Aesthetic Surgery in Adolescents: A Suggestion Informed by Adolescent Psychology

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Consider the following facts: The interval between menarche and marriage was approximately seven years in 1890. Today it is approximately twice that, extending to nearly 15 years, a phase of life in which body image is a paramount concern.

This interval, now extended, is a time when one’s sense of identity and future is in flux, when social approval of peers is a priority, and when alienation from parents’ influence and counsel is strong.

Teasing about appearance is a common experience among adolescent girls, and is a clear risk factor for body dissatisfaction. Body dissatisfaction in girls and young women is so rampant as to be almost normative, and it does not fade until the 30s and 40s, and even then, still clearly exceeds the body dissatisfaction of men (who, unlike women, experience an increase in body dissatisfaction from adolescence to middle-age, though they never average a level that approaches women’s body dissatisfaction).

Prominent theorists of human development have characterized adolescence as a time when, in the best case, a lot of testing and trying on of identity roles is occurring, and in the worst case, when extreme identity confusion emerges. A moment’s reflection on one’s own adolescence, or that of one’s own children—as well as even the most cursory reading of the literature on developmental cognition—will attest that it is a time when decision-making can be shortsighted and self-focused.

All of the foregoing combines to indicate substantial caution in major life decisions for adolescents. Indeed, this caution is substantiated in age-related legal and regulatory codes regarding such issues as voting, driving, gambling, smoking, alcohol use, gun ownership, movie attendance, home shopping, and an array of activities related to sexuality—even the use of internet social networking sites such as myspace and facebook is age-restricted—as are, of course, aspects of health care access and choices. Should aesthetic surgery be treated similarly?

On the one hand, obviously not. A 15-year-old boy with severe gynecomastia should, with parental/guardian involvement, be allowed access to a credentialed and judicious surgeon. So, similarly, should a 15-year-old girl whose overly large breasts are causing severe back and shoulder pain and restricting physical activity (breast reduction is usually done only when breast development is complete). As a general rule, in cases like these, adolescent psychology should not, of course, be ignored, but neither is it usually primary as compared with the psychosocial consequences of gynecomastia or the pain and impairment of overly large breasts.

On the other hand, age-related limitations should be more restrictive—and adolescent psychology more primary—regarding other scenarios. An obvious example is breast implants, which, except for those with clear breast asymmetry or who need post-trauma reconstruction, are prohibited by federal regulations for those under the age of 18. Somewhat more ambiguous are procedures such as rhinoplasty (which is the most common procedure among teens) and lipoplasty. Though there are clinical conditions that would indicate these procedures in teens (eg, lipoplasty for localized and relatively severe fat deposits in normal weight individuals, after diet and exercise have not achieved satisfactory results), many such procedures are purely elective and cosmetic, and thus should be subject to especially cautious review.

I would like to offer a simple suggestion for the conditions of such reviews—a suggestion that is compatible with the psychology of adolescence, and which, should the individual surgeon agree with it, will have to be molded to fit within the clinical and pragmatic features of the surgeon’s practice. The suggestion, in a word, is “delay.”
To be more specific, given the frequently shortsighted nature of adolescent decision-making, as well as the frequently tempestuous quality of adolescent family and social relations, the results of an initial consult should be confirmed by a follow-up consult, occurring several weeks to months later. (For surgeons who routinely do this for most patients, whether adolescent or adult, I am suggesting a lengthening of the usual interval for adolescents.) Under these conditions, a decision to proceed with surgery would occur only after the surgeon determines that such factors as motivations for surgery and expectations about surgery’s consequences, as well as emotional factors, are stable across a substantial time interval. Of course, this would also allow the surgeon to affirm that physical development of the body area in question is such that surgery can proceed.

Optimally, this time interval would be long enough to include different times of the year (eg, during school and then during the summer break in the United States), so that stability of motivations, expectations, and emotional factors can be affirmed even against the backdrop of changing contexts. Stability even against the backdrop of change would add further validity to a judgment of stability.

Potential pragmatic difficulties with this suggestion include added consult time, frustration on the part of adolescent patients and perhaps even their parents, and, especially in high competition areas, potential loss of patients to surgeons who may perform procedures more quickly. However, these difficulties may be minimal or even offset by benefits. For instance, adolescent patients represent only 3% of the total of those electing aesthetic surgery; therefore, added consult time is likely to be minimal, and also may provide additional data to enhance decisions about whether and when surgery should proceed. An adolescent patient’s impatience or frustration over the suggestion of a delay may signal motivations, expectations, or emotional factors that predict poor outcomes. Indeed, unrealistic expectations and emotional instability are among the strongest predictors of poor outcomes, including anger and dissatisfaction with the surgeon and his/her staff. The relatively small addition to consult time and the occasional loss of business to another surgeon may well be offset by better outcomes and the associated benefits of more satisfied patients.

Permanence is not a concept that adolescents easily grasp, and permanence, at least of a sort, is a quality of aesthetic surgery. To be sure, there are signs and indicators that inform surgeons about patients’ readiness for surgery. But, especially for patients in an age group known for identity confusion and changing psychology and physiology, how are we to ascertain that these signs and indicators are reliable? One tried and true method from psychometrics is test-retest across a substantial time interval. A basic principle of psychometrics is that a precondition for signs’ and indicators’ validity is their reliability. An initial consult, with a follow-up several weeks or months later, allows a kind of test-retest reliability check, which in turn, would inform surgeons about the validity of their judgments about patients’ readiness and thus potentially prevent poor outcomes. There are potential difficulties and costs—and of course surgeons must weigh these in context of the clinical and pragmatic features of their practice, as well as in context of the individual patient-physician relationship—but these difficulties and costs may be outweighed by better decisions and better outcomes.

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References