MEDICAL PRACTICE

Aspects of Plastic Surgery

Social and Psychological Sequelae

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British Medical Journal, 1974, 3, 322-324

Hitherto a standard conservative approach has been to deny operation to all applicants with mild or minimal deformities, since it is claimed that they must necessarily have severe underlying psychiatric problems and therefore operation must inevitably prove disastrous. Another symptom might be substituted, the patient is likely to become dissatisfied and possibly litigious, and a florid psychosis might even be precipitated. By contrast, patients with marked deformities were thought to have few basic psychological difficulties. Any maladjustment was considered as secondary to the deformity and was expected to remit after an adequate surgical reconstruction.

Nevertheless, several research projects and a growing body of clinical experience have indicated that the psychological distinction between the marked and minimal disfigurement groups is much less than had been supposed. There are instances of patients with major deformities being quite dissatisfied after a technically near perfect correction, and conversely a mediocre surgical result being hailed by the patient with intense delight and gratitude.

Some follow-up studies^{1 2} suggest that many applicants with minor deformities as well as those with severe anatomical disfigurements can derive considerable psychological and social benefit from plastic surgery. Serious postoperative sequelae have proved to be much less widespread than had been feared, even among those with minimal deformity. Out of 46 such patients in Edgerton's series¹ who had a successful anatomical alteration 45 were pleased with the result six months after the operation. Nevertheless, transient episodes of acute postoperative emotional upset were reported in more than half the patients in the series,

mainly those who had been given a preoperative psychiatric diagnosis of "psychosis" or "neurosis."

Hay² found that 16 out of 17 rhinoplasty patients with varying degrees of disfigurement felt they had been helped by surgery. There were also significant improvements in measures of attitude, personality, and psychiatric symptoms at follow-up, which was between six months and two years postoperatively. In general those with minimal deformities did as well as those with more major disfigurements.

Case History

Rhinoplasty was carried out on a 30-year-old unmarried hairdresser's assistant who had considered her nose to be too large ever since primary school, where she had been subject to mild teasing. Basically she was a shy, sensitive girl, and very dependent on her mother. Her father had died when she was two years old, and a few years later her mother had married a widower with a teenage family. Subsequently a half-sister was born who was 10 years younger than the patient. Though her stepfather was a kindly, congenial man, the patient never felt she really belonged to this complex family. Her relationship with males had always been unsatisfactory and she envied her half-sister's gay social life. Recently she had been declared redundant at work and this had intensified her chronic feelings of inadequacy and isolation.

Though her nasal deformity was only mild, there were no evident psychiatric contraindications to cosmetic surgery. At follow up two and a half years after the operation she declared how pleased she was with the result and felt that it had transformed her life. There had been no immediate postoperative problems. She had felt "like a million dollars" even before the bandages had been removed and she went out to buy herself a new set of dresses to celebrate as soon as she was discharged from hospital. She now described herself as a happy-go-lucky, hedonistic girl with a wide circle of male and female friends. In the intervening period she had been able to leave home and live in a flat with two other single girls and had found a more congenial though less skilled factory job.

Generally life was much more interesting and she felt she now had a better time than her half-sister. Though she was now more self-

confident and had improved her social life considerably, several deeper problems had not been completely solved. She still could not contemplate living in a different town from her mother and she had not succeeded in making a close, durable relationship with a man. The previous year she had in fact been engaged but had ended this relationship as she decided her fiancé was exploiting her. She had now decided that perhaps marriage was not for her, but in the meantime was concentrating on enjoying herself.

A plastic operation is not a universal panacea for personality difficulties, though in suitable cases it may promote more satisfying social interaction and help to remove some obstacles to further emotional development.

Some disfigured patients describe postoperatively a sense of exhilaration, but seem to be overwhelmed by the new social opportunities that become available. Initially their interpersonal expertise and social judgment may be unequal to the task of relating to the host of people they had formerly avoided.

Psychotic Applicants

Ultrasensitivity about minimal disfigurement should not be considered as a psychotic symptom per se. In fact, the large majority of patients presenting in this way are found to have neuroses or personality disorders of the schizoid or obsessional type rather than psychoses. The preoccupation with a body part can usually be understood in terms of the patient's personality and life history and is therefore in the nature of an overvalued idea rather than a delusion.

Nevertheless, some of the candidates may indeed be suffering from psychosis, mainly schizophrenia or psychotic depression. In British studies this proportion tends to be small, amounting to some 2% in Hay's series of rhinoplasty patients³; and 3% in the author's Aberdeen series, though Edgerton *et al.* in the U.S.A. designated 16% of their minimally disfigured applicants as psychotic.¹

Certain types of presentation should alert the practitioner to the possibility of schizophrenia:

- (1) The deformity is described in bizarre or extravagant terms. For instance, a female applicant may allege that her nose is growing larger every day and gives rise to an intense tingling sensation which implies to her that a change of sex is imminent.
- (2) The patient is quite vague about the nature of the disfigurement and correspondingly imprecise about the alteration that is required. He may declare that his "face is wrong" and he wants the surgeon to give him "an entirely new one" together with "a fresh identity."
- (3) Other people are unrealistically blamed for the disfigurement. It may form part of a paranoid delusional system where the body part is being distorted by external influences—for example, via the television or where for instance other doctors are conspiring to prevent operation taking place.

Symptoms suggestive of schizophrenia, not specifically related to the deformity, such as incongruous emotions, characteristic disorders of logical thought, delusions, or hallucinations may also be present. Feelings of ugliness, unworthiness, and excessive concern about parts of the body may be symptomatic of a depressive psychosis which should be considered especially in the case of middle-aged applicants.

The practitioner should be on the look-out for an underlying mood of depression in these patients together with other classical symptoms of "endogenous" depression such as diurnal variation of mood, early morning waking, loss of weight, lassitude, autonomic dysfunction, agitation, or retardation and self-reproach.

Screening Procedures

Understandably, plastic surgeons only operate when they think they can effect some anatomical improvement, though they may differ considerably about the minimum alteration that is acceptable. Some applicants may thus be rejected at the outset on surgical grounds.

Studies on candidates for rhinoplasty,^{2,4} augmentation mammoplasty,⁵ face lifts,⁶ and those with minimal deformities¹ suggest that many patients with different types and grades of disfigurement can benefit from plastic surgery. It is also clear that some from both the marked and the minimal deformity groups will prove unsuitable for operation. Hence it is important to evolve reliable techniques that can identify this minority at the time of referral.

Ideally a thorough understanding of the applicant and his motivation for plastic surgery requires a time-consuming psychiatric interview which considers aspects such as experiences in the family, interaction with the peer group, sociocultural pressures, personality attributes, and the individual's hopes, fears, and fantasies about the "deformity." In practice an abbreviated screening process which concentrates on discriminant features must usually be employed by general practitioners or plastic surgeons whose assessment time is limited.

This procedure essentially encourages the patient to talk freely about certain important themes: the nature and origin of "the deformity" and his feelings about its effects; circumstances which led to referral; the type of anatomical alteration desired by the patient; and his expectations about the effects of operation on his life situation.

A brief evaluation of the patient's mental state at interview should also be made. This shorter interview may reveal motivations and situations that frequently lead to unfavourable post-operative sequelae.

With adults operation is generally contraindicated on psychiatric grounds in the following circumstances:

If the request for surgery results from pressure exerted by other people—for example, mother or spouse rather than from the patient's own initiative.

In cases where the "deformity" can only be described in vague terms by the patient.

If other grosser anatomical deformities are disregarded by the patient.

Where there is a minimal disfigurement but no history of teasing about it.

A history of previous plastic operations with apparently successful anatomical reconstructions but continuing dissatisfaction by the patient. The presence of marked perfectionistic personality traits can serve as a pointer to such sequelae.

The candidate expects the operation to produce an immediate, almost magical improvement in other people's attitudes towards him due to their perception of his new appearance rather than as a result of his own increased self-confidence and friendliness.

Where a large amount of "secondary gain" is derived from the deformity. Considerable sympathy and attention may have been supplied over a prolonged period because of the disfigurement. The deformity may in fact be the patient's principal way of relating to others, or it may serve as a perpetual excuse for social or career failures that are really due to personal inadequacies.

The applicant is psychotic.

Nevertheless, several authors have emphasized that the decision to operate is not absolutely dependent on the psychiatric diagnosis.^{1,7} Clarkson and Stafford-Clark claim that certain psychotic patients with marked disfigurements that are not implicated in their delusions or hallucinations may be improved psychologically by plastic surgery. Even in these rare instances operation should be delayed until psychiatric treatment has produced remission of florid schizophrenic or depressive symptoms.

Delay and review after a year should be counselled where the desire for operation is of comparatively recent onset, or is associated with a traumatic life event, such as bereavement or divorce, lest the concern be only a transient response to psychological stress.

Doubtful cases should be referred for a psychiatric opinion. It is often convenient for a surgeon to have a regular working arrangement with one local psychiatrist so that all his psychiatric referrals are dealt with by the latter. This enables the psychiatrist to gain experience in a rather specialized area and ultimately yields more accurate and consistent assessments.

Treatment Regimens

A variety of treatment options are open to this partnership:

Operation may be advised against absolutely on psychiatric grounds, or because no anatomical improvement is possible.

Psychiatric treatment may be recommended as a substitute for operation. Usually this would be in the nature of drug or electroplexy for a psychotic condition. Few applicants seem able to accept a course of psychotherapy without the promise of surgery. Most still retain the fixed idea that only a plastic operation is relevant to their situation.

The final decision about surgery may be deferred for later review, perhaps to await the outcome of a course of psychiatric treatment—for example, electroplexy for a depressive psychosis.

Operation may be recommended but with a preparatory course of psychotherapy to help clarify the patient's ideas about the deformity and expectations about the results of surgery.

A course of postoperative psychotherapy may be offered. Social functioning may have improved, yet there may be significant residual psychological difficulties. Having had the operation, the patient may now be able to accept psychological treatment to help his readjustment and personality development.

Our present knowledge about the fascinating interface between plastic surgery and psychiatry is fragmentary and largely anecdotal. There is clearly a need for a lot more fundamental research into the relationship between body image and personality as well as further carefully designed clinical studies of the psychological effects of plastic surgery.

References

- 1 Edgerton, M. T., Jacobson, W. E., and Meyer, E., *British Journal of Plastic Surgery*, 1960, 13, 136.
- 2 Hay, G. G., and Heather, B. B., *British Journal of Psychiatry*, 1973, 122, 89.
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- 4 Meyer, E., et al., *Psychosomatic Medicine*, 1960, 22, 193.
- 5 Edgerton, M. T., Meyer, E., and Jacobson, W. E., *Journal of Plastic and Reconstructive Surgery*, 1961, 27, 279.
- 6 Webb, W. L., et al., *Psychosomatic Medicine*, 1965, 27, 183.
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Conferences and Meetings

British Medical Association

Annual Scientific Meeting 15-18 July

The first part of the report of the Scientific Meeting appeared in last week's B.M.J. (27 July p. 235). The report is concluded below.

Drug Treatment of Pain

Tuesday, 16 July

The Reckitt and Colman Lecture was delivered by Professor J. PARKHOUSE (Manchester). He pointed out the difficulty in defining what is meant by a drug, and said that the word drug in relation to the treatment of pain meant more than conventional analgesic agents. An illustration of the latter point was the use of local anaesthetics to produce analgesia locally or by nerve block. This was a whole science which deserved more critical analysis than it had so far received. Too often those concerned with pain relief separated themselves into believers in "drugs" or advocates of nerve block. In the face of the patient's needs such partisanship had no place. For the same reason other methods such as hypnosis and acupuncture deserved critical study.

The place of sedatives, tranquillizers, and related drugs also needed to be discussed in the context of pain relief. Barbiturates in fact reduced the threshold for pain sensation, yet there was little doubt of their usefulness as adjuncts to specific analgesic therapy when anxiety and insomnia were disturbing. Used alone, however, in the presence of unrelieved pain they might produce nothing more than confusion and restlessness.

Cause of Pain

It was no simple matter to separate the purely analgesic action of a drug like morphine from

its sedative and dissociative effects. The very mechanism of action in subjective terms was in question. Many patients with intractable pain were now treated with regimens not including any drug classified primarily as an analgesic. The effectiveness of diazepam in the relief of pain from muscle spasm led further towards the question of what was meant by treatment of pain. All treatment must be determined by its cause. When diagnosis was clear pain might be treated by dealing with its cause, by antibiotics in otitis media, for example. In acute or terminal cases with a definitive diagnosis considerable therapeutic success was possible in symptomatic relief of pain, but chronic pain in non-fatal situations was altogether more difficult to treat. This was particularly true when no clear cause of true pain could be established, and a diagnostic cliché like "post-herpetic neuralgia" must serve as a disguise for physiological ignorance and an apology for therapeutic impotence. It begged the question in such cases to describe treatment as merely symptomatic—the pain in truth was what was the matter with the patient.

In using drugs for symptomatic relief the drug that was good for the patient was the one which was effective. Controlled studies were a guideline to the drug likely to be effective. But if all patients responded there would have been no need for a trial in the first place. Nevertheless some form of evaluation of drug effect should exist, and it was now generally accepted that subjective assessments provided useful information.

Strategy of Treatment

Organs did not feel pain. It required an intact being with a conscious mind. This fact determined strategy in treatment. Interruption of nerve conduction by local nerve block was prevention rather than relief of pain. When a pain arose from several sites, as in rheumatoid arthritis, a systemically active drug might bring relief even if, like salicylates, it acted peripherally in the affected tissues. With severe diffuse pain the centrally acting drugs were of most value, and the search for specificity in their action continued. There was little evidence still that powerful analgesia could be separated from respiratory depression and drowsiness, and freedom from liability to dependence seemed to carry some loss of analgesic effectiveness.

It was not inevitable that dosage of narcotics should steadily increase or dependence ensue. Too little attention had been paid to genetic and environmental factors operating. With judicious drug combinations a wholesome spirit of normality should pervade a terminal care unit. When a patient was settled in the calm and competent atmosphere of a special unit, where relatives visited unburdened by anxiety and work, the whole situation in regard to pain and demand for drugs was changed. Studies emerging from such terminal care units carried lessons for the whole of society.

In pain as in death we were all equal. Some, in the treatment they received, were luckier than others. Good drugs, good techniques,