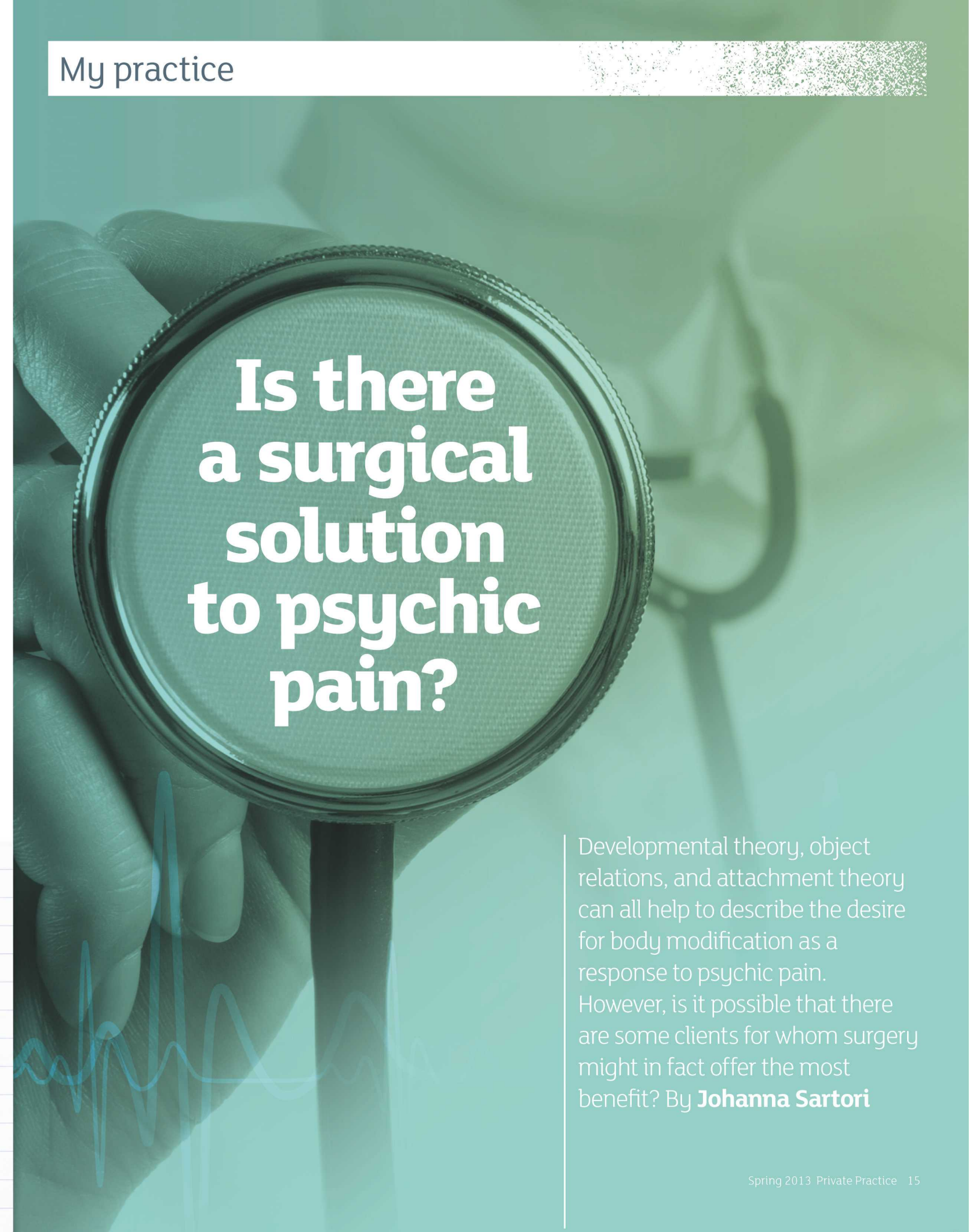




Is there a surgical solution to psychic pain?

Developmental theory, object relations, and attachment theory can all help to describe the desire for body modification as a response to psychic pain. However, is it possible that there are some clients for whom surgery might in fact offer the most benefit? By **Johanna Sartori**

My practice

During 2012 the majority of my work in private practice was with depression, anxiety, relationship problems, and bereavement. However, whilst these were the presenting issues, body image, eating patterns, and weight were all subjects that were also figural for many of my clients, echoing Susie Orbach's view that 'eating problems and body distress now constitute an ordinary part of everyday life for many people'.¹ And it's not hard to see why. Here is a small selection of the now daily headlines which demonstrate our obsession with appearance: 'I've put two stone back on, says Dieter Dawn'; 'I may be striking but I'd rather be pretty'; 'Wobbly arms: the latest on our list of body image worries'.⁴

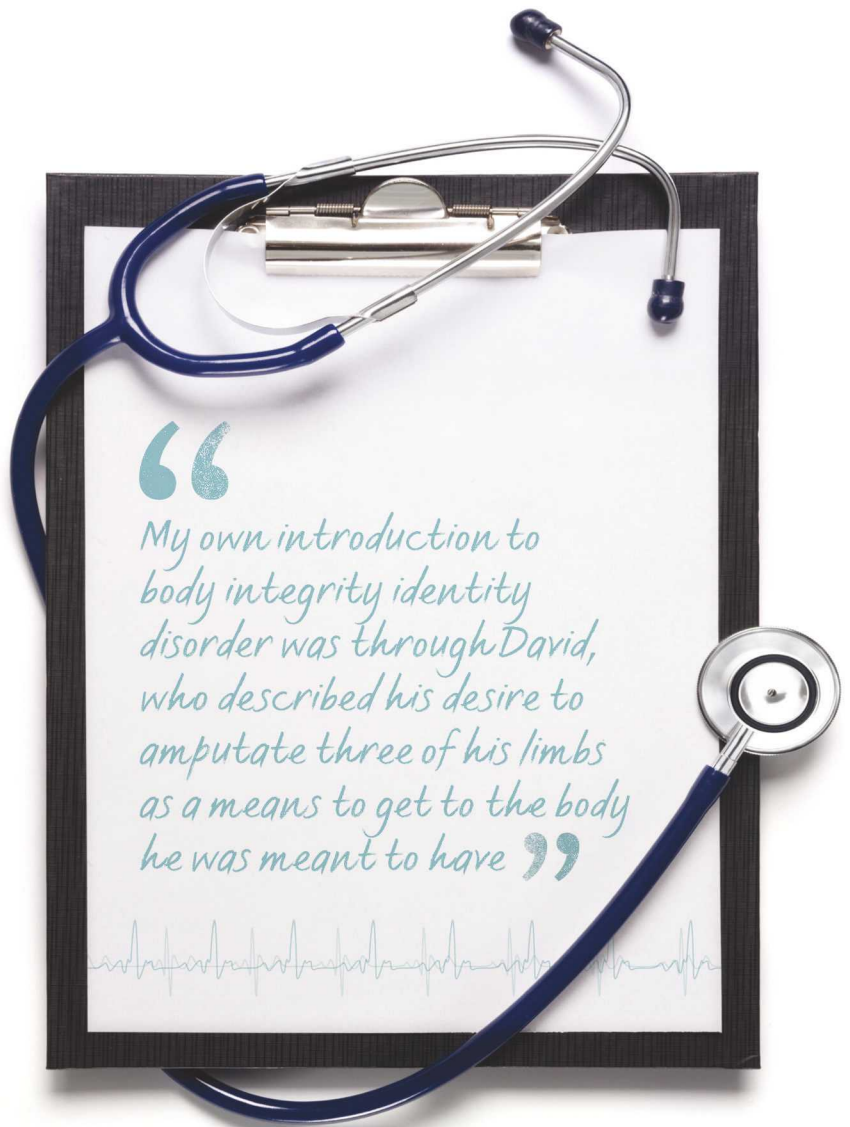
Such headlines reflect the fact that cosmetic surgery in the UK has increased year on year, at a rate of five to six per cent⁵ since 2009 (despite the corresponding downturn in the economy), with the newest procedure promising to change the look of a woman's labia. Television programmes currently reflecting the cultural obsession with outer appearance include *Baby Beauty Queens* and *Boob Job: My Big Decision* (on BBC3 alone), whilst makeover TV shows such as *10 Years Younger* are no longer content with dispensing fashion advice, but provide facelifts and cosmetic dentistry as standard. Even my own blog shows me that the most frequently read articles are the ones with the tag 'body image'.

It seems clear to me that the desire and increasingly the ability to change the way we look is both a common and shared experience. As the prevalence of body dissatisfaction inexorably rises, I was keen to revisit my understanding of the aetiology and to ask: Do I need to rethink the way I work with such clients?

Body image and early attachment

Alessandra Lemma has written extensively about her work in this area, both in *Therapy Today*⁶ and in her book *Under the Skin*.⁷ For Lemma, body issues represent the privations in our earliest relationship: 'Our experience of our body is fundamentally shaped by the quality of our relationships with others and, more particularly, whether through our earliest exchanges with others we internalise an image of ourselves as desirable.'⁷ The earliest exploration of what is self and other, where I end and you begin, and what is reflected back in a mother's face, provides the background against which a positive sense of body is nurtured or thwarted.

Echoing Winnicott's concept of the need to be able to 'go on being'⁸ or else face annihilation, Lemma argues that the baby learns to organise himself through understanding that he can arouse his mother's desire, that he can, at times, solicit her gaze, and hold her attention. If this is not experienced, particularly in the early months, the baby's perception that he is not desirable and therefore cannot solicit care becomes rooted in the body. There is a self-rejection of this body, which is not enough to engage another, and the need to improve and perfect it is born. In this way, physical enhancement and perfection becomes the quest by which the fragmented and fragile internal world can become organised. Lemma calls this need to perfect in order to be seen, the 'perfect match phantasy',⁷ but suggests that it does not always lead to actual surgery and that psychotherapy can be an effective way forward.



However, for some body dysmorphic clients, physical dissatisfaction is focused on a particular feature(s) and large amounts of energy are diverted towards covering up or hiding the perceived flaws, often leading to dangerous self inflicted 'treatments' such as the use of sandpaper or bleach on skin. The overwhelming affect of body hatred in this group of clients is pervasive and adversely affects their functioning in the world, their ability to relate to others, and thus the effectiveness of therapy. Surgery is strongly believed by this group to be the only thing that will render their body acceptable.

A third group broadly identified by Lemma typically experienced their mother as a distorting mirror; that is, a mother who brings her own unresolved body dissatisfaction to the mother baby dyad, projecting what she cannot bear about herself into the baby. ('Mother and daughter bond over plastic surgery as they go under the knife "holding hands through the whole thing"'.⁹) Thus not only does the baby experience himself as undesirable, but also internalises hostility, an ugliness which must be cut out, changed or corrected if he is to become desirable. Surgery, self harm and eating disorders can all be a response to this situation. Lemma suggests that once surgery has been embarked on, therapy is again less likely to be helpful, and that the need to cut and change can lead to more and more surgery rather than acceptance.

There is a final group of clients for whom body modification is an attempt to separate, to differentiate from a mother who was too invasive, who did not allow body and self to develop as separate from her. This is the 'reclaiming phantasy'⁷ and its roots are found in the dilemma of both separating to grow, whilst still staying connected to the safety that is mother. Piercings, tattoos and surgery can all be used to ensure a very visible difference to mother, as well as being a way to reclaim the body for oneself. Gianna Williams identifies a similar need to reclaim the body and block projections in her work with eating disorders, describing it as a 'no entry quality'.¹⁰ She vividly illustrates this with the case study of Natasha who would literally block her ears, eyes and nose, breathing through only a small gap in her lips, in an attempt to block a delusional fear of invasion by fleas. I would suggest that the need to defend against another's intrusion in such a way makes a therapeutic alliance difficult to establish.

Lemma draws on developmental theory, object relations, and attachment theory to describe body modification as a response to psychic pain. These are theories that inform my own work with clients and which make sense to me. However, Lemma acknowledges that surgery might benefit some clients, whilst for others therapy will have little or no impact. With this in mind, is it helpful as therapists to recognise our limitations and explore the value of alternative approaches? Expanding this thought, I would like to raise the possibility that there are some clients for whom surgery might in fact offer the most benefit.

Body integrity identity disorder

In 1997, Robert Smith, a surgeon at Falkirk and District Royal Infirmary, amputated the lower part of a healthy limb of an English patient. He did the same in 1999 for a German patient before permission to operate on a third was denied. All three men were suffering from what has been known since 2004 as body integrity identity disorder (BIID), in which the sufferer desires the amputation of one or more healthy limbs. There

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is anecdotal evidence that such a desire has been present in individuals for hundreds of years with the first recorded case in the late 18th century.¹¹ Following a number of attempts at classification since the 1970s, BIID was finally proposed for inclusion in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), and will appear as the only example under the category 'Other Specified Mental Disorder'. Whilst this is a residual category and does not allow for recognition of BIID as a distinct diagnosis, it will mean that an International Classification of Diseases code 10 (ICD-10) can be assigned to treatment, enabling the NHS to recoup centrally funded costs and US medical institutions to bill insurance companies.

BIID typically begins in early childhood, and because of the incomprehensibility for most people, it is felt by its sufferers to be a source of shame, and something that cannot be shared. Isolation and depression are therefore common associated feelings and clearly there is a positive role for therapy to be played here. I would hope that inclusion in DSM-5 might lead to a wider knowledge of BIID so that sufferers might at least find it easier to share their feelings with a professional. In the meantime I have struggled to find a volume of work that reflects solid experience of working therapeutically with BIID, possibly because of such isolation making therapy difficult to contemplate.

My own introduction to BIID was through David (not his real name), who described his desire to amputate three of his limbs as a means to get to the body he was meant to have. He did not like his (as he saw them) superfluous limbs, but did not regard them as ugly in the way that Lemma describes the feelings of body dysmorphic clients. A study¹² by Professor Michael First of 52 BIID 'amputee wannabees' found that only one was motivated by feelings of ugliness. Sixty-three per cent of participants concurred with David that amputation would restore them to their own identity.

Although David had told me ahead of our first session of his BIID, and I had gained some idea of what this meant, I was unprepared for my very physical reaction to hearing him describe his desire for amputation. I am aware of my own body

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as a source of power and autonomy (I can literally walk away), and how important this is to me. To be in a room with David, and to listen to his desires, impacted my sense of ownership of my body. The lack of limb(s) that I took for granted was suddenly a tangible possibility, which I could only conceive of as a catastrophic loss.

At the same time, I felt very alone in working with David. I had no theory to draw on, very little written work to which to turn, and for the first time, my supervisor also had no specific experience with which to support me. In this way my experience mirrored that of the isolation felt by David his whole life; he had never felt able to confide in anyone because he was sure they would not understand. Whilst I could accept the depth of David's conviction and empathise with his distress, I could not truly claim to understand and David was gracious in allowing this gap to remain between us. We approached our sessions as a journey on which we were both embarking, with no sure knowledge of our destination. That said, as long as elective amputation is not an option for David and other BIID sufferers, there remains the threat of what we came to call the 'railway line option'. In other words, that the urge to self-harm to the point where amputation is medically necessary might become overwhelming, and I was aware of my responsibility towards David's safety.

Our sessions coincided with David moving away from his family to live with a close friend, in whom he ultimately felt able to confide. With her support he began to role-play, that is he began to live as though his legs and left arm did not exist. He bought a wheelchair and was excitedly learning how to do things with the restricted body he felt was truly his. Living a more integrated life and no longer hiding how he felt seemed to bring David some relief, and it lessened the urge to self-harm. David left therapy feeling that he had found a way to live, and hopeful that this would be enough. Recently, however, he has contacted me again to say that this has not sustained him long term and that he would like to resume sessions. This has not yet happened and I cannot say where our journey will take us next.

I mentioned that I could not truly understand David's desire for amputation. In seeking to do so, I drew upon comparisons with gender identity disorder (GID). It makes sense to me that we all have both feminine and masculine traits and the idea of a body that does not match the inherent feeling of gender was something I could understand. Professor First, who conceived

the appellation BIID, also acknowledges the comparison saying: 'We wanted a word that was parallel to gender identity disorder. GID has built into the name a concept that there is a function called gender identity, which is your sense of being male or female, which has gone wrong. So, what would be a parallel notion? Body integrity identity disorder hypothesises that a normal function, which is your comfort in your body, has gone wrong?'¹²

There is now an acceptance that for GID the ultimate treatment is surgery with the latest thinking being that medically delaying puberty in diagnosed children will make surgery less traumatic at a later date. Again, First acknowledges the parallels, noting that when gender reassignment surgery was first mooted 'surgeons asked themselves, "How can I do this thing to someone that's normal?" The dilemma of the surgeon being asked to amputate a healthy limb is similar.'¹³

The effect of surgery on BIID was studied in Holland in 2012.¹⁴ The study devised the BIID Phenomenology Questionnaire to assess the functional impairment, severity of symptoms, associated psychiatric disorders, and anxiety and depressive symptoms experienced by BIID sufferers. The study noted that whilst psychotherapy was supportive, it did not diminish the symptoms of BIID, whereas surgical amputation for seven of the participants appeared to do just that. It was noted that 'surgery appears to result in permanent remission of BIID and in impressive improvement of quality of life'.¹⁴ Anecdotal evidence amongst the BIID community is also positive, Anil Ananthaswamy in his article *Do No Harm* reports that 'This feeling of relief and release is a sentiment expressed by just about every BIID amputee who has been studied by scientists.'¹¹

Clearly amputation of healthy limbs is a drastic treatment and the typical response might well echo the view of University of Pennsylvania bioethicist Arthur Caplan who said it was 'absolute, utter lunacy to go along with a request to maim somebody'¹². Yet this is a general statement, which allows no understanding of the individual involved. Robert Smith spent 18 months determining whether or not it was the right option for his patients. It is interesting to note that his third patient, for whom permission was denied, was Gregg Furth, a child psychologist and Jungian analyst from New York who, by virtue of his training, might be expected to have considered the



possible psychological causes of his physical distress. Smith performed the surgeries in an NHS hospital, but they were paid for by the patients. He also sought written permission from his chief executive for the surgeries and I think this reflects the lack of national clarity around the ethics of BIID. Whilst the NHS has very clear policy and governance arrangements for ethical considerations, they apply only to research projects. Ethics of the treatment of patients appears to be left to the individual health organisations through their clinical governance arrangements. Such policies aim to provide best practice and quality of care in general, rather than looking at specific cases, and do not seem fit for discussions of this nature.

I mentioned my own difficulty in accepting David's phantasy and how difficult it was to contemplate. However, revulsion towards the amputation of healthy limbs should not prevent us from considering whether or not it could be ethically recommended. I think it is time for us as therapists to ask the question: To what extent are we right in thinking that therapy is the correct or even only treatment for BIID sufferers, and indeed for other types of body modification desires? Against a background of dangerous self-harm, can eschewing surgery be said to uphold the principles of beneficence and non-maleficence? A recent review¹⁵ by NHS medical director Sir Bruce Keogh into the cosmetic surgery industry is expected to lead to new legislation and tougher regulation. Whilst this is to be welcomed, is it paradoxically time for us as therapists to consider a wider acceptance of surgical solutions to psychic pain? ■

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Johanna continues to work with David and wishes to thank him for allowing her to use his story.

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