Cosmetic surgery: The psychiatric perspective

ABSTRACT: Increased use of cosmetic surgery has led to a growing concern with its psychiatric aspects. This paper reviews psychiatric evaluation of candidates for surgery; considers the rhinoplasty patient as a prototype; examines psychiatric complications of the surgery; and summarizes the outcome in these cases.

During the 1940s, about 15,000 cosmetic surgery operations were performed each year. By 1973, an estimated 1,041,000 plastic surgery operations had been done, a large percentage of them cosmetic. The development of such procedures and their increasing availability and popularity in recent years have led to a growing interest in the motivation of patients seeking such treatment and the psychological benefits, if any, of cosmetic surgery.

Initially, great skepticism was expressed about the value of cosmetic surgery. Updegraff and Menninger stressed that a person with a sense of inferiority, particularly a feeling of sexual inadequacy, is apt to seek and find justification for this feeling in some physical defect. MacGregor and Schaffner held that the motives for seeking such surgery could be found in an unconscious denial of deeper psychological conflicts. Stekel believed that feelings of guilt resulting from inner conflicts were being displaced and symbolized in the chief complaint of physical deformity, the psychological formulation here being: "One can tell my disgrace by looking at me." Meerlo took the extreme position that patients who seek surgery for minimal disfigurements have serious psychopathology and that therefore the surgery is contraindicated. He believed that plastic surgery "intervenes in a complicated psychological battle," and often the patient's real desire was to have the surgeon refuse the operation and thereby give the approval the patient fantasied others were denying him.

The concern that serious psychopathology may underlie requests for cosmetic surgery is valid. The accumulated findings of the past several decades, however, have shown that such concern is not usually borne out, and that even when it is, cosmetic surgery is not automatically contraindicated on that account. Patients requesting cosmetic surgery may be referred to a psychiatrist by a concerned family physician or pediatrician, or by the plastic surgeon the patient has consulted. We will here review the general approach to the psychiatric evaluation of such patients; look specifically at the rhinoplasty patient as a prototype; review the psychiatric complications of cosmetic surgery; and summarize studies of outcome in these cases.

Psychiatric evaluation

Schilder was the first to draw attention to the concept of the "psychological body image," describing how it is elaborated and
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altered during the course of individual development:

"Our own beauty or ugliness will not only figure in the image we get of ourselves, but will also figure in the image others build up about us and which will be taken back again into ourselves."

He pointed out that the body image a person has may be an identification with, or incorporation of, part of the body image of that person's parent; and that one part of the body may symbolize another. Szasz noted that an individual may relate to a part of his or her own body in much the same way as he or she relates to other people. According to Hartmann, the kind of emotional investment in the physical self, the body image, depends on the pleasure or displeasure found in the development of the body. The development of the body depends on the pleasure or displeasure found in the development of the body. The development of the body depends on the pleasure or displeasure found in the development of the body.

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Whether this desire is predominantly generated from "external" or "internal" pressures. Surgery will be ineffective if the patient is responding primarily to external pressure seeking surgery as a way of pleasing others. Surgery will be ineffective if the patient is responding primarily to external pressure seeking surgery as a way of pleasing others. Surgery will be ineffective if the patient is responding primarily to external pressure seeking surgery as a way of pleasing others. Surgery will be ineffective if the patient is responding primarily to external pressure seeking surgery as a way of pleasing others. Surgery will be ineffective if the patient is responding primarily to external pressure seeking surgery as a way of pleasing others. Surgery will be ineffective if the patient is responding primarily to external pressure seeking surgery as a way of pleasing others. 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establishment of self-identity is in the formative stages. Physical changes resulting from cosmetic surgery can be more easily integrated than in adults. The existence of extremes of psychopathology is not a direct contraindication for cosmetic surgery; the psychotic patient with a disfigurement of disproportionately features who is concerned only about this can be helped.\(^2\) Clark-son and associates\(^2\) give case reports of cosmetic surgery performed on psychotic patients, stressing that the criterion for enduring such surgery "is the degree to which the patient's overall appreciation of the possibilities and limitations of the procedure are consonant with reality no matter how disturbed he or she can be." The psychiatrist evaluating candidates for cosmetic surgery must be aware of his own attitude toward it.\(^3\) He is likely to hold more a positive, about his patient's desire for such surgery if he has himself suffered because of problems connected with his own appearance. An awareness of these feelings will help prevent interference in a rational decision. It is known that deterioration in mental health has taken place in patients for whom a psychiatrist refused to endorse cosmetic surgery for an objectively evident deformity.\(^4\)

**Rhinoplasty**

Rhinoplasty is the cosmetic procedure most commonly sought.\(^2\) The dynamics likely to underlie requests for this procedure, and the way such requests are evaluated psychiatrically, are representative of the cosmetic surgery situation in general. The face is obviously the most important physical representative of our emotions, and the nose is its most prominent feature. Feelings of inadequacy, particularly of sexual inadequacy, may be displaced onto the nose in ways determined by physiological, cultural, and historical circumstances. The nose contains erectile tissue similar to that of the genitals.\(^5\) Sexual excitement, intercourse, menstruation, and pregnancy are accompanied by changes in the nasal mucosa: hyperemia, hypersecretion, and nasal stuffiness.\(^6-8\) The ancient Romans associated the size and firmness of the nose with virility. The penalty for disfigurement was amputation of the nose in cultures as widely separated as those of India 3,000 years ago and Germany in the Middle Ages.\(^9\)

Patients requesting rhinoplasty are, as a group, more disturbed than controls.\(^10\) The older woman who seeks reconstruction of her nose usually does so in response to interpersonal stress—often marital difficulties—although she may have been disheartened with her nose and preoccupied with what she considers its ugliness since her adolescence. The demand for rhinoplasty thus may mask a depression over a midlife crisis. Surgery should be performed on such a patient only after the crisis erupting her is resolved and the motivation to undergo rhinoplasty is recognized as being primarily "internal."\(^11\)

The younger woman candidate for rhinoplasty is also likely to have been concerned since adolescence about the shape of her nose. It is common for such a woman to identify her nose with her father's, and to have failed to experience her mother as an adequate model for the feminine role, especially as it encompasses any confident pleasure in being sexually attractive. In such a case, the father is apt to be the candidate's amiable ally, someone with whom she identifies intensely in ways discordant with the development of a comfortable femininity as she matures.\(^12\) The quested ambivalence toward the mother is central to the patient's conviction of being ugly; thus the young woman who seeks rhinoplasty is often seeking a way to reduce her identification with her father and to grow into more secure femininity. Her demand should be evaluated according to the guidelines described. The evaluating psychiatrist should also learn whether a young, or adolescent female candidate is acting to please a mother who has had a rhinoplasty herself or has been interested in obtaining one. Surgery should be delayed until this imitative motivation can be ruled out or clarified for patient and mother.

As with male candidates for cosmetic surgery in general, the male rhinoplasty candidate is usually psychologically more disturbed than his female counterpart. It is wise for him routinely to have psychiatric evaluation before he has surgery. The underlying dynamic is usually sexual. Dissatisfaction with the nose has been related to cases of homosexuality by several investigators;\(^13-15\) the patient may unconsciously fear that his unaltered facial profile is effeminate. Of interest, with our male rhinoplasty patients, is the absence of requests to make their noses larger or to have a bump added to the dorsum. The relationship between homosexual defenses and the high frequency of paranoia among male candidates for plastic surgery, however, has not to date been explored in terms of Freud's\(^16\) theory of paranoia and latent homosexuality.

**Psychiatric complications**

Psychiatric problems may appear in the period immediately following the cosmetic operation. These are usually short-lived manifestations of reactive anxiety and depression thought to develop in response to the sudden challenge to the body image and/or the sense of self esteem previously bound by the preoccupation with the deformity. Reich\(^17\) reported such reactions in 185 (31%) of a sample of 599, and felt that they were best handled by the supportive attitude of the surgeon. Three (15%) of 20 consecutively studied female rhinoplasty patients who had been carefully screened before undergoing surgery exhibited such a postoperative syndrome.\(^18\) A higher incidence (55%) of transient emotional disturbance was noted in a series of 98 male and female patients.\(^19\) Psychotic reactions have been reported among screened patients, but seem to be rare. It is, incidentally, interesting that the young woman who has mammmary augmentation commonly suffers transient postoperative depression more intensely than the reactive depression associated with other types of general cosmetic and surgical surgery.\(^20\)

There seem to be few long-range psychiatric complications secondary to cosmetic surgery, but Kneer\(^21\) has identified a syndrome of "feminine loss of identity" among some adult women who had rhinoplasty. They eventually had multiple procedures done, always in the hope of regaining the longer length and larger size of the original noses. The psychiatric profile is like that seen in polydysphoria. The favorable response of most patients to their cosmetic surgery is reflected in the affirmative editorials that have appeared in the leading medical journals.\(^22\) Many studies, including those of Kneer,\(^21\) Hirschfeld,\(^23,24\) and Whitaker,\(^25\) confirm this endorsement. The vast majority of patients who have undergone cosmetic surgery report, independently of any psychiatric diagnosis, subjective satisfaction with improved self-esteem, and relief from depressive symptoms. A consistent observation is improvement in interpersonal relationships without any significant change in basic personality. Hay and Heath,\(^26\) who made a quantitative follow-up study, found improvement in psychological test results unrelated to the initial degree of deformity.

Gipson and Connolly\(^27\) offer a less optimistic view, however. They were concerned about dysmorphophobia—the fear that a basically normal feature is regarded with disgust by others—and its significance as an early sign of schizophrenia. They reported on the long-term follow-up of 86 patients who had cosmetic rhinoplasty and compared them with 108 whose nasal reconstructions had been necessitated by injury. Ten years after surgery, 32 of the cosmetic patients had psychiatric disorders (five had schizophrenia); but only eight of the injured group had psychiatric illness and none was schizophrenic. These investigators concluded that rhinoplasty did not cause serious psychological disturbance. They found that it was often beneficial, even if only for a limited time, but that it was probably a waste in some cases, inasmuch as it failed to remedy an underlying illness of more sinister consequence.

**Conclusion**

Those who seek cosmetic surgery, especially men, are more disturbed psychologically than controls. The degree of their emotional illness is independent of the degree of physical deformity. Psychiatric evaluation is an appropriate approach to this type of surgery, screening out those for whom it is unsuitable, and helping clarify the perceptions and expectations of the patient in ways that enhance the generally favorable results of such surgery. Psychiatric focus is most profitably directed toward the candidate's motivation and expectations. When the patient sees his or her need for corrective surgery as primarily to improve self-esteem, and self-acceptance of his or her body image, then surgery has a reasonable likelihood of producing lasting benefit. Severe psychological disturbance is not necessarily a direct contraindication for psychiatric complications of cosmetic surgery are not
common if the surgeon is knowledgeable about the motivational patterns of his patients, and if he utilizes psychiatric collaboration in offering surgery to the more disturbed patients. When postoperative emotional reactions do appear, they are usually mild and transient.

REFERENCES