CE

Visual Disfigurement and Depression

Sharon M. Valente, RNCS, PhD, FAAN

Approximately 10% of the population has a facial disfigurement, such as a scar, blemish, or deformity that severely affects the ability to lead a normal life, and 2 to 3% have a clearly visible blemish. They may experience depressive symptoms due to disfigurement, stressful life events, or other causes. Depression is a painful and costly disorder that is often unrecognized and untreated in specialty practices; it is linked with higher costs of care, lengths of stay, and rates of rehospitalization. Often, these individuals seek plastic surgery to repair the disfigurement, and depressive symptoms are not uncommon preoperatively, perioperatively, and postoperatively. In addition, depressive disorders exist among 20 to 32% of people with a medical disease. Major depression is a recurring and disabling illness that typically responds to treatment with psychotherapy, antidepressants, and social support. Nurses have a major role to play in screening for and detecting depression so it can be evaluated and referred for treatment. Nurses also provide education, psychosocial support, and advocacy for patients with depression. Identifying those with depressed symptoms allows the nurse to recommend treatment, offer referrals, and provide supportive interventions.

Numerous psychosocial stressors are linked with being visibly different in a society that emphasizes appearance, beauty, and physical attractiveness. Visible differences are often associated with low self-esteem, negative self-image, social isolation, and fear of rejection in relationships. Multiple factors, such as genetic inheritance, growth and development, aging, accidental trauma, disease, and medical or surgical intervention may lead to disfigurements. Patients need psychological support preoperatively and postoperatively. Preoperatively, patients need education about the process and outcomes of surgery and support to cope with the fears, worries, and depressive symptoms related to the pain and symptoms associated with surgery. Postoperatively, patients need support to cope with the stress of recovery and their expectations. Depression and anxiety are both symptoms that can be diagnosed as a mood disorder according to the diagnostic criteria. Anxiety encompasses feelings of worry, fear, and dread; persons with anxiety believe that something terrible is going to happen to them that usually involves hyperalertness. Depression is primarily a mood state of sadness and lack of pleasure; it typically includes pessimism and negative thinking patterns.

People with depressive disorders may have negative and unrealistic expectations of the surgery (Schade, Jones, & Wittlin, 1998). People with depression may also have a difficult time trusting the surgeon, may call for consistent assurance from nursing staff, and may dwell on what can go wrong. During recovery, the depressed person will fear that the bruises, swelling, pain, and redness will never resolve.

An estimated 10% of the population has a facial disfigurement such as a scar, blemish, or deformity that severely affects the ability to lead a normal life, and 2 to 3% have a difference clearly visible to others (Faces, 1996). People with visible disfigurements often expect plastic surgery to help them regain their self-esteem and appearance. Although

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anesthesia and operative procedures create psychological stress, many clients also have psychological problems such as depression that may increase unrealistic expectations of plastic surgery.

Depression has a significant impact on morbidity and mortality that is broader than its well-documented correlation with suicidal behaviors. Symptoms of depression are linked with higher costs of care, lengths of stay, and rates of rehospitalization (Schade, Jones, & Wittlin, 1998). Depressive symptoms are not uncommon preoperatively, perioperatively, and postoperatively, and depressive disorders exist among 20 to 32% of people with a medical disease. Major depression is a recurring and disabling illness that typically responds to medications, cognitive therapy, education, and social support.

In cognitive therapy, the therapist and patient are partners in evaluating the patient's negative thinking patterns, irrational thoughts, and negative perceptions, and working to reduce automatic negative thinking patterns. The characteristics of major depression include sadness or anhedonia, or lack of feeling of pleasure, and five of the following symptoms occur daily for 2 weeks: significant weight loss, insomnia or hypersomnia, fatigue, worthlessness or excessive guilt, psychomotor retardation or agitation, thoughts of death/and or suicide, and diminished concentration (American Psychiatric Association, 2000). Risk factors for depression include recent losses, pessimistic outlook, previous mood disorder, alcohol or substance abuse, poorly managed symptoms, and depressive side effects of medications (Geddes & Butler, 2000). Depression can also be a complication of stroke, cancer, HIV disease, other chronic illnesses, and the side effect of medications (Geddes & Butler, 2000). The surgical experience is a time when emotional support from healthcare professionals and loved ones is critical for recovery.

This article explores the screening, assessment, and management of major depression and improved emotional support for depressed plastic surgery clients. Nurses can detect and respond to depressive symptoms, and often advocate for treatment to prevent complications of depression. They can recommend the advantages of psychological treatment for depression. Effective management of anxiety rests on sound knowledge of the evidence base.

CASE STUDY

Mr. J. is a charming, articulate, 50-year-old man who was referred by his nurse practitioner for evaluation of depression after excision of a tumor resulting in partial facial paralysis. He describes himself as "vain," and as one who takes care with his clothes and appearance. He says his "appearance is everything" in his work as a salesman. Although he previously worked in this profession, he is currently unable to work because of the facial disfigurement.

Course of Treatment

Treatment of head and neck cancer with tumor excision left his face paralyzed on one side, with weakness, persistent cough and drool, and nerve deficits that interfere with talking clearly. He is distressed by his facial asymmetry and hopes that the nerve stimulation and plastic surgery will return him to normal. Initially, all of his tumor follow-up examinations were negative, and then a second site was discovered early and treated with chemotherapy. Although he has a history of alcohol abuse during stressful periods, he has been clean and sober for many years. His prior substance-abuse history meant that his clinicians were cautious in prescribing pain medications. He put a lot of his hopes and faith in the plastic surgery to restore his facial symmetry and in the muscle stimulation to regain his articulation and prevent drooling.

Psychosocial Data

He says he is not talented or skilled, but that his appearance was a major asset in his work. He married young, felt isolated and distant from his family, and was divorced. He regrets never seeing his daughter grow up and hopes to regain contact with her. Except for his appearance, he is eager to meet her and re-establish contact. Although he emphasizes a positive outlook and faith, he feels depressed. His depression is most intense when his pain increases and when he thinks about his appearance, his unemployment, and his separation from his family. When a second tumor site was discovered, he was stunned and numb, and then his depression increased. He was unhappy when he had to quit work, however. He was a private man who told few others of his disease but considered telling his brother. He thought that the pain caused his fatigue, sadness, and depression and initially did not think his depression was treatable. As his depression worsened, he became more afraid of being a burden on his daughter, felt hopeless, and thought about suicide as a way out of suffering. When the second tumor was detected, he lost his trust in his oncology team because they had been telling him everything was fine and then this happened.

Depression

Mr. J. scored a 65 on the Zung Self-Rating Depression Scale, which indicates the presence of moderate to marked depression (Zung, 1990). Subsequently,

his depression was confirmed by his symptoms (weight loss, insomnia, sadness, anhedonia, hopelessness, death wishes, slowed behavior) during a clinical interview. He wanted to know about treatment of depression with counseling and medications. He started a regimen of antidepressants and cognitive therapy.

Outcome

Mr. J. responded well to cognitive therapy. His major therapeutic work related to grief, family relationships, sadness, suicidal ideas, and end-of-life issues. He had a major stake in the plastic surgery that he expected would return his face to normal.

LITERATURE

A vast array of sources in myth, folklore, legends, history, and advertising suggest that people who look different experience problems. A common proverb in Western cultures reflects the tendency of judging a book by its cover—or judging by external appearance. Children's literature abounds with stories that emphasize the tragedies of looking different. Without transformation, the ugly frog cannot marry the princess, and the ugly duckling remains sad, lonely, and ridiculed. Advertisers constantly extol the virtues of physical attractiveness and the merits of their products that enhance appearance and promise happiness. In Western society, language depicts those who are different and deviate from the norm as abnormal, flawed, and disfigured (Rumsey, 1998).

Congenital malformations (e.g., cleft lip, birthmarks, vascular malformations, deformed limbs), injuries from burns or trauma, dermatological conditions (e.g., acne, rosacea, neurofibromatosis) and from therapeutic intervention (e.g., scars, removal of malignancies, tracheotomy) may lead to disfigurements. Removal of a head or neck tumor may result in extensive scarring. In the worst-case scenario, surgical scars of the wrist, head, and neck may be misjudged as suicide attempts (Harris, 1997). Reconstructive techniques, such as grafting, that take a donor's flap of skin or muscle may also involve disfigurement.

Visible disfigurements have also been linked with negative emotions, including low self-esteem, self-image, and self-confidence. Many people feel ashamed, guilty, embarrassed, and stigmatized by their appearance, and they apologize for it. Social encounters with others are anxiety provoking, as visibly disfigured people feel embarrassed meeting strangers; they fear rejection and may have difficulty seeking employment (Rumsey, 1998). After a traumatic injury or surgery, people may complain that they lose their sense of identity or do not look like themselves. These reactions may involve grief related to the loss of a physical characteristic or family feature, particularly when it was unanticipated. Common coping styles of people with visible disfigurement include avoidance (e.g., social encounters, reflecting surfaces); escapist (e.g., using substances, smoking) and distraction techniques (e.g., study, exercise, alternative activities). Some used self-talk, social comparison (e.g., it could be worse), camouflage (e.g., sunglasses, make-up), and seeking further treatment (Robinson, 1997).

DEPRESSION

Major depression is a costly but treatable mood disorder characterized by sad mood or loss of interest or pleasure with a total of five symptoms over 2 weeks (e.g., fatigue, significant weight loss, insomnia, diminished concentration, thoughts of death or suicide) (American Psychiatric Association, 2000). It is distinguished from a short-term emotional upset or a few days of feeling sad and blue. A person with a major depression meets all of these criteria; those with other depressive disorders, such a dysthymia, may have fewer symptoms for a longer period of time. If a person has "the blues" for a few days, he or she has depressive symptoms but does not meet the criteria for a diagnosis of depression. The *Diagnostic and Statistical Manual* diagnostic criteria for depressive disorders identifies several of the mood symptoms but does not identify distinctive clinical features of depression that are common in specific groups, such as geriatrics. For example, older adults often display cognitive symptoms such as poor concentration and physical symptoms rather than sadness (Fiske, Kasl-Godley, & Gatz, 1998). A depressive episode may be idiopathic or secondary to another medical condition, treatment, or drug. Depression increases a patient's suffering, morbidity, and suicidal thoughts (Fiske et al., 1998). Although 75% of physicians believe they detect and treat depression well, only 14 to 20% of depressed patients are adequately identified or treated (Banazak, 1997; Banazak, Mullen, & Gardiner, 1999).

Depressive disorders sentence people to weeks and months of costly and needless emotional suffering. The costs of depressive disorders (hospital and outpatient treatment, medications, suicide and lost productivity) exceeded $44 billion in 1990 (Simon, VonKorff, & Barlow, 1995). Thompson & Richardson (1999) found that depressed patients had higher costs of medical services compared with their non-depressed peers. Leslie & Rosenheck (1999) analyzed inpatient claims data and found that treating depression reduced inpatient costs per treated

patient (44%). Further, depressive disorders result in productivity losses from increased rates of absenteeism and short-term disability as well as impaired work performance (Thompson & Richardson, 1999). Untreated depressive disorders along with other comorbid conditions may increase costly clinic visits, hospitalizations, substance abuse, and risky behaviors, and reduce adherence to treatment and quality of life.

Epidemiology

Depressive disorders range from mild (dysthymic disorder) to very severe (with psychotic and melancholic symptoms), and the demarcations between the differing types are often blurry. Estimates of lifetime prevalence of depression ranged from 3 to 18%, and the prevalence was found to be 4 to 8% in a five-site community survey and a large Edmonton survey (Spaner, Bland, & Newman, 1994; Weissman et al., 1988). Women experience depression about twice as often as men. Married individuals have the lowest rates, apparently owing to social support. Several theorists have posited that neurotransmitters, genetics, stressful life events, early environment, comorbidity, and substance abuse play a role in depression, and depression has a well-established link to suicide. Cognitive theorists suggest that depressive disorders may stem from negative thinking and irrational ideas. Other causes may include genetics, biochemical sources, unconscious conflicts, and medication and treatment side effects. According to cognitive theory, automatic negative thoughts and irrational ideas (e.g., no one will love me because my face is deformed) can lead to depression (Greensberger & Padesky, 1995). In addition, medications with depressive side effects can trigger depression.

Clinicians need not have psychiatric expertise to play a major role in detecting, screening, and assessing symptoms and referring patients for psychiatric evaluation. They can use screening tools to improve case finding. Effective treatments can reduce major depression in 80 to 90% of patients (Geddes & Butler, 2000). Clinicians who overlook or discount depressive signs and symptoms make a common error that can increase morbidity and mortality. If the screening tool indicates the patient has scored in the range that suggests depressive disorders, the clinician will be more likely to motivate the person to explore treatment after exploring individual needs and concerns as well as explaining the nature of depression and the benefits of treatment.

PREOPERATIVE AND PSYCHOSOCIAL ASSESSMENT

During this assessment, the clinician explores the patient's initial problems and expectations, current state, previous and ongoing difficulties, coping strategies, social support, expectations of the surgical outcome, and the patient's anticipation of how the surgical correction will influence current problems (Carr, 1997). The clinician also wants to determine if the desired surgery reflects the patient's wishes or pressure from others so factors triggering the request for surgery are explored. Concerns about the diagnosis and plastic repair require discussion. Screening tools can help identify those at risk for depression or high anxiety so they can be referred for thorough evaluation. Researchers have mixed findings about the role of social support in adjustment, but most findings support the beneficial effects of social support on self-esteem, body image, and levels of depression. Baker (1992) found that social support was positively linked with postoperative adjustment among head and neck cancer survivors. Social skill, communication, and confidence also influence the patient's anticipation of positive or negative response from others (Rumsey, 1998). Social skills training can help those with visible disfigurements reduce their anxiety about social encounters and elicit more positive responses from others (Rumsey).

In the preoperative and postoperative period, patients often experience depression, anxiety, and doubts about the surgical outcomes and are often distressed postoperatively by the temporary bruising and swelling. Therefore, discussion of the patient's expectations and clarification of typical response to surgery is important. When patients have unrealistic expectations, a referral for counseling is useful if brief teaching is insufficient.

SCREENING FOR DEPRESSION

Clinicians without psychiatric expertise often lack skill in detecting major depression and can improve their detection by using standardized screening tools. It matters little whether the nurse screens for anemia, smoking, hypertension, or depression, or notices a patient who coughs up blood and sounds like someone with pneumonia or tuberculosis. A nurse who notices a patient who is short of breath, complains of pain in the chest, and is flushed would hardly ignore the signs of cardiac distress and pretend nothing was wrong. Instead, the nurse would alert the physician and would also educate the patient that the symptoms could be serious and require evaluation. The nurse who detects signs of a serious disorder is in a pivotal place to bring this concern to the physician's attention and to recommend further evaluation and referral. Certainly, the patient with untreated high blood pressure on three or more visits needs a referral for evaluation of hypertension. Our patients with depression deserve

no less attention. Screening is part of health promotion and evaluation for nurses and other licensed colleagues.

In some instances, should physician colleagues focus on their specialty and not refer the patient, the nurse can suggest to the patient that "these symptoms could indicate a serious disease and you would be wise to obtain an evaluation from your primary care doctor." Nurses can also express their concern to the physician that "this patient's blood pressure is high on every visit, and I wonder about his risk for a stroke during surgery or postoperatively." In the case of a depressed patient, the complication of concern is delayed recovery and, potentially, suicide. However, the nurse who ignores the problem may feel uneasy if the patient faces serious postsurgical complications from the disorder that was ignored. Additionally, when they see a patient with serious and potentially life-threatening symptoms, nurses should consider how they would want their nursing colleagues to respond if the patient were their older relative, mother, aunt, or uncle. If the nurse detected that your relative had serious hypertensive or depressive symptoms, how would you feel if the nurse ignored these symptoms and your relative was not given the life-saving advice to seek treatment?

In studies, nurses underestimated the level of depressive symptoms in patients who were moderately or severely depressed, and they emphasized crying, depressed mood, and somatic factors (e.g., anorexia, insomnia, constipation, fatigue) that are unreliable indicators of depression in a medically ill population (McDonald et al., 1999). Most physicians and nurses only detect less than half of depressed patients on a medical service and only 10% of patients received appropriate treatment for depression (Martin, 2000).

To improve detection, nurses can use screening questionnaires to identify depressive symptoms, establish a baseline, and gather objective evidence. Routine screening incorporated into practice can improve diagnosis; however, screening alone may fail to motivate the patient to initiate treatment. The nurse can use two frequently used tests, the Beck Depression Inventory (BDI) and the Center for Epidemiological Studies Depression Scale (CED-S). The BDI (Beck et al., 1999; Wright et al., 1993) has 21 items related to depression and two suicide-related questions. Patients rate the severity of symptoms (e.g., weight loss, fatigue, anorexia, sadness, thoughts of suicide). Another reliable and valid questionnaire, the CED-S, has 20 items. It is commonly used in community settings with people with cancer (Radloff, 1977). The Beck Hopelessness Scale (Beck & Stanley, 1997) has items that evaluate suicide risk. Those who score above the norm on the screening tool require a thorough assessment, and a mental status evaluation with suicide risk is needed. The aforementioned screening tools, as well as the Zung depression scale (Zung, 1990), are easy to locate on the Internet. If needed, other screening tools can detect various anxiety disorders and substance abuse, which are common traveling companions of depression. Patients occasionally need encouragement to participate in screening as described in the following scenario.

Clinical Example

A woman seeking plastic surgery consistently appeared to be sad in the waiting room; she looked as if the weight of the world was unbearable. She declined to complete a screening tool for depression. I took time to sit with her and ask how things were going. I commented that she looked very sad and asked if she felt depressed. She replied that she "turned it all over to God" and prayer was the solution. I agreed that faith is a major support and repeated my concern about her sadness during her visits over the next several weeks. One day she was tearful, and I suggested that she looked depressed and commented that counseling at her church or a local counseling center might be helpful. I again encouraged her to complete a depression screening tool. Several months later she said she was hospitalized and treated for depression and it was the best thing that ever happened. She subsequently underwent successful surgical repair.

Treatment Modalities

Treatment for depression involves addressing psychosocial and biomedical issues (e.g., organic causes of depression such depressive side effects of medications), antidepressant medications, cognitive or brief psychotherapy or counseling, and education. Nurses need to know that antidepressants and counseling are mainstays of treatment and the challenge is to match the patient with the treatment. Electroconvulsive therapy is considered when the patient does not respond well to antidepressant medications or is severely suicidal. Although the mechanism of action of electroconvulsive therapy is unclear, it achieves a grand mal seizure that may influence the release of dopamine and norepinephrine and improve the functioning amine system. The nurse in the plastic surgery clinic is in a pivotal position to provide psychosocial support for the depressed person and to help improve resilience to stress and medication compliance. Although the nurses in a plastic surgery practice may not have expertise in counseling, they have skills in facilitating communication and problem solving. Education increases the patient's understanding of the disorder and self-monitoring of symptoms (DeRubeis, Young, & Dahlsgaard, 1998).

PSYCHOLOGICAL ASPECTS OF TREATMENT

The nurse who evaluates emotional responses, provides support, and uses therapeutic interventions and referrals enhances treatment. Often an individual requires consistent encouragement and support before seeking treatment for depression (Papadimitriou, Argyrou, & Paleoginani, 1998). The nurse begins by exploring the patient's motivation for seeking consultation and plastic surgery. A common motive is that life has been altered by the changes in the patient's appearance and this has led to problems in social interaction. Hence, the person may be self-conscious and struggle with low self-esteem. Continued problems over time may encourage consideration of mental health treatment. The nurse explores any ambivalence, mixed feelings, worries, or concerns about surgery and/or mental health counseling for depression. Such worries about surgical outcomes may be intensified in a waiting room where patients see each other in various stages of treatment. For example, the patient may see someone with red and sensitive skin from laser treatment that is unable to be camouflaged with make-up. The patient may be concerned about coping with added disfigurement during treatment and may be anxious about the swelling and bruising postoperatively. The nurse can help allay some of these fears with patient education, but the depressed person will have persistent fears that suggest a need for counseling.

If the depressed person has a negative response to the idea of mental health consultation, the nurse can point out that it is one approach to helping patients cope with the emotional issues as well as the practical issues coping with the disfigurement and surgical repair. Counseling is also useful for patients who feel that the surgeon underplays the psychological aspects and their personal concerns about the surgery. My patients express satisfaction and improved self-esteem with surgical treatment and report decreased depression, self-consciousness, and social anxiety.

EDUCATION

Providing emotional support, patient teaching, and advocacy for the depressed person are critical aspects of the nurse's role (Burgess, 1996; Ferrell & Rivera, 1997; Makinen, Valimaki, & Katajisto, 1999; Papadimitriou et al., 1998). Teaching about the nature, myths, and treatment of depression helps prepare patients for an active role in making decisions, managing self-care, and partnering with healthcare providers. Effective education is tailored to a patient's culture because it influences the patient's clinical presentations, beliefs, therapeutic decisions, expression of emotions, and sharing of information. Self-help depression manuals can be useful. In my practice, patients report that *The Feeling Good Handbook* (Burns, 1990) has useful exercises, explanations, and self-rating depression scales.

REFERRAL

Often patients prefer to see their primary care provider for treatment of depression. Nurses can always refer the patient to a therapist from the local American Psychological Association (headquartered in Washington, DC), the American Psychiatric Nurse Association, or the National Association of Mental Illness to obtain a list of therapists who treat depression in a specific geographic area. Patients who think they will need medication because of a prior depression or distressing symptoms will want a psychiatrist from the American Psychiatric Association or an advanced practice psychiatric nurse because both can prescribe or furnish medications according to their state laws. If the patient is treated by a health maintenance organization, this group will have a list of providers it recommends and reimburses. Many states also have community mental health centers or a public health department with a mental health section. Often religious patients want to seek counseling through their church or temple. However, a referral to a specialist in psychiatric mental health is indicated when patients' depression does not lift, they become suicidal, and they have bipolar disorder or their condition resists treatment. A consultation is useful to verify the diagnosis and the treatment plan. People whose depression is difficult to treat also benefit from consultation or referral.

SUMMARY

Persons seeking plastic surgical repair for visible disfigurements often experience depressive symptoms and major depression during their treatment and rehabilitation. One in 10 people has a facial disfigurement that can be visible to others and may create stigma and distress. Depression may arise from stressful life events as well as side effects of medication and treatment. Symptoms of depression are linked with higher costs of care, lengths of stay, and rehospitalization rates. Detecting those who need evaluation and treatment for depression is the first step in improving rehabilitation and recovery because depression is often undiagnosed and untreated. Nurses have an important role to play in screening, case finding, education, psychosocial support, and referral. Nurses can reinforce the concept that treatment is effective for 80 to 90% of individuals and reduce the myths and stigma that often surround

depression. Advocacy for the depressed patient includes helping the patient and the healthcare system recognize the value of treating depression.

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