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Aesthetic Plastic Surgery

The Role of Psychiatry in Aesthetic Surgery

Hiroyuki Ohjimi, Nobuyuki Shioya, and Jun Ishigooka

Kitasato, Japan

Abstract. Twenty-five patients seeking aesthetic surgery were investigated and treated with the cooperation of the plastic surgeon and a psychiatrist. Three-fourths of the patients revealed psychiatric problems in their backgrounds. On the recommendation of the psychiatrist, eight cases underwent operations, in spite of psychiatric problems, and were satisfied with the treatment. Patients not operated on had been persuaded to abandon their operation after psychiatric therapy. In conclusion, the cooperation of the psychiatrist was found to be very effective in the treatment of those seeking aesthetic surgery.

Key words: Aesthetic plastic surgery — Psychiatric problems

Many patients seeking aesthetic surgery have psychiatric problems in their backgrounds. This worries aesthetic surgeons, who lack a psychiatric diagnosis of such patients to guide their decision on whether an operation is feasible.

Furthermore, aesthetic surgeons do not treat patients after a decision has been made not to operate. Still, these surgeons have a duty to see that these troubled patients receive treatment, even though they have been passed over. Thus, in an experimental study, we have treated a number of such patients by means of psychiatry and have achieved good results.

Address reprint requests to Hiroyuki Ohjimi, M.D., Fukuoka University, School of Medicine, Department of Pharmacology, 45-1-7 Nanakuma Jonan-Ku, Fukuoka 814-01, Japan

Cases and Methods

From March 1984 to February, 1987, 5826 patients visited the Department of Plastic Surgery at the Kitasato University Hospital, which has an aesthetic surgery clinic that can accommodate 486 patients. For our study, 25 patients selected at random from this clinic were given a psychiatric assessment (Table 1). This assessment affected the decision of whether operate and if these patients needed psychiatric therapy.

For other procedures, we used our own diagnostic criteria to determine cases of dysmorphophobia [5], adding a pertinent item from the criteria proposed by Andreasen and Bardach [1].

The decision to operate was agreed on by both the surgeon and the psychiatrist. The cases of patients who were not given aesthetic surgery were followed up by a psychiatrist and their results were evaluated.

Result

(1) *Psychiatric Evaluation of Patients Seeking Aesthetic Surgery* (Table 2)

Nineteen patients, 76% of the 25 patients, were determined to be psychiatrically abnormal. Five displayed dysmorphophobia, 5 had a personal disorder, 1 showed schizophrenia, 1 was found to be mentally retarded, and 7 manifested neurosis, obsessive-compulsive, and hypochondriac behavior among the symptoms of their neurosis. The remaining 6 patients, 24% of the total, were determined to be psychiatrically normal.

Table 1. Data on patients in study

N	Age (mean)
Male 15	12–58 (29.1)
Female 10	20–57 (35.0)
Total: 25	12–58 (31.5)

Table 2. Psychiatric evaluation of patients seeking aesthetic surgery

	Male	Female	Total
Dysmorphophobia	4	1	5
Personality disorder	3	2	5
Schizophrenia	0	1	1
Mental retardation	1	0	1
Neurosis	3	4	7
Normal	4	2	6

Table 3. Data on decision to operate

	Operative	Nonoperative
Dysmorphophobia	2	3
Personality disorder	4	1
Schizophrenia	0	1
Mental retardation	0	1
Neurosis	4	3
Normal	2	4
Total	12	13

(2) *Decision Taken Regarding Their Operations* (Table 3)

Twelve patients, 48% of the total, were approved for operation, and 10 of these patients have undergone an operation while the remaining 2 were scheduled to receive surgery. Thirteen patients, 52% of the total, were rejected. These cases included 3 who were dysmorphophobia, 1 who had a personal disorder, 1 who manifested schizophrenia, 1 who was mentally regarded, 3 who had a neurosis, and 4 were determined as normal.

(3) *Results of the Operation in Patients Having Psychiatric Problems* (Table 4)

Eight patients, who were found to be psychiatrically abnormal, received surgery; seven were satisfied with the results. The remaining patient was not satisfied because of a conspicuous scar formation caused by operation.

Table 4. Results of the operation on patients having psychiatric problems

	Satisfied	Dissatisfied	Total
Dysmorphophobia	1	0	1
Personality disorder	3	0	3
Schizophrenia	0	0	0
Mental retardation	0	0	0
Neurosis	3	1	4
Normal	2	0	2

Table 5. Results of the psychiatric treatment given to the nonoperated patients

	Satisfied	Dissatisfied	Total
Dysmorphophobia	3	0	3
Personality disorder	0	1	1
Schizophrenia	1	0	1
Mental retardation	1	0	1
Neurosis	3	0	3
Normal	3	1	4

(4) *Results of the Psychiatric Treatment Given to the Nonoperated Patients* (Table 5)

With the aid of psychiatric therapy, 11 of the 13 nonoperated patients showed an improvement in their symptoms and agreed to forego their operations. The remaining two patients, one who was normal and one with a personality disorder, dropped out of this study and could not be followed up. The patient who was found to be schizophrenic was hospitalized.

Discussion

Diagnosis for Determining Dysmorphophobia

Morselli [6] was the first to report on patients who had a morbid fear for their own dysmorphy of deformity or of becoming deformed and coined the term "dysmorphophobia." Since Morcelli's time, many reports concerning dysmorphophobia have been published, yet, dysmorphophobia still has to be precisely defined. In cases reported as dysmorphophobia, there were those of so-called dysmorphophobic state and those of true dysmorphophobia as one independent disease. The former is a group of symptoms caused by neurosis, psychosis, polysurgery, and querulous delusion.

Table 6. Diagnostic criteria of dysmorphophobia [1]

(1) An excessive concern with some imagined "defect"
(2) One of the following associated traits:
(a) Corrective surgery is sought, with primary goal of improving the appearance or achieving a more ideal look, rather than with a primary goal of improving relationships with other people or work opportunities.
(b) Mixed traits suggestive of personality disorder, particularly schizoid, compulsive, or narcissistic; but none clearly dominates the clinical picture.
(3) Ideas of reference related to the "deformity." Delusions of reference, hallunications, or symptoms of a major depressive disorder are absent.

Table 7. Our proposed dysmorphophobia criteria with modified third criterion of Andreasen's list

Several disturbance of interpersonal relationships leading to poor social adjustment, most often associated with ideas or delusions of reference.
Excludes schizophrenia, major depressive disorder, organic mental disorders

Table 8. General criteria used

(1) When the surgeon thought that the operation was impossible due to some technical reason.
(2) When the patient had excessive expectation as to the results of the surgery.
(3) When patients complained of a disorder in their somatic sense.
(4) When the surgeon guessed that the patient might have some psychiatric problems.

The later is one disease in the neurosis and is similar to anthrophobia. We consider the two types as different from each other.

The criteria proposed by Andreasen and Bardach [1] seem to be the most popular and we have also used it (Table 6). We felt, however, that to apply the criteria fully would run the risk of having to include patients scheduled for polysurgery as well as patients manifesting querulous delusion. Therefore, we decided that our criteria for evaluating dysmorphophobia also should include a manifestation in the patient of a disturbance or a crisis in social adaptation or reference [5]. By applying our criteria, five of 25 patients, or 20% of the total, were diagnosed as having dysmorphophobia (Table 7).

Psychiatric Evaluation of Patients Seeking Aesthetic Surgery

Our study of these 25 patients revealed that psychiatrically abnormal patients accounted for 76% of the total. There are no other psychiatric evaluation statistics available for those seeking aesthetic surgery in Japan. As for those seeking aesthetic surgery in Europe and the United States, reports vary: The figure for those displaying some character disorder or psychosis range from 30% to 60% [3, 7].

There may be a reason for such a high proportion of psychiatrically abnormal patients in our study. Since the clinic we selected is part of a university hospital, it could be that the more difficult cases were referrals, patients who could not be handled by general clinics in Japan.

Decision Taken Regarding Their Operation

It is very difficult to standardize the criteria to use to decide whether to operate on a patient, particularly when patients are unable to be investigated as part of a controlled study [2–4]. We used general criteria (Table 8). If one of these criteria applied to a patient, we decided that an operation would not be performed. The first criterion was applied to 4 of the 13 nonoperated cases, these 4 having been determined as psychiatrically normal. After psychiatric treatment, 2 patients who had been previously rejected for surgery were operated on.

On the recommendation of the psychiatrist, 8 cases were operated on, in spite of having psychiatric problems, and almost all were satisfied with the treatment.

Eighty-five percent of the nonoperated patients were able to be persuaded to abandon their desire for an operation and to take their place in society again after psychiatric therapy. Thus, by linking the efforts of both the aesthetic surgon and the psychiatrist, we were able to avoid operating on patients who might be susceptible to some psychiatric trouble later. Furthermore, even in cases involving disturbed patients given surgery, satisfactory results were obtained.

Though some problems in our treatment system still remain, the cooperation of the psychiatrist was found to be very effective in the treatment of those seeking aesthetic surgery.

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