Importance of a Psychiatric Approach in Cosmetic Surgery

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Background: Some studies have suggested that certain types of psychiatric problems may be more prevalent in patients undergoing cosmetic surgery than in the general population. Objective: In this study, 140 patients undergoing cosmetic surgery took a screening test before surgery. The results were statistically analyzed to evaluate the importance of a psychiatric approach in cosmetic surgery. Methods: At the first visit to the clinic, an interview was carried out in the presence of a psychiatrist. If needed, a secondary evaluation was performed on those patients with suspected psychological disorders. Results: Preoperative screening led to the diagnosis of psychiatric disorders in 45 of 140 patients (32%). Final psychiatric diagnoses included neuroses such as body dysmorphic disorder and depression/depressive states. Conclusions: It is sometimes beneficial to prioritize psychiatric treatment instead of focusing solely on surgical treatment to achieve better outcomes in patients undergoing cosmetic surgery who have psychiatric disorders. Preoperative psychiatric screening should be routine in the practice of cosmetic surgery. (Aesthetic Surg J 2007;27:396–401.)

The demand for cosmetic surgery has increased in Japan as more people learn about different cosmetic procedures and become more interested in improving their appearance. Some studies have suggested that certain types of psychiatric problems may occur more commonly in patients undergoing cosmetic surgery than in the general population.

Goin and Goin \(^1,2\) pioneered the use of a psychiatric approach for patients undergoing plastic and cosmetic surgery. Previous studies revealed that 30% to 70% of patients who sought plastic and cosmetic surgery had some psychiatric problems. \(^3-7\) Sarwer et al \(^8-10\) reported that 7% of patients undergoing cosmetic surgery and 16% of those seeking plastic surgery scar revision had body dysmorphic disorder, and that compared with patients not undergoing cosmetic surgery, patients undergoing cosmetic surgery had higher rates of mental health disturbances and were prescribed psychiatric medication more frequently. A survey conducted from 1992 to 1994 in our institute showed that “35% of cosmetic surgery patients were suspected of having some psychiatric disorder.” Despite some variations in previous reports, these rates are considered high. Patients with a history of multiple operations are more likely to have such disorders. They often believe or fear that others dislike them because of their appearance; these concerns can significantly distort their social relationships.

Plastic surgeons are not psychiatrists and often will not be able to properly diagnose a patient in terms of psychiatric problems. Edgerton et al \(^11\) reported that 72% of patients who were concerned about minor deformities had psychiatric and psychological abnormalities, but most of them were not diagnosed as such by surgeons. These reports suggest that evaluating mental health is a difficult task for plastic surgeons.

In the past, patients undergoing cosmetic surgery, seeking consultation for surgery, were first referred to the psychiatric clinic according to the regular referral system in our institute where they were asked to undergo an interview and psychological tests, such as the Cornell Medical Index, YG character test, sentence completion test, and Rorschach test. Procedures such as obtaining informed consent, explaining the policies of the institute, and making sure all patients followed the same evaluation protocol helped to alleviate reluctance on the part of patients to participate in psychiatric testing. However, some patients refused to visit the psychiatric clinic. Therefore, in an effort to evaluate all patients undergoing cosmetic surgery, such patients were then interviewed with a psychia-
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Psychiatrist present at the first visit on a trial basis. A psychiatric screening test was administered at the same time. These results were statistically analyzed to assess the importance of a psychiatric evaluation and psychiatric treatment for patients seen by plastic surgeons for cosmetic surgery.

**Patients and Methods**

The study comprised 140 patients who visited the cosmetic surgery clinic at Kitasato University Hospital between April 1, 2000, and May 31, 2003. To evaluate psychiatric status, all patients were interviewed in the presence of a psychiatrist who listened to the interview by a cosmetic surgeon and asked additional questions when necessary for psychiatric evaluation. More specifically, two parameters in the Hamilton depression scale, depression and anxiety, were selected, and scoring one point or higher in either one of them raised a red flag for “suspicion of psychiatric disorder.” Furthermore, a more detailed interview was carried out in the abnormal cases, and psychiatric diagnosis was determined according to the Diagnostic and Statistical Manual on Mental Disorders, 4th edition.12

The patients were divided into two groups: Group P, with determined psychiatric diagnosis, and Group N, without diagnosis. Additionally, data were gathered on age, sex, histories, and the number of cosmetic surgery procedures undergone. Expected operation sites and type of operations were surveyed, and the results were statistically analyzed.

**Results**

**Psychiatric diagnosis**

Out of a total of 140 patients, 60 (43%) were diagnosed as “suspicion of psychiatric disorder” by psychiatric screening at the initial visit. Further interviews by the psychiatrist led to the diagnosis of psychiatric disorders in 45 (32%) of those patients (Figure 1). Neuroses such as body dysmorphic disorder and depression/depressive states were frequently found (Figure 2). However, in these diagnosed cases, only 9 patients (20%) chose to continue psychiatric treatment.

**Age and gender**

The study included 16 men and 124 women with an average age of 38.4 years (Figure 3). There was no statistical correlation between the age of the patients and the rate of psychiatric disorders. With respect to gender, only three of 95 patients (3.2%) were male in Group N. On the other hand, 11 of the 45 patients (24.4%) in Group P were male.

**History of cosmetic surgery**

Sixty-six patients (47%) had a history of cosmetic surgery; and the maximum number of operations for any one patient was 10.4. All patients with a history of 4 or more operations belonged to Group P. The average number of operations was 1.49 in Group P and 0.57 in Group N, and there was no statistically significant difference between the two groups ($P < .05$) (Figure 4).

Figure 1. Patient screening algorithm.
Sites and content of operations

Figure 5 indicates the areas of the body where patients sought cosmetic surgery. Blepharoplasty, rhytidectomy, and mammoplasty rated highest in Group N, whereas blepharoplasty, rhinoplasty, facial osteotomy, and foreign body removal rated highest in Group P. There was a statistically significant difference between the two groups in the ratings for blepharoplasty, rhinoplasty, facial osteotomy, and foreign body removal. Male patients who wanted rhinoplasty had a statistically higher risk of suffering from a psychiatric disorder compared with female counterparts (Figure 6).

Discussion

Statistical characteristics of patients undergoing cosmetic surgery

With respect to age distribution, there were a large number of patients in their 20s in both groups, but the fact that Group N had a similarly large number of patients in their 50s indicates a difference between their cosmetic surgery needs. In Group P, there was a tendency to want procedures that change facial shape or alter the patient’s identity, such as rhinoplasty and facial osteotomy. In Group N, a larger proportion of patients were older and wanted operations such as blepharoplasty and rhytidectomy, with the goal of rejuvenating facial features affected by aging.

Importance of preoperative psychiatric screening

Excluding those cases in which a psychiatric disorder had been diagnosed before the first visit, there seem to be two major patterns for development of postoperative psychiatric problems. The first involves postoperative mental stress that develops when the results of the operation are greatly different from the patient’s expectations. The second involves the existence of a psychiatric disorder that is present before surgery but is not diagnosed at the time, so that psychiatric distress develops even after successful treatment. The first pattern
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can be prevented only to some degree by improvements in surgical technique and careful preoperative evaluation of patient expectations to make sure the patient understands the purposes, likely results, and limits of the procedure or procedures under discussion. Because some time may be required to evaluate the full results of surgery, adequate follow-up of patient satisfaction levels after surgery is required. Hermans et al.13 conducted a survey on postoperative quality-of-life changes by using six questionnaires including the Short Form 36 Health Survey Questionnaire in patients before and 2 years after breast reduction.

The second pattern emphasizes the importance of preoperative psychiatric screening for all patients who seek surgery. Gipson and Connoly14 carried out a 10-year follow-up survey in 86 rhinoplasty cases in which they found five cases of schizophrenia and 32 cases of other psychiatric disorders. All of these patients were evaluated as having good mental health at the time of operation. We experienced cases in which psychiatric disorders clearly surfaced only after surgery. To provide appropriate treatment other than surgery in these cases, preoperative psychiatric screening for evaluation of psychiatric status of the patients is crucial.

Details of the screening test

Psychiatric evaluation has been an integral and important part of patient consultation from the very beginning of our practice. When a psychiatric disorder is suspected as a result of the initial screening, we try to prioritize preoperative psychiatric treatment. When patients do not require psychiatric treatment as determined by the initial screening but nevertheless seem nervous about their operations, we thoroughly examine the case with a psychiatrist and propose the minimum amount of surgery needed to achieve aesthetic goals and patient satisfaction.

During the survey period in this study, 16 of 45 patients diagnosed as having a psychiatric disorder underwent surgery. Although a surgical indication is

Figure 4. History of cosmetic surgery.

Figure 5. Distribution of aesthetic procedures.
controversial in patients suspected of having psychiatric disorder, we believe that in some cases, we should actively treat such patients in collaboration with a psychiatrist. In fact, as also noted by Druss et al., in cases with relatively mild psychiatric disorder, social functioning, as well as aesthetic appearance, improved after surgery. However, it is crucial to exercise caution in considering such surgery, because of the risk of the patients falling into polysurgical addictive states.

In this study, we interviewed patients undergoing cosmetic surgery at the first visit with the attendance of a psychiatrist for psychiatric screening; the extracted patients were further interviewed by the psychiatrist, and psychiatric diagnosis was reached by the Diagnostic and Statistical Manual on Mental Disorders, 4th edition. As a result, a psychiatric diagnosis was reached in 45 of 140 patients (32%). Because the psychiatrist that diagnosed psychiatric disorder had a knowledge of the tendency for patients undergoing cosmetic surgery to have certain psychiatric disorders, it is possible that such a bias led to higher rates of diagnosis of psychiatric disorder, but this point was considered the only limitation of this method.

Patients were offered counseling in the same clinic room without visiting a psychiatric clinic and were relatively willing to give consent. However, some patients showed discomfort with the presence of someone other than a surgeon during the initial consultation. This reaction emphasizes the need to provide a screening test that is both easier to administer and better accepted by patients.

The results show that male patients who wanted rhinoplasty had a significantly higher risk for psychiatric disorders. We anticipate the development of screening tests that allow surgeons to objectively evaluate psychiatric disorders with respect not only to specific procedures but more widely as well. One possibility is the use of a questionnaire to evaluate specific psychiatric and psychological problems that have been shown to be frequently present in patients undergoing cosmetic surgery. Because anxiety disorders such as neurosis and depression/depressive states accounted for a large proportion of the psychiatric disorders in this study, our goal is to develop a self-assessment questionnaire that uses scoring systems according to the anxiety and depression scales.

**Conclusion**

Psychiatric evaluation and treatment of patients undergoing cosmetic surgery is still a developing area of practice. The fact that less than 20% of our patients continued psychiatric treatment after diagnosis of a psychiatric disorder is discouraging. However, in other cases screening led to the acknowledgment of psychiatric problems. Some patients recognized that their long-term mental suffering was not actually a consequence of their appearance. These individuals often were willing to undergo psychiatric treatment rather than surgery to relieve their psychological distress. Preoperative screening functioned well in these cases.

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**References**


**Suggested Readings**


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