Psychosocial Issues and Their Relevance to the Cosmetic Surgery Patient

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Psychosocial issues permeate the field of cosmetic surgery:

1. The preoperative psychological profile of cosmetic surgery patients is likely to differ from that of people who don't come for surgery. Despite several decades of research, this difference is not well understood.

2. Cosmetic surgery patients often look for more than changes in their physical appearance. If these procedures do not lead to improvements in body satisfaction, self-esteem, or quality of life, then what is their purpose?

3. Patient-surgeon rapport is not simply a nice plus if it happens. Patient satisfaction, reduced legal liability, and improved surgical outcome can all be direct reflections of the surgeon's mastery of relationship-building techniques.

4. Identifying and screening out patients who should not have cosmetic surgery can prevent both patient and surgeon frustration and more extreme adverse outcomes.

5. A wide range of studies document the use of psychological techniques to improve surgical outcome.

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INCREASING numbers of physicians from a variety of specialties, and nonphysicians as well, now perform cosmetic surgery. For example, the American Society of Plastic and Reconstructive Surgeons reported that its membership performed over 1 million cosmetic procedures in 1998. These numbers represent an increase of 50% since 1996 and 153% since 1992.[1]

This increasing demand for cosmetic surgery has been accompanied by greater coverage of procedures in the mass media. Stories on cosmetic surgery regularly appear on daytime talk shows and evening news magazine programs. Newspaper and magazine articles on cosmetic surgery typically highlight recent innovations in cosmetic procedures while tapping the reader's or viewer's dissatisfaction with their physical appearance. Color advertisements featuring beautiful models often promise improvement in physical appearance, self-esteem, and quality of life. As the demand for cosmetic surgery continues to grow, it becomes increasingly important to understand the psychological factors that motivate people to seek surgery, and to determine if cosmetic surgery leads to psychological benefit.

WHO COMES FOR COSMETIC SURGERY?

The accelerating growth in both the number of procedures performed and the number of physicians performing them, reflects the American public's rapidly growing acceptance of cosmetic surgery as a means of self-improvement.[2] Stereotypes endure. Cosmetic surgery patients are cast as jet-setters with more money than taste or judgment, relentlessly trying to polish their exteriors because there isn't much going on in their interiors. Neurotic narcissists searching for the Fountain of Youth is another common cliche, or "relentless improvers" frantically obsessed with

minor flaws, perfectionistically motivated to wear the latest fashions and hair styles, running to the gym, the tanning parlor, and the cosmetic surgeon. Do these stereotypes of narcissistic or perfectionistic patients accurately represent the majority of cosmetic surgery patients?

A collaboration of psychiatrists and plastic surgeons at Johns Hopkins in the 1950's and 1960's produced the first significant body of research on the psychological functioning of cosmetic surgery patients. For the most part, these studies relied on clinical interviews of patients conducted by psychoanalytically-trained psychiatrists. Regardless of the type of surgical procedure, the majority of patients were seen as having significant psychopathology.[4-6] The most common diagnoses were personality disorders, with smaller percentages (10%-20%) of patients being characterized as neurotic or psychotic.[4,7,8]

As one example, a study of 72 patients seeking face-lifts or blepharoplasty to remove signs of aging showed intriguing consistencies according to age. The 29- to 39-year-old group had more childhood disturbance, more difficulty assuming parental roles, and more strained relationships with their own parents. The 40 to 50 year olds were intensely committed to their work lives, and sought occupational advantages from a more youthful appearance. Their personal relationships were given less priority. In the over 50 group, 90% had lost close relatives within 5 years, and many showed symptoms of unresolved grief reactions. Their desire to mask the warded-off sadness went beyond trying to act perky and upbeat. Some were explicit about the hope that the surgery would remove the physical signs of the sadness.[8]

During the 1970s, other interview research also found high rates of psychopathology. Prospective patients in several studies were described as experiencing increased symptoms of depression and anxiety, as well as low self-esteem.[9-11] Although these interview studies have been consistent in their outcomes, they typically have suffered from significant methodological problems. The majority have lacked both uniform diagnostic criteria and control or comparison groups. Therefore, it is impossible to determine if the reported level of psychological disturbance is greater than that found in the general population or in other medical patients.[12,13] While these studies do not give us an overall picture of the cosmetic surgery population, their findings can help us understand some cosmetic surgery patient's individual issues.

In contrast to the interview investigations, most studies that have used standardized paper and pencil psychometric tests have found dramatically less psychopathology. Female rhinoplasty, rhytidectomy, and breast augmentation patients reported few symptoms of psychopathology.[14-20] Although these psychometric investigations present a more favorable view of cosmetic surgery patients, they also have significant methodological problems. Some studies used only postoperative assessments and others failed to use control groups or only made comparisons to normative groups, which limit the conclusions that can be drawn from them.[12,13]

This contradictory research makes it difficult to draw firm conclusions about the psychological status of cosmetic surgery patients.[12,13] Initial interview-based studies suggested that cosmetic surgery patients are highly psychopathological. In contrast, studies which have used valid and reliable (but some might argue more superficial) psychometric measures have found little psychopathology. Both sets of studies, however, have suffered from a myriad of methodological problems. The shifting characteristics of the cosmetic surgery population over time could result in more of the earlier studies having found significant psychopathology.

Studies that suggest that the majority of cosmetic surgery patients have little psychopathology are more consistent with the experiences of the present-day cosmetic surgeon. But to accept that people who undergo cosmetic surgery are no different from those who do not seek surgery does not make intuitive sense.[12] Although the popularity of cosmetic surgery is increasing rapidly, only a small percentage of people currently seek surgery. This suggests that there must be personality characteristics that differentiate those who seek cosmetic surgery from those who do not. The most distinguishing characteristics of people who seek surgery are likely to be aspects of their thoughts and feelings about their physical appearance. Obviously, men and women seek cosmetic surgery because they are not satisfied with an aspect of their appearance. Deeper understanding of this dissatisfaction may help in defining these individuals.[12,13] Another possible differentiator is being "action oriented." Assuming equal dissatisfaction, one person frets, another calls the cosmetic surgeon.

BODY DISSATISFACTION AND COSMETIC SURGERY

Fifty-six percent of American women and 43% of American men report dissatisfaction with their overall appearance.[21] This epidemic of dissatisfaction probably motivates many behaviors—weight loss, exercise, cosmetic use, and cosmetic surgery. Do prospective cosmetic surgery patients' body concerns differ from the general population? The research results fall into 2 groups. The most consistent finding is that women who seek cosmetic surgery report increased dissatisfaction with their bodies[9,14,18,19] and report improvements in body evaluation postoperatively.[11,14,18,22]

In contrast, other studies examined this dissatisfaction in more detail, finding that prospective patients (across a range of procedures) did not report a greater investment nor increased dissatisfaction with their overall body. Yet, they did report heightened dissatisfaction with the specific body feature for which they were pursuing surgery.[12,13,23,24]

Studies of breast augmentation patients using physically similar women as controls suggest that not only do these women have greater dissatisfaction with their breasts, they also have greater investment and overall dissatisfaction with their bodies, as well as a history of more appearance-related teasing.[23,25] The breast augmentation patients also report increased symptoms of both anxiety and depression. We don't know if these symptoms are a cause or a result of their dissatisfaction with their breasts. The pursuit of cosmetic surgery to address body dissatisfaction may be an adaptive coping strategy in a culture which emphasizes the importance of physical appearance. However, these findings suggest that we should be asking if, for some patients, body dissatisfaction may be related to general psychopathology more appropriately addressed by psychotherapy than cosmetic surgery. This research also underscores the importance of listening carefully to prospective patients' need and hopes, which often go well beyond the requested physical changes.

WHAT DO COSMETIC SURGERY PATIENTS WANT?

Cosmetic surgery may produce other results, and patients may have other agendas, but let's begin with the top priority: increasing physical beauty or attractiveness.*

Chapter 2 in the "Atlas of Cosmetic Surgery" (2002) examines the wide range of forces that sculpt our views of beauty—as an experience, a commodity, and as an evolutionary imperative. Media images, social forces, peer reactions, and spousal or family pressures often influence patients' estimates of their attractiveness. The aggregate of these influences become the patients' view of themselves. The motivation for surgery can be largely *external*. Ethnic prejudice or fear of age discrimination alone may motivate surgery that would otherwise be of no interest. In extreme instances the patient may have been coerced into surgery, asking the surgeon to turn them into a spouse's, a parent's, or a boss's vision of what they should look like. Patients are also typically very receptive to the surgeon's professional evaluation of their pre-surgical appearance. At an extreme the surgeon may feel pressure to prescribe procedures to a patient who is unable to present their own preferences. More typically the patient's motivation is *internal*, and we will focus on these cases. Ideally, the patient has flexibly chosen which external influences to heed and integrate with their own desires, culminating in the decision to seek surgery. While a spouse's, friend's, or parent's feedback may be quite influential, the patient's own evaluation of their postsurgical appearance is rightfully the ultimate yardstick or outcome measure.

What is the scientific status of patients' judgments of their own attractiveness? What of its reliability, its validity? On the surface, what could be more straightforward? The patient says, "I look better than I have in years," or "I have the thighs (or nose, or breasts) that I've always wanted." If the feeling endures, this self-report measure seems both reliable and sensible. Who would presume to argue with them?

How much overlap would you expect between the peoples' own views of their appearance and ratings of a more objective "jury of their peers"? Eighty percent? Sixty percent? In fact, multiple studies suggest that normal human beings have so little awareness of their own attractiveness that we

*We will use beauty and attractiveness interchangeably but clearly one can be beautiful but unattractive, or not particularly beautiful but very attractive. This discussion will be limited to the types of beauty and physical attractiveness that are 'skin deep').[26]

must regard the inner and the outer realities as 2 almost completely disconnected entities.

Feingold's meta-analysis of 93 studies of self-ratings of attractiveness versus objective measures found correlations of .24 for men and .25 for women[27]. This means that just over 6% of our view of our appearance is predictable from our actual appearance, and that 94% is accounted for by other factors! (This 6%+ figure comes from squaring the correlation coefficient to calculate the percentage of variance accounted for).[28] We know that some patients, especially those with Body Dysmorphic Disorder (see below), present with striking and poignant discrepancies between their experience of their own attractiveness and how the rest of us see them, but these 93 studies were all of normal people, mostly college students. (One could question labelling a cross-section of American college students as normal adults.)

These figures dramatically underscore how radically different cosmetic surgery is from most other medical specialties. We could hardly imagine a drug study, new procedure, or intervention being measured by a yardstick that was 6% accurate. Do we need more objective measures of cosmetic surgery outcomes? Most likely, the pursuit of objective aesthetic standards would lead us down an absurd path. Imagine a surgeon's postoperative discussion with a patient if such measures were used:

"Mrs. Jones, I'm terribly sorry that you are unhappy with the results of your surgery, and I fully understand that you are convinced you look less attractive than before I operated. I am very concerned about this outcome. I have called in both a panel of beauty experts and a group of your peers to help us in this difficult situation. They both agree that my surgery made you look more attractive. This is objective, statistically valid data, gathered according to every accepted scientific procedure. Clearly you are mistaken."

While this might be an effective defense if Mrs. Jones sought legal redress, and might effectively intimidate her into going away, her inner reality has not been addressed. Assuming no issues of mental competence, we cannot dismiss her view. Beauty is in the eye of the beholder—but when the beholder is also the beheld—we cannot escape a conclusion with wide implications. Patients come to the cosmetic surgeon seeking an objective enhancement of attractiveness; but they measure the success of the surgery by the inner experience of feeling more physically attractive—and this experience has a minimal relationship to the objective reality.

What keeps the extreme disparity between perceived and actual attractiveness from being more troublesome in daily clinical practice? The studies deal with global assessments at one point in time. Surgery patients are presumably more focused on a specific body part and its pre versus postsurgical appearance. When they seek outside feedback from the surgeon, spouse, or friends, (all of whom are likely to be favorably predisposed) the focus is similarly on the specific part and the change from the surgery.

If the inner experience of being more or less beautiful is not a natural consequence of external physical reality, what does it reflect? In the meta-analysis, 3 dimensions were consistently linked to self-judged attractiveness: self-esteem, emotional stability, and dominance. Note that these 3 dimensions were not linked to outside judgments of physical attractiveness. Social skill levels and freedom from social self-consciousness were related to the outside measure but not to self-ratings. Both measures correlated with freedom from loneliness, opposite-sex popularity, and sexual experience.[27]

WHY DO PATIENTS WANT THE CHANGES THEY ARE SEEKING

The desire for thinner thighs or smoother skin may seem so self-evident that asking, "why?" could easily seem superfluous. In a previous paper,[29] we conceptualized cosmetic surgery as, "The use of surgical procedures, in the absence of disease or physical trauma, to alter the physical appearance of the body in pursuit of psychosocial benefit." We hypothesized that improvement in physical appearance is only part of the motivation for cosmetic surgery. These changes, although central, are a means to other psychological goals. Patient satisfaction is, ultimately, a direct reflection of the degree to which the surgery has met the patient's expectations of the costs (physical, emotional, and financial) and benefits (physical and psychosocial) of the procedure. Determination of a 'successful' surgical result can be influenced by a variety of factors that may never become apparent to the surgeon.

Physicians and staff routinely help patients shape their expectations of the physical impact of surgery. Helping patients articulate and refine psychosocial goals is a less familiar process. Individual objectives vary, but frequently share an origin in recurrent painful feelings, thoughts or experiences. Helping patients establish realistic psychosocial expectations is as essential to patient satisfaction as having realistic physical expectations. Patients may present with a variety of agendas:

1. Psychological agendas: Is the patient seeking surgery as a means to an improvement in emotional state, to diminish feelings of appearance-focussed depression, shame, social anxiety, or unlovability? Other patients are motivated by ideas like, "People are put off by my nose," "I am really so much younger than I look."
2. Interpersonal agendas: Is the patient hoping surgery will improve some aspect of a close relationship? Patients often hope that surgery will rekindle a present relationship, save a marriage, or that improving their appearance will facilitate future relationships.
3. Social agendas: Goals that focus on the larger society may center on employability or perceived suitability for promotion. The desire to be perceived as an individual rather than a member of a specific stereotyped age, ethnic, or other group are best spelled out explicitly whenever possible.

The experience of teamwork and collaboration between patient and surgeon is difficult if the surgeon is not attuned to the patient's deeper motivation for undertaking the procedure.[29]

DOES COSMETIC SURGERY PRODUCE PSYCHOLOGICAL BENEFITS?

The psychosocial impact of cosmetic surgery may be the most central question in the field. If these procedures do not lead to improvements in body image, self-esteem, and quality of life, then what is their purpose? The majority of clinical interview investigations, surveys, and anecdotal reports strongly indicate high levels of patient satisfaction and generally favorable psychological outcomes, including improvements in depression and anxiety.[10,30]

Studies using standardized tests, however, have found very mixed results. Four found favorable changes postoperatively,[17,18,31,32] 3 reported no change,[20,33,34] and 2 described a modest increase in depressive symptoms.[16,35]

Preliminary studies suggest that many patients experience postoperative improvements in body image.[24,36] While these results are encouraging, considering the postoperative literature as a whole, it is premature to confidently conclude that cosmetic surgery leads to psychological benefit in the majority of patients.[13,25,29,37]

PSYCHOLOGICAL CONTRAINDICATIONS: ARE THERE CLEAR DANGER SIGNS?

Given the increasing numbers of individuals who now pursue cosmetic surgery, it is likely that all of the major psychiatric diagnoses occur in this population. However, certain disorders, particularly those with a body image component, may be more prevalent in cosmetic surgery patients and may contraindicate surgery. These disorders include body dysmorphic disorder, thought disorders, and eating disorders.

Body Dysmorphic Disorder

Extreme body image dissatisfaction is a central component of body dysmorphic disorder (BDD). BDD is defined as a preoccupation with an imagined or slight defect in appearance that leads to significant impairment in functioning.[38] Any area of the body may be the focus of concern: the skin, hair, and nose are the most common targets.[39,40] BDD has several characteristics that distinguishes it from more normal body dissatisfaction. Persons with BDD are often so preoccupied with some aspect of their appearance that they will examine, check, or alter their appearance repeatedly. These activities can totally consume waking life, preventing holding a job or maintaining romantic and social relationships. Often all pain of the person's past and present life is attributed to the physical defect.

Cosmetic surgery or other medical treatments may feel like the only salvation. Phillips and Diaz[40] reported that in a sample of 93 women with BDD, 73% sought and 66% received nonpsychiatric treatments including plastic surgery and dermatologic care. A study of women who sought cosmetic surgery found that 7% met diagnostic criteria for BDD,[41] a prevalence greater than the

2% prevalence thought to exist in the general population. BDD, however, may be particularly difficult to diagnose in cosmetic surgery patients.[37,41] Given the newness of BDD to American psychiatry (it was first introduced in DSM-III-R in 1987), many cosmetic surgeons are unfamiliar with the diagnosis. In addition, an objective of cosmetic surgery—to improve the appearance of a person with a "normal" appearance—may make diagnosis difficult. Cosmetic surgery patients frequently seek to improve slight defects in their appearance which are frequently judged as observable and correctable by the surgeon. As a result, judgment of a defect as "slight" becomes highly subjective. We have suggested that the degree of emotional distress and behavioral impairment, rather than the size or nature of the physical defect, may be more accurate indicators of BDD in plastic surgery patients.[25,41]

Preliminary clinical reports have found that the vast majority of patients with BDD do not benefit from cosmetic surgery if the underlying emotional issues are not addressed.[39,40] After surgery, they often remain focused on the same feature or become focused on a different feature. There is also some concern that these individuals may become violent toward themselves or the surgeon. These reports suggest that BDD may contraindicate cosmetic surgery.[25,29,37]

Psychotic Disorders

Cosmetic surgery patients with schizophrenia and other psychotic disorders have been of particular interest to cosmetic surgeons. Like patients with BDD, cosmetic surgeons frequently fear that individuals with psychotic disorders are likely to threaten or become violent following unsuccessful cosmetic surgery. The presence of an active psychotic disorder is commonly thought to contraindicate cosmetic surgery.[25,37,41]

Edgerton et al[42] have made a case against screening out patients with significant psychopathology, as long as appropriate mental health care precedes or is integrated with the surgery. They report successful outcomes with a combined approach for the treatment of patients who are the most psychologically disturbed, with diagnoses including severe neurosis, character pathology, and psychosis. (Some of these patients appear to be similar to those today diagnosed with BDD.) Initial indicators of disturbance included, "extreme intensity of desire for surgery, major disruption in psychological or social functioning, exaggerated response to deformity, request for 'unusual' type of surgery, or major difficulties in communicating with the surgeon." Significantly, 60.9% had a history of previous surgery elsewhere that had left them unsatisfied. Typically, patients received an initial evaluation and a brief course of psychotherapy focusing on feelings of deformity. More extended evaluations, medication, and psychotherapy were available as necessary. Of the 87 who received an average of 3.7 varying surgical procedures each, 82.8% reported clear psychological benefit, including reduced self-consciousness, anxiety, depression, and social isolation. There were no lawsuits, suicides or psychotic decompensations within this sample of patients. This clinical report lacks many of the attributes of a research study, including standardized diagnoses and procedures, control groups, and more objective and blind outcome measures. We have no indication of the relative impact of the psychological interventions without surgery. Yet, this impressive 'real world' experience suggests that many patients who might be poor candidates for surgery alone, can receive lasting psychological benefits from combined surgical-psychological intervention.

Eating Disorders

Given the extreme body image concerns of people with anorexia and bulimia, these disorders may be disproportionately represented among cosmetic surgery patients. There are case reports of women with both disorders who have experienced an exacerbation of symptoms after both face and body procedures.[43,44] Eating disorders may be a particular concern for women interested in liposuction and breast augmentation surgery. Willard et al[45] described 2 cases of women with bulimia who underwent liposuction in an attempt to lose weight, only to experience an exacerbation of their bulimic symptoms postoperatively. Eating disorders also may be a concern for women interested in breast augmentation surgery. Breast augmentation patients are frequently of below average weight, leading to speculation that they are at risk for eating disorders.[23,35] Both anorexia and

bulimia may be potential contraindications to cosmetic surgery.

PSYCHOSOCIAL DETERMINANTS OF SURGICAL OUTCOME

A substantial literature documents the impact of psychological variables and interventions on surgical outcome across a wide range of procedures. Observational studies of pain level and wound healing time suggest that highly anxious patients experience increased pain, require more anesthesia, have longer hospital stays, and poorer compliance with postoperative instructions. Two hundred studies of interventions addressing surgical patients' psychological needs document more rapid physical recovery, decreased anxiety, reduced hospital stays, fewer postoperative complications, increased compliance, and reduced pain and need for pain medication.[46] Multiple meta-anaylses found that a wide range of interventions were effective, including education, coping skills training, relaxation, hypnotic, behavioral, cognitive, and emotionally-focused techniques. Many different formats were effective, including individual and group administration, audiotapes, videotapes, and printed materials. With very modest interventions, 79% to 84% of studies showed significantly reduced pain, psychological distress, and improvements in relevant indices of recovery. Typical rates of improvement ranged from 20%-28%.[47-49]

Is it fair to generalize from studies of major surgery to more typical outpatient cosmetic procedures? Studies of the effect of emotional state on healing of more minor wounds suggest that it is. Family members who care for a relative with Alzheimer's disease demonstrate poorer immune function than well-matched controls. These caretakers took an average of 9 days or 24% longer to completely heal a small standardized wound.[50] Wikesjo et al[51] found wound healing in dental students during summer vacation, a time of minimal emotional stress, was 40% faster than 3 days before a major examination.

SPECIAL CONCERNS FOR AGING PATIENTS

With many cosmetic procedures targeting the effects of aging throughout the lifespan, we must look especially carefully at the effects of psychosocial variables on surgical recovery later in the life span. The increasing risk of surgery with age is probably due in part to declining immune function increasing the risk of infectious complications which in turn increase surgical mortality.[46] At least one study addressed the interplay between increased surgical risk from both aging and anxiety. Not surprisingly, in a sample of elective hernia repair patients, the patients who were both older and highly anxious had less favorable outcomes.[52] It is not clear if physiologic aging produces unique vulnerability to anxiety, or anxiety uniquely contributes to heightened risks from aging, or if this group simply had the additive impact of the 2 risk factors.

Does the Patient-Surgeon Relationship Influence Surgical Success

What is the medical and psychological impact of the rapport between patient and cosmetic surgeon? We have little data on this important question, but at least one study found a significant link between the surgeon's emotional reaction to the patient and the postoperative course in 50 female face lift patients.[53]

A survey of 115 experienced cosmetic surgeons found that nearly one-half had been sued for malpractice. Of this group, 51.6% attributed the suit to lack of rapport (*v* 17% for the next highest cause: unrealistic expectations), and only 14.5% attributed the suit to poor surgical results.[54] We can easily imagine these results being skewed by the fact that a surgeon filling out a survey would be much more likely to confess poor relationship skills than botched surgical results. Poor surgeon-patient relationships may well independently reduce surgical success, and set the stage for litigation. The surgeon who does not successfully build rapport with patients heightens both medical and legal risks.

BETTER THAN WELL: MORAL AND ETHICAL ISSUES IN COSMETIC SURGERY

World War I trench warfare produced unprecedented numbers of soldiers with massive facial trauma. The "first generation" of plastic surgeons who came to their aid were able to develop their craft in morally unambiguous, even heroic context.[55] Seeds of many of the controversies which were to face surgeons for decades to come originated when they brought their skills back to civilian life. In 1916, surgeon John Staige Davis declared, "True plastic surgery, without ques-

tion . . . is absolutely distinct and separate from what is known as cosmetic or decorative surgery.[56] As late as 1958, Pope Pius XII cautioned that although cosmetic surgery had many legitimate uses, using surgery to increase the "powers of seduction, thus leading others more easily into sin . . . or to satisfy vanity or the caprice of fashion . . . was morally unlawful.[57]

Performing medical procedures in the absence of undisputed pathology, and measuring outcomes by aesthetics or patient satisfaction raises complex ethical issues. Ringel[58] provocatively revisits some of these ethical quandaries that have made regular appearances in the history of cosmetic surgery (she limits her case to aging skin, but most of her arguments are directly exportable to any alteration of physical features that do not fit the prevailing societal notion of beauty). Assuming that the essence of medicine is to promote health and healing, Ringel[58] examines 3 attempts to bring the treatment of aging skin into this framework.

1. Define skin aging as illness: "treatment of the aging face" is then on a par with treatment of any other disorder. The historical parallel with cosmetic surgeons of the early 1930s creating medical entities like "hook nose" is clear. Once a condition is designated pathological, all moral ambiguities vanish. But Ringel[58] suggests that, ." . . . in defining aging as an illness, we implicitly define life as an illness." She suggests that surgeons have a responsibility to fight ageism, the stigma of old age, and the incessant media image that the elderly must be "sick, jaded, and spent."
2. Defining the treated disease as low self-esteem which is triggered by the physical feature, permits the surgeon to proceed with moral clarity, performing a sort of surgical psychotherapy. (Surgical treatment of a so called "Inferiority Complex" is the historical analog here).[55] But Ringel[58] counters, "The self who benefits from cosmetic surgery is necessarily an impostor. Cosmetic surgeons are in the business not of enhancing who we are, but of replacing who we are with who we or they think we should be. The prescription for low self-esteem is to change the packaging rather than the package, to get a new look rather than a new awareness." She concludes, "Cosmetic surgery cannot have it both ways. If a request for cosmetic surgery implies a significant psychiatric illness, the illness should be evaluated and treated . . . "
3. Should we redefine the goal of medicine as patient satisfaction or happiness (rather than to promote health and healing)? Ringel[58] suggests that this model is dubious and inevitably reduces cosmetic surgeons to "technical entrepreneurs," little different from cosmetologists. If a patient wants decorative scars on their face, a healthy organ removed, (or even as technology permits, one might add, a second head or a bionic arm), that would be a matter between patient and surgeon alone. She makes the case that what separates the professional from the business person is the "willingness to use clinical judgment on behalf of the welfare of patients."

She concludes, "Perhaps physicians cannot change society's preoccupation with physical appearance, but they need not promote it. "

Replies to this provocative challenge were also direct and spirited, including the observation that our beauty standards have a likely evolutionary basis (see Chapter 2, "Atlas of Cosmetic Surgery," 2002) rather than being more arbitrary societal or personal whims. The article triggered vigorous defenses of the legitimacy of wanting to look one's best during an increasing life span, either for personal reasons or to avoid the impact of social discrimination, ageism or ethnic bias. Several respondents made the case that photo-aged skin is damaged and at risk. "Degenerative joint disease, dementia, and osteoporosis are all natural consequences of aging in the predisposed population. Would Ringel have us simply accept this type of degeneration and not offer treatment for these disorders?"[59] Body piercing and tattooing underscore an individual's right to decide the fate of their own bodies as a fundamental democratic value.

Glogau[60] counters (and data quoted in this paper support),."..it is self-esteem that leads many of our patients to seek help for their photodamage." He suggests patient's motivation, ."..is not that they want to look young but that they do not look the way that they feel." He also notes that medical decision making is now "patient centered rather than physician centered, . . . so it is for the physician to provide information, the patient to wres-

tle with the practical and moral dilemmas." He concludes, "there is nothing wrong with the pursuit of happiness as a goal of professional medicine. Should misery be the goal instead?"[60]

This debate has parallels in other fields of medicine. Cosmetic surgery is not unique in grappling with the application of medical procedures in the absence of pathology. Psychiatry struggles with the use of psychotropic drugs to make people "better than well." Prozac for people who don't meet the criteria for clinical depression or Ritalin to enhance performance in patients who really could not be diagnosed with Attention Deficit Disorder raises many of the same ethical issues.

Genetics has its own version of this discussion as the morality of Nobel prize winner sperm banks stimulates debate. In the Fall of 1999, an on-line auction of eggs from medically-screened California models began. The bidding begins at $15,000, up to a maximum of $150,000. A spokesman for the American Society of Reproductive Medicine states, "It's unethical and distasteful," but is anyone listening?[61]

ADOLESCENT COSMETIC SURGERY

Adolescent cosmetic surgery is a frequent, and often controversial, mass media topic. Over the course of several weeks, one of us (D.B. S.) saw stories on teens and cosmetic surgery on 2 major television magazines. It was a central feature of an article on cosmetic surgery in *Newsweek* on August 9, 1999. Each of these stories debated the appropriateness of cosmetic surgery on adolescents whose physical bodies have not reached physical maturity. Equally important issues are the potential effects of surgery on the developing body image. Adolescents' thoughts and feelings about their appearance can change rapidly—1 week a teenage girl may want a smaller nose, the next week she may want larger breasts. A particular concern is that adolescents, in their quest to improve their appearance, do not appreciate the relative permanent effects of surgery on their bodies. It may difficult for an 18 year old girl to imagine how she may feel about her breast implants when she is 38. Another concern, for both adolescents and adults, is the public's misperceptions of cosmetic surgery. Many inaccurately view cosmetic surgery as a treatment with minimal risks and few side effects. While these people may not view cosmetic surgery with the same casualness as they do orthodontic treatment (which, in some respects, is similar to cosmetic surgery), they forget it is surgery—with all of the risks and potential complications of any invasive procedure.

EFFECTIVE PREOPERATIVE INTERVIEWS

These historical, psychological, and theoretical perspectives may facilitate more effective preoperative interviews. As noted above, patient satisfaction reflects the extent to which surgery has met the patient's expectations of costs (physical, emotional, and financial) vs. benefits (physical and psychosocial). One important first step in determining patient appropriateness is taking a brief mental health history. Patients should be asked about psychiatric diagnoses, past or present, and any ongoing treatments. Patients with a positive treatment history and who are not currently in treatment, may benefit from re-establishing contact with their provider to determine current psychological status. Patients currently under care should be asked if their mental health professional is aware of their interest in surgery. These professionals should be contacted by the surgeon to confirm that cosmetic surgery is appropriate for the patient at this time. Patients who have not mentioned their interest in cosmetic surgery to their mental health provider, or refuse to allow the surgeon to contact him or her, should be viewed with extreme caution. These patients may also require a consultation with a provider known to the surgeon. Thorough screening of patients is critical to insure that postoperative expectations are met, and can also be vital to identifying the patient who becomes a management problem. Risk of legal action or violence may also be reduced through screening by a consultant.

Assessing Body Dissatisfaction and BDD

We suggest beginning the interview with the nature of the patient's appearance concerns. Inquire, "What is it about your appearance that you dislike?" Patients should be able to articulate specific concerns about their appearance (ie, "I dislike the size of my nose"). Their physical concerns should be visible with little effort. Previous studies have found no relationship between degree of physical deformity and degree of emotional distress in cosmetic surgery patients.[42] Patients who are markedly distressed about slight defects which are not readily visible may be suffering from Body

Dysmorphic Disorder and therefore may not be appropriate candidates for cosmetic surgery.

Thoroughly assess the degree of dissatisfaction—ask: "When does the feature bother you the most?" "Are there times that it bothers you more or less?" "Do your feelings about your appearance keep you from doing certain activities?" "Do you ever "camouflage" or hide the feature from others?" These questions can indicate the degree of distress and impairment a person may be experiencing.

Although we assume that all patients who present for cosmetic surgery are dissatisfied with their physical appearance, it is not clear if there is a level or type of body dissatisfaction that is too great for cosmetic surgery. It is often difficult to make a diagnosis of BDD in cosmetic surgery populations. Cosmetic surgeons will often agree with the patient that the rather modest defect is correctable, while being unaware of the degree of emotional distress the patient is experiencing.[37,41] The typical presentation of BDD patients for cosmetic surgery remains unclear. The "insatiable" patient who returns for repeated procedures may be a candidate for the diagnosis, using the successive surgery to seek relief from profound body image dissatisfaction.[13,37]

When interviewing patients who may have BDD, it can be useful to conceptualize their extreme preoccupation with the minor or imagined defect as a noble if ultimately unsuccessful attempt to distract and protect themselves from the experience of a much more pervasive underlying experience of sadness, shame, deformity, or unlovability.[29]

Assessment: What Else to Ask

What is the source of the patient's motivation for surgery? Is the patient having the surgery for modest improvements in appearance for him- or herself or for others? Assessing the patient's postoperative expectations is also helpful. Inquire: "How do you anticipate your life will be different following the surgery?" Patients with specific appearance concerns, who are internally motivated, and have realistic expectations, may be the most likely to be satisfied with the postoperative result.

Table 1 provides additional questions to help structure exploration of psychosocial issues. Patients who have difficulty following the office routine warrant further attention. Patients who frequently cancel appointments, ask for appointments outside of office hours, who do not wish to talk to anyone other than the surgeon, and who have difficulty following the office's preoperative routine should be reconsidered for surgery. A 30- to 45-minute consultation is a brief time to learn about an individual's psychosocial status. Every bit of information about an individual obtained either during the consultation, or observed during interactions with the nursing or office staff, should be used. Prospective patients will be on their best behavior during the preoperative consultation and will often expend a great deal of effort to present as "appropriate" for surgery. Nonsurgical personnel often may see different aspects of a patient's behavior during other interactions. If concerns about the patient persist, the patient should be referred to a psychologist or psychiatrist for further consultation. If BDD is suspected, given its newness to the literature it is important that the consultant be aware of the disorder and how to assess it. A well-qualified mental health consultant with a good understanding of body image dissatisfaction and BDD can be a valuable asset to a cosmetic surgery practice.

Table 1. Additional Questions for Exploring-Psychosocial Issues

1. What makes now feel like the right time for surgery rather than a month or a year ago or a month or a year in the future? (Do not stop with purely practical answers like "I have a vacation coming up" or "I just got a bonus check." Continue, "OK but is there anything else?")
2. What are three wishes about the impact on your life of a successful outcome? Please answer on a pure fantasy level- don't be realistic.
3. What are three realistic expectations of the impact that successful surgery will have on your life? Can you imagine any possible disadvantages to a successful surgical outcome?
4. How do you expect key people in your life will respond differently to you after the surgery? How about strangers?
5. Does your (target body part) remind you of anyone you know? Have met? Family members? Whose eyes or whose thighs do you have?
6. Have you noticed that your readiness to have the surgery varies from day to day or week to week. Is the desire greater with certain events, moods, or reactions of others?
7. Have you noticed any unexpected emotional reactions from surgical personnel, the office, or from talking about the surgery?
8. Have you ever had any indications that others see you differently than you see yourself?
9. Do you ever have trouble following health or beauty guidelines that you agree with?
10. What percentage of peoples' first impression of you do you believe your (target body part) accounts for? What percentage after they get to know you?

Some patients will react to mental health referrals with anger and denial, and may initially refuse to accept the referral. Patients who refuse to see a consultant are probably not good candidates for surgery. Unfortunately, many of these patients will eventually find a surgeon who will operate on them, thereby not receiving the care they need. It is important that the surgeon treat the referral to the psychologist or psychiatrist like any other referral to a medical professional. This frequently will help destigmatize the mental health professional to the patient and make the referral easier to accept.

It is important that the surgeon be honest with the patient about the referral. In addition, it is important to communicate to the patient (and also the mental health professional) the reason for the consultation. It may be useful to say: "Undergoing cosmetic surgery is an important decision. You are considering making changes to your appearance that are more or less permanent. Cosmetic surgery often leads to changes in how you feel about your appearance—some may be positive and others may be less positive. I think it is important that we both are 100% sure that surgery is right for you at this time. Therefore, I would like you to see a psychologist (psychiatrist) who often works with us to help us decide if this is the right time for surgery." Such a statement underscores the importance of the consultation to the patient in a non-threatening way and usually prevents the patient from responding with anger or hurt.

SUMMARY AND CONCLUSIONS

Psychosocial factors are powerful determinants in cosmetic surgery practice. As the demand for cosmetic surgery continues to grow, it becomes increasingly important to understand the psychological forces that motivate people to seek surgery, and promote successful outcomes, and to determine if cosmetic surgery leads to psychological benefit. The elusive search for a preoperative psychological profile of cosmetic surgery patients becomes more difficult as the range of procedures grows and their use becomes more mainstream. Mental health consultants should be used to screen out the minority of prospective patients who may be poorly served by surgery (especially those with Body Dysmorphic Disorder, Psychoses, and Eating Disorders). The remaining majority of patients are best defined and understood by their degree of focus on appearance, dissatisfaction with their bodies, and inclination to act on this discontent. Patients often come for surgery looking to alter much more than specific areas of tissue. Understanding these subtler agendas is a key building block of patient-surgeon rapport. Insuring patient satisfaction, avoiding lawsuits, and the surgical outcome itself, can all be direct reflections of the surgeon's mastery of relationship-building techniques.

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