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EDITORIAL

Cosmeticorexia: What It Is, Where It Comes from, and Why It Matters

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ABSTRACT

Cosmeticorexia (also called dermorexia) refers to a culturally reinforced preoccupation or obsession with achieving "flawless" skin that can lead to excessive, age-inappropriate, or compulsive use of cosmetic products and procedures. The phenomenon is intensified by the medicalization of beauty, the growth of "cosmeceutical" markets, and social media platforms that reward routine-based content and appearance-focused self-presentation. Emerging signals indicate that exposure and uptake are happening at increasingly younger ages, raising concerns about irritant and allergic contact dermatitis, skin barrier disruption, and the reinforcement of maladaptive appearance monitoring and compulsive grooming behaviors. Although cosmeticorexia is not recognized as a formal diagnosis in current classification systems, it may represent a clinically relevant mental disorder that warrants operationalization, standardized assessment, and epidemiological tracking. In this editorial, the authors define core features, summarize sociocultural drivers, discuss clinical implications, and outline research priorities.

Keywords: Cosmeticorexia; Dermorexia; Psychodermatology; Social media; Influencers; Preadolescents; Adolescents; Youth; Cosmeceuticals; Skin barrier; Contact dermatitis

Key Summary Points

Cosmeticorexia is a culturally reinforced obsession with attaining perfect skin that can lead to excessive or age-inappropriate use of cosmetics and cosmetic procedures.

Many social media, marketing, and influencer posts normalize multistep routines, which may increase exposure and risk, especially among preadolescents and adolescents.

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Psychologically, highly appearance-focused routines may increase preoccupation with perceived flaws, raise social comparison stress, and solidify compulsive monitoring, purchasing, and appearance-management behaviors.

Potential dermatological effects include skin barrier disruption, irritant or allergic contact dermatitis, and reinforcement of compulsive appearance-management behaviors.

Cosmeticorexia is not a formal diagnosis; priority needs include operational criteria, validated assessment tools, and epidemiological studies to define prevalence, risk factors, and outcomes.

INTRODUCTION

Cosmeticorexia (also called dermorexia) can be defined as a culturally reinforced preoccupation with attaining "flawless" skin that drives excessive, age/gender-inappropriate, or compulsive use of cosmetic products and procedures (e.g., multistep antiaging routines, early use of retinoids/alpha-hydroxy acids, injectables). Core features include escalating time and money spent on routines, anxiety or distress when unable to perform them, and reliance on skincare behaviors to regulate affect. The pattern may persist despite cutaneous irritation, financial burden, or psychosocial strain and is frequently fueled by influencer marketing and appearance-focused social comparison.

SOCIOCULTURAL AND MARKET DRIVERS

The emergence of cosmeticorexia can be situated in early twenty-first-century shifts that medicalized beauty and amplified appearance display. Active dermatologic ingredients (e.g., retinoids, alpha-hydroxy acids) and in-office procedures migrated from clinical care into everyday "self-care," blurring boundaries between treatment and routine. In parallel, visual social media and influencer economies normalized constant self-presentation and algorithmically rewarded routine-based content and "must-have" activities [1]. Within this environment, preadolescents and adolescents are especially exposed: meta-analytic evidence links higher social media use or dependence (i.e., nomophobia) with greater online social comparison, which in turn relates to increased body-image concerns, lower positive body image, and disordered appearance-management behaviors [2].

SIGNALS OF RISING EXPOSURE IN YOUTH

Platform and search metrics both indicate a growing public interest in skincare routines. Google Trends analyses show a sustained upswing in skincare- and cosmeceutical-related searches with a marked acceleration during the coronavirus disease 2019 (COVID-19) period, mirrored by short-form video (TikTok) activity around popular actives (e.g., retinol, hyaluronic acid, salicylic, and glycolic acids) [3]. At the time of this writing, hashtags such as #skincare and #skincareroutine exceed 64 million posts on TikTok and Instagram, generating hundreds of millions of views and highlighting a cultural script in which daily, multistep intervention becomes the default regardless of clinical necessity, evidence base, or potential adverse effects, with nonuse of cosmetic products and procedures increasingly construed as self-neglect [4]. Mainstream reporting has also described the "Sephora Kids" phenomenon [5, 6]—preadolescents and younger adolescents, usually influenced by social media, purchasing multistep regimens and adult actives—while dermatologists publicly question the suitability of retinoids and exfoliating acids for this age group.

Emerging empirical evidence strengthens these concerns. An analysis of TikTok videos created by minors documented complex, costly routines; frequent use of potentially irritating actives; and

infrequent sunscreen use, patterns linked by experts to risks such as irritant or allergic contact dermatitis or even flares of pre-existent dermatoses (e.g., acne, psoriasis or atopic dermatitis) triggered by cosmetics [7]. Dermatology commentary has likewise highlighted the pediatric safety issues, noting that children's skin physiology renders many antiaging actives unnecessary or potentially harmful [8]. Taken together, these converging signals argue for studying cosmeticorexia as more than a media fad: it may represent a psychodermatologic risk pattern that merits standardized criteria, validated assessment, and epidemiological tracking.

CLINICAL IMPLICATIONS

Clinically, these exposure patterns translate into tangible cutaneous and psychological risks. Psychodermatology underscores bidirectional skin–mind interactions [9], yet everyday practices often neglect basic cutaneous physiology, including the heightened reactivity of younger skin [10]. Excessive or unsupervised use of certain actives can irritate and destabilize the skin barrier, producing erythema, desquamation, itch, sensitization, inflammation, and photosensitivity. Layering multiple cosmetics or introducing activities without sun protection increases the likelihood of contact dermatitis and post-inflammatory sequelae (e.g., dyschromia and, in some cases, scarring) [11, 12]. Psychologically, appearance-centric routines may reinforce preoccupation with perceived imperfections, amplify social-comparison stress, and entrench compulsive checking, purchasing, and grooming behaviors. For some individuals, skincare becomes an avoidant coping strategy: rituals may temporarily reduce anxiety while maintaining cycles of vigilance and dissatisfaction.

DIAGNOSTIC STATUS AND DIFFERENTIAL DIAGNOSIS

Thus far, cosmeticorexia has been treated as a public-health and psychodermatologic concern rather than an official mental disorder. It is not listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) or the *International Classification of Diseases, 11th Revision* (ICD-11). The term functions as a descriptive label for a risk pattern (akin to how "orthorexia" is discussed but not DSM-recognized) [13], and there is no universally accepted definition or diagnostic criteria.

Clarifying boundaries with established disorders is essential. Cosmeticorexia can overlap with body dysmorphic disorder, particularly when distress and impairment center on perceived skin defects and repetitive appearance-related behaviors. However, cosmeticorexia is often defined less by fixed defect-focused beliefs and more by a culturally normalized, routine-based "solution." Overlap may also occur with obsessive–compulsive disorder when routines are rigid, time-consuming, and difficult to resist; yet the behavior is typically organized around appearance optimization and affect regulation rather than neutralizing intrusive obsessions. Importantly, cosmetic practices may also create or amplify objective skin changes, thereby maintaining a self-reinforcing cycle of preoccupation and escalation. These are two of the main differences that support careful screening and differential diagnosis in high-impairment presentations.

In a previous empirical research conducted by our group, the above definition was used to evaluate 217 dermatological patients that also had undergone ≥ 2 hyaluronic acid filler sessions in the previous year and had no recent trauma (to rule out post-traumatic stress). A cosmeticorexic trait was identified in 18 participants (9%): 16 women (89%) and 2 men (11%) who self-identified as female. Among these, four reported ≥ 2 panic attacks in the prior 3 months—the only psychiatric symptom reported. All cosmeticorexic participants also met criteria for nomophobia [14]. Despite converging signals of widespread exposure among youth, the absence of standardized criteria continues to undermine accurate estimates of prevalence and incidence, limiting understanding of scope and impact.

RESEARCH AND PRACTICE PRIORITIES

Progress requires moving from describing the clinical phenomenon to defining the latent construct [15]. Clear operational criteria are needed to distinguish fashion-driven routines from clinically significant symptoms and impairment and to support reliable identification in clinical and research settings. Consensus-building should prioritize standardized diagnostic features and validated assessment tools that capture psychological and behavioral dimensions (e.g., preoccupation, time spent, loss of control, problematic spending, distress/impairment), alongside dermatologic outcomes such as barrier dysfunction and irritant or allergic contact dermatitis.

Population-based surveys can estimate prevalence, characterize subtype profiles, and identify modifiers that likely reflect interactions among psychological and sociocultural factors (such as platform exposure, baseline skin conditions, developmental vulnerabilities, and parental mediation), consistent with evidence that the effects of internet use vary significantly among individuals [16]. Longitudinal studies can test whether early, excessive product use predicts later dermatologic or internalizing symptoms. Until stronger evidence accumulates, a prudent stance emphasizes prevention: age-appropriate minimalist routines; education for families; and clinical supervision when medical activities or procedures are being considered.

Ethics Statement

This article is based on previously conducted studies and does not contain any new studies with human participants or animals performed by any of the authors.

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