The Male Aesthetic Patient

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• **Just like their female counterparts, men are increasingly turning to facial plastic surgery, but male patients bring to the surgeon an array of unexplored motivations and expectations along with unresolved emotional conflicts. These feelings of ambivalence, emotional instability, and sometimes even hostility toward the surgeon make the male aesthetic patient more of a psychological risk than the female aesthetic patient. This article focuses on how the surgeon can recognize and control the male patient's emotional disturbances and, consequently, better serve his patient and protect himself.**

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A few decades ago there was a definite stigma against aesthetic (cosmetic) surgery. This attitude has gradually faded, and today society willingly accepts aesthetic surgery. Furthermore, and probably within the past decade, aesthetic surgery is no longer largely limited to women. Men are also seeking aesthetic surgery and they are up-front about it. This change in attitude adds to the aesthetic surgeon's problems. He must now realize that he cannot use the same method for psychologically evaluating both male and female patients.

On the assumption that previous psychological studies have dealt primarily with the female aesthetic patient, this article focuses on the male patient and addresses one question in particular: Is the male aesthetic surgery patient more of a psychological risk than the female patient? Keeping this question in mind, I will discuss four major topics: the increase in male aesthetic surgery; the psychological differences between male and female aesthetic patients; the dynamics underlying the emotionally disturbed male patient; and the treatment and management of the male aesthetic patient.

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INCREASE IN MALE AESTHETIC SURGERY

Goldwyn,[1] in his excellent book *The Patient and the Plastic Surgeon* (1981), states that 85% of aesthetic surgery patients are female. Prior to Goldwyn, Baker,[2] in his study of 1500 face-lift patients (1975), found that only 4% of the patients were male. Two years later he found that the percentage of male patients had doubled. Finally, in a recent poll (1986) conducted by Cash et al,[3] 45% of the women interviewed indicated that they would have cosmetic surgery, while 33% of the men stated that they would consider it. Other studies and observations bear out the increase of both the acceptance and the occurrence of male aesthetic surgery.

These percentages tell us only one fact: male aesthetic surgery is increasing. We have only speculative theories as to why aesthetic surgery has been largely devoted to women, and as to why male aesthetic surgery is increasing.

PSYCHOLOGICAL DIFFERENCES BETWEEN THE SEXES

Most authorities agree that the preponderance of female aesthetic patients stems from cultural, social, and psychological factors. Goldwyn[1] states that "our culture places a higher value on the attractive appearance of the woman than that of the man . . . that the woman, deprived of many sources of gratification available to men, has learned to use and value her body to please herself and others." Kurtz[4] points out that women have a clearer body concept than men, a greater awareness of their physical appearance, and a more articulated notion of what they do and do not want from surgery. Kurtz also notes that a husband is often more aware of his wife's aging than of his own and is frequently critical of his wife's surgical results. Prosen and Prosen[5] psychoanalytically explain this phenomenon by stating that the man who is looking for the idealized woman—his mother—in his wife will never be satisfied with the results of his wife's cosmetic surgery.

Today, we know that the psychosocial roles of the sexes are changing and becoming less differentiated. What we do not know is the effect that these changes are having on the male. Are these changes releasing men from a stereotyped role lacking in individuality and originality, or are the changes threatening to their long-term established and unchallenged role? Although we would like to believe that, since sex roles are becoming less differentiated and aesthetic surgery is becoming more acceptable, the male patient's satisfaction from aesthetic surgery will increase correspondingly, the opposite could be true. The increase in male aesthetic surgery could reflect the male's reaction to a threat or his surgical search for identity. If this is the case, the male's satisfaction with aesthetic surgery could relate inversely to the increase in male aesthetic surgery.

Although I did not find definitive

data that differentiate male and female motivations for, and expectations from, aesthetic surgery, my findings definitely substantiate the fact that the sexes differ as far as psychological stability. At the present time, the male patient is more likely to be psychologically unstable than is the female patient.[1,2,6-8] Also, the male patient, especially the male rhinoplasty patient, demonstrates more psychological pathologic features than does the female patient.[6-8] Therefore, the male aesthetic patient represents more of a psychological surgical risk than does the female.

THE DYNAMICS UNDERLYING THE DISTURBED MALE PATIENT

Aesthetic surgeons agree that the male patient is more psychologically disturbed than is the female patient. They do not agree as to why the male patient is more disturbed. I shall review some of the researchers' theories as to why the male aesthetic patient represents a psychological surgical risk.

Probably most outstanding for their research on the male aesthetic patient is The Johns Hopkins group. In 1960 Jacobsen et al[6] concluded that male patients are more likely to be "psychologically ill" than are their female counterparts. They explain their findings by pointing out that men often identify with one of their parents, focus this identification on the parental nose, and then have ambivalent feelings about breaking the identity. For example, a boy may identify with his father and (probably unconsciously) focus this identity on his father's nose. Then when growing up, he may want to disassociate himself from his father, while not wanting to lose his masculine symbol of identity. On a deeper level, he may want to rid himself of a primitive rage against his mother and want to relieve the symbolic association but not want to disturb his familial symbol. These identification conflicts often become apparent in adolescence, or they can be harbored and reactivated later in life.

The Johns Hopkins[6] group describes the male risk patient as an individual with low self-esteem, a lifelong history of inadequacies in personal, sexual, and working relationships, and a vagueness about the desired surgical results.

Gifford[7] describes the male cosmetic risk patient as a person who attributes a lifelong history of inadequacies to a "single physical defect," who has a delusional fixation on a body part, who continually seeks additional surgery, and who has a blaming, or, in extreme cases, a paranoid and persecutory attitude toward doctors.

Gifford's evaluation and prognosis regarding the male homosexual patient differs from those of other surgeons in that he feels that the homosexual patient is most likely to be dissatisfied with the results of his surgery. A speculative interpretation of this opinion is that the man who owns up to his homosexuality tends to know what he wants, such as a more feminine nose, and is usually satisfied with the surgical results; while the man who is in conflict about his sexuality or has latent homosexual tendencies is not sure what he wants and therefore is more likely to be dissatisfied.

Goldwyn[1] observed that the male patient, especially the male rhinoplasty patient, is more inclined than the female patient to be dissatisfied with the surgical results. He agrees with other authorities that the basic problem is one of identity. He advises the surgeon to be wary of the older neurotic man who will not face natural aging; the man who is in a crisis situation; the man who has unresolved grief; and the man who is seeking a psychiatrist or has a psychiatric history. Finally, Goldwyn warns the surgeon about the man who is hostile during the initial interview, stating that, despite good surgical results, this patient is most likely to sue his surgeon postoperatively.

Goin and Goin[8] agree with Goldwyn that male patients are more psychologically disturbed than female patients. They indicate that the male rhinoplasty patient who did not dislike his nose as an adolescent is a high-risk patient. Diagnostically, they relate such psychological symptoms as shyness, reclusiveness, aloofness, and strange feelings about the body to schizophrenic processes. An unexplained finding of Goin and Goin is that "Jewish men may be at lower risk than their non-Jewish counterparts."

Although Schilder,[9] Lynn and Goldman,[10] Knorr,[11] and MacGregor and Shaffner[12] did not publish studies specifically related to the male patient, their findings shed light on why the male cosmetic surgery patient is more psychologically disturbed than the female cosmetic surgery patient. Schilder,[9] in his research on body image, stresses the association between the symbol and its representation. He focuses on the fear of losing a body part, particularly an appendage. Based on this premise, he implies that the male penis-nose association stirs more fear than the female vagina-nose association. Finally, Schilder discusses how surgery can resurrect early childhood fears and how it can inadvertently cause the rage and resentment that long ago was associated with the parent to be directed toward the surgeon.

Lynn and Goldman[10] worked on the assumption that all cosmetic patients "are in effect psychiatric patients." They found that the most disturbed patients were men with a nasal fixation. To describe this exaggerated nasal focus, they coined the term *psychiatric syndrome of the rhinoplasty patient.* Lynn and Goldman believe, as do Goin and Goin,[8] that many of the disturbing psychological symptoms of the male cosmetic patient are indicative of basic schizophrenic processes.

Knorr,[11] in describing the rhinoplasty patient, notes that postsurgically the patient often feels a loss of identity, an increasing need for additional surgery, and a hostile attitude toward the surgeon that often leads to the threat of a lawsuit. He defines the surgeon's reaction as the "exhausted surgeon's syndrome." He warns the surgeon about the rhinoplasty patient, especially the male, who seeks surgery for a breathing disorder. Lastly, Knorr discusses the dangers of operating on the surgical addict, the patient who has an insatiable desire for surgery.

MacGregor, a pioneer in psychosexual studies, documented the sexual symbolism of the male nose and, as

Knorr, warns the surgeon about the male patient who attempts to hide his desire for appearance improvement by saying that he wants a rhinoplasty for reasons such as nose bleeding, difficult breathing, or a traumatic injury.

In studying the psychological aspects of the rhinoplasty patient, only Hay[13] and Wright and Wright[14] used control groups. Hay and the Wrights found that the patients (both male and female) in the rhinoplasty surgery group were more disturbed than those in the control groups. The Wrights found specific characteristics associated with the rhinoplasty patient. While rhinoplasty patients tended to be interesting, intelligent, likeable, imaginative, enthusiastic, and energetic, they were prone to be restless, impulsive, immature, self-critical, and self-centered. As to psychic pathologic manifestations, both Hay and the Wrights found that the personality disorder category of mental disorders was significantly related to the rhinoplasty patient. Patients with a personality disorder tend to act out, to manipulate, to have their pleasure at the expense of others, to disregard social mores, and to be lacking in emotional depth.

Hay,[13] in his study of 45 rhinoplasty patients, observed that the male patients were more psychologically disturbed than the female patients, but he did not find this difference to be statistically significant. Most importantly, Hay did not believe that the degree of deformity was a relevant factor in the patient's satisfaction with the postoperative outcome. The evidence of other studies support this finding.[7,8,14] Also, contrary to the observation of Jacobsen et al,[6] Hay did not find evidence of a strong identification with the parental nose.

In the Wrights'[14] study of 90 rhinoplasty patients, the 25 patients who were reevaluated 18 to 25 months postoperatively showed an improvement in the psychological clinical scales. However, this improvement was not of statistical significance. Only one patient in the group had a psychotic break following surgery. He was a single man with schizophrenic tendencies.

It is my contention that the current prevalence of emotional disturbances in male patients is based on Freud's[15] work in the early 1900s. In his classic case study "The Wolfman," Freud[15] portrayed how a surgeon who removed a mole from a man's face later received the patient's blame, hostility, and accusations.

Later (1934), based on Freud's outstanding work, Updegraff (a plastic surgeon) and Menninger[16] (a psychiatrist) published case studies depicting how unconscious fears and wishes (eg, castration) can be acted out in surgery. They also revealed how the surgeon, especially the plastic surgeon, can become the recipient of the patient's stored hostility, resentment, and even death wish. Deutsch[17] extended Freud's theory by showing how all patients have separation anxiety as well as castration fears.

Last, and most profound, the four recorded acts of homicide that I have reviewed where the patient postoperatively murdered his surgeon were all performed by male patients. Two of the three patients involved had undergone rhinoplasty. One rhinoplasty patient, because he did not like his nose after surgery, killed his surgeon, a man named Dr Alexander[18]; the second killed Dr Vazquez Anon,[19] a Spanish surgeon. The third assassin killed two Australian doctors after being accused of malingering.[20] In my opinion, these patients were all paranoid schizophrenics.

TREATMENT AND MANAGEMENT

Prevention is still the best treatment for psychological disturbances. Therefore, the aesthetic surgeon must recognize that the male aesthetic patient requires thoughtful and careful counseling, both preoperatively and postoperatively. While the surgeon need not delve into the psychological dynamics underlying the emotionally disturbed male patient, he should accept that these dynamics exist and are not just "strange Freudian concepts."

Although I do not routinely recommend psychiatric or psychological consultation for the male aesthetic patient, I do recommend it for any patient who reveals disturbing psychological symptoms or for any patient with whom the surgeon feels intuitively uncomfortable.

As to patient rejection, it is generally agreed on that there are only three criteria for refusing a male patient aesthetic surgery[21]: (1) the presence of a delusional fixation on a body part; (2) the indication of paranoid thoughts; and (3) a history of surgical insatiability. The patient with a personality disorder falls within the gray area.

Both the patient with a delusional fixation and the patient with paranoid thoughts do not have the emotional reserve to withstand elective surgery. They are likely to decompensate postsurgically and to bring harm to themselves or to their surgeon. For the patient with an insatiable desire for surgery, the surgical addict, surgery is a fantasy or an obsession, and it may destroy the patient's meager means of coping with his shaky life and encourage him to seek repetitive surgery. While the patient with a personality disorder is most prone to sue his surgeon, he should not be viewed as a reject but as a patient whose psychic pathology must be recognized and controlled.

The key to preventing psychological manifestations is control. Some specific danger signs that must be recognized and controlled in the male aesthetic patient are as follows:

- A fear of the loss of a defect that has served a long-standing defensive purpose.
- An identity or sexual conflict.
- A tendency to hide the desire for surgery behind other physical reasons.
- A history of inadequacy in relationships.
- An unresolved grief or a crisis situation.
- Being unmarried or homosexual.
- Being older or concerned about aging.
- A sudden anatomic dislike.
- A blaming attitude toward authority.
- A desire for a change in one's life situation.
- A history of seeing many doctors and being dissatisfied with them.

• A pushy or desperate approach toward the surgeon.

• A tendency to flatter or manipulate the surgeon.

• A resistance to psychiatric consultation.

In case the male patient expresses dissatisfaction or decompensates postoperatively, these conditions should be treated like other dissatisfactions or complications. Research has shown that most dissatisfactions are resolved with time and return visits.[22] Complications most often can be treated quite satisfactorily, after the surgeon has resolved both his own and his patient's emotional reactions.[23] It is especially important for the surgeon not to react defensively to the male patient's hostility, remembering that complications are not synonymous with mistakes.

COMMENT

We must keep in mind that, as cultural patterns change and male aesthetic surgery increases, we may see fewer disturbances in the male patient. Goldwyn[24] states that "men desiring eyelid-plasty and face lifts are usually as stable and as satisfied with their results as their female counterparts." He goes further, saying that, in some cases, the male is easier to please and not as "psychologically ill" as other studies[6] have reported. One wonders, "Could the prominence of psychological disturbance in the male patient result from the fact that, until recently, society only sanctioned aesthetic surgery for women and that, therefore, only psychologically disturbed men dared to have aesthetic surgery?" If this is the case, are our findings biased because of a skewed distribution?

Still, we must go with what findings support. Summarizing the observations from the literature, four findings prevail: (1) The male patient, especially the male rhinoplasty patient, is more psychologically disturbed than the female. (2) Psychological disturbances are usually long-term and tend to reflect an identity conflict or a somatic conversion of a conflict. (3) The degree of deformity cannot be equated with postoperative dissatisfaction. (4) The surgeon often becomes the recipient of the patient's repressed hostility.

Why is the male rhinoplasty patient a predominant risk? This question can only be answered by deductive, but supportive, theories. The nose is the most prominent midline protruding structure of the body. For the male, it is the landmark of masculine identity. For both sexes, it is a familiar structure of identity and has long played a part in celebrative and punitive rites. The nose is a natural site for a somatic conversion. The aesthetic surgeon is often faced with the difficult, or even impossible, task of relieving disturbing symbolic symptoms without disturbing the symbol.

Only recently, I saw a young maladjusted man who had a psychotic break following a rhinoplasty and two revisions. Postoperatively, he felt hostile toward the surgeon, blaming him for taking away his "Roman heritage" and later suing him for medical malpractice. Actually this man demanded surgery to relieve his exaggerated nasal focus and to hide his ambivalent feelings toward his mother. This case exemplifies the three criteria for refusing a patient surgery: paranoid thoughts, a delusional fixation, and an indication of surgical insatiability.

Finally, while accepting that the male aesthetic patient represents more of a risk than the female patient, this condition should be viewed as a challenging and fascinating area to be explored, rather than as an ominous or dangerous warning. Today, dramatic changes are taking place in man's role in society, and we do not know how these changes will affect man's new-found freedom to have aesthetic surgery. Only time and research will tell us whether the male aesthetic patient will continue to be more psychologically disturbed than the female aesthetic patient.

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