures. Ramos et al. [15] identified a substantial presence of appearance-related obsessive-compulsive symptoms among rhinoplasty candidates, while de Souza et al. [17] investigated the prevalence and functional characteristics of BDD in similar populations.

These studies support the relevance of psychological screening in Latin American aesthetic surgery settings. Nevertheless, the concentration of available regional evidence in Brazil limits generalization to other Latin American countries. Differences in cultural perceptions of appearance, healthcare access, psychiatric resources, and surgical practice may influence both the identification and clinical management of BDD.

Further multicenter investigations involving diverse populations are therefore necessary to establish more representative prevalence estimates, evaluate the applicability of screening instruments, and identify factors associated with postoperative satisfaction across different healthcare systems.

Multidisciplinary Assessment and Safe Patient Selection

Safe patient selection requires integrating physical examination with psychological assessment, psychiatric history, functional evaluation, and realistic expectations concerning surgical outcomes. The presence of dysmorphic symptoms should prompt clinicians to investigate whether the requested anatomical modification is proportionate to the patient's concerns and whether surgery is likely to provide the anticipated benefits.

Bascarane et al. [4] emphasized the importance of an integrated psychiatric approach within cosmetic surgery, while Mandavia et al. [2] proposed an evidence-based pathway for identifying and managing BDD in facial aesthetic practice. Both approaches highlight the value of multidisciplinary collaboration in situations involving psychological vulnerability.

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Clinical assessment should consider the persistence and severity of appearance-related preoccupations, previous surgical experiences, psychiatric comorbidities, emotional stability, and the patient's understanding of procedural limitations. When significant psychopathology is identified, psychological or psychiatric intervention may be necessary before reconsidering elective surgery.

Importantly, the purpose of preoperative psychiatric assessment is not to stigmatize individuals with mental health conditions or establish indiscriminate barriers to aesthetic treatment. Rather, it is to promote informed consent, recognize potentially modifiable risk factors, and reduce avoidable psychological or surgical complications.

GENERAL OBJECTIVE AND SPECIFIC OBJECTIVES

To critically analyze the available international and Latin American scientific evidence regarding body dysmorphic disorder (BDD) in aesthetic surgery, with particular emphasis on preoperative detection, psychiatric comorbidity, psychological vulnerability, and postoperative outcomes, in order to establish evidence-informed recommendations that support multidisciplinary assessment, clinical decision-making, and the safe selection of patients undergoing elective cosmetic procedures.

OBJECT OF STUDY

Cognitive Domain

- **Identify** the principal clinical characteristics, diagnostic criteria, and psychological manifestations of body dysmorphic disorder in individuals seeking aesthetic surgical interventions, distinguishing pathological appearance-related preoccupations from ordinary concerns about physical appearance.
- **Analyze** the prevalence and clinical distribution of BDD among candidates for different aesthetic procedures, comparing international findings with available Latin American evidence and recognizing methodological differences between epidemiological investigations [3], [13], [15].
- **Examine** the relationship between BDD and psychiatric comorbidities, including depressive disorders, anxiety symptoms, obsessive-compulsive manifestations, and suicidality, to understand their relevance to preoperative risk assessment and clinical management [18]–[20].
- **Evaluate** the scientific evidence concerning postoperative satisfaction, psychological outcomes, and persistent body-image dissatisfaction in patients presenting dysmorphic symptoms, identifying factors that may influence surgical suitability and therapeutic expectations [10], [11], [14].

Psychomotor Domain

- **Demonstrate** the appropriate application of structured preoperative screening strategies through the examination of validated assessment instruments, including the Body Dysmorphic Disorder Questionnaire and screening tools adapted for aesthetic surgery populations [1], [6], [7].
- **Organize** a systematic clinical assessment pathway incorporating psychological history, identification of appearance-related behaviors, evaluation of functional impairment, and recognition of warning signs requiring specialized mental health assessment.
- **Develop** a practical framework for multidisciplinary patient evaluation that integrates surgical findings, psychological screening results, and psychiatric considerations to support individualized decisions regarding elective aesthetic interventions [2], [4].

Affective Domain

- **Recognize** the importance of empathy, professional responsibility, and nonjudgmental communication when evaluating individuals experiencing significant distress related to their physical appearance.

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- **Value** the contribution of multidisciplinary collaboration among plastic surgeons, psychiatrists, and psychologists as a fundamental component of ethical clinical practice and comprehensive patient care.
- **Promote** patient-centered decision-making that respects autonomy, psychological well-being, informed consent, and the prevention of avoidable harm, particularly when psychiatric vulnerability may influence surgical expectations or postoperative satisfaction.

METHODOLOGY

This study employed the **Scientific Method** as the principal methodological framework, supported by a quantitative, observational, cross-sectional, and descriptive-analytical research design. The Scientific Method was selected because it provides a systematic and reproducible approach for investigating complex biological phenomena through the formulation of a research problem, data collection, statistical analysis, interpretation of findings, and evidence-based conclusions. This methodology enables objective evaluation of hormonal, dermatologic, and metabolic interactions throughout the female lifespan while ensuring methodological transparency and scientific rigor.

PHASES OF DEVELOPMENT

Identification and Delimitation of the Research Problem

The initial phase focused on defining the clinical problem associated with the identification of BDD among individuals seeking aesthetic surgical procedures. The principal concern was the potential discrepancy between objectively satisfactory anatomical results and persistent psychological dissatisfaction, particularly in patients presenting excessive appearance-related preoccupations, psychiatric comorbidity, or unrealistic surgical expectations.

The research problem was delimited to three interconnected dimensions: the detection of dysmorphic symptoms before surgery, the influence of psychiatric comorbidity on clinical vulnerability, and the implications of these factors for postoperative satisfaction and patient selection.

Previous investigations have demonstrated that BDD symptoms occur in a substantial proportion of aesthetic surgery candidates and may remain unrecognized during conventional consultations [3], [8]. These findings established the clinical justification for examining psychological assessment as an integral component of elective surgical planning.

Formulation of Research Questions and Working Hypothesis

Following the identification of the problem, the review framework was organized around questions concerning preoperative screening, psychiatric comorbidity, postoperative outcomes, and multidisciplinary decision-making.

The principal working hypothesis proposes that the integration of structured psychological screening and specialized psychiatric assessment may support earlier recognition of clinically significant dysmorphic symptoms and facilitate safer patient selection.

This proposition was informed by investigations examining screening accuracy, psychiatric vulnerability, and postoperative satisfaction [1], [2], [10]. Because the investigation is a narrative review, the hypothesis serves as an analytical framework rather than a proposition tested through experimental intervention or original statistical analysis.

Identification and Selection of Scientific Evidence

The bibliographic phase focused on identifying publications directly related to the principal research questions. The evidence base comprises 20 scientific references addressing BDD prevalence, screening instruments, psychiatric comorbidity, aesthetic surgical outcomes, and patient selection.

The methodological framework prioritizes literature indexed in PubMed/MEDLINE and incorporates relevant evidence represented in international scientific databases, including Scopus and Web of Science. Search terminology encompasses combinations of concepts related to body dysmorphic disorder, aesthetic surgery, preoperative assessment, psychiatric symptoms, and postoperative satisfaction.

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The selected references include observational investigations, clinical studies, systematic reviews, meta-analyses, and relevant narrative reviews. Particular attention was given to studies from Brazil to incorporate Latin American evidence into the international discussion [13]–[17].

Selection was based on thematic relevance and clinical applicability. This approach does not constitute an exhaustive systematic search, and no unverified identification, exclusion, or screening counts are attributed to the bibliographic process.

Critical Evaluation and Organization of the Evidence

The analytical phase involved structuring the available scientific findings according to their methodological characteristics and contribution to the research objectives. Particular consideration was given to the populations examined, assessment instruments, reported outcomes, and limitations affecting interpretation.

Evidence concerning prevalence was evaluated with attention to differences between positive screening results and confirmed psychiatric diagnoses. For example, the meta-analysis by Nabavizadeh et al. [3] reported a pooled BDD prevalence of 32.7% among rhinoplasty candidates, although substantial between-study heterogeneity limited the generalizability of the estimate.

Investigations addressing screening methods were considered in relation to their diagnostic applicability and limitations [1], [6], [7]. Psychiatric studies were examined for evidence concerning depression, obsessive-compulsive manifestations, and suicidality [18]–[20].

The evaluation also considered differences in surgical populations, symptom severity, and postoperative follow-up, recognizing that associations observed in individual studies cannot automatically establish causal relationships.

Thematic Synthesis and Integration of Findings

The synthesis phase was organized around six thematic dimensions: clinical characteristics and epidemiology, preoperative identification, psychiatric comorbidity, postoperative satisfaction, Latin American evidence, and multidisciplinary patient selection.

The integration of findings emphasized areas of agreement and uncertainty. International investigations generally support the clinical relevance of psychological screening, although differences in instrument performance and diagnostic procedures complicate direct comparisons [1], [8].

Similarly, studies examining postoperative outcomes indicate that dysmorphic symptoms may be associated with dissatisfaction after surgery, while selected individuals with milder manifestations have demonstrated favorable results in certain clinical settings [10], [11], [14], [16].

These differences were interpreted as evidence of clinical heterogeneity rather than proof of universally beneficial or unfavorable surgical outcomes. A qualitative synthesis was therefore considered more appropriate than calculating new pooled estimates from methodologically diverse studies.

Interpretation and Clinical Application

The interpretative phase focused on translating the principal findings into considerations relevant to aesthetic surgical practice.

The available evidence supports the importance of exploring appearance-related preoccupations, repetitive behaviors, functional impairment, psychiatric history, and patient expectations during preoperative consultations. When symptoms suggest clinically significant BDD or associated psychiatric vulnerability, additional assessment by qualified mental health professionals may be appropriate [2], [4].

The review also emphasizes that screening questionnaires should function as complementary clinical instruments rather than independent diagnostic tools or automatic criteria for surgical exclusion.

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From a multidisciplinary perspective, patient selection should consider the interaction between anatomical indications, psychological stability, symptom severity, informed consent, and anticipated postoperative outcomes. This framework seeks to support individualized decision-making while minimizing avoidable psychological harm.

Identification of Evidence Gaps and Research Priorities

The final phase involved identifying limitations in the available literature and defining priorities for future investigation.

Important evidence gaps include variability in diagnostic criteria, limited longitudinal follow-up, insufficient validation of screening instruments across different cultural settings, and the predominance of rhinoplasty-focused investigations.

Although Brazilian studies contribute relevant Latin American findings, additional multicenter research involving other countries in the region is necessary to improve geographical representation and determine whether existing screening approaches are applicable across diverse populations [13]–[17].

Future investigations should prioritize prospective designs, standardized psychiatric assessment, validated patient-reported outcome measures, and long-term evaluation of postoperative psychological functioning.

Collectively, these phases establish a coherent methodological framework for examining BDD in aesthetic surgery. Their integration facilitates the critical interpretation of existing scientific evidence and supports the formulation of clinically relevant recommendations concerning preoperative detection, psychiatric assessment, and safe patient selection.

RESULTS AND DISCUSSION

Figure 1.
Prevalence of Body Dysmorphic Disorder Among Aesthetic Surgery Candidates

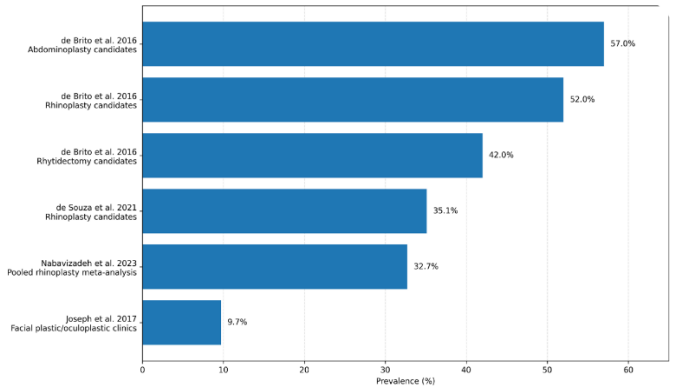

Figure 1 summarizes reported prevalence estimates of body dysmorphic disorder (BDD) or clinically significant BDD symptoms across selected studies involving aesthetic surgery candidates and related clinical populations. The graphical distribution shows marked variability among the included investigations, with prevalence values ranging from **9.7%** in the broader facial plastic and oculoplastic surgery clinic population described by Joseph et al. [8] to **57.0%** among abdominoplasty candidates in the study by de Brito et al. [13]. Intermediate values were observed for pooled rhinoplasty evidence in the meta-analysis by Nabavizadeh et al. (**32.7%**) [3], for rhinoplasty candidates in the Brazilian study by de Souza et al. (**35.1%**) [17], and for the rhinoplasty (**52.0%**) and rhytidectomy (**42.0%**) groups analyzed by de Brito et al. [13].

A first relevant result is the contrast between the **lower prevalence reported in mixed specialty clinical samples** and the **higher prevalence reported in procedure-specific aesthetic populations**. Joseph et al. identified positive BDD screening results in **9.7%** of patients attending facial plastic and oculoplastic surgery clinics [8]. In comparison, the prevalence estimates reported in studies focusing specifically on cosmetic surgery candidates were substantially higher. This pattern is visible in the graph, where the procedure-centered studies cluster above 30%, while the broader clinic sample remains below 10%. The figure therefore reflects a distribution in which prevalence appears higher when the

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evaluated population is more narrowly focused on elective aesthetic concerns rather than on a wider mixture of reconstructive and cosmetic consultations [8].

The figure also shows that **rhinoplasty-related populations occupy a central position in the available literature**, with several of the plotted values derived from rhinoplasty studies. The pooled estimate from the meta-analysis by Nabavizadeh et al. reached **32.7%** [3], while de Souza et al. reported **35.1%** among rhinoplasty candidates in their Brazilian sample [17]. In the study by de Brito et al., the rhinoplasty subgroup demonstrated an even higher prevalence of **52.0%** [13]. When viewed together, these findings indicate that rhinoplasty populations repeatedly show a substantial proportion of positive BDD-related findings across different settings. At the same time, the spread between **32.7%**, **35.1%**, and **52.0%** demonstrates that the magnitude of the estimate is not uniform across studies. The figure visually captures this variability, suggesting differences in study design, patient selection, and assessment criteria across the literature [3], [13], [17].

Another important finding represented in the figure is the **procedure-specific variation within the same study population**. De Brito et al. reported prevalences of **57.0%** in abdominoplasty candidates, **52.0%** in rhinoplasty candidates, and **42.0%** in rhytidectomy candidates [13]. Because these values were obtained within one investigation using the same broader research framework, they provide an internal comparison across different types of aesthetic procedures. In the graph, abdominoplasty appears as the highest observed value, followed by rhinoplasty and then rhytidectomy. This distribution shows that the reported frequency of BDD symptoms was not identical across aesthetic surgery categories in that study. The figure therefore highlights not only variability between studies, but also variability between procedures within the same clinical research context [13].

The visual comparison additionally reinforces the distinction between **candidate-specific prevalence** and **overall clinic prevalence**. The bar corresponding to Joseph et al. [8] represents a more heterogeneous clinical sample drawn from facial plastic and oculoplastic settings, whereas the bars for de Brito et al. [13] and de Souza et al. [17] correspond to patient groups specifically seeking elective aesthetic procedures. This is relevant to the descriptive reading of the results because the plotted values should not be interpreted as interchangeable estimates for a single universal population. Rather, the graph presents prevalence as reported in distinct clinical contexts. For this reason, the lower value of **9.7%** and the higher procedure-based estimates should be read as findings derived from different sampling frames rather than as contradictory measurements of the same patient group [8], [13], [17].

The graph also reflects the **regional contribution of Latin American evidence**, particularly from Brazil. Three of the plotted sources with quantitative candidate-specific estimates derive from Brazilian investigations: de Brito et al. [13] and de Souza et al. [17]. These studies contribute procedure-level prevalence data for abdominoplasty, rhinoplasty, and rhytidectomy, allowing the visual representation of regional evidence alongside broader international findings. In descriptive terms, the inclusion of these studies shows that the literature from Latin America provides not only contextual support, but also direct prevalence estimates suitable for quantitative comparison within the results section [13], [17].

An additional descriptive observation concerns the **range and concentration of values**. Five of the six plotted estimates are at or above **32%**, while three exceed **40%**, and two surpass **50%** [3], [13], [17]. This concentration of relatively elevated values in aesthetic candidate samples contrasts sharply with the single lower bar corresponding to the mixed clinical population in Joseph et al. [8]. The graphical arrangement therefore shows that most of the candidate-focused reports included in this figure identify a considerable proportion of patients with BDD symptoms or positive BDD screening findings. This pattern remains visible even without combining the studies statistically and serves as a straightforward descriptive summary of the reported evidence [3], [8], [13], [17].

Finally, Figure 1 provides a structured descriptive foundation for the results section by showing that the reported prevalence of BDD in aesthetic settings is **heterogeneous, procedure-sensitive, and dependent on the population evaluated**. The highest value in the selected figure corresponds to abdominoplasty candidates (**57.0%**), whereas the lowest corresponds to a mixed facial plastic and oculoplastic clinical population (**9.7%**) [8], [13]. Rhinoplasty-related values appear repeatedly and occupy an intermediate-to-high range, including the pooled prevalence estimate of **32.7%** [3], the **35.1%** reported by de Souza et al. [17], and the **52.0%** observed in the rhinoplasty subgroup of de Brito et al. [13]. These are the principal findings directly represented by the figure and constitute the quantitative basis for the subsequent results figures.

Figure 2.
Preoperative Screening Instruments and Diagnostic Assessment Characteristics

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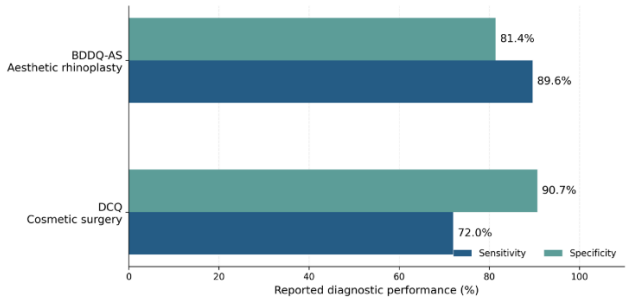

Figure 2 presents a comparative representation of the diagnostic performance of two screening instruments used to identify body dysmorphic disorder (BDD) in aesthetic surgery settings: the Body Dysmorphic Disorder Questionnaire–Aesthetic Surgery (BDDQ-AS) and the Dysmorphic Concern Questionnaire (DCQ). The graphical analysis focuses on sensitivity and specificity, which represent complementary dimensions of diagnostic accuracy. The BDDQ-AS demonstrated a reported sensitivity of 89.6% and specificity of 81.4%, whereas the DCQ was represented by sensitivity and specificity estimates of 72.0% and 90.7%, respectively. These findings illustrate differences in the diagnostic characteristics of the instruments, although the estimates originate from separate validation settings and should not be interpreted as results of a direct comparative trial [1], [6], [7].

The BDDQ-AS exhibited the highest sensitivity among the two instruments represented in the figure. Its reported sensitivity of 89.6% indicates that approximately nine of every ten individuals meeting the reference diagnostic criteria would be expected to obtain a positive screening result under the conditions of the corresponding validation study. This characteristic is particularly relevant when examining the capacity of a questionnaire to recognize individuals presenting clinically significant appearance-related preoccupations. Nevertheless, the remaining proportion of false-negative results demonstrates that a negative screening outcome does not completely exclude the possibility of BDD, especially when persistent psychological distress or functional impairment is identified during clinical assessment [1], [7].

Regarding specificity, the BDDQ-AS demonstrated a reported value of 81.4%. This estimate indicates that the instrument correctly classified approximately eight of every ten individuals without the disorder according to the reference assessment used in its validation. The remaining proportion corresponds to individuals who could receive positive screening results despite not meeting the diagnostic criteria. This distinction is important because screening questionnaires identify patterns of symptoms requiring further assessment rather than independently establishing definitive psychiatric diagnoses. The combination of relatively high sensitivity and moderate-to-high specificity characterizes the BDDQ-AS as an instrument designed to recognize potential cases while maintaining reasonable discrimination between affected and unaffected individuals [6], [7].

In contrast, the DCQ demonstrated a different distribution of diagnostic performance, with a sensitivity of 72.0% and specificity of 90.7% in the estimates represented. The sensitivity value indicates a comparatively lower proportion of correctly identified cases, whereas the higher specificity reflects a greater capacity to classify individuals without the disorder correctly. The graphical comparison therefore shows a difference between the two instruments in the relative balance of case identification and exclusion. However, differences in validation populations, diagnostic thresholds, and reference standards limit the extent to which these estimates can be compared directly [1].

The difference in sensitivity between the two represented instruments was 17.6 percentage points, favoring the BDDQ-AS. Conversely, the DCQ demonstrated a specificity 9.3 percentage points higher than that of the BDDQ-AS. These numerical differences describe the estimates displayed in the figure and should not be interpreted as statistically significant differences because the instruments were not evaluated through a common head-to-head validation design. Furthermore, the absence of directly comparable confidence intervals prevents a formal assessment of whether the observed differences exceed the uncertainty associated with the original estimates [1], [6], [7].

An additional consideration concerns the clinical populations in which screening instruments were developed and evaluated. The BDDQ-AS was adapted for aesthetic surgery candidates, incorporating questions intended to identify excessive appearance-related concerns and their associated psychological consequences. The DCQ, by comparison, evaluates broader dysmorphic concerns, including dissatisfaction with appearance and preoccupation with perceived bodily imperfections. Although both instruments address related psychological constructs, their content and validation characteristics are not identical. Consequently, differences in diagnostic performance may reflect variations in the symptoms assessed and the characteristics of the populations examined [1], [6], [7].

The findings also demonstrate the importance of distinguishing screening accuracy from diagnostic confirmation. Sensitivity and specificity describe the performance of an instrument relative to a reference standard, but they do not directly indicate the probability that an individual with a positive result has BDD. That probability depends partly on

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the prevalence of the disorder within the evaluated population. Accordingly, the positive predictive value of a questionnaire may vary between general clinical populations and groups specifically requesting elective aesthetic procedures, even when sensitivity and specificity remain relatively stable [1], [8].

This distinction is particularly relevant when considering the prevalence differences identified in Figure 1. Investigations involving rhinoplasty candidates and other aesthetic surgery populations reported substantially different proportions of dysmorphic symptoms. Such variability suggests that the interpretation of screening results must account for the characteristics of the population being evaluated. Nevertheless, the present figure does not calculate predictive values or estimate diagnostic probabilities for specific surgical specialties because the necessary population-specific information was not consistently available across the selected studies [3], [8], [13].

The reviewed literature also indicates that psychological screening instruments assess only selected dimensions of the clinical presentation. BDD involves persistent preoccupation with perceived appearance defects, repetitive behaviors, emotional distress, and functional impairment. Although structured questionnaires can identify several of these characteristics, they may not fully characterize psychiatric comorbidity, insight, symptom duration, or the psychological meaning attributed to the requested surgical intervention. Consequently, questionnaire-based findings and comprehensive psychiatric assessments represent different levels of clinical evaluation rather than interchangeable diagnostic procedures [1], [4], [5].

Figure 3.
Psychiatric Comorbidity and Psychological Risk in Body Dysmorphic Disorder

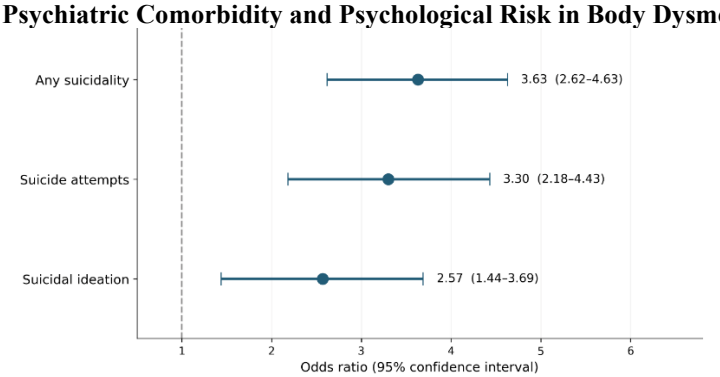

Figure 3 illustrates the association between body dysmorphic disorder (BDD) and suicidality, incorporating quantitative findings from the systematic review and meta-analysis conducted by Angelakis et al. [18]. The analysis included 17 studies and examined the relationship between BDD and suicidal ideation, suicide attempts, and overall suicidality. The results are expressed as odds ratios (ORs) with corresponding 95% confidence intervals, allowing visualization of the magnitude and precision of the reported associations. The figure is complemented by findings concerning depressive and other psychiatric comorbidities, as documented in clinical investigations involving individuals diagnosed with BDD [19], [20].

The strongest overall association was observed for the combined category of suicidality, with an odds ratio of 3.63 and a 95% confidence interval of 2.62–4.63. This estimate indicates that the odds of suicidal thoughts or behaviors were higher among individuals with BDD than among the comparison groups included in the meta-analysis. The confidence interval remained above the null value of 1.0, demonstrating a statistically significant association within the reported analysis. However, this measure represents a relative association and should not be interpreted as the absolute probability of suicidal behavior among affected individuals [18].

When the outcomes were examined separately, suicide attempts demonstrated an odds ratio of 3.30, with a 95% confidence interval of 2.18–4.43. Suicidal ideation was associated with an odds ratio of 2.57, with a 95% confidence interval of 1.44–3.69. Both estimates remained above the null reference, indicating statistically significant associations. The point estimate for suicide attempts exceeded that for suicidal ideation, although the overlapping confidence intervals do not independently establish a statistically significant difference between these two outcomes. These findings describe different dimensions of suicidality and are presented separately to preserve their clinical and statistical distinctions [18].

The graphical distribution also illustrates the variability in the precision of the reported associations. The confidence interval for suicidal ideation extends from 1.44 to 3.69, while the estimate for suicide attempts ranges from 2.18 to 4.43. The width and overlap of these intervals reflect uncertainty surrounding the estimated associations. Angelakis et al. [18] reported methodological heterogeneity and limitations in the quality of the included studies, factors that are relevant when interpreting the consistency of findings across different psychiatric populations and research settings.

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In addition to suicidality, depressive disorders represent a major component of psychiatric comorbidity in BDD. Phillips et al. [20] investigated major depressive disorder among 178 individuals with BDD and reported a lifetime prevalence of 74.2% and a current prevalence of 38.2%. These findings indicate that depressive episodes were frequently documented in the investigated clinical population. The distinction between lifetime and current prevalence is important because the former includes individuals who experienced depressive episodes at any previous point, whereas the latter represents depression present during the assessment period.

The same investigation demonstrated that participants presenting current major depressive disorder generally experienced greater BDD symptom severity than those without current depression. Furthermore, comorbid depression was associated with an increased frequency of additional anxiety or personality disorders. These findings describe a pattern of overlapping psychiatric manifestations in which depressive symptoms coexist with appearance-related preoccupation and broader psychological difficulties. However, because the investigation was observational, the results do not establish whether depressive symptoms preceded, followed, or developed independently of the dysmorphic disorder [20].

The broader psychiatric characteristics of BDD were also examined by Phillips et al. [19] in a clinical investigation involving 200 individuals. Their findings documented frequent psychiatric comorbidity and considerable variation in the manifestations and severity of the disorder. In addition to depressive symptoms, the clinical profiles included anxiety-related and obsessive-compulsive features, demonstrating that appearance-related preoccupation may occur within a complex psychiatric presentation rather than as an isolated symptom. The coexistence of multiple psychiatric conditions introduces additional variability into the clinical characterization of affected individuals [19].

An important distinction concerns the populations represented by the evidence. The studies contributing to the suicidality meta-analysis and the investigations by Phillips et al. primarily involved individuals with BDD recruited from psychiatric or related clinical settings. Consequently, the reported odds ratios and comorbidity proportions do not represent direct estimates for all patients requesting cosmetic surgery. They describe psychiatric risk and comorbidity within the populations examined by the original investigators. This distinction is relevant because the frequency and severity of psychiatric manifestations may differ between specialized psychiatric samples and aesthetic surgery candidates identified through screening instruments [18]–[20].

Overall, the findings associated with Figure 3 demonstrate a consistent relationship between BDD and substantial psychiatric burden. The meta-analysis identified increased odds of overall suicidality (OR = 3.63), suicide attempts (OR = 3.30), and suicidal ideation (OR = 2.57), while complementary clinical investigations documented high frequencies of lifetime and current major depressive disorder [18], [20]. Together, these findings provide a quantitative and descriptive characterization of psychiatric comorbidity and psychological risk in BDD, while preserving the distinction between relative risk measures, prevalence estimates, and the specific populations from which they were obtained.

Figure 4.

Postoperative Satisfaction and Psychological Outcomes in Patients With Dysmorphic Symptoms

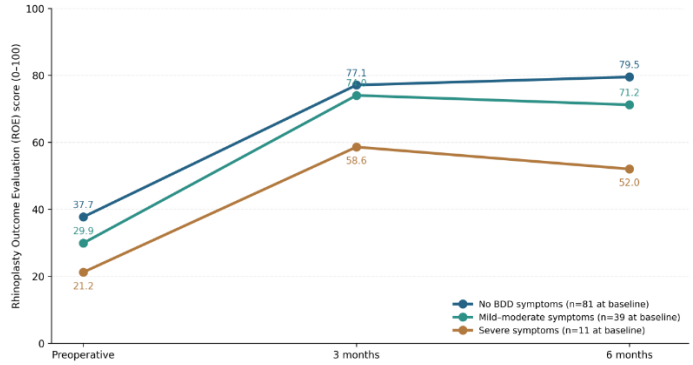

Figure 4 illustrates changes in patient-reported aesthetic satisfaction following rhinoseptoplasty according to the severity of preoperative body dysmorphic disorder (BDD) symptoms. The graphical representation is based on the Brazilian cohort investigated by Rabaioli et al. [16], which included 131 individuals undergoing aesthetic and/or functional rhinoseptoplasty. Participants were classified into three groups according to their preoperative dysmorphic symptoms: individuals without BDD symptoms (n = 81), those presenting mild to moderate symptoms (n = 39), and those with severe symptoms (n = 11). Postoperative outcomes were evaluated using the Rhinoplasty Outcome Evaluation (ROE), which measures patient-reported satisfaction with nasal appearance and related quality-of-life dimensions. Scores were assessed before surgery and at three and six months following intervention.

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The results demonstrated an increase in ROE scores across all three groups during postoperative follow-up. Among individuals without preoperative BDD symptoms, mean scores increased from 37.7 before surgery to 77.09 at three months and 79.5 at six months. This represented an improvement of approximately 39.4 points at the first postoperative assessment and 41.8 points at the final evaluation. The graphical trajectory shows a pronounced increase during the initial three months, followed by a smaller additional improvement between the third and sixth postoperative months. This pattern indicates relatively stable satisfaction during the later assessment period within the observed cohort [16].

Patients presenting mild to moderate dysmorphic symptoms also demonstrated substantial postoperative improvement. Mean ROE scores increased from 29.9 preoperatively to 74.01 at three months, followed by 71.2 at six months. The greatest improvement occurred during the initial postoperative interval, with an increase of approximately 44.1 points. Although the mean score decreased slightly between the third and sixth months, it remained substantially higher than the preoperative value. The visual distribution shows that the postoperative satisfaction trajectory of this group approached that of individuals without BDD symptoms, particularly at the three-month assessment [16].

The group presenting severe preoperative dysmorphic symptoms demonstrated a different numerical pattern. Initial ROE scores were considerably lower, reaching 21.2 before intervention. At three months, the mean score increased to 58.59, representing an improvement of approximately 37.4 points. However, at six months, the score decreased to 52.02. Despite remaining above baseline, this group consistently demonstrated lower postoperative satisfaction than the other two groups. The figure therefore identifies a descriptive gradient in which greater preoperative dysmorphic symptom severity corresponded to lower mean aesthetic satisfaction at each assessment period [16].

Comparison of the three groups reveals that the magnitude of postoperative improvement did not eliminate differences in satisfaction associated with baseline symptom severity. At six months, the mean ROE score was 79.5 among individuals without dysmorphic symptoms, 71.2 among those with mild to moderate symptoms, and 52.02 among participants with severe symptoms. The difference between the groups without symptoms and with severe symptoms was approximately 27.5 points at the final assessment. Rabaioli et al. reported statistically significant between-group differences in postoperative ROE scores, particularly when comparing individuals with severe dysmorphic symptoms with those presenting no symptoms or milder manifestations [16].

A complementary finding concerns the evolution of dysmorphic symptom severity itself. In the same investigation, the Body Dysmorphic Disorder Examination (BDDE) demonstrated reductions in symptom scores after surgery. Among participants with severe symptoms, mean BDDE scores decreased from 114.90 preoperatively to 45.16 at three months and 54.25 at six months. Patients with mild to moderate symptoms showed a reduction from 89.02 to 35.68 and 34.91, respectively. These measurements indicate that improvements in patient-reported aesthetic outcomes were accompanied by reductions in dysmorphic symptom scores within the study population. Nevertheless, the reported values represent questionnaire-based changes during a limited follow-up period and should not be equated automatically with sustained psychiatric remission [16].

The results of this Brazilian cohort can be examined alongside the prospective investigation conducted by Felix et al. [14], which evaluated 31 women with mild to moderate BDD undergoing rhinoplasty. At one year after surgery, 28 participants (90%) reported satisfaction with the surgical outcome, while 25 (81%) met the study's criteria for complete BDD remission. The investigators also reported significant reductions in dysmorphic symptom severity and time devoted to appearance-related concerns. Although these findings were obtained from a different population and used a longer follow-up interval, they document postoperative improvement among selected individuals presenting dysmorphic symptoms [14].

In contrast, Picavet et al. [10] identified negative correlations between preoperative BDD symptom severity and postoperative satisfaction following aesthetic rhinoplasty. At three months, correlations between preoperative dysmorphic symptoms and postoperative satisfaction were rho = −0.43 for nasal appearance satisfaction and rho = −0.48 for the ROE. At 12 months, the corresponding correlations remained negative (rho = −0.40 and rho = −0.41, respectively), with all reported associations reaching statistical significance ($p < 0.001$). These findings indicate that greater preoperative symptom severity was associated with lower postoperative satisfaction within the evaluated population [10].

The investigations therefore present both convergent and differing observations. Rabaioli et al. [16] documented improvements in patient-reported outcomes across all baseline symptom groups, although participants with severe dysmorphic symptoms continued to report lower postoperative satisfaction. Felix et al. [14] reported favorable outcomes among a selected group of women with mild to moderate BDD, while Picavet et al. [10] demonstrated an inverse association between preoperative dysmorphic symptom severity and later satisfaction. The studies differed in patient selection, assessment instruments, severity distributions, and follow-up duration, preventing direct numerical pooling of their results.

Figure 5.

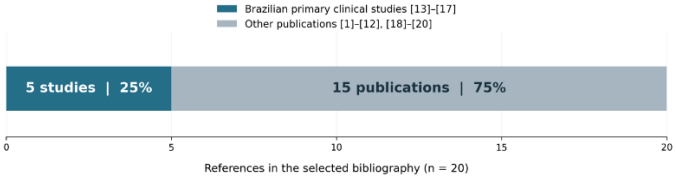

Figure 5 presents the composition of the scientific evidence included in this narrative review, emphasizing the contribution of Latin American investigations to the broader international literature on body dysmorphic disorder (BDD) in aesthetic surgery. Of the 20 selected scientific publications, five (25%) corresponded to primary clinical investigations conducted in Brazil, while the remaining 15 (75%) comprised other international clinical investigations, methodological studies, systematic reviews, meta-analyses, and publications addressing psychiatric characteristics and surgical assessment. This classification provides a descriptive representation of the geographical component of the bibliographic framework rather than an estimate of regional research productivity or disease prevalence [1]–[20].

The five Brazilian investigations were published between 2014 and 2022 and examined several clinical dimensions of BDD in individuals requesting aesthetic surgical interventions. These publications included research concerning the prevalence of dysmorphic symptoms, the relationship between appearance-related obsessive-compulsive manifestations and surgical consultation, functional characteristics among rhinoplasty candidates, and psychological outcomes following aesthetic procedures. Their inclusion established a regional component within the evidence base and provided patient-level clinical findings from Latin American healthcare institutions [13]–[17].

Within the Brazilian research group, rhinoplasty represented the most frequently examined intervention. Four investigations specifically included rhinoplasty candidates or patients undergoing rhinoplasty, while another evaluated individuals receiving aesthetic or functional rhinoseptoplasty. De Brito et al. additionally examined abdominoplasty and rhytidectomy within the same investigation, expanding the procedural range of the regional evidence. Consequently, the five Brazilian publications addressed rhinoplasty, rhinoseptoplasty, abdominoplasty, and rhytidectomy, although these procedures were not represented with equal frequency [13]–[17].

A notable characteristic of the Latin American evidence was the presence of investigations conducted through Brazilian academic and hospital institutions. The studies by Felix et al. [14] and Ramos et al. [15] included researchers associated with the Federal University of São Paulo, while de Souza et al. [17] examined rhinoplasty candidates in an institutional setting associated with the Federal University of Paraná. Rabaioli et al. [16] contributed evidence from southern Brazil, involving institutions in Porto Alegre. This distribution demonstrates participation from multiple Brazilian academic environments, although the selected regional publications were concentrated within one country.

The Brazilian investigations also exhibited methodological diversity. De Brito et al. [13] examined 300 candidates for three aesthetic surgical procedures, identifying different frequencies of dysmorphic symptoms among abdominoplasty, rhinoplasty, and rhytidectomy groups. Ramos et al. [15] conducted an investigation involving 50 rhinoplasty candidates and reported BDD symptoms in 48% of participants, together with moderate to severe appearance-related obsessive-compulsive symptoms in 54%. De Souza et al. [17] evaluated 57 rhinoplasty candidates and 31 control participants, reporting positive screening results in 35.1% and 3.2%, respectively. These investigations contributed cross-sectional clinical observations using different assessment instruments and participant populations.

Additional Brazilian studies incorporated postoperative follow-up. Felix et al. [14] prospectively evaluated 31 women with mild to moderate BDD undergoing rhinoplasty and reported postoperative changes in dysmorphic symptom severity and patient satisfaction at one year. Rabaioli et al. [16] examined 131 individuals undergoing rhinoseptoplasty and assessed dysmorphic symptoms, nasal function, and satisfaction during follow-up extending to six months. Together, these investigations expanded the regional evidence beyond prevalence estimation to include postoperative patient-reported outcomes.

The remaining 15 publications provided a broader international and conceptual framework for understanding BDD in aesthetic surgery. These references included investigations of diagnostic instruments and preoperative screening, studies examining the relationship between psychological symptoms and postoperative satisfaction, and research concerning psychiatric comorbidity and suicidality. They also included systematic reviews and meta-analyses integrating findings from different clinical settings. The diversity of these sources supported the organization of the review into complementary clinical domains, although they were not homogeneous with respect to study design, geographical scope, or population characteristics [1]–[12], [18]–[20].

Among these publications, the systematic review and meta-analysis by Nabavizadeh et al. [3] provided an international quantitative synthesis of BDD prevalence among rhinoplasty candidates, integrating 18 studies involving 2,132 participants. Other investigations focused on the clinical performance of screening instruments, including research by Picavet et al. [6] and Lekakis et al. [7]. Joseph et al. [8] contributed evidence from facial plastic and oculoplastic

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surgery clinics, while Bowyer et al. [11] examined cosmetic treatment outcomes among individuals with BDD. These publications represented different approaches to assessing the relationship between dysmorphic symptoms and aesthetic surgical practice.

The psychiatric dimension of the selected evidence was represented by investigations concerning clinical characteristics, depressive comorbidity, and suicidality. Phillips et al. [19], [20] examined psychiatric manifestations and associated conditions among individuals diagnosed with BDD, while Angelakis et al. [18] synthesized evidence regarding suicidal ideation and suicide attempts. Unlike the Brazilian procedure-focused studies, these investigations primarily examined psychiatric populations or combined evidence from different clinical contexts. Their inclusion broadened the range of psychological and psychiatric outcomes considered in the review.

The graphical distribution indicates that the selected bibliography contains a substantial international component complemented by five Brazilian primary clinical studies. However, the numerical proportions shown in Figure 5 should be interpreted exclusively as characteristics of the literature selected for this review. The 25% Brazilian representation does not indicate the actual proportion of worldwide BDD research conducted in Latin America, and the remaining 75% should not be interpreted as a geographically uniform group. Some publications included in this category synthesize evidence from multiple countries, while others focus on specific clinical populations.

A further observation concerns the geographical concentration of the Latin American component. Although Brazil contributes evidence involving different surgical interventions, assessment instruments, and institutional settings, the selected references do not include equivalent primary investigations from other Latin American countries. Consequently, the regional findings represented in the figure correspond specifically to Brazilian clinical research. This distinction is essential when describing the geographical scope of the available evidence, as Latin America encompasses diverse populations and healthcare systems that are not uniformly represented within the selected bibliography.

DISCUSSION

The findings of this narrative review demonstrate that body dysmorphic disorder (BDD) represents a clinically relevant and multifactorial condition in aesthetic surgery, particularly because of its association with psychological vulnerability, psychiatric comorbidity, and variability in postoperative satisfaction. The evidence suggests that the identification of dysmorphic symptoms requires an approach extending beyond conventional anatomical examination, incorporating psychological screening, psychiatric assessment when indicated, and individualized evaluation of surgical expectations. Nevertheless, substantial heterogeneity among published investigations limits the establishment of universally applicable diagnostic thresholds or definitive criteria for surgical eligibility [1], [2], [4].

One of the principal findings concerns the considerable variability in reported BDD prevalence among aesthetic surgery candidates. The meta-analysis by Nabavizadeh et al. [3] identified a pooled prevalence of 32.7% among rhinoplasty candidates, whereas individual Brazilian investigations reported estimates ranging from 35.1% to 57.0% across selected surgical populations [13], [17]. By comparison, Joseph et al. [8] identified positive screening results in 9.7% of patients attending facial plastic and oculoplastic surgery clinics. These differences may reflect variations in patient recruitment, surgical indications, psychological assessment instruments, and the distinction between clinically diagnosed BDD and symptoms identified through screening. Therefore, prevalence estimates should not be considered interchangeable across aesthetic specialties or clinical environments.

The particularly elevated frequency of dysmorphic symptoms reported in some Brazilian populations warrants careful interpretation. De Brito et al. [13] identified different prevalence estimates among candidates for abdominoplasty, rhinoplasty, and rhytidectomy, suggesting that appearance-related psychological concerns may vary according to the surgical procedure requested. However, differences between these groups cannot independently establish that a specific operation increases the probability of BDD. Demographic characteristics, baseline psychological functioning, recruitment patterns, and the meaning attributed to particular anatomical features may contribute to the observed distributions. Furthermore, symptom-based classifications do not necessarily correspond to confirmed psychiatric diagnoses. This distinction is essential to avoid overestimating the prevalence of clinically established BDD in aesthetic practice.

The findings also highlight the limitations of relying exclusively on surgeons' clinical impressions when evaluating psychological suitability. Joseph et al. [8] documented substantial underrecognition of positive BDD screening results during routine surgical consultations, indicating that conventional preoperative assessment may not consistently identify individuals experiencing clinically significant appearance-related distress. This observation is consistent with

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the findings summarized by Pereira et al. [1], who emphasized the potential utility of validated screening instruments in aesthetic settings. Nevertheless, screening performance varies according to the instrument, diagnostic reference standard, and characteristics of the evaluated population.

The evaluation of screening instruments further illustrates the need to distinguish diagnostic sensitivity from specificity. An instrument with higher sensitivity may identify a greater proportion of individuals presenting symptoms compatible with BDD, whereas higher specificity may reduce the frequency of positive results among individuals without the disorder. However, neither measure independently establishes the clinical usefulness of a questionnaire in every aesthetic setting. Predictive values are influenced by the prevalence of the condition, and screening accuracy obtained in one population may not remain constant across different languages, cultural environments, or surgical specialties. Consequently, the findings presented in Figure 2 should be interpreted as evidence concerning instrument-specific diagnostic characteristics rather than as a definitive ranking of available screening tools [1], [6], [7].

These considerations are especially relevant in aesthetic surgery because dissatisfaction with physical appearance does not necessarily represent psychiatric pathology. Individuals may request aesthetic interventions for reasons related to personal preferences, cultural expectations, previous injuries, or perceived disproportion without presenting clinically significant psychological impairment. Conversely, patients with BDD may describe their concerns through apparently conventional aesthetic complaints while experiencing persistent preoccupation, repetitive behaviors, and substantial functional deterioration. The distinction requires assessment of the psychological significance of the perceived imperfection rather than exclusive consideration of its anatomical visibility [5], [12].

Psychiatric comorbidity constitutes another important finding of the review. The investigations by Phillips et al. [19], [20] documented a considerable burden of depressive and other psychiatric disorders among individuals with BDD. These findings indicate that dysmorphic preoccupation frequently occurs alongside broader disturbances in emotional functioning. The coexistence of depression, anxiety, and obsessive-compulsive manifestations may complicate the interpretation of patient expectations, particularly when individuals attribute persistent emotional suffering to a specific physical characteristic. Nevertheless, the available observational evidence does not establish a uniform causal relationship between BDD and its psychiatric comorbidities.

The association between BDD and suicidality represents a particularly important clinical consideration. Angelakis et al. [18] identified increased odds of suicidal ideation and suicide attempts among individuals with BDD compared with control populations. These results demonstrate the relevance of assessing psychological distress and psychiatric risk when clinically indicated. However, the populations contributing to the meta-analysis were not exclusively composed of aesthetic surgery candidates. Therefore, the observed associations cannot be directly translated into absolute estimates of suicidal risk among individuals attending cosmetic surgery consultations. The distinction between general psychiatric populations and surgical candidates must remain explicit when applying these findings to preoperative evaluation.

An additional issue concerns the relationship between preoperative dysmorphic symptoms and postoperative satisfaction. The available evidence demonstrates that anatomical improvement and psychological outcomes are related but not equivalent dimensions of surgical success. Picavet et al. [10] reported negative associations between preoperative BDD symptom severity and satisfaction following rhinoplasty, indicating that individuals with more pronounced dysmorphic concerns tended to report less favorable subjective outcomes. Similarly, the critical review by Bowyer et al. [11] described limitations in the psychological benefits associated with cosmetic interventions among individuals affected by BDD.

However, not all investigations demonstrated unfavorable postoperative trajectories. Felix et al. [14] reported improvements in satisfaction and dysmorphic symptoms among selected patients with mild to moderate BDD undergoing rhinoplasty. Rabaioli et al. [16] also documented postoperative improvements across groups with different degrees of preoperative dysmorphic symptoms, although patients with severe manifestations maintained comparatively lower satisfaction scores. These findings suggest that symptom severity and individual clinical characteristics may contribute to differences in postoperative outcomes.

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The apparent disagreement between studies reporting persistent dissatisfaction and those documenting postoperative improvement may be partly explained by differences in patient selection and outcome measurement. Investigations involving individuals with mild to moderate symptoms may not adequately represent patients experiencing severe psychiatric impairment, poor insight, or extensive psychiatric comorbidity. Moreover, an improvement in appearance-related satisfaction does not necessarily indicate resolution of the underlying psychiatric disorder. Measures such as the Rhinoplasty Outcome Evaluation primarily assess satisfaction with nasal appearance and related functioning, whereas instruments designed specifically for BDD evaluate different dimensions of psychopathology. These outcomes should therefore be interpreted independently rather than regarded as interchangeable indicators of treatment success [10], [11], [14], [16].

The duration of postoperative follow-up introduces another limitation. Psychological responses to cosmetic surgery may change during recovery as edema resolves, scars mature, anatomical changes stabilize, and patients adapt to their appearance. Studies with short follow-up periods may capture early satisfaction without documenting whether improvements persist over subsequent years. Conversely, prolonged dissatisfaction may develop through mechanisms not adequately characterized by brief observational investigations. The diversity of follow-up intervals among the selected studies limits direct comparison and underscores the need for longitudinal investigations using standardized psychiatric and surgical outcome measures [10], [14], [16].

The Latin American evidence provides an important contribution to the international understanding of BDD in aesthetic surgery. Brazilian investigations have examined prevalence, obsessive-compulsive manifestations, perceived nasal function, and postoperative satisfaction across several surgical populations [13]–[17]. These studies demonstrate that the clinical relationship between dysmorphic symptoms and aesthetic procedures extends beyond the populations traditionally represented in North American and European research. Nevertheless, the concentration of regional evidence in Brazil limits its geographical representativeness.

Latin America encompasses considerable cultural, socioeconomic, and healthcare diversity. Differences in access to psychiatric services, social perceptions of aesthetic procedures, and the availability of specialized multidisciplinary teams may influence the identification and management of BDD. However, the selected evidence does not establish how these factors differ systematically between Latin American countries. Accordingly, potential cultural influences should be considered contextual variables requiring further investigation rather than explanations conclusively demonstrated by the available studies.

From a clinical perspective, the reviewed evidence supports the integration of psychological considerations into surgical decision-making. Bascarane et al. [4] described the importance of psychiatric assessment in cosmetic surgery, while Mandavia et al. [2] proposed a structured approach to identifying and managing BDD in facial aesthetic practice. These contributions are consistent with the findings concerning screening limitations, psychiatric comorbidity, and postoperative satisfaction. A multidisciplinary model allows the surgical team to evaluate anatomical feasibility while qualified mental health professionals assess clinically significant psychological disturbances when suspected.

However, psychiatric screening should not function as a mechanism for indiscriminate exclusion from aesthetic treatment. The presence of a psychiatric history does not automatically establish impaired decision-making capacity or predict postoperative dissatisfaction. Similarly, a positive screening questionnaire requires diagnostic clarification rather than immediate classification as a contraindication to surgery. A proportionate approach should consider current symptom severity, functional impairment, psychiatric stability, realistic expectations, treatment history, and the potential relationship between the proposed anatomical modification and the patient's psychological concerns [1], [2], [4].

The ethical dimensions of patient selection are closely related to informed consent and the prevention of avoidable harm. In elective aesthetic surgery, patients should understand the anatomical possibilities and limitations of the procedure, the likelihood of residual asymmetry, potential complications, and the distinction between physical modification and psychiatric treatment. When expectations involve complete transformation of personal relationships, social acceptance, emotional functioning, or self-worth, additional psychological evaluation may be appropriate. These considerations do not invalidate the patient's autonomy; rather, they contribute to decisions based on a realistic understanding of anticipated outcomes [4], [5], [12].

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The present review has several methodological limitations. First, its narrative design does not provide the comprehensive study identification, formal risk-of-bias assessment, or quantitative synthesis characteristic of a systematic review. Second, the selected investigations differ substantially in sample size, recruitment setting, screening methods, and diagnostic criteria. Third, a considerable proportion of the surgical literature focuses on rhinoplasty, reducing the strength of conclusions applicable to other aesthetic interventions. Fourth, several included studies relied on screening questionnaires rather than structured psychiatric interviews, potentially affecting the interpretation of reported prevalence. Finally, the regional component primarily includes Brazilian investigations, limiting extrapolation to other Latin American populations.

Despite these limitations, the integration of international and Latin American evidence provides a clinically relevant perspective on the relationship between BDD and aesthetic surgery. The findings indicate that the disorder is frequently represented among selected aesthetic surgery populations, may coexist with substantial psychiatric morbidity, and can influence postoperative satisfaction. At the same time, favorable outcomes reported in carefully selected patients demonstrate that the relationship between dysmorphic symptoms and surgical results cannot be reduced to a single deterministic model.

Future research should prioritize multicenter prospective investigations, standardized diagnostic assessment, and longer postoperative follow-up. Greater attention should also be directed toward evaluating the predictive validity of screening instruments, differentiating symptom severity categories, and identifying the clinical characteristics associated with sustained psychological and surgical satisfaction. Additional investigations involving diverse Latin American populations would strengthen the geographical applicability of the evidence and facilitate the development of culturally appropriate assessment pathways.

Taken together, the reviewed literature supports an integrated approach in which psychiatric, psychological, and surgical findings are considered complementary components of preoperative evaluation. The principal challenge is not merely identifying the presence of appearance-related distress, but determining its clinical significance, associated psychiatric vulnerability, and potential influence on surgical outcomes. This distinction is fundamental to developing evidence-informed patient selection processes that respect individual autonomy while maintaining appropriate standards of psychological and surgical safety [1], [2], [4], [11].

CONCLUSION

Body dysmorphic disorder (BDD) represents a significant clinical consideration in aesthetic surgery because of its association with psychological distress, psychiatric comorbidity, and variability in postoperative satisfaction. The evidence examined in this narrative review demonstrates that dysmorphic symptoms occur in a considerable proportion of patients seeking cosmetic procedures, particularly rhinoplasty, although reported prevalence varies substantially according to population characteristics, assessment instruments, and surgical settings. These findings reinforce the importance of distinguishing ordinary dissatisfaction with physical appearance from clinically significant psychopathology during preoperative evaluation [3], [5], [8].

Preoperative psychological screening constitutes a valuable component of comprehensive patient assessment. Instruments specifically developed or validated for identifying dysmorphic concerns may facilitate early recognition of individuals requiring additional psychiatric evaluation. Nevertheless, screening results must be interpreted alongside clinical interviews, psychiatric history, functional impairment, and patient expectations, since no single questionnaire can independently establish a definitive diagnosis or reliably predict postoperative outcomes. The integration of structured screening with individualized clinical assessment provides a more comprehensive framework for identifying psychological vulnerability [1], [2], [6], [7].

Psychiatric comorbidity emerged as another central dimension of BDD. The reviewed investigations documented substantial associations with depressive disorders, anxiety-related manifestations, obsessive-compulsive symptoms, and suicidality. These findings highlight the complexity of the disorder and the importance of recognizing psychiatric conditions that may influence emotional functioning and surgical expectations. Accordingly, the evaluation of patients presenting significant dysmorphic symptoms should incorporate appropriate assessment of psychiatric stability and

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psychological risk, particularly when severe distress, functional impairment, or unrealistic expectations are present [18]–[20].

The relationship between BDD and postoperative satisfaction remains heterogeneous. Although several investigations identified associations between greater preoperative dysmorphic symptom severity and less favorable postoperative outcomes, other studies demonstrated improvements in satisfaction among carefully selected individuals with mild to moderate symptoms. These differences indicate that the presence of dysmorphic concerns does not uniformly determine surgical outcomes. However, improvements in appearance-related satisfaction should not be interpreted as equivalent to psychiatric remission, and aesthetic surgery should not be considered an established primary treatment for BDD [10], [11], [14], [16].

Latin American investigations, particularly those conducted in Brazil, have contributed valuable evidence regarding the prevalence, clinical characteristics, and postoperative evolution of dysmorphic symptoms in aesthetic surgery candidates. Nevertheless, the concentration of regional research within a limited number of institutions and surgical specialties restricts the generalizability of these findings. Additional multicenter investigations involving diverse Latin American populations are necessary to strengthen geographical representation, validate screening instruments, and clarify the relationship between psychiatric characteristics and long-term surgical outcomes [13]–[17].

The findings support the central proposition of this review: integrating psychological screening, psychiatric assessment when indicated, and multidisciplinary evaluation may facilitate safer and more individualized patient selection. Although the available evidence does not establish that these strategies independently reduce complications or guarantee postoperative satisfaction, their incorporation is consistent with a comprehensive approach to elective aesthetic surgery. Collaboration among plastic surgeons, psychiatrists, and psychologists can contribute to diagnostic clarification, realistic expectation setting, informed consent, and the identification of patients who may benefit from mental health treatment before surgical intervention [2], [4].

In conclusion, safe aesthetic surgical practice requires recognition that technical success and psychological well-being are related but distinct outcomes. The clinical significance of BDD extends beyond dissatisfaction with appearance and involves the interaction of cognitive, emotional, behavioral, and psychiatric factors. An evidence-informed, patient-centered approach that incorporates appropriate psychological assessment and multidisciplinary decision-making offers a framework for balancing aesthetic objectives with psychiatric considerations, respecting patient autonomy, and minimizing avoidable harm. Future research should focus on standardized diagnostic criteria, prospective evaluation, and long-term outcomes to strengthen the evidence supporting individualized surgical eligibility and comprehensive patient care.

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