

# A qualitative study exploring the application of psychosocial screening to identify psychological conditions in non-surgical aesthetic patients

## Abstract

This study explores medical aesthetic practitioners' initial and ongoing application of psychosocial screening, to identify existing or emerging psychological disorders or conditions in non-surgical aesthetic patients. The increased demand for non-surgical aesthetic treatments correlates with the rise of patients who present with existing or evolving psychosocial problems or issues. Therefore, patients must be appropriately and adequately assessed, to identify those vulnerable individuals who are not suitable for treatment or whose treatments may exacerbate underlying psychological conditions. Identification can support signposting to trained professionals to ensure appropriate holistic care. Moreover, the study explores which validated screening tools have been adopted into practice, and routes for guiding patients should concerns arise.

## Key words

- ▶ Body dysmorphic disorder ▶ Screening tools ▶ Mental wellbeing
- ▶ Patient selection ▶ Psychosocial assessment ▶ Motivations

There is no doubt that non-surgical aesthetic procedures have gained popularity within the past two decades, with the American Society of Plastic Surgery stating that the use of botulinum toxin injections has risen by a staggering 845% from 2000–2018 (Balasubramanian, 2020). Further evidence indicates that individuals have an increased interest in pursuing aesthetic procedures within the next 12 months. A recent study highlighted the fact that 44% of people in the UK believe that the 2020 COVID-19 lockdowns have aged them physically and emotionally, as opposed to any other event (Pauly, 2020). Additionally, six million people in the UK are reported to be considering invasive or non-invasive treatments to treat the perceived ageing effects of lockdown (Walden, 2021). As a result, non-surgical aesthetics practitioners can expect a significant increase in demand for treatments.



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The medical aesthetics speciality has seen increased demand due to society's ever-changing expectations and values and the perpetual drive for a youthful appearance, illustrating that sociocultural factors influence a person's body image. Individuals are living longer, yet ageing at the same rate. Many strive to hold onto a youthful appearance. People will seek the services of an aesthetic practitioner to enhance their looks and delay the ageing process. Some individuals who seek toxin treatments are body-conscious and aware of the ageing process's impact on their perceived attractiveness, social status and social acceptance. This also highlights their fear of being judged by others (Molina et al, 2015).

Ultimately, many individuals have fallen victim to the social construction of beauty and society's emphasis on youth and beauty, which is more prevalent today due to social media such as Facebook and Instagram. The body is one way in which individuals express themselves and represent who they are and aspire to be. Appearance is intrinsically linked to self-worth, as well as the acceptance of society and perceived ideals. The more attractive and youthful a person is perceived, the more they feel socially accepted, and, for many, this can be the basis of achieving a higher social status (Corazza et al, 2019a).

The rise of social media and the popularity of the selfie has forced the UK population to become more image-conscious, with aesthetic intervention increasingly becoming the norm, which is supported by social media influencers and celebrities. However, studies have shown that an individual's appearance can impact many aspects of their lives and experiences, including quality of life, self-esteem and body image (Hosseini and Padhy, 2021). For example, edited and filtered photos can contribute to a skewed perception of perceived flaws, contributing to further insecurity, as individuals believe they are not as attractive as their filtered images. This could even lead to the feeling of inadequacy or be a trigger for developing body dysmorphic disorder (BDD), depression or an eating disorder (Buchanan and Kaplan, 2018).

BDD affects approximately 1.9% of the general population, with slightly more females being diagnosed (2.1%) than males (1.6%) (Buchanan and Kaplan, 2018). Additionally, approximately 13% of patients with BDD



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*The research aimed to determine how skilled practitioners assessed the psychosocial wellbeing of patients*

will attend an aesthetic clinic, compared to 1.9% in the general population (Anson et al, 2015). Treating BDD patients in aesthetic clinics can be problematic, as research suggests that 76–95% of BDD patients reported dissatisfaction with the aesthetic treatment result (Veale, 1996; Block and Sarwer, 2012). There is also evidence that BDD symptoms worsen after an aesthetic procedure, because the preoccupation shifts to a different area of the body (Higgins and Wysong, 2018). The term ‘perception drift’ was coined by Dr Fabi (2019), who said that, after several cosmetic treatments, patients may forget what they initially looked like, and their perception of the changes can be skewed. As each perceived flaw is addressed by treatment, another imperfection is recognised, meaning that the patient is never satisfied. Furthermore, treating a patient with BDD can be potentially detrimental to the practitioner and the patient. Approximately one-third of aesthetic practitioners have been threatened with legal action, and 2% have been physically threatened (Higgins, 2018). Patients can also attend numerous clinics for multiple treatments, effectively caught in a cycle of addiction and compulsion due to the obsessive nature of the condition (Gorbis, 2019).

The National Institute of Clinical Guidelines highlights the importance of adequate screening to diagnose and identify patients at risk of developing BDD (Arora, 2019) and other mental health conditions

(Gorbis, 2019). In 2010, the National Confidential Inquiry researched the experience and outcomes of aesthetic patients (Paraskeva, 2013). It highlighted that most providers fail to complete a psychological assessment as part of the initial consultation. Yet, a limited number of validated psychological screening tools have been developed for pre-procedural assessments (Dimitrov and Bewley, 2015). The tools in practice have negative reviews among practitioners for being time-consuming, difficult to interpret, not cost-effective and requiring the assistance of an expert with bespoke psychometric training (Higgins and Wysong, 2018). Even if an appropriate initial psychosocial assessment occurs within the aesthetic setting, practitioners should also have access to an effective support system for referring patients to other specialists if required (Sandler, 2014).

At present, there is no regulation to ensure that the psychological screening of patients is mandatory (All-Party Parliamentary Group (APPG) on Beauty, Aesthetics and Wellbeing, 2021). However, Peter Powis, medical director for Health Education England (HEE), reprimanded Superdrug, a national health and beauty retailer, for not being medically responsible for failing to perform a psychological assessment before commencing a patient's treatment (Campbell, 2019). Therefore, it is imperative for the safety of both the patient and the practitioner that patients with BDD or

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psychological risk factors are adequately identified. Thus, this study aimed to ascertain which validated screening tools are used in private aesthetics practices in the UK. The author also sought to establish how practitioners managed patients who demonstrated red flags during clinical interactions and the signposting processes practitioners had in place.

## Methods

### Sampling methods

A qualitative study was undertaken with practitioners working in private aesthetics practices in the UK. The selected participants were a mix of both medical and nursing practitioners with a minimum of 2 years' experience in aesthetics. Furthermore, were known to the researcher, as they are prominent in the aesthetics speciality and deemed ethical and sound in their practice. They had developed skills, a firm understanding of patient care and had acquired sound and valuable information through their frequent interactions with patients. It is possible to narrow the focus of initial data collection, identifying the most productive research sample, when the researcher has spent considerable time in the field. However, this technique risks interview bias/subjectivity, as the researcher selected the candidates.

The sample size was based on the information requirements, and 14 people were invited to take part in the study.

### Ethics and informed consent

The study's ethical application was considered a medium moral risk when accounting for inclusion/exclusion criteria (Northumbria University, 2021). Of the 14 people invited, 11 agreed to partake in the study; all of them had read the debrief and agreed with the consent form's content.

### Data collection

One-to-one semi-structured interviews were conducted via Zoom. All interviews lasted 30–45 minutes. Practitioner experience, assessment techniques, use of BDD assessment tools and referral pathways were explored and anonymity was ensured.

## Results

Of the 14 people invited to take part in the study, 11 responded and provided their signed consent to partake. All participants were from medical and nursing backgrounds and educated at a level 7 in non-surgical aesthetics.

Of the participants whose interviews were included in the study, eight were female registered general nurses, one was a female registered mental health nurse and one was a male doctor. Eight participants had been working in medical aesthetics for over 10 years, with an average of 16.5 years' experience. Nine participants had been educated to academic level 7 in non-surgical aesthetics. Four critical themes emerged from the data. These were: the importance of developing the therapeutic relationship: 'the aesthetic friend'; lack of using screening tools in clinical practice; importance of the experienced practitioner: 'the sixth sense'; and treatment refusal: 'safeguarding the patient'.

### Theme 1: the importance of the developing the therapeutic relationship

The initial patient consultation was considered to be an essential part of establishing a good therapeutic relationship. The consultation is for fact-finding and relationship-building. Time needs to be dedicated to assessing the patient and establishing their motivation for treatment, perceived flaws and desired outcome expectations. Consultations are the most effective way to identify any misconceptions and unrealistic expectations that a patient may have.

*'I think you can get far more information out of people by having sort of a general chat and talking around things and asking the sort of more specific questions and then building up sort of a little bit of a core and a relationship where then people will be more honest'* Participant 6

*'I know what information I want to get, more understanding I want to get, and I find that always comes from an easing around ... I find that works very well for me in my practice'* Participant 2

### Sub theme: honesty and trust

The depth of the patient–practitioner relationship is primarily built on honesty and trust. However,

the participants acknowledged that a patient might compromise their honesty to avoid barriers to the treatment. Indeed, participant 9 stated that patients might lie to receive treatment and that the truth can, in some instances, be a contraindication to the treatment that they have requested.

*'We know that not everyone is truthful, and we know that, if somebody wants treatment, they may be secretive and manipulative to get that treatment'* Participant 9

Participant 2 suggested that the patient would become more open and honest as the relationship developed: 'but you have established that relationship of trust, which is fundamental to working it through'.

## Theme 2: lack of using screening tools in clinical practice

An effective screening process is advantageous to both the practitioner and the patient. It can identify patients with unrealistic expectations, psychological disorders or undue social influence. As the medical aesthetics sector remains unregulated, it has been recommended that practitioners use psychological assessment tools, such as the Yale-Brown Scale, to assess an individual's mental health and wellbeing in line with their request for treatment. The results illustrated that most participants did not routinely use any psychological assessment tools suggested by the HEE in their clinical practice.

When asked about the implementation and use of validated tools, the interviewer noted that many participants seemed visibly uncomfortable and unsure of which tools they applied in practice. It quickly became apparent that question 2 of the schedule—'why did you choose to use these particular tools?'—became futile, as most practitioners were not using the recommended tools or were not informed enough to recall the specific tool applied.

For those participants who did implement a formal screening tool, it was established that some had compiled questions for psychological assessments from various sources and developed an idiosyncratic assessment framework. Thus, the evaluation was broadly relative to psychological evaluation standards and not necessarily focused on those patients with BDD or BDD characteristics. It provided a more holistic overview of their mental health and wellbeing. Participants were also hesitant about using psychological assessment specifically relating to BDD for fear that patients will think they are being categorised or psychologically assessed.

All participants had been selected to reflect and ascertain best practices based on qualification and experience within the speciality. Not only did the majority of the participants neglect to use the

suggested tools, but the overall view was that the tools were not fit for the purpose; they could not be adequately applied in the aesthetic setting and were inappropriate in most cases. One participant felt uncomfortable using these tools for all patients. There was an assumption in their use that any individual seeking aesthetic treatment was either suffering from BDD or had a vulnerability to BDD.

Furthermore, participants suggested that, as the screening tools were not designed specifically for use in non-surgical aesthetics, their application negatively impacted the therapeutic relationship and the assessment process, mainly when there was a potential inference towards psychiatric disorders. Indeed, many participants felt that the process of diagnosing BDD was outside of their remit and was best left to the psychiatric professionals. The finding that participants did not regard the BDD tools as useful in the aesthetic setting was not expected. Therefore, the researcher discussed the result with a peer who was not related to triangulation and validation.

In addition to deeming the BDD screening overly specialised for use in aesthetic clinical practice, participants raised ethical and moral concerns regarding the tool's assumptions. In essence, the BDD screening questionnaire assumes that all potential patients are at risk of suffering from BDD, which is inappropriate.

*'.. And not, look, not judge them too critically, I think, because I think that you could say that anybody coming into our clinics has some kind of dysmorphia, well I do not believe that'* Participant 1

After further extensive peer discussion for triangulation, it was concluded that the results indicated non-compliance with recommended screening tools. This was due, in part, to their perceived inappropriateness in the non-surgical aesthetic setting. The experienced practitioners had attempted to formulate their assessments, which were more in line with their aesthetic clinical practices. The avoidance of the use of recommended screening tools highlighted the need for a bespoke instrument that practitioners could readily adhere to.

## Theme 3: the experienced practitioner: 'the sixth sense'

The consensus was that practitioners relied on their own experience and intuition to gauge a patient's behaviour and psychosocial wellbeing as part of the therapeutic relationship. The participants felt that their clinical experience was a fundamental asset in the practical assessment of the psychological/social assessment of the patient.

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*'I am fairly confident in my ability, through the detailed consultation, to recognise risk factors and to lay the map and make a judgment because it is never black and white. One tick box can be offset by another ... and that comes with experience, with making mistakes, with some self-directed learning and with a lot of reflection when you have these challenging consultations'* Participant 2

It was clear that, through clinical experience and expertise, the practitioners developed a 'gut feeling' or 'sixth sense' that they also used to assess their patients for treatment. Unfortunately, this cannot be taught, which raises an issue regarding patient assessment by less experienced practitioners.

*'You get a six sense with this ... and I always find the ones that have the most immaculate makeup, and, as I am cleaning their face, those are the ones I am thinking, uh oh, right, and that, to me, is an opening to discuss'* Participant 9

#### Theme 4: refusal and referral: the ethical practitioner

There was a consensus among the participants that if the consultation and assessments identified the individual as a red flag patient, they would be refused treatment. This is to protect the patients and their mental health. Treating a red flag patient or a patient with BDD can be detrimental and indeed exacerbating existing conditions.

*'Well, I think it is that, for some people, the fear of saying no to a patient, you know, and I think that practitioners have to recognise that it is actually okay to say no, and not only in the patient's best interest, but potentially in their best interest ... because if you are going to treat somebody who does not need treatment, or is not ready for treatment, more importantly, you know, you could exacerbate feelings, or, you know, a condition that they have'* Participant 7

Practitioners also vocalised that they would refuse treatment to a patient if they believed that they had been overtreated and were in danger of looking unnatural.

*'Well, we get this quite often, obviously, people do become very reliant and they, because mainly they see that improvement initially and then that becomes the normal for them. They forget what they looked like before, and I will often and normally say to them I think you have had enough now'* Participant 1

One of the crucial issues that participants raised surrounding not treating a patient and potentially referring to psychological services was the access pathway. Participants did not feel adequately informed of whom they should signpost or the process they should follow, nor did they have confidence in the patient being seen as a priority due to the current national pandemic.

*'I think you would have to have an awful lot of red flags to give that diagnosis, and then, how to say that to your patient, because it is all very well having that diagnosis, and then you do not know what to do with [it]'* Participant 1

This further highlighted a need for training or development and the shortcomings in the screening process. If a bespoke screening/consultation tool for use in the non-surgical aesthetic field is developed, it will need to be supported by an adequate and easy access referral process. Overall, the participants showed a lack of confidence in the correct assessment process and were unanimous in vocalising the need for further structured and standardised development in this area.

The results highlighted the lack of consistency in the psychological and psychosocial screening of non-surgical aesthetics patients. Recommended BDD screening tools were not routinely used in practice. The research has indicated that a hybrid assessment or tentative questioning approach may be considered more relevant. The practitioner asks questions to establish the patient's vulnerability to BDD and other psychological issues, such as anxiety, obsessive-compulsive disorder (OCD) and addiction. The participants asked these questions as part of the fact-finding process during the consultation.

## Discussion

This research aimed to determine how skilled practitioners assessed the psychosocial wellbeing of patients, what screening process or tools they used and the referral process or signposting procedures they employed. Four key themes were identified in the thematic analysis process: importance of developing the therapeutic relationship; lack of using screening tools in clinical practice; importance of the experienced practitioner; and treatment refusal.

It is essential that an adequate psychosocial assessment of the patient is conducted, as it is accepted among researchers that many combinations of psychological factors play a crucial role in the motivation of prospective patients to engage in treatments, their expectations of the outcome and their post-treatment adjustment (Brunton et al, 2014). However, the data analysis revealed the predominant theme that most participants did not use any of the validating screening tools independently. Instead, many opted for a hybrid approach, using various questionnaires to assess their patient's psychosocial wellbeing. Additionally, most of the interviewees did not think that the employment of BDD screening tools was appropriate for use in the clinical setting, as they were too in-depth. Indeed, there was some concern that the routine use of BDD screening tools in clinical practice assumed that any individual seeking aesthetic treatment would be vulnerable to developing BDD or had a diagnosis of BDD, which the respondents did not accept.

The rise in demand for non-surgical treatments has raised ethical issues surrounding the practical psychosocial assessment of the individual before treatment. It has been recommended that all

## CPD reflective questions

- Can you detail an occasion when you had concerns about a patient's psychological wellbeing or motivation for treatment?
- Can you describe a time when you felt you needed to refuse treatment to a patient?
- How do you think you could improve your own psychosocial evaluation?

practitioners use BDD screening tools to effectively assess their potential patients to protect their mental health and provide continuity of care among aesthetic practitioners. An effective referral process should also be developed to support practitioners in identifying individuals who may need specialist psychological assessment.

The participants concurred that an effective consultation process was a fundamental tool in the practical assessment of the patient. This should always be an in-depth process that develops the therapeutic relationship and builds trust and honesty. Additionally, the consultation should be used to establish the individual's expectations of treatment and the reasons why the treatment is being sought. Consultations are the most effective way to identify any misconceptions and unrealistic expectations that a patient may have and to determine whether they may be attempting to compensate for an adverse life event through treatment (Azoo, 2021).

Despite overwhelming evidence that psychological factors play a hugely important part in many aspects of aesthetic medicine, patients often have negligible or even non-existent access to psychological support as part of their treatment plan. Therefore, aesthetic practitioners must ensure they are equipped with adequate knowledge and tools to recognise BDD and refer patients to get the help they need (Gorbis, 2019).

Unanimously, the participants in the study agreed that, if a patient who was unsuitable for treatment was identified, they would refuse or delay the treatment requested. In contrast, many felt that diagnosing a BDD patient's psychological condition was not their role. Practitioners acknowledged that there is insufficient information available regarding the correct referral process or where patients should be signposted. Indeed, there was some scepticism about how adequately a referral process would provide support to the patient. The respondents believed that clinical experience was essential in the psychosocial assessment of the individual; indeed, it was referred to as a 'gut instinct' or 'sixth sense'. They felt that they could pick up on non-verbal clues that a screening tool might miss through the consultation process, and they believed that experience was the essential factor in the assessment process. As experience and

## Key points

- Continuing psychosocial assessment of the patient is imperative at the consultation and throughout the treatment programme when being treated by a medical aesthetic practitioner
- Value is placed on the building of a therapeutic relationship that builds trust and honesty
- Validated psychosocial assessment tools have not been adopted in practice, as they were deemed inappropriate for use as they implied the potential diagnosis of a psychological condition
- A bespoke validated tool would be welcomed into practice to provide a benchmark for all practitioners and assist with record keeping.

intuition are not infallible, a uniform and structured guide or assessment tool must be developed to screen for patients who are unsuitable for treatment and protect the practitioner from litigation by proving that an assessment has been carried out. The tool should be quick and easy to use and appropriate to the non-surgical aesthetic setting, with adequate training to ensure practitioners are confident in using it. A regular formal review of this assessment should be adopted to provide a benchmark for all practitioners. Additionally, a mandatory accredited learning module would increase awareness and standardise knowledge levels across the speciality.

### Study limitations

The author acknowledges that the current study has limitations. The sample interviewed was composed of experienced, highly trained practitioners and did not necessarily represent all practitioners in the medical aesthetics sector. Therefore, it may be prudent to undertake a further study focused on less experienced practitioners to gain fuller insight. However, it may be assumed that, if an experienced practitioner does not use the recommended validated screening tools, the inexperienced practitioner would be even less likely to implement them.

Throughout the study, the researcher critically assessed the research methodology and accepted that the restrictions limited the quality of the data collected. It was concluded that it would have been more effective to have clinical observations of the consultation process and obtain a copy of the psychosocial questionnaires used for more in-depth analysis and triangulation. Despite Zoom's usefulness, the researcher noted that the platform had limitations and was far from ideal. Some interviews were disrupted due to connection issues, and there were domestic noise interruptions.

### Conclusion

Nurses continually add to their experience to give patient-centred care and understand and respond to each patient personally. Generally, nurses have more frequent contact with patients and develop more in-depth relationships with them than practitioners in other medical professions, who may not have the time to dedicate themselves. Therefore, it is essential to draw on professional experience and intuition to empathise and adapt decision-making according to the individual situation.

This research highlighted the importance of psychosocially assessing the patient and the lack of use of the recommended BDD assessments tools in practice by the participants. Additionally, the findings illustrated the fundamental need to develop a fit-for-purpose assessment tool for use in the medical

aesthetics sector that did not assume that all patients suffered from BDD. Finally, the results also stressed that a good referral process for potentially vulnerable patients should be formulated and readily available to all practitioners in the aesthetics setting. **JAN**

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