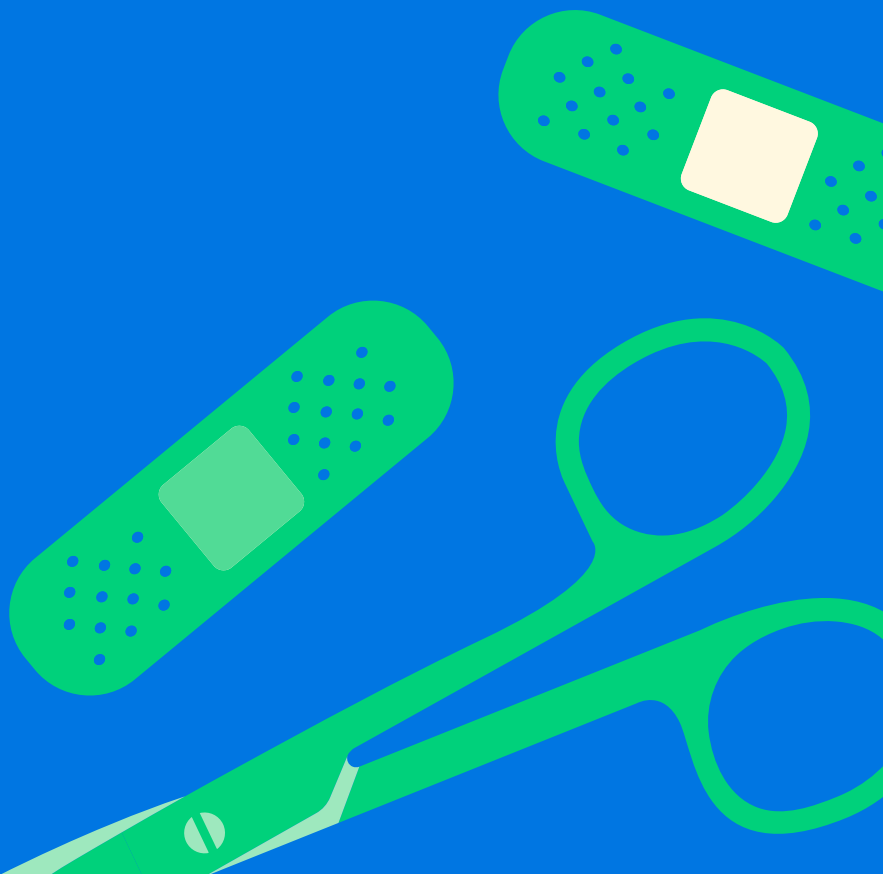
APS Australian Psychological Society

PRACTICE GUIDE

Psychological evaluation of patients undergoing cosmetic procedures



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Introduction

In 2023, the Medical Board of Australia issued the updated 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures'[1] which come into effect from 1 July 2023. The Medical Board of Australia guidelines make clear that some patients may be unsuitable for cosmetic surgery and mandate the referral of patients of concern for a psychological evaluation to establish their suitability for the intended procedure.

Under the Medical Board of Australia guidelines, a patient is considered to require an assessment/evaluation prior to undergoing a cosmetic procedure if they are:

- under the age of 18 and seeking a major cosmetic procedure; or
- an adult or a minor displaying indicators of significant underlying psychological problems which may make them an unsuitable candidate for any cosmetic procedure.

More recently, the Medical Board of Australia joined the Australian Health Practitioner Regulation Agency (Ahpra) in conducting an independent review into the regulation of medical practitioners who perform cosmetic surgery. The final report was released in September 2022[2] and it is anticipated that there may be further developments in the field following on from this report which may impact the evaluation procedure undertaken by psychologists.

This practice guide has been developed by the Australian Psychological Society (APS) to provide guidance to APS member psychologists undertaking evaluation of individuals' psychological suitability to undergo a cosmetic procedure. This practice guide reviews and synthesises current evidence about best practice in the assessment of such individuals.

Consultations and external review

A draft version of this practice guide was reviewed by experts in the area (please see the section 'Acknowledgements' for a list of these experts). The writing and editorial team revised the guide in response to reviewer suggestions.

Reviewers were asked to review and provide feedback on the guide, including a focus on the following three questions for each section:

- Are there significant gaps (in the coverage of this topic, the literature, other)?
- Are there errors in the content?
- Is the structure logical and easy to use?

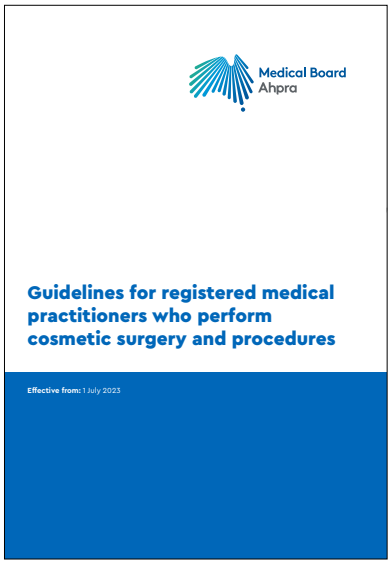
Definition of cosmetic procedures as covered in this practice guide

The 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures' provide the following definitions for cosmetic procedures and these have been adopted in this practice guide:

Cosmetic surgery and procedures: These are operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance.

Cosmetic surgery: These procedures involve cutting beneath the skin. Examples include; breast augmentation, breast reduction, rhinoplasty, surgical face lifts and liposuction.

Non-surgical cosmetic procedures: These procedures do not involve cutting beneath the skin, but may involve piercing the skin. Examples include: non-surgical cosmetic varicose vein treatment, laser skin treatments, use of CO^2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.



Procedures not considered 'cosmetic' and not covered in this practice guide

The 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures' provide the following definitions for procedures not considered cosmetic and so not included in this practice guide:

Procedures which are medically justified: Surgery or a procedure may be medically justified if it involves the restoration, correction or improvement in the shape and appearance of body structures that are defective or damaged at birth or by injury, disease, growth or development for either functional or psychological reasons. Surgery and procedures that have a medical justification and which may also lead to improvement in appearance are excluded from the definition.

Reconstructive surgery: The medical specialty of plastic surgery includes both cosmetic surgery and reconstructive surgery. Reconstructive surgery differs from cosmetic surgery as, while it incorporates aesthetic techniques, it restores form and function as well as normality of appearance.

Gender affirmation surgery: As per the guidelines, this practice guide does not apply to assessment for procedures related to gender affirming medical treatment. Practitioners are advised to undertake adequate training and supervision to ensure they provide evidence-informed psychological care in this context.

Limitations

This practice guide applies to plastic surgery when it is performed only for cosmetic reasons. It does not apply to reconstructive surgery or surgery considered to be medically justified. In practice, this can be a grey area with some patients reporting the motivation to be functional or physical whilst also desiring surgery for cosmetic reasons.[1] Regardless, determining whether a procedure is medically justified ultimately falls to the treating medical practitioner. For the psychologist, of primary concern in the evaluation is the client's emotional and cognitive preparedness, and their psychological fitness to undergo the procedure.

While every effort has been made to provide the reader with current, up to date information on the assessment of this client group, research is ongoing and relevant new original studies and systematic reviews may be published after this practice guide has been finalised. It is also likely that Ahpra will continue investigating this field and update existing guidelines and recommendations accordingly.

As per ethical standards, psychologists offering evaluations for clients wishing to undergo body modification procedures need to ensure that they are competent to deliver such services. Clinicians need to ensure they are educated and have expertise in the particular procedure they are assessing for and have a clear understanding of what is involved with each procedure, alternatives, its limitations, risks, recovery, and physical and emotional impact. Given the rapidly advancing field of body modification and cosmetic procedures offered, clinicians need to undertake continuing professional development and take steps to ensure that they remain competent to practise within this field.

Background

Prevalence of people seeking cosmetic procedures or surgery

Unfortunately, national data is not available on the prevalence of cosmetic procedures or surgery use in Australia for a number of reasons. Currently, cosmetic procedures can be performed by a range of practitioners, including medical practitioners such as plastic surgeons, GPs and dermatologists, and non-medical practitioners such as beauticians, and there is no single body to which such data is reported; secondly such procedures are elective, so are not covered and therefore recorded by Medicare.[4]

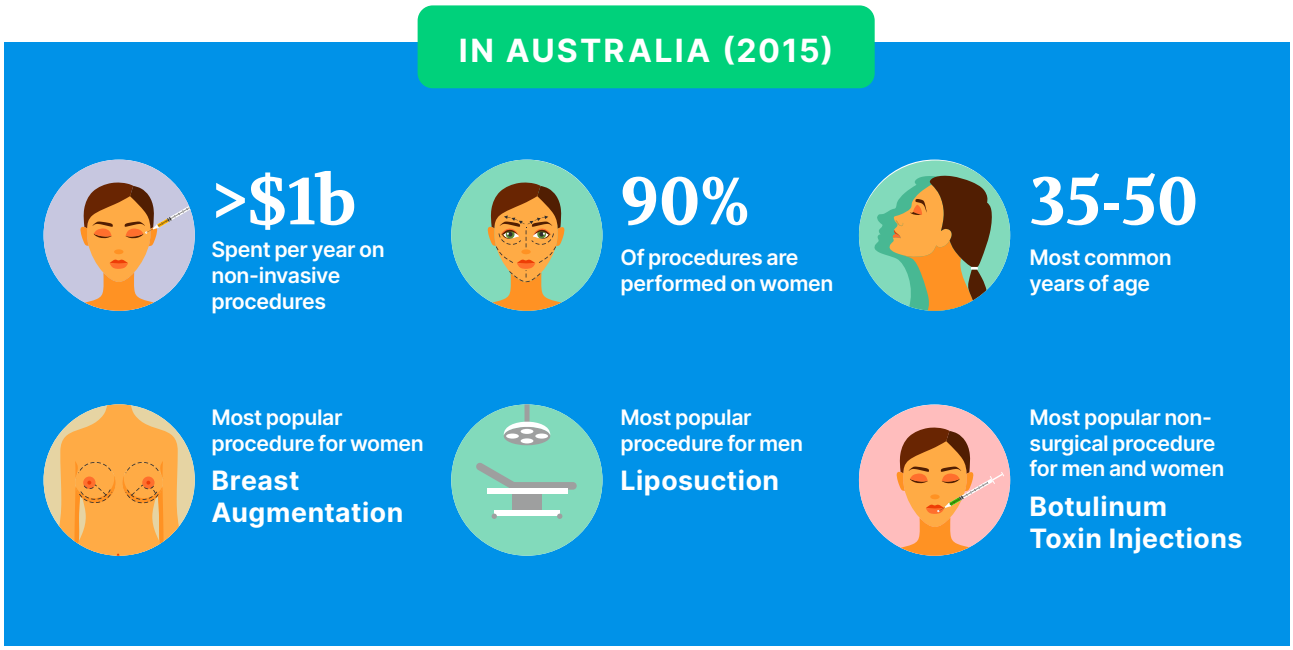
A survey conducted by the Cosmetic Physicians College of Australasia in 2015, estimates that Australians collectively spend more than 1 billion dollars a year on minimally or non-invasive cosmetic procedures, with around one quarter of the 1020 respondents reporting to have had some kind of procedure performed in the preceding month, double the number reported in the previous year.[5] There is a consensus that the use of cosmetic surgery in Australia is on the rise,[4] and that the uptake of non-surgical cosmetic procedures are also increasing rapidly.

Potential adverse outcomes

Although this field of research is characterised by methodological limitations, what is known suggests that the majority of people seeking a cosmetic procedure are satisfied with the outcome and report improvements in self-esteem, quality of life and relationships.[6-8] Research also suggests however that a minority do experience adverse psychological and social outcomes.[8]

Where there is dissatisfaction with the outcome of a procedure, the patient may experience personal distress and adjustment problems, social isolation, relationship strain, requests for additional and unnecessary procedures, financial risk and anger toward the service provider and his or her staff.[8] In some individuals, pre-existing mental health concerns, particularly body dysmorphic disorder (BDD) may indeed worsen following the procedure.[9]

Those seeking cosmetic procedures may be at higher risk for self-harm and suicide than the general population, though research is scant.[10-13] While the reason for this increased risk is unclear, it is speculated that unmet expectations (particularly where expectations are unrealistic), lack of a clear understanding of the procedure undertaken (particularly risks and recovery associated with the procedure), mental health issues, or distress



associated with medical complications arising from the procedure may all contribute to negative mood, and to the increased risk of suicide.[13,14]

BDD in particular is associated with an increased risk for suicide and self-harm, with rates similar to that of anxiety and depression and greater than that of most other mental health disorders.[12,15-17] In addition to the reasons for increased suicide risk above, which are all relevant to understanding suicide risk in BDD, being refused cosmetic surgery or other cosmetic procedures is also thought to be a particular risk factor, due to the importance people with BDD can place on cosmetic surgery being a solution to their distress, and the degree of distress they experience in relation to their perceived flaw.[10,12] This is often exacerbated by poor or absent insight, which characterises up to 60% of patients with BDD.[18]

Cosmetic professionals treating unsuitable patients are at risk of experiencing adverse outcomes themselves, including harassment by the patient, repeated demands for unnecessary procedures, complaints, and legal action.[8,10] Practitioners may also experience threats of physical violence or in rare cases, actual harm from dissatisfied clients.[10]

Psychologists conducting evaluations of the psychological suitability of clients seeking to undergo cosmetic procedures may be wrongly perceived as "gate keepers" for these procedures. This may put them at risk of experiencing negative reactions from clients which they evaluate as being at high psychological risk in relation to their requested procedure. It is important for both referring cosmetic professionals and psychologists to be aware of this risk of negative reactions and ensure that it is clearly communicated to clients that the decision regarding such procedures is ultimately made by the cosmetic professionals themselves, after considering the evaluation feedback of the psychologist.

To counter the idea of being perceived as a "gate keeper", psychologists can frame their evaluation around identifying psychological risk and providing recommendations about how the client might be best supported before, during, and after a procedure (if one was to occur).

Potential adverse outcomes include:

- dissatisfaction with the outcome of the procedure.
- personal distress and adjustment problems.
- social isolation.
- relationship strain.
- requests for additional and unnecessary procedures.
- financial risks.
- anger toward the service provider and staff.
- worsening of pre-existing mental health concerns (particularly body dysmorphic disorder (BDD)).
- risk of self-harm.

Patient characteristics associated with adverse outcomes

Research suggests that adverse outcomes are more likely in patients with certain characteristics, most commonly those with:

- unrealistic goals or expectations for the procedure
- lack of a clear understanding of the risks and emotional and physical recovery associated with the treatment.
- external motivations for the procedure.
- identity concerns.
- negative self-image and other psychosocial issues.
- certain mental health concerns such as body dysmorphic disorder.

Unrealistic goals or expectations

Research suggests that unrealistic goals – such as a desire to achieve perfection rather than for more realistic, specific or functional improvements are associated with poorer outcomes.[19] Unrealistic expectations include those in which the hope is for distal, exaggerated or global life improvements, such as obtaining a job promotion, or attracting a new romantic partner. Unrealistic expectations may also be reflected by vague descriptors such as a desire to be 'prettier' or for a feature to be 'nicer',[13,20] or by being

too rigid and specific about the desired outcome and having a "list" of desired criteria for the selected procedure.

Unrealistic expectations may also be exacerbated through social media use, by the client using filtered or edited images of themselves to indicate their desired surgical outcome, or consuming content on social media that has been digitally altered, influencing their surgical goals.[21] It is therefore important to examine how social media may play a role in shaping the client's desire and expectations for surgery.

External motivations for the procedure

External motivations such as cultural background, family or partners influencing the client to undergo the cosmetic procedure, rather that the client themselves being the driver of the process, or the belief that the surgery or procedure will improve relationships, the likelihood of employment, or popularity are also associated with poorer outcomes.[8,14]

Identity concerns

In some cases, a certain physical characteristic may be linked to a patient's personal, cultural, or familial identity. Without adequate consideration of the ramifications of altering this trait, the patient may experience a loss of identity or ruptures within relationships following the loss of a shared physical familial or cultural characteristic.[22]

Negative self-image and other psychosocial issues

Individuals seeking cosmetic procedures or surgery do so in response to dissatisfaction with an aspect of their appearance, and the majority report being satisfied with the outcome of their cosmetic procedure and with the specific change in their appearance.[23] Many also experience broader positive outcomes post cosmetic intervention, such as increased confidence and a more positive body image.[8,24]

A positive global self-concept, despite dissatisfaction with an aspect of one's physical appearance, is associated with good outcomes from cosmetic interventions.[25] Satisfied patients for example often report feeling that their outward appearance did not match their otherwise positive internal self-concept, and cite wanting to align the two as motivation for surgery.[25] Therefore, apart from dissatisfaction with a specific aspect of their appearance, those experiencing positive outcomes from their cosmetic procedure typically report being otherwise satisfied with their overall body image and sense of self.[26]

Conversely, pre-existing poor self-concept, low self-esteem, negative global body image, and relationship distress are associated with poorer outcomes.[8]

Mental health concerns

Although the actual prevalence of mental health disorders in this population is poorly understood,[10] a sizable minority, proportionately greater than that found in the general population, are thought to experience mental health issues. Importantly, research suggests this may increase the risk for patient dissatisfaction and poorer outcomes.[10,27-29] Though there is little research in this area[26] the full complement of mental health disorders is likely seen in the cosmetic procedure-seeking population, with depression, anxiety, eating disorders, obsessive-compulsive disorders, and trauma history believed to be overrepresented.[8,10,19,28,31]

Some patients seeking cosmetic surgery report trauma as a key motivation for undertaking the surgery, to rectify or change parts of their body that they feel were aged, ridiculed, or shamed through a traumatic experience. For some, this reflects a desire to treat the trauma through body modification, but for others, surgery may be a later step in their recovery from a traumatic experience.[32]

It must be noted however that high prevalence mental health disorders should not be considered 'absolute' contraindications for cosmetic procedures as research evidence is inconsistent regarding the benefits and adverse outcomes associated with a range of mental health issues.[6,10]

Body dysmorphic disorder (BDD) however is generally considered a contraindication for cosmetic procedures and has received the most attention in studies characterising cosmetic procedure-seeking populations. BDD is estimated to affect around 1.9% of the general population[33] with slightly more females affected (2.1%) than males (1.6%).[33]

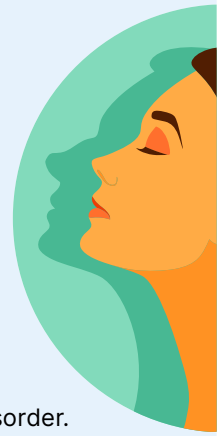
Within populations seeking cosmetic surgery or other procedures however, the prevalence is considerably higher. Among American samples, rates of BDD among individuals presenting for cosmetic surgery range from 7-13%.[10, 33] International studies using rigorous methods of evaluation estimate

the prevalence of BDD cosmetic surgery-seeking populations to be in the range of 3.2-16%. Higher rates of BDD have been reported in those seeking rhinoplasty,[33,34] dermatological treatments,[35,38] penile augmentation, and labiaplasty.[10,37] An Australian study found 25% of people seeking minor cosmetic procedures screened positive on a BDD screening questionnaire.[38]

Unlike other mental health issues where mixed outcomes of cosmetic procedures have been reported, BDD is generally associated with poorer psychological outcomes, repeat cosmetic treatments, unnecessary surgical interventions, and dissatisfaction with the procedure.[14,39,40] Given the likely dissatisfaction, secondary risks include hostility towards treating medical staff, increased risk for self-harm and although rare, increased risk of harm to others such as the treating practitioner.[9,12,40,41] There is also a risk of worsening of pre-existing mental health concerns, body image issues or BDD symptoms.[28,42,43]

Degree of distress, reflecting substantial preoccupation and dissatisfaction with appearance, is considered an important factor in predicting poor post-procedural outcomes in individuals with BDD, with severity of symptoms associated with poorer outcomes.[44] Mild to moderate BDD symptoms may not necessarily preclude cosmetic procedures, especially in procedures that have less ambiguous outcomes (e.g. reducing labia size in labiaplasty may be considered a less ambiguous outcome versus more subjective nose shape/size changes in rhinoplasty). However, in such cases it remains important that patient expectations are well-managed.[45,46]

Risk factors for poorer outcomes



- unrealistic expectations for the procedure.
- external motivations or being influenced by others to have the procedure.
- identity concerns.
- negative self-image.
- relationship issues.
- certain mental health issues such as body dysmorphic disorder.

Within an evaluation of an individual's suitability to undergo a cosmetic procedure, it is important for a psychologist to conduct a thorough psychological and psychosocial evaluation, attending to all aspects of the client's mental health, risk factors, and other factors relevant to understanding the client's motivation for the cosmetic procedure, expectations about the psychosocial impact of the procedure, and comprehension of the risks and emotional/physical recovery associated with the procedure.

Psychosocial assessment of adults

Aims and outcomes of an assessment

The primary aim of conducting a psychological assessment is to evaluate the client's suitability to undergo a proposed cosmetic procedure, so as to reduce the incidence of adverse outcomes and provide greater opportunity for those needing psychological support and treatment, to access the assistance they require.

The assessment therefore aims to:

- evaluate the psychological capacity of the candidate to provide informed consent, undergo the intended procedure, and assess their risk of experiencing a poor psychological outcome.
- evaluate and address any identified risk of psychological distress, suicide, self-harm or harm to others, and determine whether, in the client's individual situation, such a risk may be a contraindication for the intended procedure.
- determine whether psychological intervention prior to undergoing a cosmetic procedure might be warranted to reduce the risk of an adverse psychological outcome.
- reduce the incidence of adverse psychological outcomes associated with unnecessary procedures, or procedures where the prognosis is poor.
- Provide psychoeducation about the possible psychological impacts of the procedure including risks and recovery associated.

There are three potential outcomes of a psychosocial assessment. The psychologist may determine that:

- there are minimal or no concerns for the person's capacity to provide informed consent and undergo the cosmetic procedure.
- there are concerns regarding the person's current readiness to undergo the cosmetic procedure, however with psychological intervention the patient may address those issues, and following re-evaluation may be considered to be at lower risk of adverse psychological outcomes following the procedure.
- the person is considered a poor candidate for the cosmetic procedure or surgery being at significant risk of an adverse psychological outcome, with it being clearly communicated that there is a high likelihood of significant adverse psychological outcomes. A recommendation for psychological intervention might be made to address psychological concerns identified during the assessment, and to support the person with the possible distress caused by the recommendation not to proceed with the desired procedure.

It is important that these three potential outcomes are clearly outlined to the client at the outset of the assessment/evaluation, and that consent is obtained to communicate the outcome of the evaluation to the referring health professional prior to commencing the assessment.

Aims of an assessment:

- Assess the client's psychological suitability and capacity to undergo the procedure.
- Assess and address risk.
- Evaluate and identify any contraindications for the procedure.
- Determine whether psychological intervention prior to the procedure may be of benefit
- Reduce the incidence of adverse. psychological outcomes for the client.

Assessment step-by-step

A comprehensive psychosocial assessment generally involves thorough assessment and consideration of the client's:

- psychological and social functioning.
- developmental history.
- family history, including family mental health history and cultural background.
- educational and vocational history.
- health history, including previous surgeries and drug/alcohol history.
- relationship history.
- current mental state.
- mental health history and treatment, including the identification and evaluation of any possible mental health disorders and associated symptoms.
- coping skills and level of insight.
- current social support.
- understanding of the procedure they are undertaking.

An assessment ideally involves not only interviewing and observing the identified patient, but obtaining collateral information from family and significant others.[30]

The next section details the key areas to evaluate specifically around a clients' intended cosmetic procedure.

When conducting an evaluation of a client seeking a cosmetic procedure, assessment should also focus on evaluating the client's:

- perception of the identified 'flaw' and degree of pre-occupation with the 'flaw'.
- history of dissatisfaction with the perceived flaw and reason for seeking change now.
- motivations for seeking the cosmetic procedure, and their desired outcomes, goals and expectations.
- consultations with other cosmetic practitioners and previous cosmetic interventions.
- relationships with others and their degree of support for the cosmetic procedure.
- self-concept and self-esteem in relation to the physical trait.
- cultural and familial identity in relation to the physical trait.
- mental health, and the presence or absence of a mood, anxiety, or eating disorder, body dysmorphic disorder, trauma history or any other mental health disorder which may significantly impact on the client's perception of their body and their body image, and the severity of any such disorder and its symptoms.

Key areas for evaluation

Perception of the identified 'flaw' and degree of pre-occupation with the 'flaw'

This includes an evaluation of the accuracy of the client's perception and whether the client's perception of the physical characteristic in question is realistic and reasonable, whether the perceived difference has been noted by others, and whether the degree of difference perceived by the client, or their response to this perceived difference is exaggerated or distorted in any way.

Poorer outcomes have been found in patients who are vague in their descriptions of what it is about the specific body part they do not like, and what they would like changed; for example, rather than describing the length of their nose, or a bump, they report just 'not liking' their nose, that it is just 'not right' for their face, or that they just feel 'ugly'.[9,41] In contrast, being too rigid and specific about the desired outcome, for example "I would like those nostril shapes or that nose slope", or giving contradictory descriptions, for example, "I want the hump of my nose removed, but really don't want my face to look different", can also be associated with poorer outcomes.[9,40] Often clients desire an emotional gain from the procedure such as "I want to feel more confident", without recognising that modifying the external body will not automatically bring about an internal, emotional change which might lead to regret and dissatisfaction. Thorough evaluation and seeking clarification from the client about the desired change in appearance, and expected emotional gains, is therefore an important aspect of a psychological evaluation.

Assessing the degree of pre-occupation with the perceived flaw may also be informative in determining the client's suitability for the intended procedure. Clients who are highly pre-occupied with the perceived flaw are more likely to have poorer psychological outcomes from cosmetic procedures,[47] and may also be indicative of BDD.

History of dissatisfaction with the perceived flaw and reason for seeking change now

Clients may report longstanding dissatisfaction or an emerging dissatisfaction, as well as a range of triggers that may have given rise to their desire for the cosmetic procedure. This may include a history of teasing, bullying, negative comments from a sexual partner, partner violence, or other significant life events.[6,8,48-54] In particular, special care is needed with clients whose motivation for body modification is associated with "ridding" the body of reminders of past trauma such as sexual trauma, childhood abuse, and/or resemblance of the physical trait to an abusive parent.[55]

Research over the COVID-19 pandemic has also revealed a significant proportion of people feeling preoccupied or concerned with the appearance of their facial features, which emerged while spending greater time on video-calls. In turn, this is thought to be a factor underlying recent growth in interest in both surgical and non-surgical cosmetic procedures.[56,57] Viewing one's appearance through a camera lens can lead to a distorted sense of facial appearance, which may underlie motivations for surgery. It is important to assess whether an individual's concerns only developed recently, and if this is related to video-calls or 'selfie' cameras they may benefit from further psychoeducation around potential image distortion.

Motivations, desired outcomes, goals, and expectations for the cosmetic procedure

Expectations around cosmetic surgery have been categorised as surgical, psychological, and social. Surgical expectations address the specific physical changes expected as a result of the procedure. Psychological expectations include those which relate to potential improvements in psychological functioning as a result of surgery. Social expectations address the potential social benefits.[13]

Social media has also had a significant influence on the normalisation of cosmetic procedures and has been associated with increased uptake of procedures, especially for those who spend more time on social media platforms, follow more accounts, and have lower self-esteem.[58] In addition to this, social media filters and photo editing applications may be associated with increased acceptance of cosmetic procedures,[59] as well as the development of unrealistic expectations for surgical outcomes.[60,61]

Many cosmetic practitioners now advertise their services and work on social media. Due to a historical lack of regulation around advertising these procedures, patients may develop unrealistic expectations of physical, psychological, or social benefit from consuming this content.[2,62]

Better outcomes are believed to be seen in people for whom expectations are realistic, specific, and proximal to the procedure. Poorer outcomes are more often seen in those for whom expectations are unrealistic, vague and distal (for example, believing a procedure will change one's entire life or result in greater career opportunities).

In the assessment, include an evaluation of:

- whether the client's goals for the procedure are realistic
- the motivations for undergoing the procedure and what is driving the client's desire to alter their appearance
- how the client would feel if they were unable to have the procedure or deemed unsuitable to undergo the procedure
- the client's understanding and appreciation of what the procedure involves, the limitations of the procedure, the associated physical and emotional recovery, any associated risks of adverse physical and emotional outcomes, and the possible risk of imperfections and requirements of surgical revisions in the future.[55]

Consultations with other cosmetic practitioners or experience of previous cosmetic interventions

Clients may have a history of seeking treatment for the perceived flaw or for other perceived flaws. Consulting multiple practitioners, having a history of undergoing multiple procedures, or having previously been refused treatment, are considered 'red-flags' for BDD and for poorer outcomes from cosmetic interventions.[39,41]

When several options are offered to achieve the desired outcome, exploring how the client has come to select a particular procedure and chosen a particular health professional (for example, the amount and type of research a client has undertaken to select a reputable health professional, or if they have chosen a health professional based on expectations such as, 'this professional achieves the kind of nose that I like') can also be very informative in the assessment/evaluation. Recent data from the Ahpra review[2] has indicated that patients who made a complaint following cosmetic surgery were more likely to have found their treating doctor or surgeon on social media, as opposed to other means which may be more regulated (e.g. Ahpra register).

Relationships and the support of others

Relationships with others can have a large influence on the person's desire to undergo a cosmetic procedure. Family and friends can have a supportive influence, a coercive influence, or be significantly opposed to the procedure. Parasocial relationships with social media influencers may also impact and

normalise cosmetic procedures.[58,63] The client may also believe that the procedure will improve their relationships with others, such as with their partner or their chance of attracting a partner.

A history of bullying or teasing from childhood or more recent negative comments from a partner may contribute to the client's perceptions of themselves.[48-52] Research suggests an association between intimate partner violence and likelihood of undergoing cosmetic surgery.[6,52]

Although rare, body dysmorphic disorder 'by proxy' has also been documented, in which the focus is on an imagined defect or flaw in the appearance of another individual. The preoccupied individual can exert considerable influence on the other and can be a significant motivator for the procedure.[64,65] The assessment of the client should therefore screen for this, particularly in cases where the presenting client is a minor and is being encouraged towards the procedure by a parent or guardian.

An evaluation of the client's relationships with others therefore includes clarification of whether:

- members of the client's social and family network share a similar view of the client's perception of the perceived flaw.
- family or other significant people are coercing or otherwise driving the client's motivation for the procedure.
- other members of the family have undergone the same or similar procedure(s).
- the client is seeking to address relationship stress (such as improve a romantic relationship) or attract a potential partner through altering their appearance.

Self-concept and self-esteem

Better outcomes are seen in clients where their self-worth and self-concept are not defined by the presence or absence of the perceived flaw. While self-esteem might improve with a change in appearance, clients are more likely to experience positive psychological outcomes from their cosmetic procedure if what they are seeking is to align their external appearance with an already positive body image and self-concept.[24]

In the assessment therefore, include evaluation of the client's self-concept, identity and self-esteem in relation to the perceived flaw.

Cultural, familial and personal identity

For some, cultural and familial identity may be important to consider, particularly in regards to facial features and cosmetic procedures to alter facial characteristics. Explore the perceived flaw in terms of it being a potential cultural or familial trait, and whether this forms part of the person's identity, even if the trait itself is seen in a negative light.

Explore a range of potential outcomes in the event the characteristic is altered – might it affect relationships with others, with the self? Loss of identity might result where the physical characteristic in question is shared amongst family members or a certain cultural group.[24]

Some patients may require more psychological adjustment to their change in appearance than others, which may relate to the type of procedure. More extensive 'type-change' procedures which more radically alter appearance (such as rhinoplasty) may require more adjustment and may result in more adverse outcomes in regards to loss of identity than 'restorative' procedures (such as botox or facelifts).[66]

Mental health

A comprehensive mental health assessment, covering the full range of potential mental health disorders should be conducted. Such an assessment includes a mental state examination and symptom review, covering in particular, diagnostic criteria for mood disorders, anxiety disorders, eating disorders and body dysmorphic disorder; these being the most commonly cited mental health concerns in the cosmetic procedure-seeking population. The main diagnostic criteria are noted below, however more complete criteria and specifiers are found in the most recent edition of the Diagnostic and Statistical manual for Mental Disorders.[67]

The client should also be asked about whether symptoms they are experiencing impact on their day-to-day functioning including their capacity to attend to their work, activities of daily living, and relationships.[68] Level of insight about their mental health issues, coping skills, previous treatments, or lack of seeking previous treatment, should also be explored.

Interview questions, as in all interviews, should aim to clarify the presence, absence, duration and frequency of symptoms, without leading the client to answer in a specific way.[68] Observations of client behaviour in

the context of their reported mood and experiences should also be incorporated into the assessment to aid diagnosis.[69,70]

Body dysmorphic disorder

Body dysmorphic disorder (BDD) is the most researched and most commonly cited disorder associated with a heightened risk for adverse outcomes in cosmetic procedure-seeking populations. The assessing psychologist must therefore be particularly familiar with the key criteria so as to appropriately evaluate the client's presenting issues, behaviours and symptoms.

As people with BDD may wish to present in a positive light during evaluation, they may not report a full range of symptoms to the assessor. Questions which do not lead the client are important, and informal observations of the client outside of the consultation, such as in the waiting room, may reveal behaviours not evident during the session.[72]

Key issues to consider in the assessment of BDD:

1. Is the client preoccupied with a perceived defect or flaw in their physical appearance that is not observable or appears only slight to others?
2. Does the patient perform repetitive behaviours in response to the concerns (e.g. scrutinising the feature of concern in the mirror, repeatedly seeking reassurance, excessive grooming; skin picking; excessive use of makeup or other products; camouflaging the feature with clothing, hats, or hairstyles)?
3. Does this preoccupation cause clinically significant distress or impairment in social, occupational or other important areas of functioning?
4. Is the preoccupation with appearance more consistent with symptoms of an eating disorder (i.e. concerns relate primarily to body fat or weight), than with a diagnosis of BDD?[67,71]
5. Is the preoccupation with appearance limited to discomfort with primary or secondary sex characteristics and better explained by gender dysphoria?[67]

Mood disorders

In order to clarify if the client is experiencing a current major depressive episode, the client should be asked about:

- the quality, responsiveness, and pervasiveness of their mood.
- the degree of interest and pleasure in activities they typically enjoy.
- their appetite and whether they have experienced any weight gain or loss.
- how they are sleeping, including lifestyle factors which may be impacting on the quality of sleep.
- whether they are experiencing agitation or conversely, a sense of 'slowing' of movements.
- their energy levels and experience of fatigue.
- their sense of self-worth or worthlessness, or excessive or inappropriate guilt.
- their ability to think, concentrate, or make decisions.
- their thoughts of life, death or suicide.[68]

The assessor should also clarify:

- the degree to which the client's depressive symptoms are linked to their dissatisfaction about their physical appearance.
- the pervasiveness of the client's symptoms and circumstances in which symptoms improve or worsen.
- whether the client ruminates about their physical appearance or experiences excessive negative thinking in relation to their appearance.

Anxiety disorders

The presence of any anxiety disorder should be considered when conducting a mental health assessment. Concern with appearance can translate to anxiety in social situations and concern with negative appraisal by others.[73-76] While most research has looked at state and trait anxiety via self-report,[77] anxiety disorders of particular relevance in this population are:[78-80]

- social anxiety disorder (social phobia).
- obsessive-compulsive disorder.
- generalised anxiety disorder.
- panic disorder.
- agoraphobia.

Again, the assessor should clarify if the person's concerns with their physical appearance are relevant in understanding the aetiology of the anxiety symptoms, such as social anxiety being a consequence of self-consciousness related to the person's physical appearance.

Eating disorders

Research studies report that some people seeking cosmetic procedures, particularly body-contouring surgery may have an underlying eating disorder, with the preoccupation with body weight and size thought to influence their contemplation of cosmetic methods to further alter their body shape.[81-84] Potential symptoms of an eating disorder should therefore be carefully screened and assessed.

Assessors should look for signs of disordered eating and be familiar with the key diagnostic criteria of:

- anorexia nervosa.
- bulimia nervosa.
- binge-eating disorder.
- other specified feeding and eating disorders.

Personality disorders

Personality disorders, particularly clusters B and C may be more prevalent in this population and may increase the risk for adverse outcomes of cosmetic procedures, and as such should be screened for within the assessment.[85-88]

Autism

There is a high level of comorbidity between autism and eating disorders[89] and body dysmorphia,[90] which may lead to an interest in body modification/cosmetic surgery. Special care may be necessary for autistic individuals if they experience difficulties in coping with change, as this may cause emotional distress and deterioration of emotional state when their appearance is altered.

Risk

Self-harm/suicide

Due to the increased risk of self-harm and suicidality in this population, a thorough assessment of suicide risk must be included as part of a comprehensive psychological assessment.[11,12,16,91]

The assessor should use a collaborative approach to obtain specific details about whether:

- the client has had thoughts about death, dying, or that life is not worth living.
- the client has made any plans for suicide.
- the client has access to means of self-harm/suicide.
- the client has a history of attempted suicide.[91-93]

If there is concern for the client's risk for suicide, a collaborative, problem-solving approach should be adopted to provide the least restrictive treatment and risk-management response which maintains the client's safety.[91]

In addition, some people with BDD may engage in, or consider performing self-mutilating acts in an attempt to address their perceived flaw, and as such, this risk should also be evaluated.[12] Patients should be asked if they have tried or been considering any home remedies to address their concern.

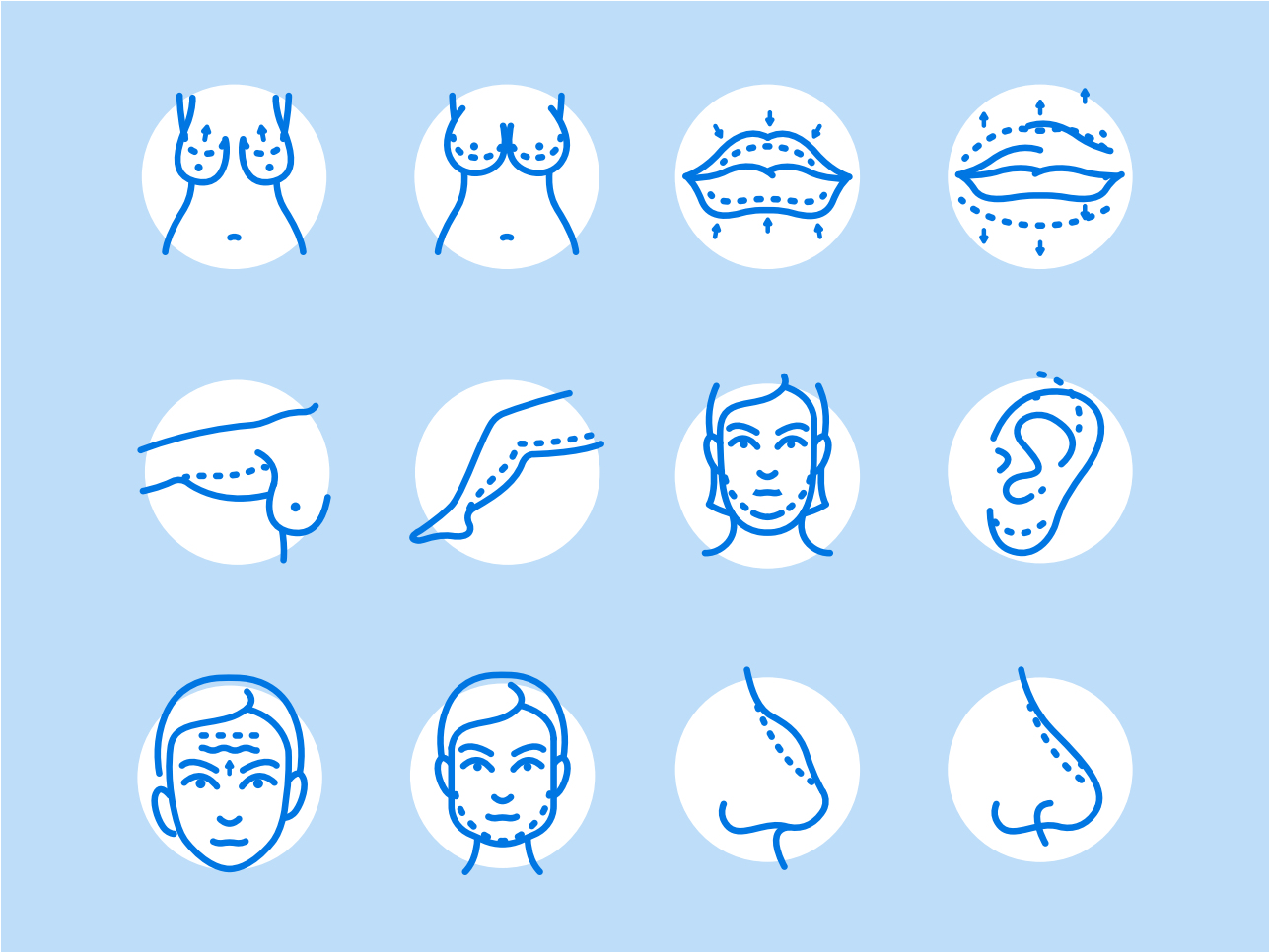
Harm to others

Although rare, there is a potential risk for harm or of litigation directed to others involved in the cosmetic procedure such as treating staff, particularly when the client has a pre-existing mental health or personality disorder, and where the client is dissatisfied with the outcome of a procedure or where a cosmetic procedure is withheld due to concerns for adverse outcomes.[40,41,94] As such, an assessment of the client's thoughts around treating staff, their beliefs around the role of staff in the client's distress, and thoughts or plans of aggression directed at others should be included in a comprehensive psychological assessment.

Clinicians should also be aware of and take mitigating steps to protect themselves against any potential harm from clients who are evaluated to be at high risk of adverse psychological outcomes if they undergo the procedure, as some of these clients might view the clinician as blocking their access to their desired procedure. Clinicians may also need to be aware of any pressure from referrers to provide a more favourable evaluation of the client's risk profile in relation to their desired procedure and will also need to ensure there is no conflict of interest with the referring surgeon or other practitioner.

Financial capacity

Cosmetic surgeries and procedures are often costly, and may involve hidden costs such as the need for revision surgeries or a long-term treatment plan to maintain outcomes. The client's means to pay for the procedure should be considered, given that some may engage in risky or dangerous methods of financing their cosmetic procedure, such as taking out loans without financial security.



Rating scales and assessment measures

Client self-report and clinician-administered assessment measures are available which may assist in the evaluation of the client. While these tools identify areas of concern, these scales have undergone limited validation, are not comprehensive enough to evaluate all aspects of a client's functioning, and do not provide a definitive diagnosis or definitive evaluation of suitability to undergo a cosmetic procedure. They should, therefore, only be used to flag further areas of assessment for the psychologist.[95,96] Screening tools do not take the place of a comprehensive assessment but can be considered one aspect of a broad and comprehensive psychosocial evaluation.[45]

Tools which may be of use to the clinician include the Derriford Appearance Scale (the DAS-59 and its short form, the DAS-24),[97] the PreFACE[95,96], the Q-series of patient-reported outcome measures,[98-105] and the Aesthetic Procedure Expectations (ASPECT) scale.[106]

The Cosmetic Procedure Screening Scale (COPS),[107,108] the Body Dysmorphic Disorder Questionnaire (BDDQ),[109] the Dysmorphic Concern Questionnaire (DCQ),[110,111] the Body Image Disturbance Questionnaire (BIDQ),[112] the Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS)[112,113] and the Appearance Anxiety Inventory (AAI)[114] are screening tools for body image disturbance and BDD in particular.

There are several clinician administered clinical interviews such as the Yale-Brown Obsessive–Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS),[115,116] the Structured Clinical Interview for DSM-5 (SCID-5) with optional modules for the evaluation of BDD[117,118] and the Mini International Neuropsychiatric Interview – Plus (MINI-Plus) which includes questions around BDD.[119] These clinician administered tools may assist the psychologist in the assessment of the patient's symptom profile as part of a broader assessment.

Concluding the assessment

Providing feedback to the client and referrer

The psychologist should provide the client and referrer timely feedback on their opinion of:

- the client's readiness and capacity for the proposed cosmetic procedure.
- issues the client presents with that may raise their risk for an adverse psychological outcome and how these issues may result in adverse psychological outcomes.
- recommendations for further evaluation which may help clarify issues regarding client risk.
- recommendations for psychotherapy which may help address issues that increase client risk for adverse psychological outcomes, and support and prepare the client for their planned procedure.
- whether the cosmetic procedure is contraindicated for that client, and the rationale for that conclusion. Psychoeducation regarding contraindications should also be provided to the client.[120]
- if the procedure was to proceed, recommendations about post-procedure resilience, how to identify adverse psychological outcomes and how to seek supports.

Client feedback

For the client, feedback should be provided both in person and in writing in the form of a detailed letter or report, to facilitate understanding of the approach taken in the assessment, and the rationale for the conclusions drawn. Feedback to the client should be provided in a collaborative, sensitive and clear manner which takes into consideration the client's own vulnerabilities, mood and mental health issues.[121] Having a clear, evidence-based rationale is of particular importance when contraindications for a cosmetic procedure are identified.

Where feedback is likely to be distressing for the client (as in the case where the recommendation is to not proceed with a cosmetic procedure),[122] issues of risk should be considered and evaluated during the feedback process with any necessary risk management plans put in place. A key risk is that a patient denied access to a procedure will immediately seek treatment elsewhere ("doctor shopping").[39] Clearly communicating the rationale for the assessment outcome, developing strong rapport and offering an alternative solution for their distress (i.e. referral to appropriate psychological treatment) is important in attempts to mitigate this risk.[123]

Referrer feedback

For the referrer, feedback should ideally be presented both verbally and in writing to ensure clarity regarding the assessment outcome and to provide adequate support for the referrer's follow-up with the client.

In providing feedback to the referring practitioner, the psychologist must be mindful of his or her responsibility to protect the client's privacy and confidentiality. Feedback to the referring practitioner should be adequate to answer the referrer's questions regarding the client's fitness to undergo the proposed cosmetic procedure. Issues which arise as part of the assessment that may help inform the psychologist of the client's fitness to undergo the procedure but which are not necessary for the referring agent to know should not be disclosed.

Psychologists are advised to familiarise themselves with the APS **Code of Ethics**, and the APS **Ethical Guidelines on Confidentiality** which relate to the sharing of information with a third party.

Psychosocial assessment of minors

Assessment of minors

As with adult evaluations, a thorough assessment of minors includes an evaluation of the young person's desired goals, whether their expectations are realistic, factors motivating them to seek cosmetic enhancements, and their mental health,[132-134] particularly regarding symptoms of BDD which most commonly emerge in adolescence.[128,135]

However, there are additional issues to consider in the evaluation of an adolescent's preparedness and suitability to undergo a cosmetic procedure. These relate to their physical and emotional maturation and changes that are likely to occur as a natural course of development,[132,136] their developing sense of self and identity,[137] and the potential for influence by others.[134,138] Their capacity to provide informed consent should therefore be carefully considered, as well as the role of parents or guardians in supporting the decision-making process.[134]

In evaluating minors, it may be beneficial to involve parents/guardians in the assessment process and in communicating the outcome of the evaluation, psychoeducation regarding the emotional impact of the desired procedure, its recovery, and associated risks. Since some body modification procedures are permanent, it is important to evaluate the minor's developmental stage and maturity to ensure the individual does not regret their decision later in life when they have a clearer sense of self and identity. It is also important that the minor is educated about the long-term impact of their desired procedure, for example, the need for revision following breast augmentation due to implants' expiry, the possible risk of being unable to breast feed following breast reduction, permanent scarring and imperfections following rhinoplasty.

Issues to consider when assessing minors

Capacity to consent

When working with minors, practitioners need to determine if the young person is capable of providing informed consent for psychological assessment and/or treatment and if parental or guardian consent is required or would be in the best interests of the young person.[139, 140]

In the case of the young person intending to undergo a cosmetic procedure, informed consent also requires that the young person understands fully the nature of the proposed intervention, expected outcomes including any initial discomfort, limitations to what can be provided, what is required of them in terms of self-care during recovery, and any potential adverse events or risks involved.[134,139]

A number of APS resources are available to support members in considering the ethical implications around gaining informed consent from minors:

- Ethical guidelines for working with young people.
- Ethical guidelines on confidentiality.

Influence of peers and the media

While concerns with body image in young people is not a new phenomenon, increased exposure to idealised images of physical appearance via social media,[59,61-62] and through television programs revolving around cosmetic enhancements[141] are adding to the influences on adolescents' satisfaction with their body image,[142,143] their acceptance of cosmetic interventions, and their desire to seek cosmetic interventions to alter their appearance.[144,147] Exposure to teasing and bullying may also play a significant role[144,148] the incidence of which appears to peak during adolescence.[48]

Some argue that cosmetic procedures can indeed decrease bullying and improve social functioning in young people.[149] It is important however for the young person to appreciate that altering one's appearance cannot guarantee improved social connectedness.[66]

Finally, undue influence of others, including family must be considered. As mentioned, whilst exceedingly rare, cases of body dysmorphic disorder 'by proxy' have been reported, where the focus is not on the self, but on a perceived flaw or flaws in the appearance of another individual. The preoccupied individual can exert considerable influence on the other and can be a significant motivator for the procedure;[64,65] a particular concern where the presenting client is a minor and is being influenced to undergo the procedure by a parent or guardian.[65]

Body image and concerns for what is 'normal'

Along with a developing self-concept and concern for physical appearance, concern for what is 'normal' may also emerge. Preliminary research suggests that in some cases, education regarding normal development and physical changes that are likely to occur over the course of physical maturation can allay fears and decrease the desire

to change one's physical appearance through cosmetic procedures. This seems particularly the case for adolescent labiaplasty.[150]

In addition, changes in weight and body shape as young people mature means that some outcomes from cosmetic procedures may also alter over time, and the desired effects may be lost or distorted.

For example, young females often gain weight in their early 20s, and with that, dissatisfaction with breast-size may decrease without intervention. Some research suggests improvement in body image generally occurs in early adulthood with or without cosmetic interventions.[136]

Summary

When assessing adults for their suitability to undergo a cosmetic procedure, it is important to consider the broad range of factors which can increase the risk for adverse psychosocial outcomes. Whilst the evidence is mixed regarding the psychosocial outcomes for individuals with depression, anxiety and other high prevalence disorders,[6,10] a substantial body of evidence suggests an increased risk for adverse psychosocial outcomes for those presenting with body dysmorphic disorder, including post-procedural dissatisfaction, distress, litigation, risk of self-harm, and in rare cases, risk of harm to others.[9,12,40,41]

A range of other factors, such as unrealistic goals or expectations, external motivations for the procedure, inadequate consideration of possible challenges to personal identity with changes in appearance, low self-esteem beyond dissatisfaction with an aspect of appearance, and coercion or lack of support from family or friends also increase the risk for adverse psychological outcomes and need to be considered when evaluating the client's psychological suitability for the procedure.[8,10,13,14,19-22]

When assessing minors, a similar processes to that of adults is followed, although aspects unique to the developmental period, including ongoing physical development, the common experience of decreased satisfaction with body image, the influence of peers and family, the development of identity and changes in self-esteem, and heightened concerns for appearance and what is 'normal' can all complicate the picture.[136,139,150,151]

Assessment of minors therefore includes consideration of these normative aspects of psychosocial development. The assessment of the adolescent client also includes establishing that the client has sufficient maturity to make an informed decision, and has the support of significant others such as parents.[150] The influence of others, including the media, peers and family is also important, to ensure that motivations for intervention are the client's, and not externally driven.[136]

Clients, whether adult or adolescent, should be evaluated on a case-by-case basis. Ensuring the client has support from family and significant others, specific goals, realistic expectations regarding the procedure including an appreciation of what the procedure involves, the associated risks and limitations, the expected recovery time, and requirements for self-care to aid recovery, improves the likelihood of positive outcomes.

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