CHANGING THE BODY

Psychological Effects of Plastic Surgery

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WILLIAMS & WILKINS
Baltimore/London

Made in the United States of America

Reprinted 1984

Library of Congress Cataloging in Publication Data

Goin, John M
Changing the body.

Includes index.
1. Surgery, Plastic—Psychological aspects. I. Goin, Marcia Kraft, joint author. II. Title. [DNLM: 1. Surgery, Plastic—Psychology W0600 G615c]
RD118.5.G64 617'.95'0019 80-21743
ISBN 0-683-03630-0

Composed and printed at the
Waverly Press, Inc.
Mt. Royal and Guilford Aves.
Baltimore, MD 21202, U.S.A.

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For
(in alphabetical order)
Jessica Michele Goin and Suzanne Jennifer Goin

Acknowledgments

We have been extremely fortunate in receiving the generous help of many people. To rank our debts in order of magnitude is clearly impossible, but certain people deserve special acknowledgment and thanks. Our greatest obligation is to our old and dear friend, William Rolph, a professional editor and writer who painstakingly read every word in the manuscript and made countless suggestions, some minor, some major, all good. Susan Henson, journalist and social critic, who in the halcyon years graced us as our office manager but deserted us for marriage and the rural pleasures of Healdsburg, California, began as an incredibly accurate long distance typist but soon assumed the additional roles of constructive critic, associate editor, indexer, and emotional supporter. Mary Helen Gianini, R.N., not only assisted with the research studies upon which parts of the book are based but presided efficiently over the myriad administrative details involved in the physical transmission of the book from our brains to the presses in Baltimore. Betty J. Wells contributed greatly by running our practice efficiently while everyone else sometimes seemed concerned only with "the book." Garry Brody, Rodney Burgoyne, Vince Flowers, Mark Gorney, Charles Hughes, Frank Kline, Tracey McCarley, Gilbert Morrison, Ann Pope, and Sherwyn Woods all read portions of the manuscript and made many valuable suggestions. Doctors Flowers and Hughes also graciously allowed us to include some of their original material. We are indebted to the staffs of the Norris Library of The University of Southern California School of Medicine, Lena Pincus, the librarian of The Southern California Psychoanalytic Institute, and in particular to Mrs. Elizabeth Sherson, R.N., B.A., B.S., M.L.S., Head of The Medical Library of The Hospital of the Good Samaritan for her patient and tireless assistance. Our editor at Williams and Wilkins, Susan Vitale, deserves our thanks for giving us encouragement and assistance when we asked for it and for leaving us alone when we did not. Others, too numerous to mention—friends, employees, associates, colleagues, relatives, erstwhile tennis partners, and previous researchers and writers—helped in many ways and we hope they know how grateful we are. Although we have had much advice over various details the responsibility for all views and facts (putative and otherwise) here advanced remains our own.

AUTHORS' NOTE

The authors are well aware that surgeons and patients and people in general may be members of either sex. Some of our best friends are male and female patients, surgeons and psychiatrists. It is cumbersome and, to our eyes, distracting to write he/she or to pluralize all patients and surgeons so that the he's and she's become "they." For that reason, throughout this book we will follow the accepted convention of English grammar which dictates that when sex is unknown, unspecified, or unimportant, the pronoun "he" is to be used. Each time "he" appears in this generalized sense, referring to either doctors or patients, please read he/she.

Introduction

One scorching June day in the late 'fifties, a good-humored, slightly gawky ex-surgical resident arrived in Metropolis (as we shall call it) to commence his training in plastic surgery. He came from a fine university hospital, which was the principal feature of a city that was scarcely more than an overgrown prairie town. The towering buildings of Metropolis, the rich-looking apartment houses with their uniformed doormen, and the urbane inhabitants walking with such confidence along the venerable tree-lined streets made him uncomfortable. His scuffed white bucks and drip-dry shirt seemed countrified to him and out of place.

He walked up a short, immaculate flight of steps, past a chaste brass nameplate engraved with the great man's name and entered a cool, paneled room where a cool lady, with what he assumed (correctly) to be an upper-class English accent, directed him to a chair in a shadowy corner. The receptionist's attention was fully occupied by a shrill, pear-shaped woman who was berating her with great skill and vigor: "I paid that man more money for this so-called face-lift than my chauffeur makes in a year. In a year! Do you realize that? Then he keeps me waiting like this. Everybody says I don't look one bit different. After all that money. And the suffering! Nobody told me about the pain. Nobody told me anything. My time is as valuable as his. I simply won't stand for it. I'm still not properly healed. I'm going to tell him ..." A buzzer sounded and the relieved receptionist said: "Doctor is free now." The woman moved toward the great man's door with the relentless menace of a tank.

The plastic-surgeon-to-be had never met the legendary professor and chairman of this famous division of plastic surgery. He had been interviewed and accepted by two of the younger professors at a meeting in Chicago. He felt a certain anxiety about the quality of the professor's mood after the onslaught of this determined patient. Silence descended on the waiting room. Then through the professor's door a male voice of great power was clearly audible: "Dissatisfied? Unhappy? Why you old cow, I could have *kicked* you in the face and made you look better!"

The door opened and the pear-shaped woman, utterly deflated, passed rapidly through the room, a handkerchief held to her face.

The buzzer sounded again and the receptionist nodded to the future plastic surgeon who arose and walked in to meet the man who would shape and mold him as a technician and physician during the 3 years to come.

Too many plastic surgeons have learned how to deal with patients from people like "the great man," whose book on patient management, had he written one, would surely qualify for the "World's Shortest Books" series. Many of us were taught nothing whatsoever about the understanding and management of plastic surgery patients. A lucky minority received continuing guidance, both direct and by example, in these skills from teachers who knew that plastic surgical campaigns are not always won in the operating room alone. This book is intended to provide a basic but comprehensive review of the special psychological and interpersonal issues that arise in the practice of plastic surgery for the former group and to fill in some gaps for the latter.

We are mindful of the words of the English literary critic, John Atkins (1):

> (this) kind of literature...is fairly prolific these days, particularly in America, and it is universally unsatisfying. To attribute every action to the Oedipus complex or homosexual desires or mother fixation is not only boring but it is almost certainly untrue.

On the other hand, we submit, it is equally untrue that actions are *never* due to those things. We will try to maintain an acute awareness of the dangers of (and tendency toward) overpsychoanalyzation and will try to write as though Mr. Atkins, a fine critic, was reading over our shoulders.

We hope that this book will be read by psychiatrists and other mental health professionals as well as by plastic surgeons and plastic surgical nurses. Cross-fertilization between the two specialties is badly needed. The following words were written nearly 30 years ago by a psychoanalyst and a surgeon, and remain as true today as the day they were written and as equally applicable to either plastic surgery or psychiatry:

> In the development of almost every field of science a periodic point is reached at which that particular group is not currently integrating or utilizing its total research advancements or parallel ones in auxiliary fields. The time lag is costly to both physician and patient. This inertia is due to the slow recognition, absorption, and integration of advances from widely scattered sources of research. It is also augmented within the medical profession by the isolation of specialist groups from one another. This contributes to a focal, rather than total, view of an existing problem. Thus, two detached bodies—surgeons and psychoanalysts—can work within the confines of the same hospital, but because of the narrowness of their specialties fail to interchange valuable pieces of new or even old knowledge (2).

Perhaps this book will penetrate those dark and forbidding interdisciplinary walls a little, and through this narrow chink, larger, more powerful intellectual wedges will someday be driven to bring them tumbling down.

A word about thinking in stereotypes. We all do it, although we know better. Count Korzybski (3) and Senator Hayakawa (4) have taught us that Cow_1 does not equal Cow_2, that words are merely symbols on an abstraction ladder (Mankind, Man, a man, a salesman, and so on, to the concrete, Joseph T. O'Malley, taxpayer identification number 556-32-7894), that certain words have no actual physical counterparts in the real world, and that the map is not the territory. Nonetheless, toward the end of a long day, the fog of stereotypy may descend. We look across the desk at a middle-aged woman. A face-lift patient. Her image is focused on our retinas. Photoelectrochemical miracles transmit this image to our brains, where we perceive—what? Too often, only what we expected to see, a face-lift patient, a stereotype, nothing more. We fail to note her twisting fingers, her failure to make eye contact, her monotonous voice, perhaps even the bizarre content of her thought. And so, weeks later, we are surprised and dismayed that things are not going well: "What ever possessed me to operate on her?"

We hope this book will help those involved in the management of plastic surgery patients to improve their abilities to see each patient as an individual.

Interspecialty stereotypes are particularly pervasive and rigid: neurosurgeons are cold and ruthless; obstetricians aren't all that bright; pathologists are reclusive intellectuals; urologists are jolly good guys who tell dirty jokes; and so on. In no instance are these cherished preconceptions more intense or more wrong-headed than in the case of the views surgeons and psychiatrists hold about each other. The icy, quasisadistic, sports-loving, antiintellectual, mechanistic surgeon* and the wild-eyed, half-crazy, countercultural psychiatric theorist regard each other warily from the opposite sides of a seemingly unbridgeable abyss. This is understandable in a way. For one thing, psychiatrists and surgeons tend, in the words of the

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* Specialty stereotyping begins early. In a 1964 (5) study of medical students' attitudes toward four medical specialties the surgeon was characterized as being "domineering and arrogant, aggressive and full of energy and mainly concerned with his own prestige."

lovers' parents in *West Side Story*, to "stay with (their) own kind." They are not often thrown together. Their occupations and daily routines seem as remote from one another's as a bibliographer's from a back-hoe operator's. One field is apparently clear-cut, well defined, "scientific," and mechanical; the other seems abstract, abstruse, theoretical, and lacking in dramatic events during which "something happens." On closer inspection, however, elements of ritualistic, nonintellectual, and antiscientific thought and behavior can be discerned in both specialties, as can clear-cut, well-thought-out, and effective treatment methods and fundamental concepts. There are events in psychiatry as decisive and momentous as any that occur in the operating room.

We have entertained many, many surgeons and psychiatrists who were previously unknown to each other. At the end of such evenings we have learned to be unsurprised by such comments as:

"Where did you find him? What a nice guy. He's the first normal psychiatrist I've ever met (hastily to hostess)—except you, of course."

Or:

"I really enjoyed talking with Paul. He's very bright and witty, and so warm and human. It's hard to believe that he's a surgeon (hastily to host)—of course, you're not a typical surgeon, either."

When our friend, Bob-the-dermatologist, telephones he always begins his conversation with, "Brother John," or "Sister Marcia " It's an old joke, the source of which we've all forgotten. But it has a nice sound to it, and it reminds us that we are members of a fraternity with more or less common goals and aspirations. So another of our hopes for this book is that, by familiarizing surgeons with psychiatry and psychiatrists with plastic surgery, it will do something to depolarize this chuckle-headed, psychiatrist-surgeon dichotomy.

If you, the reader, are not a psychiatrist we have a suggestion for you. We make it cautiously, with respect, and with a very real understanding that you don't like to be told how to do things, particularly something as ridiculously obvious as how to read a book. We don't either. Nonetheless, we will venture to propose that this book be read straight through, from cover to cover. The arrangement of the chapters is not random. The material in Part I is a psychiatric and psychological primer, designed to provide the average nonpsychiatric physician with sufficient background information to make the best use of the clinical data in Part II.

The reason for reading Part II straight through is that certain concepts (symptom substitution, and the minimal defect, for example) are elucidated in one chapter and then alluded to in other chapters without further explanation. The causes of postoperative depression are discussed at length in Chapter 15, as they relate to the face-lift operation, but also apply to many of the other operations. To avoid needless and boring repetition, details are not given elsewhere.

You will, of course, read it any way you please and perhaps, for you, your way will be best. There are many ways to read a book. We remember driving through some of the featureless hinterlands of Australia with a plastic surgeon friend who had (and has) a deep interest in wound healing. He sat in the back seat reading Peacock and Van Winkle's excellent book (6) on the subject. As he finished each page he tore it out of the book and threw it out of the car window, thus diminishing the weight of the contents of his suitcase at the rate of a nanogram a second or so. We often wondered what the aborigines and sheepherders along the road made of this esoteric paper chase.

If, on the other hand, you are a psychiatrist, you may wish to skip portions of Part I. Chapters 3, 5, 6, 7 and 8 may fail to hold your interest unless you are curious about the authors' psychiatric viewpoint. Chapters 1, 2, 4, 9, 10, 11 and 12 will probably prove to contain some unfamiliar material, unless you have a close and long-standing association with plastic surgeons, as will all the material in Part II.

We should mention in passing something about the material throughout the book which is presented in the form of dialogues or conversations. All of these are real. None has been

invented. We do not use tape recorders, so they are not verbatim transcripts, but we have striven to stay as close as possible to the spirit, if not the letter, of what was said. Some changes in details have been made to protect confidentiality.

Finally, in the pages that follow, we hope to lead you to certain conclusions:

1. That it is not only intellectually stimulating, but pragmatically essential, for plastic surgeons to know what is known about the psychological aspects of plastic surgery.
2. That a considerable and growing body of literature on the subject exists, much of it in journals not normally read by plastic surgeons or psychiatrists (as the case may be), which is essential reading for those concerned with plastic surgery patients.
3. That an understanding of body image is one of the major keys to understanding the good and bad changes that can follow plastic surgical operations.
4. That a knowledgeable psychiatrist can be an invaluable ally in efforts to improve the care of plastic surgery patients.
5. That each surgeon has his own highly individual, even unique "comfort zone." This concept is not only applicable to surgical procedures—explaining why some surgeons approach a blepharoplasty with fear and trembling, while others think nothing of reconstructing half a face in a day-long operation with free omental transfers, bone grafts, and musculocutaneous flaps—but also to patient selection. There are those who are comfortable only with the poor, or the rich and demanding, or the compliant "normal" middle-class patient; or with women, or children, or certain ethnic minorities. Perhaps this book will slightly expand or contract a few "comfort zones," but in general it is wise to recognize where one's own comfort zone begins and ends and to stay well within its confines.
6. That the practice of plastic surgery can be a noble, fulfilling, and consuming profession, provided patients are selected for operations on the basis of their *own* needs rather than the surgeon's. Very few readers of this book will need to be reminded of this—why would they be reading it if they did? But for those very few: It is perfectly possible to operate on every willing patient who walks through the door, but the cost is high. The cynical nonscreening of patients will inevitably lead to a sick conscience (if there is a conscience to sicken), increasingly frequent changes in practice location, litigation, investigation, loss of hospital privileges, the contempt of colleagues, legal maneuverings, questionable banks in the Cayman Islands, unsavory associates, and chilling phone calls in the middle of the night.
7. That patients rarely voluntarily reveal emotional problems to their surgeons. To gain access to a patient's mind, the surgeon must be willing to ask that patient about feelings of inadequacy, depression, anxiety, etc. But, more important, he must know *how* to ask these questions in a psychiatrically informed interview.
8. That the motivations for operation expressed by patients to the surgeon are not always the "real ones," or the only "real ones." Patients have learned to give sanctioned answers to the question, "why do you want to have this operation?" Deeper, less realistic motivations may be deliberately or unconsciously concealed.
9. That the outcome of plastic surgical operations is not necessarily only a function of surgical skill, but usually is influenced by an amalgam of factors: the patient's perception of "the defect," its symbolic meaning (if any), his motivations for surgery, his expectations, and the actual physical result. More than once we have sat in the audience at plastic surgery meetings, watching slides of dramatically excellent surgical results being projected, only to have someone from the lecturer's hometown lean over and whisper, "that patient is suing him."
10. That there are certain situations in plastic surgery when psychiatric consultation is mandatory.
11. That certain body parts are more "psychologically loaded" than others.
12. That the recognition and understanding of patients' basic personality patterns can, in many cases, lead to the prediction of postoperative disturbances and better management of them when they do occur.
13. That simple, unsolicited reassurance, given to the right patient at the right time, can be one of the most dramatically effective of therapeutic tools.
14. That informed consent is more and less than it seems.
15. That there are effective ways for surgeons to cope with personal dissatisfaction.

There are many other conclusions we hope you will reach, but we will stop here, before the entire book is compressed into the introduction. We have learned a great deal in writing this book and in doing the studies which led to it. We think that what we have learned has made us better doctors. There is no reason that it should not do the same for you.

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Contents

PART I

SECTION 1
Beginnings

CHAPTER 1
The Ultimate Lesson

exemplary adj: *1a: serving as a pattern b: deserving imitation:* **commendable** ⟨his courage was~⟩ *2: serving as a warning:* ***monitory*** *3: serving as an example, instance, or illustration.*
Webster's New Collegiate Dictionary

On March 14, 1977, a stocky, greying 45-year-old man was shown into the office of Doctor Jésus Vazquez Añón, a respected Madrid plastic surgeon. In the dream-like motion of an underwater ballet, the man took out a pistol and fired it at Doctor Vazquez Añón and his two nurses until it was empty. Then he reloaded the weapon and fired again. Both of the nurses were killed. The doctor staggered out of the room crying for help. Later, he died. The murderer, holding the hospital staff and bystanders at gunpoint, backed his way out of the clinic into his car. As he drove wildly out of the city he smashed into a barricade. He died a few minutes later in a hospital where a knife was found taped to his thigh. The police found additional firearms in the nearly demolished car.

Jésus Vazquez Añón was, at the time of his death, in his late 40s. He had been trained in general surgery in Spain and in plastic surgery in England, where he served as Senior Registrar with Sir Archibald McIndoe. He had been head of the Department of Plastic Surgery of the General Hospital of the Spanish Red Cross in Madrid since 1972. He was well known in Spain for head and neck cancer surgery and was probably the most experienced Spanish craniofacial surgeon. He also carried on an active practice in aesthetic surgery, a field about which he evidently harbored some ambiguous feelings.

Doctor Ulrich Hinderer has written a moving and thoughtful article on the tragic death of Doctor Vazquez Añón and his two nurses (1). In preparing his paper Doctor Hinderer not only investigated Doctor Vazquez Añón's medical records of the murderer, who, as the reader will have guessed, was his patient, but also was able to interview indirectly the local doctor, the priest, and other inhabitants of the small village where the murderer lived.

Hinderer says that Doctor Vazquez Añón on "various occasions" had "expressed his concern about the multiple psychological problems of patients who consulted him for treatment." Hinderer says that Doctor Vazquez Añón was considering giving up aesthetic surgery altogether since he felt that "the majority of persons who requested an aesthetic surgical operation needed a psychiatrist rather than an aesthetic surgeon." At the time of his

death he was evidently at the point of drastically curtailing his aesthetic practice and devoting more time to reconstructive surgery, in general, and craniofacial surgery, in particular.

Doctor Vazquez Añón often refused to operate on patients in whom he detected psychological contraindications. He was happily married and enjoyed tennis and shooting. He loved horses.

The authors never met Doctor Vazquez Añón. Two slightly enigmatic quotations from Doctor Hinderer's article provide a fleeting glimpse of his character.

> In his office he was accurate and well organized. In meetings he always expressed his opinion frankly and critically . . . As far as his work was concerned, his deep and lasting admiration for his master, Sir Archibald McIndoe, whose influence guided all his future medical activity, and his good relations with other British plastic surgeons should be mentioned. As to his Spanish colleagues in plastic and aesthetic surgery, he maintained a position of independence.

Doctor Hinderer reveals little about the two murdered nurses other than that they had worked with Doctor Vazquez Añón for many years and "thought highly of him as a surgeon and as a person."

The murderer was 45 years old, a bachelor and a reasonably affluent landowner and farmer. There is some evidence that he was not overly bright. In the village where they lived the family was known as the "big noses." The murderer lived a semireclusive existence in an old house although he could have lived much more comfortably elsewhere. He had few friends and his "social preference was for cheap prostitutes."

His family history was revealing, to put it mildly. His father and two of his brothers were killed during the Spanish Civil War. A sister had given birth to two mentally retarded children. One first cousin murdered his 16-year-old girl friend and then committed suicide. Another first cousin shot a neighbor whom he suspected was responsible for his father's death. Another cousin murdered his wife. An uncle attacked a business rival with a gun.

Using the facts revealed by Doctor Hinderer's investigations, let's try to reconstruct this fateful doctor-patient relationship.

The murderer first consulted Doctor Vazquez Añón in 1976. He said he wanted a smaller nose and some improvement in breathing. He said that he had never married because of his nose and may have indicated that there was a woman he loved who would agree to marry him if the appearance of his nose was improved.

The preoperative photographs, which are reproduced in Doctor Hinderer's paper, show a middle-aged man whose large aquiline nose had a decreased nasolabial angle; a type not uncommonly seen in Spain. Although he was not handsome, he looked strong and virile. Doctor Vazquez Añón performed a rhinoplasty and submucous resection on the patient in March 1976. Postoperatively, the patient complained of breathing difficulties and a deviation of the nose to the left side. Doctor Vazquez Añón's progress notes apparently refer on several occasions to the patient's "psychological problems." On a visit 6 months after the operation, Doctor Vazquez Añón noted that the nasal bones showed "a left-side impression with simultaneous protrusion of the spina nasalis, creating the appearance of deviation."

In December 1976 the nasal bones were refractured. The right bone was moved medially and the left one laterally and the nasal spine was partially excised. The splint was removed on the 7th day and the result was recorded as satisfactory. The patient was discharged and apparently given no return appointment. In any event, the records show that he was not seen again.

Photographs taken after the second operation show a satisfactory result in profile view and some minor irregularities in frontal view.

On at least one occasion following the second operation the patient "insisted" on being reexamined by Doctor Vazquez Añón. It seems that the doctor's nurses "protected" him from this troublesome patient and prevented the patient from seeing him. The patient interpreted the nurses' behavior as mocking, and thought they were laughing at him as a "clumsy