

Self-Esteem and Cosmetic Surgery: Is There a Relationship Between the Two?

Cynthia Figueroa

This article addresses the correlation between a patient's self-esteem and the demand for and use of cosmetic surgery. The greater purpose of this article is to broaden nurses' understanding of the profound influence of self-esteem as it relates to cosmetic surgery patients and their decision to have surgery.

A popular journalist wrote, "A woman who focuses obsessively on a perceived (or real) flaw and resorts to excessive plastic surgery may be avoiding other unhappy things in herself that require more than a nip and a tuck to fix. The person can fill her day researching different surgeries and planning who will do it, which fills time so she's not thinking about the real problems that exist within herself" (Davis, 1997, p. 220).

Since Narcissus first saw his face in a pool of water, humankind has been obsessed with appearance. The art of facial decoration has been recorded for centuries, as far back as ancient Crete. Cleopatra used natural substances to care for her skin and apply make up to her face. Sour milk baths (lactic acid), plants, such as berries, and clay were just a few natural cosmetics used to smooth the skin and brighten the face. These superficial changes in appearance are only one form of ego building and self-adornment (Dugas, 1999). The purpose of this article is to address the profound influence of self-esteem on the decision to have cosmetic surgery.

Self-Concept

Self-concept is a large and complex psychological construct composed of body image, self-esteem,

and role performance. Role performance is the ability to carry out activities and make the necessary decisions needed for the job or role in which a person participates. While not readily apparent, the perceived inability to carry out a public role or a highly visible role may fuel a desire for cosmetic surgery. Most commonly associated with actresses, the need to maintain a competitive look may exist in other occupations also, even in the corporate business world.

Body image refers to the mental picture that persons' form of their bodies. This perception is influenced by one's own beliefs and attitudes as well as ideals in society. One's body image does not remain the same but changes in response to lifestyle events (puberty, pregnancy, disability, illness, surgery, death, menopause, and even different stages in the menstrual cycle) (Body Image and Self-Esteem, 2000). Body image is closely connected to a person's self-esteem.

Self-esteem refers to how much people value or accept themselves for whom and what they are. Self-esteem refers to the degree to which people are satisfied or dissatisfied with themselves (Baumeister, 2001). Some writers have asserted that self-esteem reflects the difference between the ideal self (i.e., how one would like to be) and the actual self (i.e., how one actually is). Others have suggested that an individual with substantial distance between the actual self and ideal self will develop a negative perception of self, that is, low self-esteem, while an individual with modest distance between the actual self and ideal self

will develop a more positive perception of self (high self-esteem) (King, 1997).

Self-esteem also reflects a person's evaluation of self-worth. Global self-esteem refers to overall feelings about self and is relatively resistant to change. Specific aspects of self-image and self-esteem are more easily influenced by situational events that disrupt a particular substructure of the self, such as the person's roles, appearance, or functions.

Self-esteem is, therefore, an intrinsic concern for nurses in their practice and society in general. Whether addressing body image or self-esteem through cosmetic surgery, nurses should value and respect clients for who they are and for what they are going through during this sensitive period in their lives. Due to the complexities of these components of the psyche, exploring various theories can help the comprehension of the issue.

Self-Esteem

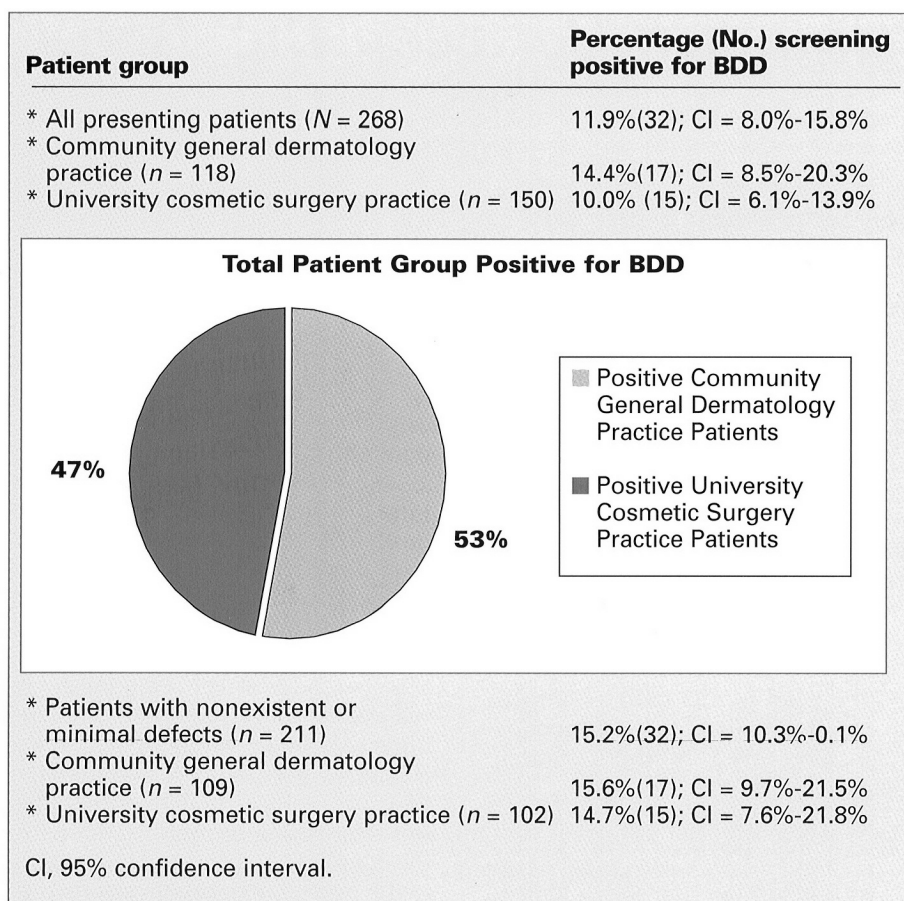
Development of self-esteem.

According to Maslow's hierarchy of needs, meeting basic needs during early developmental stages in life fosters healthy self-esteem levels. When there is a disruption in the completion of a stage, people tend to alter their level of comfort and question their level of esteem. People may alternately attempt to reach a comfort level through other methods, one of which may include cosmetic plastic surgery. Satisfaction of the self-esteem needs leads to feelings of self-confidence, worth, strength, and adequacy. But thwarting the fulfillment of these needs produces feelings of inferiority, weakness, and helplessness (Maslow's Holistic Dynamic Needs Hierarchy, 2001).

Health care professionals have long acknowledged the importance of self-esteem to mental health. Self-

Cynthia Figueroa, MSN, ARNP, is an Advanced Registered Nurse Practitioner, Barry University, Miami Springs, FL.

Figure 1
The Rate of Body Dysmorphic Disorder in 268 Dermatology Patients



esteem has been identified as a factor in the development of depression. High self-esteem has been reported to protect women from depression. Low self-esteem contributes to depression (Peden, Hall, Rayens, & Beebe, 2000).

Measuring self-esteem. Research has been conducted measuring self-esteem levels on a large variety of populations and using a variety of instruments. Medical researchers have studied self-esteem levels of postoperative reconstruction patients (Harcourt & Rumsey, 2001), and professors have studied esteem levels of their student populations (Peden et al., 2000).

An example of a commonly used self-esteem tool, the Rosenberg Self-Esteem Scale, measures an individual's self-esteem from a global or overall perspective. The instrument had a 2-week test-retest reliability of $r = .85$ in a sample of 28 subjects. Internal

consistency was measured by coefficient alpha ranges from .76 to .87 (Rosenberg, 1965). Coopersmith's (1967) Self-Esteem Inventory was used to measure self-esteem levels among grade school children. Educators performed studies using this tool while measuring children's self-esteem in conjunction with discipline difficulties (King, 1997).

Self-esteem can also be studied without instruments using qualitative research methods that interview subjects to gain understanding of a phenomenon from the person's perspective. Norris, Kunes-Connell, and Stockard- Peclie (1998) conducted a qualitative study of body image disruption on self-esteem levels. This study took place over 3, 6, 12, and 18-month periods. The operational definition of body image disruption encompassed individuals who realized significant alterations in the self

in either appearance or functioning. The physical alterations that participants experienced were planned or unplanned, desirable or undesirable. Examples of undesirable changes included burn scars, and examples of desirable changes included weight loss following gastric surgery for morbid obesity. A few subjects had expected changes following planned reconstructive procedures; most subjects experienced unplanned conditions because of illness, treatments, or accidents. Both types of changes required a recreation of body image called re-imaging. Re-imaging emerged as the basic social process that occurs in response to significant alteration in the physical appearance or functioning of the body.

Their findings indicated that grief and loss were the patient's primary emotions, which lasted for up to a year. Younger women participants were more distressed by obvious alterations in appearance than older men and women, who were more likely to have greater value for their abilities to perform work or domestic functions (role performance functions). Self-esteem was a factor mentioned by many participants as influential in determining the degree of individual interpretation, acceptance, and integration of these changes into a realistic concept of the self.

Body image and self-esteem.

Situational alterations in self-esteem can develop from changes in body image or function. Several studies report associations between negatively perceived body image changes and lowered self-esteem. The existing research on body image and self-esteem is predominantly quantitative and cross-sectional in nature, focusing on particular body alterations at specific times (Norris et al., 1998). Additionally, Beckham writes (1999) that some people receive such psychological benefits from simple wrinkle-reduction programs that it might help them avoid more intense and expensive therapeutic help. Therefore, it is important that health care providers comprehend the degree to which self-esteem may affect patient outcomes. Body image research findings have indicated that appearance and attitude of

health care providers have an impact on a patients' opinion of their surgery and recovery (Nowicki, 1998).

Body dysmorphic disorder (BDD). BDD is a relatively common, yet under recognized, psychiatric disorder. As defined in DSM-IV (American Psychiatric Association, 1994), BDD consists of a preoccupation with an imagined defect in appearance; if a slight physical anomaly is present, the person's concern is markedly excessive. Sarwer (1997) describes BDD patients as being obsessed with cosmetic surgery. These patients often have extreme body image dissatisfaction and pursue repeated cosmetic surgery procedures. The preoccupation may cause clinically significant distress or impairment in social occupation or other important areas of functioning. The most common areas of concern are the skin (i.e., minimal acne, scarring), hair (i.e., thinning), and nose. BDD is frequently associated with significant morbidity, including suicidal ideation and suicide attempts (Phillips, Dufresne, Wilkel, & Vittorio, 2000). Unanswered questions remain: Are these individuals not satisfied with themselves, do they have lowered self-esteem, or do the majority of them continue to change their looks to mimic other persons who may appear to have the ideal, sought-after image and apparent higher esteem levels?

Phillips and colleagues (2000) measured the degree of BDD in dermatology and cosmetic patients. In this study, 11.9% of patients seeking dermatologic treatment screened positive for BDD. In patients with nonexistent or minimal defects (as opposed to obvious defects), the percentage of those who screened positive for BDD was even higher (15.2%) (see Figure 1). Thus, BDD appears relatively common in general dermatology and cosmetic dermatology settings. Although the researchers had anticipated that the rate of BDD would be higher in the cosmetic university setting, this was not the case. However, one third of the eligible subjects in that setting refused to complete the questionnaire, which may have affected the

findings. It was concluded from clinical impressions that the rate of BDD was higher in patients from the cosmetic setting who did not complete the questionnaire.

Psychological Outcomes of Plastic Surgery

Cosmetic surgery is an increasingly common medical procedure whose benefits to patients have not been fully quantified objectively. Researchers Rankin, Borah, Perry, and Way (1998) examined prospectively long-term quality of life outcomes for patients undergoing elective cosmetic surgery. In this correlational study of 105 consecutive patients undergoing elective surgery or cosmetic surgery, the parameters of the quality of life index, depression, social support, and coping were determined preoperatively, and at 1- and 6-month intervals postoperatively. The findings indicated that cosmetic surgery produces positive psychological benefits by significantly improving quality of life outcomes that persist long-term, without adversely affecting social support and ways of coping.

A study performed by Dutch researchers in conjunction with the Adolescence Plastic Surgical Research Group indicated a strong correlation between body image and decreased appearance-related burden level. Following cosmetic surgery, patients gained bodily satisfaction and were relieved of many appearance-related burdens. Physical, social, and psychological burdens related to appearance satisfaction improved considerably in both corrective and reconstructive adolescent patients (Simis, Ilovius, de Beaufort, Verhulst, Koot, & The Adolescence Plastic Surgical Research Group, 2002).

A meta-analysis of outcomes in reduction mammoplasty demonstrated that consistent improvement in physical symptoms was found across most studies, as was a high degree of patient satisfaction (78% to 95% very or moderately satisfied), and some patients have also shown improvement in body image and psychological well-being (Jones & Bain, 2001).

Conclusion

The result of this literature review indicates strong, direct correlation between self-esteem levels and cosmetic surgery. Self-esteem and self-worth increase and decrease proportionally and are similarly altered with situational events. The research review acknowledges increased self-esteem with improved levels of depression, improved healing processes, and the ability to cope with changes in body image (positive or negative interpretations by the patients). Additionally, improved body image was found to decrease appearance-related burdens, have positive psychological benefits, and improve quality of life outcomes.

Research suggests that improved appearance can boost people's self-esteem and change the way others treat them (Magic in a Makeover, 2001). Nurses' and health cares' attitudes can also positively impact a patient's health-related outcome and improve the surgical recovery period for lowered self-esteem individuals.

It is essential that nurses understand and respect patients' choices for cosmetic surgery. Understanding these choices sheds neither a positive nor negative light on patients' decisions, but explores and/or offers nurses' insight into patients' views of personal significance in regards to cosmetic surgery.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (DSM-IV)* (4th ed). Washington, DC: Author.
- Baumeister, R. (2001, April). Too much self-esteem! Retrieved January 27, 2002, from www.safe-nz.org.nz/esteem.htm
- Beckham, C. (1999, June). What are the emotional ramifications of wrinkles? Retrieved February 27, 2002 from www.my.webmd.com
- Body image and self-esteem.* (2000, December). Retrieved January 17, 2002, from *Women's Health Queensland Wide*: www.wom-health.org.au/factshts/bodyimg.htm
- Coopersmith, S. (1967). *Self-esteem inventory*. Palo Alto, CA: Consulting Psychologists Press, Inc.
- Davis, S. (1997). Plastic surgery junkies: Why are perfectly pretty women getting hooked? *Cosmopolitan*,

6(222), 218-222.

- Dugas, B. (1999). The good old days: A look back at cosmetic surgery. *Plastic Surgical Nursing*, 19(2), 74.
- Harcourt, D., & Rumsey, N. (2001). Psychological aspects of breast reconstruction: A review of the literature. *Journal of Advanced Nursing*, 35(4), 477-487.
- Jones, S., & Bain, J. (2001). Review of data describing outcomes that are used to assess changes in quality of life after reduction mammoplasty. *Plastic & Reconstructive Surgery*, 108(1), 62-67.
- King, K. (1997). Self-concept and self-esteem: A clarification of terms. *Journal of School Health*, 67(2), 68-71.
- Magic in a makeover*. (2001, October 17). Retrieved February 27, 2002, from www.my.webmd.com
- Maslow's holistic dynamic needs hierarchy*. (2001, April 17). Retrieved January 27, 2002, from www.wynja.com/personality/needs.html
- Norris, J., Kunes-Connell, M., & Stockard-Peclie, S. (1998). A grounded theory of re-imagining. *Advances in Nursing Science*, 20(3), 1-12.
- Nowicki, C. (1998). Research in plastic surgical nursing. *Plastic Surgical Nursing*, 18(4), 239-247.
- Peden, A., Hall, L., Rayens, M., & Beebe, L. (2000). Negative thinking mediates the effect of self-esteem on depressive symptoms in college women. *Nursing Research*, 49(4), 201-207.
- Phillips, K., Dufresne, R., Wilkel, C., & Vittorio, C. (2000). Rate of body dysmorphic disorder in dermatology patients. *Journal of the American Academy of Dermatology*, 42(3), 436-441.
- Rankin, M., Borah, G., Perry, A., & Way, P. (1998). Quality of life outcomes after cosmetic surgery. *Plastic & Reconstruction Surgery*, 102(6), 2139-2145.
- Rosenberg, M. (1965). Rosenberg self-esteem scale (RSES). Princeton, NJ: Florence Slade, Princeton University Press.
- Sarwer, D. (1997). The obsessive cosmetic surgery patient: A consideration of body image dissatisfaction and body dysmorphic disorder. *Plastic Surgical Nursing*, 17(4), 193-199.
- Simis, K., Hovius, S., de Beaufort, I., Verhulst, F., Koot, H., & The Adolescence Plastic Surgical Research Group. (2002). After plastic surgery: Adolescent-reported appearance ratings and appearance-related bur-

dens in patients and general population groups. *Plastic & Reconstructive Surgery*, 109(1), 9-17.

Additional Readings

- American Society of Plastic Surgeons. (2001, April 23). Retrieved January 22, 2002, from *National Clearinghouse Statistics*: www.plasticsurgery.org
- Cowin, L. (2001). Measuring nurses' self-concept. *Western Journal of Nursing Research*, 23(3), 313-325.
- Edwards, S. (2000). Critical review of Rosemarie Parse's the human becoming school of thought. A perspective for nurses and other health professionals. *Journal of Advanced Nursing*, 31(1), 190-196.
- Long, A., & Baxter, R. (2001). Functional and holism: Community nurses' perceptions of health. *Journal of Clinical Nursing*, 10(3), 320-329.
- Nursing metaparadigm: Conceptual models (paradigms) and theories*. (2001, June 6). Retrieved January 27, 2002, www.4.allencol.edu/~sey0/theoryla.html
- Parse's Human Becoming Theory. (2000, January 7). Retrieved January 27, 2002, from www.uncc.edu/~wkcody/parse.htm
- Parse, R. (2001). *Qualitative inquiry: The path of sciencing*. Sudbury, MA: Jones & Bartlett Publisher, Inc.
- Rankin, M., Borah, G., & Kosa, E. (1998). Research priorities and concerns of plastic surgical nurses. *Plastic Surgical Nursing*, 18(2), 86-90.
- Test Catalog. (2002). Retrieved January 24, 2002, from www.psychtest.com/curr03/CATLG016.HTM

Editorial

continued from page 11

Other groups are beginning to shine bright lights on health care and ask us to explain ourselves. They are examining several "complications" of hospitalization to see why these complications occur, how well they are documented, and how well they are treated. Patients, our customers, can and do understand what we do and are demanding that we do it well.

We saved a man's life the other day. He came in unconscious from an MI. He was treated with lytics, placed on a ventilator and given several medications. He woke up a week later with a pressure ulcer on his heel. "He should be happy he is alive to have a bedsore" is what I was told. Really? I think it is expected that we treat MI. Is it expected that complications like this one are just part of the risk of treatment?

While I don't dispute that medical miracles occur everyday, we do have an obligation to clean up our own act. Medical errors must be dealt with up front. Health care is a human service industry therefore prone to human error. In order to reduce errors, we must conduct a root cause analysis of errors, correct system errors and feel comfortable examining and reporting our own mistakes. If we don't clean up our own act, there are others who will.

Joyce Black, PhD, RN, CPSN
Editor