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Teens and Elective Cosmetic Surgery

An Expert Commentary on Real-World Scenarios

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Editor's Note:
The topic of plastic surgery in teens has been in the news lately and raises many clinical and ethical questions. Medscape asked experts in psychiatry, cosmetic surgery, and bioethics to help us explore this issue.

Robert L. Findling, MD, MBA, Professor of Psychiatry and Pediatrics at Case Western Reserve University and Director of Child & Adolescent Psychiatry at Rainbow Babies & Children's Hospital, presented the mental health perspective. Sherrell J. Aston, MD, Professor of Surgery in the Department of Plastic Surgery at New York University School of Medicine and Chairman, Department of Plastic Surgery, Manhattan Eye, Ear and Throat Institute of Lenox Hill Hospital provided input from the surgeon's perspective. The participants also discussed some cases that, although hypothetical, represent real-world scenarios.

Medscape: Appearance is important to all of us -- none more so than teens, who are often uncomfortable with their evolving bodies. Perceived flaws do not only diminish a teen's self-image but can affect his or her social interactions, leading to difficulties in school, withdrawal, or aggression. Teens sometimes have valid cosmetic conditions that may benefit from plastic surgery.

Child and adolescent cosmetic surgery is not new, but the topic has come to the forefront as a result of recent media attention. A major factor in consideration is the fact that the patient is still growing, both physically and emotionally. The decision requires input and agreement from both the child and the parent. What are the very first factors that a clinician should consider when approached about cosmetic concerns by either a patient or a family member?

Dr. Findling: It's important to understand the psychological effects of the cosmetic concern. Certainly, there are issues where cosmetic issues could clearly affect a youngster's emotional well-being. However, there are cases where the degree of the effect of a more modest cosmetic concern on the psychological state of the patient may be less clear. Along the same line, there are times when a patient may express negative emotional sequelae about a perceived flaw, and that cosmetic concern is not even readily apparent.

Simply put, discrepancies can exist between the magnitude of the visible cosmetic concern and the expressed emotional distress associated with it. Appreciating this disconnect can be quite important. This is because such disconnects can lead to unrealistic expectations about the degree to which a surgical procedure might improve a youngster's well-being. Certainly, when the discrepancy between the emotional concern and the physical manifestations are apparent, an understanding of such disconnects can be pivotal.

According to current psychiatric nosology, there is a condition known as body dysmorphic disorder. Patients with this condition may be inordinately distressed by or preoccupied with a minor or even nonexistent cosmetic concern. I should point out that body dysmorphic disorder should be differentiated from developmentally expected body image concerns.

Dr. Aston: First, it is important for the plastic surgeon to determine that the teenager, not the parents or boyfriend or girlfriend, is initiating the request for the cosmetic procedure. The surgeon must determine that the patient has reached a level of physical maturity and that further growth is unlikely to occur. The surgeon must also decide whether the patient's anticipated surgical result is appropriate and consistent with their anatomy, and whether the patients anticipated change in their life is realistic. The surgeon needs to determine that the teenager has realistic requests and goals, as well as sufficient emotional maturity to understand the nature of their requested surgical procedure, the potential problems, the recovery process, and the anticipated long-term results.

Medscape: You both referred to the importance of determining whether the teen's desire for a cosmetic change is realistic. Dr. Findling voiced concern that the magnitude of the perceived flaw may be less significant than the teen believes it to be; Dr. Aston noted the importance of determining whether the desired change is achievable. Recognizing that there is a degree of subjectivity to these assessments, what are the metrics that can be used to evaluate both the degree of distress and the desired change on the part of the teen? Are there strategies that should be implemented in the primary care arena -- where many teens and families will begin this process -- that can assist providers in making a determination as to which child and family can and should be referred for follow-up, whether by a cosmetic practitioner or a mental health provider?

Dr. Findling: From the emotional and psychological perspective, several strategies should be considered.

1. Identify the cosmetic concern and try to gauge the subjective degree to which the cosmetic concern is "atypical." This assessment applies to both the youngster and the guardian. Compare this concern with that of the "typical" child and family -- recognizing, of course, that there is a wide range of "normal" and that a cosmetic issue that may cause great concern for one teen may be acceptable to another. That same range of perspectives applies to parents.
2. Try to assess the magnitude of distress due to the physical concern.
3. Try to assess the sequelae associated with the distress due to the cosmetic concern.
4. Attempt to identify how the youngster's life might change due to the cosmetic surgery. Is the expectation reasonable or rational?

Although there certainly is a subjective quality to this, physicians, particularly those who are familiar with working with teens, can help identify thoughts, beliefs, and ideas that would raise red flags.

Dr. Aston: Dr. Findling and I are saying the same thing, just in different words. It boils down to the individual cases. I've operated on several thousand teenagers and can't remember a case where there was a postoperative psychological problem. In general, teenagers just want to correct their area of concern and get on with life. Teens, or adults, who are emotionally immature or have unrealistic expectations should not have surgery.

Putting It Into Practice: Case Discussions

Medscape: Perhaps we could briefly discuss some individual cases to illuminate key clinical considerations.

First case: A 15-year-old moderately obese boy presents with concerns about gynecomastia. Both of his parents, who are also obese, accompany him to the visit. All report that they have engaged in multiple unsuccessful attempts at weight loss. The young man voices concern about his "embarrassing" breast development and, upon questioning, notes that he is frequently teased by other kids in school. What are the specific issues that should be addressed in this young man? For situations with alternative treatment options-- in this case, more intensive weight-loss programs -- should surgery be considered? If so, are there any guidelines to determine at what point other options can be deemed unsuccessful and a decision made to move to a surgical option?

Dr. Findling: As you noted, the question for the surgeon is, "When should surgery be done"? It is not an either/or answer of surgery or other therapies. Surgery does not preclude other strategies.

Dr. Aston: A 15-year-old moderately obese young man with concerns about gynecomastia needs a more strict dietary control regimen and exercise plan for weight loss. At 15 years of age, it is possible that hormonal influences are causing his breasts to be larger than they may be in 4 or 5 years. I would defer surgery on this young man until he is 19 or 20 years old, and then consider it only after significant dieting, exercise, and weight loss.

Medscape: Now, a second hypothetical case: A 17-year-old girl, Tanner stage 5, with mild cerebral palsy and developmental delay is referred to a local cosmetic dermatology practice. She and her parents report that she has long been teased about the size and shape of her nose. Her parents delayed seeking surgical correction until they thought she was "old enough to decide." She attends her local high school but is in special education classes and has limited interaction with students outside of her self-contained classroom. Most of the history is provided by her parents, but the teen confirms that other students are "mean" to her. Is her developmental delay a relative contraindication to surgery? Does she require assessment beyond that provided to teens whose intellectual status is age-appropriate?

Dr. Findling: There are several issues that should be explored in a situation like this:

- The emotional magnitude of the concern for the patient;
- The degree of objective substantiveness of the physical defect;
- The severity of the developmental delay, which can clearly influence the decision-making capacity of this teen, and
- The probable postoperative outcome with regard to the amount of teasing/emotional distress this youngster is likely to continue to experience.

Dr. Aston: This young lady's developmental delay is probably cause to decline surgery at this time. Most of the information is provided by her parents, making a determination of her intellectual status difficult. Although the patient will soon be of legal age to give consent for her own surgery, it is not clear from this information whether she understands the nature of the surgical procedure and its potential risks and complications, and whether she has a perspective on the anticipated result. If she undergoes surgery with an excellent cosmetic change, it is still possible that other students may continue to be "mean" to her.

Medscape: Thank you. Now, on to our third and final case: An 18-year-old woman who has just graduated from high school is preparing to enter a performing arts program at a very prestigious university. She is unaccompanied by her parents but reports that they are aware of her request for breast augmentation surgery. She described their feelings as ambivalent but states that they are "leaving the decision" in the young woman's hands. She notes that her appearance will be a strong factor in her ability to be successful in musical theater and does not believe that she will be cast for roles requiring a more robust physique. What are the issues to be considered in an older teen who makes a request for surgery to enhance her appearance that is not motivated by social concerns, such as teasing? Would you suggest that parents be involved in this decision in a teen who has reached the age of consent but is still financially dependent on parents?

Dr. Findling: Ideally, parents would be involved. Even though the child in this case is 18 years old, family support can be helpful. An important question is, How realistic is the chance of success in the performing arts with this operation? The concern about looks and performing arts is a realistic one. This was noted poignantly in the 1975 musical *A Chorus Line,* in the song "Dance: Ten; Looks: Three..."

Dr. Aston: This is the kind of patient whom plastic surgeons see frequently. It is important for the surgeon to determine that the patient has a realistic expectation of the benefits of the surgical procedure. Plastic surgeons understand that patients may not be cast for roles in musical theater regardless of the robustness of their physique. Such decisions are probably made on overall appearance, ability, talent, personality, and other factors. The patient needs to understand these points.

The fact that the patient's request for surgery is not motivated by social concerns, such as teasing, is not particularly important. What is most important is that the patient has a realistic expectation and understanding that breast augmentation will give her more of her desired body shape but will not guarantee success in musical theater.

The extent to which parents are involved in the decision-making process for a young adult varies from family to family. I think it is important for parents to give their opinions to their children. It is stated that they are leaving the decision in the young woman's hands, which suggests that they are not against her having the procedure. Who pays, and other financial considerations, should be left to the patient and her family.

Resources

As these experts have made clear, decisions about elective cosmetic surgery are complex and individual. Arguments, pro and con, are found on parenting Websites, and the lay press reports that the number of procedures is on the rise. The American Society of Plastic Surgeons (ASPS) reports that cosmetic procedures in persons aged 13-19 years accounted for 2% of the over 13 million procedures performed in 2010, although the number of procedures in this age group increased 4% between 2009 and 2010.[1] It is likely that if a primary care provider has not had yet had the experience of dealing with a family requesting information or a referral for a cosmetic procedure, it will happen sooner or later.

Initial screening can and should occur in the primary care environment. Medscape's Aesthetic Medicine resource center provides stories on the latest news, links to full-text articles from leading journals, and in-depth discussion.

The ASPS provides several helpful online resources for professionals and parents. For clinicians, Plastic Surgery For Teenagers Briefing Paper provides information about specific procedures, accreditation, and informed consent issues. For parents, Cosmetic Surgery and Your Teen -- Talking to Young Adults about Cosmetic Surgery includes discussion about specific procedures, questions for interviewing a potential surgeon, and information about insurance and payment.

References

1. American Society of Plastic Surgeons. Report of the 2010 Plastic Surgery Statistics. http://www.plasticsurgery.org/Documents/news-resources/statistics/2010-statisticss/Top-Level/2010-US-cosmetic-reconstructive-plastic-surgery-minimally-invasive-statistics2.pdf Accessed February 2, 2012.