Psychotherapy Guidebook

Aesthetic Plastic Surgery as Psychotherapy

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DEFINITION

Plastic surgery has as its purpose the improvement in functioning and the improvement of appearance. Aesthetic Plastic Surgery, or cosmetic surgery, deals primarily with the improvement of appearance. However, even this branch of plastic surgery cannot be definitely separated from reconstructive and reparative surgery that also deals with appearance along with the repairs and reconstructions. The psychological implications of this are numerous and varied, but the primary psychological purpose of the surgery is improvement in appearance in order to improve the patient's own self-image.

HISTORY

A history of Aesthetic Plastic Surgery is a history of plastic surgery in general and goes back many centuries to the early Indian and Egyptian "healers." It began perhaps in the sixth or seventh century before Christ, when Sushruta developed methods of reconstruction of the nose, amputated as a punishment for criminals or the inhabitants of conquered cities. Much of

this early knowledge was lost for a long time, but probably gradually found its way through the Arab, Persian, and Greek civilizations and finally to Rome through Jewish scholars. It was later practiced with somewhat different techniques by members of certain Italian families. The most notable of these was the Branca family, whose members developed reconstruction of the nose and other types of plastic surgery, passing the techniques down to younger members of the family. Gaspre Tagliecozzi of Bologna further advanced the cause of plastic surgery, including reconstruction of the nose. Plastic surgery received a great impetus during World Wars I and II.

TECHNIQUE

The concept of plastic surgery as a method of treating psychological problems or to supplement psychologic management of the patient may be sound if the patient is properly evaluated and is properly motivated. In short, psychotherapy by Aesthetic Plastic Surgery may be a successful method of treatment if there is an imperfection that contributes to the patient's unhappiness, either as a deterrent or as a distraction to the individual's adjustment to other problems and situations. It may sometimes be important that the decision be made by a consultation of psychologist or psychiatrist and plastic surgeon.

However, not all patients for Aesthetic Plastic Surgery need to have

psychological screening. Many patients come with very well-considered reasons for having surgery, the defect or deformity is easily recognizable, and the motivation for correction is considered logical. However, the patient who blames all his unhappiness, business failures, and marital difficulties on a physical abnormality is raising a red flag for the plastic surgeon to see. He should beware of this patient unless the patient is properly cleared by the psychologist or psychiatrist.

The patient should not be allowed to expect more than a reasonable result, and must realize that patients vary in their ability to heal. The disappointed patient may be made worse psychologically than if no surgery had been performed. Therefore, it behooves the surgeon and other consultants to judge the real need for the surgical corrections and to make clear to the patient the degree to which these deformities and defects will be corrected. A reasonably motivated patient who has a significant problem and who has emotional stability will benefit from plastic surgery in nearly every instance. However, there may be instances where a less emotionally stable patient may be helped if there is cooperation between the surgeon and the psychologist or psychiatrist.

APPLICATIONS

The applications of Aesthetic Plastic Surgery are broad and encompass

all areas of the body. Imagined defects and deformities are rarely if ever successfully operated upon, though minor defects may often cause considerable improvement psychologically if the patient's expectations are realistic. To achieve a desirable self-image (a feeling of being beautiful or at least normal), so important to most people in giving them a feeling of assurance, one considers surgery in various areas of the body for correction. The corrective rhinoplasty for correcting the nasal contour, the corrective otoplasty for correcting deformed ears, deformities of the chin to correct the "Andy Gump" chin or an overly prominent chin (prognathism) may be performed often with local anesthesia. Correction of droopy eyelids can give a much more pleasing appearance and correction of droopy eyebrows may eradicate the angry look on the patient's face. Face-lift procedures, including support of the neck, cheeks, temples, and usually combined with eyelid corrections, help to eradicate the aging of the face and is one of the most common procedures for which the plastic surgeon is called upon to perform. Corrections of the breasts for underdevelopment is done with reasonable simplicity, and reduction of overly large or sagging breasts is carried out commonly by the plastic surgeon. Procedures such as these increase the comfort of the individual as well as improve appearance. The abdomen, which has been stretched and is redundant because of multiple pregnancies, or which is obese and redundant due to excess fat, may be corrected along with any attendant separation of the muscles or hernias that may be present. Thus,

one combines functional problems and problems of appearance in correcting both. Reshaping in the hips, buttocks, and thighs is also relatively commonly done, but patients should always be aware that scars are the result of any surgery where an incision is made.

An important aspect of Aesthetic Plastic Surgery is reconstruction of the breasts. When the disease is cystic mastopathy without malignancy, a subcutaneous mastectomy is carried out with reconstruction of the breasts immediately using breast implants. This leaves a reasonably normal-looking breast with a reasonable soft natural feel in most instances. Reconstruction of the breasts following simple or radical mastectomy is also possible and is more commonly performed. The woman who has lost a breast frequently is compared in her attitude to the man who has been castrated. It is quite a blow to her feeling of femininity and often, the possibility of reconstruction is almost as important to the patient as the actual reconstruction itself. Obviously, one cannot completely duplicate the normal opposite breast, but a reconstructed breast can be very reasonable with the bra on and a satisfactory match in most instances even without the bra. The patient who knows of this possibility before her surgery can face the prospect of losing a breast surgically with much more confidence and with much less distress. The actual reconstruction can be carried out for those patients who desire it after the proper eradication of the malignant lesion. Usually this means a wait of some time when the lesion is an invasive malignancy, but often for the early

malignancies, an early reconstruction is possible.