Aesth. Plast. Surg. 24:283–288, 2000
DOI: 10.1007/s002660010047

Aesthetic Plastic Surgery

Cross-Cultural Understanding of Aesthetic Surgery: The Male Cosmetic Surgery Patient in Japan and the USA

Yuri Nakamura, M.D., John B. Mulliken, M.D., and Myron L. Belfer, M.D.

Boston, Massachusetts, USA

Abstract. This review describes the historical development of aesthetic surgery in Japan and parallels with the development of the specialty in the United States. The focus is on the consequences of aesthetic surgery in the male patient when collaboration between mental health clinicians and surgeons lags. The cultural, social, and psychological issues raised are relevant to the diverse cultural groups now seeking aesthetic surgery in the United States. Case illustrations are a reminder to aesthetic surgeons of the potential need for more comprehensive evaluation in the group of male patients who may be at added risk for negative outcomes in terms of satisfaction.

Key words: Cross-cultural—Aesthetic (cosmetic) surgery—Body dysmorphic disorder—Surgical complication

Psychological problems in male patients seeking cosmetic surgery are well known to plastic surgeons, psychiatrists, and other clinicians in the United States and Japan. However, the manner in which surgeons manage these psychological issues and their awareness of specific concerns differ in the two countries. This paper details the psychological problems specific to male patients seeking aesthetic surgery and discusses the implications for surgical intervention from a cross-cultural perspective, using Japan as a model. The authors focus on Japanese male cosmetic patients because their number is increasing and their request for change appears greatly influenced by shifts in cultural norms and expectations.

Correspondence to Myron L. Belfer, M.D., Department of Social Medicine, Harvard Medical School, 641 Huntington Avenue, Boston, MA 02115, USA

Historical Perspective

Japanese culture was primarily influenced by China and Korea and later by Western traders from the Netherlands and Portugal. During the Edo-period (1603–1867) a distinctive Japanese culture and life-style developed and flourished [1]. Not until 1856 did Japan open her ports to the American fleet under Commodore Perry. The Japanese were suddenly "astonished" by all things Western. For the next 50 years, Japan admired Western ways and rapidly modernized [1]. During the period of westernization, the first cosmetic surgery was performed by Mikamo in 1896. The operation was the formation of a double eyelid to correct "a partial defect of the muscle fibers that end on the skin of the upper eyelids making the facial expression monotonous and impassive—can also cause narrowed vision" [2]. It is interesting to note that the indications were both functional and aesthetic. The next reported blepharoplasty was two decades later, performed by Dr. Uchida [2], an optometrist. Just as blepharoplasty began to grow in popularity, along came World War II and cosmetic surgery ceased.

After the great Kanto earthquake in 1923, Tokyo emerged as a cosmopolitan city, once again receptive to Western popular culture [2]. The traditional ideal of beauty had always been "straight eyes and nose, flat eyelids, and receding chin (which expressed) the Buddhist idea of harmony and universality" [3]. The new paragon became Caucasian-like facial features, the round eyes with a tarsal crease and strong nasal dorsum. Cosmetic surgery became especially popular among young Japanese women. There was a high demand for the double-eyelid operation followed by augmentation rhinoplasty both of which remain the most frequently performed cosmetic procedures in Japan [3]. Often the double-eyelid procedure was accomplished during the lunch hour. Most Japanese plastic surgeons place the

tacking sutures from the transconjunctival rather than the external approach.

Initially, cosmetic procedures were performed by otolaryngologists, optometrists, dermatologists and orthopedists [4]. In 1956, the first team of plastic surgeons was formed in Japan in the Department of Orthopedic Surgery at Tokyo University Hospital [5]. This was done to emphasize the specific technical competence of plastic surgeons specializing in this emerging field. The term "plastic surgery" initially applied to both reconstructive and aesthetic problems, but soon the subspecialty of aesthetic surgery separated when the term "plastic" became synonymous with reconstructive surgery. This distinction was codified, and a separate Japanese specialty of aesthetic surgery was legally established in 1978.

Demographics

Although cosmetic surgery has a longer history in the United States than in Japan, there are some interesting parallel developments. In 1994, members of the American Society of Plastic and Reconstructive Surgeons (ASPRS) reported 47,410 cosmetic procedures in male patients, which is 12% of all such procedures in that year. However, by 1997 the number of male face-lift operations was almost double that in 1992. Reliable Japanese data for cosmetic procedures is not available, but requests for these operations is growing [6,7]. In particular, there is heightened interest in aesthetic surgery among men [8]. Koda et al. [8] suggested that requests for cosmetic procedures from males now approaches that for females.

Psychological Issues in Male Cosmetic Patients

American plastic surgeons underscore their concern that males seeking cosmetic changes are likely to have underlying psychological problems. Jacobson et al. [9] studied 20 male patients whose complaints and symptoms were of a cosmetic nature and whose minimal deformities were not related to trauma or congenital malformation. Eighteen of the 20 patients were referred for psychiatric evaluation and all were given a psychiatric diagnosis (psychosis was diagnosed in seven patients and neurosis in four). Seven patients were diagnosed as having a moderate to severe personality trait disorder. These investigators also analyzed 98 consecutive cosmetic patients presenting with minimal facial deformity. Of these, 14 were male, and 11 requested rhinoplasty. Ten of the 11 male patients were diagnosed with a psychiatric diagnosis as compared with 70% of the total sample. Goin and Goin [10] describe 27 selected rhinoplasty patients who had a psychological disorder; all were in therapy at the time of rhinoplasty. Ten of the 27 were male and the number of men exhibiting postoperative disturbance was high (3 out of 6). Interestingly, these authors found that overtly effeminate, homosexual males seemed to have fewer psychological disturbances following rhinoplasty. Thus, Goin and Goin [10] hypothesized that homosexual patients had less psychosexual conflict because their sexual identity was secure. In contrast, the non-homosexual male patient seeking rhinoplasty may be more confused emotionally and intellectually about his gender identity and consequently uncertain about his perception of his nose [11].

The psychological effect of a face-lift is thought to differ from other cosmetic procedures. The patient hopes to return to an earlier, more youthful appearance, i.e., the patient is not seeking to change basic appearance or assume a new physical identity [12]. Such a patient's self-image is assumed to be stable and the procedure would have less impact on this internalized image than for someone seeking a more radical change in basic appearance. In Edgerton's study of 106 consecutive patients seeking rhytidectomy, only 7 (9%) were male. Of these 7, all were found to have suffered emotional illness in the past and all had a current psychiatric diagnosis.

Although Japanese surgeons are aware of psychological issues in their cosmetic patients, they have written relatively few papers on the subject. Fukuda and Yamada [13] analyzed 274 patients (170 males, 104 females) with no observable deformity or a minimal deformity who had persistent and exaggerated complaints about how they look. Of the 274, 179 were judged by plastic surgeons to have psychological problems, including 22 patients with a delusional thought disorder. Seventy percent of the 179 patients were male, and most were between the ages 17 to 19. The surgeons had the impression that the disturbed patients maintained a masculine identity. Of the 179 psychologically disturbed patients, only 15 agreed to meet a psychiatrist, and 13 of these were diagnosed as being psychotic, including 5 with schizophrenia. The diagnoses of all 179 patients were not reported because of the difficulty in obtaining a formal psychiatric evaluation.

At Kitasato University Hospital, Ishigooka et al. [14], using a team of plastic surgeons and psychiatrists, studied a series of consecutive cosmetic patients. All fifteen patients (9 males, 5 females, age 16 to 58) who sought cosmetic surgery were evaluated by psychiatrists. Four male and 2 female patients (a total of 40% of all patients) met the diagnostic criteria for dysmorphophobia or body dysmorphophobic disorders (BDD); 7 patients (6 male, 1 female) (47%) had ideas of reference; and 7 patients (5 male, 2 female) (47%) evidenced poor social adjustment.

From the same hospital, Koda et al. [8] reported on 180 patients requesting cosmetic surgery (49 male patients and 131 female patients, mean age of 36.0 years). Sixty-three (24 male) (35%) patients were found to have psychiatric problems: 20 (11.1%) patients with dysmorphophobia; 17 (9.4%) had suffered depression; 5 (2.8%) were schizophrenic; and 21 (11.7%) had other diagnoses, including anxiety neurosis, borderline personality disorder, among others. Among the female patients, depression, neurosis, and personality disorder accounted for 74% of the diagnoses. In contrast, these psychiatric disorders were found in about 37% of male patients. Dysmorphophobia was diagnosed in 58% of male patients.

This high incidence of psychological disturbance, especially male dysmorphophobia, is consistent with other studies from Kitasato University Hospital [15].

In 1998 Ishigooka et al. [16] reported on 415 patients seeking cosmetic surgery; all had similar demographic features. Two hundred eighty-five patients were female and 130 were male. Of the 130 male patients, 85 (65.4%) met ICD-10 diagnostic criteria (because some patients were excluded from data analysis, only 72.1% of all male patients were assessed). Twenty-six patients were diagnosed with a hypochondriacal disorder (dysmorphophobia, nondelusional), 22 with neurotic disorder, 17 with persistent delusional disorder (dysmorphophobia), 7 with depression, 6 with schizophrenia, 1 with paranoid personality disorder, and 6 patients with other psychiatric diagnoses. In addition, 88 male patients were assessed as having poor social adjustment. In comparison, 113 (39.6%) of female patients had a psychiatric disorder and 118 (48%) had poor social adjustment. It was noted that male patients were significantly younger than female patients at time of psychiatric diagnosis (26.6 ± 9.5, 38.9 ± 13.6, respectively). Sixty-six male patients had more than one cosmetic procedure, however, there was no specific correlation between frequency of procedures and the diagnosis of a social adjustment disorder.

It is important to underscore that all the studies cited above were carried out in Japanese university hospitals. There could be a referral bias because in Japan university centers for cosmetic surgery are better equipped than private clinics. Thus, they could be seeing a higher percentage of referred patients who are perceived to be disturbed or at high risk. The high percentage of male patients in the university study populations contrasts with the 1:11 or 1:4 male:female ratio reported by some private Japanese clinics [17,18]. The Japanese cosmetic population shows an increasing number of older male patients as well as female patients [17], reflecting the increasing proportion of senior citizens in Japan. Kobayashi and Shirakabe [19] estimated the overall percentage of "problem patients" in the private cosmetic clinics to be less than 5%.

In summary, studies from both the United States and Japan show that male patients seeking cosmetic surgery are more psychologically disturbed than female patients seeking similar procedures [8,9,12–16,20–24]. Plastic surgeons and psychiatrists in both countries have proposed similar hypotheses to explain this observation. In the past, both societies have shown more acceptance of women focusing on physical attractiveness than men [9,12,25–28]. Thus, male patients seeking cosmetic surgery do so in a milieu of some prejudice. Namba et al. [25,29,30] reported on 108 Japanese patients (57 females and 51 males) who had a conspicuous cosmetic deformity. This study was done in the early 60s when it was less common for women to work full time. They found that men articulated more concern than women about their psychological difficulties and anxiety about the future. Namba [29] stated that ". . . it is a lie that men care less of . . . ugliness than women. In Japan, men perceive they suffer socioeconomic disadvantage when seen as being ugly . . . But in general, a focus on ugliness in men is given less importance than for women. Men in Japan tend to feel ashamed to be preoccupied with their appearance. This distress may result in greater psychological disturbance among men than women."

Characteristics Specific to Male Cosmetic Patients

Male cosmetic patients in both the U.S. and Japan are described as shy, rigid, and guarded. They are difficult to interview and are reported to have problems in interpersonal relationships, especially with women. They are sometimes described as sexually inhibited. Jacobson et al. [9] noted a specific type of relationship between these male patients and their parents, i.e., they are close to their mother and express dislike for their father. A male's sense of deformity is frequently linked with a conscious wish to dissociate himself from the father's undesirable traits or weaknesses. The inability of a boy to form a normal relationship with his father can lead to an abnormal male identification. At a less conscious level, there is a wish to disavow the primitive destructive rage, primarily directed at the mother, from whom the male patient was not rescued. In Freudian terms, this failure to master the intense ambivalence in relation to his mother is at the root of his difficulty in forming deep relationships with other women. Male cosmetic patients are frequently single or have serious problems in their marriages [8,9,22,31]. They are more likely to have a history of numerous cosmetic procedures, to be unmarried, and to be between the ages of 20 to 35. These patients have a heightened likelihood of having unrealistic expectations, and this is particularly true of male patients in their late 40s and early 50s who have face lifts. These males are often widowed or divorced, and they prefer dating younger women [12,32,33].

Druss et al. [27] explained the development of unrealistic expectations among cosmetic surgical patients as a result of either denial, projection, concretization, or preoccupation. As reality is denied, real problems are projected onto body parts. During the process of concretization, the development of a fixed focus with definable areas of concern, there is a concentration on a specific body part that requires surgical attention. This focus becomes a preoccupation. The patient goes from surgeon to surgeon and from hospital to hospital to seek help. The sequence is similar in patients with body dysmorphic disorder (BDD), once believed to occur primarily in females, in both the U.S. and Japan. Recent studies in the U.S. have shown no or minor gender differences in BDD [34,35]. The percentage of BDD male compared to female patients is higher in Japan than in the United States.

In both the U.S. and Japan, male cosmetic patients are reported to be more psychologically disturbed than female patients. Pertschuk et al. [36] found that in response to a questionnaire comparing body image in men who seek cosmetic surgery with women seeking similar procedures that male and female patients do not differ in the

degree of dissatisfaction with the specific body part they were considering for correction, or in their overall physical appearance. However, males reported significantly more symptoms of BDD. Other investigators hypothesized that the etiology of BDD is a heightened sensitivity to asymmetry [37]. Based on the fact that in both the animal and human world, symmetry implies better biological fitness and resistance to developmental disruptions. Thus, animals and humans value symmetry, and humans seek it when possible. BDD patients may be able to perceive subtle deviations of symmetry and become obsessed with what they perceive to be asymmetries.

Despite the psychological disturbances noted in male cosmetic surgery patients in the U.S., they are often described as intelligent, highly educated achievers, with good work records and well-adjusted social lives but are preoccupied with their self-perceived deformity. On the contrary, Japanese men who seek surgery are described as having a poor social life, as being nervous and introverted, and exhibiting aggressive behavior [8,14,16,25, 29].

Psychiatric Assessment

Notwithstanding the evidence for psychiatric concerns in male and female patients undergoing cosmetic surgery, it is the consensus that these patients, even those with BDD, can benefit from a change in their appearance, particularly if undertaken in conjunction with psychiatric intervention. Edgerton et al. [23] reviewed the long-term outcomes of 100 (65 females and 35 males) aesthetic surgical patients presenting with significant psychological disturbances. Of the 100, 87 underwent a variety of procedures. The average time between the initial consultation and the operation was 13.7 months for males and 9.8 months for females. Seventy-two of the 87 patients (82.8%) had a clearly positive psychological outcome, 12 (13.8%) reported no discernible subjective or objective change, and only 3 patients (3.4%) were negatively impacted by the operation. There were no major negative reactions after the cosmetic procedures, such as incidence of attempted suicide or psychotic decompensation. Edgerton et al. commented "The combination of psychological assessment-intervention and surgery is the key to helping these long-suffering patients."

In Japan by contrast, although many surgeons are aware of the importance of psychiatric consultation, they rarely refer these patients to a psychiatrist, and collaboration between surgeons and psychiatrists is uncommon. This difference in referral and collaboration probably relates to the patient and surgeon's concerns with stigmatization, but may also reflect a lack of the surgeon's interest in referral as being essential and routine to the evaluation. Fukuyama and Yamada [38], both surgeons, succeeded in gaining consent from only 15 of 179 patients who were thought to have psychiatric problems. They stressed the barrier posed by the negative connotation of seeing a psychiatrist and also the psychiatrist's unfamiliarity with the psychological aspects of cosmetic surgical procedures or the impact on patients. There is general agreement among cosmetic surgeons that psychological support, either by the plastic surgeon or consulting psychiatrist, is critical to a favorable outcome in these patients. In general, patients who seek cosmetic surgery, whether in Japan or the West, are anxious to improve their body image, self-confidence, or self-esteem, in other words, their psychological well being. Many surgeons do not consider psychiatric/psychological intervention and, instead, rely on their own psychological acumen, especially for unrealistic expectations.

Case Reports

The following patient described by Nawate [39], a Japanese plastic surgeon, illustrates the danger of cosmetic surgery when the motivations or understanding of a procedure is not adequately explored.

A 22-year-old Japanese college student was told by his dance partner, "You look good when you open your eyes wide." Motivated by her words, he underwent a double-eyelid procedure at a cosmetic clinic in Tokyo but was not satisfied with the results. He became distressed and stopped attending classes, stayed in his apartment, and spent all day looking at himself in a mirror. He visited several plastic surgeons, including one at a university hospital, and asked that they return him to his former appearance, but none agreed to undo the procedure. He finally went back to his hometown where his mother lived.

When he again presented to a surgical clinic, he was wearing black sunglasses, and often burst into tears. The surgeon's impression was "There is no doubt that he will need a psychiatrist if his condition doesn't change." After the surgeon learned of the patient's history he advised him to return to college, obtain a job, and stop seeking additional procedures.

But a year later, having problems in relationships at work, he again became preoccupied with his appearance. At that time, he was diagnosed by a psychiatrist as having schizophrenia. He was hospitalized and discharged after a course of treatment.

In contrast, the next case, described by Edgerton et al. [23], illustrates a successful outcome when surgical care is combined with psychological consultation.

E.D. was a 20-year-old man with a history of having undergone three rhinoplasties and one septoplasty. He acknowledged that these operations "straightened the bridge of my nose, but it made the tip more bulbous appearing, diminishing my small chin and mouth." E.D. was preoccupied with self-examination of his small chin and mouth. Psychiatric treatment was recommended to the patient but he rejected it. Under duress, however, he consulted the team's psychiatrist. After careful team evaluation over a 7-month period, a surgical procedure was suggested.

E.D. underwent nine surgical procedures, designed ac-

cording to the patient's wishes, addressing refinement of the nose and widening of the jaw line. He stopped seeking surgical correction after 12 years stating, "My nose looks the best it has been." Fourteen years after his last procedure, E.D. was reevaluated and found to be proud of his appearance. He did not request any more procedures.

Cosmetic procedures among the older population are increasing in both the U.S. and Japan. The following case report from the U.S. illustrates a common scenario associated with male patients seeking cosmetic alteration [40].

M.L., a 37-year-old married management consultant, sought a rhinoplasty at age 35 when he was at a high point in his career. He was referred for preoperative psychiatric consultation because of the general concern about adult males who request rhinoplasty.

In college, he had few outside interests other than his studies and few friends. He had never dated before college. M.L. received a doctorate degree in a science but to achieve financial security he chose a career in management, in which he was successful. He married the first woman he dated, one who made few demands and who by virtue of her training could be financially independent. Retrospectively, M.L. saw his marriage as a calculated decision, made at the right time with the right person, and one that caused the least disruption of his family.

Although M.L. had a nasal deformity, he had a more divergent strabismus. At the time he requested the rhinoplasty, he stated that he was feeling better about himself, generally took more pride in himself, and wanted a rhinoplasty to achieve a more pleasing profile. He had previously lost 13.6 kg through diet and exercise and had begun to dress fashionably. There was no evidence of overt marital discord, but M.L. said that his wife "lacked the vision of the future" that he had attained as he became successful.

Postoperatively M.L. expressed immediate satisfaction with his rhinoplasty. Two months later he called the psychiatric consultant for an appointment and said that he was considering a separation from his wife. There had been no intervening psychological crises. Others response to the rhinoplasty, at work, socially, and within his family, was entirely satisfactory. However, the patient now felt that his wife would be unable to match his lifestyle, and when he confronted her with the changes he wanted her to make, she refused; this led to their eventual separation and divorce. At a 20-year follow-up M.L. had been in a new stable marriage for over 15 years and he had continued to enjoy success in his work. He never again asked for another cosmetic surgical procedure.

Conclusions

Cosmetic surgery had its shadowy beginnings in the late 19th century in both Japan and the United States, but evolved in different ways, influenced by culture and clinical practice. Traditional Japanese values reflect the view that "more precious in a woman is a virtuous heart than a face of beauty" [41]. Furthermore, if a woman was obsessed with glamour it was seen as detracting from her efforts to achieve inner beauty and role fulfillment. For example, facial makeup is still forbidden in some high schools in Japan because "to care about outside beauty disturbs the concentration on study," or it is often stated "You get tired of beauty after 3 days but get used to ugliness after 3 days."

The U.S. is composed of people from many different countries whereas Japanese society is almost uniracial. People grow up in relatively the same culture and with individuals of similar appearance. Perhaps this phenotypic uniformity makes them more sensitive to any kind of deviation. Other factors, such as the influence of Western culture and globalization, along with the new pressures on males to compete with peers and younger individuals, are causing changes in cultural norms, including acceptance of cosmetic surgery.

There are relatively few collaborative efforts between plastic surgeons and psychiatrists in Japan. Plastic surgeons point to psychiatrists' lack of experience and knowledge for assessing and intervening with patients seeking cosmetic surgery, with specific reference to the assessment of body dysmorphic disorder and other body image distortions. The barrier imposed by stigmatization of patients seeking psychological evaluations needs to be overcome through better integration of psychological and surgical services, and development of teams wherein the surgeon can introduce the psychiatrist as a partner in the care of the patient.

At the dawn of the 21st century, there is increasing acceptance of cosmetic surgery among both men and women in both cultures. Edgerton et al.'s [12] statement is prescient, "In the future, as cultural patterns change, we may see male patients of less disturbed type." For those potentially at risk in seeking cosmetic correction it is important to develop culturally specific and acceptable surgical-psychiatric collaboration.

References

1. Shirakabe Y, Kinugasa T, Kawata M, Kishimoto T, Shirakabe T: The double-eyelid operation in Japan: Its evolution as related to cultural changes. *Ann Plast Surg* **15:**224, 1985
2. Sergile SL, Obata K: Mikamo's double-eyelid operation: The advent of Japanese aesthetic surgery. *Plast Reconstr Surg* **99:**662, 1997
3. Shirakabe Y: The development of aesthetic facial surgery in Japan: As seen through a study of Japanese pictorial art. *Aesth Plast Surg* **14:**215, 1990
4. Furukawa M: Historical consideration of aesthetic plastic surgery. Nihon biyo-geka gakkai kaishi (*Ann Jpn Soc Aesth Surg*) **1:**26, 1979
5. Onizuka T, Kakutani T: Positioning of aesthetic surgery in medicine. Nihon biyo-geka gakkai kaishi (*Ann Jpn Soc Aesth Surg*) **1:**7, 1979
6. Ichida M, Toda M, Uchinuma E, Kamiishi H, Ito M, Shioya N: The current trend of interest of modern Japanese

women in cosmetic surgery. Nihon biyo-geka gakkai kaiho (*Bull Jpn Soc Aesth Surg*) **3:**18, 1981
7. Nakamura M, Uchinuma E, Ohtake N, Shioya N, Ichida K: Thoughts and opinions about esthetic surgery among female students: Survey results. Nihon biyo-geka gakkai kaiho (*Bull Jpn Soc Aesth Surg*) **14:**49, 1992
8. Koda R, Fukuyama Y, Nishiwaki J, Ishigooka J, Miura S: Psychological traits of patients seeking cosmetic surgery. Seishin igaku (*Psychiatry*) **36:**523, 1994
9. Jacobson WE, Edgerton MT, Meyer E, Canter A, Slaughter R: Psychiatric evaluation of male patients seeking cosmetic surgery. *Plast Reconstr Surg* **26:**356, 1960
10. Goin JM, Goin MK: Changing the body: Psychological effects of plastic surgery. Williams and Wilkins, Baltimore/London, 1981
11. Goldwyn RM: The patient and the plastic surgeon. Little, Brown and Company, Boston, 1991
12. Edgerton MT, Webb Jr WL, Slaughter R, Meyer E: Surgical results and psychosocial changes following rhytidectomy. *Plast Reconstr Surg* **33:**503, 1964
13. Fukuda O, Yameda: Statistical analysis of dysmorphophobia in out-patient clinic. Keisei-geka (*Jpn J Plast Reconstr Surg*) **20:**569, 1977
14. Ishigooka J, Yamashiro I, Fukuyama Y, Wakatabe H, Miura S: Psychiatric consultation work on patients seeking cosmetic surgery. Kitasato Igaku (*Kitasato Med*) **15:**88, 1985
15. Ohjima H, Shioya N, Ishigooka J: The role of psychiatry in aesthetic surgery. *Aesth Plast Surg* **12:**187, 1988
16. Ishigooka J, Iwao M, Suzuki M, Fukuyama Y, Murasaki M, Miura S: Demographic features of patients seeking cosmetic surgery. *Psychiatr Clin Neurosci* **52:**283, 1998
17. Muto Y: The aging society and aesthetic surgery. Nihon biyo-geka gakkai kaiho (*Bull Jpn Soc Aesth Surg*) **13:**44, 1991
18. Abe M: Practice of aesthetic surgery in a small local city—reflections on 5 years. Nihon biyo-geka gakkai kaiho (*Bull Jpn Soc Aesth Surg*) **15:**35, 1993
19. Kobayashi K, Shirakabe T: Psychiatric check for aesthetic surgery patients. Shujutsu (*Surgery*) **45:**934, 1991
20. Edgerton MT, Jacobson WE, Meyer E: Surgical-psychiatric study of patients seeking plastic (cosmetic) surgery: Ninety-eight consecutive patients with minimal deformity. *Br J Plast Surg* **13:**136, 1960
21. Webb Jr WL, Slaughter R, Meyer E, Edgerton MT: Mechanisms of psychosocial adjustment in patients seeking "Face-Lift" operation. *Psychosom Med* **27:**183, 1965
22. Edgerton MT, Langman MW, Pruzinsky T: Patients seeking symmetrical recontouring for "perceived" deformities in the width of the face and skull. *Aesth Plast Surg* **14:**59, 1990
23. Edgerton MT, Langman MW, Pruzinsky T: Plastic surgery and psychotherapy in the treatment of 100 psychologically disturbed patients. *Plast Reconstr Surg* **88:**594, 1991
24. Furuyama N: Aesthetic surgery and dysmorphophobia. Shujutsu (*Surgery*) **45:**929, 1991
25. Namba K, Okazaki H, Torigoe Y: Relationship between psychology of "ugliness" and treatment by plastic surgery. Part I. Keisei-geka (*Jpn J Plast Reconstr Surg*) **6:**263, 1963
26. Taylor BW, Litin EM, Litzow TJ: Psychiatric considerations in cosmetic surgery. *Mayo Clin Proc* **41**(9):608, 1966
27. Druss RG, Symonds FC, Crikelair GF: The problem of somatic delusions in patients seeking cosmetic surgery. *Plast Reconstr Surg* **48:**246, 1971
28. Goldwyn RM: Current status of aesthetic surgery in the United States of America. Nihon biyo-geka gakkai kaiho (*Bull Jpn Soc Aesth Surg*) **14:**8, 1992
29. Namba K: About the effect of ugliness on psycho-health. Keisei-biyo-geka (*Jpn J Plast Aesth Surg*) **3:**257, 1960
30. Namba T, Okazaki H, Torigoe Y: Relationship between psychology of "ugliness" and treatment by plastic surgery. Part II. Keisei-geka (*Jpn J Plast Reconstr Surg*) **7:**171, 1964
31. Knorr NJ, Edgerton MT, Hoopes JE: The "insatiable" cosmetic surgery patient. *Plast Reconstr Surg* **40:**285, 1967
32. Baker TJ, Gordon HL: Rhytidectomy in males. *Plast Reconstr Surg* **44:**219, 1969
33. Baker TJ: Patient selection and psychological evaluation. *Clin Plast Surg* **5:**3, 1978
34. Phillips KA, McElroy SL, Keck Jr PE, Pope Jr HG, Hudson JI: Body dysmorphic disorder: 30 cases of imagined ugliness. *Am J Psychiatr* **150:**302, 1993
35. Phillips KA, Diaz SF: Gender differences in body dysmorphic disorder. *J Nerv Ment Dis* **185:**570, 1997
36. Pertschuk MJ, Sarwer DB, Wadden TA, Whitaker LA: Body image dissatisfaction in male cosmetic surgery patients. *Aesth Plast Surg* **22:**20, 1998
37. Veale D, Gournay K, Dryden W, Boocock A, Shah F, Willson R, Walburn J: Body dysmorphic disorder: A cognitive behavioural model and pilot randomized controlled trial. *Behav Res Ther* **34:**717, 1996
38. Fukuyama O, Yamada A: Psychiatric problem in plastic surgery: Dysmorphophobia. Rinsyo seishin igaku (*Clin Psychiatry*) **6:**1467, 1977
39. Nawate K: Iatrogenic disease in cosmetic surgery. Nihon biyo-geka gakkai kaiho (*Bull Jpn Soc Aesth Surg*) **12:**40, 1990
40. Belfer ML, Mulliken JB, Cochran Jr TC: Cosmetic surgery as an antecedent of life change. *Am J Psychiatr* **136:**199, 1979
41. Kaibara E: Greater learning for women. In: Brians P et al. (eds) Reading about the world, Vol 2, 3rd ed. Harcourt Brace–Custom Book, Boston, 1999