

The symptomatology of abnormal appearance: an anecdotal survey

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Summary—From a systematic analysis of 54 anecdotal accounts written by patients with various abnormalities of appearance, a common pattern of experience has been discovered which is divisible into six parts: induction and development of self-consciousness, defence mechanisms, unavoidable distressing activities, downgrading of self-concept, difficulties with interpersonal relationships, and rationalisation. This scheme of symptomatology is presented as a basis for history-taking and as a base-line for future comparative studies of different types of abnormal appearance.

To the doctor, the importance of symptoms lies in their value as clues to a diagnosis of the bodily dysfunction which causes them. To the patient, symptoms are all important, being the distress and disabilities which reduce his quality of life. As there is no bodily dysfunction in a patient who complains of an abnormality of appearance, there is no diagnostic procedure for the doctor to follow prior to the exercise of surgical judgement for its treatment. The symptoms of abnormal appearance, which are all important to the patient, therefore hold little practical importance for the cosmetic surgeon. Or do they? Surgical judgement is the weighing of the distress and disabilities of a patient's symptoms against the limitations of a surgical procedure to correct their cause, taking account of the operative risks to the patient of performing it. In general surgical practice, the effectiveness of an operation can be measured in terms of its effectiveness in curing the bodily dysfunction which caused the symptoms, but in surgery for abnormal appearance this cannot be as there is no bodily dysfunction. How else, then, can the effectiveness of surgery for abnormal appearance be measured other than by describing the relief of the distress and disabilities which are the pre-operative experience of the patients who seek such surgery? Without a knowledge of the symptomatology of abnormal appearance, how can a plastic surgeon obtain a structured history of his patient's distress and disabilities? As a general rule, a given pattern of symptoms is caused by a specific pathological process. Is the symptomatology the same for

different abnormalities of appearance as, if so, its psychogenesis is likely to be the same as well. It is thus surprising that a structured account of the symptomatology of abnormal appearance has not been described previously.

This paper reports a preliminary investigation into the symptomatology of abnormal appearance, with the purpose of providing a base-line of understanding both for use as an aid to history-taking and from which the symptomatology of different abnormalities of appearance may be investigated and compared.

Method

Fifty-four post-operative patients who acknowledged the need of the medical profession to understand the suffering of a person with abnormal appearance, were asked to write anecdotal accounts of their experiences, as if explaining to someone else what it feels like to live with, for example, enlarged breasts. They were chosen to represent an age range from childhood to adulthood and a range of abnormalities from severe to minor. These abnormalities have been classified into 4 aetiological groups (Fig. 1):

- (i) Those resulting from congenital malformation.
- (ii) Those resulting from disease and injury.
- (iii) Those resulting from physiological processes such as ageing or reproduction.
- (iv) Those resulting from developmental disproportion.

Congenital malformations (14)	Physiological processes (6)
<ol style="list-style-type: none"> 1. Deep haemangioma of neck and face 2. Small naevus on neck 3. Incomplete unilateral facial palsy 4. Bat ears 5. Bat ears 6. Bat ears 7. Bat ears 8. Bat ears 9. Bat ears 10. Cleft lip/palate 11. Cleft lip/palate 12. Cleft lip/palate 13. Cleft lip/palate 14. Cleft lip/palate 	<ol style="list-style-type: none"> 1. Baggy eyelids 2. Facial rhytides 3. Abdominal striae 4. Ptotic atrophic breasts 5. Ptotic atrophic breasts 6. Ptotic atrophic breasts
Disease and injury (11)	Developmental disproportion (23)
<ol style="list-style-type: none"> 1. Tattooed arm 2. Skin graft on leg after excision of melanoma 3. Mastectomy 4. Mastectomy 5. Mastectomy 6. Mastectomy 7. Facial scars (trauma) 8. Facial scars (trauma) 9. Facial scars (acne) 10. Hemifacial atrophy 11. Unilateral facial palsy 	<ol style="list-style-type: none"> 1. Lower body lipodystrophy 2. Hypoplastic breasts 3. Hypoplastic breasts 4. Hypoplastic breasts 5. Hypoplastic breasts 6. Gynaecomastia 7. Hypertrophic breasts 8. Hypertrophic breasts 9. Hypertrophic breasts 10. Hypertrophic breasts 11. Hypertrophic breasts 12. Hypertrophic breasts 13. Hypertrophic breasts 14. Hypertrophic breasts 15. Hypertrophic breasts 16. Nasal disproportion 17. Nasal disproportion 18. Nasal disproportion 19. Nasal disproportion 20. Nasal disproportion 21. Nasal disproportion 22. Nasal disproportion 23. Nasal disproportion

Fig. 1 Abnormalities of appearance in 54 patients classified aetiologically. This series has a "patient key" to help understand the information given in Figs. 3–7.

From a systematic analysis of these accounts, most of which were very comprehensive, averaging 2,000 words, a pattern of experience has emerged which is common to all the patients and into which every described experience of every patient can be fitted. It is divisible into six parts (Fig. 2). The incidence of symptoms for each patient is illustrated in Figs. 3–7, where a black circle indicates that a symptom was described. It cannot be assumed that a blank space indicates absence of a symptom in that patient's experience, merely that the patient did not volunteer that he or she had experienced it.

The symptomatology of abnormal appearance

1. *Induction and development of self-consciousness* (Fig. 3)

Most patients were quite clear about the age at which they became self-conscious of their abnormalities. For patients with congenital malformations this was usually between five and six, and for patients with developmental disproportions, during early adolescence. Self-consciousness of abnormalities caused by disease and injury and physiological processes started at the time the abnormality was produced or developed.

Symptomatology of abnormal appearance

1. Induction and development of self-consciousness.
Self-criticism.
Criticism by others: overt—hostile teasing
friendly teasing
covert.
Mistaken identity.
2. Defence mechanisms
Camouflage techniques: posture, gestures
hairstyle, cosmetics
clothing
other.
Restricted lifestyle: occupational, social, domestic.
recreational.
Artificial behaviour.
3. Unavoidable distressing activities: Occupational, social,
domestic, recreational.
4. Downgrading of self-concept. Secrecy.
5. Difficulties in interpersonal relationships: with friends,
strangers, opposite sex, spouse, doctors.
6. Rationalization.

Fig. 2 Symptomatology of abnormal appearance.

Some patients were aware of the abnormality before actually becoming self-conscious of it. Induction was caused either by a self-conceived realization that the abnormality existed or, more frequently, by another person commenting on its presence. A similar abnormality in a parent seemed to heighten a subject's susceptibility to become self-conscious of his/her own abnormality.

Self-consciousness was reinforced after induction both by self-criticism and by the experience of critical attitudes shown by others.

Self-criticism consisted of the subject comparing his or her own appearance with that of others normal, either in life, or illustrated in magazines, posters, films or television. Subjects tended to take an unusual interest in the appearance of other people's features of which they were self-conscious "endlessly searching for a nose worse than mine".

Critical attitudes of others can be divided into those of an *overt* nature, namely hostile and friendly teasing, and those of a *covert* nature. *Hostile teasing*, often with the allocation of nicknames, was reported mainly by patients during their primary and secondary schooling and was principally suffered by patients with congenital malformations and developmental disproportions. *Friendly teasing*, jokes at the subject's

INDUCTION AND DEVELOPMENT OF SELF-CONSCIOUSNESS

Ind. HT FT CC MI
Ind. HT FT CC MI

1	●	●	●	●	●
2	●				●
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4	●	●	●		
5	●	●	●		
6		●			
7	●	●			
8		●			
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10	●	●	●		
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12	●	●	●	●	
13	●	●		●	
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21	●			●	
22	●		●		●
23	●	●		●	

Fig. 3 Incidence of symptoms anecdoted by 54 patients. Ind=induction; HT=hostile teasing; FT=friendly teasing; CC=covert criticism; MI=mistaken identity.

expense, leg-pulling by members of the subject's family, and isolated remarks by passers-by, especially children, were experienced by patients from all aetiological groups and, although said without malice, had an equal effect as did hostile teasing on the further development of self-consciousness.

Covert reactions and comments from others—that is the subject's awareness of being stared at and the over-hearing of remarks made behind the subject's back—also served to reinforce self-consciousness. For example, "If you look weird, then other people look at you. They can't help it." "I always noticed people's eyes staring." "Some of my most embarrassing moments were being an adult amongst children who hadn't seen me before. They used to stare at my flat nose and cleft lip."

A further factor in the development of self-consciousness was that of *mistaken identity* either of the feature itself, which was not recognised by others for what it was, or because the disfigured feature in question labelled the subject as someone of a different character or type from that which he or she really was. For example, the "Jewish" nose, the naevus on the neck which was mistaken for a fly and the patient with baggy eyelids who looked tired. One patient with a deep haemangioma of the side of the neck and lower face wrote, "If you have a hare-lip or a big nose, or an arm or leg missing, people can see what is wrong with you. With my disfigurement it gets mistaken for so many things. I think that is why people stare, they don't know what it is. Blackberry season is always a bad time for me. Everywhere I go, people stop me in the street and say I've got blackberry stains all over my face. A boy was told off by his dad for playing with me as, by the look of my mouth, I had a bad heart."

2. Defence mechanisms (Fig. 4)

An important realisation that has emerged from this study is the lengths to which subjects will go to hide their abnormalities from the sight of others and to disguise their self-consciousness of them. This self-protective behaviour is the subject's defence mechanism, which can be divided into three headings.

(a) Camouflage techniques

Subjects often developed certain *postures* and *gestures* to hide their abnormalities. Thus, subjects with hypertrophic breasts developed a

round-shouldered stance and sat with their arms folded; subjects with disproportionate noses avoided their profile views to others; subjects with most types of facial abnormalities held a finger to the face to cover it, or hung the head and avoided the other's eyes when talking to someone. Those with facial palsy avoided smiling.

Hair was styled to hide an abnormality such as bat-ears, facial palsy and facial scars, or to disguise an abnormality such as a disproportionate nose. Similarly, cosmetics were used either to hide or disguise facial scars, facial rhytides and disproportionate noses.

Clothing was chosen to camouflage abnormalities of the trunk and limbs. For example, subjects with disproportionate breasts (hypertrophic and hypotrophic) tended to choose loose fitting jumpers which they wore in all seasons; they avoided bikinis and they often avoided nudity in front of others, including husbands.

Other camouflage techniques included intentional obesity to minimise the obviousness of hypertrophic breasts, walking at the rear of a group, avoiding brightly lit places (especially with fluorescent lighting) and the regular one of sticking plasters and bandages to hide naevi, skin grafts and tattoos.

(b) Restrictions to lifestyle

Subjects from all groups restricted various aspects of their lifestyles to avoid those situations which they had learnt from experience to be embarrassing. These activities can be divided into occupational, social, domestic, recreational and other.

Occupationally, several children played truant, or feigned illness to avoid going to school and one adult stopped going to work.

Many patients described how they withdrew from social activities or, if they went, would sit in a corner or away from bright lights. They avoided mixing with strangers, or kept their views to themselves, or left the room if the subject of their abnormality was raised in conversation.

Domestically one patient was so self-conscious of his facial scarring that he avoided answering the front door and spent much of his time in bed.

Recreationally, patients with bat-ears avoided windy conditions and getting their hair wet;

DEFENCE MECHANISMS

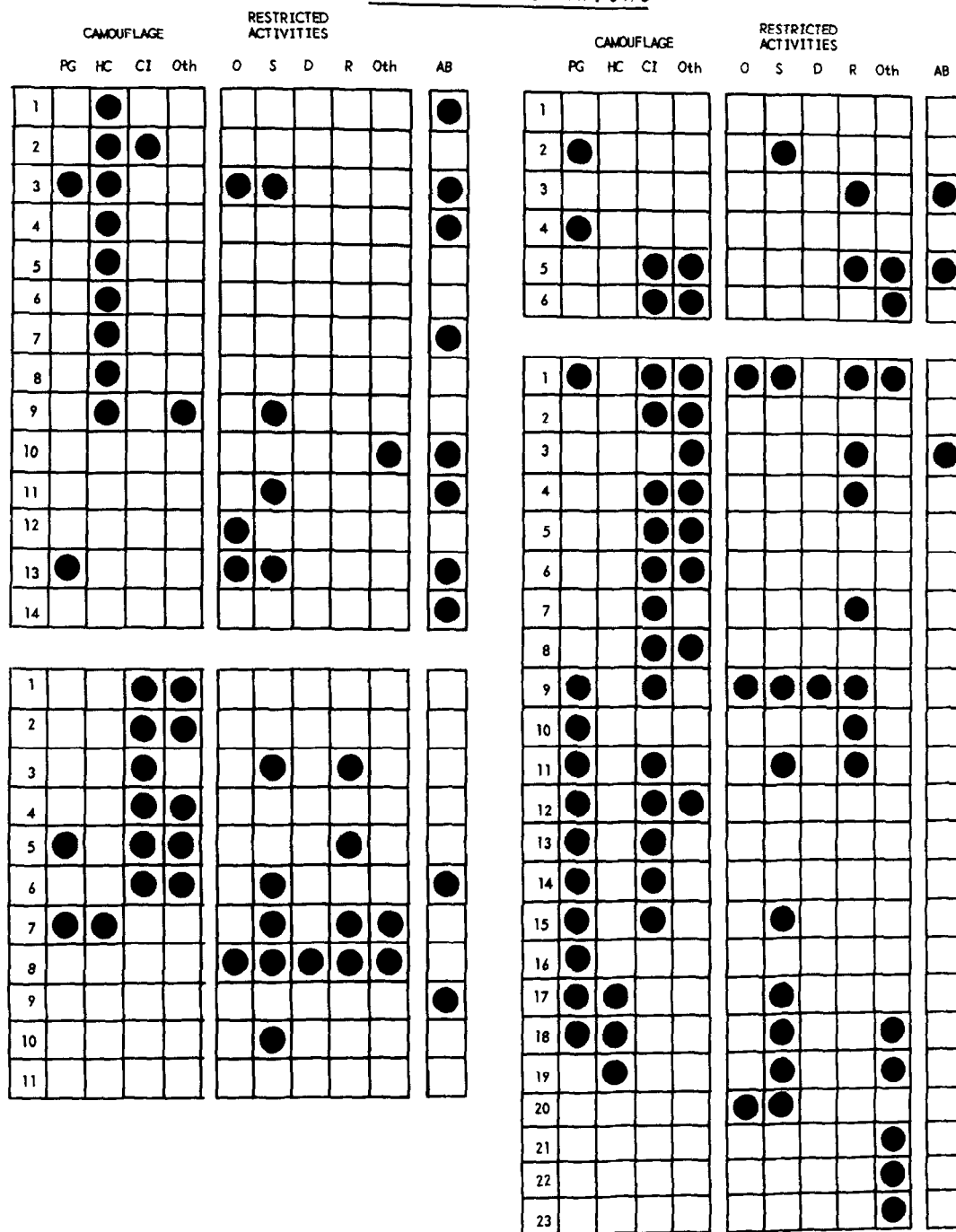


Fig. 4 Incidence of symptoms anecdoted by 54 patients. PG=posture, gesture; HC=hairstyle, cosmetics; CI=clothing; Oth=other; O=occupational; S=social; D=domestic; R=recreational; AB=artificial behaviour.

those with breast abnormalities variously avoided communal changing rooms, public showers, swimming, sunbathing, running, dancing, visits to the beach and gave up playing badminton.

Other activities which were avoided included being photographed, looking in mirrors, and shopping in department stores for clothes, often preferring the privacy of home-buying from catalogues.

These self-imposed defence mechanisms caused distress:

"I seemed apart from the world, living a sham life—a life of pretence and always fearful lest someone should find me out."

"From the outside all looked normal, but inside of me was in a turmoil."

"I felt I couldn't do the things normal people do."

"If it was windy I couldn't go out, I spent the day shut up in my room, tormenting myself."

(c) Artificial behaviour

Being that which the subjects adopted in order to minimise the distress of overt comments and to disguise from others the extent of their self-consciousness, was described by about half the patients. The following examples are representative:

"The only thing I wanted to do was hide away."

"I built up a guard around me for protection, appearing less than friendly."

"I became very promiscuous as a way of getting affection."

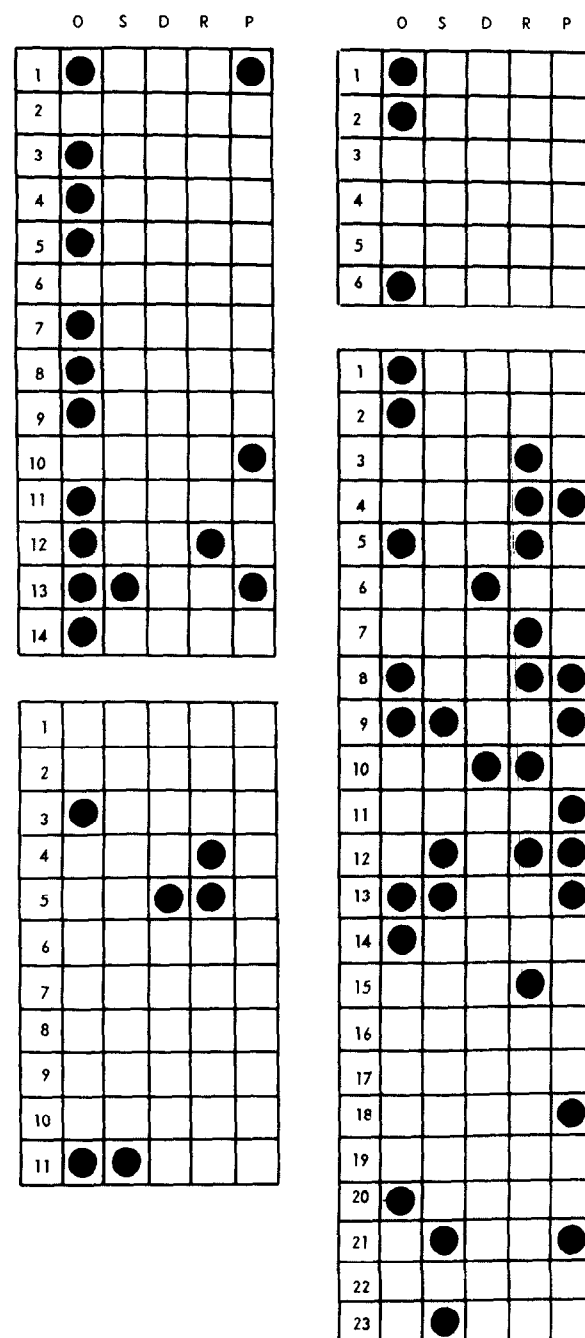
"Which way to behave—I was either overacting or not enough. I rebelled against myself which was anorexia nervosa—it was a way of cutting myself off from society."

"Whenever women's figures were mentioned in casual conversation, I would always make a disparaging remark against myself, preferring to laugh at my shortcomings rather than have the humiliation and heartbreak of someone else making fun."

"It hardened me into a little tough guy."

"Being a member of the boys seemed to help. But soon enough it got me into serious trouble."

UNAVOIDABLE DISTRESSING ACTIVITIES



into occupational, social, domestic, recreational and other.

Most children described the distress of having to go to school where they suffered hostile teasing and were required to take part in school activities which they found embarrassing, such as organised sport and physical education. The following quotations indicate the depth of their distress:

"Life at school was hell. Each day was a torment for me."

"School life was miserable. I used to come home from school very depressed and foul-tempered."

"There was always tomorrow to face."

Occupational distress was also described by two patients whilst at college, by a publican and by three school teachers.

An example of distressing social activities was given by a patient with breast hypertrophy whose husband was required to mix socially because of his job. She wrote "These occasions became a nightmare for me, always feeling dowdy and poorly dressed." Others described walking into social situations expecting derision, being embarrassed if the centre of attention and hating going where there were a lot of people.

Amongst distressing domestic activities the most commonly described was the need to answer the front door before appropriate steps could be taken to camouflage the abnormality, and the distress of sexual relationships for women who were self-conscious of sexually unattractive features, particularly hypoplastic breasts and lax abdominal skin.

Of the recreational activities, those that caused most distress were visits to the beach for women with abnormal breasts. For example:

"I used to dread the summer, with thoughts of going to the beach."

"On the beach I would wish that the ground would swallow me up. Holidays I used to find a nightmare."

Other activities mainly concerned those which placed the subject in the public eye, such as going into town, meeting children in the street, shopping for clothes and particularly lingerie, visiting the hairdresser and sitting next to or opposite someone on public transport. Such activities were described as "embarrassing", "an ordeal", "a harrowing experience". As one

patient wrote, "I always felt uneasy and afraid people would make fun of me."

4. *Downgrading of self-concept* (Fig. 6)

About two-thirds of the patients described feelings of inferiority, unattractiveness, lack of self-confidence, insecurity, loss of femininity and being unlovable. They are illustrated by the following extracts:

"I began to feel very unsure of myself because of my ageing and unprepossessing appearance."

"I felt old and unattractive, unfeminine, I had a huge inferiority complex."

"I had intense feelings of inferiority, it was like a degradation and it permeated everything I did."

"I felt insecure, afraid of what people might think of me."

"I lacked the confidence to be a winner—always being content with second or third place."

Most patients concluded their accounts with descriptions of the changes that had occurred following their operations and the most commonly described benefit was an improvement in self-confidence. By inference, these patients experienced a lack of self-confidence as a direct result of being self-conscious of their abnormalities.

Secrecy, seemingly a product of the downgraded self-concept, was a problem for many patients who described how afraid they had been to tell others of their self-consciousness and distress. Thus:

"I would never have told anyone, I was far too ashamed."

"I was too inhibited to ask for advice."

"I was just too shy and insecure to admit publicly how much it meant to me."

5. *Difficulties with interpersonal relationships* (Fig. 7)

Can be divided into those with friends, those with strangers, those with members of the opposite sex, those with a spouse and those with the doctor.

Broadly speaking, difficulties in making friends was the experience of patients with congenital malformations during their primary school years, whilst difficulties in relationships with strangers was a symptom of adults. As would be expected, difficulties with members of the opposite sex

SELF-CONCEPT, SECRECY

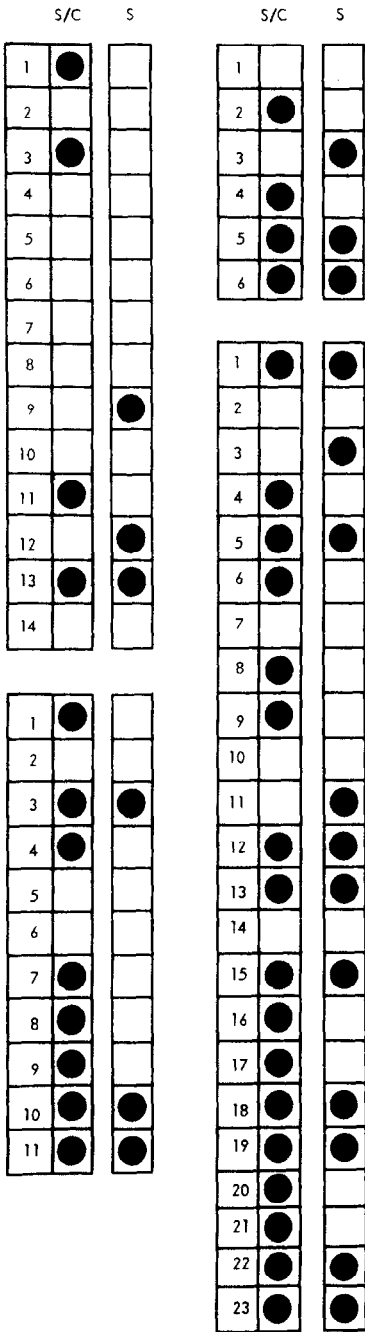


Fig. 6 Incidence of symptoms anecdoted by 54 patients. S/C = self-concept; S = secrecy.

DIFFICULTIES WITH INTER-PERSONAL RELATIONSHIPS

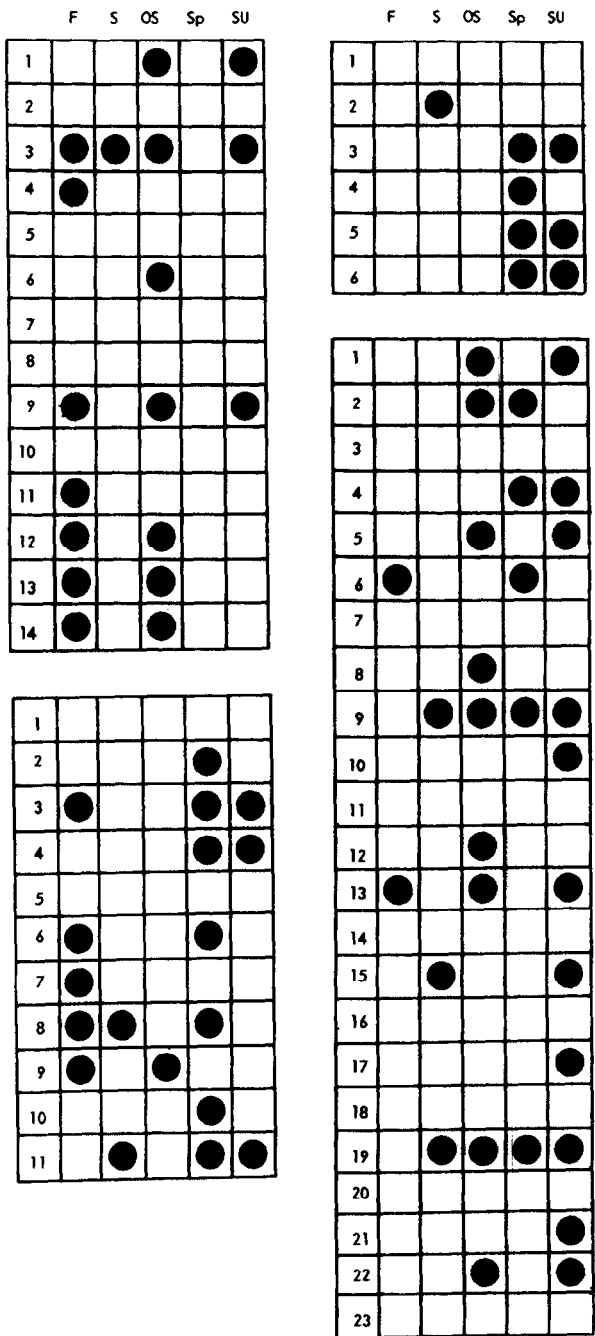


Fig. 7 Incidence of symptoms anecdoted by 54 patients. F = friends; S = strangers; OS = opposite sex; Sp = spouse; SU = lack of sympathy and understanding.

were experienced by teenagers. Several patients whose abnormalities of appearance were obvious to others, described anxieties that they were an embarrassment to those who they were with. For example, a patient with breast hypertrophy wrote: "It is simply not possible to make a good relationship if you feel that you are an embarrassment to the other person." And from another patient: "Comments from others obviously put a strain not only on me, but on the person I was with."

Difficulties in marital relationships and particularly sexual relationships with a spouse were commonly described by patients with abnormalities of the breasts, for two reasons. Firstly, because they felt themselves to be sexually unattractive, and secondly, because they felt insecure as a result of their unattractiveness. This led to almost obsessive anxiety in some patients if the husband showed interest in the appearance of other women, either in real life, or pictured in a magazine or on television. They described a deterioration in their sex lives, either because the husband was repelled by his wife's appearance, or, more commonly, because the abnormality became taboo in sexual foreplay and, if touched, further progress towards intercourse was abandoned. Several marriages had broken up as a result.

Subjects described two aspects of the doctor-patient relationship. First the degree of sympathy and understanding shown by the doctor: more patients found that their doctors were sympathetic rather than unsympathetic, and this often surprised them. Second, subjects commonly described how embarrassed they were to talk to doctors about their problems. For example:

"Having to approach my own doctor before being put in touch with the surgeon did prevent me from having treatment earlier. I put it off again and again because I couldn't summon up the courage to approach him. I was sure that he would treat my request with contempt or ridicule and possibly suggest that I see a psychiatrist."

"When I went to see my doctor I was very embarrassed as I thought she might tell me off for being so vain."

"My doctor kept prescribing anti-depressants for me, but I couldn't pluck up the courage to tell him why I was getting depressed."

A recurring theme throughout this study was the lack of sympathy and understanding which

these subjects experienced and, indeed, it was the principal motive which prompted them to contribute their accounts. Thus:

"I found no one to share the problem with and no one to sympathise with me."

"If you haven't had a disfigurement it's very hard to understand a person who has."

"Few people understand what it is like to *feel* physically deformed."

6. Rationalisation

Many subjects described how they had tried to rationalise their feelings about their abnormalities of appearance, but without success. That they should be able to do so seems to be a fairly common attitude amongst those who are not disfigured (which is probably due to the general lack of understanding of just what it *is* like to live with an abnormality of appearance).

A patient with facial palsy wrote: "I tried to put it to the back of my mind, but it is harder to do than people realise. I know there are a lot of people worse off than me, and I keep trying to tell myself that, but it doesn't help."

And from a patient with breast hypertrophy: "However hard one tries, one can't overcome such feelings with an act of will."

And from a patient with cleft lip and palate: "I remember asking my Mum why was I born like this, why me and not them."

The following abridged accounts have been selected to illustrate the comparable experiences of five patients whose abnormalities of appearance represent the four aetiological groups.

1. Congenital malformations

"I was born with a hare lip and cleft palate and although the disabilities which accompany this are very slight, it has caused me many unhappy and frustrating moments over the past 18 years. When I was three or four years of age I attended play school. This I thoroughly enjoyed. I think this was because the other children did not notice or even care what I looked like. On my fifth birthday I was quite looking forward to going to primary school. There was going to be a rude awakening for me. When I arrived there my life was hell. I never thought the other children could be so cruel and nasty. Each day was a torture for me. I tried very hard to mix, but I was an outcast. I knew I was different, but I did not expect to be so cruelly abused. For years this went on.

They made fun of my appearance and also of my speech in my primary and junior school. I said nothing to my parents about school. Then it all began to get on top of me. I started to make excuses not to go to school, pretending to be ill. It was not long before my parents realised something was wrong because I was acting in such an unusual manner. They tried to make me realise I was no different from anyone else. It did not make any difference. I still felt an outcast and inferior. I was ashamed of my appearance and the way I spoke. Years passed. Life at school, as well as outside, was still rough. By now, as I grew older, I did not take so much notice of the crude remarks. I tried to ignore them, which was not easy. I was slowly accepted and I worked hard. My parents never pressurised me. It was myself who was pushing me. My social life had pretty well deteriorated—I only ever went out with my parents. This was either to the beach or to town with my Mum. It was a very rare occasion that I would go to town myself or to a disco and I was usually persuaded to go. Wherever I went I always felt I was being watched and talked about and that people were laughing at me. There were certain feelings in me. I felt insecure and also out of place. All I wanted to do was hide. I could never seem to act naturally. It was a case of either overacting or not enough."

2. *Disease and trauma*

"After ten years of living with and never accepting the mutilation of my breasts, plus the accompanying misery, the normality of my appearance is still intoxicating and it is a struggle to make myself remember and to relive that painful time. After the fourth operation for the removal of breast cysts, during which the surgeon removed all tissue to prevent any further trouble, I ventured to remark tentatively that my husband found my appearance repulsive. He replied, 'We'll have to do something about that,' but he never again mentioned the matter and I was too inhibited to mention my distress or to ask for more advice. My husband avoided me and finally destroyed what had been a very happy marriage, forming a liaison with a young married woman. This was followed by a long period of severe distress for me, leading to two years of medical care and supervision, sedatives, tranquillisers and the loss of 34 lbs weight until I weighed 6 stone 3 lbs and looked like an insect.

"My breasts, which had had little substance before this loss were now almost flaps of skin. I was becoming neurotic to even look at my body without bringing on periods of prolonged weeping and I was adopting a pattern of life which led me to total withdrawal from society. I was becoming desperate about my appearance, feeling a non-person and without self-confidence. I was in a continuous state of depression and anxiety. At this stage I should like to say that cosmetic surgery should not ever be regarded as frivolous or vanity, although vanity as an expression of self-esteem is psychologically good."

Most patients went on to describe their experiences after surgery and this part of the account often contained information which supplemented the description of pre-operative distress. This patient went on to write:

"Since the restoration of my breasts I have started to take part in activities I have shunned for years. I have joined a health club, taken swimming lessons and regularly visit the sauna. My clothes hang beautifully and I sunbathe and wear a bikini without embarrassment. Most important of all, I no longer feel the guilt and shame of being untouchable. The bitterness of rejection which was a constant factor in my life has left me. I feel a complete and whole woman, and that could never have happened but for the operation which has restored me to normality. I do wish that doctors would understand the real need people have for this kind of help. I am sorry to have to ask for anonymity. I should like to cry from the housetops but my doctor's attitude mirrors this puritanical society."

3. *Physiological processes*

"For several years prior to undergoing plastic surgery, I had suffered from the effects of the ageing process. I suffered in two distinct ways. Firstly, with regard to the obvious physical changes to my appearance, about which I worried constantly, and also in respect of what I can only describe as considerable distress on a mental basis. I found myself becoming reluctant—almost afraid! to meet people—especially new clients and business colleagues. I felt that as the head of a flourishing company I should present a dynamic, confident personality, but as time went on I began to feel very unsure of myself because of my ageing unprepossessing appearance. I developed mannerisms calculated to try and disguise

certain features, such as constantly placing my fingers over the corner of my mouth where I knew the indentations were deepest. I also began to 'lift' my eyebrows as high as possible in an effort to mitigate the drooping eyelids! I refused invitations to dinner whenever possible, and as time went by I found myself retreating further and further into an anti-social environment. My mental state was extremely low—a situation that worsened as time progressed.

"Finally I underwent cosmetic surgery for—in layman's parlance—a 'face-lift'. The result was immediate and startling! With a tightened jawline and 'opened' eyes, my appearance was changed beyond my wildest expectations, but what was equally important to me was the realisation that my confidence and self-esteem had been restored. All my old ebullience returned, together with the ability and eagerness—to meet people again!"

4. *Developmental disproportion*

"I began to develop breasts when I was ten and a half and by the age of twelve was clearly larger than all my classmates and also larger than most adult women. The periodic teasing, or outright hostility that children of that age practise simply confirmed this. I was intensely embarrassed and ashamed. I rarely talked to anyone about how I felt, not even my mother since it seemed to me that I must have large breasts as some kind of punishment. Early in my teens I developed a personality which enabled me to hide as much of my embarrassment as possible. I even became someone who did not like the sun, so as to avoid going swimming or sunbathing. I became a very untidy and sloppy dresser and wore baggy clothes so as to hide my breasts. I became very promiscuous as a way of getting some affection but these relationships never developed very far beyond sex since I was too ashamed of my defect to expect anyone to take me seriously. It was very difficult to buy clothes. I don't think that I was ever unaware of my appearance, even for half a second. I never once relaxed and forgot how I looked.

"I had a breast reduction ten months ago. My life is completely different now in many ways, some of them predictable, others not so. It feels like having my body back after fifteen years of having lost it. This is no exaggeration. Suddenly I discovered that I did not feel angry with the world any more. I felt grateful for being alive, instead of irritable and jealous and ungrateful.

Nowadays I laugh a lot and I love people more. I feel more confident, I no longer walk into social situations expecting derision. My life is not dominated by a self-consciousness about my body. Femininity is now open to me as it never really was before. It is simply not possible to make a good relationship if you feel that you are an embarrassment to the other person and that you are not really attractive to them. It is so wonderful just to be able to lead a normal life, to sunbathe in the garden, discuss holidays, wear ordinary summer clothes and so on. I am still discovering all the different things that have been closed to me for years. I wish now that I had had the operation when I was much younger, but at that time I had not explored all the other possibilities and I had not learnt that however hard one tries, one cannot overcome such feelings with an act of will. I was concerned before the operation that I might afterwards simply attach the same feelings to some other part of me. I think this is one of the widely held misconceptions about plastic surgery. I didn't. My biggest problem in life has been solved permanently."

5. "At the age of nine I loathed my nose and avoided any side profile stances, especially photographs, and felt most self-conscious if I had to wear my hair in a ponytail; this fear developed into habits of burrowing my face in my shoulder when talking to strangers and holding a finger over my nose as if stroking it. Later on I was subjected to jokes and unkind nicknames which undermined by confidence severely, so much so that I became unable to speak in public for fear of people staring at me. During early adult years I experimented with cosmetics to over-emphasise my eyes and minimise my nose and this proved fairly successful in boosting my self-esteem and stemming further fears. However, on reaching the ripe old age of 33 and experiencing the stresses and strains of life generally I suddenly noticed my face becoming leaner, resulting in a more pronounced and prominent nose. Once again the Jewish jokes began and the feelings of self-consciousness were reawakened. I then felt that if I did not do something soon it would become more obsessional and no way could I face the future years with the mental hang-ups which would get worse as I got older.

"The happiness I feel now is beyond words—little things like choosing a new hairstyle, or

catching a reflection of myself is a pleasure. I like what I now see, and like myself much more. This is giving me a new-found confidence and self-assurance, lacking previously, and which is needed being in my own business and leading a busy life-style. I am quite able to face a crowd of people easily and naturally, and I look forward to the future with an inner happiness that serves to make my family happy too."

Discussion

This six-part scheme reflects the collective experiences of 54 patients who have had various abnormalities of appearance dealt with surgically. The choice of post-operative patients was two-fold; firstly, they would not be tempted to overstate their experiences with a view to influencing surgical judgement, and secondly, they would be in a better position, from hindsight, to distinguish those distressing experiences which were the direct result of their self-consciousness from those which were not. Inevitably there was some selection in the choice of patients who were asked to contribute to this study, but this is inconsequential, bearing in mind that the purpose of the study was to establish a comprehensive base-line of symptoms from which further comparative studies of a non-selective nature could be undertaken. By and large these accounts were unprompted and all were written spontaneously. It can, therefore, be assumed that this description of the collective symptomatology of abnormal appearance is factual and realistic. The order of symptoms described in the patients' accounts varied widely. The order presented in this paper reflects the author's concept of their psychogenesis which has been developed during the course of this study. Thus, self-consciousness of an abnormality is induced by a specific experience, often at a time in life when self-awareness is heightened (when starting school and during early adolescence). Self-criticism and criticism by others reinforces the induced concept of abnormality and leads to a development of self-consciousness which may become a constant feature of the subject's life. The defence mechanism is a reaction to this self-consciousness and is a measure of its degree. Self-consciousness, which is further reinforced by the need to exercise defence mechanisms that are often distressing in themselves and the day-to-day experience of unavoidable distressing activities, leads the subject to recognise the social and competitive disad-

vantage of having abnormal appearance and causes a downgrading of self-concept. All this interferes with his ability to interrelate normally with others and makes him secretive about what he sees as a weakness of his identity. He attempts to rationalise these disabilities and the associated distress but finds that he is unable to do so.

Because the symptomatology for each patient is probably incomplete no comparative conclusions can be drawn from the data shown in Figs. 3-7. These figures are presented firstly to complement the description of symptomatology and secondly to show that the various symptoms are fairly evenly distributed throughout the series and show little bias for the various abnormalities of appearance that have been studied. This is important, for it suggests that the psychogenesis of symptoms in patients who were treated for gross disfigurements (mainly resulting from congenital malformations and disease and injury) is the same as that in patients who were treated for aesthetic disfigurements (mainly those resulting from physiological processes and developmental disproportions), and that the two groups of disfigurement cannot be regarded as separate aspects of abnormal appearance. The author has hypothesised that the factors which determine whether or not a subject becomes self-conscious of an abnormality of appearance are circumstantial and constitutional and that the constitutional factor could be the subject's aestheticity—his innate sensitivity of aesthetic perception (Harris, 1982). The results of this study lend credence to this hypothesis.

Note

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