British Journal of Plastic Surgery (1982) **35**, 281–286

0007-1226/82/0371-0281 $02.00

Cosmetic surgery—where does it begin?

DAVID L. HARRIS

Plastic Surgery and Burns Unit, Derriford Hospital, Plymouth

"**Cosmetic surgery:** the undertaking of an operation plastic or otherwise which will improve appearance, or the avoidance of one which will having a disfiguring effect." *Butterworth's Medical Dictionary (1978).*

In contradistinction to other fields of surgery plastic surgery has dual objectives: to restore function and to restore and preserve normal appearance. The plastic surgeon has the latter objective in view in all that he does, be it the repair of a cleft lip, the treatment of a burn injury, the augmentation of hypoplastic breasts or the reconstruction of a defect left after excision of a malignant lesion. Cosmetic surgery began with the plastic surgeon's sympathy with the lot of the disfigured.

The abnormalities of appearance that are dealt with by cosmetic surgery can be classified aetiologically as those resulting from:

(i) congenital malformation;
(ii) disease and injury;
(iii) physiological processes such as carbohydrate storage, reproduction and ageing;
(iv) disproportionate development of bodily and facial features.

But such a classification is of little value to an understanding of cosmetic surgery, the purpose of which is to relieve and prevent the distress that is suffered by those who are self-conscious of abnormal appearance. Experience has taught plastic surgeons that the amount of distress caused by abnormal appearance varies from one person to another and bears little relationship either to its aetiology or to the degree of abnormality as judged by the observer. One person may be only slightly distressed by an extensive port wine stain of the face whilst another may be severly distressed by a relatively insignificant hump on the nasal bridge. In contrast to other branches of surgery, the application of cosmetic surgery should be judged, not on the grossness of the abnormality but on the degree of emotional distress that an abnormality of appearance produces. Cosmetic surgery is psychotherapeutic.

To understand the *raison d'être* of cosmetic surgery (the question posed by the title of this essay) it is necessary to understand the rôle of appearance in society, the factors which determine the distress suffered by those who are self-conscious of abnormal appearance and the attitudes of their observers.

The role of appearance in nature and in human society

The appearance of any living thing is the product of its genetic inheritance and is influenced during its life time by physiological processes (carbohydrate storage, reproduction, ageing, pigmentation etc.,) disease and injury. The appearance of a living thing is informative to others who can see it. It tells them the species to which the living thing belongs, whether it is friend or foe: it tells them its gender, its age, its fitness and health and its attitude of the moment.

The significance of appearance in nature is greatest in the day-to-day inter-relationships of a group of the same species. Many species have the ability to discriminate quality of appearance amongst their group membership. For example, it is well known that normal appearing members of a species group will reject or kill other members who appear abnormal for their group. This qualitative distinction between normality and abnormality of appearance, which is basic to the nature of animal life, must be fundamental to the origin of cosmetic surgery. We must therefore ask the question: what determines the "normal" appearance of a species group when the detailed structure of each individual member of that group is unique? It must be that "normal" appearance is the sameness of the majority. Amongst the majority, some will look more normal than others. It follows that there must also be a minority who have "abnormal" appearance and, again, amongst these some will look more abnormal than others.

For most biological characteristics, "normals"

can only be defined scientifically in terms of "ranges of normal" due to the complexity and diversity of biological creation. Values outside these ranges are considered "abnormals". The scientific selection of values to establish "normal ranges" are at best mathematical guesses based on statistical analyses that standardise deviations from central means, medians and modes. It follows that for a characteristic of any group of like individuals there will inevitably exist a number of individuals who fall into a grey zone between normality and abnormality when it becomes a matter of debate or opinion as to whether their characteristic is normal or abnormal. Take, for example, the weights of 100 randomly selected naked people of the same height, age and sex. There are two ways of dividing them into normal and abnormal sets.

Firstly, they can be divided scientifically into a "normal" set of people whose weights fall within the normal range of weights for the group's parameters and an "abnormal" set of people whose weights are outside this range. Secondly, 10 observers could be asked, one at a time, to divide them into a "normal weight" set and an "abnormal weight" set, the selection depending on the individual opinions of the observers. Those of the group with average weights will always be placed in the normal set and the fattest and thinnest will always be placed in the abnormal set. Opinions will vary, however, as to the sets into which the fatter and thinner members of the group should be placed so that at the end of the exercise there will be a number of fatter members and a number of thinner members who had been placed at one time or another in both sets. These constitute a third set, a grey zone, where "normality" and "abnormality" is debatable.

Let us imagine that the exercise is repeated using the characteristic general appearance and that the 10 observers are asked to divide a similar group of naked people into those with normal appearance and those with abnormal appearance (unlike the characteristic of weight, there is no predetermined "normal range" of appearance by which to divide the group scientifically). At the conclusion of the exercise there will be three identifiable sets: the "normal appearing" set (the majority), the "abnormal appearing" set and a third intermediate set of people who at one time or another had been placed in both sets. This should be appreciated as a philosophical concept.

The existence of a "grey zone" set results from variability in the sensitivity of aesthetic perception between one observer and another. As there is no word in the English language to describe sensitivity of aesthetic perception, I shall introduce the word *aestheticality* in the sense that musicality denotes quality of musical appreciation—an analogous quality of perception that has variability amongst individuals. We can therefore apply the term *aesthetic disfigurement* to describe those abnormalities of appearance which are viewed by some to be abnormal and by others to be normal and we can use the term *gross disfigurement* to describe those abnormalities of appearance which are viewed by all as abnormal.

Is this classification of the quality of appearance (normal, aesthetic disfigurement, gross disfigurement) just an intellectual exercise or does it have validity in nature in the same way that abnormality of weight is known to reduce healthiness and physical efficiency? There are several reasons to presume it does. Mention has already been made of the susceptibility of the grossly disfigured animal to his rejection or execution by normal members of its species group and in human society the disfigured commonly experience rejection and ostracism. For many animal species, including mankind, attractiveness is fundamental to reproduction and the choice of mates. It is the experience of mankind that there is an inherent desire, common to everyone, to feel that each is accepted by the other members of the society with which the individual lives—the so-called herd instinct. The benefits of cosmetic surgery most commonly described by post-operative patients are an increase in self-confidence coupled with the observation that they now look normal and feel normal. Normality of appearance is important in nature and abnormal appearance is a disadvantage.

It is possible that, as normal appearance is fundamentally important in nature, individuals have an inherent fear of looking other than normal. At the very least they would have a vested interest in establishing the normality of their appearance and its acceptability by their peers. This indeed seems to be the case, for once children begin to mix with their peer group outside the family within which they have been reared, they demonstrate curiosity of unusual appearances and seek to confirm the normality of their own appearances by comparison with those

of their peers. They view themselves objectively. Also, children with disfigurements caused by congenital malformations usually become aware of the abnormality of their appearances around the age of five when they start attending school. The inherent desire to conform, to look like the majority, underlies the commercial success of the fashion industry. There is comfort and security in the knowledge that one is like others.

Thus the hypothesis can be argued that quality of appearance is fundamentally important in nature and plays a basic role in the interpersonal relationships of human society. Every individual has an inherent desire to confirm the normality of his or her appearance and the acceptability of that appearance by peers. We may have an inherent fear of appearing abnormal. Normality of appearance is determined by individual aestheticality so that any population can be divided into three sets of differently appearing individuals: normal, aesthetically disfigured and grossly disfigured. This classification of abnormal appearance by quality of observation is unrelated to the aetiological classification of abnormal appearance given earlier. Aesthetic disfigurement can include abnormalities of appearance from all the aetiological groups, as can gross disfigurement. For the subject who is self-conscious of being abnormal in appearance, the distinction between aesthetic and gross disfigurement is largely irrelevant. He sees himself as a member of the population with abnormal appearance. The distinction does have relevance for the variations in the attitudes of his observers.

Subjective aspects of abnormal appearance

By definition, all members of the gross disfigurement set of a population will be aware of the abnormality of their appearance, while amongst the aesthetic disfigurement set, some will be aware and others will not. Self-consciousness arising out of awareness of abnormal appearance is induced partly by self-comparison with others normal and partly from criticism of the abnormality by others. Experience of patients seeking cosmetic surgery indicates that, in the large majority, self-consciouness is induced by criticism of the abnormality: this is subsequently reinforced by self-comparison, by further overt criticism (teasing) and covert criticism (staring, comments behind the subject's back).

Why are some people with aesthetic disfigurement self-conscious of abnormal appearance whilst others are not, and, amongst people who are self-conscious of the abnormalities of both aesthetic and gross disfigurement, why is there such a wide range of experienced distress and disability? The answer is partly circumstantial and partly inherent in the constitutions of the individuals concerned yet it is fundamental to the solution of the question posed by the title of this essay.

Circumstantial factors that may determine self-consciousness of abnormal appearance are the amount of hostile or friendly teasing that the subject suffers, the age at which the subject first becomes self-conscious of the abnormality (people tend to be most concerned about normality of appearance during early childhood and during teenage when the secondary sexual characteristics are developing) and the part of the body that is disfigured and whether or not the abnormality can be camouflaged or hidden from the sight of others.

Constitutional factors that determine self-consciousness of abnormal appearance are the subject of psychology and psychiatry: the academics of these sciences have sought to explain the variable attitudes of people to disfigurement within existing theories of psychology that have been mostly developed from the investigation of neurotics and psychotics. Thus students of Schilder's body image theory explain self-consciouness in terms of symbolism whilst students of Freud's psycho-analytic theory offer the concept of displacement of underlying conflict. Whichever the psychological theory and there are many (reviewed by Hay, 1970), the attention of psychologists and psychiatrists has been confined in the main to those people with abnormalities of appearance who come from the aesthetically disfigured set and whose abnormalities are aetiologically classified as the result of disproportionate development (nasal deformities, abnormalities of breast size) and physiological processes (obesity, striae gravidarum, facial wrinkles). Here lies the weakness of their case for they have assumed that the psychogenesis of distress caused by aesthetic disfigurement (regarded as abnormal) must be different from that caused by gross disfigurement (regarded as normal). The distinction is based on the observed differences in the degrees of disfigurement and the assumption that, for a normal person, distress

should be proportional to the observed degree of disfigurement. As plastic surgeons know, this is not the case. Indeed, it is my personal observation that the pattern of distress suffered by a person who is self-conscious of an aesthetic disfigurement is the same as that of a person who is self-conscious of a gross disfigurement. I would argue that the main constitutional factor that determines the degree of self-consciousness amongst subjects of both aesthetic and gross disfigurement sets is aestheticality: that those with a more highly developed sense of aestheticality are more self-conscious of abnormalities of appearance than those in whom the sense of aestheticality is less well developed: and far from being an abnormal psychological reaction, self-consciousness of abnormal appearance in general is a natural and normal response. It is, however, accepted that for a very few people, professed self-consciousness of abnormal appearance may be symptomatic of an underlying psychosis (dysmorphophobia).

Variations in aestheticality could equally explain the known variations in the amount of distress suffered by those who are self-conscious of abnormal appearance. Such a person who has a highly developed sense of aestheticality could be expected to regard the abnormality as a constant source of irritation, grating against his inborn sensitivity towards harmony of form and colour—a constant "sore thumb". It is unlikely that he would rationalise that others who viewed him had lesser aestheticality, so he would assume that they were as much offended by the abnormality as he was. This supposition is supported by the frequent complaint of aesthetically disfigured patients that no one seems to understand or sympathise with their concern over the abnormality in question; that others usually respond by remarks such as "I don't see what you're worried about" or "You look alright to me".

It has been argued that abnormal appearance is a disadvantage in nature. The disadvantage lies in the competitiveness of interpersonal relationships and activities. The subject who is self-conscious of abnormal appearance experiences this competitive disadvantage with the result that he loses self-confidence and may downgrade his self-concept to a level which is inferior to that of his peers. His ability to relate to others on equal terms is reduced: for instance, it is commonly found that cosmetic surgery patients are embarrassed and ill at ease in the presence of strangers. The person who is self-conscious of an abnormality learns to hide it as far as possible from the sight of others by adopting changes in posture (the rounded shoulders of the woman with disproportionate breasts), by gestures (covering of a facial abnormality with the hand) and by camouflage (cosmetics, hairstyle, choice of clothing etc.,). He learns to restrict his lifestyle to avoid those situations which are most likely to expose the abnormality to the view of others (visiting the beach, swimming, nudity in front of others including spouse, social activities etc.,). He minimises to others the importance that his abnormality has for him by either being secretive about it or by deliberately raising the subject of his abnormality in conversation. He may compensate for the disadvantage of his abnormal appearance by unnatural aggressiveness, unnatural withdrawal or an unnatural determination to excel in some other sphere of life. History is full of the consequences of this compensatory mechanism used by individuals who were self-conscious of short stature—the "little man" complex.

The effect of abnormal appearance on the subject is thus determined by circumstantial and constitutional factors of which aestheticality is likely to be the most influential. The consequence to the subject who becomes self-conscious of his abnormality is a disability to enjoy a lifestyle that he would otherwise have had were it not for his self-imposed restriction on it and as a result of this and the experience of overt and covert criticism from others, emotional distress, loss of self-confidence and an inferiority complex. He is unable to overcome his feelings by rational thought because aestheticality is inborn.

The attitudes of observers towards abnormal appearance

Although the observers of abnormal appearance are members of all appearance sets, practically speaking we need only consider the attitudes of the majority, those of the normal appearance set. These people are, by definition, self-confident of the normality of their appearance. Their set has a similar range of aestheticality to that of disfigured sets. They recognise, by definition, members of the gross disfigurement set as having abnormal appearance but, depending on their aestheticality, they may or may not recognise abnormalities of appearance amongst members of the aesthetically

disfigured set. Their attitudes towards those in whom they recognise abnormality will be either curiosity if the abnormality is unusual, or in most cases disregard if it is commonplace. They can afford to adopt such an attitude because they are secure in the knowledge that their own appearance is normal. This disregard of those with abnormal appearance is often manifest as a negative attitude that results in social rejection and ostracism of the disfigured. Thus many subjects with abnormal appearance complain that they have difficulty in making friends and that they feel social outcasts. Some observers adopt an aggresive attitude which leads to taunting, teasing and labelling the disfigured person with a nickname related to his abnormality. Such observers are numerically few in the experience of those with abnormal appearance, but the consequences of their attitude can be profound. Such aggressive attitudes are probably motivated by a need to capitalise on the weakness of another.

The most important observers, as far as cosmetic surgery is concerned, are the medical profession. The doctor is, by instinct and training, sympathetic and is spontaneously sympathetic to those patients who complain of abnormal appearance when the abnormality is obvious—members of the grossly disfigured set. He may or may not be sympathetic to a patient from the aesthetically disfigured set, depending on his own aestheticality. That is, unless he is aware of the existence of this set and understands the distress and disabilities that such a patient can suffer. If so, he will be able to determine the validity of the patient's request for surgery by paying attention to the patient's experience of living with the abnormality, rather than judging the need for surgery on his personal concept of it.

Conclusion

The application of cosmetic surgery, particularly for the treatment of those with aesthetic disfigurement, is empirical in that the selection of patients is not based on scientific criteria. This does not debase the therapeutic value of cosmetic surgery for its practitioners know that it works, but it does lessen its acceptability by others of the medical profession who are ignorant of its *raison d'être*. As with any surgical discipline, cosmetic surgery begins with the patient, a knowledge of his symptoms and an understanding of their cause. Those who practice cosmetic surgery are duty bound to their patients to elevate the status of cosmetic surgery from the empirical to the scientific for cosmetic surgery is equal to and often excels other surgical specialities in its ability to improve the quality of patients' lives.

In answer to the question "Where does cosmetic surgery begin?", I have argued a personal concept of its *raison d'être* which is summarised by the following hypothesis. It is offered as a basis for the further study of the science of abnormal appearance.

The hypothesis

(i) Quality of appearance is important in nature so that every individual has a basic need to establish the normality of his own appearance and confirm its acceptability to others.

(ii) In human society, quality of appearance is subject to aesthetic judgement which varies from one person to another according to their sensitivities of perception. The word aestheticality has been introduced to describe this.

(iii) Any population consists of three sets of individuals with differing qualities of appearance: a normal set, an aesthetically disfigured set and a grossly disfigured set.

(iv) Awareness of abnormal appearance is universal amongst members of the grossly disfigured set but affects a proportion only of members of the aesthetically disfigured set depending on circumstantial and constitutional factors of which the member's aestheticality is the most influential.

(v) A person in whom self-consciousness is induced from awareness of abnormal appearance and who experiences the disadvantages it has for his interpersonal relationships and activities suffers emotional distress and a restricted lifestyle.

(vi) The distress and disabilities caused through self-consciousness of abnormal appearance are unrelated either to its aetiology or to the degree of disfigurement as judged aesthetically by observers.

Reference

Hay, G. G. (1970). "Psychiatric aspects of cosmetic nasal operations." *British Journal of Psychiatry*, **116**, 85.

The Author

David L. Harris, MS, FRCS, Consultant Plastic Surgeon, Plastic Surgery and Burns Unit, Derriford Hospital, Plymouth PL6 8BG.

The Kay-Kilner Prize takes the form of an Essay Competition. In any competition there has to be a winner and the task of the adjudicators is invidious when there are several excellent entries. It was the unanimous decision of the awards sub-committee that we should ask Mr David Harris for permission to publish his entry, a request to which he graciously consented.

Editor

1982 Kay-Kilner Prize Essay

This prize of £25 was endowed by Professor T. Pomfret Kilner through a legacy received from the late Sir Joseph Kay. The subject for the 1982 Prize Essay is "The primary management of hand injuries: whose responsibility?". Candidates must be Members or Associates of the British Association of Plastic Surgeons and essays should not bear the name of the writer but should be identified by a pseudonym. Entries should be accompanied by a sealed envelope bearing the pseudonym on the outside and containing the candidate's name and address on the inside.

Entries should be received by the Honorary Secretary of the **BAPS** at the *Secretariat not later than 1st September, 1982.* Candidates are advised that their material should not exceed three thousand words in length. Illustrations are not normally required and should only be used where the particular view cannot be described. The essay should be based on the author's personal views. References and bibliography are not essential. Names of prominent workers in the field may be mentioned only in respect of their particular contribution to the subject under discussion.