A Model of Decision-Making for Men Pursuing Cosmetic Hair Restoration Surgery

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LOYOLA UNIVERSITY CHICAGO

A MODEL OF DECISION-MAKING FOR MEN PURSUING
COSMETIC HAIR RESTORATION SURGERY

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

DEPARTMENT OF COUNSELING PSYCHOLOGY

BY
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I wish to dedicate this thesis to the memory of my grandfather, Charles Mueller. Although he was unable to see me complete my education, he was instrumental in making me the person I am today.
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CHAPTER I

INTRODUCTION

Physical appearance and attraction are large areas of research interest in the field of psychology. Cosmetic surgery, which can significantly alter a person's outward physical appearance and attractiveness, can also affect a person's perceptions of self and how others view him. In the past, research on cosmetic surgery has focused primarily upon women, particularly women who have had mammoplasty, surgical breast augmentation, and rhinoplasty. Few studies focus on the motivational aspects of seeking surgery and fewer studies address men and cosmetic surgery. According to the American Academy of Cosmetic Surgery (1996) about three and a quarter million cosmetic procedures have been performed in the United States during this past year. This number illustrates a 21% rise in the number of procedures performed since 1994. Almost seven hundred thousand men in the United States have had cosmetic procedures, and of these, 217,083 men have had hair transplantation procedures. This number represents 31.4% of cosmetic procedures performed on men. By far, this is the most often performed surgery on men. It should also be noted that the field of hair transplantation has not been regulated as thoroughly as other areas of cosmetic surgery so the actual number of cases may be far greater than is noted in the AACS survey. These statistics justify an answer to the questions why are men preoccupied about their hairloss, what would motivate them to seek a surgical solution, and what decision-making processes are utilized to decide upon a
course of action, surgical or otherwise. This paper will review existing literature in the areas of physical attraction, physical self-concept, stereotypes about physical attributes, motivation for treatment, and personality traits of surgical patients. Since few of these studies focus directly upon hair loss, baldness, and hair transplantation, extrapolation and extension of similar research will be necessary to posit answers to these questions.
CHAPTER II

LITERATURE ON PHYSICAL ATTRACTION

When investigating a cosmetic topic, one would be remiss to exclude the area of physical attraction. It is assumed that through cosmetic surgery one hopes to become more physically attractive to oneself or to others.

In a study by Cash, Cash, and Butters (1983), the researchers were examining whether contrast effects occur on self-evaluations of a physical attractiveness variable. Female college students were placed into three stimulus criteria; not attractive, attractive, and professionally attractive. All participants initially completed the Self-Consciousness Inventory which contains three scales; private self-consciousness, public self-consciousness, and social anxiety. Each group of subjects was then presented pictures of women who were deemed by consensus as either not attractive, attractive, or professionally attractive. The women were asked to fill out rating questionnaires that included ratings of a person's physical attractiveness moderated by evaluations of familiarity and noticeability. After these ratings, subjects were asked to fill out self-evaluation scales as "a part of another research project." Subjects rated their own physical attractiveness on a 10-point Likert scale and completed the Body Satisfaction Questionnaire which asked the women to make 6-point ratings of their satisfaction or dissatisfaction with 24 body parts and with their overall appearance. Results indicate that
subjects' rated the not attractive condition significantly lower on the 10-point Likert scale than either the attractive or professionally attractive conditions. As predicted, subjects exposed to either the attractive or professionally attractive conditions rated themselves lower on physical attractiveness than subjects exposed to the not attractive condition. Also, subjects in the attractive condition rated themselves lower on physical attractiveness than subjects in the professionally attractive condition. This may indicate that people compare and contrast themselves with peers that are a more appropriate standard of social evaluation than professional models. In a practical sense, this suggests that exposure to professional models through mass media may have little effect upon peoples' self-image. Additional results show that women who were less socially anxious, more privately self-conscious, more satisfied with their body parts and overall appearance reported more attractive self-perceptions. Conversely, people who were socially anxious and more dissatisfied with their bodies made less positive evaluations of their physical attractiveness.

The effects of cosmetic use on physical attractiveness and the body image of college women has also been explored by Cash, Dawson, Davis, Bowen, and Galumbeck (1989). Subjects were photographed in two condition groups; cosmetics-present and cosmetics-absent. Peer judges rated the attractiveness of these women in either the cosmetics-present or cosmetics-absent group. There were two primary findings. Results indicated that subjects in the cosmetics-present condition were given more positive body-image cognitions and affect than subjects in the cosmetics-absent condition. And as a rule, the more makeup worn by a subject, the greater the differences between the two cosmetic conditions. Cash also posits that physical attraction is not a fixed trait, but is dynamic and
can be managed and controlled to improve self-image.

Cash, Rissi, and Chapman (1985) explored some individual differences among women in their cosmetics use. First, considering that cosmetics are generally sex-specific, the relationships with sex-role identity and sex-role attitudes were assessed. Second, since cosmetics use can be used as a tool for self-presentation, social self-esteem and locus of control are examined. Subjects were given the Personal Attributes Questionnaire to measure psychological masculinity and femininity, the Attitudes Toward Women (ATW) scale to examine women's sex-role attitudes, the Texas Social Behavior Inventory to assess social self-esteem, the Multidimensional Multiattributional Causality Scale to determine locus of control, and the Cash Cosmetics Use Inventory to rate the quantity of products used and the qualitative pattern of use; consistent, dispositional use or inconsistent, situational use. The results indicate that women who use more cosmetic did identify more strongly with the feminine end of this sex-identity dimension. Also of note, the feminine end of this continuum can reflect a histrionic personality pattern. People who identify strongly with this side of the continuum are prone to theatrical emotionality, engage in attention-seeking, and seek social support. Sex-role attitudes were effected by cosmetics use on the ATW scale. Egalitarian and profeminist views were associated with dispositional users which could be considered counterstereotypical to some feminist attitudes. Situational users were more liberal in their viewpoints. Concerning locus of control, more internal attributions of cause of achievement success were made by high-quantity users of cosmetics. Situational users ascribed a more internal locus of control for affiliative outcomes. This may suggest that situational users are discriminative about their
cosmetic use. Increasing cosmetics use when it is viewed as beneficial in affecting social outcomes and decreasing cosmetics use when it is perceived as inconsequential or inappropriate.

Other studies that address the use of cosmetics suggest that grooming behaviors not only manage and control social impression formation, but self-image as well (Cash 1988). Graham and Jouhar (1981) investigated the effects of cosmetics use on average-looking women. When subjects were rated with and without makeup, results indicate that cosmetics use augmented physical attractiveness and generally produced more favorable personality attributions. Cash and Cash (1982) also identified a link between cosmetics use and positive evaluations of body image, facial satisfaction, and feelings of social confidence and effectiveness.

In addition to cosmetics use, physical attractiveness may be effected by age and may effect marital adjustment. Kirkpatrick and Cotton (1956) found evidence that physical attractiveness in women may be associated with marital adjustment. Using the cooperator-subject reporting method on subjects from Minnesota and Indiana, evidence suggests that well-adjusted wives are rated as more attractive, better-looking wives are more likely viewed as well-adjust than better-looking husbands, and equality of attractiveness, or small differences, between husband and wife is favorable to marital adjustment.

Noles, Cash, and Winstead (1985) acknowledge the central role that physical attractiveness and physical self-concept, or body image, play in determining global self-concept. This study explored the relationship between these two variables and depression.
Subjects were classified as depressed or nondepressed using the Center for Epidemiological Studies Depression scale (CES-D) to assess depressive symptoms and also asked to self-classify themselves on their current level of depression. In addition to the CES-D, subjects also completed the Body Parts Satisfaction Scale (BPSS) to assess overall body satisfaction and the Body-Self Relations Questionnaire (BSRQ) to assess subjects' attitudes toward their own physical appearance, physical fitness, and physical health. The last measure taken was that of physical attractiveness. Student judges, not participating in the study, were asked to rate photographs of each of the subjects on a 7-point scale ranging from very physically unattractive to very physically attractive. As opposed to their nondepressed counterparts, depressed subjects were less satisfied with their overall physical appearance, viewed themselves as less physically attractive, were less satisfied with certain aspects of their bodies, and rated their physical appearance in an unfavorable manner. Poor body image was related to more symptomatic measures of depression than subjects with body images that were moderate to high. No support was found that objective raters would evaluate depressed subjects as less physically attractive than nondepressed subjects. The final result found was that depressed subjects negatively distorted their body images. Depressed subjects reported less satisfaction with their physical attractiveness. Depressed subjects also reported themselves to be less physically attractive than the objective raters' evaluations of their attractiveness. Another interesting finding was that nondepressed people also distorted their body images, although in a positive manner. Also discussed is the fact that cosmetic surgery patients do report frequent depressive bouts and often negatively distort their body images (Cash & Horton,
Jacobi and Cash (1994) look at the discrepancies perceived among self-ideal percepts of a variety of physical dimensions. Physical attributes included were weight, height, muscularity, body size, eye color, hair color and length, and female breast size. Physical ideals explored were personal assumptions about how one sex viewed the opposite sex and the actuality of the ideals expressed by each sex. Whether ideals were viewed from self or other-sex, both sexes indicated significant discrepancies from self-ideal on most physical attributes. Of importance in this study is that both sexes also tend to exaggerate what they believe the other sex idealizes in them.
CHAPTER III
LITERATURE ON STEREOTYPES AND PERCEPTIONS

In relation to physical attractiveness, it is important to appraise stereotypical ideals and perceptions about people’s appearance and specifically about hair loss and baldness to examine how these beliefs effect men’s decisions whether to seek treatment for their condition.

Cash (1990) explores the influence that baldness has on the formation of social impressions. Photographic slides of men in various stages of hair loss from no hair loss to extreme hair loss were matched on actual age, race, and other physical attributes. These photographs were shown to groups of men and women who rated the pictures on seven dimensions; self-assertiveness, social attractiveness, intelligence, life success, personal likability, physical attractiveness, and estimated age. Addressing whether people perceived a difference between balding and nonbalding men, Cash found that hair loss has a negative effect on initial perception. Balding men are perceived as less physically attractive, less self-assertive, less socially attractive, less likely to experience success in work and personal life, and less personally liked by the evaluators than nonbalding counterparts.

Hair loss also effected evaluators judgements about age. Nonbalding men were identified as two years younger than their actual age, whereas balding men were identified
as more than three and a half years older than their actual age.

In addition to evaluators estimates about age, social perceptions toward balding men were also effected. Cash discovered that older balding men were perceived as less self-assertive. Regardless of age, balding men were perceived as less successful in life and less attractive. Interestingly, the effects on physical attractiveness were stronger against older balding men and the effects on success were stronger against younger balding men. Ageism was also found present in this study where older men were viewed as less physically attractive than younger men. However, older men were perceived as more intelligent than younger men.

Social stereotyping, which was also found in this study, may depend upon the sex and age of the perceiver. Both men and women perceive balding men as less personally likeable than nonbalding men, however men exhibit a stronger negative reaction than women. When balding men were perceived by a younger and older group of women, both groups perceived balding men as less successful and physically attractive. The younger group viewed younger balding men as less intelligent, successful, likeable, and physically attractive. Older women viewed younger men as more intelligent, successful, likeable, and perceived them to be as physically attractive as nonbalding men.

In conclusion, Cash discovered that baldness stereotyping was mediated by physical attraction perceptions. Less physically attractive men were judged less self-assertive, less socially attractive, less personally likeable, less successful, less intelligent, and judged older. When physical attractiveness was statistically controlled, only social attractiveness and judgements about age differed. This suggests that physical
attractiveness may mediate most perceptions about baldness.

Wogalter and Hosie (1991) studied the effects of cranial and facial hair on perceptions of age and person. Faces were constructed from different features in the Maca-Mug Pro identification kit which utilizes a computer program to generate variations of facial features from base digitized photographs. Variants were age, degrees of cranial hair loss, and presence or absence of facial hair. It was found that men with less cranial hair appeared much older than men with cranial hair and that men with facial hair appeared older than men without facial hair. Men without cranial hair also appeared more intelligent than men with cranial hair and interestingly, women found men without cranial hair even more intelligent than judged by men. Lastly, men with facial hair were perceived as less attractive and less sociable which is supported by research done by Cash (1990). Wogalter and Hosie found that attractiveness and sociableness were not influenced by the quantity of cranial hair which is contrary to the results found by Cash. In addition to these results, it is suggested that perceptions of how balding men are viewed may influence men to seek various treatment options.

Sigelman, Dawson, Nitz, and Whicker (1990) have looked at hair loss and how it may effect a politician’s electability. Two studies were conducted. The first study examined the prevalence of balding or baldness between governors and members of Congress. It was found that these politicians were much more likely to have hair than men in the general public of the same age, therefore suggesting that bald men were underrepresented in political office. The second study was an experimental test of voter bias against bald or balding candidates. Voters were presented simulated campaign
material showing a picture of the candidate with various degrees of hair loss; naturally balding, bald, or with a professionally fitted hairpiece. Although candidates without hair loss were perceived as younger in this experiment and candidates with hair loss were perceived as older, hair loss did not effect a candidate's electability. It is suggested in this article that other self-perceptions and attitudes may effect whether a person would consider a political run for office, and not baldness determining the electability of a candidate.

Roll and Verinis (1971) used semantic differential scales to determine first impressions about illustrations that depicted men with varying hairstyles, colors, and quantities of hair. A full head of hair was rated favorably as handsome, strong, virile, sharp, and active. Balding hair was rated most favorably as good and kind, least potent, soft, weak, and least active and dull. A bald head was rated least favorably as unkind, bad, ugly, and hard. Also investigated by Roll and Verinis (1970) that illustrates the influence hair may have in our society, is a study that examines hairiness and a large penis stereotype. Hairy arms and chests were associated with more potency and activity and large penises were rated as more potent than small penises. The stereotypical assumption would be that hairy men have larger penises although this is not true in reality.

Many recent papers dealing with perceptions and stereotypes of balding men that have yet to be published but provide new insights and information about men and hair loss issues are available in Dissertation Abstracts. Muscarella (1991) examined how men and women socially view balding and facial hair. Social maturity, including intelligence and helpfulness, appeasement, and age were related to balding conditions. The balding man
was also perceived as less attractive and aggressive.
CHAPTER IV
LITERATURE ON SELF-CONCEPT AND PERSONALITY

As noted earlier, hair loss can be associated with lower perceived physical attractiveness and negative stereotypes. It is apparent that others may hold negative or skewed views of balding men. This section examines how the balding man views himself in the face of negative stereotypes and the personality traits exhibited by balding men.

Wells, Wilmoth, and Russell (1995) explored the psychological effects that baldness has upon a variety of men of different ages and degrees of hair loss. The purpose of the study was to see if a correlation exists between degree of hair loss and a variety of psychological variables as measured by a demographic questionnaire, a 10-item self-esteem scale, the Beck Depression Inventory (BDI), and the revised short form of the Eysenck Personality Inventory. The researchers hypothesized that baldness would be a possible predictor of depression, low self-esteem, psychoticism, and neuroticism. Self-rated attractiveness and extraversion were also explored because lower self-esteem and feelings of unattractiveness could be indicators of social withdrawal. It was also postulated that these feelings and self-perceptions would be more pronounced in younger balding men. Results were consistent with predicted outcomes. Increasing hair loss was associated with a loss in self-esteem. Although there is a general loss of self-esteem with increasing age, the loss of self-esteem due to hair loss was much greater in younger men.
The findings for depression indicate that, regardless of age, it is depressing to lose hair. The results for extraversion were similar to those found for self-esteem. Hair loss resulted in greater introversion among all ages of men. However, younger men were noted to be disproportionately unsociable. Greater hair loss was associated with higher neuroticism scores with data suggesting that young balding men are much more likely to be upset. Item 14 on the BDI yielded a strong effect for baldness on feelings of unattractiveness and also indicating that this effect is heightened in younger men. Greater levels of psychoticism were not found among balding men of any age.

Franzoi, Anderson, and Frommelt (1990) explored the individual differences in men’s perceptions of and reactions to thinning hair. It was suggested that one personality trait, public self-consciousness, was likely related to hair loss in men. Fenigstein, Scheier, and Buss (1975) define public self-consciousness as a tendency to be concerned or aware of one’s public appearance. Other studies have linked high public self-consciousness with greater tendencies of social conformity and greater social sensitivity. Therefore, it was speculated that men who where more attuned to their public self-aspects would be more likely to conform to the social belief that hair loss is associated with a diminished social value by others. Franzoi, Anderson, and Frommelt tested three hypotheses. First, it was suggested that men with high public self-consciousness who are faced with hair loss believed themselves to be less attractive, less appealing to the opposite sex, and less valued as employees than men with no hair loss. Second, in terms of individual differences in concerns and reactions toward thinning hair, it is suggested that balding men view themselves as less attractive than men who are not balding, that balding men with high
public self-consciousness have lower body esteem, and that men high in public self-consciousness are more concerned about hair loss than men low in public self-consciousness. And because of these self-beliefs, men high in public self-consciousness with hair loss are more likely to seek out hair loss alternatives and treatments. Third, although public self-consciousness has been shown to be a fairly stable trait in adolescents, it was questioned if hair loss could change public self-consciousness. And if hair loss can change public self-consciousness, do men with different states of hair loss have differing levels of public self-consciousness.

Franzoi, Anderson, and Frommelt administered the Personal Reaction Questionnaire (PRQ) which measures an individuals’ public and private self-consciousness and the Physical Appearance Questionnaire (PAQ) which asks questions concerning hair loss as it pertained to the individual.

In terms of individual perceptions about thinning hair, it was found that 47% of the population agreed that balding men are less attractive than nonbalding men. Forty one percent of men agreed with the statement that women are less likely to date balding men and 89% disagreed with the statement that balding men are discriminated against in the workplace. Balding and nonbalding men did not significantly differ in terms of their beliefs about thinning hair. However, there was a main effect on these beliefs as a result of their level of public self-consciousness.

On self-perceptions of attractiveness, younger men judged themselves to be more attractive than the older men. Balding men viewed themselves as less attractive than their nonbalding counterparts. As hypothesized, balding men with high public self-
consciousness were significantly more concerned with hair loss and more likely to seek
treatment options than men with low public self-consciousness. Also consistent with
predicted outcomes, nonbalding men with high public self-consciousness were significantly
more concerned with the prospect of hair loss than men with low public self-
consciousness. In addition, there is no evidence that a correlation exists between hair loss
and change in public self-consciousness or that state of hair loss is related to level of
public self-consciousness.

In the assessment of self-concept, it is important to illustrate that cosmetics or
cosmetic alterations will lead to improved self-concept or the efforts at change will be
efforts in futility. At present, there are very few articles that directly question whether
change in self-concept occurs after cosmetic alterations. Wright, Martin, Flynn, and
Gunter (1970) explore whether self-esteem or self-concept can be changed by alterations
in external appearance through the use of cosmetics. The MMPI was administered to
female subjects before and three months after the treatment condition, proper cosmetics
application. Two scales from the MMPI, depression and psychasthenia, were chosen
because of their sensitivity to changing levels of self-concept. The results show that a
significant difference occurred between pre and post-conditions for both the depression
and psychasthenia scales indicating that changes in external appearance can alter self-
concept.

Another study by Trexler (1992) examined the pre and post surgical self-esteem
and body image of women undergoing breast augmentation surgery. Breast augmentation
was not found to have a significant effect upon self-esteem or body image. However,
When group pretest differences on body image were adjusted, women in the experimental group undergoing breast augmentation showed significantly higher post-test body image scores than controls. Also, a pre and post-test comparison showed that women that had their breasts surgically augmented reported greater satisfaction with regard to their breasts than the control group. Although there is no evidence that breast augmentation significantly alters the self-esteem of women, there is evidence that breast augmentation does significantly alter general body image and specific body image with respect to breast satisfaction.

In addition to beliefs about self, certain personality traits and attitudes have been linked to people who have experienced hair loss or seek cosmetic surgery. Gosselin (1984) examined the effects that hair loss has on personality and attitudes. The subjects were divided into three groups: men using a hair weave as a treatment, men who used a weave as a treatment, but no longer wish to use it, and men who underwent no treatment and expressed little concern over their hair loss. All three groups were administered the Eysenck Personality Questionnaire, the Autonomy and Self-Esteem scales in Eysenck and Wilson (1975), and a questionnaire on self-rated beliefs ranging from "much worse" to "much better" concerning subjects attitudes in dealing with working situations, social and sexual life, visual appearance, age, and family hair loss. Results for all three groups showed higher Neuroticism and Psychoticism scores than for a normative population of men. The weave wearing group, interestingly, had significantly lower Extraversion scores than a normative group. The group that discontinued wearing the weave showed significantly higher Neuroticism scores and significantly lower self-esteem scores than the
weave wearing group. Lastly, scores illustrated a similarity between men wearing the weave as a treatment and men who received no treatment.

In addition to the score results, two additional hypotheses were discussed. The fact that all three groups demonstrated higher Psychoticism scores than a normative population gives strong evidence for a link between Psychoticism and testosterone (Eysenck & Eysenck, 1976) and testosterone and hair loss (Tamm, Volkwein, & Tressueres, 1980). Also, higher Psychoticism and Neuroticism scores could be considered symptomatic of a greater incidence of psychosis or neurosis for men who lose hair earlier in life.

De Koning, Passchier, and Dekker (1990) studied hair loss problems and the policies of general practitioners by having physicians complete questionnaires. Of interest, is that physicians identified 50% of their patients who experienced hair loss problems as having psychological problems. Although the psychological problems consisted mostly of low self-esteem in men and fear and anxiety in women, the findings suggest that many patients experiencing hair loss may require more psychological support from their physicians.

Romweber (1996) investigated the emotional experience of losing hair between men and women. Although men losing their hair do experience feelings of emotional distress, women were found to be more profoundly distressed about hair loss.

Venneman (1996) explored psychological differences to discriminate between those suffering from alopecia areata and male or female pattern baldness (MPB/FPB). Subjects were measured for anxiety (STAI), depression (BDI), aversive life events
(PERI), Positive and Negative Affect (PANAS), and explanatory style (ASQ). For women, anxiety, depression, and Positive Affect discriminated between the two groups. Women with FPB were more anxious and depressed than women with alopecia areata. Women with FPB scored lower on Positive Affect than women with alopecia areata, however women with alopecia areata did not differ with women in the general population. This study was unable to identify a discrimination between men with MPB and alopecia areata. Although, men suffering from both were shown to be more anxious, depressed, and exhibit higher Negative Affectivity than men in the general population.
CHAPTER V

LITERATURE ON MOTIVATION

In order to understand the decision-making process of how men decide to undergo hair replacement surgery, it is important to examine different reasons and motivations for surgery.

In an article by Dull and West (1991), the authors explored the decisions that surgeons make about cosmetic patient selection and the motivations that patients cite in their decision to pursue cosmetic surgery. Data was collected through interviews from ten cosmetic surgeons and twenty three cosmetic surgery patients. One rationale cited by both surgeons and patients to pursue cosmetic surgery was that surgery was considered a "normal, natural" pursuit. Many described the experience of surgery as akin to getting your hair done or wearing makeup. Cosmetic surgery was seen as an activity done by anyone, where descriptions of surgery were considered explanations for having surgery. The researchers noted many contradictions with this rationale for surgery. First, many patients who characterized surgery as normal and natural often agonized over their decisions to have surgery performed. Second, some surgeons and former patients who compared surgery with other trivial activities discussed their decisions to undergo surgery with defensiveness. For example, having surgery is no vainer than pursuing other endeavors that are considered vain. Third, there was an implication that although surgery
was seen as normal and natural, it was only viewed in this vane for women. Surgery was only described in comparison to activities performed by women, not activities such as shaving one’s beard which are deemed masculine.

In addition to views that surgery was normal and natural, many surgeons and patients considered criteria for specific surgery as objective indicators of the necessity for surgery. In this regard, many viewed facial or bodily features as “objectively” flawed or problematic. One example described a woman whose eyelids became droopy with age, thereby necessitating surgery. One surgeon pointed out that a twenty five year old does not need a face lift, but implicit in the statement is the fact that surgery is or may be necessary for an older person because the face will wrinkle with age. Another surgeon explained that “objective” indicators may be relative across persons and situations. This surgeon cited an example of a career model in her twenties who underwent face and eye surgery. Although she had not endured the rigors of aging, she felt that she was losing her edge to teenagers. She decided to undergo surgery to lengthen her modeling career.

Another area for concern about objective criteria for surgery was that many patients and surgeons viewed various ethnic features as “objective” grounds for surgery. Many surgeons noted the subjectivity of these claims by patients, but felt that their sole concern was with the improvement of the appearance of the individual patient. Although many patients rationalized reasons for surgery on the assumption that their ethnic features were flawed, some patients characterized their surgeries as subtle alterations. A Jewish women stated that her surgeon was not going to give her a cute little “WASPy” nose, but one that was proportionate to her face.
The researchers also noted that the background of the patient may be considered an objective indicator for surgery. The socio-economic status of the patient may determine the availability of surgical services and the opportunity to utilize these services. Data indicates that although patients may have limited financial resources which may hinder them from pursuing surgical options, these financial limitations do not prevent patients from seeking surgical treatment. Patients of different socio-economic statuses usually differed on their perceptions of surgery as either investments or luxuries, depending upon the financial demand of surgery in relation to household income.

Aside from the decision to pursue surgery because of a perceived flaw, some patients indicated that they were undergoing surgery just for themselves. There was no overt blemish, but a sense that surgery would improve their self-esteem and self-image. However, a few contradictions existed. Some former patients admitted that significant others had influenced their decisions. Surgeons also acknowledged that they might suggest specific procedures that were not the patients’ original intent for surgery.

Dull and West conclude their article with the identification of the missing link between the previous motivations for surgery as the accomplishment of gender. Accomplishment of gender is posited because of the difference in perceptions toward surgery expressed by men and women. In their research, it was obvious that surgery was not considered normal and natural for men, but it was for women. Many surgeons claimed that women’s concerns about their appearance were considered essential to their existence as women. Their claim is that society teaches women to look good and take care of their physical appearance. So physical appearance becomes a characteristic that is essential to
women in our society. Cosmetic surgery is regarded as a natural extension of maintaining women's appearance. Men's concerns over their physical appearance were most often characterized as extrinsic to their roles as men. Motives for surgery in men were not seen as normal and natural. One surgeon noted that a man misrepresented his reasons for surgery by explaining that he could not breathe. This was meant to conceal his wish for a better looking nose. The only instance where men could accept surgery as normal and natural was if it involved job-related concerns. A further discrepancy acknowledged by researchers between genders was the use of objective indicators. Cultural perceptions may influence which objective indicators are of concern. Because of the existence of double standards, men's and women's objective criteria differ. It is seen as acceptable for men to express signs of aging because men are perceived to age gracefully and become dignified with greying hair and wrinkles. The expression of aging in women is viewed less than positively. Since any sign of physical aging is viewed negatively, women have far more "objective" indicators to focus upon as impetus for surgery.

Schouten (1991) also investigated the motives for peoples decision to undergo cosmetic surgery from a self-concept dynamics approach. Self-concept theory in this text is the cognitive and affective representation of who and what people are. Both a priori and subsequent emergent themes were explored. Four a priori themes were examined. First, based upon research that patients after rhinoplasty noted an improved body image (Horowitz, 1983) Schouten posited that a poor body image with a specific focus upon one body part was grounds for cosmetic surgery. Second, because of the importance of physical attractiveness in our society, surgery was seen as a way to improve key social
roles. Being more attractive might afford certain opportunities and status upon actors, lawyers, and physicians as opposed to their less attractive counterparts. Third, based on the research of McAlexander and Schouten (1989) which suggested that certain appearance changes seem to be important for coping during role transitions, it was hypothesized that surgery was a means of self-completion during critical life events or changes such as divorce, middle-age, or change in occupation. The fourth a priori theme examined self-concept in terms of self-schemas which are hypothetical positive or negative structures that motivate approach or avoidant behaviors. Cosmetic surgery in this sense was viewed as a means to approach positive and avoid negative self-schemas.

Multiple ethnographic interviews of key informants who underwent cosmetic surgery consistently supported the a priori themes that were hypothesized. Consistent with the findings of Horowitz (1983), many interviewees reported increased body image which led to greater self-esteem. Interestingly, many participants seemed to have developed their negative body images during adolescence when sexual desires were evolving and social expectations were changing as quickly as their bodies. Parent and peer influence may also have contributed to peoples’ overall body image.

As hypothesized, the importance of improving key social roles was highly supported in interviews. One man discussed his decision to have eyelid surgery in terms of its importance to his occupational status. Other women were concerned about their ability to engage in meaningful sexual relationships because of their breast sizes.

Evidence for the third a priori theme was also supported. As some interviewees aged, their perceived physical appearance sometimes became incongruent with their own
conceptions of self. Surgery was seen as a way to achieve congruence and complete the self-image, thereby increasing self-confidence.

The fourth a priori theme was supported by the consequences of peoples’ decisions to pursue surgery. People made their decisions by weighing the associated positive and negative possibilities about the outcome of their surgeries. Patients who assigned mostly positive outcomes to surgery exhibited much less ambivalence than people who did not assign strongly positive outcomes to surgery.

In addition to the data collected for the a priori themes, data analysis revealed that certain emergent themes were strengthened again or yielded greater information than expected. Four emergent themes were discovered. The first theme, role transitions, consists of two subthemes: reintegration of the self and catalyst for further change. Plastic surgery allows for a reintegration of self by altering physical appearance which contributes to a patients’ greater comfort with oneself. As a catalyst for further change, cosmetic surgery is viewed as part of a growth process which enhanced self-esteem and confidence. Role transitions can be caused by external or internal forces and lead to a destabilization of the self which needs to be reintegrated. This destabilization allows people to be receptive to goods, services, or ideas that previously were not considered. In this vane, surgery becomes a powerful symbolic act that induces reintegration.

Sexual selves and romantic fantasies is the second emergent theme where negative body images held during intimate relationships or in sexual relations led to the decision to have cosmetic surgery. Two subthemes emerged. Cosmetic surgery, which altered body image in relation to a sexual self, was seen to increase a patient’s comfort with their sexual
selves. Some interviewees imagined themselves in romantic fantasies as their ideal selves. Plastic surgery allowed them to bridge the gap between their real self and fantasy self which is seen to lead to a more desirable sense of sexual self.

Taking control, the third emergent theme, allowed interviewees to exercise control over their bodies and destinies through cosmetic surgery. Being able to exercise the decision to have surgery was also found to improve personal efficacy. However, greater difficulty in decision making led to reduced personal efficacy.

The fourth theme, identity play, involved trying on a new look through photographs, molds, mirrors, and role playing. Identity play created a more concrete set of expectations and heightened people’s sense of longing for surgery and for a change of self.

Schouten (1991) found additional data in the analysis to support a process of identity reconstruction using the concepts of rites of passage, liminality, and possible selves. Rites of passage generally occur in three phases: separation, transition, and incorporation. In the separation phase, a person makes a break from a social role or status. During the transition phase, a person must learn to adapt to new social roles. The transitional, or liminal, period can also be seen as a period of ambiguity, uncertainty, and a lack of a sense self where new selves can be created, altered, and played with. And during the incorporation phase, a person integrates his or her new social roles into the self. Plastic surgery becomes a self-imposed personal rite of passage where body features are physically separated from an existing sense of self, altered, and then incorporated into a new sense of self. The decision to have surgery occurs during a liminal period or state.
And having the surgery can hasten the passage through a liminal period to one of more stability because it provides a physical symbol of the motivation to move through the transition. Identity reconstruction occurs when a separating event, internally or externally driven, propels a person's sense of self from a nonliminic state to a transition period. As the person moves through the liminal period, the self adjusts itself and plays with new roles which are then incorporated into the new self. Reconstruction happens when the self adapts to these new roles. How identity reconstruction will occur varies depending upon the time and energy spent making the decision to pursue surgery, the magnitude of change perceived necessary, the decisiveness of a person, the imaginative tendencies of a person, the perceived attainability of the goal, and a person's sense of efficacy.
CHAPTER VI
A MODEL OF DECISION MAKING

Now that the literature on physical attraction, stereotypes, perceptions, self-concept, personality, and motivation has been addressed, it is time to look at how men arrive at the decision to pursue cosmetic hair restoration surgery. Using Sabatelli and Shehan’s (1993) textbook chapter on exchange and resource theories, a model for engaging in hair transplant surgery seeking behaviors will be suggested. Although exchange theory usually is reserved to explore relationships from a marriage and family perspective, in this paper the theory will be used to explore the relationship between people seeking a solution for their hair loss problems and the surgeons, or institutes, that can provide a treatment.

In order to understand the decision making process of men seeking hair restoration surgery, it is necessary to discuss the core assumptions and concepts of the exchange framework. There are core assumptions of human nature and of the nature of relationships. Six core assumptions of human nature are examined. People seek rewards and avoid punishment. If possible, people engage in behaviors that will maximize profits and minimize costs. Human beings are rational, but have limitations when calculating the rewards, costs, and weighing the alternatives before acting upon a decision. Standards that people choose to make evaluations differ between people and time. Also, the
importance that other people have in decision making differ between people and time. And last, if the value of a reward exceeds expectations, then the reward will be devalued in the future.

There are five core assumptions about the nature of relationships. Interdependence characterizes social exchanges. That is, profits from relationships are contingent upon providing others with rewards. Experiences will present relationships guide subsequent exchanges in relationships. Relationships are mediated by norms of reciprocity, which will be covered later in this chapter. Norms of fairness also guide exchange relationships. Lastly, the dynamics and stability of relationships are effected by imbalanced levels of attraction and interdependence by those involved.

In addition to these core assumptions, it is important to understand four major concepts of exchange theory. Resources, definitions of rewards and costs, expectations, perceptions of alternatives, and exchange orientation are characteristics that people bring into relationships. Norms and rules guide the fairness, equity, and reciprocity of all exchange relationships. Satisfaction with outcome, perceptions of fairness and reciprocity, trust of other, and commitment are experiences that can influence decisions to remain in or leave an exchange relationship. Also, power and control within relationships can effect exchange dynamics.

Rewards, costs, and resources are factors that can influence the decision to pursue cosmetic hair replacement surgery. Resources and rewards are the benefits exchanged between people in relationships. Rewards can be defined as pleasures, satisfactions, and gratifications enjoyed because of exchanges. These rewards can also be seen as positive
reinforcers that influence decisions. Blau (1964) identified five types of social rewards that can be sought through exchanges: personal attractiveness, social acceptance, social approval, respect/prestige, and compliance/power. These rewards are consistent with the goals sought out by cosmetic surgery patients cited in previous chapters of this paper (Dull & West, 1991; Schouten, 1991). Resources are basically the commodities exchanged to gain rewards. Foa and Foa (1980) named six types of resources: love, status, services, goods, information, and money. In the relationship addressed by this thesis, money and information are the only resources exchanged in the pursuit of surgery. Money is paid to a surgeon or institution in return for services rendered. And information is exchanged between surgeon and patient to decide which courses of action are possible or practical. Three types of costs have been addressed (Blau, 1964): investment, direct, and opportunity. Investment costs are the time and effort expended to acquire the ability to reward others. In this situation, time and energy is spent gathering information about hair transplantation procedures, researching possible treatments, interviewing a variety of surgeons, and deciding whether to pursue the procedure. The direct cost for a person seeking this surgery is the hard currency spent to have the procedure performed. Opportunity costs are the rewards that are forgone because of the decision to engage in a relationship. For example, a person who decides to spend ten thousand dollars on a hair transplant may have spent the money on a new automobile or for a European vacation.

After the discussion of costs and rewards, it is time to address the first stage in the process to undertake hair restoration surgery (Fig. 1). The first stage in the decision making model is the decision to seek treatment. At this stage, a person is dissatisfied with
their current state of baldness or thinning, weighs the rewards and costs of pursuing treatment, and makes the decision to seek out treatment options. In addition to the description of costs and rewards previously, cultural norms, individual personality factors, and previous relationship experiences also weigh to varying degrees upon perceived rewards and costs, therefore affecting the decision to seek treatment. Cultural norms might include acceptable hairstyles for peer groups, fads, advertisement and media, acceptability of cosmetic surgery within socio-economic status and ethnic group, and perceptions and stereotypes about baldness and physical attractiveness. Personality factors might include personal locus of control (internal or external), level of public self-consciousness, self-concept, body image, and other biological factors. And last, relationship experiences might include relationships with parents, friends, spouses, and medical professionals.

After weighing the rewards and costs, a person will either seek treatment options or decide not to seek options. If perceived rewards are proportionate to perceived costs or higher than costs, then a person is more likely to engage in treatment seeking behaviors. If costs are higher than rewards or are not proportionate, then a person is less likely to seek treatment. When the person decides to seek treatment options, an information gathering process begins. This information gathering will occur to varying degrees depending upon whether the person enters an extended decision making process or a limited decision making process. Extended decision making processes are usually reserved for important and costly decisions, and require larger amounts of information for a person to make an informed decision. A limited decision making process requires much
less information, or is influenced by an emotional reaction. Only a few factors may be
taken into consideration before a person feels he or she can make a decision. This
information gathering occurs concurrently with the second stage of the decision making
process.

At the second stage of the process, perceived costs and rewards are again weighed
to determine whether a person will have treatment or not have treatment. Specific factors
that may effect the decision to have surgery can be the relationship with medical
professionals encountered, the type of clinics that were explored (large business clinic or
small medical office), the amount of clinics or doctors visited, the perceived quality of the
procedure, the perceived and actual costs of the procedure, the time spent in the decision
making process, and the amount of knowledge acquired about the procedure. Cultural
norms, personality factors, and relationship experiences also affect this stage of the
process. After gathering information and weighing the costs and rewards, a person then
must decide whether to have surgery. Again, if costs outweigh rewards, then a person is
less likely to have surgery. And, if rewards outweigh costs or are proportionate, then a
person is more likely to have surgery performed.

If a person has surgery performed, the actual outcome of the surgery is compared
with his perceived outcome to see if surgery matched expectations. This will determine
satisfaction with the procedure. Satisfaction with the procedure is obtained from
evaluations of possible and previous outcomes of procedures. Outcomes are measured by
subtracting the costs from the anticipated, or experienced, rewards. Generally, positive
outcomes are accompanied by high levels of satisfaction. In this model, satisfaction
occurs when actual outcome is proportionate to or greater than perceived outcome. However, if actual outcome is substantially greater than the costs or the perceived outcome, then the value of the procedure is cheapened. Satisfaction will occur, however the procedure may be taken for granted in future exchanges with the same or a different professional. Dissatisfaction arises when actual outcome is less than perceived outcome. The person may feel he did not get as much as expected out of the procedure.

Expectations also weigh very heavily upon satisfaction. Many patients have the expectation that having hair will positively effect other aspects of their lives such as their intimate associations, career pursuits, and their own personal efficacy. It is very important to educate prospective patients about the realistic expectations they should anticipate in order to ensure satisfaction. Although surgery from a technical standpoint may be flawless and the objective outcome excellent, patients may be dissatisfied if their expectations were unrealistic. Therefore, realistic expectations will more likely lead to greater satisfaction and unrealistic expectations will more likely lead to greater dissatisfaction.

Satisfaction arising from the procedure will lead to the completion of the hair restoration process through additional grafting sessions. Depending upon the techniques of the surgeon, usually 3-5 procedures are needed to complete the hair restoration process. After each initial session, the satisfied patient will return to Stage 1 of the model to decide whether he wants to seek additional hair grafting or seek alternatives. Satisfied patients are more likely to remain with their original surgeon for further treatment until completion. However, some patients may be influenced by important factors such as cost of the procedure, geographical proximity to surgeon, or perceived "advanced or superior"
techniques. As stated earlier, if overvaluation of the actual outcome arises, patients may take their results for granted. Patients may wrongfully view that all transplant methods yield similar results, and not realize this until they have unfavorable outcomes with other surgeons. Dissatisfied patients may decide to seek alternatives for their perceived negative outcome or may decide not to seek alternatives. This patient also follows the negative feedback loop back to Stage 1 of the model. After gathering additional information, the dissatisfied patient may decide to have surgery again, but the decision to have surgery again will usually not be entered into lightly and the rewards and costs are weighed more heavily.

Dependence in exchange theory is the degree to which a person believes that outcome is reliant upon the other person in the relationship. If a patient believes that only one surgeon is capable of performing this procedure to his specifications, he will be less likely to pursue or consider other alternatives. Dependence is also mediated by barriers that discourage a person from leaving a relationship. Barriers can be internal or external. Internal barriers such as feelings of obligation and indebtedness raise the psychological costs of dissolving the relationship making termination difficult. Many patients who have had surgery at other clinics feel guilty about their decisions to find a new clinic or a better doctor. It is difficult to leave their current situation because surgery at another clinic is sometimes viewed as betrayal of the doctor-patient relationship. External barriers such as primary affiliation groups (places of employment, church), community pressures, legal considerations, and financial demands raise the social and economic cost of terminating a relationship. Although a person may desire that surgery be done by another, more
artistically qualified surgeon, the price for surgery may be prohibitive.

Societal norms are also responsible for influencing people's decisions. Normative orientations in exchange theory are societal views about what is acceptable and appropriate relationship behavior. One rule of equity, distributive justice, states that rewards should be proportional to costs and that profits should be proportional to investments. If disproportion exists, then likelihood of engaging in these relationships is decreased. The norm of fairness asserts that certain degrees of proportionality are expected in relationships. The more proportionate the relation between rewards, profits, costs, and investments, the greater chance that expectations have been met and exchange relationships will be engaged. The final rule regulating exchange relationships is the norm of reciprocity. The norm of reciprocity states that exchanges are sensitive to each other and determine when and how resources are repaid. The motivation to adhere to reciprocity norms is linked with indebtedness. The more indebted a person feels, the more emotional arousal and greater discomfort is experienced, and the stronger the attempts made in order to deal with or minimize feelings of indebtedness. For example, a man losing his hair may believe that his hair was responsible for the quality of women that were attracted to him. This man may place greater worth upon his hair, feeling indebted to his hair for the attentions he believes it brought him. This person may experience depression (emotional arousal) and discomfort with subsequent interactions which increase the likelihood that he will seek a solution to his problem. And the decision to pursue a course of treatment will reduce his feelings of indebtedness.

Another component that effects the decision making process is whether a person
trusts the surgeon and observes a commitment to the process. Trust is the belief that the surgeon will not exploit or take advantage of him. Development of trust and commitment between surgeon and patient is facilitated by the adherence to norms of reciprocity, equity, and fairness. Commitment, on the other hand, is the willingness to cooperate in a relationship for a prolonged period of time. Increased levels of commitment lead to overall stability in the relationship if gratifying over a sufficient amount of time. Stability is also built because of the increasing dependence one experiences during a committed relationship. As trust and commitment are formed within a relationship, the less likely a person is to leave the doctor-patient relationship. As trust grows, a commitment is formed between patient and surgeon which decreases the likelihood that the patient will question the quality of the procedure and the quality of the surgeon, or go elsewhere for surgery.

The exchange dynamic of power and balancing of power and dependence within the relationship between the surgeon and patient can influence the decision to have surgery or pursue alternatives. Power is defined as controlling another’s behavior through the ability to force or counter compliance. Authority, as opposed to power, is viewed as the ability to legitimately extract compliance. Two statements illustrate the fundamental effects of power on exchange relationships. First, dependence and power are inversely related. The greater reliance one has upon another, the less power that person brings to the relationship. And second, resources and power are linearly related. For example, a man who is financially advantaged may not be as concerned with the price of the hair restoration procedure and can focus upon the quality of the surgeon and work performed. This change in focus gives this man greater power over his decisions.
The exchange relationship itself is a dynamic that is characterized by attempts to balance power and dependence within the relationship. Balancing power and dependence provides protection from exploitation and allows individuals to seek alternatives when discrepancies exist.

Given the structure of the model, it may be helpful to examine a profile of a man who might be more likely to consider having hair transplantation surgery. The decisions of men are affected by internal and external pressures. Internal pressures are personality factors, biology, and self-concept. External pressures are stereotypes, perceptions, cultural norms, and previous relationship experiences. Based on the research presented in this paper, a profile for men more likely to consider hair transplantation might include: negative body image with regard to hair, depressive characteristics, an external locus of control, high scores on measures of public self-consciousness, neuroticism, and psychoticism, low self-esteem, and undergoing a transition period in life. Although not discussed in great detail, locus of control may exert a strong influence over men and affect their susceptibility to cultural norms, stereotypes, perceptions, and relationship influences. Men with an internal locus of control may not be influenced as strongly by cultural norms and stereotypes as men with an external locus of control. Therefore, it would be expected that men with an external locus of control would be more likely to pursue surgery because of their proneness to social influences. Also not discussed at length in the literature, is the influence of relationships. Most men, in my experience, seek surgery because they fear that others will view them negatively. Family members and especially romantic partners can be strong motivators. Many men believe that their physical appearance with respect to
hair will affect the quality of relationships that can be attained. Although cultural norms, personality factors, and relationship experiences do influence whether men will have surgery, it does not ensure satisfaction.

Whether a patient is satisfied with the resultant outcome is also affected by the same internal and external influences as the decision to have surgery. For example, a man with an internal locus of control is probably more likely to experience satisfaction with a procedure than a man with an external locus of control. This man's initial decision to undergo surgery was based more upon his personal feelings and desires than the feelings and dictates of society. Therefore, he is exerting control over his own destiny and does not feel that society dictates his actions. People who have surgery while in a depressive state may also be more dissatisfied than others who are not depressed. Depression may cloud judgment during and after the decision making process. Satisfaction usually does not arise out of the accomplishment of one goal. It is the overall balance achieved between outcome and costs. If outcome is not proportionate to costs and expectations, then dissatisfaction will arise. However, if they are proportionate, then satisfaction will occur.

In summary, social exchanges are guided by core assumptions about human nature and the nature of relationships. Although influenced to varying degrees by cultural norms, personality factors, and relationship experiences, balding men who are dissatisfied with their current state of baldness weigh the costs and rewards of seeking a solution to their baldness, decide whether to seek treatment, weigh the costs and rewards of having the surgery, and decide whether to have treatment or not. After comparing their actual
outcome with their perceived outcome, a satisfied or dissatisfied patient then decides whether to continue the process, seek alternatives, or to remain at their current state. Norms of fairness, equity, and reciprocity mediate the doctor-patient relationship by providing structure to the relationship and to insure that these relationships are equitable, fair, obtainable, and practical. Satisfaction, or perceived satisfaction, about an outcome, perceptions of fairness and reciprocity, trust of partner, and level of commitment are emergent characteristics of the relationship between the doctor and patient that influence decisions to remain with their current treatment giver or go elsewhere. And lastly, the exchange dynamics of power, control, and dependence are balanced within a relationship to guard against possible exploitation and provide alternatives for unsatisfactory circumstances.
CHAPTER VII
DISCUSSION

The intention of this paper is to review current related literature concerning topics about men and cosmetic surgery with a specific focus upon hair loss and the decision to seek cosmetic surgery. The social exchange model of decision-making is suggested as a means of furthering psychological research in the field of hair restoration surgery and cosmetic surgery with regard to men.

Many difficulties were encountered in the process of researching this subject. First and foremost, there is very little psychological research on hair loss and cosmetic surgery. And even less research on the psychological issues of men and cosmetic surgery. Most of the literature cited in this paper is indirectly related to the topic of men's decisions to pursue cosmetic surgery. These indirect references reflect the absolute lack of comprehensive research about this topic. One reason that little research exists is the relative newness of the field of hair restoration surgery. Although hair transplantation has been performed in the United States for about forty years, the widespread practice of this procedure with natural quality results has only been available for about ten years. Another reason for the underdeveloped research in this field is a new, almost faddish, perception of vanity. Because of new technologies, men and women who are dissatisfied with certain aspects of their appearance now have the ability to alter these problems and prevent the
march of time physical appearance. And people are flocking to have these procedures performed. Unfortunately, because technological advances in cosmetic surgery are developed so quickly, research that might be explored may become obsolete in a number of years. With respect to hair restoration, a variety of drugs are now being employed in the arsenal of treatments to prevent or delay hair loss. And the human genome project has recently identified to genes responsible for alopecia totalis. It may not be long before the genes for alopecia androgenetica (male pattern baldness) are identified and a gene therapy is developed to prevent baldness altogether. Thus making the decision to seek cosmetic hair replacement surgery obsolete.

Additional research is also needed to examine multicultural and ethnic perceptions about cosmetic surgery. Most of the literature reviewed utilized white female subjects. Although one article discussed negative assignations to ethnic features, the article did not explore how these features were perceived within their own ethnicity and whether other ethnic groups differ in their perceptions about physical appearance and cosmetic surgery.

Research on the personality characteristics of men exhibiting hair loss and seeking cosmetic surgery is necessary to help identify true sources of anxiety, depression, and malaise associated with hair loss. Additional research in this area could identify those at psychological risk for pathology as a consequence of hair loss. And interventions can be taken to protect men at risk from the psychological impact of hair loss.

Quantitative research on motivation is also needed to investigate the rationales for seeking cosmetic surgery. Many men pursue hair transplantation for reasons other than hair loss. Knowing more precisely why men are seeking surgery could prevent men who
think that surgery will improve certain aspects of their lives from making poor judgement
decisions that will literally and permanently scar them for life. Examining these motives
could distinguish between reasons that will create favorable outcomes and reasons that do
not make a patient an ideal candidate for surgery.

The last area of research that was surprisingly lacking is the field of men's issues.
In general, psychological research in the area of cosmetic surgery, vanity, and men's issues
is shoddy, at best. Men are now seeking cosmetic procedures in record numbers.
Although one author suggested that men do not perceive the decision to pursue cosmetic
surgery as natural and normal, societal views seem to be changing in response to growing
demand. It is now time to investigate the impact that surgery and hair loss have on men.

Another difficulty encountered in the research of this paper is the inherent
limitation of social exchange theory. Social exchange theory is primarily used to describe
marital and family relationships. Although the theory is useful in the conceptualization of
decision making within a theoretical relationship, it does not explore in great detail the
inner psychological structures and processes at work in the individual seeking cosmetic
surgery. Additional theoretical orientations need to suggest possible models of decision
making in these circumstances and need to be tested. A cognitive decision making model
might be helpful to explore the conscious and unconscious motivators in the decision
making process. Because of the financial reward to surgeons performing this type of
elective surgery and the business orientation of many hair institutes, a cost/benefit model
may be useful to explore the benefits, rewards, and losses associated with decisions.

There are serious implications that need to be examined with respect to men and
hair restoration surgery. In my six year experience as surgical technician and consultant for a hair restoration clinic, it is my belief that many surgeons do not fully understand the motives of patients seeking surgery. Some surgeons are concerned about their patients, but because of the elective nature of the surgery, many surgeons are not concerned with patient outcome. Unfortunately, the field of plastic surgery is, just that, plastic. Vanity, prestige, and financial reward are the driving forces in many surgeons lives, not patient care. Fifty percent of the patients seen in the clinic where I work have had work done elsewhere by a supposedly experienced doctor, have been dissatisfied with their results, and are seeking repair of poor quality transplantation. They are jaded, misinformed, depressed, and in some cases, suicidal because cosmetic hair transplantation has made them look freakish or less physically attractive. These negative experiences are usually attributed to patients who did not receive adequate information, received misleading information, or were emotionally coerced into making poor decisions. Many clinics employ salespeople with no medical training to consult prospective patients. Their only goal is to get you to sign on the dotted line. To my knowledge, this is the only area of cosmetic surgery, or for that matter, any surgery where a medical professional may not be involved in diagnosis and consultation. This practice needs to be addressed to ensure that prospective patients do not end up with negative permanent consequences for their actions. Men seeking hair restoration surgery must take a buyer beware stance and engage in extended long-term decision making that will allow them to make rational informed decisions. Surgeons and medical professionals also must become more aware of their role in the life of the patient. In gaining awareness, these professionals must learn
which clients are good candidates and which clients should not be considered for surgery because a poor result could psychologically affect them for life. A greater understanding of patient motives and feelings is important to ensure a positive therapeutic treatment relationship and to insure that people make the right choices for appropriate reasons.
Figure 1

Model of Decision Making for Hair Restoration Surgery

Stage 1
Decision to Seek Treatment

Stage 2
Decision to Have Treatment

Process Completion
REFERENCES


VITA

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