ASPECTS OF PHYSICAL APPEARANCE AND CLOTHING BEHAVIOUR

by

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I declare that ***Aspects of Physical Appearance and Clothing Behaviour*** is my own work and that all the sources that I have used and quoted have been indicated and acknowledged by means of complete references.

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ABSTRACT

The literature survey reports that persons electing cosmetic plastic surgery for aesthetic or medical reasons, or those persons not electing any form of surgery, often experience physical, psychological and socio-cultural problems. The complexity among the associated variables, body images, identity status, fashionable clothing behaviour and social self-consciousness were investigated comparatively, using a biopsychosocial approach.

The samples consisted of cosmetic surgery patients (n=25), Black and White female fashion participants (n=60) and breast oncology case studies (n=3). The research methods included descriptive and inferential statistics. A maximum of six questionnaires was administered per individual.

The results indicated that a positive body image perception was related to identity integrity, fashionable dressing and a sense of social acceptance.

Insight into the importance placed on the body as a means of self-expression can contribute to successful cosmetic and breast oncology surgery and also promote intercultural harmony, by reducing body-based prejudice.

Key Terms:

Biopsychosocial; body images; identity; social self-consciousness; clothing behaviour; fashion; physical appearance; cosmetic surgery; breast oncology; Black and White women; clinical health psychology.

PREFACE

This research is the original work of the author and has not been submitted in any form to another university.

The text of this study gives a clear indication where use was made of the work of other authors and duly acknowledges these contributions.

The research described in this dissertation was carried out in the Department of Psychology, University of South Africa under the supervision of Dr SA Grobler, and joint supervised by Prof. L Schlebusch, Head of the Sub-Department of Medically Applied Psychology, Faculty of Medicine, University of Natal, Durban, South Africa.

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NOMENCLATURE

Abdominoplasty: The surgical excision of skin, fat or redundant tissue of the abdomen (Regnault & Daniel, 1984).

Augmentation mammaplasty: Plastic reconstruction of the breast with increase of its volume by insertion of an autogenous or prosthetic material (Dorland, 1981)

Blepharoplasty (eye-lid surgery): The surgical removal of dermochalasis of the eye-lids; that is, the natural aging changes in the eye-lids such as folds of redundant skin (Pierce, 1982).

Body attitude: Encompasses a broad spectrum of feelings, attitudes and emotional reactions towards the body (Fawcett & Frye, 1980).

Body cathexis: The degree and directions of feelings towards one's body (Franzoi & Shields, 1984).

Body perception: Refers to the direct mental experience of the physical appearance of the body (Fawcett & Frye, 1980).

Body space: Perceived body space is the amount of space individuals perceive their bodies to occupy and indicates perceptions of the limits of body boundaries (Fawcett & Frye, 1980).

Breast reconstruction: The surgical procedure for reconstructing a new breast after mastectomy (Regnault & Daniel, 1984).

Classics: Styles that are conservative in design, are stable over an extended time and that undergo only minor revisions periodically (Kaiser, 1985).

Collective selection/mass market theory: A theory which proposes that fashions are disseminated in a horizontal process through which individuals in similar social worlds influence one another (Kaiser, 1990).

Conspicuous consumption: The desire to show one's wealth or status by the wearing of prestiguous or fashionable clothing (Hann & Jackson, 1987).

Cultural relativity: Judgements of what is 'good' or 'bad' according to one culture are applied to another culture (Adey & Andrew, 1993).

Early adopters: Consumers who wear a new apparel style early in the fashion cycle (Kaiser, 1990).

Ethnocentricity: The tendency on the part of one culture or subculture to judge other cultures according to its own cultural norms and values (Adey & Andrew, 1993).

Fashion adoption: Relates to individual behaviour in relation to the acceptance of new styles (Kaiser, 1990).

Fashion behaviour: Relates to motives to imitate, to be exclusive, and to the desire to consume conspicuously (Kaiser, 1990).

Fashion cycle: An indication in terms of time, of the amount and length of acceptance of a given style (Kaiser, 1990).

Fashion diffusion: The process of collective behaviour through which a style spreads from its introduction by apparel manufacturers to its adoption by the majority of consumers (Kaiser, 1990).

Fashion innovators: People who provide the initial exposure of a style to others, ie. the earliest communicators of a new style for other fashion consumers (Kaiser, 1990).

Fashion isolates: Consumers who are late adopters of a style (Kaiser, 1990).

Fashion opinion leaders: Provide legitimation for a style as their taste in fashion and approval are respected by others (Kaiser, 1990).

Fashion: A form of collective behaviour that is socially approved at a given time but is expected to change (Kaiser, 1990).

Global body attitude: Refers to an individual's general overall global attitude or feeling about the outward form and appearance of their body and incorporates evaluation potency and activity ratings of the body (Kurtz & Hirt, 1970).

Individual identity: Refers to a person's subjective awareness of her uniqueness and individuality (Gerdes, Moore, Ochse, Van Ede, 1988).

Lipectomy (abdominal): The excision of a mass of subcutaneous adipose tissue as from the abdominal wall (Dorland, 1981).

Mastectomy: Excision of the breast; mammectomy (Dorland, 1981)

Personal identity: Refers to a person's sense of continuity, of being one and the same person throughout life and across different situations (Gerdes *et al.*, 1988).

Public identity/social identity: Refers to one's position in society or to social roles (Gerdes *et al.*, 1988).

Reduction mammaplasty: Plastic reconstruction of the breast to reduce its size (Dorland, 1981).

Rhytidectomy (face lift): The excision of skin for the elimination of wrinkles (Dorland, 1981).

Self concept/self image: A person's view of her own attributes which may be categorised in terms of certain aspects, eg. appearance, physical strength, psychological and intellectual self (Gerdes et al., 1988).

Social world: A loosely bonded level of social organisation whose interests are shared by participants (Kaiser, 1990).

Subculture leadership theory: Fashion styles that percolate upwards from specific sub-cultures in society to the fashion establishment (Kaiser, 1990).

The trickle-down theory: A process which involves a downward flow of fashion styles, from the upper classes to the middle and lower classes motivated by a desire by fashion followers to conspicuously consume (Kaiser, 1990).

CHAPTER ONE

THE PROBLEM AND ITS SETTING

1.1 INTRODUCTION

The significance of socio-cultural variables which affect people's everyday lives are evident in the search, expressed cross-culturally, to attain the ideal norms for physical appearance and adornment.

Major socio-cultural changes such as intergration and the transition toward a multicultural society have taken place in South Africa in recent years. Observations on the possible impact of these changes on a person's self-perceptions prompted the choice for the topic of this research; *Aspects of physical appearance and clothing behaviour.*

The extent of cultural diversity in South African society presupposes that a biopsychosocial approach be taken in order to gain an understanding of people's attitudes on the following perspectives:

- physical appearance
- variations in clothing behaviour
- a sense of self-identity
- body image
- a sense of social acceptance.

As a basis for contrasting these aforementioned perspectives, two diverse cultural groups from KwaZulu Natal were chosen for research purposes:

- Black, Zulu speaking South African women
- White, English speaking South African women

Similarities and differences among persons of diverse cultural backgrounds are evident in the emphasis placed on a variety of socio-cultural variables attributed to each culture. These include an acceptable physical appearance, norms for clothing behaviour, a clear sense of self-identity and a positive body image. These variables are often accompanied with the emphasis placed on 'slimness' in Western society.

Dress and physical appearance are two variables which emphasise the degree of importance placed on the body as a means of self-expression. As socio-cultural variables, dress and physical appearance may act as social equalisers or enhance cultural individuality and non-conformity.

The increasing number of persons seeking elective cosmetic surgery to change aspects of their physical selves and subsequently enhance their clothing choice is evidence of the need people have to feel socially equal and acceptable.

Reports from four leading cosmetic plastic surgeons (Prof. A Madaree, Mr J Cooke, Mr W Morris, Mr E Bowen-Jones, Personal communication, Durban, May 1995) indicate the following trends as set out in Table 1.1.

Table 1.1: Statistics of number of female patients who underwent cosmetic plastic surgery in 1994/1995 (Prof. A Madaree, Mr J Cooke, Mr W Morris, Mr E Bowen-Jones, Plastic Surgeons, Durban, 1995)

	YEAR	NUMBER
REDUCTION MAMMAPLASTY		
Private (i.e. fee-paying) patients	1994	86
Private patients (Jan - May)	1995	53
Non-private (i.e. non-fee-paying) patients (Provincial Hospital, i.e. Wentworth)	1994	±100
Non-private patients (Provincial Hospital, i.e. Wentworth) (Jan - May)	1995	±100
AUGMENTATION MAMMAPLASTY		
Private patients	1994	57
Private patients (Jan - May)	1995	28
Non-private patients (Provincial Hospital, i.e. Wentworth)	1994	±25
Non-private patients (Provincial Hospital, i.e. Wentworth) (Jan - May)	1995	±25
ABDOMINOPLASTY		
Private patients	1994	56
Private patients (Jan - May)	1995	15
Non-private patients (Provincial Hospital, i.e. Wentworth)	1994	15 - 20
Non-private patients (Provincial Hospital, i.e. Wentworth) (Jan - May)	1995	15 - 20
RHYTIDECTOMY		
Private patients	1994	27
Private patients (Jan - May)	1995	9
Non-private patients (Provincial Hospital i.e. Wentworth)	1994	5 - 10
Non-private patients (Provincial Hospital i.e. Wentworth) (Jan - May)	1995	5 - 10

Prof. A Madaree (Head of Department of Plastic Surgery, Wentworth Hospital, Durban, personal communication, May 1995) commented, for example, on the increase in requests by contemporary Black South African females for reduction mammaplasty in order to alleviate medical problems due to the size and weight of their breasts, and to improve their physical appearance and style of dress. Prof. A Madaree's comments serve to highlight the changing attitudes and health beliefs evident in South Africa among urban Black patients.

In recent research on health beliefs of a sample of Black patients, Schlebusch and Ruggieri (1996) state that the degree to which patients take responsibility for their chosen behaviour influences their health beliefs. It appears that more Black patients are choosing to change undesirable physical features through cosmetic plastic surgery (Pierce, 1982; Bond & Cash, 1992; Table 1.1, 1995). Pierce (1982) gave specific consideration to ethnicity in relation to elective cosmetic surgery.

Reports from Wentworth Hospital also showed, however, that requests for augmentation mammaplasty numbered less than half of those for reduction mammaplasty.

The following two points may be noted with regard to variation in the choice of and estimates for elective cosmetic surgery patients and numbers:

(i) Reduction mammaplasty is classified as a medical problem and does not fall under cosmetic surgery due to the medical implications often involved in oversized breasts, e.g. skin irritation, back and neck ache. Funds for breast reduction surgery may be claimed from medical aid associations.

(ii) Wentworth Provincial Hospital in Durban is limited in the number of operations permitted per month for cosmetic surgery. Accurate estimates of prospective elective surgery patients are therefore difficult to make on a regional or national level.

Expenditure in terms of time, effort and finance as is evident in multi-media reports locally as well as internationally, is demonstrative of the degree to which people are prepared to comply with what is perceived to be the 'ideal' norm for fashionable dress and body shape.

Gehardt (1993) reveals the extent to which media exploitation influences people's self-perceptions for commercial gain. Further documented research draws attention to the devastating effects of the thinness and fitness obsession. This has been observed among women specifically, and is becoming increasingly evident in the general population, affecting children as young as nine years of age (Spillman & Everington, 1989; Craig & Catterson, 1990; Kiesouw, 1994; Agenda, TV1, SABC, May 1995). Commercial expenditure associated with the development of fashion related industries includes sectors such as:

- high fashion apparel manufacture
- the production of mass market commercial fashion ranges

- high technology synthetic fibres development
- extensive fabric design and production
- fashion accessories co-ordination
- the promotion of high-technology beauty therapy
- the development of highly specialised medico-surgical procedures to change, modify or reconstruct aspects of physical appearance.

The debate on aspects of physical appearance and clothing behaviour arises from the need to understand why and what people want to change with regard to their physical, psychological and social selves. This knowledge may contribute partly to successful predictions of the

- type of clothing behaviour that people will adopt
- level of a person's body image satisfaction
- strength of a person's self-identity
- persons' perceived level of social acceptance.

In view of the type of clothing behaviour that will be adopted in South Africa, four prominent fashion personalities were consulted for this study (Personal communication, June 1995). These were fashion opinion leaders, Mr C Levine (Couture designer, Johannesburg), Ms M Fassler (Couture designer, Johannesburg), Mr A Aboud (Head of the Fashion Department, Technikon Natal) and Ms J Button (Couture designer, Cape Town). A brief, integrated review of their opinions on aspects of fashion follows. This review serves to give meaning to the fashion process of adoption and diffusion in South Africa and sheds light on possibilities of future fashion areas.

- Both Black and White consumers become more clothes conscious when their disposable income grows and their social status changes. This has implications for the rapidly changing consumer profile in a changing South Africa. Marketers and producers of fashion need to be keenly aware of new areas of interest and occupation, particularly for Black consumers.
- Black and White consumers have slightly different perceptions of what is fashionable. Black consumers are found to be very colour conscious and co-ordinated in terms of accessories. Conspicuous dressing is a sought after feature of their fashion behaviour. This is often demonstrated in elaborate lace-wear, blouses, headwear and their particular choice of occasion wear. White consumers tend to be less conspicuous favouring black, beige and navy with very basic accessories. Western influence on urban Black consumers has shown a tendency for some Blacks to dress classically. Generally, Black consumers insist on quality clothing as do White consumers, particularly in the corporate culture.

- Political solidarity is shown by wearing ethnic details; that is, large collars and cuffs in embroidery or in animal prints. Co-ordinated headgear is worn with tops and skirts of ethnic printed fabric. This trend is rarely seen in White culture. Ethnic dressing is a feature at rallies, political gatherings and public celebrations.
- European and American fashions have a major impact on South African fashion. All four fashion opinion leaders agreed that presently South Africa is unable to sustain a unique, exportable South African range in fashionable clothing. However, African design, adapted largely from West Africa, Nigeria, Zaire and Ghana is used by many new young Black designers as a means of expressing national and individual identity. Attempts by South African designers to establish an exportable fashion trend continues (TV1, SABC — GMSA Fashion Expo, April 30, 1996).
- Township sub-cultures, interest in jazz and American sport such as baseball and basket ball are influencing 'street fashion' for both Black and White consumers.
- Corporate wear for both Black and White business women, television presenters, performers and women in Government positions is a growing consumer area, although selective.
- In South Africa the influence of National and international participation in sport is making a strong impact on fashion design and adoption in South Africa. As sport is made more accessible to the broader population and particularly as a new area of interest to Black females, clothing influences are acting as social equalisers and enhancing South African national identity.
- Aspects of fashion trends, aspired to by persons after cosmetic plastic surgery, were confirmed by the fashion opinion leaders; that is, the preference of fashion conscious consumers for figure shaping, revealing tops and blouses and dresses, as well as fitted skirts and trousers and attractive body-revealing swimwear.

In terms of body image satsifaction Thomas (1989) notes that most recent research has focused on White female samples. In view of this, by assessing the level of body image satisfaction among Black South African women in this dissertation, a more balanced perspective of cross-cultural attitudes could be provided.

The level of body image satisfaction is thought to be influenced by attitudes towards physical appearance as well as by the reaction to a person's appearance by significant others (Thomas, 1989). Accordingly the issue of ethnicity in relation to body image becomes an area of cultural significance and sensitivity specifically when this is related to skin colour (Bond & Cash, 1992). Athough difficulties in body image perceptions emanate from the controversies surrounding the core nature of this concept, Keeton, Cash and Bond (1990) propose that the additional cognitive

affective and interpersonal dimensions implicit in an holistic understanding of the concept be taken into account.

The sub-section on breast oncology afforded the researcher the unique opportunity to relate results which have been generalised to the individual situation, as has been discussed in the case studies. The case studies also afforded the researcher the opportunity to integrate both sides of the continuum of individual and general observations while taking full cognisance of the fact that the general consensus of the biopsychosocial aspects of this study are the product of individual contributions.

Although generalisations are made in research using large samples, the importance of the needs of an individual as a person in her own right must never be neglected. Generalised information can serve as a reference to evaluate individual needs, understand the individual and obtain success in surgery. The uniqueness of the individual response to environmental stresses and challenges is thus underscored.

Due to the descriptive nature of the case studies (n=3 breast oncology patients) used for this dissertation, the results cannot be generalised; however, they may serve the following strategic functions:

- To demonstrate the importance of utilising research results from a dual perspective, that is, to utilise observations from the sample to the broader population and from the population to the individual.
- To emphasise that although a population represents the sum of individual needs, each individual still has specific requirements which need to be addressed in order to facilitate attitudinal and behavioural change.

More serious consideration of a person's vanity needs by professionals and significant others, could minimise possible anxiety that arises from a poor self-esteem and body image, and maximise the level of post-surgical satisfaction for those persons opting for elective cosmetic surgery. According to recent research, Schlebusch and Ruggieri (1996) recommend that Western trained specialists who work in cross-cultural health care settings should practice culturally sensitive health care delivery.

Cash and Pruzinsky (1990) stress the importance of creating further awareness of the surgeon/patient interaction in terms of a positive psychological outcome to surgery and a respective patient body-image perceptual enhancement.

Gruendemann (1975) emphasises how insight and understanding of a person's body-image perceptions could facilitate the degree of acceptance and success of surgical outcomes.

Cash and Horton (1983) comment on the challenging void in research on the psychosocial aspects of aesthetic surgery. Furthermore, Cash and Pruzinsky (1990) note the importance of

measuring the influence of cosmetic plastic surgery on changes in clothing behaviour to facilitate positive psychological change.

Perry, Schutz and Rucker (1983) state that researchers have not provided sufficient empirical research about the relationship between clothing interest and personality.

Zweeney and Zionts (1989) strongly recommend that further research with a mixed socio-cultural population be provided in order to clarify the hypothesis that clothing has an impact on the self-concept.

Accurate medico-psychological research, educational workshops, and interpersonal understanding between professionals and patients, could enhance the patient's sense of post-operative self-acceptance.

Psychologists and medical professionals could assess their patients with enhanced sensitivity by taking into account the impact of body-image on their overall functioning.

Insight into the positive and negative biopsychosocial adjustments of people to the new context in South African society is required with regard to clothing behaviour and to post-operative physical change. It is hoped that this insight will enhance an understanding of people's attitudes towards the issues of clothing behaviour, body image, self-identity and physical appearance in relation to the perceived level of social acceptance experienced by people.

On the basis of the considerations outlined in the introduction (1.1) the following objectives are listed.

1.2 OBJECTIVES

This study aimed to:

- determine people's attitudes towards their body image and self-identity in relation to their clothing behaviour and their desire for cosmetic surgery for aesthetic reasons.
- determine various socio-cultural variables to be evaluated, for example, the level of social acceptance experienced by a person with regard to feelings of well-being or acceptance, due to physical change incurred and the wearing of acceptable fashionable clothing.
- establish a clearer understanding of people's behaviour with regard to changes in their physical appearance resulting in possible changes in their choice of clothing. The direct consequences of physical change were evaluated with regard to the perceived level of social acceptance thought to be attained by the person.

In order to fulfil the aims of this dissertation, consideration was given to the feasibility of the study, basic underlying assumptions and, for the practical execution of the study, assessment of

the delimitations and an explanation of operational definitions. Following this the statement of the problem and subproblems (1.7 and 1.8) are set out. These are based on the literature survey (Chapters two - four).

1.3 FEASIBILITY OF THE STUDY

This study on *Aspects of Physical Appearance and Clothing Behaviour* was feasible because:

- patients and hospitals were accessible
- the budget required for administering the questionnaires was not excessive
- the non-clinical, that is, 'fashion' sample population group was accessible.

1.4 ASSUMPTIONS

(i) It was assumed that an holistic biopsychosocial approach to understanding people's needs and reasons for change with regard to aspects of their physical appearance and desire for fashionable clothing would add to the interpretative knowledge sought in a multi-disciplinary study such as this one.

(ii) It was assumed that patients would be honest and open in answering questionnaires and giving information during personal interviews.

(iii) It was assumed that surgeons and professionals from organisations would provide accurate accounts of patient needs and trends in terms of elective cosmetic surgery.

(iv) It was assumed that appearance would be equally as important to patients with life threatening diseases, such as cancer, as to patients who agreed to surgery for vanity reasons only.

1.5 DELIMITATIONS

The parameters of this study were delimited to the needs and changes in aspects of physical appearance and clothing behaviour in a multicultural South Africa.

This study was not intended to cover all ethnic groups in the country and was limited to women from the White and Black cultural groups only.

This study was not intended to cover aspects of extreme behaviour variations such as pathological depression or anxiety.

This study was not intended to cover all aspects of the psychology of appearance, but addressed either cosmetic facial surgery, augmentation mammaplasty, reduction mammaplasty, abdominoplasty and breast alterations after mastectomy, lumpectomy, or breast reconstruction.

The aspects of fashion centred on establishing what the generally acceptable cultural norm was at the time of the study for the dominance of particular fashion trends in clothing; for example, an individual's or group's preference for French, Italian or American fashions as opposed to an expression of local ethnic fashion (not necessarily traditional clothing) originating in South Africa. People's attitudes towards these choices were identified.

The study involved only the female gender. In the general discussion, the feminine gender is used in order to simplify references and to ensure continuity.

1.6 DEFINITIONS

For the purposes of this dissertation, the following concepts are defined operationally:

Body Image/Body Images

The plural term body-images is used interchangeably with the singular term body image as it is argued that a person has many differing body perceptions and attitudes about her body. The definition used for this study was based on research findings pertaining to the development of body images concepts over a period of decades (Secord & Jourard, 1953; Fisher, 1986; Gleghorn, Penner, Powers & Schulman, 1987; Cash & Pruzinsky, 1990), i.e. body images are dynamic, circumstantially changing facts, feelings, and sometimes biased perceptions or conceptual representations, either conscious or unconscious, that one holds about one's body in space, and in relation to others' reactions to them. These perceptions are based on the socio-cultural norms held within a particular society and in terms of a person's total self appraisal.

Biopsychosocial

The biopsychosocial model of health care stresses that the biological, psychological and social structures of each individual are affected by multiple interactions on differing systemic levels. This occurs within each person and as part of the large system or society (Schlebusch, 1990). For the purpose of this study a biopsychosocial approach stressed the interaction between a person's physical, psychological and social qualities in relation to the socio-cultural aspects of the broader society.

Health Psychology

Health psychology is the aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the

prevention and treatment of illness and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction (Matarazzo, 1980, p.185 cited in Schlebusch, 1996).

1.7 STATEMENT OF THE PROBLEM

The problem of understanding how personal satisfaction with physical appearance, and how choice of clothing contribute to an enhanced self-identity and more positive sense of body image within the present South African context, needed to be explored in relation to a person's sense of perceived requirements for social acceptance and their need to change aspects of their physical appearance through cosmetic surgery.

1.8 THE SUBPROBLEMS

1.8.1 Subproblem one

To what extent would psycho-physical aspects of body image and identity induce a person to request/agree to surgery to change aspects of her physical appearance?

1.8.2 Subproblem two

To what extent would psycho-physical aspects of body image and identity, due to cross-cultural differences, induce a person to change aspects of her physical appearance through non-surgical methods.

1.8.3 Subproblem three

Would a person's clothing behaviour and her need for cosmetic facial surgery/breast augmentation or reduction/abdominoplasty be negatively or positively influenced by socio-cultural norms for acceptable body images and codes of fashionable dress?

1.8.4 Subproblem four

Would a person's anxiety level and personality traits differ post-operatively as a result of an improved physical appearance after cosmetic plastic surgery?

1.8.5 Subproblem five

Would a person's clothing behaviour be negatively or positively influenced by cross-cultural differences and socio-cultural norms for acceptable body images and codes of fashinable dress?

1.8.6 Subproblem six

Would the integration of the results from subproblems one, two, three, four and five establish the level of satisfaction with physical changes resulting from surgery, or no surgery, the choice of clothing behaviour and the perceived level of social acceptance felt to have been attained by the individual?

CHAPTER TWO

LITERATURE SURVEY

BODY IMAGE AND IDENTITY

The literature survey is divided into three chapters. Chapter Two comprises two sections, Body Image (2.1) and Identity (2.2). Chapter Three focuses on cosmetic plastic surgery (3.1) and Chapter Four consists of the section on fashion and clothing behaviour (4.1). The authors and dates referred to in the literature study and dissertation as a whole have been arranged in sequence according to Plug (1993).

An interdisciplinary assessment of the topic *Aspects of Physical Appearance and Clothing Behaviour* based on a biopsychosocial approach, presupposes the inclusion of the following concepts:

- body image
- aspects of self-identity
- physical appearance
- elective cosmetic surgery
- fashion and clothing behaviour
- social acceptance.

A biopsychosocial approach involves an interrelated evaluation of the physical, psychological and socio-cultural aspects of each of these concepts. Implicit in the socio-cultural aspects are the issues of cultural diversity and social acceptance specifically prevalent in South African society.

Due to the complexity and use of multiple variables in this study each concept is dealt with individually, divided over three chapters, yet is presented within an holistic framework. In this way a comprehensive view of the research conducted is presented.

2.1 BODY IMAGE: GENERAL CONCEPT AND BACKGROUND

Many controversies surround the problem of what constitutes the core nature of body image. For this reason it is important to appreciate the complexities involved in defining body image as either a unitary or a multi-dimensional concept, that is, as 'body image' or conversely as 'body images'. In South Africa the complexities involved in defining body image/images become acute due to the extent of cultural diversity and differences in perceptions concerning norms for acceptable physical appearance. The multi-dimensional concept and term 'body images' is used for this study as it incorporates perceptual, cognitive, affective and interpersonal dimensions.

In general, two distinct areas of concern are evident from the research on body images:

i. The external objective attributes of physical appearance which have both personal and social implications, in terms of human development and experience.

ii. The internal subjective representations of physical appearance and bodily experience, namely, perceived 'body images' (Cash & Pruzinsky, 1990).

In order to clarify these distinct areas of concern with regard to the development of body images concepts and definitions, five observations on body images have been reported.

i. Development

Research has indicated that emphasis is placed on body images as a dynamic, continuously changing process. Body images is one of the first of the self-structures to emerge during development. Most writers agree that individuals develop positive or negative feelings towards their bodies. These feelings are modified by the environment, cultural background and various life stages (Platzer, 1987; Rauste-von Wright, 1989; Sweeney & Zionts, 1989).

ii. Complexity

From observations made in the literature, it is well recognised that body images is a complex, multi-faceted concept, and forms a network of interrelated biopsychosocial processes which influence the person's attitude towards herself. This complexity is intensified in a multi-cultural society in which cultural values and norms toward aspects of physical appearance such as body weight or shape may vary (Price, 1990). Difficulties arise in understanding where the differences and similarities in attitudes toward body images lie and for what reasons. The challenge of this study was therefore to unravel these ambiguities within the South African context.

iii. Socio-Cultural

An integrated continuous process exists between the person and her environment (Adams, 1977). This occurs in relation to the person's body images, within a given culture or society. Adams (1977) comments on the strongly held cultural beliefs about what constitutes two key aspects of the body image process:

- What constitutes the ideal female figure
- How physical attractiveness is evaluated.

However, it is important to note that within a particular culture, individuals differ in degree as to how they evaluate their body images and the importance they place on physical appearance.

Self-perceptions of physical appearance, which implies a degree of body images evaluation, may be a critical factor in an individual's behavioural choices. Social desirability, which is included in these self-perceptions, could influence the possibility of

attaining a particular goal in life, as well as impact forcefully on interpersonal relationships.

It may be observed that 'body images' are formed in a social as well as in a personal context (Cash & Pruzinsky, 1990; Price 1990).

iv. Physical Alterations

An appreciation of the level of social acceptance experienced by a person is basic to an understanding of why and to what extent an individual may want to change aspects of her physical appearance. Cosmetic surgery constitutes a highly developed medico-surgical option to achieve physical change. Adjustment to physical changes is a lengthy process (Fisher, 1970). This may contribute to a loss in body images integrity with uncomfortable psychological implications, for example, feelings of being socially unacceptable. Insufficient feedback information by significant others in the social environment as well as changes to physical appearance can rapidly lead to body image distortion and impaired body boundary awareness.

Time emerges as a notable factor linking the main components of body image construct development and level of successful surgical outcome.

v. Status of body image terminology

Owing to the lack of precise operational definitions, the concept body images has variously been referred to as:

- Body schemata, postural model, perceived body, body ego, body boundary, body concept and body percept.

This shows that, despite empirical efforts and numerous theoretical discussions, body image remains ambiguously defined (Collins, Beumont, Touyz, Krass, Thompson & Philips, 1987).

However, there remains agreement in the literature that body images typically comprises two highly related components:

- A mental image or composite of body images a person has of her body;
- The notion of the body as a psychological experience which includes attitudes towards and feelings individuals have about their bodies. Body-cathexis is the value laden aspect of how body images are experienced and describes the degree of satisfaction or dissatisfaction with the body (Van der Velde, 1985; Kaslow & Eicher, 1988; Hutchinson, 1989).

A positive body image has been associated with a positive self-concept and with high self-esteem. These personality variables in turn influence body image perception. This fact highlights

the inter-relatedness and complexity of body-image-function in social and object relationship formation.

The functional aspects of body image serve to stabilise the individual's psychological world by providing self-definition and direction for self-orientation.

2.1.1 Examples of contributors to the concept and definition of body image or body images

Many exponents of the body image concept have influenced trend perceptions and promoted body image as a continuum, within a socio-cultural context. The following researchers have made major contributions to the concept and definitions of body image as either a unitary or a multi-dimensional concept.

2.1.1.1 Paul Schilders' contribution

As early as 1935, Schilder (1964) spoke of the image of the human body as a picture the individual forms in her mind. Included in Schilders' eclectic exposition of body image are conscious and unconscious feelings, body sensation and a Gestalt-like unity which reflects desires, emotional attitudes and interpersonal interaction. Schilder foresaw the significance of body image attitudes in explaining behaviour, and mediating choices with regard to aesthetic preferences, clothing behaviour and the ability to empathise with the actions of others (Schilder, 1964). Schilder was uniquely qualified for instituting a multi-faceted approach to the body image experience, although he used a singular term, 'body image' to explain a multi-dimensional construct (Cash & Pruzinsky, 1990). Schilder's (1964) reference to body size is a central feature of prominent recent studies on anorexia nervosa. Furthermore, Schilders' speculations about the differences in perception of body interior versus surface areas, and his observations concerning fantasies about body intrusions anticipated later research concerned with body image boundaries, for example, in the works of Fisher and Cleveland (1968)(Fisher, 1970; Fisher, 1974; Fisher, 1986).

Schilder's (1964) most unique contribution was that he was the first author to introduce the idea that body image variables have central pertinence, not only for pathological, but also for everyday life events.

2.1.1.2 Aspects of Van der Velde's contribution

Van der Velde (1985) proposed a new interpretation of body images based on a number of premises.

The first premise reflects a departure from the traditional adherence to Schilder's notion of 'The Image of the Body' which suggests that humans have only 'one' body image. The limitations of the individual's visual perception make it impossible to perceive her body as a whole. Bodily perceptions direct, or indirect, (e.g. photographs, video recordings) are always restricted to parts of the body, either front, side, or back views. Many different perceptions of a given part of the body are formed through variations in movements, facial expressions and focal nuances.

The result is that body perceptions are formulated in different, independent and established body images. Body perceptions are also associated with others' appraisal of and reactions to one's appearance and actions. These perceptions result in images that can be designated as extraneous body images.

Van der Velde (1985) suggests that we perceive others also by means of partial and ever-changing appearances and actions and as such form a multitude of extraneous body images.

i. Extraneous body images

Extraneous body images form the foundations of people's concepts of others, through which the person interprets others' social behaviour and gains insight into their psychological qualities. They are the first functional body images formed in life and mediate the beginnings of human psychological development, for example, basic trust, attachment and human interaction. Extraneous body images affect a person's choice of friends, marital partners and the occurrence of transference and counter-transference (Van der Velde, 1985).

ii. Exposition of Van der Velde's Definition and Development of Body Images

Body images is defined as the mental representation of a past sensory experience (body percepts) and one's awareness of on-going sensory experience (Van der Velde, 1985).

iii. Relationship to Self-Identity

An essential aspect of Van der Velde's (1985) exposition of body image concept is the notion of developmental continuity over time, which results in the formation of personal identity.
At the earliest stage, a child is made aware of significant others' opinions about her physical characteristics and actions. These opinions impact on the child's psychological and social development by providing an empirical framework for behaviour and appearances in order to

obtain the necessary approval and rewards desired. These opinions are qualifications of the kind of person the child is, and provide her with a basis for the formation of personal identity.

iv. Dialectics

Another important dimension of Van der Velde's (1985) observations is the function of dialectics in the formation of the body image experience. The term dialectics refers to the inseparable, inter-connectedness of two opposing events, or thoughts. A person's encounters with others are only possible because of others' encounters with them. It follows that body images not only provide the basis for a person's awareness of interactional dialectics, they are the instruments of a person's dialectical interactions. It is apparent that Van der Velde's (1985) orientation focuses on both the broader biopsychosocial elements as well as interpersonal and self-relation aspects of the body image experience.

v. Psychological Concepts about the Body: Neurological Perceptions

As illustrated by Van der Velde (1985), body images are composed of both a physical and a psychological component. The psychological component is rooted in neurology. Initially the uniqueness of body perceptual distortions, through brain damage, captured the attention of neurologists and the concept of bodily self in space was given impetus. Perceptual distortions included:

- denial of existence of body parts
- inability to distinguish right from left side of the body
- refusal to acknowledge the incapacitation of paralysed body parts or to integrate new body parts into the body concept.

It was through neurologists and early neurological observations that the study of body image was made scientifically acceptable (Van der Velde, 1985).

2.1.1.3 Body as a Psychological Object

Within the framework of psychological concepts about the body, Cash and Pruzinsky (1990) provided a succinct summary of nine primary topical areas. The two marked with an asterisk are discussed in this study.

- Perception and evaluation of one's own body appearance*
- Accuracy of perception of one's body size
- Accuracy and perception of one's body sensations
- The ability to judge the spatial position of one's body
- Feelings about definiteness and the protective value of body boundaries

- Distortions in body sensations and experiences associated with psychopathology and brain damage
- Responses to body damage, loss of parts and surgery*
- Responses to various procedures designed to camouflage the body cosmetically, or to improve physical appearance
- Attitudes and feelings pertinent to the sexual identity of one's body.

With reference to the second last point, this study focused on *clothing behaviour* as a powerful means of improving or modifying physical appearance and body image.

2.1.2 Perspectives on body image

A brief consideration of two perspectives on body image serves to illustrate the multi-disciplinary and broad intra-disciplinary base of the body image concept. These are psychoanalytic and philosophical concepts. In the assessment of body image attitudes, links to these perspectives, among others, may serve to explain behaviour related to physical appearance.

2.1.2.1 The psychoanalytic perspective

Cash and Pruzinsky (1990) explain that Freud's libido theory, by incorporating its oral and genital states, is fundamentally a theory of how attention and behaviour are presumably mediated by signals linked to certain major body areas infused with symbolic meaning. Ego is then first and foremost a body ego. Freud's major concepts and mechanisms entail many body image concepts, for example 'Castration Anxiety' which is the mechanism for resolving the Oedipus complex in males.

Fisher (1970) acknowledges that personality dynamics also incorporate explicit references to body experience. It seems that often, when an individual perceives one aspect of her body as inferior, the inferiority experienced is generalised and affects the total self-concept of the person. This example demonstrates the strong link between feelings and perceptions of body image to those of self-identity and self-concept as a whole. How this is further affected by variables such as clothing behaviour is at the core of this study.

Jung (1954) and associates elaborated on the notion that people conceptualise their bodies as containers or protective enclosures within which they find refuge and protection from attack.

The phenomenon of body boundary (2.1.3) expanded within the psychoanalytic framework, led to a new era of empirical research which dealt with the organisation of body experience and

eventually produced detailed findings concerning the relationship of the body boundary to personality, psychosomatic symptomatology, psychopathology and patterns of autonomic response.

Central to healthy psychological functioning is the concept of ego boundary, in which individuals experience a distinction between what is inside and what is outside the body as a prerequisite for reality testing. Without an adequate sense of boundary, individuals were said to experience the world as strange and depersonalised.

Cash and Pruzinsky (1990) note that some aspects of body image experience are easily available to conscious awareness, whereas others are concealed at unconscious levels. It is no longer acceptable to compress the concept of body image into a few narrow categories or to quantify an isolated area of body experience and then label this "The measure of Body Image". This is apparent from the list of diverse areas pertaining to body image experiences (2.3.2.6).

2.1.2.2 The philosophical perspective

A second perspective on body image serves to demonstrate the inter-disciplinary nature of this topic. Essential to the philosophical perspective is the notion of body in space and body movement.

It is evident from philosophical writings that from Plato and Aristotle through to Descartes, philosophers wrestled with the dualism of soul (or mind and body) and tried to forward a reasonable account of how these two entities could interact. Philosophical interest has centred on:

- the role of the body in being human
- the structure of the ego
- the construction of reality.

(Edwards, 1972).

The body schema has been proposed as a mediating device in the process of integrating behaviour and as a basic means of establishing a linkage between self and world (Cash & Pruzinsky, 1990). In philosophical literature the body has been depicted as a basic experiential agent that introduces order and meaning into interactions with other objects and offers a persistent line of stability for perceptions. The body sustains purposeful movement and superimposes human space on physical space (Edwards, 1972). Philosophical contributions to the formation of body image concept and knowledge emphasise the role of kinaesthetic sensations in defining the experience of spatial continuity (Cash & Pruzinsky, 1990). The role of body sensations and feelings is crucial in mediating behaviour and modulating psychophysical judgements.

An eclectic orientation is evident in the combination of psychoanalytical trends together with a classical perceptual methodology. This combination assists in gaining insight and meaning necessary for a basic holistic understanding of body images as a concept.

2.1.3 Body boundary

Within the framework of the psychoanalytic perspective outlined in 2.1.2.1, the question of the extent body boundary influence has on psychological behaviour becomes a salient feature worth brief comment.

Fisher (1970) explains body boundary as the differentiation of one's body as a separate entity from the world, i.e. non-self objects. Variations in the manner individuals experience the limits of body periphery and perceive their body boundaries, indicate that body image boundary is a fundamental aspect of body image. The body boundary may be experienced as definite or sharply bounded or as indefinite and vague. The notion of openness and penetrability that individuals ascribe to their bodies is an integral part of body boundary perception. Conversely, an understanding of defensive barriers, that is, the lack of openness and penetrability, or strictness of boundary limits set by the individual, could reveal the nature of the person's interactions with others. It follows that the concept of body image boundaries presupposes the idea of how a person's relationships are structured with others and the environment, and influences aspects of her personality, identity and the manner in which she dresses, that is, her clothing behaviour. This may be exemplified by drawing a comparison between high and low barrier persons.

2.1.3.1 High and low barrier persons

The contrast between high and low barrier persons is their relative perceptual focus on either the body exterior or the body interior due to

- Differences in significance assigned to body exterior or interior at an early stage in life
- The differential physiological activities experienced at either interior or exterior sites
- The experiential reinforcement derived by individuals from the importance of body exterior and interior (Fisher, 1970).

High barrier persons assign the importance of their body schema to the boundary regions of the body, e.g. the musculature, because of the independent 'voluntary' interaction with the environment. By contrast, low barrier persons assign significance to interior aspects of body functions and sensation. Fisher (1970) noted further correlations with regard to high and low

barrier persons, e.g. high barrier scores correlated with persons having a special interest in attainment, that is:

- a strong intent to preserve independence
- an enhanced ability to function adequately.

Data indicating that the barrier score is positively correlated with achievement drive in individuals support the above suggestions (Fisher, 1970).

High barrier scores are also positively correlated to clarity of identity, as defined by interview evaluations, as well as to the ability to cope with stress. Accordingly, barrier scores are negatively correlated with measures yielding suggestibility and hypnotic susceptibility. Barrier scores are also correlated with being communicative and sensitive to the needs of others in group situations.

The notion of high and low barrier persons has significant socio-cultural connotation within the complex multi-cultural context of South African society. For this reason a brief review of social-cultural aspects of body image boundaries follows.

2.1.3.2 Boundary and social-interaction

The following two aspects of body image demonstrate the relationship between the degree of boundary experienced by the individual and the person's level of communication and clothing behaviour.

a) Body Image Communication

Several studies on body image boundary (Fisher, 1974) focus on the finding that body definiteness is positively related to:

- frequency of initiating messages to others in social interaction
- communicativeness in an interview setting
- acceptance of other group members
- the reciprocity of the influence of people's bodies on the bodies of others
- individualisation which provides the individual with self-confidence and sensitivity.

Fisher (1974) notes that it is this self-security that facilitates communication and provides the necessary skills to initiate contacts spontaneously, which is a clear advantage in the socialisation process for clearly bounded individuals. Moreover, Fisher (1974) postulated that body is an integral component of identity and of the individual's social world.

The philosopher, Merleau-Ponty (cited in Edwards, 1972, p.281) also emphasised a clearly articulated area of space, that is, the individual's own body space, in which the person experiences identity and a sense of existence. By contrast, a delimitation of body space could manifest in the incapacity of an individual to experience the body as securely rooted and as a source of continuity (Fisher, 1974).

In a multi-cultural society, personal space may be interpreted diversely. Some cultures place more value on individuality and privacy, whereas other cultures value community living and shared space. This is evident in South Africa where body image attitudes and the effect of body boundary definiteness could vary due to cultural differences between Blacks and Whites. This could affect a person's sense of social acceptance and form a barrier to communication. Cognisance of these cultural differences would be important in any assessment of body image boundary definiteness, identity and ultimately clothing behaviour. For this reason it is necessary to explore body boundary in relation to clothing behaviour.

b) Body boundary and clothing behaviour

Clothing behaviour expresses the values and attitudes of the wearer and may clearly convey messages about how the individual wishes to be viewed physically. Clothing behaviour is mediated by the individual's degree of body boundary definitions (Fisher, 1970). Clothing and body embellishments and decorations are often used in an attempt to reinforce body boundary. Paradoxically, on the removal of clothes, an individual's body boundary may be reinforced. The individual is confronted with her body as a perceptual object, with particular emphasis on the skin, which becomes a source of new sensation and experience. Noteworthy studies (Fisher, 1970) additionally dealt with the issue of the influence of barrier scores on clothing behaviour. Low barrier women were found to utilise fashionable clothing to bolster weak body boundaries, whereas persons who felt they had secure boundary regions wore clothes with confidence. Novel styles of clothing requiring energy and ingenuity in their choice, were found to provide low barrier persons with a sense of reassurance and protection. Paradoxically, current fashions, and the culture surrounding the pressure to adopt certain fashions, imply that a person's body is a standardised frame, irrespective of individual differences, which may not be compatible with current trends. The outcome may be feelings of body depersonalisation. Uniformity in adhering to other forms of bodywear, for example, underwear, hair styles, cosmetics and accessories, set by current or ideal societal norms for a particular group or culture also affects barrier scores. These factors complicate the process of understanding and clarifying the reasons for a person's or a group's clothing behaviour.

2.1.4 Socio-cultural aspects of body image

Due to the significance of environmental and psychological influences on body image and consequently on human behaviour, an investigation into the socio-cultural aspects of body image is of major significance in this study.

What is desirable and attractive with regard to a person's perception of her body image is often culturally bound and validated by consensus. A person's body images include her perception of the cultural standards for a particular group of people at a particular time. The degree of significance placed on the feelings of how a person measures up to these standards influences her attitude towards her body (Cash & Pruzinsky, 1990). For example, generally today, in Western society, a woman's perception of the ideal female body shape is a thin shape (Silverstein, Perdue & Kelly, 1986). Often her perception is that she is heavier than the ideal. A review of the literature indicates that the influence of this perception on the individual's self-concept is greater for females than for males. Furthermore, women are more likely than men to equate self-worth with what they think they should look like and what they believe other people think they should look like (Craig & Caterson, 1990; Brodie, Slade & Riley, 1991). Cash and Pruzinsky (1990) note that it is potentially more stressful to a woman to conclude that she is overweight, and that she is more likely to alter her shape than a male.

These two brief examples highlight the relationship between women's attitudes to their figure shapes and the socio-cultural determinants or norms for the ideal body. In this context the cultural ideal that contemporary Western society has set is one of 'thinness' for women. In order to understand some of the influences of culture on the formation and maintenance of body image, a discussion of what constitutes and defines culture, as well as what defines beauty or attractiveness, follows.

2.1.4.1 Explanation of the term 'Culture'

Culture, broadly defined, is the complex pattern of behaviour that is common to members of a society who share similar world views or tend to make the same assumptions about their environment (Bochner, 1983; Adey & Andrew, 1993). According to Pedersen, Lonner and Draguns (1976) culture is the shared behaviour patterns that are learned and handed down from one generation to the next. Each culture structures behaviour and shapes the attitudes of its members in such a way that a characteristic style, 'a way of living', emerges for each nation. As a dynamic concept, culture can assist in unifying members of a group, nation or sub-group through shared norms, aspects of beliefs, values, ideas, customs, attitudes and symbols.

Conversely, culture may contribute to the individual's stress or to national discontent by imposing unrealistic rules or restrictions on behaviour. An example, in relation to this study, would be the unrealistic standard of 'thinness' expected in order to meet the socially acceptable standard for present day physical attractiveness in Western culture today.

There may be resistance on the part of society to change cultural norms, customs, attitudes and values. However, culture is adaptive and non-static, especially through advanced technological progress and extended media and communication facilities, for example, film, television, magazines, journals and computerisation. With regard to body image perception and clothing styles 'cultural assimilation' may occur. This is where the dominant culture enforces its norms on another, and where some of its elements, perceived as desirable, are incorporated or adopted by another culture (Pedersen *et al.*, 1976). In contrast to cultural assimilation, 'cultural encapsulation' occurs when an individual or group defines reality according to a mono-cultural set of assumptions and stereotypes which then become more important than the real world.

Pedersen *et al.* (1976) note that each individual harbours unreasonable assumptions that she accepts without proof. When these assumptions are threatened by an alternative view, either cultural, political or religious, the person may become easily fearful or defensive. For example, the individual who has a body shape which does not conform to what is socially acceptable as the 'ideal image' may resort to extreme behaviour such as excessive dieting. Through a careful analysis of the attitudes of the Black/White sample population groups in this study toward either Western or ethnic trends in clothing style and physical appearance, the impact of unreasonable assumptions and stereotypes could become evident.

a) Cultural background and social relationships

In multi-cultural democratic South Africa, intercultural adoption of norms for body image and clothing issues may be facilitated and affected by the promotion of equality in social relations and a more equitable platform for the exchange of ideas and flow of socio-cultural influences. Dress and body image variables are among the more visible aspects of socio-cultural interaction through which social identity may be modified.

In Western society, achievement is a prime motivating factor (Pedersen *et al.*, 1976). A person is defined according to what she achieves by objective, visible, measurable criteria. Clothing behaviour is a prime example of such an external criterion. The desire to achieve is often executed rigorously to the point of developing eating disorders, or to the extent of undergoing multiple surgical procedures in order to conform to the ideal social norm for body image and appearance prevailing at a given time (Thompson, 1990). An assessment of the attitudes of persons in the sample population for this study who have elected cosmetic surgery,

should reveal to what extent environmental influences have influenced their decisions to change aspects of their physical appearance.

It follows that intercultural harmony is therefore an important factor in either the acculturation process or the process of cultural interchange, and in how this influences personality and psychological variables such as a person's sense of identity and belonging. Research has demonstrated that merely getting members of different groups together is not enough to produce understanding and harmony (Taft, 1977; Pedersen *et al.*, 1986). The direction of change depends on whether change occurs under favourable conditions that tend to reduce prejudice and promote inter-group contact, or under unfavourable conditions that increase prejudice, such as competition between groups. With regard to the trends in this study, these factors may affect the adoption or rejection of aspects of physical appearance and clothing behaviour promoted by a particular group.

Any significant comparative study on cross-cultural differences in attitude and physical appearance also necessitates a brief review of how socio-cultural norms and ideals change through time. This is outlined briefly in the following discussion.

Kaslow and Eicher (1988) reported that research in South Africa at the time, focused on reducing forms of body-based prejudices by promoting intercultural acceptance of differences in physical appearances. The different South African ethnic groups present different body shapes, body images and body ideologies. However, little research has been done in South Africa, specifically with regard to comparative cross-cultural body image appreciation. This field constitutes a promising new area of enquiry for South Africa (Kaslow & Eicher, 1988).

2.1.5 Cross-cultural ideals of physical appearance

There are strongly held cultural attitudes about what constitutes the ideal female figure and how physical attractiveness is evaluated. Satisfaction with body image is significantly influenced by the importance a woman attaches to being physically attractive in addition to how positive she is about her worth as a person and the amount of control she feels she has over life events in general (Rackley, Warren & Bird, 1988; Spillman & Everington, 1989).

The question posed by researchers is '*Is there a universal standard for beauty?*' It is evident from the differences among countries and tribes throughout the world that there are widely varying criteria for judging attractiveness and beauty. In spite of this great variability, consensus of what constitutes attractiveness prevails within a given culture regardless of age, status, ethnic differences or changing standards. Certain basic qualities seem to appeal to most

societies such as:

- smoothness of skin
- firmness of body type even though shape and size may vary
- roundness rather than angularity.

Cash and Pruzinsky (1990) observe that the rise of mass media in the twentieth century is more likely to impose a more uniform standard of what constitutes both physical beauty and fashion throughout the world, than has previously existed. The message often received through the media is that the adequacy and attractiveness of a woman's body will assure her future well-being, social acceptance and security (Dion, Berscheid & Walster, 1972; Kaiser, 1990). Failed expectations often lead to negative body image and dissatisfaction.

From a feminist perspective, Bergner, Remer and Whetsell (1985) point out that most feminists believe that women have been over-identified with their bodies, that is the women-as-body syndrome. Psychologically this implies that women's self-worth has become contingent upon the prevailing norm for physical attractiveness. Body image, according to this perspective, is value laden thoughts and feelings about one's body, derived from cultural influences and as such is an internalised representation of cultural norms.

In order to understand fully the impact of socio-cultural influences on body image, it is necessary to briefly mention the negative consequences of body image dissatisfaction and its effects on the individual.

2.1.5.1 Negative body image

According to Hutchinson (1989), negative body image is reaching epidemic proportions, for example, among the American female population. This negativity is evident in many aspects of the individual's life, significantly affecting relationships, the individual's capacity for intimacy and sensual expression, career development as well as personal growth and fulfilment. Feelings of self-doubt, fear, depression, shame, guilt and low self-esteem are some of the psychological functional disturbances apparent in the individual. This makes negative body image a clinical issue of considerable magnitude.

As a social phenomenon, body image negativity is perpetrated through a culture that nurtures the myth that there is only one way for a woman to look, thus socialising its female members to conform to this norm. It has been hypothesised that the recent increase in eating disorders may be related to the increasing social pressures for youth, physical beauty and success (Hutchison, 1989; Jackson, Ervin & Hodge, 1992).

Women in the 1990s, globally, continue to attempt drastic changes to their physical selves. Compared with early civilisations and tribal women, contemporary women may focus on differing body parts according to cultural norms at a given time. However, with advanced high-technology surgical procedures comparative levels of change are insisted upon by women today. These include the cosmetic surgery procedures to be assessed in this study.

2.1.5.2 Modifications of body shape and size

Certain practices, for example, wearing a corset, drastic dieting, liposuction or cosmetic surgery procedures may force the body into unnatural shapes or forms. Laver (1952) noted that in past centuries a woman of status, for example, Catherine de Medici of France and Elizabeth I of England, wore steel-ribbed corsets which required them to endure an estimated pressure of up to eighty pounds. This caused restricted breathing by tight constriction around the rib cage, simultaneously inducing a regal posture and small feminised motions. The wearing of a stiff foundation garment compensated for feelings of imperfect, shapeless natural figures (which women of the Nineteenth Century seemed to believe they possessed), and was conducive to the prevailing norm. A tightly constricted waistline was associated with high moral codes and social propriety, hence the term 'straight laced'. It was considered loose behaviour to leave the house without 'stays'.

In Twentieth Century United States of America the uptilted cupshape with high rounded breasts has remained the fashionable ideal, although breast size has changed (Cash & Pruzinsky, 1990). The change can be gauged from photographs, art and fashion magazines. In the 1930s and 1950s when American women were still encouraged to stay at home, large breasts were the feminine ideal. However, in the decades where feminist activities were energetic, that is, the 1920s and present 1990s streamline breasts were and are in fashion, in line with the ideal of thinness and fitness. However, clothing styles and padded bras may change the appearance of breast size, but surgery is required for permanent alteration. In tribal societies, breast alterations are rare so as not to interfere with breast feeding, and breasts are rather painted or decorated with ornamental objects. Breast ornamentation as an aesthetic procedure is shared by many urban societies. Some Western females are now also piercing the nipples for the attachment of rings, chains and other jewellery (Cash & Pruzinsky, 1990; Agenda, TV1 SABC, May 1995). In contemporary society, breast alterations are often requested to change body proportions or to change the actual breast size.

The notion that each cultural group has its own unique definition of beauty which varies over time is supported in the literature by authors Cash and Pruzinsky (1990). These authors caution

that, because methodology of measuring body image is so diverse, it is difficult to draw cross-cultural conclusions unless a direct comparison of two different cultures is made. This study assessed two culturally diverse groups of Black and White women.

2.1.3.2 The media - a socio-cultural determinant of body image perception

It is apparent from the literature that the extent to which people are willing to change physical attributes may even reduce body effectiveness or threaten its existence in order to pursue and meet socially imposed or perceived ideals. In this regard the role of the media (films, television, magazines, newspapers) has become a powerful cultural force exerting influence on perceptions of body image. Both Western and Eastern cultures, for example, America and Japan, place a high value on physical beauty, appearance and outer image. The media, as a powerful tool of cultural transmission, reinforces and exploits this value for commercial as well as socio-cultural gain (Gehardt, 1993).

Stereotypical images promoted by the media continue to exist for the three classically defined stereotypes, based on the pioneering work of Sheldon (Spillman & Everington, 1989). These are:

- endomorph: a fat body type
- mesomorph: average or muscular body
- ectomorph; a thin body type.

Variations in body type are related to individual differences in physical attractiveness, with endomorphic and ectomorphic physiques generally being regarded as less attractive than mesomorphic or mesoectomorphic physiques (Cash & Pruzinsky, 1990). The different social behaviours expressed toward people varying in body type are possibly different social reactions toward people differing in physical attractiveness. With reference to these descriptions of body types, analyses confirmed previous findings that, in general, the stereotypical images continue to exist favourably for the mesomorph and unfavourably for the endomorph. However, for females the ectomorph or thin body build has been associated with positive characteristics. It appears, from research findings (Spillman & Everington, 1989), that young women also choose this body build as 'the image' they would like to project. These findings confirm preoccupation with thinness and fitness observed among college women and thought to be promoted by the media (Spillman & Everington, 1989).

Personality characteristics ascribed to the three body types include:

- endomorphic persons, who are described as socially aggressive, easy and unattractive
- mesomorphic persons, who have been associated with strength, happiness and dominance

- ectomorphic persons who are generally described as nervous, socially withdrawn and submissive (Spillman & Everington, 1989).

Women are constantly being confronted, through the media, with the physical perfection of fashion models who represent the ideal rather than reality. Through this, unrealistic weight standards have been set by society and the media (Mori & Morey, 1991; Gehardt, 1993).

As the media appears to influence people's thoughts, desires and self-concepts, its role in promoting obsession with weight, chronic dieting and eating disorders, especially among young women, deserves greater attention with regard to research and the means of modifying or changing media impact in terms of this growing social obsession.

2.2 IDENTITY, BODY IMAGE AND CLOTHING

This section of the study considers the psychological and the social aspects of identity formation and how these aspects relate to the previous section (2.1) on body images.

From a developmental perspective it is evident that, at certain life stages, a redefinition of a person's identity may be needed. This could occur after major changes to the physical appearance through elective cosmetic surgery, or with the adoption of a new trend in fashionable clothing. With reference to South Africa in particular, redefinition of a person's identity could occur due to cross-cultural influences. An understanding of how identity is initially formed will assist in the clarification of the redefinition process. Aspects of the redefinition process will be similar to those of the initial identity formation cycle (Gerdes *et al.*, 1988).

A biopsychosocial approach to the concept and development of identity illustrates that identity has mainly three inter-related parts (Gerdes *et al.*, 1988):

- public or social identity, which refers to one's position in society or to social roles
- personal identity, which refers to a person's sense of continuity; that is, being the same person throughout the life span irrespective of changing situations, for example, after undergoing major cosmetic surgery the person still feels the same person
- individual identity, which refers to a person's sense of individuality or uniqueness. Physical appearance and body image would form a significant portion of this aspect of identity.

2.2.1 Development of the public identity

Role definition, which gives rise to public identity, begins from infancy and changes throughout the life span according to the various roles and situations a person occupies.

Adolescence marks the beginning of an extreme private and public self-consciousness, psychologically and physically. Physically, this self-consciousness results in a growing accumulation of body images, each of which represents a different body perception. According to Van der Velde (1985), the formation of a person's own body images has two cardinal consequences in relation to identity formation:

i. Because a person's own body images are the mental representations of the physical self and inseparably associated with the reflections of the psychological self, they are in the most comprehensive sense of the term, self images. Therefore a person's conceptual composite of her own body images forms the foundation of the self-concept and hence, sense of self-identity.

ii. As body images are the 'mental reflections' of a person's appearance and her effect on others, they serve as 'mental blueprints' for the design of a person's social behaviour and provide three social functions:

   a) They enable a person to project how others see her by means of her appearances and actions.

   b) They enable a person to 'selectively' control the establishment and presentation of a desirable view of herself and this affects her personal and social identity, either positively or negatively.

   c) They enable a person to create, within others, impressions (i.e. public or social identity) that do not necessarily or precisely reflect her actual self, or true personal identity.

Erikson (1968) points to the explicit relationships between attractiveness, its inter-personal meaning and importance in a female to reach her full identity. The abovementioned author noted the possibility that much of a young girl's identity is already defined in her kind of attractiveness. Part of the significance of this lies in the fact that physical attributes of a pleasing nature are likely to stimulate the type of positive social action from others that will lead to a healthy psychological make-up. One of the main developmental tasks of adolescence is thought to be 'accepting one's physical self and using the body effectively' (Erikson, 1968; Adams, 1977). It seems this would apply to the adult sample population of this study in that changes to aspects of physical appearance would provoke a new definition of public identity and body image and either acceptance or rejection of the aspect changed. The significance of these changes also lies in the subsequent evaluation of self and others and the impact of this on the outer and inner social/psychological processes.

2.2.2 Public identity, body images and clothing

According to Van der Velde (1985), clothing either reinforces the identity or is instrumental in forming a barrier or even hiding true identity. Clothing is prevalent in almost every aspect of the individual's life and is often a factor that seems to be ignored. Moreover, clothing plays a significant part in the socialisation process that leads to the development of one's psychological self. Clothing is seen as a second skin or extension of the bodily self both physically and socially (Sweeney & Zionts, 1989; Horn, 1975). Hence, within the biopsychosocial orientation of this study, the task is to investigate the development and extent of the relationship between clothes, physical self and social acceptance within a mixed socio-cultural sample population group. It was argued that the similarities and/or differences revealed from the investigation would either support or negate aspects of this discussion.

Sweeney and Zionts (1989) note that the ways in which adolescents use clothing have been the subject of many investigations. Price (1986) proposes that life involves a constant modification of our body images for ourselves and others. One of the ways in which we emphasise and support our developing body image is through fashion. Clothing has been used over the centuries to conceal, enhance and modify body contours. Further factors which affect both physical and emotional aspects of body image and hence our public identity are culture and race. A person usually tries to protect her own image and reinforce her own cultural and public identity by her clothing behaviour. In order to adapt socio-culturally to a pluralistic society as in South Africa, the reinforcement and protection of body image and public identity may be even more intense.

Research has shown (Theron, Nel & Lubbe, 1991) that physical self and body images are integral parts of the self-concept of which identity and its aspects form the basis. Theron *et al.* (1991) note that subjects with negative body images show significantly more social introversion; that is, an inhibited social identity, whereas subjects who are socially well adapted; that is, having positive social identity, have a better body image and are more self-confident. It can be deduced from this that a positive body image, will be associated with less self-consciousness. Self-consciousness, like body image, influences behaviour.

Fenigstein, Scheier and Buss (1975) identified three dimensions of self-consciousness:

- private self-consciousness
- public self-consciousness
- social anxiety.

Theron *et al.* (1991) note that when private self-consciousness, that is, the focus on cognitions and feelings about the self, is high, there is more self-disclosure and a decrease in feelings of social isolation and loneliness. Conversely, public self-consciousness is the awareness of the

self as a social object. A positive awareness of the self as a social being is indicative of a positive public identity. The opposite applies where the awareness of the self as a social object is negative. By comparison, other research findings have shown a significant negative correlation between social anxiety and sociability where social anxiety means the discomfort felt in the presence of others (Theron *et al.*, 1991). Reported findings also reveal that self-rated attractiveness is negatively related to social anxiety, but positively related to private self-consciousness. It appears from these results that the higher the subject's body image scores, the lower the scores on measures of self-consciousness either private or public (Theron *et al.*, 1991). In relationship to body image scores and physical attractiveness, it follows that the use of fashionable clothing and other grooming behaviours such as cosmetic use, would positively affect scores on social interaction and social and public identity.

Finn (1975) points to further descriptive terms in relation to public identity and public self-consciousness namely, field-independent and field-dependent persons. Field-independent persons have a clear distinction between themselves and their physical surroundings (high-barrier persons), whereas field-dependent individuals have an unclear differentiation of their surroundings and depend on clues from the outside world to orientate themselves (low-barrier persons).

In relation to this study, it was argued that an individual's positive social identity and body image would depend on clues and reactions from the outside social world, and clothes would be used more as a support mechanism than as a means of self expression.

From a psychosocial viewpoint this could be further related to the concepts of locus of control. Whether internal or external, locus of control refers to where a person believes the control lies for the events occurring in her life. A person with an internal locus of control shapes and takes responsibility for events in her life, whereas a person with an external locus believes that external circumstances and other people are responsible for events in her life. Either extreme leads to maladjustment (Gerdes *et al.*, 1989). A person with an internal locus of control is likely to be field independent, whereas a person with an external locus of control would be field dependent. In a discussion on self-identity and aspects of personality, both of which are considered in this study, the issues of field independence/dependence and locus of control become significant issues to be explained. However, from the literature review it seems logical to expect that an individual with a positive social identity and body image would be more likely to have an internal locus of control, be low in social anxiety and be field-independent. Fashionable clothes under these circumstances would be worn more as an expression of self to enhance outward appearance than as a means of camouflage to hide the individual's public or personal identity.

2.2.3 Personal identity

Gerdes *et al.* (1989) point out that personal identity refers to a person's sense of being the same person over time and through changing experiences and situations. Notably this aspect of identity is reflected in the word 'identical' which means 'one and the same'. For example, in relation to this study, a person's physical body and or body image may undergo major changes as a result of elective cosmetic surgery. However, the person remains the same person bound through consciousness and memory. Where there is an impairment in neurological functioning or a pathological dissociative mood disorder due to extreme emotional stress or amnesia, the sense of identity continuity may be interrupted or the person may assume multiple identities as a result (Gerdes *et al.*, 1989). Furthermore, a sense of personal identity is supported by stabilising facts such as being recognised, evaluated and generally treated more or less consistently by others.

The abovementioned authors point to a further distinction which is needed in order to clarify the many aspects of the broad term identity, that is; individual identity. Individual identity is a person's subjective awareness of her uniqueness and individuality and is as such closely related to, yet not synonymous with, the self-concept. The distinction drawn is that subjective evaluations belong to the self-concept, for example, 'I like my body', whereas individual identity comprises the individual's view of herself in relation to other individuals and within the social system. Individual identity is formed not only through selective identification with other groups or individuals with whom the person wishes to associate, but specifically through the ability of the person to define herself as a separate unique individual with certain attributes, affiliations, interests, values and beliefs.

As this study specifically included a Black sample population a specific discussion on ethnic identity development is included. Any similarities and/or differences found between the two groups will be a source of significant departure for a discussion on the results of the dependent variables for this study.

2.2.4 Ethnic identity development

Racial identity development theory concerns the psychological implications of racial-group membership; that is, belief systems that evolve in reaction to perceived differentials of racial group membership (Helms, 1990). The term 'racial identity' refers to a sense of group or collective identity based on one's perception that he or she shares a common racial heritage with a particular racial group (Helms, 1990).

What people believe, feel and think about distinguishable racial groups can have major implications on the individual's intra- and inter-personal functioning. Helms (1990) further states that ethnicity refers to a group classification of individuals who share a unique social and cultural heritage (customs, language and religion) passed on from generation to generation. Ethnicity is not biologically acquired and therefore race and ethnicity are not synonyms. Members of different racial groups could belong to the same ethnic group. However, members of different ethnic groups need not belong to different racial groups.

Ethnic identification is a psycho-sociological process. How a person perceives her ethnic identity is at the core of her self-concept. This in turn results from an accumulation of life experiences, personal perceptions, social interaction and developmental growth (Gay & Barber, 1987). How a person conveys her ethnicity through her behaviour reflects different levels of ethnic identity development. Clothing behaviour expresses one aspect of this ethnic development.

2.2.4.1 Stages of ethnic development

A summarised version of the three main stages of ethnic development in the South African context follows. The following has been adapted from Gay and Barber (1987).

Stage I: Pre-encounter ethnicity

At this stage a person's ethnic awareness is either subconscious and subliminal or dominated by White South African, European or Euro-American values and concepts of a Black group, or group other than White. Ethnicity does not shape attitudes and behaviour in any conscious or deliberate ways — often subliminal and indirect images, values and perceptions are taught to young children through the style and substance of the communications they hear, and interactions and standards of behaviour they are expected to observe.

Gay and Barber (1987) note that psychologically captivated pre-encounter individuals of ethnic groups other than White, use White expectations as the yardstick for determining what is good, desirable or necessary. This may be reflected in the clothes they wear and attitudes to physical appearance and body image. Rejection of a person's own ethnicity in terms of these aforementioned factors may reflect the plight of an ethnically oppressed person who has internalised negative images of her ethnic identity. Fashions may be adopted which do not complement her personal appearance in terms of colour or style.

Furthermore, Gay and Barber (1987) argue that physical appearance, including skin colour (whiteness) and hair texture, are important criteria of physical beauty to psychologically captive pre-encounter Afro-Americans. Afro-Americans enjoy bright colours and flamboyant styles similar to Black South Africans. Ultra conservative clothes may be worn as compensation for

feelings of inadequacy in wearing ethnic clothes, or simply because this is what suits the person best.

Stage II: Encounter ethnicity

The second stage of ethnic identity development has two categorical phases:

- the event or situation that sets off the transformation process;
- the 'search' for a new ethnic identity referent.

The encounter itself for Black people, according to Gay and Barber (1987), is a conscious confrontation with being Black. This has an explosive impact on a person's existing perceptions of ethnic self and ethnic group. This shift in perceptions moves a person from pre-liberation, preconceptual innocence and psychological captivity to a deliberate recognition and acknowledgement that her ethnic identity may need revision.

There is a growing awareness of double standards of acceptability applied to Blacks and Whites in society, for example, in America and South Africa. In America the 1960s was a period where symbolic and stylistic signs indicated that cultural imperialism and White oppression were unacceptable. This is true of South Africa in the 1990s. 'Black is beautiful' became a slogan and has been expressed in 'Afro' hairstyles and ethnic styles in dress.

The redefinition process of identity is difficult, as negative beliefs and perceptions about one's personal and ethnic group's worth are not easily abandoned. Anger, stress and confusion are often the result. Socio-culturally this may be expressed in rejection.

Stage III: Post-encounter ethnicity

The attitudinal and ideological changes inherent at this stage of ethnic identity development are almost imperceptible because of their holistic integration with the person's style, presence and behaviour patterns. The post-encounter stage is evident in the sense of security, self-direction, confidence and comfort with ethnic self the person emanates. There is less need to reject 'White' standards and glorify all things 'Black' (Gay & Barber, 1987) or to prove ethnic authenticity. Ethnic identity clarification involves rather an acceptance of positive and negative aspects of the person's ethnicity, and adoption of a positive sense of inner security, of self-actualisation and self-direction at the same time as being open and receptive to other groups. Ethnic shame, degradation and self-hate are replaced by a sense of inner self-worth and personal acceptance.

The stages of ethnic identity development present a transformation of believing and being that impacts on the individuals' whole being, including their style and profile (Gay & Barber, 1987).

As individuals move through the transformation process, their interaction with self and their own ethnic group, and their compassion for those of other ethnic groups improve. The stage progression is neither inevitable nor invariant. Some people remain fixed at the pre-encounter

stage. It is unlikely, however, that post-encounter individuals will regress to earlier stages except in cases of psychic trauma.

As individuals progress through stages of ethnic redefinition, their behavioural expressions may change, becoming less stylised and more flexible. In the case of South African Blacks, for example, the wearing of ethnic dress may be reserved for ceremonies and important occasions. Western fashion may be adopted where it is felt to be appropriate and not as a necessity to strengthen feelings of social acceptance or self-worth (Mr C Levine, Courture Designer: Personal communication, June 1994).

2.2.4.2 Body image with reference to a Black South African sample population group

Thomas (1989) states that women's satisfaction with their body image is influenced not only by their physical characteristics but also by the way others react to them. They may compare their physique to that of others in their immediate environment and apply cultural ideals and standards to themselves. The author further notes that although body size and shape may be a critical factor in body image evaluation, other variables play a contributing role, for example, self-esteem may be a key factor influencing body image satisfaction. Self-esteem and ethnic identity are closely linked. Self-esteem, and hence body-image satisfaction, may be affected depending on the level or stage of identity development of the individual. Thomas (1989) observed that most researchers investigating body-image satisfaction used White female samples in their studies. One of the tasks of this study has been to narrow this gap and discuss body image and identity in relation to the socio-cultural variables of social anxiety and clothing from a Black, as well as a White sample perspective.

2.2.4.3 Ethnicity and body image — Body image and skin colour

Skin colour forms an integral part of body image perception specifically among ethnic groups and in relation to imposed Western ideals of physical beauty. As Bond and Cash (1992) note, the history of the Afro-Americans provides considerable evidence that the skin colour of a 'Black' American has exerted powerful and persistent influences on societal attitudes towards and treatment of Afro-Americans by White Americans. With regard to South African history, the dimension of the psychological effects of negative attitudes towards and treatment of 'Black' South Africans is probably incalculable. However, how do Afro-Americans and Black South Africans feel about the colour of their own skin and what effect, if any, does this have on their body image, self-concept and identity?

Bond and Cash (1992) observe that preferential treatment given by both Black and White cultures to Afro-Americans with light skins and other Western features or physically approved attributes has conveyed to many dark-skinned people that the more they physically conform to the White standard of beauty, the more rewarding their lives would be. The influence of Western cultural standards of beauty as well as media influence in South Africa may well have conveyed that particular message to Black South Africans. However, scientific research on attitudes to skin colour by both Black and White South Africans is presently unavailable.

Bond and Cash (1992) note that during the civil rights movement of the 1960s, many 'Black' Americans celebrated cultural pride that 'Black is beautiful'. However, Thomas (1989) reports that a sizeable proportion of Afro-Americans have voiced some degree of body image dissatisfaction. Consistent with earlier research, Thomas (1989) notes that there is a significant discrepancy between women's current and ideal weights, with a thinner figure viewed as ideal. In addition, women's body weights are inversely correlated with their body images satisfaction. However, Thomas (1989) reports that the relationship between self-esteem and body image satisfaction is not as strong as may have been expected if one generalised results of studies on 'White' women. Afro-American or Afro-South African women may not have internalised either American or South African society's recent standards of beauty and fashion and, significantly, have not related their overall self-worth with various aspects of physical appearance. Noteworthy is the fact that, the perception of 'significant others' were strongly related to their body image satisfaction, specifically those of significant men in their lives. Thomas (1989) notes that although demographic and cultural factors, for example, socio-economic status, social networks and sex role stereotypes have been found to play a major role in body image satisfaction, these factors may or may not be generalised to minority groups, for example the Negroid population in America.

This present study, however, examined the level of body image satisfaction of a sample of the Black South African population group so as not to generalise the above factors usually associated with body image satisfaction. Although not a minority group, the South African Black women have been an oppressed group prior to1994. It was argued that this fact could have influenced body-image satisfaction, a sense of social acceptance as well as clothing choice.

CHAPTER THREE
LITERATURE SURVEY
COSMETIC PLASTIC SURGERY AND PHYSICAL ATTRACTIVENESS
A BEHAVIOURAL MEDICINE PERSPECTIVE

3.1 INTRODUCTION

It is evident that some people are unable to transcend the effects of features that are personally and socially unattractive. People who once felt they had no choice except to live with unacceptable aspects of their physical appearance now consult plastic surgeons in order to rectify or modify unattractiveness through surgery (Cash & Horton, 1983; Rogers, 1990).

Post-operatively the individual's perception of negative reactions from significant others may elicit disappointment, guilt, anxiety, depression and self-attribution of vanity and blame, as well as feelings of anger toward the surgeon. Comparatively, post-operative increase in attention from others may be attributed to increased attractiveness rather than to internal qualities and behaviours. Cash and Horton (1983) point out that to the extent that the surgical alterations of aspects of physical features modifies the faulty self-stigmatising attributions, patients may experience psychosocial improvements, mediated by actual social reactions. These authors clearly state that a challenging void exists in the research literature on the psychosocial aspects of aesthetic surgery.

This study attempted to enlarge current themes on aspects of aesthetic surgery, by extending the study on the influence of changes to physical appearance on body image to how these changes affect clothing behaviour. Clothing behaviour is a psychosocial variable of major significance with regard to body image and self-esteem and one which remains relatively unexplored. An overview and background to cosmetic plastic surgery is necessary for the purpose of gaining an understanding of why surgery is chosen in order to enhance physical appearance. Cosmetic plastic surgery may be either elective surgery, in terms of a patient's desire to improve aspects of her physical appearance, for example, augmentation mammaplasty or reduction mammaplasty, or it may be recommended surgery in cases of burns, skin or other severe physical abnormalities.

For the purpose of this study, the focus was on the patient's free choice in electing cosmetic plastic surgery.

The areas chosen for study in this dissertation were thought to be those most likely to affect the clothes a person chooses or desires to wear but is unable to wear because of actual or perceived physical unattractiveness or discontent. The physical aspects chosen for study were also thought to be those most likely to affect body image perception, personal and social identity

and feelings related to physical attractiveness. These were augmentation mammaplasty, reduction mammaplasty, abdominoplasty (tummy tuck) and rhytidectomy (face lift).

Within the biopsychosocial framework of this study, cosmetic surgery provides a unique opportunity to enhance understanding about body image development, deviance and change.

Although aesthetic plastic surgery is undertaken to improve the patient's appearance, one of the main purposes is to facilitate positive psychological change. Cash (1988) notes that some of the earliest developers of plastic surgery articulated this goal by stating that the only rationale for performing plastic cosmetic surgery is to improve the patient's psychological well-being. The necessity for surgeons to evaluate the potential patient's subjective body image and the emotional and inter-personal contexts of body image experience in order to conduct safe and successful surgery is also well documented (Cash & Pruzinsky, 1990; Schlebusch, 1990).

According to Larson, Anderson, Maksud and Grunert (1994), the American Society for Plastic and Reconstructive Surgery reported that there were dramatic increases in requests for changes to physical appearance, specifically for liposuction, augmentation mammaplasty, blepharoplasty, rhinoplasty (nose surgery) and rhytidectomy over the past decade in the United States of America. In South Africa, statistical evidence about requests for plastic surgery considered during this study, as well as observations made from the plastic surgeons interviewed (personal communications, Durban, 1995), points toward an increase in this country of breast reductions and abdominoplasty, liposuction and blepharoplasty similar to those mentioned as most sought after in the United States of America.

3.1.1 The nature of surgical change

Gruendemann (1975) maintains that surgery is an intense experience, a planned physical action performed on a person's body. The physiological and psychological effects cover a wide and diverse range because each person perceives surgery in their own personal and specific way. Physical trauma is always accompanied by emotional response proportional to the degree of intensity of the threat felt. Gruendemann (1975) further points out that sometimes the patient forms an intense emotional attachment to the affected physical area which he describes as compartmentalised body narcissism. The central question usually asked by patients is 'What will surgery do to me as a person and will it change my body? Will surgery make me look better?' Gruendemann (1975) observes that only a few body image studies are recorded, and states the necessity for health care professionals, for example nurses and surgeons, to understand the concept of body image, through pre/post-operative assessments which include patients' feelings about their bodies.

Price (1990) suggests that an understanding of body image is imperative because the professionals involved are the key persons guiding the patient through an experience that profoundly affects their body images. In summary, he states that knowledge of body images adds a new dimension to the quality of professional assessment of patients by nurses and surgeons.

Gruendemann (1975) states that among some of the threats posed by surgery, some patients fear

- harm to their bodies because of perceived loss of personal identity in the operating theatre
- loss of a body part or organ, for example, breast or abdomen.

Conversely, some patients expect total positive body change and have only minimal feelings of threat. When this is the case the physical discomforts which accompany surgery become more acceptable because the patient's expectations of the outcome are so high. From these observations it is apparent that surgery can either enhance or disrupt psychological and physiological integration; it therefore, always demands revised modifications of the patient's profile.

3.1.2 Surgery and the re-organisation of body image

In terms of physical and psychological wholeness, it is necessary that readjustment of body image be in realistic accord with the actual physical changes caused by surgery. This necessitates an acceptance of the body as it is, or has become, and likewise an adaptation to this change. Gruendemann (1975) points out that if this acceptance does not occur, anxiety accompanied by various degrees of emotional response is the result.

Cosmetic plastic surgery procedures can roughly be categorised as 'type changing' or 'restorative surgeries' (Cash & Pruzinsky, 1990). Much of cosmetic plastic surgery is restorative, that is, it restores a person to their previous physical characteristics, for example, rhytidectomy or blepharoplasty. The average rhytidectomy patient has little or no need to adjust psychologically to a sudden deterioration in the size and shape of a body part with the attendant possibility of body image distortion (Cash & Pruzinsky, 1990). However, type changing operations create an appearance that the person has not previously had, for example, changing the basic shape of the nose (rhinoplasty), or the breasts (breast reconstruction after mastectomy, or augmentation mammaplasty). Generally the psychological impact of 'type changing' operations is more profound than for restorative procedures.

According to research (Cash & Pruzinsky, 1990), it is quite unusual for a restorative operation such as a face lift to cause any serious degree of body image disturbance as their basic

appearance is unchanged; however, they generally look younger and feel renewed. Some patients express disappointment at the lack of basic change achieved (Personal interviews, 1995).

3.1.3 Patient's dissatisfaction with the degree of surgical outcome

Patients may have unrealistic expectations of the impact of surgery on their lives. Surgery alone does not necessarily improve or change one's social life. However, it is a catalyst for changing one's relationship with oneself. Dissatisfaction and disappointment can occur if the surgeon has not explained the nature of surgery in terms that the patient can understand. According to Cash and Pruzinsky (1990), patient dissatisfaction is ultimately the physician's responsibility. Adequate and appropriate surgeon/patient communication is a difficult and challenging task for which surgeons are seldom trained, or have the time to carry out.

In the present study, the importance of surgeon/patient interaction in terms of a positive psychological outcome to the surgery and with regard to a positive patient body image was explored. The need for trained medical psychologists, and how such personnel could facilitate the final degree of acceptance and success of the patient's attitudes and the surgery itself were subsequently stressed. It was also argued that a knowledgeable psychologist or psychiatrist could be invaluable as a member of the therapeutic team of individuals treating plastic surgery patients.

3.1.4 A model of body image change

Cash and Pruzinsky (1990) propose the following model as a framework for a comprehensive study of the whole process of body image change:

- patient's perception of change
- factors affecting stages of change
- post-surgical negative psychological change
- social evaluation of surgical change.

3.1.4.1 Patient's perception of factors and stages affecting change

The patient's perception of appearance involves the evaluation of the aesthetic effect of surgery; that is, proportion, line, shape and texture. With regard to ethnicity the surgeon considers whether ethnicity is enhanced, and considers the effects of scarring. Cash and Pruzinsky (1990) point out that perceptual changes also include sensory modifications (for example tactile sensations) which are especially important when considering the role in developing and

maintaining body images. Fundamental to post-surgical body image adjustment is the experience of changed physical sensations in addition to visual alterations. Consequently, perceptual changes in appearance and sensations are the foundation for the cognitive, emotional and behavioural changes that result from cosmetic surgery. A significant period of time is often needed for adjustment to new body images resulting from surgery. Anxiety is also reduced by the time factor as temporary scarring or discolouration dissipates with continued healing.

Despite the prevalent positive reports of patient satisfaction with cosmetic surgery (Cash & Pruzinsky, 1990; Schlebusch & Mahrt, 1993), there is evidence in the literature concerning negative psychological reactions, although they are majorly transient.

3.1.4.2 Post-surgical negative psychological changes

Any account of body image change in cosmetic surgery must consider negative emotions. These are briefly commented upon as any detailed reference to depression or negative emotional states is beyond the scope of this study.

Types of negative emotional change include the experience of no emotional change, that is no relief or satisfaction with the surgical outcome or, conversely, an overwhelming negative emotional reaction. Conversely, some patients may acknowledge positive change in appearance, but are unable to integrate this change into their self-concepts. They still perceive and conceive of themselves as unattractive (Cash & Pruzinsky, 1990). Some individuals will experience a constant refocusing of their self-conscious bodily concerns on other body parts. This may account for the recent increase in the number of insatiable patients who request multiple cosmetic surgery. Such patients are more psychologically disturbed than those patients who simply experience no change or who refocus their self-consciousness on other body parts. There are also those patients who repeatedly request multiple operations on the same body part. These patients often have borderline personality organisation which is characterised by a generalisability in psychological identity that is likely to include body image diffuseness and/or volatility (Smith, Burlew & Lundgren, 1991). These qualities contribute to the difficulty the patient may have to experience a 'match' between the desired body image change and the change brought about by surgery. The resulting confusion regarding the individual's identity and body images makes successful surgery unlikely.

3.1.4.3 Social evaluation of surgical change

Social evaluations are critical in determining the degree of success or failure of the person's ultimate adjustment to physical changes. The surgeon's evaluation of the patient's surgical outcome can greatly influence the patient's perception of the final result. Hearing a positive outcome from the surgeon, as opposed to a negative response could, for example, enhance the process of assimilation of change and acceptance by the patient.

3.1.5 Factors which influence the evaluation of surgical change

These factors are:

- the age factor
- feminine identity
- interpersonal relationship
- clothing.

3.1.5.1 The age factor

A consistent observation in the literature (Cash & Pruzinsky, 1990) is that younger patients psychologically adapt to 'type changing' surgical procedures more easily than older patients. For example, older patients undergoing rhinoplasty often have a longer, more difficult course of post-operative psychological adjustment and have more frequent psychological problems, especially feelings of loss of identity following surgery. The most common explanation for this consistent clinical observation is the common-sense notion that older patients have a much stronger, long-term bond between their perception of physical appearance and their sense of personal identity. Younger patients have not had as long to develop the bond between their appearance and identity resulting in the fact that the body image is possibly more adaptive early in life.

3.1.5.2 The feminine identity

Female desire for augmentation mammaplasty or nasal changes is very often an expression of the need to achieve a closer feminine ideal. Individuals have a current concept of their body, as well as expectations regarding their future body images. These current and future body images correspond to components of actual, present or ideal 'future selves'. Patients have a picture in

their minds of what they will look like post-surgically. They have expectations regarding changes in attractiveness, the feminisation of their appearance or alteration of their ethnicity (Cash & Pruzinsky, 1990). If surgery has been technically successful, but does not match a patient's conception of her appearance, the patient will react negatively. Patients ideally should have a clear idea of the type and degree of surgical change they can expect.

In accordance with the biopsychosocial framework of this study, Cash and Pruzinsky (1990) further explain that the body is part of what we are. It is through our bodies that we recognise our existence in the world and distinguish the world ourselves. The body is the medium of experience and the instrument and seat of our actions and sensations. Fisher (1986) notes that medical procedures that heighten concern about the body intensify bodily awareness. Bodily awareness in turn remains a major issue for the physically dissatisfied or disadvantaged. This profoundly shapes the construction of the self-concept, part of which comprises personal and public identity. According to researchers Cash and Pruzinsky (1990) a positive change in appearance (that is, cognitive and emotional evaluations of appearance) and behavioural change impact on the patient's social relationships. Patients become more outgoing or, at least, less socially inhibited.

3.1.5.3 Clothing behaviour

The present study emphasised the socio-cultural issue of clothing behaviour in relationship to identity and body image, as individuals often display clothing styles that hide certain physical features.

After surgery, patients may experiment with changes in clothing style. Reports show that 60% of breast augmentation patients begin wearing more revealing clothing after surgery (Cash & Pruzinsky, 1990; Schlebusch & Mahrt, 1993). Individuals who feel better about their appearance may even begin to adopt new forms of movements and non-verbal behaviour. Such changes can have considerable psychosocial importance given the significance of movement and the role of non-verbal behaviour in social interaction.

In conclusion, it would appear that a surgical operation, by removing a single persistent symptom, has long-term positive effects and by releasing previously repressed and inaccessible energies, allows the patient to develop a significantly different life style. This occurs through an increased self esteem and personality development associated with the changed or modified body part (Goin & Goin, 1981; Cash & Pruzinsky, 1990; Comer, 1990).

3.2 COSMETIC PLASTIC SURGERY AND SPECIFIC ASPECTS OF PHYSICAL APPEARANCE

Tourkow (1974) significantly draws the distinction between traditional surgery and transplant or implant operations. Traditional operations are generally seen as life saving. In addition to being life saving, transplant or implant operations are seen as life extending or life enriching. On the other hand, a transplant, reconstruction or implant operation enhances body image. What was previously non-ego now needs to be integrated into the ego. Surgery involving removal or reduction of a body part or organ, reduces body image and needs to be eliminated from the ego. Reference to an altered body image is usually made with regard to change to the exterior appearance or surface anatomy, for example, through surgical procedures for the removal of a body part, or through loss of a body part. In such a case the person has to cope with a restriction of body image (Schlebusch, Pillay & Louw 1992). In this study, abdominoplasty (surgical reduction of the abdomen due to redundancy), although not an exterior alteration to the body, was used as an example of body image restriction due to the removal of internal body mass. By contrast, augmentation mammaplasty was used to represent an example of extended body image or enlarged internal body image (Schlebusch, 1987; Schlebusch *et al.*, 1992). Moreover, this study intended to clarify whether an extension to, or reduction of, body image due to elective cosmetic surgery would affect a person's:

- sense of self identity
- aspects of her personality
- changes in clothing behaviour.

3.2.1 Augmentation mammaplasty

This is a surgical procedure to increase breast size through the implantation of a prosthesis either subpectorally or above the muscle (Pierce, 1982).

Through the ages the female breast has been symbolic of idealised standards of female beauty, femininity and female sexuality (Spalding, 1990; Schlebush and Mahrt, 1993).

Spalding (1990) further notes that the female breast, because of its symbolic equation with femininity, is a structure of considerable psychological importance. Unacceptable size and shape of breasts are frequently attended by psychological effects often out of proportion to the functional purpose of the breasts. These psychological effects include feelings of being conspicuously unfeminine if breast size is considered too small. Spalding (1990) also found that 81% of a sample population (n = 64) experienced feelings of inadequacy in relation to breast size.

Based on these findings, he postulates that there are deeper, more complex psychological issues to be considered in addition to the relatively obvious social and cultural factors, namely, body image and self-concept. In support of this postulation, Spalding (1990) notes that many psychologists ascribe a key role to the body image and self-concept as factors in the integration of personality in the motivation of behaviour, and in achieving mental health. In the light of this, the present study attempted to explore further psychological and socio-cultural issues associated with augmentation mammaplasty. These included self-identity, selected personality variables and clothing behaviour.

3.2.1.1 Patient expectations

The individual presenting herself for augmentation mammaplasty typically complains of small breasts (Pierce, 1982) and often desires to improve both self-image and body image so as to increase the probability of positive interpersonal as well as intimate relationships. According to Schlebusch and Mahrt (1993), the expectations underlying a request for augmentation mammaplasty are that improving one's physical appearance will contribute positively to the individual's psychological and social development.

Research has shown that many patients presenting themselves for augmentation mammaplasty have a history of depression, low self-esteem and a negative body image. On the basis of this observation, recommendations have been made for pre- and post-operative psychological evaluations of the patient to ensure the successful outcome of augmentation mammaplasty cosmetic plastic surgery (Cash & Horton, 1983; Noles, Cash & Winstead, 1985; Schlebusch & Mahrt, 1993).

Persons requesting elective surgery for augmentation mammaplasty expect a high degree of surgical success and satisfaction, as well as a positive psychological outcome (Schlebusch & Mahrt, 1993). Some patients request post-operative psychotherapy to facilitate the process of accepting physical change into an 'extended body image' and to overcome a previously restricted sense of femininity.

This study measured pre/post-operative attitudes to physical change, and changes in personality and psychological variables. This was executed in order to assess possible post-operative change in attitudes and to gain an insight of the need for psychological adjustment.

3.2.1.2 Requests for augmentation mammaplasty

Table 3.1: Trends in requests for augmentation mammaplasty

Researcher	Date	Increase	Decrease
Six Durban-based plastic surgeons in private practice (Spalding, 1990)	1986	Increase	
Schlebusch and Mahrt	1993	Notable increase	
Six Durban-based plastic surgeons for an economically and culturally mixed group (Personal communication, 1995)	1994		Decrease

Schlebusch and Mahrt (1993) point out that the notable increase in requests for augmentation mammaplasty is partly due to the symbolic nature of breasts and to the pressure to conform to the standards imposed on Western society largely through the media, fashion and fitness magazines, diet and sports programmes.

By contrast, as recently as 1994, Durban-based plastic surgeons in private practice and the Head of the cosmetic plastic surgery unit at Wentworth Hospital (Prof. A Madaree) have noted a sharp decrease in requests for augmentation mammaplasty (Ref. 1.1 Introduction). This is presumed to be due to the controversy currently raging in the United States of America and globally, as to the efficacy and safety of silicone gel implants and the implications of their use as a health risk factor. Reports of a sharp decrease in augmentation mammaplasty surgery have also been noted in the United States of America, and have been ascribed to uncertainty regarding safety factors (Duffy & Woods, 1994).

Spalding (1990) notes that most of the available studies on augmentation mammaplasty patients to date have been conducted in the United States of America. These findings cannot be generalised to the South African population because of cultural differences, particularly in the area of attitudes towards cosmetic surgery. In the United States of America, women tend to be more open about cosmetic surgery while in South Africa a request for cosmetic surgery is often treated as confidential. Spalding (1990) concentrated on the emotional aspects of augmentation mammaplasty patients and proposed that any success of cosmetic surgery could not be based on physical results alone.

With regard to aspects of this dissertation, it was argued that the additional dimension of studying clothing behaviour in relation to a changed physical appearance would contribute new information on this topic in terms of research in South Africa. Moreover, it was felt that the inclusion of a multicultural sample population of Blacks and Whites of varying socioeconomic status, that is fee paying and non-fee paying patients, could extend completed research on this topic locally as well as internationally.

3.2.1.3 Clothing issues

Studies done in South Africa (Schlebusch & Mahrt, 1993) have noted that beauty and femininity, as related to perceived cultural expectations, are important factors generating request for augmentation mammaplasty. Schlebusch and Mahrt (1993) report the following percentages in relation to clothing style for augmentation mammaplasty patients.

Table 3.2: Pre-/post-operative clothing behaviour for augmentation mammaplasty patients

	Clothes	Year	Pre-operative	Post-operative	Experience of discomfort/comfort
1.	Fashionable Clothes	1993	90%		Problem
				100%	No problem
2.	Bathing suits		15%	55%	No problem
3.	Low-cut garments		100%		Problem
				100%	No problem
4.	Tight fitting garments		40%	60%	No problem

An analysis of the data reveals that most patients felt more comfortable purchasing more fashionable clothes after augmentation mammaplasty surgery (Schlebusch & Mahrt, 1993). Data on the more revealing, low-cut garment styles show a 100% improvement in post-surgery feelings of attractiveness and comfort.

3.2.1.4 Success of augmentation mammaplasty

Breast implants form an integral part of the augmentation mammaplasty procedure and are fundamental to the success or failure of the physical aspect of the process. The recent critical

debates as to the safety of breast implants have directly influenced patient sample numbers presenting for augmentation mammaplasty as is evident from Table 3.1.

Mammary prostheses in current use for augmentation and reconstruction purposes consist of hollow silicone shells filled with either medical-grade silicone gel or sterile saline. Despite a long record of successful use, controversy has recently surrounded these implants. Capsule formation, silicone-related 'allergic' reactions and the obstruction of mammographic signs of breast cancer, whether based on fact or merely speculation, have been attributed to gel-filled implants.

As mentioned before, the success of augmentation mammaplasty does not depend on physical aspects alone, although it is often positively evaluated according to post-operative physical appearance of the breasts (Schlebusch & Mahrt, 1993). Rather, emotional attitudes and psychological perceptions of physical appearance strongly influence the success of augmentation mammaplasty. Emotional and psychological perceptions of patients are influenced by the prevailing societal concepts, cultural factors, personality make-up and by symbolic association of the breasts. An integrated, holistic approach is clearly needed for an accurate assessment of patient satisfaction with the results of augmentation mammaplasty.

This study therefore aimed at an accurate patient assessment through the use of an integrated range of questionnaires which, it was argued, would reflect both physical and emotional perceptual changes, and specific personality variables.

3.2.1.5 Breast implants in augmentation mammaplasty

In support of other recent research, Dowden (1994), Duffy and Woods (1994) and Lin *et al.* (1994) note that although the problems surrounding these implants are overall proportionately small considering the large number of implant procedures performed annually, they serve to underscore the point that the ideal biologically compatible implant has yet to be developed.

Research efforts in the past focused primarily on altering the properties of the covering shell; only recently has attention been directed to the implant filler material itself. In a discussion based on their study, Lin *et al.* (1994) point out that, although silicone gel mammary implant use over the past 20 years has been associated with a high degree of patient and physical satisfaction, issues of radiolucency and biocompatibility of the fill material have prompted the search for new alternatives. Recently both a bio-oncotic gel polymer matrix and peanut oil have been tried as new filler materials. Both exhibit superior radiographic resolution characteristics when compared with silicone gel. Although promising, both materials have the disadvantage of being foreign to the human body. Hyaluronic acid is present in mostly all connective tissue matrices of humans. Hyaluronic acid-filled implants not only compare favourably in softness with silicone gel-filled

implants, but also with normal breast tissues (Lin *et al.*, 1994). Due to the unique role of hyaluronic acid in wound repair, it may even be beneficial to have small amounts of hyaluronic acid within the tissues immediately adjacent to the implant as a modifier of the healing process. Hyaluronic acid spilled into the soft tissue surrounding ruptured ganglion cysts in humans has not been known to cause any adverse reactions. As a pilot study investigation, Lin *et al.* (1994) acknowledge the necessity for further research in this area, that is a comparison of hyaluronic acid with bio-oncotic gel or peanut oil.

3.2.1.6 The risks and benefits of silicone (polydimetyl siloxane) gel implants

Patients' awareness of the risks and benefits of silicone gel implants will influence decisions to undergo surgery, and will have possible effects on post-surgical success. The risks and benefits of silicone gel implants continue to be a matter of great controversy, as assessed by Federal Regulatory Agencies and the Scientific Medical Community in the United States of America (Duffy & Woods, 1994). Allegations that silicone gel implants may be carcinogenic or may cause human immune-related disorders have been made. Duffy and Woods (1994) point out that the public has been confused by the unfavourable but not necessarily 'health-risk' result with silicone gel-implants. For example, risks could involve capsule formation, asymmetry and pain as opposed to causing connective tissue or auto-immune disease. These aforementioned authors clearly acknowledge that plastic surgeons recognise these risks, but agree that allegations that silicone gel implants are causative agents in auto-immune or connective tissue disease have yet to be proved. They base this on the finding that of 2 033 patients, only 65 (i.e. 3%) experienced the problem of silicone gel implant rupture. Of these six patients demonstrated Siliconoma due to a ruptured implant and a disruption of the para-implant capsule. None of the patients experienced any outward silicone-gel related health problems. Duffy and Woods (1994) concluded that, while their study did not disprove a causal relationship between silicone gel breast implantations and subsequent development of an inflamatory connective tissue disorder or malignancy, the information presented also failed to provide evidence for any such causal relationships. Conclusions of Duffy and Woods' (1994) study revealed that 577 (87%) of implants were intact in 135 (67,5%) patients and that 65 (32,5%) patients experienced 104 (15%) implant failures out of a total implant population of 2 033 patients. Duffy and Woods (1994) report that these findings were correlated with the patients' current medical evaluation and specific diagnosis such as immune-related disorders, silicomas or new or recurrent malignancies were made. The results showed that no excess of expected immune-related disorders or carcinomas was identified in a

very select sub-group of 65 patients in whom the silicone gel implant elastomer had completely failed or was deteriorating.

In conclusion Duffy and Woods' (1994) argued that in their 30 years' experience with silicone gel breast implants for augmentation mammaplasty or breast reconstruction, no clinically evident adverse health problems had been experienced by those women who subsequently experienced a silicone implant failure. This finding is supported by recent Food and Drug Association (United States of America) investigations into long term safety of breast implants in general and silicone breast implants in particular (Duffy & Woods, 1994).

Dowden (1994) explains that a tiny percentage of breast implant patients reports systematic symptoms which disappear after explantation. The symptoms include malaise, fatigue, muscle aches and joint pain. When symptoms abate after implant removal, the patient cannot be said to have a permanent disease caused by implants, but the symptoms appear to be connected to the implants. Dowden (1994) points out that auto immune disease is very common in North America affecting over six percent of adult women of all ages. Women with or without implants will develop lupus, arthritis, connective-tissue disease or scleroderma. However, despite intensive ongoing research, there is no direct evidence linking these diseases to breast implants. Statistical analyses have failed to show that any of these diseases are more common in implant than in non-implant patients of comparable age and weight. The hypothesis is that the presence of virulent bacteria around an implant can cause fatigue, malaise and links or joint discomfort suggestive of a variety of auto-immune disorders.

The fact that patients improve dramatically completely and rapidly when, despite the fact that silicone not only remained in their bodies but was also present prior to insertion of the implant, raises serious doubts against the theoretical concept of 'Silicone Toxicity'.

In a study by Larson *et al.* (1994), an effort was made to determine public attitude regarding breast implants with regard to what is considered biased media publicity by many researchers and plastic surgeons. Larson *et al.* (1994) state that within the past two years there has been a wealth of information distributed to the public, women in particular, regarding silicone gel-filled implants. More recently, all silicone-associated products have come under scrutiny. Efforts have been made to determine public attitude regarding breast implants in the wake of unprecedented publicity about their safety. According to Larson *et al.* (1994) seventy-eight percent of respondents who had heard of the breast implant issue reported significant hesitancy in the use of implants or would not have implants at all as a result of media coverage. Of 60 invidivuals who completed the breast questionnaire, 3,3% indicated that as a result of the publicity about silicone gel-filled breast implants, they would have no hesitance whatsoever in using them for themselves or as a family member if medically appropriate in the future (Larson *et al.*, 1994).

Patients have a right to adequate information on the safety and development of silicone gel implants from their surgeons. Patients may then make an informed decision about surgery and formulate realistic expectations as to the final outcome.

3.2.1.7 Public perceptions of breast implants in respect of breast reconstruction

Larson *et al.* (1994) reported that in the breast-reconstruction group, 20 out of 54 subjects experienced difficulties with reconstruction. Nine subjects received a gel-filled implant, and three had these implants removed because of difficulties, two (10%) reported no hesitancy with the use of implants, 8 (40%) reported some hesitancy, seven (35%) reported significant hesitancy and three (15%) would not have the procedure. The researchers noted that almost 60% of the augmentation mammaplasty patients in their study indicated that media coverage had caused them none or only some anxiety about augmentation mammaplasty surgery, while 21% had average anxiety and the same percentage experienced much anxiety. In conclusion, the majority of all respondents (range 63-85%) felt that women should have the right to choose a gel-filled implant after being given informed consent.

With regard to the South African mixed sample population represented in the present study, it was difficult to assess the level of awareness of patients' knowledge about the silicone gel implant controversy due to the small sample size. However, patients interviewed indicated that discussion had taken place with their surgeons and that they were sufficiently reassured to expect a reasonable post-operative success rate over a period of at least 10 years. However, based on statistics from Wentworth Hospital, Durban (Prof. A Madaree: Personal communication, 1995) the decrease in numbers of augmentation mammaplasty patients discussed in 3.2.1.5 has been attributed partly to the silicone gel safety conflict given prominence in the media.

In a study by Larsen *et al.* (1994) (Table 3.3) 14 women in an American sample group, had all heard of the silicone implant procedure and the possible dangers associated with it. After negative reports in the media, four subjects indicated the intention to reconsider their plans for reconstruction and 10 reported no change. The majority of respondents indicated that they would not have the procedure.

Table 3.3: Public perceptions of 14 American women on silicone breast implants in respect of mastectomy (Larson *et al.*, 1994)

Number of persons Total = 14	%	Report of decision or item
14		All had heard of silicone implants
4		Intention to reconsider use of implant
10		No intention to change their plans
	14,2	No hesitancy in using the implants for themselves or a family member
	7,1	Indicated some hesitancy in using the silicone breast implants
	7,1	Indicated an average hesitancy in using implants
	28,6	Indicated they would not have the procedure

Larson *et al.* (1994) concluded that the impact the media have on the public is clearly significant and exaggerated. The patient who underwent breast reconstruction after mastectomy in this study stated no hesitancy in using breast implants for herself. In his discussion on Larson *et als'* (1994) study, Pruzinsky (1994) focuses on the relative lack of attention given to the psychosocial and quality of life factors associated with breast implants. Pruzinsky (1994) states that his major contention is that the public's often misconception of silicone breast implants is partly based on the lack of appreciation of the powerful psychological motives underlying the desire to undergo breast implant surgery and notably the potential of this intervention to improve the quality of a patient's life. Pruzinsky (1994) further noted that over the three years preceding his study, the mass media had published a large amount of negative information regarding the safety of breast implants which had created untold levels of anxiety in women who had opted for augmentation mammaplasty. The subsequent withdrawal of breast implants by the Food and Drug Association (FDA) and the proposed 4,75 billion dollar settlement being offered to patients by manufacturers contributed to the disproportionate amount of attention given to medical risks as compared with benefits with regard to augmentation mammaplasty.

Pruzinsky (1994) states that the ability to change psychology by 'changing the body' is a key factor in all plastic surgery. He argues that psychometrically sound measures and methodologically valid research designs to date have been insufficient in demonstrating the potential of breast implants to improve the quality of life. Pruzinsky (1994, p327) has the

following to say:

> "I believe that the public, patients, patients' families and the profession of plastic surgery can benefit from a more complete understanding of the powerful role body image plays in psychological functioning and the contribution the plastic surgical procedures can make to enhance quality of life. Such understanding will help us to empathise with women who have already undergone breast implant surgery as well as with those who seek such surgery in the future."

In the light of the above discussions, this study attempted to emphasise the bio-medical effects as well as the psychosocial variables of plastic surgery, with regard to, inter alia augmentation mammaplasty, which may positively contribute to changes in physical appearance, body image, identity and clothing behaviour.

3.2.2 Reduction mammaplasty

Breast reduction is the appropriate surgical procedure to reduce breast size and to position the breast properly on the chest wall (Stark, 1980).

3.2.2.1 Patient requests

Patient requests stem from two main conditions:

- hypertrophic breasts
- ptotic breasts, or both.

The following points about these conditions are noted (Stark, 1980):

- Hypertrophy is excessive glandular enlargement due to an oversupply of ectodermal anlage tissue (harmartoma) where the breast consists almost entirely of glandular tissue with little fat.
- The weight of the breast puts a strain on the cervical as well as the thoracic spine.
- Osteoarthritic changes are revealed on x-ray examination.
- In severe cases breast weight causes brassiere straps to form shoulder grooves and occasionally the grooves become pigmented.
- Ptosis of the breasts creates secondary problems such as intertrigo between interior breast and chest wall.
- Patients experience discomfort and difficulty with clothing fit as ptosis and excessive weight together are difficult to conceal in ready-to-wear clothes.

- Difficulty to contain and compress breast mass into acceptable shapes. Custom-made brassieres may be essential.
- The fitting of clothes requires extensive alterations, adding to the high costs in an effort to hide the problem on the part of the patient.
- Patients' problems include the expression of embarrassment at having to disrobe in public locker rooms, and obvious exclusion from many sports.
- Breast excess prevents graceful movements and inhibits the person's desire to participate in many activities and social events.
- Breast distortion may prove a detriment to marriage and an aesthetic impediment to sexual satisfaction (Stark, 1980).

What is lacking in Stark's (1980) analysis is any reference to cross-cultural differences in the aesthetic appeal of large breasts. Large breasts may not impede sexual satisfaction among the Black cultural groups. It must be stressed that Black patients in South Africa requesting reduction mammaplasty do so for definite medical reasons (Prof. A Madaree, May, 1995: Personal communication).

3.2.2.2 Contra-indications

Reduction mammaplasty is not recommended in the following cases:

- underdeveloped breasts
- general ill-health
- an unsuitable psyche
- surgeon inexperience, where the difficulty of achieving smaller, symmetrical breasts with appropriately and viably placed nipples is imperative.

3.2.2.3 The aim of surgical correction

The aim of surgical correction includes the surgeon's ability to:

- bring about an adequate reduction mammaplasty to alleviate the patient's symptoms
- obtain, symmetrical, conical breasts with nipples at the apices
- ensure short scars.

A combination of a good result from reduction mammaplasty includes the required reduction, good blood supply and aesthetic appeal.

According to Stark (1980), the Ragnell procedure to reduce breasts is ideal since it:

- corrects pendulousness
- reduces surface area of the breast and creates symmetry.

3.2.2.4 Assymmetry of the breast

The following need to be considered prior to reduction mammaplasty (Stark, 1980):

- Abnormal assymmetry of the breast which requires bilateral reduction. Usually the left breast is slightly larger than the right;
- The dilemma for the patient and surgeon is the decision to reduce the larger breast, augment the smaller or modify the size of both;
- Reduction of the larger breast is more common than augmentation of the smaller;
- A patient with adequate information about assymmetry of the breast is equipped to make a decision that will be the determinating factor in post-surgical adjustment and psychological success.

3.2.2.5 Risks of reduction mammaplasty

From an analysis of Stark's (1980) information, the following risk factors are apparent:

- necrosis (partial loss) of the skin flap or areola
- total areola loss. A new areola can be constructed by borrowing from the opposite areola or from a labium minor of the vagina.

With this information adequately explained to a patient, post-operative psychological conflict or post-operative trauma due to areola loss or replacement may be mediated or reduced.

3.2.2.6 Psychosocial benefits for reduction mammaplasty

Psychosocial benefits for reduction mammaplasty include:

- expectations of an improved appearance as change is highly visible
- the relief of less weight
- the comfort of smaller breasts
- an improved body image
- the desire to experiment with a variety of clothing styles
- physical and psychological satisfaction, including an increased self-confidence
- a sense of social acceptance through a modified physical appearance.

Stark (1980) proposes that aesthetic plastic surgery can no longer be considered vanity surgery, due to the powerful psychological impact patients gain from elective surgery. Research results have indicated an overall improvement in the patient's lifestyle and quality of life; that is, positive work performance, interpersonal relations and feelings of approval and acceptance (Stark, 1980).

3.2.3 Rhytidectomy

Rhytidectomy is another area in plastic surgery where positive psychological effects may be rapidly gained, as the female face in Western culture, unlike Eastern Muslim culture, is highly visible. According to Regnault and Daniel (1984), a rhytidectomy (face-lift) lessens facial folds and wrinkles, creating a more youthful appearance. The incisions are placed in areas of concealment, the redundant skin is excised and any tension is taken into the scalp. Endoscopal lifts on the forehead may eradicate all horizontal and diagonal lines in addition to the SMAS (deep muscle lift) for the neck and lower face. Cheek and lipo implants are also used for fine detailing during a face-lift procedure. The subperiosteal forehead lift is yet another technique which may be included in the overall surgery.

Regnault and Daniel (1984) state that recent advances in surgical technique have broadened the range of applicability of this process, including the possibility of coping with a broader range of conditions that can be ameliorated through surgery. Furthermore, the duration of improvements can be extended significantly. This revolutionary advance has been due to the modification of:

- deeper structures, including the facial network, technically termed the superficial musculoaponeurotic system
- the facial muscles (platysma, orbicularis oculi) and excision and contouring of fat deposits.

Careful analysis of the patient's condition and desires is essential for selection and for the optimal operation. In addition, the surgeon must be highly skilled in a broad range of surgical procedures.

3.2.3.1 Patient evaluation

Stark (1980) notes that as the face becomes progressively less attractive, many persons seek improvement from the plastic surgeon. The patient is highly motivated toward surgery, often as a

result of articles in fashion magazines which simplify the complexities of the surgery and encourage misleading or unrealistic expectations from prospective patients. Patients usually assume that the decision to operate need only be made unilaterally. Not all persons are candidates for rhytidectomy, for example:

- the patient who is unrealistic in regard to self-image and who expects surgery to achieve an entirely new identity
- the patient who has just emerged from a personal tragedy
- the patient who is overly talkative, or who pressurises the surgeon through flattery. This poses a threat to the ultimate success of the surgery.

As this study comprised a mixed cultural sample population, ethnic considerations for patient evaluation were discussed in 3.4. This included rhytidectomy.

3.2.3.2 Patient requests

According to Stark (1980) the following factors have produced an unprecedented demand by females in America and South Africa for cosmetic surgery.

- leadership roles require a vital, dynamic appearance
- a performer's role requires youthfulness
- the 'Star' model of film and TV has generated an intolerance for ageing
- the current 'ideal' beauty of models is desired and promoted by the media and supported by the cosmetic and fashion industries.

Plastic surgeons are likely to accept patients who have stable personalities, and where actual soft tissue redundance can be improved. These factors increase the likelihood of surgical success.

3.2.3.3 Contra-indication

The main reasons not to perform rhytidectomy are:

- the absence of a clear-cut indication, for example, a young patient who hopes to prevent the facial changes associated with ageing by prophylactic rhytidectomy
- the absence of visible evidence of a need to perform surgery as revealed by photographs. This will also form a post-operative base for comparison which will assist the dissatisfied patient in accepting the operation and the effective changed appearance.

3.2.3.4 Psychosocial benefits

Benefits with regard to quality of life and psychological well-being have been noted in individuals deflated by divorce, widowhood or desertion. These persons may regain self-respect and plan for a life ahead (Stark, 1980). Furthermore, cosmetic plastic surgery may be a viable means to achieving the goals of persons who wish to remain in a labour market where a youthful appearance is associated with persons who wish to:

- remain employed in a labour market partial to youth
- ensure protracted leadership
- ensure performer's roles.

In the case where a full face-lift is not indicated, or where a more conservative approach is requested by patient or surgeon, blepharoplasty (eye-lid surgery) may be performed. Adequate explanation of the procedure to patients and a careful analysis of the possible outcome or success rate will again assist the patient to formulate more realistic expectations as to what changes to her face may occur.

3.2.4 Abdominoplasty

Abdominal dermolipectomies are surgical excisions of excess skin and fat in patients with obesity (abdominal lipectomies) or redundant tissue (abdominoplasties)(Regnault & Daniel, 1984).

Because the problems experienced by these patients are quite diverse, the aesthetic surgeon must employ a variety of techniques. Patients demand fine aesthetic results including a minimally visible scar and a natural appearing umbilicus. Often the demands and expectations of the patient are unrealistic. Successful outcome of the operation is limited to cases of an extreme obese abdomen and very firm adipose tissue (Regnault & Daniel, 1984).

3.2.4.1 Indications

Stark (1980) states the following objectives:

- to quantitatively reduce large numbers of fat cells making the gross accumulation of abdominal fat less likely
- to improve appearances and to remove an obese abdomen
- to remove as many striae and lower abdominal scars as possible
- to restore the umbilicus to its normal position

- pre-operative weight loss is essential. This tests patients' determination and motivation, two qualities necessary for post-operative success.

Two types of incisions are preferable:

- a transverse incision
- a 'W' incision.

3.2.4.2 Possible risks

In spite of the fact that some post-operative complications, usually minor, are an integral part of the operation, for example, minor skin loss, fat necrosis and partial wound disruption, research has shown that results are extremely gratifying to patients and to those closely associated with them (Regnault & Daniel, 1984).

3.2.4.3 Psychosocial benefits

An analysis of Stark's (1980) information reveals the following psychosocial benefits:

- an improved body image
- a positive change in clothing behaviour, for example renewed interest in a variety of clothes accompanied by experimentation
- improved social and interpersonal relations.

It was argued that results from this dissertation would show similar benefits, including less anxiety about physical appearance. However, should results differ, interpretations would need to be made bearing in mind the culturally mixed sample population group, norms for the culturally ideal physical appearance and personality variables.

3.3 ONCOLOGICAL ASPECTS OF PHYSICAL APPEARANCE: MASTECTOMY, LUMPECTOMY AND BREAST RECONSTRUCTION

This section of the study has been included as part of the medical behavioural perspective of cosmetic plastic surgery and does not form the main focus of the study. It is intended as an introduction to the assessment of oncological breast patients and as a basis for further research. However, detailed analyses of three breast cancer patients were done in measures of body-image, identity, clothing behaviour, social self-consciousness and personality variables. Due to the small sample size a report on the outcome of the interviews is included in the results.

In relation to the biopsychosocial orientation of this study, research has shown that ever since psychological issues became a focus of attention in oncology, breast cancer treatment has been seen as especially traumatic to women with regard to body image perception and inter-personal relationships, especially sexual relationships (Jamison, Wellisch & Pasnau, 1978;Schover, 1991,).

3.3.1 Mastectomy - the surgical removal of the breast

In recent years, with increasing emphasis on the psychosocial aspects of mastectomy, perceptions of post-mastectomy emotional adjustment have been observed clinically with particular regard to relationships with spouses, degree of clinical depression and change to body image attitudes. According to Schover (1991), many authors have commented on the symbolic nature of breasts with regard to women's feelings of femininity and attractiveness, and hence the frequent devastating impact of mastectomies on perceptions of body image and femininity.

Mastectomies were also believed to be frequent precipitants of divorce or of break-ups in relationships (Lasry *et al.*, 1987). Furthermore, until very recently the surgical treatment for breast cancer was radical, or modified radical mastectomy. This approach was based on the Halstedian idea that cancer spread along anatomical planes and that only radical surgery could control it (Lasry *et al.*, 1987). These authors point out that with changing views of cancer biology, an alternative hypothesis was considered, namely that cancer is a systemic process and that less aggressive surgical procedures should be equivalent to radical ones. Adherents to the traditional mastectomy felt that extensive resection was a necessity for cure. Lumpectomy advocates argue that the psychosocial gains from a less disfiguring procedure were worth serious consideration.

Until a few years ago the majority of breast cancer patients in North America still underwent mastectomy (Lasry *et al.*, 1987). Although the trend is shifting toward lesser surgery, many surgeons still feel reluctant to change their surgical practice and the debate continues. More recent research (Schover, 1991) has confirmed the hope that breast conserving surgery, for example lumpectomy or breast reconstruction, would have clear and significant psychological, as well as psychosocial advantages for the patient. Schover (1991) notes that there is increasing evidence that localized treatment of breast cancer, whether or not it involves breast conservation, affects only a minority of patients with regard to intimate relationships. A woman's overall psychological health and relationship satisfaction – physical as well as emotional –are a far stronger predictors of post-cancer level of functioning than the actual extent of breast damage (Schover, 1991).

3.3.2 Breast conservation

Breast conservation is considered a major advance in the treatment of breast cancer. Although the amount of tissue removed, location of the incision and doses of post-surgical radiotherapy all affect the cosmetic appearance of the breast, the majority of patients have good to acceptable results (Schover, 1991). A number of researchers have compared quality of life after mastectomy with that after breast conserving surgery with radiotherapy. Schover (1991) notes that a consistent finding is that women whose breasts are conserved have more positive feelings about their bodies, particularly their appearance in the nude, than do women after mastectomy. When women are allowed to choose between mastectomy and breast conservation, those who opt for breast conservation express more concern about body image. Women who care most deeply about their appearance avoid mastectomy.

This study not only assessed body image change in patients who received breast treatment, surgical removal or conservation, but also changed body image in relation to clothing behaviour. As an introductory subsection, this study assessed one patient in terms of a breast reconstruction post-mastectomy.

3.3.3 Breast reconstruction

Developments in breast reconstruction include tissue expanders, use of myocutaneous flaps, options for nipple reconstruction and the use of nipple areola prostheses. All these have provided viable alternatives for women to choose from after mastectomy. However, only a small percentage of women eligible for reconstruction choose to undergo surgery (Schover, 1991).

3.3.3.1 Breast reconstruction and body image

It is significant to note that the strongest impact of breast reconstruction is an improved body image. Hopwood and Maguire (1988) clearly state that an improved body image may enhance self-esteem and self-image which could consequently have a very positive effect on how patients cope with their cancer diagnosis, ongoing uncertainty, and even a recurrence of cancer. Women's most common motivation for breast reconstruction is to feel whole again, to eliminate a breast prosthesis and in terms of this study, to be able to wear a variety of clothing styles (Schover, 1991). An understanding of the process of breast reconstruction may assist the patient in accepting a new breast or breasts even though the final result may not be perfect.

3.3.3.2 Breast reconstruction with mycutaneous flaps

Kroll, Schusterman, Reece, Miller and Smith (1994) note that as the popularity of breast reconstruction has grown, so has the number of patients who are physically not ideal candidates, due to previous radiotherapy treatment. Kroll *et al.* (1994) report that out of 59 breast reconstructions in previously irradiated patients, only 42% achieved satisfying results. By comparison, Kroll *et al.* (1994) reported that out of the nine patients in their series where reconstruction was done with transverse rectus abdominus mycutaneous (TRAM) flaps, all except one were successful.

3.3.3.3 Post-mastectomy breast reconstruction

Patients who have undergone previous radiotherapy may present themselves as candidates for post-mastectomy breast reconstruction. Kroll *et al.* (1994) state that it is now a fairly well established fact that previously irradiated patients make poor candidates for reconstruction by simple implant insertion or tissue expansion alone. Experience has led them to believe that capsular contracture rates are increased by irradiation, hence the use of distant flaps of non-irradiated tissue for the reconstruction of irradiated breasts. The TRAM flap is the technique used most frequently for this purpose.

3.3.3.4 Aesthetic outcome

The aesthetic outcome of reconstruction in previously irradiated patients, as judged by four independent observers, was poorer than those found in non-irradiated patients. This may be due in part to the greater proportions of delayed reconstructions found in the irradiated group. The authors, Kroll *et al.* (1994), note that the results of intermediate reconstruction tend to be aesthetically more pleasing than those which are delayed. Knowledge about these different success rates for breast reconstruction patients and the reasons for non-aesthetic or unsuccessful results are felt to be important in this study because, if the patient's ultimate aim is to improve physical appearance and body image social acceptance, awareness of different techniques and their consequences are essential.

3.3.4 Chemotherapy and body image

Women in chemotherapy must cope with changes in their physical appearance such as alopecia, pallor and weight changes that are far more obvious to the casual observer than is mastectomy. Nausea and decreased well-being related to their cyclical course of treatment are often experienced by patients. Even after chemotherapy, hair may not grow again as before and weight gained may be difficult to lose. For many women breast cancer is a common and dreaded experience (Schover, 1991). It is usual for a diagnosis of breast cancer to evoke grief, anger and intense fear. However, most women face this crisis without developing major psychiatric disorders or disruptive inter-personal or intimate relationships.

The options of breast conservation or reconstruction give women a new sense of control over their treatment and are quite successful in helping women feel comfortable with their bodies again. The additional option of wearing attractive clothes is significant in its therapeutic effect in improving the individual's self-esteem, and in procuring a sense of group equality and acceptance.

3.3.5 Psychosocial aspects of breast cancer

Interest in the psychosocial consequences of breast cancer surgery is quite recent. Studies assessing this impact may be grouped into four main areas into four main areas (Lasry *et al.*, 1987; Schover, 1991; Schlebusch & Mahrt, 1993; Kroll *et al.*, 1994):

i. Psychological distress; which deals with feelings and emotions aroused by the cancer. The most frequent psychological reaction to cancer is depression, often coupled with anxiety or fear.

ii. Daily life impact; which includes physical discomfort, impact on body image, reduction in activity, sleep disturbances and sexual dysfunction.

iii. Negative impact on body image which result in:
   - work adjustment deteriorisation specifically after the first months following mastectomy
   - problems in intimate relationships both physically and emotionally.

iv. Fears included:
   - the fear of the disease itself
   - fear of recurrence of the disease
   - fear of death
   - concerns about disfigurement
   - loss of femininity.

With advances in breast conserving techniques and procedures, the question is whether psychosocial effects will differ between mastectomy patients and breast conservation patients. Lasry *et al.* (1987) compared the psychological and social consequences of a total mastectomy to that of lumpectomy. The authors hypothesised that the quality of life of women who had a lumpectomy would be better; that is, they would have less psychological distress, better self-esteem and body image and less interpersonal difficulties in intimate relationships. Lasry *et al.* (1987) reported that several studies linked depression to mastectomy as a psychological consequence. In one study the global depression score was double that of a normal population. The three groups involved were:

i. lumpectomy group
ii. total mastectomy
iii. lumpectomy receiving radiation.

Lumpectomy patients were not more fearful of recurrence than mastectomy patients. However, patients receiving chemotherapy displayed greater fear of recurrence (Lasry *et al.*, 1987).

3.3.6 Body image and breast conserving surgery

Lasry *et al.* (1987) notes that women who had lumpectomies had less psychological distress, better self-esteem and body image and less sexual and marital difficulties. They showed a highly significant correlation with breast conserving surgery. Those who had total mastectomies were significantly less satisfied than the lumpectomy patients.

Body image was negatively affected by the more extensive surgery. This influence was particularly evident in the item assessing the patient's fear of not being sexually attractive following surgery. Lumpectomy patients were not really concerned, while those who had mastectomies were quite fearful (Jamison *et al.*, 1978; Lasry *et al.*, 1987).

Contrary to expectations, the fear of recurrence was not significantly higher in the partial mastectomy group than in the total mastectomy group. However, women who underwent lumpectomy were more fearful of recurrence than those whose breasts were totally removed. Fear of recurrence was clearly greater among patients receiving chemotherapy.

An unexpected finding was the influence of radiation therapy on breast surgery. Although radiation therapy does not influence body image, it is clearly related to depressive symptoms (Lasry *et al.*, 1987). Patients receiving breast conserving surgery and radiation expressed twice as many symptoms than patients in the lumpectomy and total mastectomy group. Lasry *et al.*

(1987) made the following observations:

- Radiation therapy could well be more frightening to breast surgery patients than had been previously anticipated by doctors
- The use of radiation, the physical setting, the machinery and the length of treatment could all contribute to negative feelings.

The abovementioned authors recommend that anticipatory counselling could benefit patients. The negative impact of physical treatment and environmental factors could be reduced through counselling. Positive aspects of experimenting with new clothing styles, engaging in a variety of social situations and improving interpersonal relationship could be maximised through counselling. Furthermore surgeons seriously consider a variety of psychosocial aspects of breast cancer surgery when choosing treatments and discuss these with their patients.

Similarly, areas of psychological importance highlighted by Jamison *et al* (1978) included:

- depression
- body image
- fear of recurrence.

Post-operative adjustment is essential in these areas for improved post-surgical quality of life. Further information on post-surgical psychosocial adjustment on other important dimensions includes:

- marital satisfaction
- general well-being
- social support systems

(Jamison *et al*., 1978; Schlebusch & Mahrt, 1993; Kroll *et al*., 1994).

The aim of Lasry *et al*.'s (1987) suggestions are clearly twofold; one area focuses on the immediate relief of negative biopsychosocial influences. The other area pinpoints longitudinal psychosocial adjustments needed for an improved quality of life.

Clothing behaviour should not be overlooked in the context of the overall well-being of the patient, as clothing is clearly associated with body image and uniquely related to the patient's sense of comfort, well-being and sense of social approval. Sensitivity by health care professionals toward the patient's vanity needs and understanding demonstrated in terms of the patient's changed body image, are essential factors in efforts to assist patients to readjust to a new physical experience. Sensitivity by health care professionals is also required toward the differences in physical appearance of different cultural groups. Ethnicity is an aspect of cosmetic surgery which cannot be ignored in the South African context.

3.4 ETHNIC CONSIDERATIONS IN COSMETIC PLASTIC SURGERY

The impact of aesthetic and psychic considerations in cosmetic plastic surgery has been well documented (3.1.1 - 3.3.6). What is lacking is sufficient exploration of ethnicity in elective cosmetic surgery (Pierce, 1982). Documented literature dealing with elective cosmetic surgery and the South African Black population is scarce.

A comparative study on cosmetic plastic surgery for a Black/White sample population group is not within the parameters of this dissertation. However, observations which could form the basis for future research on elective cosmetic surgery specifically for a Black South African sample population group are made as part of the recommendations (8.15).

3.4.1 Image awareness

Pierce (1982) comments that in recent years an 'image awareness' has developed among various racial and ethnic groups throughout the world. A greater sense of self-esteem based on how one looks, has emerged. Pierce (1982) notes that the communications media are highly promotional of 'interest in oneself'. People want to look good and feel good even if it requires surgery and in some cases multiple surgery. The extent to which Black South Africans are prepared to undergo cosmetic plastic surgery in order to look and feel good needs careful consideration.

3.4.2 Aesthetic and psychic considerations

With reference to American sample populations, Pierce (1982) states that Black Americans have been neglected with regard to cosmetic plastic surgery, even though media force has graphically demonstrated that "Black is Beautiful". A deeply pigmented skin today is less of a problem as acceptance of skin colour has become a less traumatic event. To what extent this example is applicable to the South African Black population requires greater awareness, insight and scientific enquiry on the part of researchers, if one bases this conclusion on the present amount of available information. The problem remains as to how to resolve the discrepancy between results which are surgically satisfactory and the actual expectations of a particular patient. Ethnic consideration in plastic surgery touches the psyche of the individual. Pierce (1982) emphasises that serious consideration must be given to social and psychological implications in the light of changes in appearance which could alter personality and identity.

Experimentation with fashion and new clothing styles after surgical changes to physical appearance, enhances a person's sense of well-being and social acceptability.

3.4.3 Patients

Pierce (1982) notes that in the United States of America, operating on Black patients is said to be difficult with unpredictable and perhaps unsatisfactory results. This is also true of Black South Africans (Prof. A Madaree, Head of Department of Plastic Surgery, Wentworth Hospital, Durban, 1995). Consequently many surgeons are mindful of keloid formation, scarring and pigmentary changes and the Black patient is routinely rejected. However, Pierce (1982) notes that recent research has shown surprising results, namely, that cosmetic plastic surgery may produce the same expected results for both White and Black patients. What is significant is the criteria of patient selection as a dominant factor irrespective of race.

Pierce (1982) states that the necessity of a consultation and/or psychological assessment of a prospective candidate for cosmetic surgery is imperative. Underlying pathalogical conditions dictate a lack of suitability for cosmetic surgery, as these conditions are often accompanied by unrealistic expectations by the patient. This holds true for both White and Black patients.

3.4.4 Methods

Pierce (1982) states that cosmetic surgical procedures including rhytidectomy (face-lift), and blepharoplasty are technically done in a similar manner in all race groups: slight modifications in technique, for example in rhinoplasty, are necessary. Patient selection emerges as a key factor when considering whether a Black patient may be at risk for keloid or dyschermic formation. The risk factor is determined from the family history and by close examination of previously traumatic skin changes. A negative history does not necessarily mean that the patient will have unsuccessful results as the risk factor can generally be decreased with significant background information. However, the surgeon's dilemma whether to operate or not, and selecting the appropriate candidate, remains a difficult choice in all race groups. Pierce (1982) notes that patient selection for cosmetic plastic intervention is a high psychological phenomenon. The long-term success of the medical procedure depends not only on the surgeon's operating skills, but also on patient expectations concerning the desired outcome. In elective plastic cosmetic surgery the challenge lies clearly with the surgeon who must attempt to understand what the patient desires in terms of physical appearance, especially if the patient is of an ethnic or cultural group different from that of the surgeon.

In ethnic considerations for cosmetic surgery the need for:

- good interpersonal communication
- accurate information about the surgery itself
- possible risks and benefits
- realistic expectations

become compelling factors for post-surgical satisfaction and success.

In the light of this the present study focused on the significance of the interrelation between aesthetic physical appearance and psychosocial factors. Clothing behaviour was introduced as a mediating factor which could reduce the negative impact of dissatisfaction with physical appearance. The biopsychosocial orientation of this dissertation, where socio-cultural as well as physical and psychological aspects of the person are considered, is implicit in the type of success expectations by both patient and surgeon.

3.4.5 Specific surgery and ethnic considerations

3.4.5.1 Augmentation mammaplasty

The following observations are made in the literature (Pierce, 1982) with regard to patients requesting augmentation mammaplasty:

- The number of Black females requesting augmentation mammaplasty is quite small compared with the number of patients who actually desire this procedure.

3.4.5.2 Reduction mammaplasty

Pierce (1982) cites examples of breast surgery performed on Black females which include reduction and augmentation mammaplasty as well as breast reconstruction following cancer surgery. However, reduction mammaplasty remains the operation most often performed on negroid females.

According to statistics at Wentworth Hospital, Durban, South Africa, an average of ± 15 reduction mammaplasty operations are performed at this hospital on Black South Africans per month.

3.4.5.3 Rhytidectomy

Pierce (1982) notes that rhytidectomy is being done on a limited scale on Black patients. However, blepharoplasty (eye-lid) is often the preferred treatment to minimise the more prominent signs of ageing about the eyes, without performing an entire face-lift. Significantly, in line with recent research, Pierce (1982) states that while patients may exhibit a tendency toward keloid formation below the neck, this does not necessarily preclude the careful execution of cosmetic surgery procedures of the face. In conclusion Pierce (1982) notes that while there are significant anatomical differences in the racial physiognomy of White and Black, only a few modifications in technique are required in rhytidectomy.

3.5 PHYSICAL ATTRACTIVENESS: A LINK BETWEEN THE CONCEPT OF BODY IMAGE AND CLOTHING BEHAVIOUR

In view of the previous sections (2.1 and 3.1) on body image and elective cosmetic surgery respectively, a brief investigation of the physical attractiveness variable, as part of the concept of the psychology of appearance, is considered. An awareness of how physical aesthetics and attributes, including schematic self perceptions, affect people's lives becomes a powerful source of information on cultural attitudes towards physical appearance.

In South Africa, the difficulty of assessing attitudes towards physical attractiveness is compounded by the cultural diversity of Black and White groups. Variations in clothing behaviour and fashion awareness, diffusion and adoption discussed in section 4.4.2, could be attributed partly to the differences in values each cultural group attaches to the concept of physical attractiveness.

3.5.1 The importance of physical attractiveness as a psychosocial variable

During the past fifteen years, research has demonstrated that there exists a physical attractiveness stereotype that has a profound impact on an individual's personal and social evaluations (Price, 1986). Physically attractive persons are assumed by others not only to possess more sociably desirable personalities than less attractive persons, but also to be happier and more successful (Franzoi & Hertzog, 1987; Goldsmith, Heitmeyer & Goldsmith, 1990).

Although there is some general disapproval of reactions to, and discriminations made against persons based mainly upon physical appearance, Cash and Pruzinsky (1990) note that the social world clearly discriminates, against unattractive people in a variety of important everyday

situations. Unattractive people are more likely to encounter social responses that may be non-responsive or even rejecting, and which discourage the development of social skills and have a negative effect on the self-concept.

As a psychosocial variable, the physical attractiveness stereotype may differ from culture to culture. However, deviation from the norm, whether real or perceived, irrespective of the culture, impacts on the individual. How this impact affects the individual in terms of interpersonal and cross-cultural social acceptance, needs to be clearly understood. Insight is likely to be gained from an assessment of attitudes towards personal identity, body image, clothing behaviour, and sense of social acceptance.

Contributions to physical attractiveness include body and facial attractiveness, although Cash, Winstead and Janda (1986) found neither variable a more powerful predictor than the other. Physical attractiveness, in Western rather than ethnic cultural groups, is also judged in terms of weight issues (Berscheid, Walster & Bohrnstedt, 1973; Garner, Garfinkle, Swartz & Thompson 1980; Cash *et al.*1986; Gibson & Thomas, 1991).

Despite cultural differences with regard to face body and weight issues, Adams (1977) proposes that physical attractiveness stereotypes do exist intra-culturally, for example, the body image stereotype and the fashion norm stereotype. How fashionable clothes influence overall physical attractiveness is explained in Chapter Four on fashion and clothing behaviour. Adams (1977) further suggests that physically attractive persons are differentiated from their less attractive peers across a variety of experiences and at various stages of the life cycle, for example, in the workplace and in a variety of social contacts.

3.5.2 Physical attractiveness and the self-concept

Attractive individuals appear to experience more social and career success, receive a greater variety of positive interpersonal contacts and more positive peer appraisal than unattractive persons (Goldsmith *et al.* 1990). This results in a linear relationship between attractiveness, peer acceptance and self-esteem (Adams, 1977). This in turn relates to the previous discussion on the self-concept (2.2.1) in which it was shown that throughout the lifespan the approval and evaluations of others, influence the self-concept.

3.5.3 Physical attractiveness and adornments

Cash *et al.* (1986) note that although researchers of physical attractiveness often attempt to control non-verbal communication factors, they seldom distinguish between natural unadorned

attractiveness of facial and bodily characteristics, and attractiveness that incorporates adornments. This observation relates to the core purpose of this study. Often the body-image of the 'clothed person' is measured or commented upon without considering the influence of the adornments; that is, the clothes themselves. Furthermore, the fact is that the adornment is often carefully selected for a variety of social, psychological and physical reasons (Kelson, Kearney-Cooke & Lansky, 1990). In this study the determining factor under investigation was 'fashion' as it pertains to clothes, body shape and attractiveness.

Cash, Rissi and Chapman (1985) observe that, as a result of this dynamic relationship between attractiveness and adornments, little is actually known about the psychosocial dynamics of altering one's appearance, either through a simple universal process of grooming behaviours or through rarer or more drastic techniques of plastic surgery in order to enhance attractiveness.

When considering the psychosocial dynamics of altering appearance, it is important to note that one of the many techniques for the aesthetic enhancement of one's physical appearance studied by Cash *et al.* (1985) is that of the use of cosmetics. By comparison, this study emphasised the use of fashionable clothing to enhance or camouflage aspects of physical appearance; that is body image and physical attractiveness. Cash *et al.* (1985) point out that cosmetic use may reflect taking pride in one's appearance and producing feelings of accomplishment with aesthetic self-enhancement. A similar process may occur with respect to the use of fashionable clothing for the self control of affective states (Francis & Evans, 1987).

Furthermore, Hewitt and German (1987) point out that although people are more attracted to those who are high in physical attractiveness, little is known about the specific dimensions that contribute to physical attractiveness. Fashionable clothing may be one such dimension, although this will obviously vary with both culture and social class (Goldsmith *et al.* 1990).

Determinants of physical attractiveness may be composed of either:

- static components, that is, stable and enduring physical characteristics or
- dynamic components, fluctuating, changing components, that is, grooming, facial expression and non-verbal components, for example, clothing, make-up, hairstyles.

3.5.4 Effects of grooming behaviour on physical attractiveness and body image

Historically, Cash *et al.* (1989) point out that research on the psychology of physical appearance has focused primarily on the effects of physical attractiveness as a state, or fixed attribute, of the individual. Unfortunately, this dominant approach ignores the fact that individuals often actively control and modify their physical appearance and physical aesthetics across situations and within

relatively brief periods of time. People vary their grooming behaviour, for example, clothing behaviour, hairstyles and the use of facial cosmetics. Grooming behaviour influences perceived physical attractiveness as well as inferred personality characteristics (Graham & Jouhar, 1981). Grooming behaviour generally functions to manage and control, not only social impressions, or impression management per se, but also self-image, self-perceptions and mood states (Cash *et al.*, 1989). These aforementioned authors further note that the control facets of self-image, for example, body-image and physical attractiveness, are the key motivators of the self-management of appearance and as such, of the effects of clothing behaviour on self-image.

Cash and Pruzinsky (1990) refer to the lack of scientific study concerning the effects of clothing on body image affective states. Clothing, and other mediums for improving appearance are simultaneously 'mood altering substances'. Individuals may indulge in appearance managing behaviour to create desired self-perceptions and specific emotional experiences (Francis & Evans, 1987). The abovementioned authors point out that creative thinking about the clinical application of the findings and perspectives on, for example, cancer patients undergoing appearance altering chemotherapy or surgery such as breast construction, is needed.

Cash and Pruzinsky (1990) note that, in the research literature, social images are not identical to personal body images, yet the inter-relatedness of the two converges in meaningful ways to the point of significantly influencing human development, social relations and personal experiences.

An investigation into clothing behaviour and what constitutes fashion is one way of demonstrating the use of self-adornment as a medium of self-expression and social self-management. Individual choice, the need for successful social interaction and the need to feel accepted are among the variables which prompt people to make changes to their physical appearance through clothes, cosmetics or elective cosmetic surgery.

CHAPTER FOUR
FASHION AND CLOTHING BEHAVIOUR

4.1 INTRODUCTION

Fashionable clothing as part of grooming behaviour and its psychosocial consequences, for example, feelings of socio-cultural acceptance, body image satisfaction and sense of personal and social identity, has not been extensively researched (Cash, 1988). In order to enhance the inter-relatedness of these concepts, the background to and current concepts on fashion and clothes are now discussed.

4.2 THE PSYCHOLOGY OF APPEARANCE IN RELATION TO CLOTHING

A person's physical appearance together with her gender identity, is the most obvious personal characteristic that is either acceptable or unacceptable to others in social interaction. Erikson (1968) explicitly points to a proposed relationship between physical appearance, its interpersonal meaning and its importance in assisting an individual to achieve full identity. Attractive physical attributes are likely to stimulate the type of positive social action from others that will lead to a positive psychological outcome. Further factors such as culture and race affect both physical appearance and emotional aspects of body image. Prejudices aimed at other races may enable the individual to protect and elevate her own image. However, the negative aspects of racism affect such variables as skin colour, facial features, weight and overall physical appearance, including clothing behaviour (Bond & Cash, 1992).

4.3 CLOTHING

"Clothes are a billboard of the self. They express dreams and disguises, rank and status, pride and dismay. Without them we are vulnerable, and largely anonymous: with them we are clad in an armor of cloth ..." (Dienstfrey, 1982, p.68).

Clothing has been conceived as a universal and visible cultural element consisting of sets of body symbols, deliberately designed to convey messages on different social and psychological levels (Kuper, 1973). Clothing can be described as part of the total structure of physical appearance, which includes alterations to physical appearance, hairstyles, ornaments, decorations and masks.

Clothing, like other social phenomena, cannot be analysed in isolation, or in terms of only one set of social relations, as it forms an integral part of the total status system; hence the biopsychosocial orientation of this dissertation towards the study of clothing behaviour.

Kuper (1973) describes 'styles' of clothing as cultural correlates of social differentiation and social stratification. Differentiation is referred to as a universal phenomenon stemming from biological variations in gender and age. In terms of this framework, clothing is described as a visible symbol of social differentiation based on age, gender and socio-economic status.

Goldsmith *et al.*, (1990) note that the buying and wearing of clothes fulfil a number of psychological needs for most women. Researchers are interested in the influence that personal and social values have on clothing attitudes and behaviour. Similarly, social values influence attitudes about consumption and give some insight into the motives behind specific clothing attitudes. Clothing also serves the function of communication, not only with regard to the wearers' attitudes, but also in terms of her personality.

Kuper (1973) states that different parts of the structure of personal appearance are consciously manipulated to assert and demarcate differences in status, identity and commitment at various levels of relationships, intra- and inter-culturally. In relation to Kuper's (1973) conception of clothing, this study further sets out to explore clothes as part of the total structure of social physical appearance closely integrated with body image, identity and socio-cultural variables such as group acceptance.

Aspects of personality and socio-cultural interaction and attitudes are fundamental aspects of the holistic approach to this dissertation.

4.3.1 Why wear clothes?

A brief look at two reasons why clothes are or are not worn, clarifies an understanding of varying attitudes towards clothes and differing clothing behaviour.

4.3.1.1 Climate

Climate does not always determine whether or not clothes are worn. For example, in Tierra del Fuego, despite the Antarctic climate, the primitive tribesmen saw no need to protect themselves from the elements (Polhemus & Procter, 1978).

4.3.1.2 Modesty

The extreme cross-cultural variability of the definition and expression of modesty in dress accentuates the fact that the wearing of clothing does not arise out of any innate sense of modesty, but that modesty results from customs and habits of wearing clothing or ornamentation on the body (Polhemus & Procter, 1978). Modesty is a sentiment that not only varies from place to place, but also through the ages. For example, Arab women caught bathing by strangers may be embarrassed; however, they do not cover their bodies, they cover their faces. In China, until recently, it was thought highly indecent to expose the feet to public gaze. Laver (1952) notes that tribes who wear the most clothing are by no means the most moral or modest, for some African tribes wear clothing in a way which has nothing to do with modesty as we know it. In fact, the quantity of clothing worn seems to be often enough in the inverse ratio to modesty and morals.

Laver (1952) further points out that clothing designed to show the social position of its wearer has a long history. Many societies passed decrees, known as sumptuary laws, to prescribe or forbid the wearing of specific styles by specific classes of people. Further explanations of why people wear clothes include attempts to overcome inferiority, to achieve conviction of superiority over other species and over members of their own group, to win admiration and assure themselves that they 'belong'.

Solomon (1985) states that clothing refers to a universal necessity and becomes part of a large economic sector. According to Solomon, different kinds of clothes define ethnic groups and are prescribed for different social occasions, for example, college wear or military attire. In conclusion, Solomon notes that clothes are of primary importance in social orientation, in unfamiliar situations and in serving as clues in impression formation and social perception.

4.3.2 Clothing: personal and social issues

Hartmann, (1949) states that although clothing varies greatly in intensity and expression, few would deny that it is one of life's fundamentals. Clothes are both a stimulus and a response. Clothes are a source of stimulation to the wearer and, in turn, influence reaction towards physiological needs, social expectations and aesthetic tensions of the wearer.

Clothing has been used over the centuries to conceal, enhance and modify body contours (Collins *et al.*, 1987). As early as 1949 Rosencranz (1949) recognised the need for co-operative research in the fields of clothing and social psychology in order to understand not only the physical, but also the psychological meaning and importance of clothing in the lives of women.

4.3.2.1 The value of clothes

Hartmann (1949) states that clothes are valuable to the degree that they enhance the value-experience of the persons who wear them or who are otherwise affected by them. Hartmann (1949) continues that the subjective worth of any article of clothing is proportionate to its contribution or enrichment of the self.

4.3.2.2 Clothing and the self-concept

Research has shown that clothes evoke some degree of ego-involvement on the part of the wearer and are valuable in their ability to enhance a person's self-esteem or general feeling of well-being (Hartmann, 1949).

Sweeney and Zionts (1989) examined emotional effects of the use of clothing on individuals, for example, the ability to influence mood. A prevalent theme in their study is the notion that body satisfaction increases self-satisfaction which in turn generates positive reaction from others. Furthermore, clothing forms an integral part of the person's entire life and plays a significant role in the socialisation process that leads to the development of oneself.

Sweeney and Zionts (1989) investigated the eight clothing uses as defined by Humphrey, Claasen and Creekmore (1971) (Table 5.7). Five factors were apparent, four of which had relevance to this study. The factors reflected:

- the importance of clothing to the individual
- the degree of non-conformity; that is, attracting attention by dressing differently
- the level of experimentation which could be measured; that is, the amount of thought involved in the selection of clothing
- the dependent variable which could be ascertained; that is, the emotional effects of the use of clothing.

These authors found that the non-clinical sample (that is the control group) was more likely to use clothing to influence mood.

Sweeney and Zionts (1989) strongly recommended further research with a mixed economic, social and cultural population as they argued that this might provide further clarification of the hypothesis that clothing has an impact on self-concept.

By comparison, this study investigated a mixed socio-cultural sample population group and looked at the impact of clothing behaviour on body image, self-identity and social self-esteem (that is, personal social security).

4.3.3 Clothing interest and personality

Past research focused primarily on the relationship between interest in one's clothing and demographic characteristics of e.g. age, education, income, marital status, occupation and gender (Perry *et al.*, 1983). A review of the literature revealed that few studies provided empirical research data about the relationship between personality and clothing interest. Attempts noted have employed the Cattell's Sixteen Personality Factor Questionnaire with the purpose of exploring the relationship between clothing interest and an holistic concept of personality and self-actualisation.

This study utilised the 16 PF (clincial sample) in an attempt to establish levels of selected personality variables in relationship to aspects of physical appearance and clothing behaviour. The following five examples illustrate some aspects of clothing behaviour in relation to personality variables found in the literature:

i. As early as 1949, Hartmann proposed that the importance placed on clothing varies with levels of personality development; that is with higher levels of development the importance of clothing diminishes.

ii. Ryan (1966) postulated that subjects with low degrees of clothing interest were self-directed, while those with greater interest depended more on their environment for adjustment.

iii. Perry *et al.* (1983) identified subjects with high degrees of interest in clothing as conventional, conscientious, compliant before authority, stereotypical, persistent, suspicious, insecure and tense.

iv. Perry *et al.* (1985) found that a positive relationship existed between a general level of clothing concern, and personality characteristics such as conscientiousness, perseverance, and staid-and-rule-bound; on the other hand, concerns with aesthetics, management of dress and use of clothing to win social approval were related to a high self-concept.

v. Sullivan and Harnish (1990) noted an important relationship between clothing and self-monitors. Self-monitoring is a personality variable in which the individual is particularly attuned to the way she presents herself in social situations and to the way she regulates her behaviour to create a desired impression. These authors observed that high self-monitors were highly sensitive to social and interpersonal cues of situationally appropriate behaviour, and regulated the expressive self-presentation for the sake of desired public appearance. In contrast, the expressive self presentation of the low self-monitor reflected her own attitudes, feelings and beliefs.

Fisher (1986) suggested that self-monitoring is possibly a significant factor in the study of body image because of the implication of increased self-awareness. High self-monitors are aware

of their behaviour in social situations in order to regulate or control their expressive selves. One method self-monitors might use to accomplish their impression management goal is to enhance their physical appearance. Sullivan and Harnish (1990) report that high self-monitoring females use clothes to attain social approval and attention. The above findings suggest that self-monitoring is related to self-perceptions of body image in terms of attention to, and awareness of, physical appearance.

In relation to the biopsychosocial orientation of this dissertation, it is important to note that, according to Sullivan and Harnish (1990), high self-monitoring females may focus on their physical appearance because of culturally accepted standards of attractiveness. They state that females may use the 'right' self as a guide to perception, stressing a standard of physical appearance that they feel obligated or responsible to maintain. They pose the question whether the high self-monitoring female is focused on appearance because of culturally imposed standards of attractiveness or because of self-imposed standards of attractiveness (that is, the ideal self). Furthermore, they ask whether these processes are addictive.

Williamson (1989) proposes that societal norms of beauty become internalised, particularly by young people who are highly susceptible to other people's opinions. Dissatisfaction with personal attractiveness is a natural outcome of these dilemmas. American society, for example, has developed standards of physical beauty in recent years that extol an unrealistic image of perfection and extreme thinness for females.

In recent studies it has been emphasised that the cultural standard of female attractiveness is now that of a slimmer woman than at any time since the 1930s (Garner *et al.*, 1980; Silverstein *et al.*, 1986; Sacra, 1990; Davis & Cowles, 1991).

From the general discussion on clothing in relation to physical appearance, social issues and personality variables, a more specific discussion follows on clothes as fashion. In this way the interrelatedness and interdependence of the themes and concepts (outlined in 2.1 - 3.9) are investigated in terms of a fashion perspective.

With a clearer idea of fashion as a concept and the differences between style and fashion having been discussed, fashion as a process or activity becomes a relevant issue in any assessment to be made on individuals' attitudes to, and choice of, clothing.

4.4 THE CONCEPT OF FASHION

By definition (Kaiser, 1985), fashion is a form of collective behaviour that is socially approved at a given time but expected to change. This change is induced by individuals' interpretations and modifications of apparel styles. Kaiser (1985) notes that fashions are socially constructed, and

that social feedback plays an important role in individual orientations towards fashions. In addition, Schrank and Gilmore (1973) state that fashion can be defined as a socially derived valuation of an idea, practice or product, or as a form of collective behaviour that has implications for many facets of human group living.

The role fashion plays in the diffusion of ideas, practices and products reflects changing relationships between human beings and their material culture. The great force and all pervasive influence of fashion have been noted from early in the twentieth century until the present day (Nystrom, 1928; Schrank & Gilmore, 1973; Kaiser, 1990). Definitions by these authors have been adapted for use in this dissertation, as they have clear implications for the holistic orientation and approach of this study toward aspects of clothing behaviour.

Hann and Jackson (1987) define fashion as a style of dress that is temporarily adopted by a discernible proportion of members of a social group because the chosen style is perceived to be socially appropriate for the time and situation. Hann and Jackson (1987) note the social dimension of fashion and that the pressures of conformity within the social groups are a determinant of what is considered to be fashionable and appropriate. Fashions have a limited lifespan and are continuously subject to obsolescence.

An early definition by Nystrom (1928) states that fashion is nothing more nor less than the prevailing style at any given time. However, some writers have made clear distinctions between the concepts of style and fashion. Fashion has been viewed as a characteristic or distinctive method of expression, presentation or conception. In relation to fashion, style has been conceived of as a distinctive mode of tailoring, with only a few styles eventually being accepted as fashion, by consumers, at any given time (Nystrom, 1928; Hann & Jackson, 1987). Solomon (1985) included a socio-cultural dimension to the concept of 'style', which he defined as a combination of personal expression and social norms influenced by dominant values.

4.4.1 Concepts and theories of the fashion process: Fashion diffusion and fashion adoption processes

A comprehensive understanding of the 'Fashion Process' which includes the innovation, adoption and dissemination of fashion, presupposes a brief discussion on fashion theory and concepts.

4.4.1.1 Symbolic interaction theory

Symbolic interaction refers to interaction among people who 'define' or 'integrate' one another's actions instead of merely reacting to them. This communication is mediated by the use of

symbols, or by interpreting the meaning of an individual's intentions and purposes (Solomon, 1985). Symbolic interaction theory provides a conceptual framework for research on the significance of clothing in the perception of a person's characteristics and how these facilitate and stimulate the adoption process. Knowledge of personal characteristics is important for fashion designers and the fashion industry in terms of production and marketing.

Symbolic interaction theory is relevant to this dissertation, particularly due to the impact of the cultural diversity in South Africa today. Closer interaction among people is likely to affect their clothing choice and affect them personally, in terms of this study specifically, with regard to body image, identity and perceived social acceptance.

4.4.1.2 Modernism and fashion

Solomon (1985) points out that knowledge of the principles of modernism is important in understanding the structure of clothing during the 1980s and 1990s. This will aid the designer as well as the social scientist in terms of insight and perception with regard to fashion research in clothing behaviour.

Modernism is a stylistic movement which dominated the early and middle part of this century. Solomon (1985) notes the distinction of two principles in Western art form, the denial of which is evident in the application of modernism to fashion; that is:

i. The separation between visual representation and linguistic reference. An art piece was named separately until the birth of modernism. By comparison, in fashion, 'text' is used as part of the design. Verbal messages denote origin and manufacture of clothes, previous experience, political views, social and commercial affiliations and any other current important identities. Verbal messages facilitate self-presentation (Darden & Worden, 1991).

ii. The assumption of a close relationship between representations and resemblance. An art piece was originally named for what it visually represented until the birth of modernism. In adapting modernistic art to fashion, a distinctive feature of the recent period is the separation of style from social status. Status is not always communicated through the channel of clothes. Technical advances have reduced the differences in fabric and style associated with wealth, as replicas closely simulating costly styles and fabrics are now easily produced. Against this background, Solomon (1985) notes that due to the contrasts in perspectives on the phenomenon of fashion, for example, psychologists may speak of fashion as the 'seeking of individuality'; or sociologists may see class competition and social conformity in norms of dress. A more general theory of fashion is emerging based on the concept of the fashion process.

4.4.2 The fashion process

Fashion process is a dynamic mechanism of change through which a potential fashion object is transmitted from its point of creation to public introduction, discernible public acceptance and eventual obsolescence (Solomon, 1985). Fashion process involves individual as well as collective behaviour (Kaiser, 1985). On an individual level what is considered 'fashionable; that is, the degree to which trends are followed, is subjective and variable. On a collective level, fashion becomes an objectified process with a higher degree of influence than that of individual innovators specifically if the ideas are widely accepted. Conceptually, the fashion process occurs in the following six sequential phases which form an integrative framework for a number of behavioural science theories of fashion (Solomon, 1985):

Table 4.1: Sequential fashion phases

Stages	Item	Explanation
i	Intervention and introduction	A designer or innovator creates a new fashion.
ii	Fashion leadership	The fashion object is introduced to the public by a small group of fashion adopter or leaders.
iii	Increasing social visibility	The fashion object receives increasing endorsement among the fashion conscious consumers and becomes more visible among a wide range of social groups and lifestyles.
iv	Conformity within and across social groups	The fashion object receives social legitimacy. Communication and mass marketing ensure widespread adoption of the fashion.
v	Social saturation	The fashion object becomes a daily occurrence in the lives of consumers; being overused it begins to decline.
vi	Decline and obsolescence	New fashions are introduced as replacements of socially exhausted fashions.

(compiled from Solomon, 1985, p.56)

4.4.3 Behavioural sciences theories of fashion

4.4.3.1 Fashion diffusion

The concept of fashion diffusion forms the background for the following behavioural science theories of fashion:

- sociological models
- cultural models
- psychological models
- economic models.

'Fashion Diffusion' is defined as being the process of collective behaviour through which a style 'spreads' from its introduction by apparel manufacturers to its adoption by the majority of consumers (Kaiser, 1985). The goal of fashion makers is to achieve the maximum diffusion as quickly as possible in order to introduce new styles before their competitors. Kaiser notes that the consumer influences what styles will eventually become fashion. Only a few styles each season reach maximum diffusion level.

4.5 SOCIOLOGICAL MODELS

4.5.1 The trickle-down theory

The earliest theory of fashion diffusion (Simmel, 1904 in Kaiser, 1985, p. 332) states that styles '...filter down from the elite or upper class to the lower societal strata'. A primary factor in this process is the lower class motivation to want to 'look rich' by imitating the next highest class. Two functions of fashion in this process are evident, namely imitation and demarcation.

According to Simmel (1904)(cited in Kaiser, 1985), the lower classes imitate the elite as less expensive versions of the styles are made available on a larger scale. These styles are soon abandoned by the elite and new styles are sought in order to ensure distinctiveness.

Solomon (1985) notes that the term 'trickle-down' has been criticised in research as a misnomer, for it is not the downward force that drives the diffusion dynamic, but rather, an upward search by a subordinate group in order to attain upper-class status.

Kaiser (1985) further argues that Simmel's original theory, while suitable for the study of sixteenth, seventeenth and eighteenth century European fashion, cannot account for the fashion of modern society, as 'style differentiation' no longer distinguishes social classes. However, Kaiser agrees that Simmel's theory has provided lasting contributions to fashion process theory by emphasising the following points:

- fashion requires a certain type of society within which to occur
- the desire for prestige and distinction operates in fashion diffusion, and
- a natural process of change is indigenous to fashion.

Kaiser (1985) notes that, according to economists, fashion behaviour today consists of some motives evident in Simmel's (1904) earlier theory; that is:

- the drive to imitate
- the search for exclusivity
- the desire to consume conspicuously.

Furthermore, he concludes that taste, technology and prevailing socio-cultural and economic factors are interdependent in the fashion process.

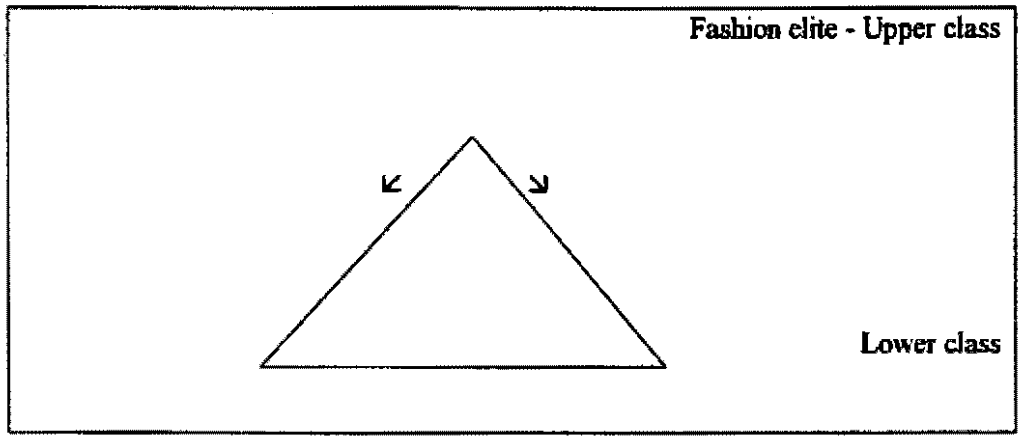


FIGURE 4.1: THE TRICKLE DOWN PROCESS - DOWNWARD FLOW

4.5.2 The collective selection behaviour model

Sociologists and marketing theorists have noted that styles frequently diffuse horizontally within a given stratum or subculture in a society (Kaiser, 1985). This process is dynamic and relies on two main factors:

- fashion innovators, and
- fashion adopters.

Fashion innovators are influentials who adopt new styles and introduce these styles to their own social worlds. According to symbolic interactionists (2.11.1), social worlds are diffused and loosely bounded levels of social organisation where there is a perceived sphere of interest and involvement for participants (Kaiser, 1985).

Early fashion adopters interact and make favourable impressions on others in their social worlds. This process is referred to as 'collective selection'. Kaiser (1985) notes that social interactions are more vital to fashion change than class structure. Fashionable dress is prestigious to the wearer, which subordinates the need to merely imitate the upper classes.

4.5.3 The mass market theory

Kaiser (1985) comments on the Mass Market Theory to explain the horizontal diffusion of fashion. Information of fashion styles is disseminated to all socio-economic classes at the same time. Mass production and mass media account for simultaneous availability of new styles. Moreover, communication models of fashion diffusion emphasise the role of the mass media,

interpersonal communication and professional change agents in stimulating and propagating the fashion process.

4.6 CULTURAL MODELS

4.6.1 The subculture leadership model

During the 1960s in the United States of America, fashion theorists became aware that styles do not necessarily trickle down but may also move upward from specific subcultures, for example youth, ethnic groups, streetwear, worker, to the emergence of new styles diffused to the fashion elite (Kaiser, 1985). Fashion designers are also influenced by grass roots movements. It is also advantageous for the apparel industry to introduce styles that have already been seen on the streets. The youth culture of the 1960s became a powerful force. The desire to look young replaced the elitist motive of conspicuous consumption. Many standards in fashion have been popularised by the anti-class youth and counterculture, specifically during the anti-establishment movement of the 1960s and the early 1970s

An example of counterculture trends features long hair, headbands, beads, tie-dyed apparel, vests, miscellaneous leather and suede, faded and torn jeans. In South Africa in the 1990s, elements from ethnic groups show a similar upward flow trend. Traditional and ethnic fashions are prominently visible at major social and public gatherings. The wearing of ethnic and traditional fashions reinforces a sense of social acceptance among minority or, in the specific case of South Africa, majority groups.

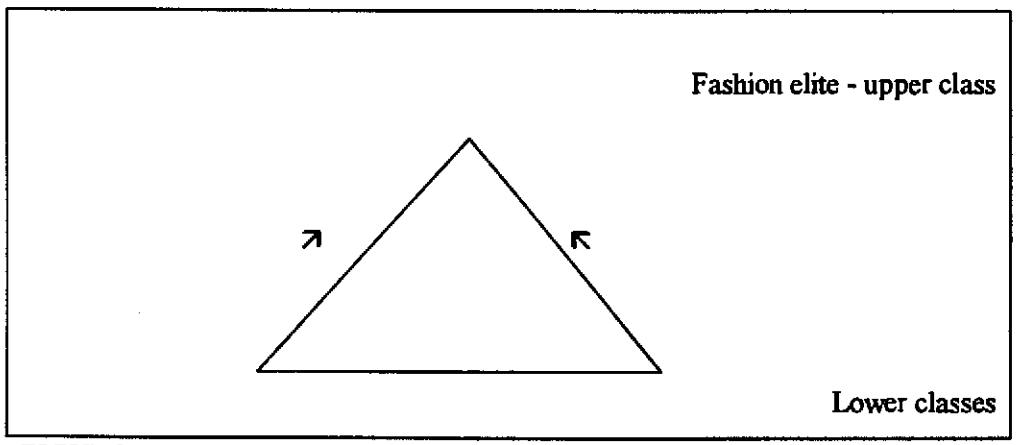


FIGURE 4.2: THE UPWARD FLOW OF FASHION DIFFUSION THEORY

Kaiser (1985) notes that fashion has been influenced by other social movements such as the civil rights movement, anti-war sentiments, women's liberation, gay rights and the green

movement. Styles symbolising these courses have influenced fashion trends and social standards, for example, 'punk' and 'new wave' fashions and more recently 'grunge', a combination of rags, tattered and torn garments. It is evident from research that in a democratic post-industrial society, fashion is a visible force in its own right, and the upward flow of diffusion will increase in importance whatever the social order is or the social movements that influence the values of the masses (Kaiser, 1985). In South Africa, from 1994 the use of fashion as a means of expressing values in a changing social order is illustrative of the transition to a multi-cultural democratic society.

4.6.2 The social conflict model

This model proposes that there are two forms of dress having specific cultural functions:

- Anti-fashion or customs of dress that show stability and cultural identity
- 'Fashions' which symbolise cultural change.

A combination of both these trends is apparent in South African society in 1995. Media representation, through television, fashion magazines and newspapers gives evidence of clothes symbolising cultural change that establishes the new social order, for example, the informal dress, by Western standards, of prominent political leaders at public gatherings, or the continued styling following fashions in Europe and America by South African fashion designers.

4.6.3 Psychological models

4.6.3.1 Individualism-centred models

These models propose that when a fashion becomes widespread, it begins to decline. Novelty seekers or creative individuals experiment with new styles leading to new fashions. Conformity-centred models explain the powerful focus motivating the growth of fashion trends, whereas the uniqueness motivation model suggests that people compare themselves with others, searching for similarities and differences and subsequently form specific identities (Solomon, 1985).

4.6.3.2 Economic models

According to Solomon (1985) examples of economic models include:

- The demand model, which proposes that at high prices demand for fashion is limited, but as prices drop demand grows substantially.

- The scarcity - rarity model, which states that objects that are rare, scarce or in short supply can have special value and command the highest prices.
- The conspicuous consumption model, which suggests that the rising 'wealth classes' desire to display their growing prosperity through conspicuous consumption, leisure and conspicuous waste.
- Geographic models, which show that there are significant differences in the interpreation of fashion globally. The world looks to Europe for innovative designs and Central Europe is often ahead of America, South Africa and Asia in fashion concept and distribution.
- The spatial diffusion model. The basis of this concept is that diffusion of innovation occurs in three stages of geographic distribution and the spread is usually from urban to rural areas:
  i. a primary stage when diffusion centres are established
  ii. a diffusion stage, where neighbourhoods adopt innovations
  iii. a saturation stage when diffusion ends.

4.6.3.3 Historic models

- The historical resurrection model proposes that designers look to history for inspiration and fashion often reflects the past with, however, notable changes.
- The historical continuity model. The concept basic to this model is that each new fashion is an evolutionary outgrowth and elaboration of the previous fashions. That is, fashion changes are rarely revolutionary and each new fashion represents only a proportionate design change from the recent past.

4.6.3.4 Aesthetic models

- The art movement model. According to Solomon (1985), this concept involves identifying relations between art movements and evolving fashion. Changing fashions have reflected such movements as neo-classicism, romanticism, eclecticism, functionalism, expressionism, pop art and op art. Solomon (1985) observes that societies have certain 'ideals of beauty'. There are standards for the most elevated aesthetic expression in appearance and these are shaped by social and historical influences.
- The aesthetic perceptions and learning model. A consumer's decision to adopt a new style involves a process of aesthetic perception and learning. Consumers learn to 'like' new stimuli that are not too different from or too complex in comparison with familiar stimuli.

4.6.3.5 Business marketing models

The Market Infrastructure Model. Originally it was proposed that fashion designers, retailers and the fashion media have the ability to create planned obsolescence of established fashions by bringing out and glamorising new fashions. The contemporary view (Solomon, 1985) is that planned obsolescence does not work. The modernised 'supply-side' model proposes that the most widely adopted innovations are those where business makes it easy and pleasant for consumers to adopt fashions by increasing availability, variety, convenience and affordability of apparel. This means designing market strategy (target markets) to assure consumers' wants are satisfied, and designing infrastructures for production, distribution and retail outlets.
The following frame (Figure 4.3) of a general fashion theory gives a clear summary of the stages of fashion process. It also illustrates how the behaviour sciences models of fashion are categorised at each stage (Solomon, 1985).

A basic understanding of a general fashion theory is particularly relevant to the South African market presently, largely because of the need to understand perspectives of consumers, innovators and designers for successful fashion marketing. The current climate of socio-cultural change is bound to affect self-expression and identity mirrored through clothing.

In South Africa, as in other countries, any of the processes discussed in Chapter Four may be noted in today's fashions although collective selection is probably the most common because fashion is a more democratic process in the 1990s than in earlier historical periods as the debate in 4.6.1 indicates.

STAGES OF THE FASHION PROCESS		EXPLANATORY NOTES
INVENTION AND INTRODUCTION ↓	←	BUSINESS (MARKET INFRASTRUCTURE) CULTURAL (SUBCULTURAL LEADERSHIP) AESTHETIC (ART MOVEMENTS, IDEALS OF BEAUTY) HISTORICAL (HISTORICAL RESURRECTION, HISTORICAL CONTINUITY)
FASHION LEADERSHIP ↓	←	PSYCHOLOGICAL (INDIVIDUALITY) SOCIOLOGICAL (TRICKLE DOWN) COMMUNICATIONS (SYMBOLIC COMMUNICATIONS, ADOPTION AND DIFFUSION) AESTHETIC (ART MOVEMENTS, IDEALS OF BEAUTY, AESTHETIC PERCEPTION) ECONOMIC (SCARCITY, CONSPICUOUS CONSUMPTION) CULTURAL (SOCIAL CONFLICT)
INCREASING SOCIAL VISIBILITY ↓	←	COMMUNICATIONS (ADOPTION AND DIFFUSION) PSYCHOLOGICAL (UNIQUENESS) SOCIOLOGICAL (COLLECTIVE BEHAVIOUR) BUSINESS (MARKET INFRASTRUCTURE, MASS MARKET) GEOGRAPHIC (SPATIAL DIFFUSION) AESTHETIC (AESTHETIC PERCEPTION)
CONFORMITY WITHIN AND ACROSS SOCIAL GROUPS ↓	←	PSYCHOLOGICAL (CONFORMITY) COMMUNICATIONS (ADOPTION AND DIFFUSION) SOCIOLOGICAL (COLLECTIVE BEHAVIOUR) ECONOMIC (DEMAND) GEOGRAPHIC (SPATIAL DIFFUSION)
SOCIAL SATURATION ↓	←	SOCIOLOGICAL (COLLECTIVE BEHAVIOUR) PSYCHOLOGICAL (INDIVIDUALITY) BUSINESS (MASS MARKET, MARKET INFRASTRUCTURE) ECONOMIC (DEMAND)
DECLINE AND OBSOLESCENCE	←	BUSINESS (MASS MARKET, MARKET INFRASTRUCTURE) PSYCHOLOGICAL (INVIDUALITY) HISTORICAL (HISTORICAL CONTINUITY) ECONOMIC (DEMAND) COMMUNICATIONS (ADOPTION AND DIFFUSION, SYMBOLIC COMMUNICATION)

FIGURE 4.3 AN INTEGRATED FRAMEWORK FOR A GENERAL FASHION THEORY
(i) STAGES OF THE FASHION PROCESS
(ii) EXPLANATORY MODELS (adapted from Solomon, 1985, p.56)

4.7 FASHION ADOPTION PROCESS

An investigation into the level of individual involvement with fashion, plus an understanding of the stages of fashion adoption, will yield information on individual differences in orietation toward new clothing styles.

Fashion adoption and fashion diffusion are interdependent processes. In order for fashion diffusion to occur, styles must be adopted by individuals (Forsythe, Butler & Kim, 1991).

Personal involvement with fashion is the degree to which a person is interested in fashion and influenced by either social contacts, media and a sense of inner commitment (Kaiser, 1985). Effective communication forms the basis of a person's social role. In relation to fashion, this communication is non-verbal. However, these non-verbal cues influence social interaction in a manner in which the person may either feel accepted or alienated. The study of fashion adoption focuses on this micro-level; that is,personal involvement, as compared with the macro analysis of fashion diffusion as explained through behavioural sciences models of fashion diffusion in the previous section.

From an analysis of the information presented by Kaiser (1985) and Forsythe *et al.* (1991) on the theories of fashion adoption, the following similarities are noted:

- A stage of cognitive awareness, where alertness and exposure to new styles take place.
- A stage of seekership or habituation where there is a self-motivated interest in adopting fashions. This is achieved through discussions on fashion trends, readership of fashion media, the investment of time and expenditure of funds.
- A stage of evaluation where the advantages and disadvantages of adopting a style are weighed.
- A trial or comprehension stage where an individual adopts an innovative style and tests the reactions from peers. An attitude is formulated toward the product and the consumer may seek further legitimisation for adopting the style by picking up cues in social interaction.
- A rejection stage. On the basis of comprehension and evaluations, an individual may reject a style due to a decision-making process resulting from all previous abovementioned stages.

4.7.1 Differences in the adoption models

Kaiser (1985) notes the distinction between understanding the influence of fashion in normative everyday fashion worlds as opposed to groups of individuals involved with the fashion industry, for example manufacturers and model agencies. Individuals in the more formalised fashion

worlds are exposed first hand to new fashion trends and play a role in the creation and control of new styles.

i. closure, which involves a person's sense of obligation to dress fashionably in order to obtain career goals or the advancement of career, and to meet social obligations
ii. drift, which involves a sense of freedom and confidence in respect of dressing in a fashionable or innovative manner
iii. a need for a product, and comprehension, which entails understanding of both the product and the consequences of purchasing the product.

It is important to note that the processes of fashion adoption described in 4.7 are not mutually exclusive and that individuals may adopt fashion processes for more than one reason.

4.7.2 Ideal types of consumer adopters

According to Kaiser (1985), researchers have attempted to develop profiles of consumers and to classify them so as to understand the characteristics of early and late adopters of styles. Consumer types are generally classified relative to the stage of the fashion cycle in which they are likely to accept a style. The following eight consumer types are classified:

4.7.2.1 Innovators

Innovators are fashion originators of styles or 'looks'. They provide the initial exposure of a style to others. They may or may not be influential in causing others to respond favourably to the style.

4.7.2.2 Fashion opinion leaders

Fashion opinion leaders are early adopters or 'change agents' in the diffusion process. They provide legitimisation for a style through their own approval. These are individuals whose fashion taste is respected by others.

4.7.2.3 Early conformists

Early conformists are early adopters of a style or trend. They are influential in inducing fashion followers to adopt a style through social interaction.

4.7.2.4 Mass market consumers

Mass market consumers are consumers who adopt a style at the peak of its cycle.

4.7.2.5 Fashion retailers

Fashion retailers attempt to stock styles in large quantities immediately prior to the peak stage in the fashion cycle.

4.7.2.6 Late fashion followers

Late fashion followers adopt a fashionable style in its final stages of the fashion cycle.

4.7.2.7 Fashion isolates

Fashion isolates adopt styles without overwhelming interest because they are inexpensive or because of pressure to comply.

4.7.2.8 Fashion laggards

Fashion laggards are consumers who are late adopters through non-exposure to many of the influences that lead to an awareness of or an interest in fashionable styles.

Consumers not classified as ideal, who however form a significant sector of the buying population, are the physically disproportionate, the physically challenged, the overweight. Potential cosmetic surgery patients form part of this group due to either oversized or undersized breasts or assymetrical disproportioned chests due to mastectomy.

For the purpose of providing current information on the direction and trend of fashion in South Africa the views of four South African fashion opinion leaders were incorporated in this study. Fashion opinion leaders serve the function of providing legitimisation for a style by giving it their stamp of approval. These are individuals whose fashion taste is respected by others. Opinion leaders are sometimes referred to as editors of fashion — they may adopt a slightly modified version of a style. They play a major role in providing the needed impetus for others' adoption process.

Profiles and characteristics of a 'fashion sample population' were sought for the purpose of attempting to assess clothing behaviour and predict, to some extent, style and direction of fashion interest between two culturally diverse groups in South Africa today.

4.7.3 Goal of fashion marketers

Kaiser (1985) and Perna (1987) point out the importance of marketers having a clear understanding of the target consumers' preferences and characteristic behavioural patterns with regard to fashion adoption. In this way, co-ordination among marketing goals is achievable; that is, providing the right merchandise at the right time and place in realistic quantities to satisfy consumer demand.

Kaiser (1985) emphasises the need to understand 'change agents' or fashion leaders, so that marketing strategies can be more accurate. These strategies create some awareness on the part of fashion followers. However, a significant goal is to create interest in, and evaluation of, a style by potential change agents, in order to gauge possible selling or buying direction. Normal fashion cycles are shaped similarly to a bell curve, with a gradual increase in acceptance, a peak during mass acceptance and a gradual decline. Fads usually occupy a short duration and are often found in certain subgroups and subcultures of society. They may influence fashion trends. Classics, by comparison, are wisely accepted over an extended period of time incorporating features that are moderate and undergo only minor revisions over time.

Post-cosmetic surgery patients who have previously been conservative about fashionable, fitted or revealing clothes due to perceived physical disproportion, are likely to be consumers who display renewed interest in fashionable styles. Their earlier reluctance to wear attention gaining styles prior to elective or reconstructive surgery may become a willingness to try something new.

This study attempted to clarify, through a sample population, some consumer preferences and characteristic clothing behaviour.

4.7.4 Fashion behaviour and personality

The following brief outline gives an indication of personality variables and possible clothing behaviour of some fashion consumers. This reinforces the psychosocial approach to this study. Fashion innovators are the earliest communicators of a new style for other fashion consumers and provide both visual display and initial exposure of the style (Kaiser, 1985). Innovators tend to be more inner-directed than non-innovators, and are unlikely to need or seek conformity with others as may other fashion consumers. Innovators under-conform with social norms as a greater inner direction and strong individuality are needed to be among the first to adopt a new style. They feel more socially secure than non-innovators (Kaiser, 1985).

4.7.5 Fashion opinion leaders

Fashion opinion leaders influence fashion followers by legitimising fashion styles. Fashion followers are influenced by opinion leaders' levels of taste and sense of social appropriateness. According to Kaiser (1985), female opinion leaders are physically mobile, cosmopolitan, gregarious and active in social organisations, whereas Schrank and Gilmore (1973) indicated that fashion opinion leaders appear to be more interested in clothing than fashion innovators. This fact indicates fashion opinion leaders' intensity about their roles in influencing others. Fashion opinion leaders' role was positively related to anxiety that may interfere with performance, which suggests fashion opinion leaders dress partly to compensate for feelings of anxiety and low self-concept.

Kaiser (1985) suggested that fashion opinion leadership is positively related to public self-consciousness or an awareness of self as a social object as well as with self-presentation. Kaiser (1985) further points out that opinion leaders feel the need to direct others and are characterised by competitive exhibitionist tendencies. They are highly involved in keeping up with fashion trends and perceive themselves in this way.

4.7.6 Innovative communicator

Innovative communicators are dual-change agents who provide functions of both the fashion innovator (visual exposure) and the fashion opinion leader (legitimisation) and are likely to be quite influential in the diffusion process. Innovative communicators therefore seem to be of a high socio-economic class, physically and socially active and extremely appearance conscious. Obvious personality traits are exhibitionism, narcissim and impulsiveness, which are likely to lead to buying behaviour patterns and influence others similarly.

4.8 SOCIO-CULTURAL VARIATIONS IN DRESS

4.8.1 Dress as an aspect of culture

A socio-cultural approach to clothing behaviour incorporates the concept of society and culture. Society is described as the level of human organisation involving a collectivity of people. Culture is identified as a way of life of a social group at a given time (Kaiser, 1985). Culture involves a set of learned beliefs, values, attitudes, habits and forms of behaviour that are shared by a society and transmitted from one generation to another within that society (Hann & Jackson, 1987; Adey

& Andrew, 1993). Clothing behaviour and personal adornment as forms of collective behaviour, provide an integrative means of understanding clothing as both a societal structure and a cultural expression. Clothing serves to identify and differentiate groups within a society; that is, individuals who dress uniquely, groups or organisations with collective clothing symbols, or sub-cultures who initiate fashion trends.

In South Africa, and with regard to this study, it is important to note the change from traditional ethnic clothing to Western urban fashions or the return to ethnic trends as a mark of national pride. It is significant to note that until the middle of the nineteenth century fashionable clothes were affordable only to the wealthy elite in most developed countries. The development of the sewing machine in 1845 by Elias Howe revolutionised the possibility for developing clothes at quantity levels. Eventually 'store bought' clothes gained recognition, although the negative connotations of inferiority of clothes manufactured outside the home persisted well into the 1900s (Kaiser, 1985).

In the United States of America an increased awareness of fashion trends led to the development of a uniquely American fashion influence, for example The Home Buy Look, and not a mere copying of Paris fashions. With the integration of cultures and intercultural interchange, local resources may form a greater part in setting fashion trends for the South African, as well as the export, market (Personal communication: Fashion opinion leader, Chris Levine, Johannesburg, June, 1995).

'Planned obsolescence' is a major factor of fashion change in urban industrial societies with the usual impact of lessening fashion symbolism and de-emphasizing traditional aspects of culture (Kaiser, 1985). However, South African fashion may presently be evincing a parallel where, although fashion change; that is, planned obsolescence, is rapid, ethnic symbolism and fashions are a prominent feature of clothing behaviour. This confirms the rights, individuality and pride of a developing nation in a changing cultural climate.

4.8.2 Fashion as collective selection

As briefly discussed in the previous section on social behaviourists' theories of fashion diffusion, Kaiser (1985) notes that fashion, as a form of collective selection, may help people to collectively adjust to social change by symbolically displaying change in the following three ways:

- Firstly, fashion provides new incentives; that is, styles that are socially relevant. It was significant for the purpose of this study to establish whether the wearing of socially relevant styles facilitated a person's sense of being socially acceptable.

- Secondly, fashion allows people to deal with the present in an orderly way by providing a sense of normative values that help to define what is socially acceptable.
- Thirdly, fashion helps people to prepare for the immediate by providing a sense of anticipation which is often not at a conscious level. Clothes are selected for future plans, career, holiday, professional commitments. Fashion is not merely an industrial play to force waste of clothing that is still wearable, but it is also a form of collective behaviour that impresses people's need to adjust to rapid changes in post-industrial societies.

Clothing reflects the evolution of an individual's society, and it provides a means of self-expression and satisfying interpersonal behaviour. An understanding of developmental patterns in societies helps to provide a background for identifying variations in cultural patterns, both among diverse cultures and intraculturally as a function of social change. It is important to note that consumers also play a part in accelerating fashion change as they become more involved in social movements and are influenced by incoming stimuli, the mass media, mass communication and mass transportation.

4.8.3 Clothing as a symbol of socio-cultural stratification

Dress may communicate, to some extent, a person's demographic characteristics, for example, income possibilities, education and occupation as well as psychographic characteristics such as lifestyle and consumption patterns. Perceivers are likely to make evaluations of a person's position in life from the way in which they dress. The interactions arising from the influence of these evaluations are likely to influence a person's self-esteem (Kaiser, 1985).

Persons opting for cosmetic surgery to change aspects of their physical appearance are aware of the influence of clothes on social interactions and the resulting effect on their self-esteem and sense of social acceptance. This also influences a person's sense of self-identity.

Inequality refers to unequal advantages that some groups in society have over others of either economic or social origins. When variables, for example power, status or money, are not equally distributed among all members of the society, social stratification is apparent. Societies differ with regard to the systems of stratification.

An important variable in such systems is the presence or lack of social mobility. Social immobility, present in democratic societies, tends to be a motivating factor for fashion change (Kaiser, 1985). In relation to this study the social mobility of the Black population in democratic South Africa today could reflect a growing interest in Western fashion and stimulate fashion

change. In this regard, the following three points are noted (Davis, 1989):

- Clothing is a symbol of stratification that symbolises a person's status; that is a person's position in a social hierarchy. However, through the democratisation of some clothing styles, for example blue jeans, this has not always been the case in the past thirty years
- Clothing affords prestige; that is, the evaluation applied by perceivers to a person's position in a status hierarchy, for example, social recognition, respect, admiration
- Clothing represents a form of privilege and influences power negotiations.

Clothes that symbolise high-status positions provide status and ego-enhancement. They are part of a reward system that functions and motivates upward mobility.

According to Barnes and Rosenthal (1985) clothes are tools for impression management. First impressions are vital in society and are often influenced by an individual's clothes and style of dress. Paradoxically, there is also a decline in clothes as status symbols due to the democratisation that mass production brings to a post-industrial society.

The following factors have contributed to the decline of clothes as status symbols (Kaiser (1985):

- affluence
- lack of desired recognition in social circles, due to the inability of persons to detect real differences in quality or cost of material objects
- the environmental movement, which promotes the recycling of apparel and the use of natural fibres
- rapid fashion change which affords many people the opportunity to express themselves uniquely
- status disguise; that is, the importance of less expensive copies of clothes that confer status. These are readily available to the masses and due to their availability they no longer render prestige, for example, designer jeans of the early 1980s.

The mass production of designer labels, counterfeit jeans and cheaper copies influenced the decline of jeans as status symbols. Status symbols presuppose exclusivity, not mass production (Kaiser, 1985). As designer labels decreased in popularity, emphasis on style and diversity in design features in sportswear became increasingly important. This trend demonstrates the importance of style as opposed to status symbolism in post-industrial societies.

Kaiser (1985) reports that for both male and female, exclusivity in clothes has a significant impact on impressions of competence. Males appear significantly more potent, bold and powerful when dressed in high status occupational attire such as a shirt, tie and dress shoes. Females, when dressed in high status clothes, appear of better character and friendlier than those dressed in low status clothes; that is, inexpensive skirts and blouses.

Many people realise the impact and significance that clothes, adornments and physical appearance have on their work, careers, assigned competence level, character and social interactions. Cosmetic surgery and the pursuit of exclusive clothes seem a small price to pay for the anticipated personal and social rewards of appropriate self-presentation and grooming. As Kaiser (1985) notes, self-presentation and social interaction play important roles in the fashion process as a style becomes fashionable only when it has been accepted and worn in social context.

4.8.4 Style and taste as socio-cultural variables

With regard to the fashion process, it is important to distinguish between style and taste. Style is a relatively tangible concept wherein apparel is described as possessing characteristic features, for example, silhouette construction, of the many style variations introduced by designers. However, only a small number has become fashionable.

Taste has been described as a sensitivity to objects of social experience, formed in the context of social interactions. The prospects for a style becoming fashionable depend upon individual and collective tastes (Kaiser, 1985). Collective tastes represent social norms and are socially learned; individual tastes are personal and unique preferences. There is a reciprocal relationship between individual and collective tastes. That is, individuals play a role in shaping collective tastes, and social norms, as applied in social contexts, mould individual tastes. People in common areas of interaction are likely to have similar experiences and thus develop common tastes.

Roach-Higgins and Eicher (1992) state that on the basis of a person's sensitivity to apparel styles, judgements about the aesthetic quality and social appropriateness are factors in an individual's level of involvement with fashion, and represent the degree of importance of fashion in a person's everyday life. The fashion process represents a form of collective behaviour with compelling power and should not be ignored by social scientists or health care professionals.

4.8.5 The concept of fashion paradox

From the foregoing discussion (4.7 - 4.7.4), fashion seems to provide a simultaneous means of identification and differentiation. Subcultures may allow individuals to identify with other members in the same subculture and to distinguish themselves from members of other subcultures. The social acceptance of clothing symbols may spread from subcultures and sub-units of society to society as a whole. The distinction between identification and differentiation

may become vague as a result of individuals influencing one another, at least visibly, with apparel styles.

Sproles (1979) distinguishes between two ways of looking at fashion: fashion as an object and fashion as a process. It is through the process of consumer adoption of a style that a fashion object is created and that meanings are assigned to a style. The meanings people assign to fashion objects are not static and go through variation stages.

4.8.6 Fashion process stages as socio-cultural indicators

Meanings are continually modified as a style goes through the following series of fashion processes:

- creation
- introduction to the market place
- adoption by influential consumers
- diffusion to other consumers.

If fashion features such as lapel widths, trouser legs or skirt lengths are moderate in proportion, they are more likely to last longer as fashionable objects. 'Extreme styles' tend to be less likely to endure in the market place because they lose the meaning of social acceptability with great speed.

4.8.7 Intercultural aspects of clothing influence: an example

Kuper's (1973) comparative study in society and history focuses on the incorporation of Western manufactured clothing into Swazi-style clothing. Aspects of this study are thought to be relevant to this dissertation as an example of the effect of Western style clothing on a multi-cultural South African society.

As in South Africa, European models have consisted of conventional sets of clothing which conveyed specific messages and, at times, particular body adjustments. The contrasted systems of clothing symbolise contrasting cultures; different types of Western clothes are associated with different categories of people. According to Kuper's (1973) study, the attitudes of Whites towards the Swazi wearing of Western clothing was ambivalent. On the one hand traditional 'African' clothing was denigrated, and on the other hand there was a reluctance to have Swazis appear in the more fashionable Western clothing. Initially, Whites who were not prepared to see Blacks as equals used clothing as a symbol maintaining 'inequality'. In Swaziland, with the development of political movements for independence from colonial rule, clothing assumed a new

significance (Kuper, 1973). At the time Cultural Nationalism became one avenue for the expression of political nationalism and modern political parties expressed themselve in different cultural styles. Leaders either copied the British style, were more experimental or emphasised the traditional cultural idiom as may be observed to the present day.

In South Africa traditional clothing, as an 'ethnic group statement' seems presently to be made at public celebrations or political meetings. The influence of Western style clothing, however, seems to dominate in urban areas.

As appears to be the case in South Africa, Swazis, once indepence had been re-acquired, continued to use clothing on national and international occasions to express national as well as cultural identity. According to Kuper (1973), the Swazis have been increasingly stimulated to become a market for Western clothing and there is a deliberate effort by foreign investors, as well as the local White population, to encourage a Westernised Black middle class. Kuper (1973) notes that the clothing of this Black middle class was responsive to changing Western fashions. One of the current Western fashion influences was textiles with African motives. This illustrates the interactive nature of fashion influence.

Kuper's (1973) example illustrates the complexity of the influences of clothing in a modern African nation. Some influences appear similar to the clothing behaviour of Black South Africans in which the bilateral influence of both ethnic and Western clothing traditions is apparent. Through the Swazi example, it now becomes intelligible why a person's relationship to her clothing is at once different from, and more intimate than, her relationship to all other material objects. Kuper's observation supports a further core concept of this study, namely, the importance of assessing body image and personal identity in terms of the clothed person, which presupposes a study of clothes and clothing trends.

From a biopsychosocial perspective, the following conclusion can be proposed: that if the power of clothes can motivate a national resistance to certain trends, then clothes can be equally as powerful in their potential for therapeutic effect.

CHAPTER FIVE

FORMULATION OF HYPOTHESES

5.1 INTRODUCTION

The literature survey (Chapter Two - Chapter Four) formed the basis for the five main hypotheses set out in Chapter Five and on which the research for this dissertation is based. On the basis of this literature survey, the primary objectives (1.2) and the subproblems in Chapter One (1.8.1 - 1.8.7), the following main hypotheses were addressed in this study.

5.2 THE HYPOTHESES

5.2.1 Hypothesis 1

THAT PERSONAL ATTITUDES TOWARD BODY IMAGE AND SELF-IDENTITY ARE RELATED TO THE NEED A PERSON HAS TO CHANGE HER PHYSICAL APPEARANCE THROUGH SURGERY

Rationale

A person who has a high level of dissatisfaction regarding her body image and self-identity would explore various methods to adjust physical imperfections. This is evident from the increase in requests for cosmetic plastic surgery globally (Larson *et al.*, 1994) and locally (Spalding, 1990; Schlebusch, 1993; Prof. A Madaree, personal communication, 1995). Increases in Durban showed up to 50% for both private and non-private patients in 1995 (Table 1.1). High technology medico-surgery affords persons the opportunity to rectify previously unadjustable physical imperfections (Schlebusch, 1990).

The mediation of faulty self-stigmatising physical attributes enhances psychosocial improvements and reactions (Gruendemann, 1975; Cash & Horton, 1983; Rogers, 1990). It is therefore reasonable to hypothesise that personal attitudes towards body image and self-identity are related to the need a person has to change her physical appearance through surgery.

5.2.2 Hypothesis 2

THAT PERSONAL ATTITUDES TOWARD BODY IMAGE AND SELF-IDENTITY DIFFER CROSS-CULTURALLY, AND ARE RELATED TO THE NEED A PERSON HAS TO MEDIATE HER PHYSICAL APPEARANCE THROUGH CLOTHING BEHAVIOUR OR OTHER NON-SURGICAL PRACTICES

Rationale

Negative body image perception is reaching epidemic proportions among many female population groups (Hutchinson, 1989). Body image is thought to be value laden thoughts and feelings about one's body derived from cultural influences and is an internalised representation of cultural norms (Kaiser, 1990; Bond & Cash, 1992; Cash & Jacobi, 1992; Keisouw, 1994). Negative body image perceptions are evident in psychological functional disturbances such as self-doubt and self-identity imbalances (Hutchinson, 1989).

Theron *et al.* (1991) note that the use of fashionable clothing and grooming behaviour other than surgery, for example fitness programmes and weight control, to enhance physical attractiveness would positively affect scores on social interaction and self-identity.

It is, therefore, reasonable to propose that personal attitudes toward body image and self-identity are influenced interculturally and related to the need a person has to mediate her physical appearance through non-surgical methods.

5.2.3 Hypothesis 3

THAT THERE IS A POSITIVE RELATIONSHIP BETWEEN SURGICAL CHANGES TO PHYSICAL APPEARANCE AND CHANGES IN CLOTHING BEHAVIOUR WITH REGARD TO SOCIO-CULTURAL NORMS FOR ACCEPTABLE BODY IMAGE AND FASHIONABLE CODES OF DRESS

Rationale

Any person, irrespective of socio-cultural origins, after an elective surgical procedure must take part in the socio-cultural life offered in the community to which they belong. In the process, adherence to norms for acceptable body image and clothing choices is often desired.

Positive post-operative changes in body image perception and in clothing behaviour have been documented in the research literature both globally (Cash & Pruzinsky, 1990) and locally (Spalding, 1990; Schlebusch & Mahrt, 1993; Keisouw, 1994).

Furthermore Stark (1980) reported that psychosocial benefits, post-abdominoplasty, included an improved body image, a positive change in clothing behaviour, including experimentation, and improved social and interpersonal relationships.

In a study by Schlebusch and Mahrt (1993) (Table 3.2) a 100% improvement in post-surgery feelings, attractiveness and comfort with the wearing of low cut revealing garment types was shown for a sample of (n=20) augmentation mammaplasty patients.

It appears therefore, reasonable to propose that there is a positive relationship between surgical changes to physical appearance and changes in clothing behaviour with regard to socio-cultural norms for acceptable body image and codes of fashionable dress.

5.2.4 Hypothesis 4

THAT THERE IS A POSITIVE RELATIONSHIP BETWEEN ELECTIVE COSMETIC SURGICAL CHANGES TO PHYSICAL APPEARANCE, CHANGES IN ANXIETY LEVELS AND CHANGES IN PERSONALITY TRAITS

Rationale

Post-operative psychosocial benefits for cosmetic plastic surgery include an improved body image, renewed interest and change in clothing behaviour as well as improved social and interpersonal relations (Stark, 1980). A close relationship between anxiety and personality traits is also revealed in the research survey where increased levels of self-confidence, spontaneity and independence are correlated with lower levels of post-operative anxiety (Stark, 1980; Cash & Pruzinsky, 1990; Spalding, 1990; Schlebusch & Mahrt, 1993; Larson *et al.*, 1994).

It seems reasonable then to hypothesise that there is a positive relationship between elective cosmetic surgical changes to physical appearances, lower anxiety levels and more positive personality traits.

5.2.5 Hypotheses 5 and 6

Hypothesis 5

THAT THERE IS A RELATIONSHIP BETWEEN THE LEVEL OF SATISFACTION RESULTING FROM PHYSICAL CHANGE IN ELECTIVE COSMETIC SURGERY, CHOICE OF CLOTHING BEHAVIOUR AND THE LEVEL OF PERCEIVED SOCIAL ACCEPTANCE IN TERMS OF AN IMPROVED BODY IMAGE AND SELF-IDENTITY.

Hypothesis 6

THAT THERE IS A DIFFERENCE BETWEEN CROSS-CULTURAL LEVELS OF SATISFACTION RESULTING FROM PHYSICAL CHANGE THROUGH NON-SURGICAL MODIFICATIONS, THE CHOICE OF CLOTHING BEHAVIOUR AND THE LEVEL OF PERCEIVED SOCIAL ACCEPTANCE.

Rationale for Hypotheses 5 and 6

A sense of social security in terms of the desire a person has to be accepted by the society to which she belongs, is evident in the level of enhanced interpersonal relations, positive social identity and self-confidence gained through changes in physical appearance through elective surgical procedures or non-surgical grooming behaviour.

Negative body image is positively correlated with more social introversion and an inhibited social identity, whereas subjects with positive body images are less self-conscious and socially well adapted (Theron *et al.*, 1991).

The three dimensions of self-consciousness, that is, private and public self-consciousness and social anxiety (Fenigstein, Scheier & Buss, 1975) are reported to be related to subjects' body image scores. Research findings reveal that self-rated attractiveness is negatively related to social anxiety (Theron *et al.*, 1991; Bond & Cash, 1992).

It is therefore reasonable to propose that the use of fashionable clothing, elective cosmetic surgery and non-surgical grooming methods to enhance physical appearance would positively affect scores in cross-cultural social interaction.

In Chapter Six the methods used for testing the hypotheses discussed in Chapter Five are presented.

CHAPTER SIX

RESEARCH METHODS

6.1 OVERVIEW

The previous five chapters focused on the problems, logistics and origins underlying the importance and motivation for this study. The discussions in chapters one, two, three and four captured the essential features fundamental to a debate on the interrelatedness among aspects of the chosen variables:

- body image
- identity
- cosmetic plastic surgery
- fashion
- social self-consciousness.

Chapter Five sets out the hypotheses based on the literature study. Chapter Six outlines the methodology used to measure the research data. The standardised questionnaires, sample selection, administration of data capturing and data collection procedures are explained. The limitations of the study and the criteria for admissibility of the data are identified.

6.2 METHODOLOGY

The research design incorporated both inferential and descriptive analyses. Although sample sizes were small in some cases the *t*-test was preferred to a non-parametric test because of small variations and symmetric distributions.

6.2.1 The descriptive data

The primary objective of this study was to assess people's attitudes towards aspects of their physical appearance and identity, and how these attitudes related to their body images, and to the clothes they wore. The extent to which these attitudes influenced the person's sense of social acceptance also needed to be identified. All attitudes were identified by means of standardised questionnaires (Annexures 1, 2, 3, 4, 5, (6, is referred to for numbering purposes only, and is obtainable from the Test Library, University of South Africa), and 7).

6.3 SAMPLE DESCRIPTION AND SELECTION: PATIENTS (CLINICAL) AND PARTICIPANTS FASHION (NON-CLINICAL) — FASHION OPINION LEADERS AND BREAST ONCOLOGY PATIENTS (SUB-SECTIONS)

The sample population consisted of two main groups and two subsidiary groups. A description of the groups and methods of sample selection follows.

6.3.1 Main Groups. These consisted of:

i. The clinical sample; that is, persons electing plastic cosmetic surgery;
ii. The non-clinical sample; that is, participants with a fashion awareness undergoing no form of elective surgery.

6.3.1.1 Clinical sample

The clinical sample was divided into the following sub-groups:

- Reduction mammaplasty
- Augmentation mammaplasty
- Abdominoplasty
- Rhytidectomy
- Breast oncology: breast reconstruction, mastectomy and lumpectomy.

These groups were of a culturally mixed nature; that is, both Black and White persons.

6.3.1.2 Non-clinical sample

The non-clinical group was divided into two groups:

- White cultural group
- Black cultural group (KwaZulu-Natal Zulus)

All groups consisted of married or unmarried Black and/or White females aged 18 - 55 years with a minimum education qualification of matric or equivalent, or a proficiency which enabled them to answer the questionnaires, with understanding, in English. The sample population groups were regionally based; that is, the province of KwaZulu-Natal, South Africa.

6.3.2 Subsidiary groups

i. Fashion opinion leaders; that is, reputedly recognised persons in the field of fashion
ii. Oncology patients, that is, medical patients treated for cancer of the breast.

6.3.3 Subject selection

The subjects selected formed two main groups, clinical and non-clinical and two subsidiary groups, fashion leaders and breast oncology patients.

6.3.3.1 The clinical sample

The clinical sample (i.e. patients) volunteered to participate in the study by responding to requests from surgeons or surgeons' assistants to participate in the study. Patients were handed a 'Letter of Information' (Annexure 10) which outlined the purpose of the study, the significance of their participation and the procedure for contacting the researcher (Tables 6.1 and 6.2).

6.3.3.2 The non-clinical sample

Groups of fashion orientated persons were identified by the researcher. They were fashion students at Technikon Natal, Durban, fashion merchandisers and sales personnel from chain stores, for example, Edgars, Truworths and from boutiques (Tables 6.1 and 6.2). Participants were handed a 'Letter of Information' (Annexure 12) which explained the reasons for the study and the significance of their participation

6.3.3.3 Fashion opinion leaders

Four fashion personalities were requested, through personal telephonic communication, to answer a set of questionnaires (Annexures 1 - 7) which would identify them as fashion opinion leaders. These four personalities comprised two leading South African fashion designers who were selected from Johannesburg, one from Cape Town and one from KwaZulu-Natal, namely, the

Head of the Department of Fashion at Technikon Natal, Durban (Tables 6.1 and 6.2). Technikon Natal is the convenor technikon for fashion departments at tertiary institutions in South Africa.

This subsection will not be dealt with in depth. The information from this section was used in a supportive capacity as it did not form the main focus of the study.

6.3.3.4 The breast oncology patients

The breast oncology patients volunteered to participate in the research by responding to requests from surgeons or surgeons' assistants.

Table 6.1: Sample selection of clinical and non-clinical subjects

SAMPLE GROUP	TYPE OF SURGERY	SAMPLE SIZE
Clinical (surgical)	Reduction Mammaplasty	n = 12
	Augmentation Mammaplasty	n = 7
	Abdominoplasty	n = 3
	Rhytidectomy	n = 3
Sub-section (clinical)	Breast oncology	n = 3
	TOTAL	n = 28
	CULTURAL GROUP	
Non-Clinical (fashion)	Black	n = 30
	White	n = 30
	TOTAL	n = 60
Sub-section: fashion opinion leaders		n = 4
	TOTAL	n = 4

6.4 DATA COLLECTION FOR SUBPROBLEMS ONE AND TWO

The first two subproblems were to evaluate whether the sample groups' attitudes towards their body image and self identity were negative to the extent that they requested surgery to change aspects of their physical appearance. The data needed for testing the hypotheses of subproblems one and two, stated in section 1.8 were obtained from the answers to the standardised questionnaires shown in Table 6.2 under subproblem one and two.

Table 6.2: Standardised questionnaires used for subproblems one and two

SAMPLE GROUPS	QUESTIONNAIRE NAME	NO	AUTHOR	SUB-PROBLEM
Clinical	Multidimensional body-self relations questionnaire	1	Cash *et al.* 1986; Cash, 1990	one & two
	Scale for Measuring identity conceived by Erik Erikson	2	Ochse, R. adapted for use in South Africa, 1983	one & two
Clinical sub-section (i.e. oncology)and	Methods for measuring clothing variables	3	Creekmore, 1971	three & five
Non-Clinical (fashion)	Public and Private self-consciousness assessment and theory	4	Fenigstein, Scheier and Buss, 1975	six
Clinical	IPAT Self Analysis Form	5	Human Sciences Research Council (1979) Cattell, Scheier and Madge (1968)	four
Clinical sub-section only (i.e. oncology)	16 Personality Factor Questionnaire	6	Cattell, Saunders & Stice (1957) (American authors) adapted for use in South Africa. Madge and Du Toit, 1991	four
Fashion sub-section only Non-clinical	Fashion opinion leader	7	Shrank and Gilmore, 1983	none

6.4.1 Administration of the data capturing procedure of ordinal and interval scales for subproblems one and six

6.4.1.1 Sample groups

i. Clinical Sample Group

The groups (Table 6.2) were tested pre-operatively within two weeks or at the hospital one day prior to surgery and post-operatively after a time lapse of three months. The following questionnaires were used in both instances: Questionnaires, 1, 2, 3, 4, 5, 6 (Table 6.2). The frame of reference for the pre-operative questionnaires was derived from the literature survey (Table 6.2). The pre-operative questionnaire served as a baseline against which to measure post-operative attitudes and behaviour.

The pre-operative interviews were not restricted to a fixed time period prior to surgery; however, post-operative interviews were strictly limited to a time frame of three months. The reason was to standardise post-test evaluations. All interviews were conducted by the researcher. This allowed for the standardisation of interview bias.

ii. Non-clinical sample group

Only questionnaires 1, 2, 3 and 4 were used (Table 6.2). No pre/post-test administration and no time limits were required. The questionnaires were administered once only.

6.4.2 Sample administration and interview procedure

Cognisance was taken of the sensitivite and confidential nature of the sample administration process and interview procedure. A detailed description follows:

6.4.2.1 Sample administration

i. Clinical Group

- Appointments were made telephonically for the researcher to visit selected, Durban-based, plastic surgeons in private practice and those operating in provincial hospitals.
- Appointments were also made telephonically for the researcher to visit oncologists and therapists at the Durban Oncology Centre.

- Information on the research project was provided verbally and in writing to the surgeons and their co-operation and support were requested.
- Surgeons were asked to canvas persons who elected to undergo plastic surgery for reduction mammaplasty, augmentation mammaplasty, rhytidectomy, abdominoplasty and treatment for breast oncology.
- To assist surgeons in gathering the experimental group, letters of introduction to the study were provided for each surgeon (Annexure 8).
- The letters of introduction explained the purpose of the study and pledged confidentiality. A list of questionnaire titles and authors accompanied the letters.
- A separate letter of introduction was prepared for the patients (Annexure 12). This included:
    * an introduction to the study
    * a request for patient participation and the importance thereof
    * a pledge of confidentiality.

ii. Non-Clinical Group

- Permission was requested from the Head of Department, Personnel Managers and owners to verbally address students of the Fashion Department, Technikon Natal, employees at chain stores (for example, Edgars) and private individuals in boutiques, respectively.
- Letters to participants of the fashion sample group were distributed and requests for participation were made.
- The letters introduced the study, explained the purpose of the study and pledged confidentiality (Annexure 13).

iii. Fashion Opinion Leaders

- Leading fashion personnel were contacted telephonically or visited personally. Appointments were arranged through their receptionists.
- Information on the research project was communicated verbally to the Head of Department (Fashion), Technikon Natal, and participation was requested.
- Letters of introduction were also supplied to leading fashion persons (Annexure 13). The letters explained the purpose of the study and pledged confidentiality.

- Permission was requested by the researcher to quote leading fashion personnel on specific issues discussed during personal communication. In all cases permission was granted.

6.4.2.2 Interview Procedure

i. Pre-test for the clinical sample group (Questionnaires 1, 2, 3, 4, 5, 6)

- Surgeons' receptionists were provided with the same information as the surgeons.
- Surgeons' receptionists were requested to assist with the canvassing of patients. A number of 'Letters to patients' (Annexure 10) were given to both surgeons and receptionists for distribution.
- A verbal commitment from the patient to participate in the study and to contact the researcher was procured. Permission was also requested from the patient for the researcher to contact her telephonically.
- In some cases patients made the initial contact with the researcher following the information received through the letter to patients, and contact with the surgeon or surgeon's receptionist.
- Patients were requested to complete consent forms (Annexure 11) prior to commencing the interview questionnaires.
- Regular weekly telephonic contact was maintained with the surgeons' receptionists in order to ensure efficient follow-up contact with prospective interviewers.
- Questionnaires 5 and 6 (Annexures 5 and 6) were answered in the presence of the researcher during private, confidential interviews. At no time were the patients left unattended and under no circumstances were the questionnaires left with the patients.
- Pre-interviews were held in the hospital wards or in a pre-selected venue convenient for both patient and researcher; that is, private homes, offices or board rooms.

ii. Post-test for the clinical sample group

- Patients were informed of a post-test in the letter of information to patients (Annexure 10).
- The researcher independently contacted patients for the post-test three months after surgery.
- All patients agreed to the post-test, although they were informed that they were free to withdraw from answering the questionnaires without suffering any disadvantages.
- A 100% response rate for pre/post-tests was attained from the clinical sample group.

- Post-interview procedures followed the same sequence as pre-interviews (6.4.2.2) with the exception of the need for surgeon or surgeon assistant canvassing.
- Venue change for the post-test, if necessary, was still conducive to confidentiality and for the standardisation of extraneous variables, for example, the noise factor.

iii. Non-clinical sample group (Questionnaires 1, 2, 3 and 4, Table 6.2)

- Questionnaires were distributed in groups or individually.
- Letters of 'Information to Participants' (Annexure 10) accompanied the questionnaires.
- Instructions were carefully read and explained to participants by the researcher, or personnel manager (trained assistant).
- Extraneous variables; that is, noise, temperature and privacy, were controlled for the avoidance of bias during questionnaire response.
- Participants answered the questionnaires in one sitting. The questionnaires were collected by the researcher or personnel manager (assistant).

iv. Fashion Opinion Leaders

Four leading fashion personalities were identified on the basis of their reputation as leading active designers or for the fact that they held key positions in the South African fashion world, the rationale being to establish additional, individual comment on opinions of fashion norms or trends in the current South African context.

- Appointments for interviews were made through receptionists.
- Questionnaires were distributed to leading fashion persons either personally during the interview, or by post or fax.
- There was no fixed time period for questionnaire return. All procedures for questionnaire response in a noise-free, private venue, where confidentiality was respected, were proposed.
- It was proposed that questionnaires be completed in one sitting.

6.4.3 Description of the instruments

6.4.3.1 Objectives (general)

Information for all the standardised questionnaires used to test the operational hypotheses (Section 5.2) was obtained from the literature review (Chapters two, three and four).

The standardised questionnaires (Annexures 1, 2, 3 and 4) used to collect the data were chosen in order to analyse the following variables:

i. Independent variables

The socio-demographical information included:

- Age
- Cultural group
- Educational qualifications
- Home language
- Occupation (uncategorised).

The information was used to determine:

- the clinical/non-clinical sample groups
- identify the test as pre/post-surgery
- classify the type of elective cosmetic surgery
- categorize the fashion groups according to race; that is, Black or White.

ii. Dependent Variables

Data analyses revealed attitudes in terms of the following variables:

- level of positivity/negativity to body images
- level of social self-consciousness
- strength of self-identity
- level of positivity toward clothing behaviour
- level of pre/post-operative anxiety
- personality traits which affect attitudes.

6.4.4 Choice of questionnaires, structure and processing

6.4.4.1 Questionnaire 1

The multidimensional body-self relations questionnaire (hereinafter referred to in the text as MBSRQ)(Cash *et al.*, 1986; Cash, 1990)(Annexure 1).

Body image assessment is imperative for:

- gauging successful outcome for elective cosmetic surgery (Stark, 1980)
- assessing changes in clothing behaviour post-operatively in terms of norms for fashionable clothes

- establishing a person's sense of social acceptance after changes to physical appearance have been incurred
- As the orientation of this study was a biopsychosocial approach, it was argued that the administration of the MBSRQ would be appropriate as it accounts for both psychological and somatic domains, as well as for the measurement of pre/post-test body images attitudinal change (Cash *et al.*, 1986; Cash, 1990).

i. Structure: The MBSRQ is a 69 item self-report inventory divided into the following sections:

- A 54 item body-self relations questionnaire which includes:
  - * Appearance evaluation and orientation
  - * Fitness evaluation and orientation
  - * Health evaluation and orientation
  - * Illness orientation.
- A body areas satisfaction scale of nine items.
- A weight related satisfaction scale including:
  - * Fat anxiety
  - * Weight vigilance
  - * Self-classified weight
  - * Diet and restraint.

ii. Data processing and interpretation for Questionnaire 1 (MBSRQ) was measured on a 1 - 5 Lickert type scale. For the first 57 items, *'1 - definitely disagree'* was the lowest score and *'5 - definitely agree'* was the highest score. Items 58 - 60 are each supplied with their own responses. For items 61 - 69, a 1 - 5 point scale was used to indicate how satisfied/ dissatisfied the person was with aspects of her body.

Statistical methods and calculations

For Questionnaire 1 descriptive statistics of item means and standard deviations were calculated for continuous data and percentages for categorical data. A factor analysis was computed for the fashion groups only (i.e. Blacks and Whites separately) because of an adequate sample size (n=60). Paired *t*-tests were calculated for the clinical group to compare pre/post-test means and standard deviations. Unpaired *t*-tests were calculated to compare the Black and White non-clinical sample group. The presentation of the MBSRQ is summarised in Table 6.3.

Reliability and validity (MBSRQ: Cash *et al.*, 1986; Cash, 1990)

Test, re-test reliability after one month for n=71 females ranged from 0,91, $p<0,001$ for *Dieting*. *Fitness orientation* showed a test, re-test reliability of 0,94, $p<0,001$. Internal consistency for the body self relations Questionnaire (Brown, Cash & Milkulka, 1990) for n=1064 females ranged from alpha 0,90 for *Fitness orientation* to alpha 0,75 for *Illness orientation*.

6.4.4.2 Questionnaire 2 - Scale for measuring identity as conceived by Erik Erikson (1964) adapted for use in South Africa by Ochse and Plug (1983)(Annexure 2).

A study of identity is highly significant in a socio-culturally mixed sample population, where inter-cultural influences are inevitable and could well affect a person's sense of identity. In the context of South Africa presently, change is likely to influence a person's sense of self, in which identity, body images, social acceptance and clothing behaviour form an integral part of the process of adaptation to a new order.

i. Structure: The identity scale consists of sub-scales for measuring eight dependent variables, namely, trust; autonomy; initiative; industry; identity; intimacy; generativity; social desirability.

A four-point rank order scale consisting of options ranging from *never - very often* applied to a total of 93 statements. Seventeen social desirability statements were interspersed in the test. Ten statements were marked with an asterisk and negatively scored. The structure of identity scale (Ochse & Plug, 1983) is summarised in Table 6.4.

ii. Data processing and interpretation

The four-point rank order scale indicates how often the statement applies to the person, ranging from *never* (0 score) to *very often* (3 score). The scores indicate to what extent the person is affected negatively or positively by a particular statement. A high score on any of the eight variables indicates more of the specific quality, for example, a high sense of identity or trust.

Low scores on any of the eight variables would indicate the person possessing less of the specific quality, for example, not taking the initiative easily, dependence and non-trusting behaviour. Low scores would indicate that the person does not have a strong sense of self-identity.

Table 6.3: Questionnaire 1: The multidimensional body self-relation questionnaire

VARIABLE	INSTRUMENT	STRUCTURE	ITEMS
Body images	APPEFV	Appearance evaluation	5, 11, 21, 30, 39, 42,*48
	APPORT	Appearance orientation (attention/importance action)	1, 12, 22, 31, *40, *49, 2, 13, *23, *32, 41, 50
	FFEVF	Fitness evaluation	24, *33, 51
	FTTORF	Fitness orientation (attention/importance action)	3, 4, 6, 14, 15, 16, *25, 26, *34, *43, 44, 53
	HEAVF	Health evaluation	7, *17, 27, *36, *45, 54
	HEAORF	Health orientation	8, 9, 18, 19, *28, 29, *38, 52
	ILLORF	Illness orientation	*37, 46, *47, 55, 56
	BASS	Body areas satisfaction	61, 62, 63, 64, 65, 66, 67, 68,
	APPSAT	Appearance satisfaction	69
	WTSAT	Weight satisfaction	67
	WTLABE	Weight label	59, 60
	FATANX	Fat anxiety	10
	WTVIGIL	Weight Vigil	20
	DIET	Diet	57
	RESTR	Restraint	58

* reverse scored

Note: For item descriptions see Annexure 1

Source: Cash *et al.* (1986); Cash (1990)

Table 6.4: Questionnaire 2: Scale for measuring identity

VARIABLE	INSTRUMENT	STRUCTURE	ITEMS
Identity	Scale for measuring identity (Conceived by Erikson, 1964)	Social desirability	9*, 39, 13, 19, 23, 29*, 33, 39, 43*, 49, 53*, 59, 63*, 69, 73*, 79, 83
		Trust	1, 11*, 21, 31, 41*, 51, 61*, 71, 81*, 91*
		Autonomy	2, 12*, 22, 32, 42, 52, 62, 82*
		Initiative	4, 14*, 24, 34*, 44*, 54*, 64*, 74, 77, 84*
		Industry	5*, 15, 25, 35*, 45, 55, 65*, 72, 75, 85*, 89
		Identity	6, 10, 16*, 20, 26*, 30*, 36*, 40, 46, 50*, 56*, 60, 66, 70, 76, 80, 86, 90, 93*
		Intimacy	7, 17*, 27, 37*, 47, 57*, 67, 87
		Generativity	8, 18, 28, 38*, 48*, 58, 68*, 78*, 88*, 92

* reverse scored

Note: For item descriptions see Annexure 2

Source: Ochse & Plug (1986)

Statistical methods and calculations for Questionnaire 2. Descriptive statistics of item means and standard deviations were calculated for continuous data and percentages were calculated for categorical data. Factor analysis was done for the Black and White fashion groups only. Mean scores were calculated for the various factors. For the Black and White fashion sample, the groups were compared using an unpaired *t*-test.

Reliability and validity of the instrument. Ochse and Plug (1986) report mean scores, standard deviations and reliabilities for the Erikson sub-scales used for their main study on a mixed cross-cultural heterogenous group including Whites and Blacks (Table 2, p.1244). Cronbach Alpha scores for the total scales were 0,92 (Whites, n = 790 females) and 0,90 (Blacks, n = 168 females).

High reliability for the total scale showed that some underlying factor was systematically measured; that is, *identity in the global sense, as an integrated system of personality components*. Ochse and Plug (1986) further state that although the Erikson sub-scales were acceptable for research purposes, the results on Blacks should be interpreted with some reservation.

Results of the statistical outcome of Questionnaire 2 are presented in Tables 7.7, 7.8 and 7.9.

6.4.4.3 Questionnaire 5: The IPAT Anxiety Scale, Human Sciences Research Council (HSRC, 1979)(Annexure 5)

This test was administered to the clinical sample groups only. An holistic approach to data measurement is essential in a multi-disciplinary study such as *'Aspects of Physical Appearance and Clothing Behaviour'*.

The IPAT anxiety scale is a brief, verbally undemanding, clinically valid questionnaire for measuring anxiety applicable for a variety of educational levels and for ages of 15 years upward. It is primarily designed to measure free-floating manifest anxiety level, whether it is situationally determined or relatively independent of the immediate situation.The anxiety scale can be linked to the personality variables measured on the 16 PF questionnaire (Cattell *et al.*, 1957) also used in this study.

i. Structure: The structure of the IPAT Anxiety Scale consists of 40 questions distributed among five anxiety-measuring factors, or components, according to each personality component's centrality as a source or expression of anxiety. The items are divided into:

- covert, hidden, purpose cryptic probes; that is, in the first 20 items of the A score sheet
- those which manifestly refer to anxiety; that is, the last 20 items of the test B score. The score is called overt, symptomatic conscious anxiety.

The structure and presentation of the IPAT Anxiety scale (HSRC, 1979) are summarised in Table 6.5.

Table 6.5: Questionnaire 5: Ipat Anxiety Scale

VARIABLE	INSTRUMENT	STRUCTURE	ITEMS	
Anxiety	IPAT Anxiety Scale	Q_3(-) Defective integration, lack of self sentiment	1, 2, 3, 4	21, 22, 23, 24
		C(-) Ego weakness, lack of ego strength	5, 6, 7	25, 26, 27
		L Suspiciousness or paranoid insecurity	8, 9	28, 29
		O Guilt proneness	10, 11, 12, 13, 14, 15	30, 31, 32, 33, 34, 35
		Q_4 Frustrative tension of Id pressure	16, 17, 18, 19, 20	36, 37, 38, 39, 40
			COVERT (Hidden)	OVERT (Symptomatic)

NOTE: For item descriptions see Annexure 5.

Source: Human Sciences Research Council (1979)

ii. Data processing and interpretation

Each question has three alternative answers. Responses are arranged so that left to right positions cannot affect the anxiety score. High score keyed responses are indicated by *'yes/true'* rather than disagreeing *'no/false'*. A higher score always means more anxiety. A single total anxiety score based on all 40 items is recommended for the majority of cases.

- An individual sten score of 1, 2 or 3 indicates stability, security and mental health generally.
- Sten scores of 4, 5, 6 and 7 fall into the 'normal' range; that is, no further particular enquiry is necessary if the individual shows no other signs of psychological difficulty. A sten score of 7 begins to be borderline high and requires monitoring.

- Sten score levels of 8, 9 and 10, if constant in repeated tests (for example, pre/post-tests of this study) indicate definite psychological morbidity, almost certain to have adverse effects on work and social-emotional adjustment. There is a definite need for counselling and guidance for situational or for problems regarding character (HSRC, 1979).

  Anxiety levels sometimes fluctuate markedly over time in any one person; these can be measured by the IPAT anxiety scale. Anxiety is only one aspect of personality but an important one.

  Part scores are not meant to stand alone in the interpretation as they are too brief and unreliable. They are useful leads to analyse various sources and expressions at any anxiety level.

Statistical methods and calculations

Descriptive statistics of item means and standard deviation for continuous data and percentages for categorical data were calculated. No factor analysis was done on the IPAT Anxiety Scale as the test was used for the clinical sample only and the surgical groups were too small in size to produce statistically valid results. The paired *t*-test was used to compare the pre- with the post-scores for each of the four clinical groups and for the clinical subsection which included breast oncology patients (n=3).

Reliability and validity

The IPAT Scale was developed from extensive research and practice in order to extract clinical anxiety information rapidly, objectively and in a standard manner. The scale gives an accurate appraisal of free anxiety level, supplementary clinical diagnosis and facilitating research (Cattell *et al.*, 1968). The reliability is reported in three types of co-efficients:

- test/re-test co-efficients (re-test after approximately two weeks)
- split half co-efficients
- co-efficients based on Ferguson's variation of the Kuder-Richardson's formula:20.

The test/re-test co-efficient is a measure of the reliability of the instrument as a whole. The reliability of the test is highly satisfactory and results of test/re-test applications are reported in Table 7, p.7 (Cattell *et al.*, 1968), for example 0,88 on a sample of n=85 English speaking girls.

The validity of the Anxiety Scale was tested in two ways:

- from the correlation scale with another instrument; that is, the adjustment questionnaire of the National Bureau of Social and Educational Research
- from estimating the square root of the split-half reliability.

In both cases a satisfactory level of construct validity was demonstrated.

6.4.4.4 Questionnaire 6: Sixteen Personality Factor Questionnaire (16 PF)(Cattell *et al.*(1957) American Authors adapted for use in South Africa by Madge & du Toit (1991))

This test was utilised in this study as it represents a summary of core personality traits which are universal and stable across all people. The test describes testees' personality and predict behaviour using a set of selected, structured items (Table 6.6). The universality of the tests is appropriate for the multi-cultural nature of the sample population used for this dissertation. However, there is still an urgent need for cross-culture knowledge about the value possibilities for application and validity of the 16 PF, when testing people originally not from Western cultures (Madge & du Toit, 1991). The rationale behind the 16 PF is that it is based on revealed traits of core personality variables which are universal and stable across all people, and is therefore capable of measuring reliability and validity of the true personality constructs present in humans (Prinsloo, 1991).

This questionnaire was used for the purpose of collecting information on the relationship of the following issues with relevant personality variables:

- the person's attitudes to her body image
- the successful outcome of elective cosmetic surgery
- how the person adapts to a changing society
- how the individual expresses her personality through clothes.

i. The Structure

The structure of the 16 PF is as follows:

- The general purpose of the 16 PF is to describe personality and predict behaviour using a set of selected, structured items through factor analysis. This is done by analysing the specific patterns of responses on the 16 first order, and the five and eight second order factors.
- The A form of the test consists of 187 items and is suitable for adults with a standard 10 or equivalent qualification.
- The 16 factors are a summary of core personality traits which are universal and stable across all people.

The structure and presentation of 16 PF questionnaire (Cattell *et al.*, 1957, adaptation for South Africa by Madge & du Toit, 1991) is summarised in Table 6.6.

ii. Data processing and interpretation

- Individuals respond by selecting one out of three given choices (a, b or c) for every question.
- The questionnaire has to be answered on a specific 16 PF answer sheet. Answer sheets are scored by hand or by means of an optical scanner.
- There is no fixed time duration for the test. The average time needed is between 40 - 60 minutes per form.
- Sten scores vary between 1 and 10. The average sten score is 5 and 6.
- The 187 items follow one another directly; there is no subdivision or sections to the questionnaire.
- The factors on the scoring stencils are marked with letters of the alphabet, i.e. A, B, C, E, F, G, H, I, L, M, N, O, Q_1, Q_2, Q_3, Q_4.

  The 16 PF test profile (Table 6.6) shows what characteristic each letter indicates, for example: FACTOR A: A low score description indicates reserved, detached, critical, cool characteristics. A high score description indicates outgoing, warm hearted, easy going, participating characteristics.

Statistical methods and calculations

The 16 PF Questionnaire was used for the clinical sample group only. Due to small sample sizes for each cosmetic surgical type, no factor analyses were computed. Descriptive statistics consisting of means and standard deviations for continuous data were calculated. Categorical data were calculated and values were given as percentages. Factor mean scores were compared pre- to post-test using the paired *t*-test for each surgical group and for the breast reconstruction patient in sub-section two.

Table 6.6: Questionnaire 6: 16 PF variable personality traits (Cattell *et al.* (1957) American authors, adaptation for South Africa by Madge & du Toit (1991))

FACTOR	LOW SCORE DESCRIPTION	HIGH SCORE DESCRIPTION
A	Reserved, detached, critical cool (Sizothymia)	Outgoing, warmhearted, easy-going, participating (Cyclothymia)
B	Less intelligent, concrete-thinking (Lower scholastic mental capacity)	More intelligent, abstract-thinking, bright (Higher scholastic mental capacity)
C	Affected by feelings, emotionally less stable, easily upset (Lower ego strength)	Emotionally stable, faces reality, calm (Higher ego strength)
E	Humble, mild, obedient, conforming (Submissiveness)	Assertive, independent, aggressive, stubborn (Dominance)
F	Sober, prudent, serious, taciturn (Desurgency)	Happy-go-lucky, heedless, gay, enthusiastic (Surgency)
G	Expedient, a law to himself, by-passes obligations (Weaker superego strength)	Conscientious, persevering, staid, rule-bound (Stronger superego strength)
H	Shy, restrained, diffident, timid (Threctia)	Venturesome, socially bold, uninhibited, spontaneous (Parmia)
I	Tough-minded, self-reliant, realistic, no-nonsense (Harria)	Tender-minded, dependent, over-protected, sensitive (Premsia)
L	Trusting, adaptable, free of jealousy, easy to get on with (Alaxia)	Suspicious, self-opinionated, hard to fool (Protension)
M	Practical, careful, conventional, regulated by external realities, proper (Praxernia)	Imaginitive, wrapped up in inner urgencies, careless of practical matters, bohemian (Autia)
N	Forthright, natural, artless, sentimental (Artlessness)	Shrewd, calculating, worldly, penetrating (Shrewdness)
O	Placid, self-assured, confident, serene (Untroubled adequacy)	Apprehensive, worrying, depressive, troubled (Guilt proneness)
Q_1	Conservative, respecting established ideas, tolerant of traditional difficulties (Conservatism)	Experimenting, critical, liberal, analytical, free-thinking (Radicalism)
Q_2	Group-dependent, a 'joiner' and sound follower (Group adherence)	Self-sufficient, prefers own decisions, resourceful (Self-sufficiency)
Q_3	Casual, careless of protocol, untidy, follows own urges (Low integration)	Controlled, socially-precise, self-disciplined, compulsive (Higher self-concept control)
Q_4	Relaxed, tranquil, torpid, unfrustrated (Low ergic tension)	Tense, driven, overwrought, fretful (High ergic tension)

Reliability and validity

The 16 PF has been revised many times with the outcome of a variety of different forms of the test. The South African adaptation has been utilised for this dissertation. The final 16 factors of the 16 PF were obtained by grouping large numbers of descriptions through factor analysis and were seen as a reliable summary of core personality traits which are stable across cultures (Prinsloo, 1991). The broad based practical application of the 16 PF highlights the test's validity as a measuring instrument in a variety of settings; that is, career and industrial situations, marital and family therapy, clinical settings and for research and academic applications. Reliability coefficients based on the Kuger-Richarson 8-reliability are given for specific scales or factors. The tables used for this dissertation were Table 2, p.13 (n=12) and Table 16, p.27 (n=221). The author (Prinsloo, 1991) cautions that there is an urgent need for further cross-cultural knowledge on the value and possibilities for application on validity of the 16 PF, specifically concerning people from non-Western backgrounds.

6.5 DATA COLLECTION FOR SUBPROBLEMS THREE AND FIVE

The third and fifth subproblems evaluated people's attitudes to their clothing behaviour and body image in terms of socio-cultural norms for codes of fashionable dress and figure shape. Post-surgical attitudes to a changed physical appearance and any related change in dress was deemed significant in subproblems three and five.

The data needed for testing the hypothesis of subproblems three and five were obtained from the answers to standardised Questionnaires 3, 4 and 5 (Annexures 3, 4 and 5) shown in Table 6.2 under subproblems three and five.

Questionnaires1, 5 and 6 have been described in 6.4.4.1 - 6.4.4.4 for both the clinical and non-clinical sample groups.

6.5.1 Sample selection

The sample selection for subproblems three and five questionnaires 3 and 4 are discussed in 6.3. The sample selection was the same for both the clinical and non-clinical groups.

Table 6.7: Questionnaire 3: Creekmore Scales of Eight Clothing Variables

VARIABLE	INSTRUMENT	STRUCTURE	ITEMS
Clothing behaviour	Creekmore scale of eight clothing variables	Free standing	1
		Aesthetics	2, 3, 4, 5, 6, 7, 8, 9 10, 11, 12, 13
		Interest	14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25
		Comfort	26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36
		Attention	37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47
		Approval	48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59
		Modesty	60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70

NOTE: For item descriptions see Annexure 3

Source: Creekmore (1971)

6.5.2 Administration of the data capturing

The administration for questionnaires 3 and 4 (subproblems three and five) were the same as for those administered for subproblem one (6.4.1.1(i), i.e. Questionnaires 1, 2, 5 and 6). All six questionnaires were administered simultaneously for the pre-test and later for the post-test under the conditions described in 3.3.2. For the non-clinical sample questionnaires 3 and 4 were administered simultaneously with questionnaires 1 and 2 (see 6.4.1.1(ii)). For the non-clinical sample only one test was required and no time limits were imposed.

6.5.3 Description of the instruments

6.5.3.1 The objectives were twofold:

- to determine various socio-cultural variables, for example, the level of social acceptance experience by a person.
- to assess the person's perceived sense of belonging in a group due to:
    - change in physical appearance through elective cosmetic surgery (clinical sample)
    - change in clothing behaviour due to elective cosmetic surgery
    - identify attitudes toward clothing behaviour in relation to the socio-cultural norms for fashionable dress in the non-clinical (that is, fashion) sample.

i. Independent variables:

Independent variables remain the same as for the testing of hypothesis 1 (5.2.1).

ii. Dependent variables:

Data analysis revealed attitudes to the following variables in terms of the level of satisfaction or dissatisfaction with:

- post-surgical change in body image
- clothing behaviour in relation to a changed physical appearance
- clothing behaviour, where elective cosmetic surgery has not been administered
- fashionable codes of dress.

6.5.4 Choice of questionnaires: structure and processing

6.5.4.1 Questionnaire 3: Creekmore's (1971) Methods of Measuring Clothing Variables (Annexure) (Table 6.4)

This study entailed a consideration of how changes to body image attitude affect clothing behaviour and how a sense of social acceptance is affected by clothing behaviour. The importance underlying the investigation into clothing variables is the role clothing plays in enhancing the level of self-confidence of the individual. According to Gurel and Gurel (1979), Creekmore's (1971) test for measuring clothing variables is the most comprehensive and most thoroughly investigated item pool available. Questionnaire 3 (Creekmore, 1971) was utilised in this study on the basis of its recommended comprehensiveness and consistency in measuring clothing behaviour.

i. The structure consists of the following sections:

- An 89 item clothing inventory
- Out of eight interpretable factors, five were seen as central components of clothing interest:
  - * concern with personal appearance
  - * experimenting with appearance
  - * heightened awareness of clothes
  - * clothing as enhancement of security
  - * clothing as enhancement of individuality.
- The remaining three dimensions — conformity, modesty and attention to comfort — are interpreted as primarily personality variables (Creekmore, 1968).

Table 6.7 represents a summary of one of the measuring instruments used to collect data for subproblems three and five; that is, methods of measuring clothing variables.

ii. Data measurement and interpretation

The instrument entitled 'Importance of Clothing' consists of eight separate scales. Each Likert scale is composed of 11 statements. In order to limit the length of the questionnaire, dependency and management were omitted. An alpha coefficient was used for the remaining items or factors. Responses to the statements are made on a 5-point scale from *almost always* (score 5) to *almost never* (score 1). The five-point scale indicates how much or how little of the attitude or actions of the specific item is performed. Statistical results for this study are tabled in 6.7. Six specific aspects of clothing included for measurement were:

- Aesthetics
- Attention
- Comfort
- Interest
- Modesty

These variables express the following patterns of clothing behaviour:

- Aesthetics: clothing behaviour is used to achieve a pleasing or beautiful appearance.
- Approval: clothing behaviour is used to attain the approval of others, usually indicates conformity to group norms.
- Attention: the seeking of prestige or status through the use of clothing.
- Comfort: the use of clothing to achieve comfort, i.e. tightness, looseness, response to textures, temperature.

- Interest: willingness to give attention, investigate, manipulate or experiment with clothing.
- Modesty: preference for inconspicuous clothing, quite conservative in colour, fit, design and body exposure.

A high score on these variables would indicate frequent occurrence of the behaviour being measured.

Statistical methods and calculations

Descriptive statistics consisting of means and standard deviations for continuous data and percentages for categorical data were calculated for all groups on Questionnaire Three for subproblems three and five. Factor analysis was done on the non-clinical sample for questionnaire three only. The input for the factor analysis was a correlation matrix, and a principal component analysis was used for factor extraction. Common factors were rotated using a varimax rotation method. Factors with eigen values greater than one were included in the analysis. This procedure was not done on the clinical groups due to small numbers. The unpaired *t*-test was used to compare the Black and White sample groups and a paired *t*-test was used to compare pre- with post- scores for each clinical group.

Reliability and validity

Creekmore (1971) reported analyses of the responses of n=236 boys and n=269 girls. Hoyt's analysis of variance method for estimating reliability of responses was used. The reliability for the scale for girls ranged from the highest, 0,77 for *interest* to 0,46 for *aesthetics* (estimated reliability co-efficients for responses of girls and boys, p.98). The item total co-efficient ranged from 0,07 to 0,75 and the discriminatory power of the statements ranged from 0,42 to 2,30. Fetterman concluded that five of the eight scales attained satisfactory reliability co-efficients. The most satisfactory were, *interest, dependence, attention, approval* and *modesty* scales. Validity was established by comparing subjects' scores on each aspect of clothing with a rank ordering or descriptive phrases.

6.5.4.2 Questionnaire 4: Private and Public Self-Consciousness Assessment and Theory (Fennigstein *et al.*, 1975) (Annexure 4).

The importance of this test for the study was found in the notion that self-awareness is a central concept in several divergent approaches to behaviour and life. Within the South African context and present stage of transition where change is a rapid process, a sense of belonging or acceptance becomes a vital aspect of a person's sense of well-being. The private and public self-consciousness scale measures individual differences in self-consciousness and social behaviour.

i. Structure

The questionnaire consists of 23 items divided into three sections. Two sections represent separate aspects of self-consciousness:

- Private self-consciousness, which are private deliberations over the self
- Public self-consciousness, which is concern over the self as a social stimulus
- Social anxiety.

Public self-consciousness may be a necessary antecedent of social anxiety. Self-awareness does not necessarily imply social anxiety (Fennigstein *et al.*, 1975). The following division of sections is noted:

- Private self-consciousness (10 items)
- Public self-consciousness (7 items)
- Social anxiety (6 items).

Table 6.8: Questionnaire 4: Private and Public Self-consciousness

VARIABLE	INSTRUMENT	STRUCTURE	ITEMS
Self-consciousness scale	Scale of measuring private and public self-consciousness	Private self-consciousness	1, 3, 5, 7, 9, 13, 15, 18, 20, 22
		Public self-consciousness	2, 6, 11, 14, 17, 19, 21
		Social anxiety	4, 8, 10, 12, 16, 23

Note: For item descriptions see Annexure 4

Source: Compiled from Fenigstein, Scheier and Buss (1975).

ii. Data measurement and interpretation

Each item is rated on a scale of four, ranging from (1) *extremely uncharacteristic* to (4) *extremely characteristic*. A high score indicates a high level of self-consciousness. Self-conscious persons closely examine their beliefs and feelings. A low score indicates less of the characteristic being measured; less private and/or public self-consciousness.

Statistical methods and calculations

The same statistical methods and calculations applied to Questionnaire 4 as described in 6.5.4.2 for Questionnaire 3. However no factor analyses were computed for the 23 item scale.

Reliability and validity

In a study done by Fenigstein *et al.* (1975), reliability was calculated by administering the test (Public and Private self-consciousness: Questionnaire 4) to a sample of 84 subjects who completed the scale twice within a two-week interval between administration.

Test/re-test correlations for the sub-scales were:

- Public self-confidence: 0,84
- Private self-consciousness: 0,79
- Social anxiety: 0,73
- Total score: 0,80.

These correlations established that the scale and sub-scales were reasonably reliable; that is, they demonstrated the stability of individual scores over time.

Validity. It was found that correlations in the study done by Fenigstein *et al.* (1975) remained stable in replication studies; that is, firstly to n=179 males and n=233 females and secondly to another sample of n=152 college undergraduates.

6.5.5 Case study methodology: Sub-section two – Oncological aspects of physical appearance for three case studies

Three patients, who underwent different types of surgery for breast cancer, were selected as single case studies in order to illustrate the effects of either lumpectomy, mastectomy, or breast reconstruction on physical appearance and clothing behaviour variables.

The smallness of the sample (n=3) did not permit extensive statistical analyses. However, the six standardised questionnaires used for this study (Annexures 1 - 6) permitted the use of an in-depth descriptive method. Research has revealed that the value of the information gained through a careful analysis of single cases, may contribute to the completeness of the overall picture. New tendencies may be revealed which hold clinical rather than statistical significance (Rachman, 1980; Edward & Talbot, 1994; Snyman & Storm, 1994). Moreover, the evaluation of an outcome in the individual case is the keystone to good clinical practice (Rachman, 1980).

Part of the main goal of surgery, specifically cosmetic or reconstruction surgery, is to enable the patient to attain psychological wholeness. Quality pre-test data assessment and understanding

may assist in attaining this goal (Edwards & Talbot, 1994). Post-surgical differences in attitudes and perceptions would permit a fine-tuned exploration of the complex sets of interrelationships among the various variables.

6.6 PILOT STUDY

Having selected the standardised instruments and relative questionnaires (described in 6.4 - 6.5) to be used in the study, the research process was pre-tested in a pilot study. The sample selection is described in Table 6.9.

Table 6.9: Summary of the sample distribution

SAMPLE GROUP	TYPE OF SURGERY	SAMPLE SIZE
Clinical sample	Augmentation mammaplasty	n = 4
	Reduction mammaplasty	n = 5
	Abdominoplasty	n = 3
	Rhytidectomy	n = 3
	Breast reconstruction, mastectomy and lumpectomy	n = 3
	CULTURAL GROUPS	
Non-Clinical group	Black	n = 5
	White	n = 5

6.6.1 The sample selection procedure

The administration procedure of the data capturing, the realisation of the sample and the interview procedure were strictly adhered to as described in 6.2 - 6.4.2.

6.7 REPORT ON THE PILOT STUDY

All questionnaires were personally administered in order to establish whether all respondents interpreted the questions in the same way. Comments were invited from the participants in order to constructively criticise the data collection process and to make the necessary adjustments. It was established during the pilot study that each interview would take approximately one hour and thirty minutes to complete for the clinical sample group (Questionnaires 1 - 6). The non-clinical sample group (fashion) would take approximately one hour (Questionnaires 1 - 4).

Although some negative comments were made on the length of time taken to complete the questionnaires, no suggestions were made to omit any questions and no patients wanted to

withdraw on account of tiredness. Most patients showed an intense interest to complete the full set of questionnaires. It was decided on this basis to administer the questionnaire set in its entirety for the full duration of the interview process.

CHAPTER SEVEN
RESULTS

7.1 INTRODUCTION

The results reported in chapter 7 were obtained by utilising the various methods described in chapter 6. The data were then analysed using descriptive and parametric statistics and summarised in the various tables and figures presented in this chapter. It is important to note that due to the small sample sizes for the augmentation mammaplasty (n=7), abdominoplasty (n=3) and rhytidectomy (n=3) patients, the results indicate trends rather than statistically significant mean differences. It is understood that any other group of three patients for abdominoplasty, rhytidectomy or augmentation mammaplasty surgery could yield statistically more meaningful results and a larger sample size could yield statistically significant results. The nature of this study precluded a readily available sample for the specific stage and time allocated for sampling.

7.2 DEMOGRAPHIC DATA

Descriptive statistics of means and standard deviations were calculated for the demographic data of the clinical and non-clinical subjects. Table 7.1 reports the distribution of mean ages for the clinical and non-clinical sample groups.

The mean ages for the non-clinical sample were 24,9 and 24,0 years for the 30 Black and 30 White subjects respectively. The clinical sample was categorised into four types of surgical procedures. The largest group, reduction mammaplasty, consisted of 12 subjects. The smallest groups, abdominoplasty and rhytidectomy, consisted of three subjects each. The sample group for augmentation mammaplasty comprised seven subjects. No distinctions between the Black and White subjects were made for the age variable among the clinical sample subjects. The mean ages for the clinical sample ranged from 31 years to 43 years. The lowest and the highest means were for reduction mammaplasty (31 years) and abdominoplasty (43 years) respectively. The mean age for augmentation mammaplasty was 35,7 years and for rhytidectomy 38,0 years. The investigation for augmentation mammaplasty patients by Schlebusch and Mahrt (1993) showed a comparable mean age for this surgical group of 34,5 years.

Distribution of frequencies and percentages are shown in Table 7.2 for the non-clinical subjects of 30 Black and 30 White women for demographic variables of culture, education and language. The cultural distribution of subjects was 30 Black and 30 White women. An educational level of less than matric was obtained by one Black subject (3,3%) and one White

subject (3,3%). More Whites 19 (63,3%) than Blacks, 14 (46,7%) held matric certificates. A higher average for tertiary level education was recorded for the Black sample, 11 (36,7%) whereas eight (23,3%) of the White subjects held a certificate or diploma. Of the sample group, four (13,3%) Blacks and three (3,3%) Whites held a degree or part degree. Twenty-five (83,3%) Black subjects and one (3,3%) White subject stated African languages (not specified) as their home language. None of the Black subjects stated Afrikaans as a home language whereas Afrikaans was a home language for three (10%) of the White sample group. Three (10%) of the Blacks 25 (83,3%) of the Whites stated English as a home language. Unclassified languages were stated as home languages for two (6,7%) of the Black subjects and one (3,3%) of the White subjects.

Table 7.1: Questionnaire 1: Demographic data of the mean ages for the non-clinical sample of 30 Black and 30 White women, and a clinical sample of 25 women.

Sample Type	Sample Category		n Sample size	*M* Age	*SD* Age
Non-clinical	Black		30	24,9	5,90
	White		30	24,0	7,80
		TOTAL	60		
	RM		12	31,3	10,20
	AM		7	35,7	10,40
	ABD		3	43,3	7,30
	RHY		3	38,0	7,00
		TOTAL	25		

RM=Reduction mammaplasty; AM=Augmentation mammaplasty; ABD=Abdominoplasty; RHY=Rhytidectomy, *M* =Mean, *SD* =Standard Deviation

Table 7.2: Questionnaire 1: Demographic data of frequencies and percentages for the non-clinical sample of 30 Black and 30 White women

		Black fashion		White fashion	
Variable	Item	Frequency	%	Frequency	%
Cultural	Black	30	100,0		
Group	White			30	100,0
Educational	Less than matric				
Qualification	Matric	1	3,3	1	3,3
	Certificate or Diploma	14	46,7	19	63,3
	Degree/Part Degree	11	36,7	7	23,3
		4	13,3	3	3,3
	TOTAL	30	100,0	30	100,0
Home	African Language	25	83,3	1	3,3
Language	Afrikaans	0	0	3	10,0
	English	3	10,0	25	83,3
	Other	2	6,7	1	3,3
	TOTAL	30	100,0	30 30	100,0

Table 7.3: Questionnaire 1: Demographic data of frequencies and percentages for the clinical sample of 25 women

			RM (n=12)		AM (n=7)		ABD (n=3)		RHY (n=3)	
Variable	Item		Frequency	%	Frequency	%	Frequency	%	Frequency	%
Cultural Group	Black		2	16,7	0	000,0	0	000,0	1	33,3
	White		10	83,3	7	100,0	3	100,0	2	66,7
		TOTAL	12	100,0	7	100,0	3	100,0	3	100,0
Educational Qualification	Less than matric		2	16,6	4	57,1	1	33,3	0	000,0
	Matric		5	41,7	2	28,6	1	33,3	1	33,3
	Certificate or Diploma		5	41,7	1	14,3	1	33,3	2	66,7
	Degree/Part Degree		0	00,0	0	00,0	0	00,0	0	00,0
		TOTAL	12	100,0	7	100,0	3	100,0	3	100,0
Home Language	African Languages								1	33,3
	Afrikaans									
	English		12	100,0	7	100,0	3	100,0	2	66,7
	Other									
		TOTAL	12	100,0	7	100,0	3	100,0	3	100,0

RM= Reduction Mammaplasty; AM= Augmentation mammaplasty; ABD= Abdominoplasty; RHY= Rhytidectomy

Distribution of frequencies and percentages is shown in Table 7.3 for the clinical subjects, three Black and 22 White women (n=25) for the variables, cultural group, educational qualifications and home language. The cultural distribution for reduction mammaplasty was two Blacks (16,7%) and ten Whites (83,3%). All seven subjects (100%) for augmentation mammaplasty were White. Three White subjects (100%) underwent abdominoplasty, and two Whites (66,7%) and one Black subject (33,3%) elected rhytidectomy. An educational level of less than matric resulted for two reduction mammaplasty subjects (18,2%), four augmentation mammaplasty patients (57,1%) and one abdominoplasty (33,3%). Five reduction mammaplasty subjects (45,5%) held matric certificates, whereas two augmentation mammaplasty subjects (28,6%), one abdominoplasty subject (33,3%) and one rhytidectomy subject (33,3%) each held matric certificates. Certificates or diplomas were held by five reduction mammaplasty patients (36,4%), one augmentation mammaplasty patient (14,3%), one abdominoplasty patient (33,3%) and two rhytidectomy patients (66,7%). English as a home language was spoken by all 12 reduction mammaplasty subjects (100%), all seven augmentation mammaplasty subjects (100%) and all three abdominoplasty patients (100%). One rhytidectomy subject (33,3%) cited an African language (non-specified) as her home language while English was the language medium for the two (66,7%) other rhytidectomy subjects.

7.3 ANALYSES OF THE DATA FOR SUBPROBLEMS ONE AND TWO FOR THE CLINICAL (n=25) AND THE NON-CLINICAL (n=60) SAMPLES

Questionnaires 1 and 2 were used for both sample groups to measure body image attitudes and strength of identity respectively. Questionnaires 5 and 6 were used to measure the level of anxiety and personality variables for the clinical sample only.

7.3.1 Clinical sample group

Questionnaire 1, the Multidimensional body self-relation Questionnaire (Cash *et al.*, 1986; Cash 1990) referred to as the MBSRQ (6.4.4.1) was used to measure the body image attitudes of all four surgical groups, reduction mammaplasty, augmentation mammaplasty, abdominoplasty and rhytidectomy. The impact of elective cosmetic surgery on subjects' body image attitudes may be observed from the pre-test, post-test means over a range of sixteen factors reported in Table 7.4.

Table 7.4: Questionnaire 1: Comparative pre-/post-operative factor means and standard deviations of body image attitudes obtained by the clinical sample of 25 women

	RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)		
Tests	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Factors	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
1. APPEFV	3,13(1,03)	3,60(0,78)	0,03*	3,06(0,60)	3,31(0,42)	0,27	2,14(0,66)	4,05(0,79)	0,04*	3,62(0,50)	3,91(0,58)	0,63
2. APPORF	4,03(0,48)	4,00(0,50)	0,71	3,83(0,56)	3,64(0,70)	0,20	4,11(0,43)	3,83(1,30)	0,60	4,18(0,80)	4,33(0,58)	0,32
3. FITEVF	3,44(0,88)	3,67(0,84)	0,04*	3,52(0,54)	3,52(0,66)	1,00	4,00(0,00)	3,78(0,19)	0,18	3,67(1,20)	4,22(0,77)	0,20
4. FITORF	2,85(1,03)	3,16(0,93)	0,02*	3,03(0,31)	3,01(0,68)	0,92	2,97(0,22)	3,08(0,27)	0,75	3,28(0,77)	3,28(0,62)	1,00
5. HEAVF	3,94(0,47)	3,75(0,51)	0,16	3,76(0,70)	3,86(0,70)	0,46	4,00(0,18)	3,83(0,73)	0,67	3,28(1,07)	4,33(0,33)	0,31
6. HEAORF	3,85(0,66)	3,73(0,65)	0,37	3,48(0,61)	3,48(0,81)	1,00	4,13(0,98)	3,54(0,13)	0,56	4,33(0,51)	3,96(1,13)	0,45
7. ILLORF	3,23(1,03)	3,33(0,98)	0,65	2,66(0,64)	2,94(1,11)	0,49	4,13(0,81)	3,73(0,70)	0,60	3,20(0,87)	3,53(0,70)	0,42
8. BASS	3,16(0,61)	3,64(0,56)	0,00*	2,95(0,54)	3,41(0,86)	0,24	2,80(0,38)	3,71(0,62)	0,03*	3,13(0,70)	3,92(0,44)	0,31
9. APPSAT	3,67(0,99)	4,18(0,52)	0,96	3,14(0,90)	3,86(0,90)	0,01*	3,33(0,58)	4,00(0,00)	0,18	3,00(1,00)	4,00(0,00)	0,23
12. WTSAT	3,00(1,35)	3,25(1,29)	0,19	3,29(1,38)	3,29(1,25)	1,00	3,33(0,58)	4,33(0,58)	0,00	2,67(1,53)	4,33(0,58)	0,30
11. WTVIGIL	3,92(1,17)	3,75(1,22)	0,62	3,29(1,25)	3,43(1,13)	0,60	4,33(1,16)	4,00(1,00)	0,74	3,67(2,31)	3,67(1,53)	1,00
10. FATANX	4,33(0,99)	3,83(0,84)	0,03*	2,57(1,72)	3,00(1,73)	0,51	4,67(0,58)	3,67(0,58)	0,26	3,67(2,31)	4,33(1,16)	0,42
13. DIET	3,42(1,83)	2,83(1,80)	0,28	1,57(0,98)	1,14(0,38)	0,36	2,67(2,08)	2,33(2,31)	0,42	2,33(1,53)	2,00(1,00)	0,84
14. RSTRN	2,67(1,50)	2,33(1,23)	0,10	1,14(0,39)	1,43(0,79)	0,17	2,67(2,08)	2,00(1,73)	0,18	2,67(2,08)	2,67(0,58)	1,00
15. WTLABEL	3,58(0,60)	3,46(0,54)	0,20	2,29(0,81)	2,50(0,87)	0,08	3,83(0,29)	3,33(0,58)	0,23	2,67(0,58)	3,00(0,00)	0,42
16. WTPREOC	3,58(0,93)	3,19(0,77)	0,00	2,14(0,80)	2,50(0,82)	0,00	3,58(1,38)	3,00(1,32)	0,00	3,08(1,91)	3,17(0,38)	0,00

RM = Reduction Mammaplasty; AM= Augmentation mammaplasty; ABD = Abdominoplasty; RHY = Rhytidectomy

* Significant values

Note: For factor descriptions see Annexure 1 and Table 7.3

The impact of elective cosmetic surgery on subjects' body image attitudes was observed from the comparative pre-test, post-test means and standard deviations scores presented in Table 7.4. Emphasis was placed on statistically valid mean differences in order to interpret and understand patients' perceptions of an altered body image.

Factor One: Appearance evaluation. Significant mean differences were observed for reduction mammaplasty and abdominoplasty patients only. The pre-test mean score $\underline{M}$ = 3,13 for the reduction mammaplasty patients was below the average reported by Cash *et al.* (1986) for a non-surgical female sample (n = 1070) $\underline{M(SD)}$ = 3,38(0,85). The increased post-test score was indicative of reduction mammaplasty and abdominoplasty patients' more positive attitude to how they perceived the changes to physical appearance after surgery. The post-test $\underline{M\ (SD)}$ = 2,14(0,66) for the abdominoplasty patients fell above the average reported by Cash *et al.* (1986), where $\underline{M\ (SD)}$ = 3,38(0,85) for a sample size of n = 1070.

No statistically significant mean differences were observed for *Factor two: Appearance Orientation*. No difference in pre-test, post-test mean scores could indicate that patients dedicated similar amounts of time, attention and importance to their physical appearance before and after elective cosmetic surgery.

A significant mean difference was observed for the reduction mammaplasty (n = 12) sample on *Factor Three*. This result indicated that an increased level of fitness evaluation was experienced by reduction mammaplasty patients after the weight of excess breast mass had been surgically reduced.

Factor Four: Fitness orientation. A significant mean difference was observed for the reduction mammaplasty (n=12) sample. The post-operative $\underline{M(SD)}$ = 3,16(0,93) was above the mean recorded for the non-clinical female sample n = 1070 by Cash *et al.* (1986). Post-operatively patients appeared to gain renewed interest in sport and physical fitness programmes and to the attention and importance they placed on their strength and athletic skills. An increased fitness orientation level forms part of a positive body image attitude.

Patients for all four groups, reduction mammaplasty, augmentation mammaplasty, abdominoplasty, rhytidectomy showed no statistically significant difference to the importance and attention they placed on their health, or the manner in which they evaluated health issues after cosmetic surgery (*Factors Five and Six*). Patients appeared to rate the time, importance and attention they paid to signs and symptoms of illness equally before and after surgery, for example, the scores for reduction mammaplasty patients (n = 12) were $\underline{M(SD)}$ = 3,23(1,03) pre-test and $\underline{M(SD)}$ = 3,20(0,87) post-test.

A marginal change in attitude toward positive body areas satisfaction, *Factor Eight*, was observed for the reduction mammaplasty patients (n = 12), post-surgically. A significant mean

difference was also noted for the abdominoplasty sample (n = 3) on body areas satisfaction. Subjects appeared to feel more satisfied post-operatively across eight body area items: face, hair, lower, mid and upper torso, muscle tone and weight. For item 69 on the MBSRQ (Cash *et al.*, 1986) a significant pre-/post-test mean difference indicated a higher level of satisfaction with overall appearance for the reduction mammaplasty and abdominoplasty sample alike. It is important to note, however, that the post-operative means for both these sample groups were below the mean recorded for the non-clinical sample (n = 1070F) by Cash *et al.* (1986) where $\underline{M(SD)}$ = 3,80(0,88).

A marginal difference in pre-test, post-test $\underline{M(SD)}$scores was obtained for reduction mammaplasty (n=12) subjects (Table 7.4). Indications were that patients experienced an increase in appearance satisfaction due to a smaller breast size.

Increased post-surgical mean scores obtained may be indicative of more post-operative appearance satisfaction. The abdominoplasty (n = 3) sample, post-operative $\underline{M(SD)}$ scores also increased for *Factor Nine: Appearance satisfaction*. The post-test mean scores for all three groups, reduction mammaplasty, rhytidectomy and abdominoplasty of $\underline{M}$ = 4,18, $\underline{M}$ = 4,00 and $\underline{M}$ = 4,00 respectively, were higher than the mean recorded for the non-clinical female sample (n = 1070) by Cash *et al.* (1986).

Subjects' fat anxiety level, *Factor Ten*, remained constant before and after surgery for all four surgical groups, reduction mammaplasty, augmentation mammaplasty, abdominoplasty, rhytidectomy, as shown in Table 7.4. No significant mean differences were recorded for changes in anxiety level about perceived fatness or for weight vigilance (*Factor Eleven*).

A significant difference pre- and post-surgery for attitudes towards weight satisfaction (*Factor Twelve*) was recorded for the reduction mammaplasty (n = 12) subjects, with $\underline{M(SD)}$ = 3,00(1,35) pre-test and $\underline{M(SD)}$ = 3,25(1,29) post-test, $P< |t| = 0,03$. Reduced breast size and weight appeared to satisfy reduction mammaplasty patients with regard to their overall weight experience and perception.

All clinical subjects' (n = 25) attitudes towards diet and weight related issues, *Factors Thirteen, Fourteen, Fifteen and Sixteen,* appeared to remain constant before and after surgery with no significant mean differences recorded. The indications appeared to be that subjects had similar attitudes about weight changes, becoming fat and dieting after surgery, as they had before surgery. These last four factors constitute the new weight preoccupation scale. Cash's (1990) study reported means which ranged from $\underline{M(SD)}$ = 1,93(1,12) for restraint to $\underline{M(SD)}$ = 3,85(1,27) for weight consciousness for a female sample of (n = 1070). Similar means were recorded for the clinical sample groups (n = 25) as shown in Table 7.4. For example, for pre-test scores on restraint $\underline{M(SD)}$ scores 1,14(0,39) for augmentation mammaplasty patients (n = 3) and

3,92(1,17) for reduction mammaplasty (n = 12) on *Factor Eleven: Weight Vigilance* (i.e. weight consciousness, Cash, 1990).

Although positive changes in body images perceptions seemed to occur, these were not always statistically significant for the rhytidectomy and augmentation mammaplasty patients. As previously explained (7.1), results on parametric tests on such a small sample size must be treated with great caution.

7.4 ANALYSES OF THE DATA FOR SUBPROBLEM TWO FOR THE NON-CLINICAL SAMPLE (n = 60)

Questionnaires 1 and 2 were used to measure attitudes toward body image and strength of identity for the non-clinical sample. Unlike the clinical sample, Questionnaire 5, for measuring the level of anxiety, and Questionnaire 6, 16 PF Questionnaire were not used for this sample.

7.4.1 The non-clinical sample

Attitudes towards body image were measured using the Multidimensional body self-relation questionnaire (Cash *et al.*, 1986; Cash, 1990) for both the Black sample (n = 30) and the White sample (n = 30). Means and standard deviations and results of an unpaired *t*-test over a range of sixteen factors are shown in Table 7.5.

Table 7.5 shows that significant differences between the means on an unpaired *t*-test to measure body image perceptions were noted in *Factor Seven: Illness orientatio;, Factor Eleven: Weight vigilance; Factor Thirteen: Fat anxiety; Factor Sixteen: Weight preoccupation;* and a marginal difference was observed for *Factor Six: Health orientation.*

Factor Seven: Illness orientation. Black women subjects showed a greater extent of reactivity to being or becoming ill than White women subjects, $\underline{M(SD)}$ = 3,97(0,72) and 3,22(0,96), $P<|t| = 0{,}001$. The indications were that the Black women sample were more alert to personal symptoms of physical illness and show heightened concern about seeking medical attention. A higher mean value for weight vigilance, *Factor Eleven*, for the Black female sample reflected a greater concern and awareness of even small changes in weight than for the White female sample.

Table 7.5: Questionnaire 1: Comparative mean and standard deviation scores for the unpaired *t*-test procedure on body image attitude obtained by the non-clinical sample group of 30 Black and 30 White women.

	Black		White		
Factors	*M*	*SD*	*M*	*SD*	P>|t|
1. APPEFV	3,70	0,58	3,47	0,69	0,17
2. APPORF	4,07	0,43	4,10	0,53	0,80
3. FITEVF	3,58	0,65	3,76	0,53	0,24
4. FITORF	3,53	0,49	3,38	0,71	0,39
5. HEAVF	3,64	0,63	3,93	0,86	0,14
6. HEAORF	4.08	0,55	3,81	0,55	0,07
7. ILLORF	3,97	0,72	3,22	0,96	0,001*
8. BASS	3,53	0,59	3,41	0,57	0,42
9. APPSAT	3,97	0,93	3,77	0,57	0,32
10. WTSAT	2,87	1,36	3,20	1,03	0,29
11. WTVIGIL	4,27	1,05	3,37	1,27	0,01*
12. DIET	2,77	1,63	1,87	1,04	0,01*
13. FATANX	4,70	0,79	3,73	1,14	0,01*
14. RSTRN	2,40	1,16	2,20	1,27	0,53
15. WTLABEL	3,35	0,68	3,27	0,59	0,62
16. WTPREOC	3,53	0,83	2,79	0,97	0,01

* Significant values

Note: For factor explanations see Annexure I and Table 7.3

Fat anxiety, *Factor Thirteen*, reflected a significant mean difference for the Black sample *M(SD)* = 4,70(0,79) compared with the White sample *M(SD)* = 3,73(1,14), P<|t| = 0,003. The extent of Black and White subjects' emotional apprehension about becoming fat was higher than the norm shown by Cash *et al.* (1986), *M(SD)* = 3,60(1,39) (n = 1070F) for a non-clinical sample of American women. Anxiety about becoming fat was highest for the Black sample in both the South African and American examples discussed.

Factor Sixteen: Weight preoccupation incorporates items concerning dieting, eating restraint and extent of weight watching. A significant difference between the means of the Black and White female samples, indicated the persistent and greater concern by Black subjects about becoming overweight.

A marginal difference in the mean scores between the Black and White sample groups was also evident for *Factor Six: Health orientation*. Heightened awareness about health-related matters was apparent for the Black female sample. The remaining factors shown in Table 7.5 showed no significant mean differences in perceived body images between the Black and White non-clinical subjects.

7.5 PRINCIPAL COMPONENTS ANALYSES: NON-CLINICAL BLACK AND WHITE FEMALE SAMPLE GROUPS

7.5.1 Attitude toward body image

The results of a principal components' analysis on attitude toward body images using a varimax rotation are presented in Tables 7.6 and 7.7 for the Black (n = 30) and White (n = 30) samples respectively. The new emergent factors for the two sample groups differed from each other, and from the original conceptual scoring of the MBSRQ (Cash *et al.*, 1986; Cash, 1990). All factors with eigen values >1 were documented in order to extract new information on subjects' perceptions of body image (dependent variable) in relations to demographic variables of culture, age and sex (independent variables). As the item numbers become increasingly fewer for each factor, the information becomes less clear and more confused. For this reason, results of the first eight to twelve factors are given or the equivalent number to the original standardised test, for example, the Multidimensional body self-relation questionnaire (Cash, 1986; Cash, 1990) contained sixteen factors. The new factor analysis contained twenty factors for the Black female sample and seventeen for the White female sample. Significant factors according to the Scree graph are reported. Results for the remaining factors are available from the researcher on request.

Table 7.6 comprised 20 factors related to body images. After factor 20, less than 1% of the variance could be explained. Eigen values reflected the relative importance of factors that were >1. The first factor explained the most variance. The variance ranged from 13% to 0,2 % and 96% of the cumulative variance could be accounted for.

Table 7.6: Questionnaire 1: Principal components analysis and eigen values of body image attitudes obtained by the non-clinical sample of 30 Black women.

	FACTORS							
Item	1	2	3	4	5	6	7	8
67	0,87							
56	0,53							
41	0,46							
59	-0,89							
	0,13(9,07)*							
18		0,78						
19		0,73						
55		0,69						
16		0,64						
6		0,63						
4		0,58						
46		0,53						
26		0,49						
		0,11(7,81)*						
9			0,77					
27			0,75					
22			0,71					
3			0,68					
23			0,45					
15			-0,52					
			0,09(5,84)*					
33				0,86				
17				0,76				
38				0,62				
53				-0,57				
68				-0,60				
				0,08(5,38)*				
63					0,82			
69					0,79			
39					0,53			
52					0,47			
32					-0,55			
					0,08(5,26)*			
24						0,91		
54						0,62		
50						0,59		
14						0,53		
						0,06(4,41)*		
2							0,93	
51							0,48	
43							-0,68	
							0,06(4,23)*	
57								0,69
1								0,61
60								0,57
49								-0,82
								0,05(3,21)*

* Variance explained and the eigen values.

Note: For item descriptions see Annexure I

The order of the item numbers for each of the following factors corresponds with item numbers in Table 7.6 according to the sequence of factor values, that is, the highest values placed first.

Factor One: Well-being orientation explained 13% of the variance in the data (items 67; 56; 41; 59). Items that loaded high on this factor seemed to be associated with subjects' concern about health, weight and overall physical well-being. *Factor Two: Health control* explained 11% of the variance (items 18; 19; 55; 16; 6; 4; 46; 26). High factor loadings demonstrated that subjects focused on health control, and the importance of developing a healthy lifestyle. *Factor Three: The vigour factor* explained 8% of the variance (items 29; 22; 3; 23; 15). Items loading high on this factor seem to explain the level of concern for actively maintaining physical fitness and a good appearance. *Factor Four: Stamina orientation* explained 8% of the variance (items 33; 17; 38; 53; 68) and is related to subjects' perceptions of physical strength and capabilities. *Factor Five: Personal presentation evaluation* (items 63; 69; 39; 52; 32) explained 8% of the variance. High factor loadings seemed to reflect subjects' perceptions about overall physical attractiveness. *Factors Six and Seven* explained 6% of the variance. *Factor Six: Contentment factor* (items 24; 54; 50; 14) endorsed high loadings on physical fitness and appearance awareness. *Factor Seven: Appearance vigilance* (items 2; 51; 43) reflected a high factor loading on the relationship between satisfaction with physical appearance and clothing behaviour. *Factor Eight: Self-presentation discipline* explained 5% of the variance (items 57; 1; 60; 49) and seemed to relate subjects' perceptions of weight and appearance. The highest factor loading reflected concern about weight gain, followed by awareness of changes in weight. *Factor Eleven: Self-consciousness* also explained 4% of the variance (items 13; 29; 31). High factor loadings identified subjects' perceptions of their grooming and how they are viewed by others in social interaction. High factor loadings for *Factor Twelve: Appearance satisfaction* (items 30; 11; 7; 21), *Factor Thirteen: Appearance vulnerability* (items 21; 45; 48) and *Factor Fourteen: Improvement control* (items 35; 44; 12) indicated subjects' preceptions of maintaining and improving their body images. These three factors each explained 3% of the variance. The lowest variance explained was 2% for *Factors Fifteen* to *Nineteen*. Due to the repetitive nature of the remaining results, details are not reported but are available from the researcher on request.

Table 7.7: Questionnaire 1: Principal components analysis and eigen values of body images attitudes obtained by the non-clinical sample of 30 White women.

	FACTORS							
Item	1	2	3	4	5	6	7	8
69	0,90							
39	0,89							
67	0,87							
64	0,84							
30	0,65							
65	0,63							
63	0,60							
42	-0,58							
58	-0,60							
57	0,75							
60	0,81							
59	-0,86							
	0,17(11,95)*							
35		0,84						
53		0,68						
52		0,67						
9		0,57						
26		0,65						
3		0,54						
6		-0,78						
25		-0,78						
16		-0,87						
		0,23(8,62)*						
45			0,90					
36			0,84					
17			0,81					
27			-0,07					
7			-0,70					
54			-0,75					
			0,10(7,16)*					
22				0,75				
13				0,60				
1				0,58				
12				0,54				
24				-0,54				
32				-0,69				
23				-0,82				
				0,07(5,12)*				
37					0,90			
47					0,75			
38					0,50			
56					-0,57			
46					-0,61			
					0,07(4,57)*			
55						0,84		
5						0,82		
21						0,49		
61						-0,52		
19						-0,72		
						0,06(4,18)*		
20							0,91	
10							0,64	
50							0,53	
31							0,46	
40							-0,62	
							0,04(3,09)*	
4								0,77
14								0,50
62								-0,76
								0,04(2,96)*

* Variance explained and the eigen values.

Note: For item descriptions see Annexure 1

Seventeen factors with eigen values >1 emerged from White subjects' responses to the MBSRQ (Cash *et al.*, 1986; Cash, 1990) and explained 92% of the cumulative variance (Table 7.7). This number of factors (that is, 17) closely approximates the original conceptual scoring of the MBSRQ (Cash *et al.*, 1986; Cash, 1990).

Factor One: Self-presentation explained 17% of the variance (items 69; 39; 67; 64; 30; 65; 63; 42; 58; 57; 60; 59). High factor loadings indicated a direct concern in terms of subjects' perceptions of their overall appearance, clothes, weight, body areas, mid, upper and lower torso, diet and others' perceptions of their appearance.

Factor Two: The vigour factor, explained 13% of the variance (items 35; 53; 52; 9; 26; 36; 25; 16); high loadings reflected the subjects' perceptions of being actively in control of their physical fitness and strength. *Factor Three: Well-being* factor, explained 10% of the variance (items 45; 36; 17; 27; 7; 54); high factor loadings indicated subjects' anxiety at being physically vulnerable. *Factor Four: Appearance orientation* explained 7% of the variance (items 22; 13; 1; 12; 24; 32; 23) together with *Factor Five: Illness orientation* (items 37; 47; 38; 56; 46). High factor loadings on *Factor Four* indicated the subjects' perceived investment in appearance management, whereas high factor loadings on *Factor Five* identified subjects' concern with health issues. *Factor Six: Appearance vigilance* explained 6% of the variance (items 55; 5) and identified subjects' awareness of health changes in the body and the significance of being viewed as sexually appealing. *Factor Seven: Opinion evaluation* (items 20, 10, 50, 31), *Factor Eight: Physical endurance* (items 4; 14; 62), *Factor Nine: Contentment* factor (items 43; 11) and *Factor Ten: Health knowledge* (items 29; 28) explained 4% of the variance. Factors loading high on *Factor Seven* indicated subjects' high concern for weight changes. For *Factor Eight*, developing physical strength was identified as important. *Factors Nine to Seventeen* became increasingly repetitive, mainly confirming earlier clearly identifiable variables, *Factors One to Eight*. Details of these remaining factors are, however, documented for reference.

Only two items; that is, item 39 in *Factor One* and item 62 in *Factor Eight*, loaded similarly on the respective factors in the original factor analysis (Cash *et al.* 1986; Cash, 1990). The new factor analysis indicates the differences in value and importance of body image issues between the Black (n = 30) and White (n = 30) South African sample. Similar findings were recorded for the original factor analysis based on the American female sample (n = 1070) (Cash *et al.*, 1986).

7.6 ANALYSES OF THE DATA FOR SUBPROBLEMS ONE AND TWO TO MEASURE IDENTITY AS CONCEIVED BY ERIK ERIKSON (OCHSE, 1983) FOR THE CLINICAL (n = 25) AND NON-CLINICAL (n = 60) SAMPLES: QUESTIONNAIRE 2 (ANNEXURE 2)

Erikson's (1968) concept of identity formation includes the development of a sense of continuity, consistency of self-image and a set of social self-perceptions that corresponds with the way one is viewed by others (Ochse & Plug, 1986).

7.6.1 The clinical sample

Pre-test, post-test factor means and standard deviations were calculated to establish subjects' sense of self identity before and after elective cosmetic surgery. A paired *t*-test for the independent groups indicated whether the differences were statistically significant or not. Table 7.8 shows the distribution of means and standard deviations and *t*-test probabilities for all four surgical groups, reduction mammaplasty, augmentation mammaplasty, abdominoplasty and rhytidectomy, over a range of eight factors incorporating 93 items (factors are itemised in Annexure 2). The items pertained to the question of trust, generativity, autonomy, social desirability, industry, identity, intimacy and initiative.

Pre-test, post-test factor means and standard deviations were calculated to establish subjects' sense of self-identity before and after elective cosmetic surgery. A paired *t*-test for the independent groups indicated whether the differences were statistically significant or not.

Mean attitude scores of issues contained within the global identity concept were reflected by patients' attitudes over eight factors shown in Table 7.8. A paired *t*-test indicated if differences in mean attitude scores for the independent surgical groups, pre- and post-operatively, were significant.

Only one statistically significant mean difference emerged on *Factor Six: Sense of Identity* for the rhytidectomy (n=3) sample. The results showed a significant change post-surgically for the rhytidectomy (n = 3) subjects, who underwent physical modifications to their faces. This implies that patients' sense of being one and the same person, being recognized and treated consistently by others may have altered after elective cosmetic surgery. Pre-test scores were M (SD) = 3,11(0,61), whereas post-test scores were 2,93(0,27), $P>|t| = 0,04$. It is acknowledged that due to the small sample size this result could vary for any other group of three rhytidectomy patients.

Table 7.8: Questionnaire 2: Comparative pre-/post-factor means, standard deviations and paired *t*-test scores for measuring identity obtained by the clinical sample group of 25 women before and after cosmetic surgery

Tests		RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)	
	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Variable	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
Trust	3,09(0,36)	3,17(0,44)	0,27	2,73(0,58)	2,75(0,31)	0,91	3,25(0,33)	3,13(0,50)	0,42	2,79(0,80)	2,79(0,52)	1,00
Autonomy	3,05(0,44)	3,23(0,33)	0,84	3,09(0,47)	2,77(0,35)	0,65	3,04(0,40)	3,13(0,22)	0,74	2,79(0,63)	2,88(0,45)	0,40
Social desirability	2,89(0,35)	2,91(0,28)	0,16	2,98(0,49)	3,04(0,27)	0,26	3,11(0,10)	3,04(0,27)	0,74	2,91(0,34)	2,76(0,57)	0,71
Initiative	3,18(0,22)	3,25(0,28)	0,18	2,79(0,49)	2,69(0,31)	0,87	3,07(0,42)	2,85(0,23)	0,23	3,19(0,76)	3,22(0,38)	0,92
Industry	3,24(0,38)	3,36(0,34)	0,25	3,07(0,37)	2,87(0,37)	0,35	3,21(0,45)	3,18(0,33)	0,83	3,12(1,05)	3,03(0,41)	0,48
Identity	3,12(0,37)	3,20(0,33)	0,70	3,00(0,47)	3,83(0,22)	0,29	3,09(0,58)	3,05(0,35)	0,13	3,11(0,61)	2,93(0,27)	0,04*
Intimacy	3,27(0,52)	3,30(0,47)	0,87	3,29(0,52)	2,98(0,28)	0,14	3,75(0,25)	3,17(0,29)	0,42	3,21(0,44)	2,83(0,31)	1,00
Generativity	2,90(0,40)	2,91(0,39)	0,11	3,01(0,39)	2,59(0,31)	0,11	2,80(0,20)	2,90(0,10)	0,69	2,77(0,57)	2,77(0,57)	0,75

RM: Reduction Mammaplasty; AM: Augmentation mammaplasty; ABD: Abdominoplasty; RHY: Rhytidectomy

* Significant values

Note: For item descriptions see Annexure 2 and Table 6.4

7.6.2 The non-clinical sample

Data analyses for measuring *Identity* (Questionnaire Two, Annexure 2) for the non-clinical sample of Black (n = 30) and White (n = 30) women were computed by using an un-paired *t*-test and a varimax, principal component analysis. Results of subjects' *Identity statuses* are reported in Table 7.9.

Table 7.9: Questionnaire 2: Comparative factor mean, standard deviation and unpaired *t*-test scores to measure identity obtained by the non-clinical sample group of 30 Black and 30 White women.

		Black		White		
	Variable	*M*	*SD*	*M*	*SD*	Probability P>|t|
1	Trust	3,10	0,34	2,88	0,44	0,04*
2	Autonomy	3,15	0,43	2,97	0,41	0,09
3	Social Desirability	3,04	0,30	2,81	0,30	0,005*
4	Initiative	3,27	0,30	3,14	0,35	0,11
5	Industry	3,12	0,39	3,81	0,40	0,70
6	Identity	3,07	0,31	2,90	0,37	0,07
7	Intimacy	3,16	0,42	3,05	0,56	0,38
8	Generativity	2,82	0,40	2,94	0,42	0,26

* Significant values

Note: For item descriptions see Annexure 2 and Table 6.4.

Statistically significant mean differences between the attitudinal scores on identity for the Black and White subjects were noted for the following factors:

Factor One: Trust. A higher mean score for Black subjects (n = 30) *M* (*SD*) = 3,10(0,34) compared with White subjects (n = 30) 2,88(0,44) was statistically significant, P<|t| = 0,04. This result reflected that a higher degree of trust was shown by the Black women sample toward themselves, others and their future prospects in life, and a lower degree of mistrust than the White female sample. Ochse and Plug (1986) caution, however, that opposites may be influenced by different sets of factors so that which influences positive effect may not necessarily decrease negative effect. When interpretation is focused on a balance between two opposing dimensions, one may infer that a higher degree of one measure implies a relatively low degree of its opposite.

Social desirability: Factor Three. The statistically significant *t*-test result indicated a greater desire by the Black female sample than by the White female sample for a strong public image, to be viewed by others favourably, and to be socially acceptable.

Ochse and Plug (1986) point out that items that load on social desirability (Annexure 2) should not be left out, yet should not be allowed to contaminate measures of relations between relevant constructs. It should be noted that Ochse and Plug's study (1986) included a mixed South African sample of Black and White men and women (n = 1 859).

A marginal significance for differences between the means was noted for *Factor Six: Identity*; *M*(*SD*) = 3,12 (0,30) for Black subjects and 3,14(0,35) for White subjects, P>|t| = 0,07. This trend, in relation to previously described significant results, implies that the Black female sample enjoyed a higher identity status than the White female subjects. In terms of the independent variables as well as the socio-cultural transition taking place in South Africa presently, this becomes a valid observation. However, Ochse and Plug (1986) warned that results pertaining to Black subjects, even though they may have been urbanised in the Western tradition, should be interpreted circumspectly.

No further significant differences between the means were detected from the results presented in Table 7.7 for all factors representing overall identity.

7.6.3 Principal components analysis for the Black (n = 30) and White (n = 30) female samples to measure *Identity*, as conceived by Erik Erikson (Ochse & Plug 1986; Questionnaire 2, Annexure 2)

The results of a principal components analysis for measures of identity, using a varimax rotation for the Black (n = 30) and White (n = 30) female sample groups respectively, showed the following diverse results. The same conditions for analysis were applied to the interpretation of the Identity Scale as applied to the MBSRQ (Cash *et al.*, 1986; Cash, 1990) (7.5); that is, the number of factors to be discussed per group was based on the scree test. The most significant factors numbered between 8 - 10.

Table 7.10: Questionnaire 2: Principal components analysis and eigen values to measure identity obtained by the non-clinical sample of 30 Black women

	FACTORS							
Item	1	2	3	4	5	6	7	8
91	0,87							
88	0,85							
78	0,79							
93	0,71							
89	0,69							
85	0,62							
43	0,61							
16	0,58							
36	0,55							
62	0,43							
31	-0,47							
80	-0,53							
4	-0,71							
	0,15(13,52)*							
45		0,87						
70		0,85						
60		0,78						
22		0,75						
21		0,70						
10		0,69						
28		0,65						
3		0,63						
77		0,61						
25		0,58						
76		0,55						
75		0,54						
72		0,50						
42		0,46						
		1,11(9,96)*						
92			0,88					
64			0,75					
11			0,74					
44			0,59					
56			0,54					
48			-0,47					
71			-0,64					
58			0,79					
			0,10(9,75)*					
67				0,83				
47				0,78				
2				0,68				
55				0,56				
38				0,43				
90				-0,51				
35				-0,57				
13				-0,59				
37				-0,81				
				0,09(7,92)*				
74					0.88			
34					0,73			
84					0,60			
17					0,53			
5					0,47			
33					-0,54			
					0,07(6,05)*			

continued / ...

* Variances explained and eigen values

Note: For item descriptions see Annexure 2

Table 7.10: (continued) Questionnaire 2: Principal components analysis and eigen values to measure identity obtained from the non-clinical sample of 30 Black women

	FACTORS							
Item	I	2	3	4	5	6	7	8
81						0,97		
53						0,72		
65						0,43		
29						-0,53		
49						-0,53		
						0,06(5,84)*		
12							0,95	
82							0,80	
14							0,66	
							0,06(5,40)*	
50								0,83
19								0,68
32								0,55
61								0,49
57								-0,38
39								-0,49
23								-0,85
								0,05(4,8

* Variances explained and eigen values
Note: For item descriptions see Annexure 2

Table 7.10 comprised 18 factors accounting for 98% of the variance. After *Factor Eighteen*, the remaining factors represented less than 1% of the variance. Eigen values P>1 reflected the relative inportance of factors. The first factor explained the most variance; this ranged from 15%, the highest variance, to 2%, the least variance. Eight factors reported as factors beyond that point became repetitive.

Factor One: Identity security explained 15% of the variance (14 items described in Table 7.10). Items that loaded high (for example 0,86, Item 91) on *Factor One* seemed to be associated with subjects' sense of well-being with self and society, and with a sense of future security and determination to succeed. Negative values for *Factor One* (for example -0,46, Item 31) implied Black subjects' dislike for disorganization, incompetency and mistrust. This confirms the result of the unpaired t-test where a statistically significant mean difference for the Black female sample (n = 30) on *Factor One: Trust* indicated an attitude of trust in self and society versus an attitude of general mistrust.

Factor Two: Identity recognition focused on the level of self-determination experienced by the Black female sample and accounted for 11% of the variance. High factor loadings (for example 0,87, item 45) indicated Black subjects' determination to be recognized and to succeed. *Factor Two* contained nine items described in Table 7.10. The results on these first two factors, *Identity*

security (Factor One) and *Identity recognition (Factor Two)* contrast with the result of Ochse and Plugs' (1986) study where the highest factor loadings (over 0,12) indicated feelings of inadequacy and no confidence for a mixed Black sample of men and women (n = 384) (Table 4, p.1245). These negative feelings of the Black sample in Ochse and Plugs' (1986) study contributed just under one half of the variance of the scale; that is, 46%. *Factors One* and *Two* of the present study indicated a positive change in the Black female sample's level of self-confidence and determination. A combined variance of 26% was noted for these two factors. Table 7.10 illustrates a contrast to the 46% negative variance recorded in the study by Ochse and Plug (1986).

Factor Three explains 10% of the variance. Items loading high on this factor, *Identity stability*, seemed to explain subjects' levels of self-satisfaction in being who and what they are; that is, item 92 (0,83) Table 7.10.

Social Identity: Factor Four, explained 9% of the variance. High factor loadings (that is, item 67, 0,82; item 47, 0,78) seemed to express subjects' positive sense of belonging to a community and their level of community spirit or involvement. A low negation loading, -0,51 (item 35) confirmed the level of Black subjects' identity status.

High factor loadings on *Factor Five: Initiative*, indicated at what level the Black female sample was prepared to take responsibility for their choices in life, to be competitive and risk intimacy, for example, item 34 (0,72) and item 74 (0,88). *Factor Five* explained 7% of the variance. High factor loadings referred to subjects' sense of trust of others, item 81 (0,97) and seeing the good in others, item 53 (0,71). These items in the context of *Factor Six: Social desirability* indicated an underlying need for social approval by Black subjects and the desire to be favourably viewed by others. *Factor Six* explained 6% of the variance.

Factor Seven: Autonomy focused on the degree of control and autonomy subjects perceive themselves to have in relation to the choices they make and to others. High factor loadings, item 12 (0,95) and item 82 (0,80) supported the possibility of the Black sample's ability in this area. *Factor Seven* explained 6% of the variance.

Factor Eight and *Factor Nine* both explained 5% of the variance. *Factor Eight: Identity approval* referred to subjects' perceptions of their identity status, and their need for favourable approval, item 50 (0,83) and item 19 (0,67). *Factor Nine: Public image*, confirmed subjects' attitudes, reflected in *Factor Eight* of needing to be acknowledged and approved by others; item 26 had a loading of 0,92, (Table 7.10).

The significance of the first eight to ten factors represented in Table 7.8 confirmed the level and awareness of the Black female sample's overall identity status. This corresponded to the

statistically significant factor results on the unpaired *t*-test discussed in 7.6.3 and shown in Table 7.10.

7.6.4 Principal components analysis

The results of a principal components analysis to measure *Identity*, as conceived by Erik Erikson (Ochse & Plug, 1986) using a varimax rotation are presented in Table 7.11 for the White female non-clinical sample (n = 30).

The distribution of items from the various sub-scales for the factor analysis of the White female sample (n = 30) differed from the original eight factors based on Erikson's concept (Ochse & Plug, 1986). However, similarly to the Black female sample factor analysis, all significant identity constructs were contained within the first eight main factors. Factors with eigen values >1 are presented in Table 7.11 and accounted for 98% of the variance.

The first factor explained the most variance; that is, 22%, and accounted for nearly a quarter of the total variance. Less distinct factors which accounted for only 2% and 1% of the variance are represented by a combination of items (Table 7.11) which relates to components that theoretically develop during childhood and become integrated into the personality during adolescence. These identity constructs could have become merged in subjects older than 15 years of age and therefore render them difficult to distinguish. Ochse and Plug (1986) caution that most of the research based on Erikson's work has been confined to studies of adolescence and youth and that his suggestions on development during adulthood are still largely untested. This may account for the number of new factors that emerged on the factor analysis for the White female sample; *M* Age = 24 years (Table 7.1), although a principal components' analysis, based on eigen values, usually yields a large number of factors. The order of the item numbers for each of the following factors corresponds with item numbers in Table 7.11 according to the sequence of factor values, that is, the highest values placed first.

Factor One: Self-confidence comprised 28 items and explained 22% of the variance. The items are described in Annexure 2. High factor loadings were recorded for the first 16 items, which ranged from 0,85 (item 51) to 0,51 (item 66). Self-confidence emerged as the second factor for the Osche and Plug (1986) study and by comparison explained 14% of the variance. Their sample, however, was a mixed White male/female sample (n = 1 475). Mean ages ranged from 15 years to 16 years. The independent variable, mean age, for the present study for the White female non-clinical sample was *M* Age = 24,0 years. The self-confidence factor indicated that the White subjects had positive perceptions about who and what they were, positive attitudes about their abilities, competency levels, sense of purpose and the contribution they could make to

society; that is, generativity. However, a low negative score for items 91 (-0,72) and 56 (-0,74) indicated some insecurity with regard to belief and trust in the world around them. This may be compared with *Factor One* of the Black female sample where trust in the future and society emerged strongly (7.6.4). Given the present changes in the South African transitional period, a comparison of these results becomes significant.

Table 7.11: Questionnaire 2: Principal components analysis and eigen values of measures of identity obtained by the non-clinical sample of 30 White women

	FACTORS							
Item	1	2	3	4	5	6	7	8
51	0,85							
52	0,85							
60	0,78							
71	0,77							
80	0,77							
70	0,72							
42	0,69							
55	0,68							
67	0,68							
10	0,67							
7	0,67							
40	0,66							
58	0,65							
76	0,61							
46	0,60							
42	0,60							
86	0,57							
2	0,54							
6	0,54							
59	0,51							
66	0,51							
68	-0,33							
9	-0,38							
38	-0,43							
16	-0,48							
91	-0,72							
56	-0,74							
	0,22(20,40)*							
19		0,93						
43		0,76						
89		0,67						
53		0,53						
88		0,50						
77		-0,54						
75		-0,55						
24		-0,57						
23		-0,91						
		0,10(9,15)*						

continued / ...

* Variance explained and eigen values

Note: For item descriptions see Annexure 2

Table 7.11: (continued) Questionnaire 2: Principal components analysis and eigen values of measures of identity obtained by the non-clinical sample of 30 White women

	FACTORS							
Item	1	2	3	4	5	6	7	8
21			0,87					
27			0,69					
8			0,63					
4			0,61					
17			-0,44					
85			-0,48					
36			-0,55					
81			-0,61					
57			-0,80					
			0,08(8,26)*					
25				0,94				
45				0,77				
49				0,77				
3				0,71				
35				-0,44				
5				-0,49				
				0,08(7,09)*				
39					0,80			
90					0,78			
20					0,54			
59					0,49			
					0,07(6,31)*			
84						0,94		
						0,05(4,48)*		
73							0,82	
78							0,46	
							0,05(4,19)*	
63								0,88
79								-0,58
69								-0,64
								0,04(3,48)

* Variance explained and the eigen values.

Note: For item descriptions see Annexure 2.

Factor Two: Self approval explained 10% of the variance. High factor loadings (0,93, item 19) represented favourable impressions of subjects with regard to themselves and their abilities or sense of industry and initiative. However, subjects may either be genuinely endowed with these positive qualities or feel the need to report themselves in a favourable light (Ochse & Plug, 1986). A combination of both these interpretations is likely, for example high factor loadings on item 43 (0,76), item 89 (0,67) and a low negative score on item 23 (-0,91) (Table 7.11).

A higher number of low negative scores (5) compared with high factor loadings emerged in *Factor Three: Trust/mistrust*, which explained 8% of the variance. High factor loadings, for example, 0,87 (item 21) indicated that subjects appeared to believe in their own sense of judgement about society and people. The low negative scores, -0,55 (item 36) or -0,61 (item 81) indicated a degree of insecurity and mistrust among the White female sample with regard to the

public recognition and understanding they receive. Factor loadings on items 17 (-0,44) and 57 (-0,80), intimacy constructs reflected negative attitudes towards feelings of belonging and sharing (Ochse & Plug, 1986).

Factor Four: Industry explained 4% of the variance. High factor loadings, 0,94 (item 15) and 0,77 (item 45) demonstrated positive attitudes of White subjects toward their determination to achieve, and toward their level of perceived competency.

Identity status: Factor Five, explained 7% of the variance. Items loading high on this factor revealed subjects' level of identity resolution. Identity resolution implies characteristically genuine behaviour, as well as a clear social self-definition. This was apparent from factor loadings on, for example, item 39 (0,80), item 90 (0,78) as described in Table 7.11.

Only one item, item 84 (0,94) loaded on *Factor Six: Initiative*. Clearly, White subjects showed a willingness for innovative behaviour. *Factor Six* and the following factor, *Factor Seven: Social desirability* each explained 5% of the variance. High factor loadings on *Factor Seven* indicated subjects' willingness to accept criticism either for an honest appraisal or to be favourably accepted by others. The factor loading on item 7 was 0,82.

Factor Eight: Social self-image, a high factor loading on item 63 (0,88) and negative factor loadings on items 79 (-0,58) and 69 (-0,64) endorsed subjects' level of consideration for others.

Later factors became more difficult to interpret with regard to identifying the degree of subjects' crises resolutions for the various stages of identity development. However, factors that explained 1% or 2% of the variance, contributed significantly to confirming or disconfirming identity trends that have been previously clearly defined, *Factor One - Factor Eight*, Table 7.11. It is important to note that Ochse and Plug (1986) refer to instances in the research literature where authors have commented on the fact that Erikson's constructs are often imprecisely specified, complex, vague and overlapping. However, according to Ochse and Plug (1986) Erikson explicitly states which types of subjective feelings are likely to be experienced by those who have successfully or unsuccessfully resolved the crises involved in the stages of identity development.

7.7 QUESTIONNAIRE 5: THE IPAT ANXIETY SCALE (CATTELL, SCHIER & MADGE, 1968)

This scale was used for the clinical sample group only for subproblem four. The IPAT Anxiety Scale measures free-floating, manifest anxiety.

The five factors which were grouped together as anxiety components and measured were: *Defective integration - lack of self-sentiment ($Q_{3(-)}$); Ego weakness, lack of ego strength ($C_{(-)}$);*

Suspiciousness or paranoid insecurity (L); *Guilt proneness (O)* and *Frustrative tension or ID pressure (Q_4)*. According to Cattell *et al.* (1968), actual scoring breakdowns into parts are possible, but are necessarily less reliable than total scores on all 40 questions. For this reason, and because group sample sizes were small for the clinical sample, the largest group was reduction mammaplasty (n = 12) and the smallest groups were abdominoplasty (n = 3) and rhytidectomy (n = 3) item analyses of the IPAT Scale are not reported, only total mean raw scores (Total Raw) and total mean sten scores (Total Sten).

Table 7.12 shows only one statistically significant mean difference on the A score for the paired *t*-test to measure pre- and post-surgical anxiety levels for the abdominoplasty (n=3) subjects. The means and standard deviations for the A score were 12,67(3,22) before surgery and 17,00(3,61) after surgery $P<|t| = 0,05$ and Total Sten = 4,00.

High A score levels of anxiety, post-operatively, for the abdominoplasty (n = 3) would usually show subjects' proneness to unrealised, covert anxiety. The results for *Factor One: Defective integration, lack of self-sentiment* $Q_{3(-)}$, implied that the level of abdominoplasty (n = 3) in terms of subjects' anxiety was higher post-operatively due to lack of a clear self-concept. This result may demonstrate a tendency in anxiety level change due to loss or confusion over body mass reduction. However, caution is needed in the interpretation of results with a small sample size. Therefore, although not statistically significant, the following tendencies were observed and are reported on due to the fact that patients openly discussed aspects of anxiety during personal interviews (Durban, 1995).

For *Factor Two: Ego weakness, lack of ego strength C(-)*, the higher post-operative mean indicated a lowered capacity of abdominoplasty (n=3) subjects to control and express tensions and frustrations in suitably realistic ways after surgery.

It appeared that abdominoplasty patients (n=3) experienced more anxiety with regard to social difficulties and insecurity after surgery; that is, for *Factor Three: Suspiciousness, paranoid type insecurity, L*. It was noted that the Total Sten score = 4 post-operatively was below the fixed average level of 5,5 (Cattell *et al.*, 1968), which was the lowest mean sten pre- and post-operatively for the clinical sample (n = 25).

A higher post-operative A score would appear to indicate more anxiety after surgery than before with regard to feelings of unworthiness, depression or guilt for *Factor Four: Guilt proneness, O*, for subjects who had excess body mass removed. This may exemplify a sense of ego-reduction by the abdominoplasty (n=3) patients as a reaction to loss of body mass.

A higher post-operative A score with regard to *Factor Five: Frustration, tension, Id pressure, Q_4*, seems to imply that abdominoplasty (n=3) patients experienced more covert anxiety in terms

of unsatisfied or frustrated needs, for example, the need for recognition, and may be descriptively expressed in higher levels of emotionality, tension or irritability.

Tendencies in anxiety levels, pre- and post-operatively, for reduction mammaplasty, augmentation mammaplasty, abdominoplasty and rhytidectomy subjects are briefly discussed.

A low Total Sten score indicated that reduction mammaplasty patients (n=12) appeared to be generally satisfied and lacked the emotional tension and irritability that usually accompany frustrated needs. The Total Sten anxiety scores, both before and after surgery, were the lowest for the reduction mammaplasty (n=12) out of the clinical sample (n=25) except for the post-test previously discussed for the abdominoplasty (n=3) sample. It appeared that subjects in this group were generally the most satisfied and relaxed. The Total Sten anxiety scores, pre- and post-operatively, were below the fixed average of 5,5 for the general population (Cattell *et al.*, 1968). This confirmed reports by the plastic surgeons consulted for this study (Personal communication, Durban, 1994), who stated that the reduction mammaplasty patients were usually the most satisfied and rewarded out of the cosmetic surgery groups chosen for this study. Personal interviews with the patients resulted in strong evidence of relief and self-satisfaction after surgery for breast reduction.

No statistically significant mean score differences were noted for the augmentation mammaplasty (n=7) patients for anxiety before and after surgery. However, the Total Sten scores, both pre- and post-operatively, were marginally higher than the fixed average sten score of 5,5 for the general norm (Cattell *et al.*, 1968). It would appear that the augmentation mammaplasty (n=7) subjects experienced higher anxiety levels than the abdominoplasty (n=3) or reduction mammaplasty (n=12) patients. Schlebusch and Mahrt (1993) reported elevated anxiety levels post-operatively for eight (45%) augmentation mammaplasty patients out of a sample of 20, and also cautioned that these elevated anxiety levels measured by a Mental State Examination (MSE) were not of sufficient severity to diagnose an anxiety disorder. Augmentation mammaplasty (n=7) subjects pre-test B score mean was, however, elevated, 18,57(9,07) compared with a post-operative B score mean of 14,86(7,24). A high pre-operative anxiety level is confirmed by Schlebusch and Mahrt (1993) who also referred to a variety of research findings. These authors noted that pre-operative low self-esteem, negative body image, anxiety and depression improved post-operatively. This finding is supported by the lower post-operative B score mean for augmentation mammaplasty subjects in this study (Table 7.12).

Table 7.12: Questionnaire 5: Comparative pre-/post-test factor means, standard deviations and paired *t*-test scores to measure anxiety obtained by the clinical sample group of 25 women before and after cosmetic surgery

	RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)		
Tests	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Scores	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
A score	15,83(5,75)	17,00(5,64)	0,34	15,43(7,35)	15,00(8,08)	0,81	12,67(3,22)	17,00(3,61)	0,0059*	17,33(2,08)	16,67(4,04)	0,79
B score	14,92(5,71)	14,00(8,01)	0,52	18,57(9,07)	14,86(7,24)	0,16	15,67(7,23)	15,00(9,54)	0,90	14,67(8,74)	20,67(2,08)	0,31
TOT-RAW	30,75(10,49)	31,00(11,89)	0,89	34,00(15,70)	29,86(14,87)	0,32	28,33(9,07)	32,00(13,00)	0,53	32,00(10,82)	37,33(6,11)	0,44
TOT-STEN	4,67(2,19)	4,75(2,09)	0,59	5,71(2,81)	5,14(1.86)	0,51	5,00(1,73)	4,00(2,))	0,23	5,33(2,08)	6,00(1,00)	0,63

* Significant values

A score = A score TOT RAW = Total Raw Score

B score = B score TOT ST = Total Sten Score

For ASC and BSC descriptions see Annexure 5

Note: RM = Reduction mammaplasty, AM = Augmentation mammaplasty, ABD = Abdominoplasty, RHY = Rhytidectomy

The highest mean B score $\underline{M}$ ($\underline{SD}$) = 20,67(2,08) and Total Sten score 6,00 were observed for the rhytidectomy patients (n=3) after surgery for a face-lift. A Total Sten score of 6,00 was above the fixed average of 5,5 for the general unselected population (Cattell *et al.* 1968). This result; that is, a Total Sten score of 6,00 had implications for both covert, cryptic anxiety and overt symptomatic anxiety. rhytidectomy patients (n=3) post-operatively, seemed to have a more negative self-concept (*Factor One: Lack of self-sentiment development, $Q_{3(-)}$)*, and expressed this in less integrated behaviour, and more socially-bound character structures and habits for item descriptions of overt B score and A score covert anxiety (Annexure 5 and Table 7.12).

Results from *Factor Two: Ego-weakness $C_{(-)}$* implied that subjects with elevated anxiety levels, rhytidectomy (n=3) patients, could have an insecure ego with many ego defenses, or that a high anxiety level had interfered with normal ego strength. Anxiety could also cause social difficulties and lead to withdrawal and isolation (*Factor Three: Suspiciousness, paranoid type insecurity, L*). The higher anxiety Total Sten score of 6,00 could also mean a post-surgical depressive reaction, perhaps for the rhytidectomy subjects, through unrealistic expectations of the outcome of cosmetic surgery to the face (*Factor Four: Guilt proneness, O*).

Factor Five: Frustration tension, Id pressure, Q4, is one of the most central components in anxiety (Cattell *et al.*, 1968). A high overall anxiety score for the rhytidectomy patients would show itself descriptively in proneness to, for example, emotionality and tension. Experiencing irritability was also likely for the rhytidectomy subjects as it takes a long time for the face to settle after surgery (Personal communication with Plastic Surgeons, Durban, 1995). Patients may also have been disappointed or apprehensive about the changes to their faces (Personal interviews with patients, Durban, 1994).

The inter-relationship between anxiety, body images and identity will be discussed in relation to the patients' sense of social security and clothing behaviour; that is, subproblems one, three, four and six, in the general discussion in Chapter 7.

7.7.1 Questionnaire 6: The Sixteen Personality Factor Questionnaire (16 PF) (Prinsloo, 1991)

The A and B forms of the Prinsloo (1991) version of the 16 PF were used to describe personality variables for the clinical sample of 25 Black and White subjects before and after elective cosmetic surgery.

The IPAT Anxiety Scale Questionnaire 5, was used in conjunction with the 16 PF for this study, as the part scores for the IPAT scale are based on 16 personality factors. The norm, as indicated in Table 2 (Prinsloo, 1991, p 13) seemed the most practically variable norm, from what

was available; that is, mean averages for first year White female university students (n=912). However, part of the interpretative information of the data for the 16 PF, for this study, was based on similar up-dated studies also dealing with cosmetic surgery patients, (Schlebusch & Mahrt, 1993). Pre-/post-test means, standard deviations and paired *t*-test scores obtained to ascertain mean differences of personality variables for the clinical sample of 25 women are presented in Table 7.13.

Table 7.13 indicates statistically significant differences between the means for variations in personality traits pre- and post-operatively, for the four surgical groups (reduction mammaplasty, augmentation mammaplasty, abdominoplasty, rhytidectomy). These are discussed independently for each variable. The purpose of analysing mean differences in testees' scores was to describe personality and predict behaviour.

The first marginally significant mean difference worthy of note was observed for the abdominoplasty (n=3) subjects on variable B, where a low score description indicated less intelligent concrete-thinking and a high score description indicated bright, abstract thinking and a higher intellectual acuity. The pre-surgical mean score on variable B for the abdominoplasty (n=3) subjects was *M* (*SD*)= 5,67(1,53) and a co-efficient of variation for the mean value of 26%, whereas the post-surgical mean increased to *M* (*SD*)= 8,00(1,00) with a co-efficient of variation for the mean value of 12,5%. The co-efficient of variation decreased from 26% pre-test to 12,5% post-test. The higher post-operative mean score was in the average range for the norm for female students (n=912) according to Prinsloo (1991, Table 2, p.13); that is, *M* (*SD*) = 8,11(1,83). However, the abdominoplasty (n=3) co-efficient of variation, post-test, was smaller than the co-efficient variation for the Prinsloo (1991) study where the variation was 22%. The indications were that the abdominoplasty (n=3) seemed to regain a post-operative level of bright, unimpaired intellectual functioning, whereas pre-operatively this capacity fell below the norm (Prinsloo, 1991, Table 2, p.13). This result corresponds to the IPAT anxiety scale (Table 7.13) where the mean Total Sten score = 4,00 for the abdominoplasty (n=3) (Cattell *et al.* 1968). This fell within the average range for anxiety level even though abdominoplasty (n=3) subjects experienced higher A score (covert-anxiety) levels post-operatively.

The following variable to show a statistically significant mean difference was variable F, which describes subjects' personalities as either sober, prudent, serious and taciturn for those scoring below the *M* of 14,17 and *SD* of 4,69 (Prinsloo, 1991, Table 2, p.13), or easy-going, relaxed, heedless, gay and enthusiastic for those scoring above the norm for variable F. This variation in personality trait and behaviour is reported for the rhytidectomy (n=3) subjects in Table 7.11, *M* (*SD*) = 14,67(2,08) before surgery and *M* (*SD*) = 12,33(1,53) after surgery. The post-operative *M* (*SD*) = 14,17(4.69) for the rhytidectomy (n=3) subjects fell below the norm for

the Prinsloo (1991) study. It was observed that the dispersion of variation on the mean value scores, pre-test 14% and post-test 12% for the rhytidectomy (n=3) subjects, was smaller than the *SD* = 31% for the Prinsloo (1991) study. It appeared that the rhytidectomy (n=3) subjects were more inhibited and serious, three months after surgery to the face, than before the cosmetic changes took place. This corresponds to the IPAT anxiety scale (Table 7.12) which showed a post-operative increase in B score (overt anxiety) for the rhytidectomy (n=3) patients, as well as a Total Sten score of 6,00 which was above the mean for the unselected population of 5,5 (Cattell *et al.*, 1968). The implications of a Total Sten of 6,00, which incorporated both the A score (covert anxiety) and the B score (overt anxiety), were less integrated behaviour and more socially-bound character structures and habits for the rhytidectomy (n=3) patients.

The rhytidectomy patients (n=3) showed a further pre-, post-test significant mean difference for variable G. Prior to cosmetic surgery to the face, rhytidectomy (n=3) subjects were more rigid in their functioning, for example, rule-bound, staid and very conscientious. However, post-surgical indications were descriptive of a more flexible relaxed attitude to life. The pre-test *M* (*SD*) = 15,67(2,89) (18%) and the post-test *M* (*SD*) = 12,67(2,08) revealed only a 2% pre-/post-test difference in the co-efficient of variation for the mean value. The post-surgical decrease in the mean was equal to the norm; that is, *M* (*SD*) = 12,14(3,76) for the Prinsloo (1991) study. However, the co-efficient of variation for the mean value between the two studies was 9%; that is, 30% for the Prinsloo (1991) study compared with 8% for the rhytidectomy (n=3) pre-test result (Table 7.13) for this study.

A similar trend was observed for the augmentation mammaplasty (n=7) patients for variable G. The pre-test *M* (*SD*) = 11,43(4,39) with a co-efficient of variation for the mean value of 38% and the post-test *M* (*SD*) = 13,43(4,16) and a co-efficient of variation for the mean value of 30%, P>|t|0,09. The mean for the Prinsloo (1991, Table 2, p.13) study was *M* (*SD*) = 12,14(3,76). The marginally above average mean for the rhytidectomy (n=3) subjects of this study appeared to describe a relaxed, less rigid post-operative attitude to life and behaviour patterns. These results compared favourably with the Schlebusch and Mahrt (1993) study, where most augmentation mammaplasty patients (n=20) rated themselves as more confident, independent and assertive post-operatively (Schlebusch & Mahrt, 1993, Table 2, p.269).

Table 7.13: Questionnaire six: 16 PF. Comparative pre-/post-test means, standard deviations and paired *t*-test scores obtained by the clinical sample group of 25 women, before and after cosmetic surgery.

	RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)		
Tests	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Variables	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
A	13,82(2,89)	12,58(2,15)	0,17	13,29(1,98)	11,86(2,55)	0,23	14,67(2,31)	11,33(4,93)	0,29	11,33(1,15)	14,00(3,00)	0,37
B	6,36(1,21)	5,92(1,31)	0,61	5,71(1,38)	5,29(1,80)	0,62	5,67(1,53)	8,00(1,00)	0,07	7,33(1,53)	5,00(3,00)	0,12
C	16,18(2,89)	16,17(3,33)	0,48	14,71(4,61)	16,43(4,79)	0,30	15,33(5,69)	16,67(6,81)	0,18	15,67(2,52)	14,67(5,29)	0,48
E	14,46(3,50)	14,75(3,33)	0,59	10,86(2,04)	12,29(3,82)	0,35	10,67(3,06)	10,33(3,79)	0,81	13,33(2,52)	14,00(5,29)	0,84
F	15,36(5,07)	15,42(4,17)	0,77	13,00(2,77)	13,57(4,28)	0,71	11,33(6,81)	15,00(5,29)	0,26	14,67(2,08)	12,33(1,53)	0,02*
G	14,64(3,12)	13,75(2,05)	0,15	11,43(4,39)	13,43(4,16)	0,09	16,67(1,53)	16,00(3,00)	0,53	15,67(2,89)	12,67(2,08)	0,04*
H	15,64(5,05)	13,92(4,32)	0,005	11,14(7,84)	14,43(6,02)	0,20	12,67(7,57)	14,33(6,66)	0,46	17,00(5,20)	14,67(5,51)	0,56
I	12,36(2,50)	12,00(3,33)	0,34	11,43(1,27)	11,86(1,95)	0,53	10,00(0,00)	10,33(3,06)	0,87	9,67(2,87)	14,33(2,52)	0,18
L	9,09(2,98)	8,50(3,09)	0,40	8,43(3,41)	9,14(3,24)	0,25	6,00(5,29)	3,67(1,53)	0,42	10,00(5,29)	8,00(2,65)	0,37
M	14,09(2,66)	13,50(3,34)	0,58	15,00(3,46)	15,00(3,00)	1,00	12,00(2,65)	11,67(2,08)	0,67	15,00(3,46)	16,00(3,61)	0,58
N	12,00(1,90)	11,75(2,38)	0,42	10,00(5,10)	11,00(3,51)	0,67	10,68(2,08)	10,68(2,08)		11,67(0,58)	11,67(1,15)	1,00
O	10,64(5,16)	10,50(4,03)	0,59	11,00(4,69)	11,29(4.68)	0,79	12,67(5,51)	6,03(5,51)	1,00	12,67(2,08)	11,00(2,00)	0,46
Q1	10,27(3,55)	10,33(3,34)	0,77	9,43(1,62)	8,29(1,60)	0,05	7,67(1,53)	7,67(11,33)	3,06	13,67(3,51)	9,33(3,51)	0,17
Q2	11,09(3,24)	10,08(3,68)	0,47	11,00(2,94)	10,71(3,40)	0,75	11,33(3,06)	12,33(3,22)	0,42	13,33(2,31)	12,00(3,46)	0,18
Q3	11,55(2,34)	11,92(3,29)	0,44	9,14(5,01)	11,29(1,98)	0,22	13,33(3,06)	14,67(1,16)	0,42	12,00(0,00)	11,67(2,52)	0,84
Q4	11,18(4,71)	13,17(4,28)	0,29	14,71(7,27)	12,00(6,22)	0,06	8,67(3,06)	5,53(4,16)	0,04*	6,33(3,51)	9,67(3,21)	0,15

* Significant values

RM = Reduction mammaplasty; AM = Augmentation mammaplasty; ABD = Abdominoplasty; RHY = Rhytidectomy

A statistically significant pre-test, post-test mean difference was evident for the reduction mammaplasty (n=12) patients on the next variable, variable H (Table 7.11). The pre-test *M*(*SD*) = 15,64(2,50) had a co-efficent variation for the mean value of 15% and the post-test *M*(*SD*) =13,92(4,32) had a post-test co-efficient of variation of 16%. It was evident that both these results were well above the norm for the Prinsloo (1991) study (Table 2, p.13), where *M*(*SD*) = 11,33(4,88) had a co-efficient of variation for the mean value of 43% (n=912). Reduction mammaplasty (n=12) patients demonstrated socially bold, uninhibited, spontaneous and venturesome personality tendencies both prior and post-surgically, as opposed to being shy, restrained and timid. This was supported by the low anxiety levels recorded on the IPAT anxiety scale (Table 7.12) where reduction mammaplasty (n=12) patients appeared to be the most relaxed of the four surgical sample groups both before and after cosmetic surgery.

Patients in the augmentation mammaplasty (n=7) sample, revealed more conservative, traditional personality styles, both before and after surgery, as opposed to characteristics which involve experimentation and liberal, free-thinking. A significant mean difference was observed for variable Q1. Pre-test, post-test means and standard deviations were *M* (*SD*) = 9,43(1,62) with a co-efficient of variation of 17% and *M* (*SD*)= 8,29(1,60) with a co-efficient of variation of 19%, $P<t = 0,05$. These scores fell below the norm for the female student sample (n=912) *M*(*SD*) = 9,60(3,85) (40%) of Prinsloo's study (1991, Table 2, p.13). The results for the augmentation mammaplasty (n=7) subjects compared well with those of Schlebusch and Mahrt (1993), who observed that augmentation mammaplasty patients appeared to be shy, restrained, submissive and serious. Personal face-to-face interviews with the augmentation mammaplasty (n=7) patients (Durban, 1994) confirmed patients' expression of traditional conservatism. However, patients verbally expressed satisfaction and more self-confidence post-surgically (Personal communication, Durban, 1994).

Variable Q4 is descriptive of either relaxed, tranquil, unfrustrated personality and behaviour patterns (low score) or a tense, driven, overwrought attitude (high score). Statistically significant mean differences were evident for both the augmentation mammaplasty (n=7) patients; that is, *M*(*SD*) = 14,71(7,27) (pre-test) and *M*(*SD*) = 12,00(6,22) (post-test), $P>t = 0,06$, and for the abdominoplasty (n=3) subjects; that is, *M*(*SD*) = 8,67(3,06) (pre-test) and *M*(*SD*) = 5,33(4,16) (post-test), $P<t = 0,04$. The norm for the Prinsloo (1991) (n=912) female sample was *M*(*SD*) = 12,54(5,13). Whereas the augmentation mammaplasty (n=7) subjects fell within the norm (Prinsloo, 1991) post-surgically, the abdominoplasty (n=3) subjects remained below the norm both pre- and post-surgically. From these results (Table 7.13) it appeared that pre-

surgically augmentation mammaplasty (n=7) patients manifested higher anxiety levels, which manifested in tenseness and feelings of being driven and being overwrought. This corresponded with the augmentation mammaplasty (n=7) results on the IPAT anxiety scale, which showed higher pre-test anxiety levels for the sample (Table 7.12).

The below average pre- and post-surgical anxiety levels for the abdominoplasty (n=3) group (Table 7.11) demonstrated that abdominoplasty (n=3) subjects appeared to be more relaxed, tranquil and unfrustrated, particularly after surgery to remove surplus abdomen mass. The statistically significant results reported in Table 7.13 emphasised primarily that variables which centred on mood variations were those to show significant pre-/post-surgical mean differences for the clinical sample (n=25), for example whether patients were depressed, or happy, enthusiastic or anxious, inhibited or exhibitionistic, confident, outgoing and relaxed, or traditionalist and conservative.

No statistically significant mean differences before and after surgery for elective cosmetic surgery were evident on the variety of other personality traits on the 16 PF, which included characteristics such as interpersonal skills, levels of maturity, sociability, assertiveness or submission, introversion and extroversion.

7.7.2 Analysis of data for subproblems three, five and six

Two questionnaires were used for subproblems three, five and six for both the clinical (n=25) and non-clinical (n=60) samples; that is, Questionnaire 3, The Creekmore Scales of eight clothing variables (Creekmore, 1971) and Questionnaire 4, Public and Private Self-consciousness (Fenigstein, Scheier & Buss, 1975). Questionnaire 3, The Creekmore Scales (1971) consisted of eight sub-scales, which could be used independently. The relevant sub-scales chosen for measurement for this study included aesthetics, interest, comfort, attention, approval and modesty.

7.7.3 The clinical sample: Subproblem three, Questionnaire 3

Table 6.14 shows the distribution of means and standard deviations and paired *t*-test results for all four surgical groups, reduction mammaplasty, augmentation mammaplasty, abdominoplasty and rhytidectomy, over a range of six sub-scales for measuring clothing variables (Creekmore, 1971) (Annexure 3).

Mean attitude scores of patients' perceptions on a variety of clothing issues were reflected by the pre-test, post-test means and standard deviation scores. The significance of the mean differences

was evident from the paired *t*-test results for each independent group, and on each sub-scale (items are described in Annexure 3).

Marginally significant mean differences were noted for *Factor One: Aesthetics* for the augmentation mammaplasty (n=7) and rhytidectomy (n=3) groups. Pre-test, post-test mean differences increased for both groups. augmentation mammaplasty patients' scores were $\underline{M}(SD)$ = 2,88(2,30) pre-test and $\underline{M}(SD)$ = 3,01(0,38) post test, P>|t| = 0,08. Although not statistically significant, these results indicated important trends for the clinical sample with regard to clothing behaviour. After surgery both the augmentation mammaplasty and rhytidectomy patients gained more interest in, and paid more attention to their clothes. This included considering fabric with the line of the garment, paying attention to pleasing colour combinations, and being aware of accessories and fashionable clothing. These results may be compared with those of Schlebusch and Mahrt (1993) who reported that post-operatively all patients in their augmentation mammaplasty sample (n=20) reported purchasing fashion garments more frequently and doing so with more enjoyment than they had done previously.

A further comparison was drawn with the study of Gurel and Gurel (1979), who indicated the importance of aesthetic personal appearance through the use of clothing for undergraduates (n=55) in a textile and clothing course. High factor loadings were reported for aesthetics; that is, 0,650, for experimentation 0,682, and conformity 0,710 (Gurel & Gurel, 1979, Table 1, p.278).

Augmentation mammaplasty and rhytidectomy patients utilised clothing more intensely post-operatively in order to achieve a pleasing or beautiful appearance. The reduction mammaplasty and abdominoplasty patients utilised clothing in a similar manner pre- and post-operatively to achieve a pleasing appearance. The willingness of patients to give attention to, to investigate, manipulate or experiment with clothing remained at a similar level post-operatively and pre-operatively. Patients in all four surgical groups showed relatively the same interest before and after surgery in experimenting with a variety of accessories and new clothing, updating their fashion interests through magazines and newspapers, trying out different hairstyles and co-ordinating clothing accessory trends. However, post-test means in *Factor Two: Fashion interest* increased for the augmentation mammaplasty and rhytidectomy groups, augmentation mammaplasty $\underline{M}(SD)$ = 3,58(0,77) pre-test and $\underline{M}(SD)$ = 3,70(0,65) post-test, whereas the results were $\underline{M}(SD)$ = 2,22(0,67) pre-test for the rhytidectomy patients and $\underline{M}(SD)$ = 2,41(0,44) after surgery (Table 7.14). These trends were reversed for the abdominoplasty and reduction mammaplasty groups where, in both cases, excess body mass had been removed, which may have had an ego-decreasing effect, as opposed to the ego-extending effect of augmentation mammaplasty and face lift.

Table 7.14: Questionnaire 3: Comparative pre-/post-test factor means, standard deviations and a paired *t*-test scores for measuring clothing behaviour obtained by the clinical sample of 25 women before and after surgery

	RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)		
Tests	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Variables	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
Aesthetics	2,86(0,39	3,02(0,32)	0,18	2,31(0,55)	2,83(0,71)	0,07	2,86(0,39)	3,02(0,32)	0,18	2,31(0,55)	2,83(0,71)	0,07
Interest	322(0,63)	3,17(0,63)	0,63	2,22(0,67)	2,41(0,44)	0,34	3,22(0,63)	3,17(0,63)	0,63	2,22(0,67)	2,41(0,44)	0,34
Comfort	2,41(0,46)	2,52(0,82)	0,80	2,52(0,47)	2,55(0,40)	0,81	2,41(0,46)	2,52(0,82)	0,80	2,52(0,47)	2,55(0,40)	0,81
Attention	4,21(0,10)	3,94(0,37)	0,36	2,61(1,05)	2,63(0,57)	0,95	4,21(0,10)	3,94(0,37)	0,36	2,61(1,05)	2,63(0,57)	0,95
Approval	3,97(0,91)	4,00(0,71)	0,91	3,50(0,71)	3,94(0,29)	0,37	3,97(0,91)	4,00(0,71)	0,91	3,50(0,71)	3,94(0,29)	0,37
Modesty	3,27(0,72)	3,81(0,57)	0,10	3,51(0,78)	3,03(0,92)	0,32	3,27(0,72)	3,82(0,57)	0,10	3,51(0,78)	3,03(0,92)	0,32

RM = Reduction mammaplasty; AM = Augmentation mammaplasty; ABD = Abdominoplasty; RHY = Rhytidectomy

Factor Three: Comfort. Clinical patients' (n=25) attitudes toward the use of clothing to achieve comfort remained stable pre- and post-operatively for all surgical groups. Patients expressed the importance of how clothes felt on their bodies, their preferences for certain textures and fabrics and their sensitivity toward finding clothing suitable to the temperature. Tightness or looseness of garments also featured as a comfort indicator.

A statistically significant mean difference pre-test, post-test was observed for *Factor Six: Modesty* for the reduction mammaplasty subjects. The post-operative mean score indicated an increased preference for inconspicuous clothing, conservativeness in colour, fit design and body exposure for the reduction mammaplasty (n=12) subjects. Pre-test, Post-test mean scores were $\underline{M}(\underline{SD})$ = 3,14(0,53) and $\underline{M}(\underline{SD})$ = 3,45(0,44), P< |t| 0,04.

Although few statistically significant pre-test/post-test results were observed for the clinical subjects on the standardised test for measures of importance on clothing variables (Creekmore, 1971), face-to-face documented interviews revealed increased expressions of positive attitudes post-operatively towards clothing interest, willingness to experiment and eagerness in wearing clothing styles which had previously been considered inappropriate, specifically for the reduction mammaplasty, abdominoplasty and augmentation mammaplasty subjects.

No factor means and standard deviations were given in the following studies using Creekmore's (1971) clothing questionnaire. However, factor loadings were available for a comparison of underlying dimensionalities; that is, Gurel and Deemer (1975), Perry *et al.* (1983), Gurel and Gurel (1979). Factor analyses were not computed for the clinical sample (n=25) in this study due to the small sample sizes.

7.7.4 The non-clinical sample: Subproblem Five, Questionnaire 3

Table 7.15 shows the results of means and standard deviation scores and an unpaired *t*-test for the non-clinical samples of Blacks (n=30) and Whites (n=30) on the Creekmore (1971) scale for measuring clothing variables (Annexure 3).

Statistically significant mean differences were observed on a number of variables for measuring clothing behaviour (Creekmore, 1971) from an unpaired *t*-test between the non-clinical sample of Black (n=30) and White (n=30) subjects (Table 7.15).

Individual statement; that is, statement one, and the last statement of each of the original factors, represent the degree of subjects' search for understanding of self and others relative to their clothing behaviour (Creekmore, 1971).

The importance of *personal appearance* to subjects was evident on item one which showed a statistically significant difference between the Black (n=30) and White (n=30) sample groups; that is, $\underline{M}(SD)$ = 1,69(0,85) (Blacks) and $\underline{M}(SD)$ = 1,30(0,54) (Whites) P<|t| = 0,04. These results were confirmed by other significant statistical outcomes on *Factor One*. The Black fashion subjects demonstrated careful consideration of fabric texture with the line of the garment. Item 5 confirmed the desire by Black subjects to enhance personal appearance by hiding physical imperfections through the skilful use of colour, line and texture. The $\underline{M}(SD)$ scores for Black subjects were 3,43 ± 1,55 and the $\underline{M}(SD)$ = 2,40(1,30) for White subjects P<|t| = 0,01. A higher degree of attention to colour was expressed by Black subjects $\underline{M}(SD)$ = 2,21(1,26) compared with $\underline{M}(SD)$ = 1,67(0,92) for White subjects P>|t| = 0,07 for item 7 which was marginally significant.

In terms of measures of clothing behaviour by Creekmore (1971) Black subjects expressed a stronger preference for European trends in design, for example, French and Italian styled clothing to local South African fashions (item 13) $\underline{M}(SD)$ = 2,79(1,40) compared to White subjects $\underline{M}(SD)$ = 1,63(0,85) P<|t| = 0,0003. For *Factor One: Aesthetics*, Black subjects demonstrated a higher concern with personal appearance than White subjects (Table 7.15) although the co-efficient of variation for the mean value for both groups was equal (19%).

Confirmation of Black subjects' concern with *appearance experimentation* and interest in clothes was evident by statistically significant items in *Factor Two: Clothing interest* which revealed their clothing behaviour, for example for item 14 the $\underline{M}(SD)$ = 4,14(1,33) for Black subjects compared with the $\underline{M}(SD)$ = 3,33(1,4) for White subjects, P<|t| = 0,027. This demonstrated the level of determination expressed by Black subjects in their efforts to find out about what is new in clothing. The mean difference between Black and White subjects was statistically significant for item 21 (Table 7.15).

Factor Three: Clothing comfort. A marginal mean difference was reflected between the Black and White samples for item 30 (Table 7.15) which demonstrated similar levels of clothing comfort consciousness for the two groups.

For both items 31 and 33 (Table 7.15) higher mean scores for Black subjects demonstrated clothing behaviour attitudes conducive to improving the comfort of clothing they wear or desire to wear.

Table 7.15: Questionnaire 3: Comparative mean, standard deviation and unpaired *t*-test scores to measure clothing behaviour obtained by the non-clinical sample of 30 Black and 30 White women

Item	Black Fashion *M*	White Fashion *M*	P>|t|	Item	Black Fashion *M*	White Fashion *M*	P>|t|
1	1,69(0,85)	1,30(0,54)	0,04*				
F1- Aesthetics				F4-Attention			
2	4,10(1,14)	3,97(0,89)	0,61	37	3,66(1,14)	3,33(1,12)	0,28
3	2,39(1,40)	2,37(1,16)	0,94	38	3,28(1,44)	3,30(1,32)	0,95
4	2,31(0,93)	1,83(0,99)	0,06	39	3,21(1,18)	2,20(1,03)	0,0009*
5	3,43(1,55)	2,40(1,30)	0,01*	40	2,97(1,02)	2,53(1,31)	0,16
6	4,48(0,95)	4,33(0,92)	0,54	41	3,28(1,19)	3,23(1,28)	0,90
7	2,21(1,26)	1,67(0,92)	0,07	42	2,79(1,21)	2,60(1,10)	0,52
8	1,97(1,27)	2,17(1,02)	0,50	43	2,93(0,92)	2,87(1,07)	0,81
9	2,28(1,28)	2,07(1,20)	0,52	44	3,17(1,28)	3,20(1,35)	0,94
10	4,36(1,03)	3,97(0,93)	0,13	45	3,07(1,07)	3,43(1,14)	0,21
11	3,03(1,32)	3,03(1,27)	0,10	46	4,21(0,98)	3,33(1,12)	0,002*
12	3,07(1,31)	2,67(0,99)	0,19	47	3,17(1,07)	2,47(1,04)	0,013*
13	2,79(1,40)	1,63(0,85)	0,0003*				
Factor Mean	3,03	2,68	0,0024*	Factor Mean	3,25	2,95	0,08
F2-Interest				F5-Approval			
14	4,14(1,33)	3,33(1,40)	0,027*	48	3,82(1,16)	2,83(1,21)	0,0024*
15	2,48(1,24)	2,27(1,05)	0,47	49	2,96(1,35)	3,30(1,24)	
16	2,97(1,18)	2,60(1,10)	0,22	50	3,57(0,79)	3,40(1,16)	0,52
17	3,00(1,25)	2,77(1,07)	0,45	51	4,79(0,50)	4,30(0,60)	0,0014*
18	2,17(1,34)	1,77(1,01)	0,19	52	3,78(1,31)	3,47(1,22)	0,36
19	2,21(0,94)	2,00(1,08)	0,44	53	4,75(0,44)	4,40(0,77)	0,039*
20	2,97(1,40)	2,83(0,91)	0,67	54	4,39(0,92)	3,80(1,16)	0,06
21	2,55(1,18)	1,87(0,97)	0,018*	55	3,96(0,96)	3,57(1,04)	0,14
22	3,45(1,35)	2,97(1,40)	0,18	56	2,29(1,24)	2,50(1,14)	0,50
23	3,03(1,12)	3,47(1,04)	0,13	57	4,61(0,79)	4,20(0,71)	0,04*
24	3,31(1,17)	2,40(1,22)	0,0049*	58	4,29(1,05)	3,37(0,91)	0,0012*
25	3,69(1,11)	3,93(1,17)	0,42	59	3,61(1,17)	4,30(0,92)	0,014*
Factor Mean	2,98	2,68	0,041	Factor Mean	3,51	3,47	0,68

continued / ...

* Significant values

Note: For item descriptions see Annexure 3

Table 7.15: (continued) Questionnaire 3: Comparative mean, standard deviation and unpaired *t*-test scores to measure clothing behaviour obtained by the non-clinical sample of 30 Black and 30 White women

Item	Black Fashion *M*	White Fashion *M*	P>|t|	Item	Black Fashion *M*	White Fashion *M*	P>|t|
F3-Comfort				F6-Modesty			
26	1,62(0,94)	1,47(0,73)	0,48	60	2,69(1,11)	3,17(1,05)	0,10
27	2,07(1,05)	1,90(1,19)	0,30	61	3,07(1,36)	3,63(0,91)	0,07
28	3,21(1,21)	3,13(1,22)	0,82	62	2,48(1,18)	2,70(1,15)	0,48
29	2,28(1,19)	1,83(0,95)	0,12	63	2,97(1,24)	2,27(1,14)	0,03*
30	3,51(0,99)	3,00(1,05)	0,06	64	3,43(1,29)	3,50(1,20)	0,83
31	4,03(1,05)	3,37(1,13)	0,02*	65	3,79(1,15)	4,03(0,89)	0,37
32	3,03(1,57)	3,50(1,17)	0,20	66	3,17(1,34)	3,60(0,93)	0,16
33	3,17(1,17)	2,50(1,25)	0,04*	67	3,03(1,24)	3,57(1,10)	0,08
34	2,14(1,35)	1,73(0,94)	0,18	68	3,10(1,52)	2,63(1,25)	0,20
35	2,35(1,08)	2,30(1,15)	0,88	69	2,9(1,42)	3,87(0,78)	0,0018*
36	2,59(1,05)	2,60(1,07)	0,96	70	3,35(1,08)	3,37(0,81)	0,93
Factor Mean	2,74	2,48	0,77	Factor Mean	3,09(0,63)	3,30(0,52)	0,60

* Significant values

NOTE: For item descriptions see Annexure 3

A statistically significant mean difference was reflected in the clothing behaviour of Black subjects with regard to impression management and attention to some aspects of clothing behaviour for, *Factor Four: Attention*, for example, item 46 ... *I wear different clothes to impress people*, *M*(*SD*) = 4,21(0,98) compared to White subjects *M*(*SD*) = 3,33(1,12), P<|t| = 0,002. Black subjects also showed a higher degree of interest in attention they pay to unusual clothes worn by others, *M*(*SD*) = 3,17(1,07) (Blacks) and *M*(*SD*) = 2,47(1,04)(Whites), P<|t| = 0,013.

Factor Five: Approval showed that clothing behaviour, demonstrative of a strong need for approval and the need to identify with friends, was higher for Black subjects than for Whites. Item 48 (Table 7.15) shows a *M*(*SD*) = 3,82(1,16) for Blacks and *M*(*SD*) = 2,83(1,21) for White subjects, P<|t| = 0,0024. The co-efficient of variation for the mean value was greater for the Black sample (32%) compared with the White sample (10%). A higher mean score for the Black

sample on item 51 expressed the insistence of this group to wear clothes which are the fashion norm even if they do not particularly suit them.

Approval seemed to be further sought by the Black sample, as shown in other clothing behaviour, for example, a statistically significant mean difference was reflected for item 53 where Black subjects expressed more of a need to dress like others in their group so as to be identified as friends by other people. Results showed $\underline{M}(\underline{SD})$ = 4,75(0,44) for Blacks compared with a $\underline{M}(\underline{SD})$ = 4,40(0,77) for the White sample, P<|t| = 0,03. This persistent need for others' approval by the Black sample was evident in item 54 where the mean difference between the Black and White samples was $\underline{M}(\underline{SD})$ = 4,39(0,92) for the Black subjects and $\underline{M}(\underline{SD})$= 3,80(1,16) for the White subjects, P>|t| = 0,06. The co-efficient of variation for the mean value was, however, greater for the Blacks (47%) than for the Whites (32%). A statistically significant mean difference on item 57, confirmed the desire expressed by the Black fashion sample to dress similarly to their friends. A higher mean score for item 58 indicated the interest by the Black fashion sample to analyse others' clothing behaviour. The $\underline{M}(\underline{SD})$ for the Blacks was 4,29(1,05) compared with the Whites 3,37(0,91), P>|t| = 0,0012. Highest mean scores on item 59, demonstrated a preference by the White fashion sample for clothes which offer a local (Afro) or ethnic feel (not to be confused with traditional tribal wear) which would express their national identity (that is, South African). The score for the White fashion sample was $\underline{M}(\underline{SD})$= 4,30(0,92) compared with 3,61(1,17) for the Black fashion sample P>|t| + 0,014.

Statistically significant mean differences for *Factor Six: Modesty* revealed that White subjects showed clothing behaviour which was marginally more conservative than Black subjects, item 61, $\underline{M} \pm \underline{SD}$ = 3,07 ± 1,36 for Blacks and $\underline{M} \pm \underline{SD}$ = 3,63 ± 0,91 for White subjects, P>|t| = 0,07. Black subjects felt more vulnerable than White subjects when going to a public beach or pool for the first time in a season (item 63); the mean was $\underline{M}(\underline{SD})$ = 2,97(1,24) for the Black subjects and $\underline{M}(\underline{SD})$ = 2,27(1,14) for the White subjects, P<|t| = 0,03.

A higher marginal trend, however, was reflected for the modesty factor by White subjects who expressed embarrassment when exposed to others whose clothes were too tight (item 67), $\underline{M}(\underline{SD})$ = 3,03(1,24) for Black subjects compared with $\underline{M}(\underline{SD})$ = 3,57(1,10) for Whites, P>|t| = 0,08. Moreover, the White sample (n=30) showed a significantly higher contempt of people whose clothing behaviour seemed to reveal too much of their bodies: $\underline{M}(\underline{SD})$ = 2,9(1,42) for the Black sample and $\underline{M}(\underline{SD})$ = 3,87(0,78) for the White sample, P<|t| = 0,0018 (Item 69, Table 7.15)

7.7.5 Principal components' analysis to measure clothing behaviour for the non-clinical Black and White female sample (n=60) for subproblem five

The results of a principal components analysis (using a varimax rotation) to measure the importance of six clothing variables (Creekmore, 1971) are presented in Table 7.16 for the non-clinical female sample of Black women (n=30) and White women (n=30). The original standardised questionnaire consisted of eight clothing variables (Creekmore, 1971), of which six relevant variables were utilised for this study. The principal components analysis yielded eighteen factors with eigen values >1. Eight to twelve factors emerged as the most important, according to the Scree Test. The remaining factors are not discussed as it was found that they became increasingly less clearly interpretable.

7.7.5.1 Factor analysis for the non-clinical female samples (n=60) for subproblem five

The distribution of items from the various sub-scales for the factor analysis of the Black female sample (n=30) differed from the original eight factors based on Creekmore's (1971) study. The most important factors emerging; that is, one to ten, will be dealt with in more detail than less identifiable factors. Factors with eigen values >1 were included in the analysis.

The order of the item numbers for each of the following factors corresponds with item numbers in Table 7.16 according to the sequence of factor values, that is, the highest values placed first.

Factor One: Personal appearance, explained 15% of the total variance of 95%. High factor loadings on item 4 (0,84), item 17 (0,82) and item 42 (0,68) indicated the level of importance placed by the Black sample on utilising the aesthetic appeal of clothes to gain attention and approval. The factor loading on item 4 was higher than that for the same item in the Gurel and Gurel (1979) study (n=500), where item 4, also *Factor One*, was 0,41.

Factor Two: Experiment with appearance explained 10% of the variance and expressed Black subjects' interest and attention in trying out new styles, combining accessories, co-ordinating colours; for example, item 40 (0,74), item 19 (0,73), item 37 (0,69) and item 11 (0,68) (Table 7.16).

Factor Three: Impression management through clothes explained 6% of the variance. A high factor loading on item 46 (0,85) indicated subjects' attitudes and use of clothes to create an impression and to attract attention in social situations.

Table 7.16: Questionnaire 3: Principal components' analysis to measure clothing behaviour attitudes obtained by the non-clincal sample group of 30 Black women

	FACTORS							
Item	1	2	3	4	5	6	7	8
4	0,84							
17	0,82							
42	0,68							
1	0,67							
13	0,67							
41	0,60							
18	0,44							
52	-0,38							
10	-0,71							
	0,15(10,37)*							
40		0,74						
19		0,73						
37		0,69						
20		0,68						
11		0,68						
70		0,48						
		0,10(7,23)*						
46			0,85					
6			0,76					
22			0,59					
9			-0,68					
			0,09(6,05)*					
25				0,75				
65				0,73				
54				0,72				
51				0,68				
59				0,57				
68				0,48				
				0,08(5,53)*				
58					0,82			
29					0,72			
47					0,59			
24					0,54			
55					0,38			
62					-0,49			
36					-0,63			
					0,06(4,25)*			
28						0,91		
38						0,59		
35						0,59		
30						0,57		
3						0,55		
						0,06(3,99)*		
5							0,81	
8							0,73	
39							0,48	
							0,05(3,77)*	
67								0,89
66								0,53
61								0,52
69								0,50
60								0,49
7								0,45
								0,05(3,47)*

* Variances explained and the eigen value

Note: For item descriptions see Annexure 3

Factor Four: Approval explained 9% of the variance. Black subjects' concern for how significantly others dress, as well as how their clothing behaviour gains the approval of others, was reflected in the factor loadings for item 25 (0,75), item 65 (0,73) and item 54 (0,72). Items 59 and 25 related to subjects' sense of self-expression.

It is important to note that each original subscale (Creekmore, 1971) included a final theoretical item, which measured the highest intensity of that aspect of clothing behaviour or a striving to understand the self, and others, relative to overt clothing behaviour, (Gurel & Deemer, 1975). High factor loadings on *Factor Five*, item 58 (0,82) and items 47 (0,59) and 24 (0,54) demonstrated that searching for understanding as expressed through overt clothing behaviour was important to Black subjects. *Factor Five* corresponded, in its underlying dimension, to *Factor Five: Heightened awareness of clothing* in Gurel and Gurel's study (1979), where factor loadings ranged from 0,64 to 0,41 for theoretical questions which pertained to subjects' searching for understanding about self and others' basic values, needs and motivations.

Factor Six: Comfort. High factor loadings indicated Black subjects' significant concern for, and sensitivity to issues of comfort, specifically temperature, item 28 (0,91), and texture of fabric, item 35 (0,59). The variance explained by *Factor Six* was 6%. The value for item 35 approximated the Gurel and Gurel (1979) study which showed a factor loading of 0,61 (n=500).

Factor Seven: Clothing concern. High factors loadings, specifically on items 5 (0,81) and 8 (0,73) showed specific concern by Black subjects for clothing details which may affect others' opinions about them.

The aspect of *Modesty: Factor Eight*, (item 67) which seems of significant concern to Black subjects was that of clothes worn too tightly, as this appeared to embarrass them. The factor loading on item 67 was (0,89) compared with Gurel and Gurel's (1979) study where the factor loading for item 67 was 0,70 (n=500). Important items of modesty concerned unlined, revealing or low-cut clothes. These results of the factor analysis for *Modesty: Factor Eight*, confirmed the results of the unpaired *t*-test where the mean difference was significant for Black subjects (Table 7.16). The modesty factor explained 5% of the variance.

Factor Nine: Appearance improvement expressed Black subjects' determination in gaining information and understanding of their own and others' clothing behaviour in order to enhance physical appearance. Item 12 carried one of the highest factor loadings (0,94) for all items presented in Table 7.16.

Factor Ten: Conformity demonstrated that Black subjects preferred clothing behaviour which would closely identify them with their friends; that is, item 2 (0,85). The Gurel and Gurel (1979) study (n=500) showed a factor loading of 0,32 for *Factor Three: Conformity.*

Factors became less clearly definable from *Factor Eleven* to *Eighteen*, although more than 1% of the variance was expressed. Earlier, clearly definable trends, concerning clothing interest, aesthetics and awareness were recurrent and served to support earlier expressions of clothing behaviour by Black subjects.

Eight main factors explaining 5% or more of the variance emerged for the factor analysis of the non-clinical White female sample (n=30). Ten less clearly definable factors with eigen values >1 emerged and explained only between 4% and 2% of the variance, yet yielded significant information. The distribution of the items and sub-scales differed from the original factor analysis of Creekmore (1971) and Gurel and Gurel (1979). The order of the item numbers for each of the following factors corresponds with item numbers in Table 7.17 according to the sequence of factor values, that is, the highest values placed first.

Factor One: Approval, the most important factor, explained 12% of the variance and compared closely with Creekmores' (1971) original Factor Five: Approval, with five out of the ten original items being represented (53, 57, 52, 50 and 54). Factor loadings ranged from the highest at 0,89 to the lowest at 0,53 (Table 6.17).

Factor Two: Attention also explained 12% of the variance and indicated White subjects' level of clothing behaviour which would ensure that they receive attention and status. High factor loadings were noted: item 40 (0,86), item 37 (0,78 and item 41 (0,63).

The extent to which subjects' would be willing to investigate, give attention to, manipulate or experiment with clothing was evident from the high factor loadings on *Factor Three: Interest* which explained 9% of the variance. Factor loadings ranged from 0,86 for item 21 to 0,46 for item 17 (Table 7.14). White subjects (n=30) indicated that they read magazines and newspapers, experimented with accessories and the newest clothes each season and spent time paying attention to detail, in order to achieve a pleasing appearance.

Factor Four: Experimentation with appearance explained 7% of the variance and described White subjects' interest in experimenting with accessories and styles through clothing behaviour, in order to achieve acceptable levels of personal appearance. Item 16 (0,66), item 22 (0,44), a negative loading on item 13 (-0,46) confirmed White subjects' earlier attitudes which expressed a preference for more ethnic based South African fashions to European classical trends, ie. French and Italian, trends in clothing design which are not necessarily based on cost. The unpaired *t*-test (Table 7.15, item 13) showed a significant mean difference between the Black and White subjects with regard to this question where $\underline{M}(\underline{SD})$ = 2,79(1,40) for the Black subjects and $\underline{M}(\underline{SD})$ = 1,63(0,85) for the White subjects, $P<|t| = 0,0003$.

Table 7.17: Questionnaire 3: Principal components' analysis to measure clothing behaviour attitudes obtained by the non-clinical sample group of 30 White women

	FACTORS							
Item	1	2	3	4	5	6	7	8
53	0,89							
57	0,89							
52	0,84							
50	0,75							
54	0,53							
30	0,46							
	0,12(8,43)*							
40		0,86						
37		0,78						
41		0,63						
1		0,59						
59		-0,53						
25		-0,65						
		0,12(8,10)*						
21			0,86					
18			0,77					
19			0,71					
11			0,69					
7			0,54					
62			0,47					
17			0,46					
2			-0,56					
			0,09(6,19)*					
31				0,82				
28				0,67				
16				0,66				
22				0,44				
23				0,43				
13				-0,46				
				0,07(4,87)*				
43					0,74			
46					0,66			
48					0,65			
42					0,57			
6					0,47			
49					0,44			
					0,06(4,49)*			
39						0,34		
						0,05(3,67)*		
4							0,88	
35							0,85	
27							0,67	
							0,05(3,54)*	
64								0,86
66								0,61
44								-0,53
								0,04(3,10)*

* Variances explained and the eigen value

Note: For item descriptions see Annexure 3

High factor loadings on *Factor Five: Clothing as enhancement of security*, item 43 (0,74), item 46 (0,66) and item 48 (0,65) indicated the need for White subjects to feel secure with what they wear and with the social approval they gain. The loadings for items 43 and 46 were higher than the loadings for the Gurel and Gurel (1979) study (n=500) which were 0,54 and 0,38 respectively.

Factor Six: Aesthetics implied that White subjects used clothing to a large extent to attain a beautiful or pleasing appearance. *Factor Six* explained 5% of the variance. High factor loadings on item 3 (0,89), item 9 (0,70) and item 8 (0,65) (Table 6.17) underscored the aesthetic dimension of clothing behaviour by the White sample (n=30) for this study. This compared with findings by Gurel and Gurel (1979) (n=500) for items 9 and 8 where factor loadings were 0,65 and 0,61 respectively. For item 3, however, the factor loading for the Gurel and Gurel (1979) study was only 0,32.

High factor loadings for *Factor Seven: Comfort*, item 4(0,88), item 35 (0,85) and item 27 (0,67) indicated White subjects' use of clothing to achieve comfort in relation to physical response to fabric texture, tightness or looseness of garments and sensitivity to temperature. Although item 4 had a lower factor loading (0,41) for the Gurel and Gurel (1979) study, this item (i.e. 4) appeared on *Factor One*. However, the rest of the items pertaining to comfort appeared on *Factor Eight: Sensitivity to comfort*, for the Gurel and Gurel (1979) study, which confirmed the results of the present study.

Factors Eight, Nine and *Ten* each explained 4% of the variance, and described subtle differences in the clothing behaviour of White subjects. *Factor Eight* described *conservative behaviour*, for example items 64 and 66, which had factor loadings of 0,86 and 0,61 respectively. A negative value on item 44 (-0,53), *I enjoy wearing very different clothing even though I attract attention*, confirmed the conservative approach result explained by the previous two items.

Factors Fourteen to *Factor Twenty* each explained 2% of the variance and confirmed White subjects' concern to achieve approval, comfort and modesty through their specific style of clothing behaviour.

7.7.6 Questionnaire 4: Public and private self-consciousness (Fenigstein, Scheier & Buss, 1975)

Analysis of the data for subproblem six included the use of Questionnaire 4: Public and private self-consciousness (Fenigstein *et al.*, 1975) which was used to assess individual differences in self-consciousness. Self-consciousness is the tendency of persons to direct attention inward or outward. Underlying the self-consciousness trait, is the awareness of how one's behaviour affects others within a particular social context. The private dimension of self-consciousness focuses on thoughts and reflections that deal solely with the self. Similarly, the essence of public self-consciousness is the self as a social object. Public self-consciousness may be a necessary antecedent of social anxiety, the discomfort experienced by the person in the presence of others.

7.7.6.1 The clinical sample

Table 7.15 shows the distribution of means and standard deviations and results of a paired *t*-test for the clinical sample (n=25) for four surgical groups, reduction mammaplasty, augmentation mammaplasty, abdominoplasty and rhytidectomy over a range of three sub-scales for measuring self-consciousness (Fenigstein *et al.*, 1975).

Mean attitude scores of patients' perceptions of their private and public self-consciousness and level of social anxiety were reflected by the pre-test, post-test means and standard deviation scores. The significance of these mean differences was evident from the paired *t*-test results for each group on each subscale.

A statistically significant mean difference was noted for the reduction mammaplasty (n=12) sample on *Subscale One: Private self-consciousness*. A decrease in the post-test mean for item 5 (Table 6.18) indicated that reduction mammaplasty subjects were more self-focused prior to surgery than after surgery to remove excess breast mass: $\underline{M}$ ($\underline{SD}$) = 2,58(0,90) pre-test and $\underline{M}$ ($\underline{SD}$) = 2,17(0,94) post-test, $P<|t| = 0,05$. The marginally significant mean difference on item 7 (Table 7.18) demonstrated a further decrease in self-focused attention, post-operatively, and confirmed the significant mean difference in decreased self-absorption indicated by item 5, after reduction mammaplasty surgery. Based on these results, it is reasonable to assume that the reduction mammaplasty group rated higher in private self-consciousness due to oversized breast mass prior to surgery than after surgery when breast mass had been reduced.

Table 7.18: Questionnaire 4: A private and public self-consciousness scale. Comparative means, standard deviations and paired *t*-test scores to measure social security obtained by the clinical sample of 25 women before and after surgery

	RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)		
Tests	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Item	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
1	2,33(1,07)	2,58(1,08)	0,19	2,29(1,11)	2,29(0,95)	1.00	3,33(1,15)	2,33(0,58)	0,23	2,00(1,73)	1,67(1,15)	0,84
3	3,08(0,10)	2,75(1,14)	0,34	2,86(1,07)	3,43(0,53)	0,23	2,67(1,53)	2,67(1,15)	1,00	3,00(1,00)	2,33(1,52)	0,18
5	2,58(0,90)	2,17(0,94)	0,05*	2,28(0,95)	1,71(0,49)	0,17	2,67(0,58)	2,33(0,58)	0,42	2,33(0,58)	2,00(1,73)	0,80
7	2,83(0,83)	3,42(0,10)	0,08	3,14(0,90)	2,71(1,25)	0,29	2,67(1,15)	2,67(1,15)	1,00	2,67(0,58)	2,33(1,53)	0,67
9	2,83(0,94)	3,00(0,85)	0,58	3,00(1,54)	3,14(0,69)	0,83	2,33(1,53)	2,67(1,15)	0,42	3,67(0,58)	3,33(0,58)	0,42
13	1,58(0,51)	1,75(0,75)	0,55	1,57(0,53)	1,71(0,49)	0,36	1,67(0,58)	2,00(0,00)	0,42	2,00(1,00)	2,33(1,52)	0,42
15	2,50(0,90)	2,42(0,90)	0,75	2,14(0,70)	2,00(0,82)	0,69	2,33(0,58)	2,33(0,58)	—	2,00(0,00)	2,00(1,00)	1,00
18	3,33(0,78)	3,16(1,11)	0,44	3,43(0,53)	3,14(0,90)	0,46	3,67(0,58)	3,67(0,58)	1,00	2,67(1,15)		0,18
20	1,75(0,75)	1,58(0,67)	0,44	1,86(0,70)	1,71(0,76)	0,74	2,00(0,00)	2,67(1,15)	0,42	2,00(0,00)	2,00(1,00)	1,00
22	1,58(0,51)	1,50(0,67)	0,59	2,14(0,90)	1,57(0,79)	0,10	1,33(0,58)	1,00(0,00)	0,42	1,67(1,15)	1,33(0,58)	0,42
2	2,50(1,09)	2,17(0,94)	1,67	2,43(1,13)	2,14(1,07)	0,17	2,33(1,52)	2,33(1,52)	0,00	1,33(0,58)	1,67(0,58)	
6	1,67(0,89)	1,83(1,19)	0,64	2,00(1,15)	1,43(0,53)	0,28	1,33(0,58)	1,00(0,00)	0,42	2,33(0,58)	1,67(1,15)	0,63
11	2,33(1,07)	2,00(1,04)	0,54	2,14(1,21)	1,86(0,70)	0,36	2,33(1,15)	1,33(0,58)	0,23	2,00(0,00)	1,33(0,58)	0,18
14	2,25(0,97)	1,92(0,67)	0,37	2,14(1,07)	2,00(1,00)	0,80	2,00(1,00)	2,33(1,53)	0,42	2,67(1,15)	1,67(0,58)	0,23
17	2,08(0,10)	2,17(1,11)	0,67	2,42(0,98)	1,86(0,90)	0,17	2,33(1,53)	2,00(1,73)	0,42	2,33(1,53)	1,33(0,58)	0,23
19	2,42(0,79)	2,67(0,89)	0,43	2,43(1,13)	2,29(0,95)	0,60	3,00(1,00)	2,33(0,58)	0,18	2,00(1,00)	2,00(1,00)	0,18

RM = Reduction mammaplasty; AM = Augmentation mammaplasty; ABD = Abdominoplasty; RHY = Rhytidectomy

* Significant values

NOTE: For item descriptions see Annexure 4.

continued / ...

Table 7.18: (continued) Questionnaire 4: Private and public self-consciousness scale. Comparative means, standard deviations and paired *t*-test scores to measure social security obtained by the clinical sample of 25 women before and after surgery

	RM (n=12)			AM (n=7)			ABD (n=3)			RHY (n=3)		
Tests	Pre	Post		Pre	Post		Pre	Post		Pre	Post	
Item	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|	*M*	*M*	P>|t|
21	1,41(0,51)	1,50(0,80)	0,72	1,43(0,79)	1,57(0,53)	0,60	1,33(0,58)	1,00(0,00)	0,42	1,00(0,00)	1,00(0,00)	—
4	2,50(1,09)	2,42(0,97)	0,82	2,57(0,96)	1,86(0,70)	0,05*	3,00(1,00)	2,33(1,53)	0,42	3,33(0,58)	3,33(0,58)	—
8	2,42(0,90)	2,33(0,98)	0,72	2,29(0,95)	2,00(1,00)	0,17	3,00(1,00)	2,67(1,54)	0,42	3,67(0,58)	3,33(1,15)	0,74
10	2,42(0,67)	2,58(1,08)	0,59	2,57(0,98)	2,14(0,70)	0,08	3,00(1,73)	2,67(1,53)	0,42	3,67(0,58)	4,00(0,00)	0,42
12	1,75(0,75)	1,42(0,67)	0,22	2,29(1,11)	2,14(1,07)	0,60	2,33(1,53)	2,67(1,15)	0,84	1,33(0,58)	1,00(0,00)	0,42
16	2,25(0,97)	2,25(1,22)	1,00	2,00(1,00)	1,86(1,07)	0,60	1,67(0,58)	1,67(0,58)	—	2,33(1,53)	4,00(0,00)	0,20
23	2,83(1,11)	2,75(1,14)	0,81	2,57(0,98)	2,29(0,95)	0,17	2,33(0,58)	2,33(1,15)	—	3,67(0,58)	3,33(1,15)	0,42

* Significant values

RM = Reduction mammaplasty; AM = Augmentation mammaplasty; ABD = Abdominoplasty; RHY = Rhytidectomy

NOTE: For item descriptions see Annexure 4.

No further significant mean differences were evident pre-/post-operatively for the remaining three surgical groups, augmentation mammaplasty, abdominoplasty and rhytidectomy. Levels of private self-consciousness often remained precisely the same pre- and post-operatively, for example, the abdominoplasty subjects' pre-test/post-test means and standard deviation were $\underline{M}$ ($\underline{SD}$) = 2,67(1,15) pre- and post-test for item 7, $\underline{M}(\underline{SD})$ = 2,33(0,58) pre- and post-test for item 15 and $\underline{M}$ ($\underline{SD}$) = 3,67(0,58) pre- and post-test for item 18. These items represented the most stable pre-/post-surgical levels of any variables over the entire battery of six questionnaires for the clinical sample group (n=25). The implications of these stable results suggested that for the clinical subjects (n=25), with the exception of the reduction mammaplasty sample, levels of self-consciousness; that is, private thoughts about the self, attention to inner feelings, self-analysis and alertness to changes of mood, remained at an equal level over a three-month period, even though physical alterations to the body had been undertaken. The factor mean for *Subscale One* for women (n=253) reported by Fenigstein, Scheier and Buss (1975) was $\underline{M}(\underline{SD})$ = 2,66(5.1) (Table 2, p.525).

No statistically significant mean differences pre-/post-operatively were noted for the clinical sample (n=25) for *Subscale Two: Public self-consciousness*. It appeared that levels of self-consciousness related to the self as a social object, and patients' perceptions of how others viewed them remained the same prior to and after elective cosmetic surgery. Patients were equally concerned both pre- and post-operatively about their style of self-presentation, their appearance and the impression they made on others.

A statistically significant mean difference is reported in Table 7.18 on *Subscale Three: Social anxiety* for the augmentation mammaplasty (n=7) subjects. The post-operative mean score for item 4 showed a decrease in value compared with the pre-operative value; that is, $\underline{M}$ ($\underline{SD}$) = 2,57(0,96) (pre-test), and $\underline{M}$ ($\underline{SD}$) = 1,86(0,70) (post-test), $P<|t| = 0,05$. These results indicated that augmentation mammaplasty subjects reported feeling more self-confident in a social context after an increase to their breast size through surgery. Patients seemed more easily able to overcome their shyness in new situations, which implied less feelings of discomfort in the presence of others. These results may be compared with those of Schlebusch and Mahrt (1993) who reported that 70% of the augmentation mammaplasty patients (n=20) expressed a marked improvement in self-confidence and 80% felt socially more acceptable. The Fenigstein *et al.* (1975) study showed that the factor mean for *Subscale Three: Social anxiety* for (n=253) women was $\underline{M}$ ($\underline{SD}$) = 58,7(8,9) (Table 2, p.525).

A marginally significant pre-test/post-test mean difference for item 10 showed a decrease in the post-operative score for the augmentation mammaplasty subjects on *Factor Three: Social*

anxiety sub-scale, before surgery. Patients reported getting embarrassed far less easily after surgery for augmentation mammaplasty. No other significant differences in levels of social anxiety were reported pre-/post-operatively for the remaining three surgical groups, reduction mammaplasty, abdominoplasty and rhytidectomy.

7.7.6.2 The non-clinical sample: Questionnaire 4: Public and private self-consciousness (Fenigstein *et al.*, 1975)

Table 7.19 shows the distribution of means and standard deviations and the results of an unpaired *t*-test for the non-clinical sample of Black (n=30) and White (n=30) female subjects on three sub-scales to measure public and private self-consciousness. Significant trends in mean differences were observed on three variables for measuring public and private self-consciousness (Fenigstein *et al.*, 1975) between the non-clinical sample of Black (n=30) and White (n=30) female subjects (Table 7.19).

For *Sub-scale One: Private self-consciousness*, item 9 indicated a marginally higher mean difference for White subjects than for Black subjects. This suggests that White subjects had a higher level of private self-consciousness than Blacks subjects; that is, thoughts and reflections that deal solely with the self. A further marginally higher mean difference for item 15, confirmed the ongoing activity by White subjects of attending to their inner thoughts and feelings, trying to analyse their moods and feelings and examining their attitudes and behaviour patterns.

Subscale Two: Public self-consciousness reflected a statistically significant mean difference on item 11 between the Black sample $\underline{M}$ ($\underline{SD}$) = 1,70(0,88) and $\underline{M}$ ($\underline{SD}$) = 2,33(0,84) the White sample, $P<|t| = 0,006$. White subjects perceived themselves as feeling more aware of themselves as social objects; that is, in the way they present themselves and the effect they have on others. However, Black subjects indicated more concern for what other people think of them, for example for item 19, $\underline{M}$ ($\underline{SD}$) = 2,17(0,99) for the Black sample and $\underline{M}$ ($\underline{SD}$) = 2,00(0,87) for the Whites. For item 14, *I usually worry about making a good impression*, the higher mean for Black subjects did not show statistical-significance; however, it indicated important trends (Table 7.19).

Table 7.19: Questionnaire 4: public and private self-consciousness scale, comparative mean, standard deviation and unpaired *t*-test scores to measure social security obtained by the non-clinical sample group of 30 Black and 30 White women

Item No	Black Fashion (n=30) *M*	White Fashion (n=30) *M*	P>|t|	Item No	Black Fashion (n=30) *M*	White Fashion (n=30) *M*	P>|t|
1	2,07(1,02)	2,17(0,99)	0,70	11	1,70(0,88)	2,33(0,84)	0,006*
3	2,80(1,07)	2,93(0,94)	0,61	14	1,90(0,96)	1,57(0,57)	0,11
5	2,28(1,00)	2,00(0,87)	0,26	17	2,07(1,17)	1,83(0,83)	0,38
7	2,57(1,05)	2,37(0,89)	0,42	19	2,17(0,99)	2,00(0,87)	0,49
9	2,53(1,04)	2,97(0,89)	0,09	21	1,47(0,73)	1,30(0,47)	0,30
13	1,60(0,56)	1,73(0,74)	0,44	4	2,37(0,96)	2,60(1,07)	0,38
15	2,07(0,74)	2,40(0,77)	0,09	8	2,13(0,86)	2,03(0,96)	0,67
18	2,73(0,94)	3,07(0,74)	0,13	10	2,30(0,92)	2,60(0,97)	0,22
20	1,87(0,78)	1,70(0,65)	0,37	12	2,00(0,79)	1,90(1,09)	0,69
22	1,73(0,87)	1,83(0,79)	0,64	16	2,20(0,76)	1,93(0,94)	0,23
2	1,93(0,94)	2,07(0,96)	0,59	23	2,53(1,07)	2,47(1,11)	0,81
6	1,57(0,77)	1,67(0,80)	0,63				

* Significant values

Note: For item descriptions see Annexure 4

Subscale Three: Social anxiety endorsed an equal degree of social anxiety for the two non-clinical sample groups of Black (n=30) females and White (n=30) females. No significant mean differences were found (Table 7.19). This indicates that for the independent variables of culture, sex, and age where there was a mean difference of nine months, both groups (Black and White females (n=60) experienced similar comfort or discomfort in social situations. The factor mean norm reported by Fenigstein *et al.* (1975) (Table 2, p.525) for women (n=253) was $\underline{M}$ ($\underline{SD}$) = 12,8(4.5). No other norms were available at the time of this study. Fenigstein *et al.* (1975) stated that norms for diverse clinical populations of age and class are obviously needed..

7.8 SUBSECTIONS ONE: FASHION OPINION LEADERS

Of the two subsections included in the study (7.8; 7.9), the first was:

- *Fashion opinion leadership*, which had implications for both the clinical (n=25) and the non-clinical (n=60) sample with regard to clothing behaviour;

As the two subsections were intended merely as introductions in support of basic assumptions or aspects of the topic *'Aspects of physical appearance and clothing behaviour'*, no statistical results are reported. However, trends in feelings and attitudes will be commented upon, and in this way create an awareness for further research in these areas. Furthermore, awareness is also created in respect of the broadness of the multi-disciplinary intent of this topic within a biopsychosocial context.

Questionnaire 7: Correlates of Fashion Leadership – Implications for Fashion Process Theory (Shrank & Gilmore, 1973) was used to establish whether the four prominent fashion persons were in fact fashion opinion leaders. This was necessary in order to gain significant understanding of local fashion trends.

7.8.1 Women's clothing fashion opinion leaders: Questionnaire 7: Correlates of fashion leadership implications for fashion process theory (Schrank & Gilmore, 1973).

Fashion innovativeness, and fashion opinion leadership, have implications with regard to the process of fashion diffusion, through psychological, social and economic variables (Shrank & Gilmore, 1973). The degree of acceptance and rejection of clothing innovations, within a local social system, is at the core of clothing behaviour patterns for that particular society or social group. Intrinsic to the process of fashion adoption is the reflection of changing relations among people of diverse cultural groups and between humans and their material culture.

Due to the all-pervasive influence of fashion as a significant force in many areas of human life, either face-to-face or telephonic interviews were held with four prominent persons in the fashion world (Mr C Levine, Ms M Fassler, Ms J Button, Mr A Aboud), in order to seek further current information on local South African trends in clothing behaviour.

Before discussions on the topic of clothing behaviour in South Africa could be addressed, Questionnaire 7 was administered to the fashion opinion sample (n=4) in order to establish whether they were fashion opinion leaders or not. It is important to note that the sample group consisted of persons from the educational, haute couture and commercial sectors of the fashion world. Specific demographic data were not collected; however, the sample consisted of two males and two females between the ages of thirty-five to fifty-eight.

Table 7.20 shows that the opinion leadership (n=4) expressed the following mean scores across three factors, to measure the level of opinion leadership qualities.

Table 7.20: Mean scores for three factors to measure the level of fashion opinion leadership of four selected fashion personalities (n=4)

Factor No.	Variable	Item mean score	Percentage
One	Fashion opinion leadership	93,75	94
Two	Interest	95,33	95
Three	Non-conformity	77,25	77

The reliability co-efficients for the above scales were:

- 93 for fashion opinion leadership (Schrank & Gilmore, 1973)
- 85 for attitudes toward conformity (Creekmore, 1971)
- 92 for clothing interest and importance scale (Creekmore, 1971)

The high total mean scores for each factor on the fashion opinion leadership questionnaire, Questionnaire 7 (Table 7.20) indicated *mean percentages* which ranged from 77,25 (77%) for *Factor Three: Conformity*, to 95,33 (95%) for *Factor Two: Interest*. The total mean score for *Factor One: Opinion leadership*, was 93,75 (94%). The high percentage values on each factor indicated that the fashion persons interviewed, possessed qualities of fashion opinion leadership.

For *Factor One: Fashion opinion leadership*, the mean percentage of 94% showed that fashion persons (n=4) passed on fashion information to others and were consulted by others for the latest fashion trends. Fashion persons had confidence in their ability to give advice about fashion and enjoyed discussing fashion. According to Shrank and Gilmore (1973) fashion opinion leaders engage in verbal activity in obtaining and dispensing information. This

consciousness of verbal activity may be more intense than that necessary for adopting and wearing a new style early in the fashion cycle (that is, by the fashion innovator), and thus identifies such persons as having fashion leadership qualities.

For *Factor Two: Interest* the mean percentage of 89% demonstrated that fashion persons (n=4) enjoyed clothes to a point where they invested extra time, money and energy into reading and studying fashion magazines. Fashion persons (n=4) enjoyed planning and selecting their clothing, keeping up with fashion and fabrics and attending fashion shows regularly. Furthermore, the fashion subjects' (n=4) attitude was that clothes are important in expressing one's creativity. Fashion subjects (n=4) often window shopped in order to be well informed and, where possible, kept their wardrobes in top condition at all times. In the study by Shrank and Gilmore (1973), a positive relationship was observed between clothing interest and fashion opinion leadership. The correlation co-efficient of 0,764 was indicative of the strength of this relationship (Shrank & Gilmore, 1973, Table 1, p.538).

The fashion samples' (n=4) mean score on *Factor Three: Conformity* was 77%. This result indicated that it was not important to dress similarly to others specifically within one's group or social circle.. Fashion opinion leaders (n=4) indicated that they felt it was important to show their unique characters by dressing differently from those with whom they associated and that they would not necessarily dress like everyone else in order to gain acceptance into a group. Opinion leadership correlation co-efficient on conformity was 0,434 in a study by Shrank and Gilmore (1973, Table 1, p.538).

Based on his findings, Solomon (1985) postulated that there exists a positive relationship between high self-monitors; that is, persons who are sensitive to communicating the most appropriate self-image for a specific social situation, and fashion opinion leaders, who are aware of the clothing of others and their influence on others' clothing. Summers (1970) furthermore pointed out that some individuals exert a disproportionate amount of influence on the behaviour of others; that is, the opinion 'leader', or 'influentials'. The demographic and sociological characteristics found by Summers (1970) related positively to the fashion personalities selected for this sample (n=4).. The characteristics included those segments of the sample who had higher incomes, higher occupational status and higher education out of a sample of (n=1 000) females. Sociological characteristics included a measure of 'cosmopolitaness' and physical mobility. These variables appeared to allow individuals greater opportunity for exposure to new and different fashion ideas, which may in turn provide fashion information for social conversation. "*Social communications, affiliations with organizations and participation in social activities represent three dimensions of gregariousness which promote social interaction which has been linked with opinion leadership in all topic contexts in previous research findings....*" (Summers, 1970,

p.180). On this basis the three leading national designers and the leader in fashion education, selected as possible influential fashion personalities, were considered as fashion opinion leaders. Their opinions were used, where appropriate, in the general discussion, chapter eight, on fashion variables in South Africa for 1995/1996.

7.9 SUBSECTION TWO: ONCOLOGY

The second subsection in this study was:

- *The oncological indications* of patients towards body image, identity, clothing behaviour and level of social anxiety. These indications applied to case studies of one breast reconstruction patient, one post-mastectomy patient who did not elect to undergo a breast reconstruction process, and one lumpectomy patient.

Three breast oncology patients were selected for analysis in order to compare pre/post-surgical differences in attitudes and perceptions towards changed in their physical appearance and clothing behaviour. Differences among the three case studies selected focused on demographical data and surgery type. The overall picture of the case studies selected for this dissertation illustrates the attempts to understand the unique problems of an individual case. Emphasis has been placed on the meaning and complicity of the interrelations which were apparent from the data collected. Questionnaires 1, 2, 3, 4, 5, and 6 (Annexures 1, 2, 3, 4, 5 and 6) were administered to the oncological patients as an introduction to gaining insight into the attitudes and feelings of persons with a life threatening disease toward variables relating to physical appearance, body images identity, clothing and sense of social acceptance.
In the discussion, the emphasis on the descriptive and illustrative nature of the design is stressed. Awareness of the existence of problems in the application of statistical techniques to data from individual case designs was taken into consideration. It is acknowledged that, since there was no estimate of population variability, there was no basis for generalisation in terms of the population from which the subject had been selected (Rachman, 1980; Edwards & Talbot, 1994; Snyman, 1994).

7.9.1 Case study one: The breast reconstruction patient

7.9.1.1 Questionnaire 1: The Multidimensional body self-relation questionnaire (Cash *et al.*, 1986; Cash, 1990)

Demographic characteristics

The breast reconstruction patient was an affluent White English speaking woman of fifty-five years of age. She was married and lived in an elite residential area in Durban. She has three adult sons and is an active housewife who enjoys extra mural activities. She held a matric certificate. Prior to surgery for breast reconstruction, the breast reconstruction patient expressed confidence and anticipation about the possibility of a new breast. She expressed some fear and anxiety about pain and the surgery itself. The breast reconstruction patient had waited for an interval of two years after mastectomy before deciding on having surgery for breast reconstruction. The breast reconstruction patient explained that making a decision to have surgery was extremely difficult for her. The breast reconstruction patient's feelings towards her body images and appearance before and after surgery were as follows:

i. Physical appearance

Before surgery for breast reconstruction, the breast reconstruction patient reported an attitude of interest in overall appearance, on being attractive and buying clothes that would make her look her best. These positive tendencies were also apparent post-surgically (before surgery for breast reconstruction). Test values indicated negative attitudes toward the breast reconstruction subject's experience of her body as being sexually attractive, feeling unattractive without her clothes. The patient reported being dissatisfied with her looks and avoided excess use of the mirror, although she reported she always tried to improve her physical appearance. Both pre- and post-operatively, the breast reconstruction patient indicated the use of many grooming products and felt that it was important to always look good. Post-operatively the breast reconstruction patient expressed complete satisfaction with the way she looked without her clothes on and appeared to be most compatible with the way her clothes fitted. Jamison *et al.* (1978) noted for their sample of (n=41) that women who were in supportive relatinships coped far better with mastectomy, and post-surgical success for breast reconstruction was more likely under such circumstances.

ii. Physical fitness and health orientation

The breast reconstruction patient reported feeling more in control of her health, post-operatively. Physical fitness appeared to remain important both pre- and post-operatively. The breast reconstruction patient appeared to place great significance on working to improve her physical

stamina before and after surgery. Before surgery, good health seemed of less importance than after surgery. She appeared to be most concerned about threats to her health pre- and post-test. After mastectomy she indicated she did not play sport regularly. However, after breast reconstruction she appeared to play a sport regularly. After surgery for breast reconstruction, the breast reconstruction patient indicated more concern for small changes in her physical health than before surgery for breast reconstruction. It was observed that she always appeared to keep herself informed of health issues.

iii. Weight preoccupation and weight orientation

It was observed that the breast reconstruction patient's scores were consistently low on all matters concerning pre-occupation with weight and diet programmes after mastectomy, but before breast reconstruction. The breast reconstruction patient perceived herself to be of normal weight and seemed to perceive others as viewing her as normal weight.

iv. Body areas satisfaction

High scores were observed for the breast reconstruction patient pre-operatively for breast reconstruction for maximum satisfaction with her height, weight, muscle tone and hair, and a medium level of satisfaction seemed to be expressed for facial features and overall appearance. The breast reconstruction patient appeared to be completely dissatisfied with her upper torso (chest or breasts, shoulders and arms); lower torso (buttocks, hips, thighs and legs) and partly dissatisfied with the mid torso area. After surgery for breast reconstruction her scores on weight preoccupation and satisfaction seemed to remain the same as pre-operatively, and she expressed a lack of concern for weight related problems or need for diet programmes. However, scores that related to her body areas satisfaction increased maximally after breast reconstruction surgery. She appeared to be highly satisfied with her upper, mid and lower torso, satisfied with her overall appearance and fairly satisfied with her facial features.

7.9.1.2 Questionnaire 2: Scale for measuring Identity as conceived by Erik Erikson (Ochse & Plug, 1986)

The following section describes the breast reconstruction patient's identity status in terms of changes made to her physical appearance through surgery for breast reconstruction.

i. Trust

The pre/post-test differences for the breast reconstruction patient were observed for items 51, 81 and 91 (for item descriptions see Annexure 2) where higher scores post-operatively demonstrated that the breast reconstruction patient developed a higher sense of self-satisfaction, of being valued as a person and of having more positive beliefs in the future after surgery for breast

reconstruction. The breast reconstruction patient also reported gaining a greater sense of authority and assertiveness, although in a certain sense her need for social approval and recognition remained apparent. Social desirability scores for the breast reconstruction patient showed an increase on most items post-operatively. The scores for the breast reconstruction patient post-operatively on most items pertaining to initiative, exemplified and elevated sense of self-confidence and positivity toward achieving her goals despite competition and risks. She also indicated a higher sense of responsibility for choices she made post-operatively.

ii. Identity

Higher scores post-operatively for issues pertaining to idendity showed the breast reconstruction patient's more positive sense of self-identity and the consistency with which she perceived others to view her. No difference in scores, pre-/post-operatively for the breast reconstruction patient was observed on *Factor Seven: Intimacy*. It appears that through the trauma of life-threatening disease, the removal of a breast and the reconstruction of a new breast she remained stable in her ability for closeness, intimate relationships and perceived sense of feeling wanted and not alone in the world. As reported by Schover (1991) the majority of women, particularly those in healthy supportive relationships coped well with the stress of cancer surgery.

iii. Generativity

After surgery for breast reconstruction the breast reconstruction patient demonstrated notably higher levels of *Factor Eight: Generativity*, in the expression of her care of others, belief in herself and others and sense of contribution to the community. In conclusion the results on identity indicated positive trends post-operatively for the breast reconstruction patient; that is, higher levels of clear self-definition and positive identity functioning. No scores were low enough to suspect identity disintegration or foreclosure in relation to a life-threatening association with a disease. It appears that a positive change in body images perception could impact positively on self-identity. Her socio-economic background, occupation, life-style and secure relationship could be contributing factors to this complete interrelationship and outcome.

7.9.1.3 Questionnaire 3: The Creekmore scales of eight clothing variables (1971)

For the sub-section measuring attitudes and interest in clothing variables for the breast reconstruction patient, the descriptive data, although not statistically significant, gave indications of some main tendencies and were supported by reports from interviews (Personal Communication, Durban, 1994). In the discussion, the clinical significance of these results are emphasised, and the interrelation among the clothing, body-images and identity variables and

their possible interactional influences on overall perception of the patient's self-concept are stressed.

The most notable pre-/post-test differences for the breast reconstruction subject included the expression of heightened interest in the way she looked in her clothes post-operatively, and more definite attention to details of colour combinations and co-ordination of accesories than previously (*Factor One: Concern with personal appearance*). A notable difference post-operatively was her interest in reading latest media articles on what is new in clothing. Expermentation with garments, accessories, hairstyles and trying on clothes in the store (*Factor Two*) were also areas of renewed interest after surgery for a new breast. She stated a preference for contemporary European fashion as opposed to ethnic fashions. Prior to receiving a new breast; that is, post-mastectomy, she perceived herself as being slightly more conforming than after surgery for breast reconstruction (*Factor Three*).

Modesty: Factor Four scores on this factor for the breast reconstruction patient seemed to indicate less conservatism in style and colour, post-operatively. She did not appear to express anxiety over issues of modesty. For *Factor Six: Comfort* she indicated that comfort did not come before fashionable trends. However, she expressed less irritability to uncomfortable clothes and less sensitivity to the texture of the fabric post-operatively.

7.9.1.4 Questionnaire 4: Public and private self-consciousness (Fenigstein *et al.*, 1975)

How a changed physical appearance, a more positive sum of identity and renewed interest in clothing may affect a person's sense of acceptance and belonging where the trauma of cancer has been a factor, is illustrated by the following results for case study one.

i. Private self-consciousness

No specific differences were noted for the breast reconstruction patient, pre- and post-surgery for *Factor One: Private Self-consciousness*. Observations of scores, however, showed that she perceived herself as having moderate levels of inner self-awarenss or self-consciousness, and was moderately attentive to inner feelings, motivations and mood changes. She indicated that it was partially characteristic of her to be self-reflective and self-analytical. However, in terms of public self-consciousness the breast reconstruction patient indicated being more self-conscious about the way she looked before and after reconstruction of a new breast. She also showed she checked on her appearance in the mirror more often prior to surgery for breast reconstruction, and was fairly concerned about what other people thought of her. Post-surgically she was similarly concerned about what others thought of her, and less self-conscious about the way she looked; however, she was more concerned about making a good impression.

The most notable differences were evident from the scores of *Factor Three: Social anxiety* which appeared to increase for the breast reconstruction patient post-surgically. She indicated attitudes of shyness, getting embarrassed very easily, difficulty in talking to strangers and feelings of anxiety in speaking in front of a group. She also indicated that large groups made her nervous. No further notable differences were observed for the breast reconstruction patient on the self-consciousness scale. It seems reasonable to suggest that although the breast reconstruction patient acknowledged the positive changes to her body images and identity, she may not have fully integrated these changes into her self concept three months after surgery, particularly in a social situation (Shover, 1991). It is likely that follow-up time interval assessments would yield different results.

7.9.1.5 Questionnaire 5: The IPAT Anxiety Scale (Cattell *et al.*, 1968)

No difference was noted for the total A score = 16 whereas the post-test total A score = 14. The Total Sten = 5 pre-test was within the average range for level of anxiety (Cattell *et al.*, 1968). A notable descrease in total B score = 14 was observed for the breast reconstruction patient, which indicated a higher level of pre-surgical overt or symptomatic anxiety; that is, pre-test total B score = 14 , post-test total B score = 5 and Total Sten = 3. A sten score of three indicated stability, security and mental health generally (Cattell *et al.*, 1968). The high pre-test B score (invert symptomatic anxiety) appeared to indicate the breast reconstruction subject's anxiety about a conscious self-sentiment in loss of breast and about social approval. In a face-to-face pre-surgery interview with the patient (Durban, May 1994), she expressed anxiety about the surgery and pain and stated that she had been considering surgery for a long time. However, the breast reconstruction patient's attitude toward the prospects of the final results appeared to be positive. Post-operatively, the breast reconstruction patient reported an improved self-confidence and was very satisfied with the final result of her new breast (Personal communication, Durban, August 1994).

7.9.1.6 Questionnaire 6: 16 PF (Prinsloo, 1991)

Only descriptions of notably varying personality variables are given. The breast reconstruction subject's score on *Factor B* was elevated, pre-surgically, for breast reconstruction and described a sharper, more abstract mode of thinking or dealing with problems, than for the three-month period post-surgically. A notable difference occurred for *Factor O* where the pre-test raw score for this factor was 13 and the post-test score was 3. A higher score on *Factor O*, describes a

person who is apprehensive, worrying, depressive and troubled. Although not statistically valid, the pre-operative score for the breast reconstruction patient was well above the mean score; that is, $\underline{M}$ = 8,73 for n=221 (Table 16: Prinsloo, 1991, p.29). This result, however, gave an indication of the breast reconstruction subject's emotional pre-operative state and was confirmed by scores previously discussed for Questionnaire 5 on the IPAT Anxiety Scale where a total B score = 14 was recorded pre-operatively, indicating an elevated level of pre-operative anxiety compared with a total B score = 5 post-operatively. The post-operative score = 3 indicated untroubled adequacy and was below the norm of 8,73 for the 1989 (n=221) study (Prinsloo, 1991). A further notable pre-/post-test difference was observed for *Factor Q* where a low pre-operative score Q_1 = 3 compared with a post-operative score Q_1 = 7 indicated a higher level of conservatism after mastectomy and before breast reconstruction. In the three-month period after surgery for breast reconstruction, the breast reconstruction subject showed tendencies of being more experimental, free-thinking and confident.

A decrease occurred in the score post-operatively for *Factor* Q_4 where the pre-test score was Q_4 = 12 and the post-test score was Q_4 = 6. The high pre-operative score indicated high ergic tension; that is, tense, driven, overwrought or distressed, whereas the low post-operative score indicated low ergic tension, i.e. relaxed, tranquil and unfrustrated tendencies. No further notable differences were observed on the 16 PF for the breast reconstruction patient pre- and post-surgically.

7.9.1.7 General

On the whole, the breast reconstruction patient was extremely positive about the physical, psychological and social changes she experienced after surgery for breast reconstruction. Her enhanced quality of life was visually expressed through her interest in fashionable clothing. This is supported in the literature where women's most common motivations for breast reconstruction were reported (Schover, 1991, Table I, p.114, 155) as being to feel whole again, to eliminate a breast prosthesis and to wear a wider variety of clothing styles.

7.9.2 Case study two: The mastectomy patient

Demographic characteristics

The mastectomy patient was a White English speaking widow in her mid-fifties. She held a matric equivalent certificate. She was a caterer and classified herself as being in the middle income bracket. She lived twenty kilometres inland from the city (Durban) and had no adult

children living with her. She described herself as depressed and lonely after being diagnosed for breast cancer. There was a long waiting period before a decision to operate was taken. The mastectomy patient's feelings toward her body image and appearance before and after surgery for mastectomy were as follows:

7.9.2.1 Questionnaire 1: The Multidimensional body self-relation questionnaire (Cash *et al.*, 1986; Cash 1990)

i. Physical appearance

With regard to overall physical appearance, the mastectomy patient reported that she was careful to choose clothes that made her look her best after surgery. However, she was completely dissatisfied with her unclothed body, and expressed feelings of unattractiveness and ambivalence in rating her body as sexually appealing. She expressed feelings of reduced femininity and avoided looking at herself in the mirror. Although this was a single case study, similar findings are reported in the literature. According to Jamison *et al.* (1978), a sizeable proportion of women in their sample (n=41) for mastectomy stated that they had considerable or profound problems in dealing with themselves post-surgically. They suffered a great deal as a result of what they perceived to be mutilating, defeminising and disfiguring surgical procedures. However, 60% of women rated their overall post-mastectomy adjustment as good. This included perceptions of their body images, emotional adjustment and overall coping strategies. Jamison *et al.* (1978) noted that it was clear from their data that the physical and emotional effects of mastectomy were much more far reaching in younger women, unmarried or divorced women, than for married women in supportive relationships. Jamison *et al.* (1978) had divided their sample (n=41) into two groups, women 45 years or older (n=25) and those under 45 (n=16), and found that the younger women rated their post-mastectomy adjustment as significantly poorer ($F=5,15$, $P<02$, p.434).

The mastectomy patient reported feeling self-conscious if her grooming was not right. However, she managed to adjust the fit of her clothes in order to feel comfortable and acceptable after the removal of her breast. It appeared that generally, post-mastectomy adjustment for her was difficult, being out of the city and with no supportive intimate relationship.

ii. Physical fitness and health orientation

Both prior to and post-mastectomy, the mastectomy patient seemed very concerned about fitness. She also adopted a positive attitude to health related issues post-operatively (items 44, 45, 55 - Annexure 1). Responses to these items indicated that the mastectomy patient lacked vulnerability

to negative feelings about illness. The extent of the importance she placed on physical health and her refusal to become neurotically absorbed with minor health changes were also expressed.

iii. Weight preoccupation and weight orientation: Body areas satisfaction

The mastectomy patient demonstrated little concern for weight related issues, and seemed fairly satisfied with all body part areas, except for her height, with which she expressed dissatisfaction. After mastectomy the mastectomy patient expressed being neither satisfied nor dissatisfied with her mid torso or upper torso. This was found to be an interesting observation in relation to the mastectomy patient's previous (7.9 (i)) expression of complete dissatisfaction with her unclothed body. However, when focusing on specific body areas, the trauma of breast removal, shock and denial are thought to be a reasonable explanation for her lack of a more specific indication of her satisfaction or dissatisfaction with her upper torso. Her positive attitude and determination not to allow fears of recurrence to overwhelm her, appeared to be important factors in her overall physical and emotional adjustment. This finding is supported in the literature. Schover (1991) reported that the majority of women coped well with the stress of cancer surgery and the loss of a breast. Although it appeared that the loss of a breast was definitely emotionally distressing, this did not necessarily result in elevated prevalences of psychiatric disorders or sexual dysfunction. Schover (1991) (Table I, p.114, 155) noted that the one consistent finding is that women whose breasts are conserved have more positive feelings about their bodies, particularly their appearance in the nude, than do women after mastectomy. The mastectomy patient did not express a desire for breast reconstruction at the time of the questionnaire administration and interviews, although her difficulty in accepting her physical appearance after mastectomy was apparent.

7.9.2.2 Questionnaire 2: Scale for measuring Identity as conceived by Erik Erikson (Ochse & Plug, 1986)

i. Trust versus mistrust

The mastectomy patient's lower scores on items 21, 11 and 41 (for item descriptions see Annexure 1) seemed to be demonstrative of less positive feelings of certainty and trust in others and self although the mastectomy patient indicated being optimistic about future.

ii. Autonomy

In terms of autonomy the mastectomy patient indicated self-confidence in continuing with her work and being successful in her occupation. The mastectomy patient indicated a lack of energy

for task completion but not for competency or work pleasure. High scores on *Factor Five: Industry* seemed to indicate a level of determination to work and achieve for the mastectomy patient despite the loss of a breast and the emotional and psychological effects this may carry. The mastectomy patient did not express an increase in her need for social approval after mastectomy.

iii. Identity

After the removal of a breast, the mastectomy patient seemed to possess a clear-cut sense of identity. Although not statistically significant, the observations were that the mastectomy patient was consistent in attitudes and feelings about who she was, how she perceived others viewed her and how she perceived and evaluated the worth of her own life.

iv. Intimacy

Demographic characteristics of being a widow, living outside the city, age and income would partly contribute to the results on intimacy for the mastectomy patient. The mastectomy patient expressed sharing less intimate relationships with others and seemed to express herself less closely in her general interpersonal relationships after mastectomy. According to Jamison *et al.* (1978) (Table I, p.434) the most pervasive assumptions about mastectomy were the profound negative effects on the woman's body image and her sexual relationships. Although some women reported "no change" in their intimate relationships, others, especially younger women, reported feelings of anger and outrage, and were less likely to be as confident in close relationships. Younger women (n=16) reported mastectomy as having a negative influence on their sexual relationship (F=5,11, P< 0,03)(Jamison *et al.*, 1978). The general lack of closeness in relationships through months after mastectomy for the mastectomy patient was also noticeable in her attitude toward her participation and involvement in community life. She appeared less confident about her involvement with the demographic variables; that is, difference in age and the loss of a breast may appear to be contributing factors to this difference in trends pre- and post-operatively. Score differences were low enough to note any indication of stagnation or sense of life wasted. On the whole for identity the mastectomy patient expressed the same mistrust and uncertainty about herself and others after the surgical removal of her breast. Her ability for closeness seemed disturbed; however, she appeared to use determination and optimism as coping mechanisms in the difficult post-mastectomy adjustment phase.

7.9.2.3 Questionnaire 3: The Creekmore scales of eight clothing variables (1971)

For the subsection measuring attitudes and interest in clothing variables for the mastectomy patient the following observations are reported. Again, the clinical significance of these results is emphasised, as well as the impact of these interrelations among body images, identity and clothing variables on the patient's life.

i. Attitude towards clothes

After mastectomy, the mastectomy patient expressed how important clothes were to her. More significantly, clothes were used as a means of disguising physical problems and imperfections through the skilful use of colour, line and texture. This was confirmed by previous results when the mastectomy patient expressed carefully choosing fabric texture with the line of the garment. The mastectomy subject also indicated that she paid much attention to pleasing colour combinations as well as carefully co-ordinating the accessories she wore with each outfit. After mastectomy, scores for the mastectomy subject indicated a definite interest in keeping up with the latest trends in fashion, being informed about the newest clothing styles each season, and experimenting with many accessories. These attitudes were expressed in higher scores on *Factor One: Concern with personal appearance, Factor Two: Experimenting with appearance* and *Factor Five: Heightened awareness of clothes with enhanced individuality*. The mastectomy patient did not indicate any special comfort needs or particular sensitivity to fabric texture on *Factor Six: Sensitivity to comfort*. However, notably, the mastectomy subject did indicate that she selected clothes that did not call attention to herself (item 66, *Factor One: Concern with personal appearance*). The result may be related to the outcome on the identity scale where the mastectomy patient showed a low need for the approval of others or in order to be viewed favourably by others (social desirability, 7.9.2.2(ii)).

ii. General

The overall picture of the clothing variables for the mastectomy patient depicts the importance of clothing in her life. Clothes were useful as a tool for physical appearance management, and as an aesthetic expression of herself. Fashion interest, and keeping up-to-date with the latest trends, formed an integral part of her clothing behaviour.

7.9.2.4 Questionnaire 4: Public and private self-consciousness (Fenigstein *et al.*, 1975)

i. Public self-consciousness

No extremely characteristic or uncharacteristic attitudes dominated for any of the factors for the mastectomy patient in terms of feelings of acceptance and belonging in a group, after surgery for mastectomy. As in Questionnaire 3, *Factor One: Personal appearance* (7.9.2.3) the mastectomy patient indicated being unusually aware of her appearance and always checking on her grooming. She indicated being partially self-conscious about the way she looked (*Public self-consciousness: Factor Two*).

ii. Private self-consciousness

What seemed of improtance to her was her awareness of her mood changes (*Private self-consciousness: Factor One*), although at no point did she express negativity with regard to feeling rejected or excluded. However, the emphasis on mood change expressed by her may be reasonably associated with the medicinal adjustment needed after body-part loss.

iii. General

As could be expected, the mastectomy patient demonstrated higher levels of concern with private self-consciousness than with aspects of public self-consciousness as discussed.

7.9.2.5 Questionnaire 5: The IPAT anxiety scale (Cattell *et al.*, 1968)

The mastectomy patient demonstrated a high overall level of anxiety both pre- and post-operatively. The total A score = 6 (covert, hidden anxiety) was above the average for the general population as reported by Cattell *et al.* (1968).

A detailed analysis of these results revealed that contrary to the results on the need for social approval as previously discussed (7.9.2.3 and 7.9.2.4) the mastectomy patient was highly anxious in terms of the following factors:

- concern with social approval due to the removal of a breast;
- feelings of depressing or unworthiness (item 15)(for item descriptions see Annexure 3);
- feelings of fear and frustration;
- lack of control in unsettling situations (item 24).

The indications of higher scores on *Factor Five: Frustration, tension, ID pressure* (item 4), were descriptively expressed by the mastectomy patient's perception of herself as prone to emotionality, tension and irritability.

7.9.2.6 Questionnaire 6: 16 PF (Prinsloo, 1991)

i. Change in personality traits

The most noticeable features of the mastectomy patient's personality traits which differed after mastectomy, were observed from the following results. A low score on *Factor C*, C=10, demonstrated that the mastectomy patient was affected by feelings of anxiety and was easily upset, post-mastectomy. This score was lower than the mean on *Factor C*, C=17,06 for n=221 (Prinsloo, 1991: Table 16, p.27). Furthermore, a low *Factor E* score = 10 indicated that the mastectomy patient was more submissive and conforming rather than being assertive, dominant and independent. She expressed being more shy, restrained and timid, rather than uninhibited, socially bold or spontaneous, particularly after surgery. The implications were that the mastectomy patient demonstrated more conservatism post-operatively. High scores for *Factor* Q_2 = 16, Q_3 = 14 and Q_4 = 16 compared with the mastectomy scores for the 1989 study (Prinsloo, 1991: Table 16, p.27) which were Q_2 = 10,22, Q_3 = 12,06 and Q_4 = 9,31 respectively, indicated personality variables for the mastectomy patient pertaining to self-sufficiency, self-control and high level of tenseness or being overwrought or fretful compared with a low ergic tension which is typical of more casual, relaxed and unfrustrated personality type.

ii. General

The picture of the mastectomy patient's personality after mastectomy appeared to be one of overall conservatism, restraint, emotionality and anxiety. However, the possibility of further changes needs to be carefully considered as the three-month post-mastectomy period is often a time when the patient is at her most sensitive stage (Schover, 1991). Any assessment needs to take into account the possibility of transience. Follow-up assessments would need to be done at different time intervals to increase the validity of the results. Aspects of physical appearance, identity, integrity and intimacy were not entirely positive for the mastectomy patient. She did, however, express determination, optimism for the future, competency and a definite interest in maintaining her interest level in fashionable dressing and overall grooming behaviour.

7.9.3 Case study three: The lumpectomy patient

Schover (1991) noted that the strongest impact of breast conservation was the improvement or maintenance of a positive body image. Results for the lumpectomy patient showed the following perceptions and attitudes before and after surgery and treatment for a malignant breast lump.

Demographic characteristics

The lumpectomy patient was a thirty-seven year old White female who spoke English but who was Afrikaans. She was divorced and a single parent to one child, and lived on the outskirts of the city (Durban). She classified her income as low, although she held a matric certificate and worked as a clerk. She expressed some fear about her treatment for lumpectomy but was very happy she did not have to undergo a mastectomy. Being fairly young and unmarried, she also expressed concern about scarring. She had no prior history of malignancy, although she expressed anxiety about the possibility of the recurrence of a malignant breast lump.

7.9.3.1 Questionnaire 1: The Multidimensional body self-relation questionnaire (Cash *et al.*, 1986; Cash, 1990)

i. Physical appearance

Prior to surgery the lumpectomy patient reported that overall physical appearance was very important to her and that she generally bought clothes that made her look her best. Post-surgically the lumpectomy patient did not express very positive perceptions about the sexual attractiveness of her body, although she agreed that she liked the way she looked without her clothes on. The lumpectomy patient did not appear to be over concerned with her grooming or with others' opinions of her appearance; however, she liked to be comfortable in her clothes and was mostly satisfied with how her clothes fitted. She reported feeling sensitive around the area where breast surgery had been done as well as due to the effects of radio therapy.

ii. Physical fitness and health orientation

The lumpectomy patient seemed to adopt a mediocre attitude to keeping fit. However, her attitude toward good health appeared to be significant. She adopted a positive attitude toward illness management, to ensure she would not become overly vulnerable. She placed importance on being physically healthy and demonstrated a lack of self-absorption with minor health changes.

iii. Weight preoccupation and weight orientation

After lumpectomy, the lumpectomy patient expressed little concern about becoming overweight or about minor weight changes and perceived herself as normal weight. Scores on the body part satisfaction scale showed that the lumpectomy patient was mostly satisfied with all areas of her body including hair and face, very satisfied with her weight and height and mostly satisfied with her overall appearance. Schover (1991) noted that fear of recurrence of cancer was higher for lumpectomy patients than for either mastectomy or breast reconstruction patients. The lumpectomy patient for this case study did not demonstrate an enhanced fear of cancer recurrence at the time of the interview.

iv. General

The lumpectomy patient was generally satisfied with her physical appearance, health and her clothing behaviour; she was not overly fussy about her details of grooming nor was she anxious about the way others viewed her. Her demographic characteristics, however, would possibly influence these attitudes to some extent. Being a single parent, with no live-in partner and receiving a low income, may leave her little time to attend to grooming details in the face of her responsibilities. Not having a partner may also have influenced her lack of concern for approval. She expressed the necessity of being physically fit in order to maintain her independence and survive with her child.

7.9.3.2 Questionnaire 2: Scale for measuring identity as conceived by Erik Erikson (Ochse, 1986)

i. Trust

The lumpectomy patient appeared to show neither a very positive nor negative level of trust in self or others. The lumpectomy patient expressed the need for self-reliance in her position; however, she reported that neither the trauma of divorce nor the fear of cancer recurrence had caused her to be overly doubtful, apprehensive or mistrusting (Personal communication, Durban, 1994).

ii. Autonomy versus shame or doubt

Consistent with her previous reports, the lumpectomy patient continued to show an elevated sense of autonomy and competency after surgery and radio treatment for lumpectomy. As the breadwinner, she reported her need to maintain her position as a clerk, and improve her level of competency in her occupation (Personal interview, Durban, 1994).

iii. Social desirability

The average scores of the *Social Desirability Factor* both pre- and post-surgically for the lumpectomy patient implied her lack of need for social approval or to be viewed favourably by others. This confirms earlier reports by the lumpectomy patient on physical appearance (7.9.3.1) where she expressed disinterest in the opinions of others for that variable.

iv. Initiative: Factor Four

Although the lumpectomy patient showed determination, other indications were that for *Factor Four* she appeared to have an average level of initiative. This result may again be related to socio-demographic variables of educational level, income and added stress of single parenting, as well as the need for breast cancer surgery. However, it is important not to exclude other possible contributing factors such as a lack of a supportive intimate relationship and characteristic personality traits. It is interesting to note that relationship between a high level of industry demonstrated by the lumpectomy patient and, as previously discussed, a high level of competency (7.9.1.1.(ii)).

v. Identity

High scores were also noted for the lumpectomy patient on issues relating to certainty about self-direction, integrity and evaluation of self-worth as perceived by herself and others.

vi. Intimacy

The lumpectomy patient expressed attitudes of emotional closeness with others after treatment and surgery for breast conservation. Although she did not have a current partner, the lumpectomy patient enjoyed emotional support from a variety of sources, family and friends, and did not express any negative feelings about inter-personal relationships, her ability for closeness or her enjoyment of intimate relationships. Jamison *et al.* (1978) pointed out, however, that some women reported better emotional adjustment after treatment for removal of a lump in the breast was completed than just after a lump in the breast was diagnosed. Women who were rated high on emotional adjustment had significantly lower scores on the EPI Neuroticism Scale ($P< 0,05$), had more external locus of control on the Rotter I-E scale ($P< 0,003$), had been married for longer ($P< 0,04$), and were older ($P< 0,04$). Emotionally well-adjusted women perceived significantly more understanding and emotional support from their physicians ($P< 0,03$), spouses ($P< 0,02$), surgeons ($P< 0,03$), nursing staff in the hospital ($P< 0,011$) and their children ($P< 0,01$)(Jamison *et al.*, 1978).

vii. Generativity

Average pre-/post-test scores for *generativity* based on the responses by the lumpectomy patient, indicated a balanced perception and attitude to her commitment and input with regard to other people and her community. In terms of the lumpectomy patient's age, life-stage and responsibilities, a three-month post-operative and radio therapy treatment phase may be insufficient to assess a variable such as *generativity*. However, there were no indications of a sense of isolation or stagnation. The lumpectomy patient on the whole showed a high level of identity integrity.

7.9.3.3 Questionnaire 3: The Creekmore scales of eight clothing variables (1971)

After treatment and surgery for breast conservation, the lumpectomy patient acknowledged that the comfort of her clothing was more important to her than either the aesthetic appeal or its fashionable content. This attitude was reinforced with low scores on items in *Factor One* and *Factor Five* (Annexure 3). The lumpectomy patient appeared to have little interest in experimenting with appearance (*Factor Two*) but expressed a definite irritability if clothes were uncomfortable (item 34, Annexure 3). The lumpectomy patient also described herself as conservative in clothing style and felt vulnerable in a bathing suit in public. Negative scores on *Factor Three: Conformity*, indicated a lack of need on the part of the lumpectomy patient to conform to influences and trends in clothing directed by the media or worn by friends or colleagues. These attitudes are reinforced by the expressed and previously discussed body image variables (7.9.1.1.(ii))

7.9.3.4 Questionnaire 4: Public and private self-consciousness (Fenigstein *et al.*, 1975)

i. Private self-consciousness

Consistent with some items in Questionnaire 3, for example *Factor Three: Conformity* and *Factor One: Concern with personal appearance*, the patient treated for lumpectomy showed little interest in trying to make a good impression, or being concerned about what others thought of her paying extra attention to personal appearance (*Factor One: Private self-consciousness, Factor Two: Public self-consciousness*). Low scores on *Factor Three* seemed to indicate that the lumpectomy patient did not experience above average levels of social anxiety in any form.

7.9.3.5 Questionnaire 5: The IPAT Anxiety scale (Cattell *et al.*, 1968)

The level of anxiety for the lumpectomy patient treated for lumpectomy fell within the average range fixed for the general population (Total Sten = 5,5, (Cattell *et al.*, 1968)), Total Sten = 4 for the lumpectomy patient, and little difference was noted between the total A score = 12 and the total B score = 11. No further enquiry was necessary into establishing differences between overt symptomatic anxiety issues (B scores) or covert, "hidden" subconscious anxiety (A scores). The lumpectomy patient expressed satisfaction in being treated for lumpectomy rather than for mastectomy and did not express over-anxiousness about fear of the return of breast lumps (Personal interview, Durban, April 1994).

7.9.3.6 Questionnaire 6: 16 PF (Prinsloo, 1991)

Scores for the lumpectomy patient were either the same or similar to the norms reported by Prinsloo (1991, Table 16, p.27). For example, *Factors C,H,I,G,B* (for item descriptions see Annexure 6) indicated a balance in being conscientious, venturesome, and realistic. High scores for these factors, *mastectomy* = 17 and n=13 compared with scores reported on Table 16 (Prinsloo, 1991, p.27) seemed to indicate the lumpectomy subject's perception of herself as shrewd, calculating, worldly and imaginative rather than conventional or over proper (praxemia). The lumpectomy patient acknowledged having a high sense of self-discipline and self-control. The lumpectomy patient expressed an elevated sense of self-worth and a strong self-concept. This may be compared with results in Questionnaire 5 (7.9.3.5) where there was little anxiety expressed by the lumpectomy patient in terms of her perception of overall sense of self, both pre- and post-operatively.

7.9.3.7 Conclusion

It was evident that the nature of the treatment for breast conservation did not have the same impact in incurring perceptual and behavioural changes pre- and post-surgically for the lumpectomy patient as radical mastectomy or breast reconstruction had for the patients in case studies one and two. In the three month post-surgical follow-up it was apparent that the lumpectomy patient was self-directed, and self-reliant. She expressed this clearly in her conservative sense of clothing behaviour where comfort rather than fashionability was important, and the impression she made or opinion of others was of little consequence to her. Low levels of either overt or covert anxiety and the pattern of typical personality traits evident of her self-control and discipline completed the picture for case study three.

7.9.4 Oncology patients: General discussion

Three oncology breast patients were selected for analysis with regard to their attitudes towards the aspects of physical appearance and clothing behaviour represented in this dissertation. The demographic characteristics for the oncology breast patients (n=3), that is, breast reconstruction, mastectomy and lumpectomy, were as follows:

Table 7.21: Demographic characteristics for oncology patients (n=3), lumpectomy, mastectomy and breast reconstruction

Category	Variable	No of patients
Type of surgery	Mastectomy	1
	Lumpectomy	1
	Breast reconstruction	1
Mean age	52 years	
Cultural group	Black	
	White	3
Educational Qualifications	Less than matric	1
	Matric	2
	Certificate/Diploma	
	Degree/Part Degree	
Occupation	Professional	
	Non-professional	3
Home language	Afrikaans	1
	English	2

The demographic data for the oncology patients (n=3) showed that only one patient elected to have a breast reconstruction after mastectomy. One mastectomy patient and one lumpectomy subject who had no surgery for breast removal, however, suffered the anxiety of a possible life-threatening disease. The mean age of the oncology patients (n=3) was 52 years and all three patients were White females. By comparison, the mean age for the Jamison *et al.* (1978) study (n=41) was 52,7 years. Two patients held matric certificates and one subject had a matric equivalent. None of the patients was occupied in a profession and two of the oncology patients spoke English as their monther tongue while one patient spoke Afrikaans as her mother tongue.

The results of the survey (that is, descriptive data) on three cancer patients with regard to their attitudes toward self-identity, body-image, clothing behaviour, anxiety and personality variables and their attitudes toward feelings of social acceptance indicated the following main trends (Table 7.21).

7.9.4.1 Questionnaire 1: The Multidimensional body self-relation questionnaire (Cash *et al.*, 1986; Cash, 1990) - Physical appearance

i. Physical appearance

The breast reconstruction patient (n=1), pre-test/post-test after mastectomy, before breast reconstruction, reported an attitude of interest in physical appearance, on being attractive and

buying clothes that would make her look her best. These positive tendencies were also apparent in the breast reconstruction patients' attitudes after breast reconstruction surgery. Pre-test values however, indicated negative attitudes toward the breast reconstruction subject's (n=1) experience of her body as being sexually attractive, feeling unattractive without her clothes on, and dissatisfied with the fit of her clothes. The breast reconstruction patient reported being dissatisfied with her looks and avoided excess use of the mirror, although she reported she always tried to improve her physical appearance.

After breast reconstruction, positive values were reported for feelings of sexual attractivenss. The breast reconstruction patient (n=1) reported more satisfaction with her looks the way they were and utilised the mirror more often in order to improve her appearance. Both pre- and post-operatively the breast reconstruction patient indicated the use of many grooming products and felt that it was important to always look good. Post-operatively the breast reconstruction patient expressed complete satisfaction with the way she looked without her clothes on and appeared to be most comfortable with the way her clothes fitted.

With regard to physical appearance both the mastectomy and the lumpectomy patients reported that they were careful to choose clothes that made them look their best. Both the mastectomy and the lumpectomy patients felt ambivalent toward the sexual attractiveness of their bodies. Although the lumpectomy patient agreed that she liked the way she looked without her clothes on, the mastectomy patient completely disagreed, and indicated her complete dissatisfaction with her unclothed body.

The mastectomy patient indicated feeling self-conscious if her grooming was not right; however, the lumpectomy patient did not appear to be over concerned with grooming or with others' opinions of her appearance. Both patients (lumpectomy and mastectomy) were satisfied with the fit of their clothes.

ii. Physical fitness and health orientation

The breast reconstruction patient reported feeling more in control of her health, post-operatively. Physical fitness appeared to remain important both pre- and post-operatively. The breast reconstruction patient appeared to place great significance on working to improve her physical stamina before and after surgery. Before surgery, good health seemed of less importance than after surgery. The breast reconstruction subject appeared to be most concerned about threats to her health pre- and post-test. After mastectomy the breast reconstruction patient indicated that

she did not play sport regularly. However, after breast reconstruction, the breast reconstruction subject appeared to play a sport regularly throughout the year. After surgery for breast reconstruction, the breast reconstruction patient indicated more concern for small changes in her physical health than before breast reconstruction. It was observed that the breast reconstruction patient always appeared to keep herself informed of health issues.

The lumpectomy patient seemed to adopt a mediocre attitude to keeping fit. However, her attitude toward good health appeared to be significant. The mastectomy patient seemed more concerned about fitness and also adopted a positive attitude to health related issues, on items 45, 54, 55 (for item descriptions see Annexure 4) ratings. These items indicated a lack of vulnerability to illness, the importance of being physically healthy and a lack of neurotic absorption with minor health changes for both the lumpectomy and mastectomy patients.

iii. Weight preoccupation and weight orientation

It was observed that the breast reconstruction patient's (n=1) scores were consistently low on all matters concerning pre-occupation with weight and diet programmes after mastectomy, but before breast reconstruction. The breast reconstruction patient seemed to perceive herself as normal weight and seemed to perceive others as viewing her as normal weight.

iv. Body areas satisfaction

High scores were observed for the breast reconstruction patient pre-operatively for breast reconstruction for maximum satisfaction with her height, weight, muscle tone and hair, and a medium level of satisfaction seemed to be expressed for facial features and overall appearance. The breast reconstruction patient (n=1) appeared to be completely dissatisfied with her upper torso (chest or breasts, shoulders and arms); lower torso (buttocks, hips, thighs and legs) and partly dissatisfied with the mid torso area.

After surgery for breast reconstruction, the breast reconstruction patient's (n=1) scores on weight pre-occupation and satisfaction seemed to remain the same as pre-operatively, and expressed a lack of concern for weight related problems or a need for diet programmes. However, scores that related to body areas satisfaction increased after breast reconstruction surgery. The breast reconstruction patient (n=1) appeared to be highly satisfied with her upper, mid and lower torso, satisfied with her overall appearance and fairly satisfied with her facial features.

The mastectomy patient demonstrated little concern for weight related issues, and seemed fairly satisfied with all body part areas, except for her height, with which she expressed dissatisfaction. After mastectomy the mastectomy patient expressed being neither satisfied nor dissatisfied with her mid torso or upper torso.

After lumpectomy, the lumpectomy patient expressed little concern about becoming overweight or about minor weight changes and perceived herself as normal weight. Scores on the body part satisfaction scale showed that the lumpectomy patient was mostly satisfied with all areas of her body including hair and face, very satisfied with her weight and height and mostly satisfied with her overall appearance.

Similarly to breast conservation, the strongest impact of breast reconstruction is in improved body image. Women's most common motivations for breast reconstruction were reported (Schover, 1991, Table I, p.114, 115) as being to feel whole again, to eliminate a breast prosthesis and to wear a wider variety of clothing styles.

7.9.4.2 Questionnaire 2: Scale for measuring identity as conceived by Erik Erikson (Osche & Plug, 1986)

Although not statistically significant, the following observations for the oncology patients were made for *Factor One: Trust versus mistrust.*

i. Trust

The pre-/post-test differences for the breast reconstruction patient for the factor *trust*, were observed for items 51, 81 and 91 (for item descriptions see Annexure 2) where higher scores post-operatively indicated a higher sense of self-satisfaction, of being valued as a person and more positive beliefs in the future of others and self after receiving a new breast. However, for the mastectomy patient, lower scores on items 21, 11, and 41 (for item descriptions see Annexure 2) seemed to be demonstrative of a less positive feeling of certainty and trust in others and self although the mastectomy patient indicated being optimistic about her future. Scores on *Factor One: Trust* for the lumpectomy patient appeared to show neither a very positive nor negative level of trust in self or others.

ii. Autonomy

For the *Second Factor: Autonomy versus shame or doubt* the only differences pre-/post-test observed for the breast reconstruction patient were higher scores on items 2, 32 and 12 (for item descriptions see Annexure 2) which indicated a greater sense of autonomy and assertiveness post-operatively. The scores on *Factor Two: Autonomy* for the mastectomy patient appeared to show a substantial level of autonomy, although not as positive as the breast reconstruction patient. Scores observed for the lumpectomy patient were similar to those of the post-test for the breast

reconstruction patient and were demonstrative of an elevated sense of autonomy as opposed to feelings of shame and doubt.

iii. Social desirability

High scores on *Social desirability: Factor Three*, gave an indication of the patient's need to appear socially favourable, or be regarded as socially acceptable. Alternatively, the person genuinely possessed the qualities being measured and was sincere in her attributes of altruism. *social desirability* scores for the breast reconstruction patient showed an increase on most items post-operatively. The responses appeared to be more definite, either indicating high attributes with regard to the qualities described which included those of integrity and generosity; that is, items 39, 23, 29, 53 and 63 (for item descriptions see Annexure 2), or were demonstrative of the greater need for social approval by the breast reconstruction patient after a new breast reconstruction.

Low or average scores for the patient who underwent mastectomy appeared to show a lack of desire or need to seek social approval. The patient who was treated for lumpectomy showed average scores for all items pertaining to the *social desirability factor*.

iv. Initiative

The *Fourth Factor* measured was *Initiative*. The indications of higher scores for the breast reconstruction patient post-operatively on most items pertaining to initiative, exemplified an elevated sense of self-confidence and positivity toward achieving her goals despite competition and risks. The breast reconstruction patient also indicated a higher sense of responsibility for choices she made post-operatively.

The patient who underwent surgery for mastectomy seemed to achieve higher scores for *Initiative: Factor Four* than for the other factors pertaining to identity; that is, on *trust*, *autonomy* or *social desirability*. Although the patient who underwent treatment for lumpectomy showed determination, other indications were that for *Factor Four* she appeared to have an average level of initiative compared with both the breast reconstruction patient and the mastectomy patient.

v. Industry

The patient who received a new breast indicated higher levels of energy and pleasure from working, after breast reconstruction surgery. The breast reconstruction patient also indicated feeling more competent and less afraid of failure in completing a difficult task. Consequently for

Factor Five: Industry the breast reconstruction patient, post-surgically, appeared to achieve at a higher level.

The mastectomy patient indicated a lack of energy for task completion but not for competency or work pleasure. High scores on *Factor Five: Industry* seemed to indicate a level of determination to work and achieve for the mastectomy patient despite the loss of a breast and the emotional and psychological effects this may carry. The patient treated for lumpectomy showed a high level of industry; no negative indications for *Factor Five* were observed.

vi. Identity

The breast reconstruction patient showed either the same scores pre- and post-operatively for *Factor Six: Identity* or, as in most cases, higher scores post-operatively for issues pertaining to clarity of identity of self and perceived consistent clarity of how she was viewed by others. It appeared that a more positive sense of identity emerged for the breast reconstruction patient post-surgically, even after the trauma of a life-threatening disease. Scores on *Factor Six: Identity* showed that after removal of a breast, the mastectomy patient seemed to possess a clearcut sense of identity. Although not statistically significant, the observations were that the mastectomy patient was consistent in attitudes and feelings about who she was, how she perceived others viewed her and how she perceived and evaluated the worth of her own life.

vii. Intimacy

High scores were also noted for the lumpectomy patient on issues relating to certainty about self-direction, integrity and evaluation of self-worth as perceived by herself and others.
No differences in scores, pre- or post-operatively for the breast reconstruction patient were observed on *Factor Seven: Intimacy*. It appeared that through the trauma of a life-threatening disease, the removal of a breast and the reconstruction of a new breast, the breast reconstruction patient remained stable in her ability for closeness, intimate relationships and perceived sense of feeling wanted and not alone in the world.

Trends for scores on *Factor Seven: Intimacy* for the patient after surgery for mastectomy, were not as high as those for the breast reconstruction patient. Although statistical mean differences were not calculated for the small sub-section, the indications were that the mastectomy patient shared less intimate relationships or seemed to express hereself less closely to others, than the breast reconstruction patient. According to Jamison *et al.* (1978) (Table 1, p.434) the most pervasive assumptions about mastectomy were the profound negative effects on the woman's body image and her sexual relationships. Although some women reported 'no change' in their intimate relationships, others reported feelings of anger, outrage and were less

likely to be as confident in close relationships, especially younger women. Younger women (n=16) reported mastectomy as having a negative influence on their sexual relationships (f=5,1, P< ,03) in the study by Jamison *et al.* (1978).

The breast conservation; that is, the lumpectomy patient, expressed attitudes of emotional closeness and shared intimacy with others. No significant low scores were noted on *Factor Seven: Intimacy* for the lumpectomy patient.

viii. Generativity

After surgery for breast reconstruction the breast reconstruction patient demonstrated notably higher levels of *Generativity: Factor Eight*, in the expression of care of others, belief in herself and others and sense of contribution to the community. This trend, however, was observed to be lower for the mastectomy patient, who was observed to appear less confident about her involvement with the community, care of herself and sense of having made a useful contribution to society. Demographic variables; that is, difference in age and the loss of a breast may appear to be contributing factors to this difference in trends. Score differences were not low enough to note any indication of stagnation or sense of a life wasted.

Average scores were reported for the breast conservation patient as compared with either the breast reconstruction or the mastectomy subjects for *Factor Eight: Generativity.*

From the report of results on the subsection for the oncology subjects, it was noted that the positive trends post-operatively for the breast reconstruction patient indicated higher levels of clear self-definition, and positive identity functioning than for either the pre-test levels or in comparison with the mastectomy subject. No scores were low enough to suspect identity disintegration or foreclosure in relation to a life-threatening association with a disease.

7.9.4.3 Questionnaire 3: The Creekmore scales of eight clothing variables (Creekmore, 1971)

For the subsection measuring attitudes and interest in clothing variables for the oncology subjects (n=3), the following observations are reported. Although not statistically significant, the descriptive data gave indications of some main tendencies and were supported by reports from interviews (Personal communication, Durban, 1994).

i. Personal appearance

The most notable pre-/post-test differences for the breast reconstruction subject (n=1) included the expression of heightened interest in the way she looked in her clothes post-operatively, more definite attention to details of colour combinations and co-ordination of accessories than

previously (*Factor One: Concern with personal appearance*). A notable difference post-operatively was observed for the breast reconstruction patient in reading the latest media articles on what is new in clothing. Experimentation with garments, accessories, hairstyles and trying on clothes in the store (*Factor Two*) were also areas of renewed interest after surgery for a new breast. The breast reconstruction patient stated a preference for contemporary European fashion as opposed to ethnic fashions.

ii. Conformity

Prior to receiving a new breast, ie. post-mastectomy, the breast reconstruction patient perceived berself as being slightly more conforming than after surgery for breast reconstruction (*Factor Three*).

iii. Modesty

Factor Four:Modesty scores for the breast reconstruction patient seemed to indicate less conservatism in style and colour, post-operatively. The breast reconstruction subject neither pre- nor post-operatively, appeared to express anxiety over issues of modesty.

iv. Comfort

For *Factor Six: Comfort* the breast reconstruction subject indicated that comfort did not come before fashionable trends. However, she expressed less irritability to uncomfortable clothes and less sensitivity to the texture of the fabric post-operatively.

After mastectomy, the mastectomy patient,expressed how important clothes were to her; more significantly, clothes were used as a means of disguising physical problems and imperfections through the skilful use of colour, line and texture. This was confirmed by a previous result when the mastectomy patient expressed carefully choosing fabric texture with the line of the garment. The mastectomy subject also indicated that she paid much attention to pleasing colour combinations as well as carefully co-ordinating the accessories she wore with each outfit. The mastectomy subject appeared to pay more attention to these details than either the breast reconstruction or the lumpectomy patients.

After mastectomy, scores for the mastectomy subject indicated a definite interest in keeping up with the latest trends in fashion, being informed about the newest clothing styles each season, and experimenting with many accessories. These attitudes were expressed in higher scores on *Factor One: Concern with personal appearance, Factor Two: Experimenting with appearance* and *Factor Five: Heightened awareness of clothes which enhanced individuality*. The mastectomy

subject did not indicate any special comfort needs or any particular sensitivity to fabric texture on *Factor Six: Sensitivity to comfort*. However, notably, the mastectomy subject did indicate that she selected clothes that did not call attention to herself (item 66, *Factor One: Concern with personal appearance*).

It appeared, as indicated by the low scores on items in *Factor One* and *Factor Five* that the breast conservation patient (that is, lumpectomy) showed more of a decreased interest in clothing awareness and concern with personal appearance than either the breast reconstruction patient or the mastectomy patient. The lumpectomy patient did not appear to have any interest in experimenting with appearance (*Factor Two*), but expressed a definite irritability if clothes were uncomfortable (item 34). The lumpectomy patient also described herself as conservative in clothing style and felt vulnerable in a bathing suit in public. Negative scores on *Factor Three: Conformity* indicated a lack of need on the part of the lumpectomy patient to conform to influences and trends in clothing directed by the media or worn by friends or colleagues.

7.9.4.4 Questionnaire 4: Public and Private self-consciousness (Fenigstein *et al.*, 1975)

Questionnaire 4, was administered to the oncology patients (n=3) and indicated the following results:

i. Private self-consciousness

No specific differences were noted for the breast reconstruction patient, pre- and post-surgery for *Factor One: Private self-consciousness*. Observation of scores, however, showed that the breast reconstruction patient perceived herself as having moderate levels of inner self-awareness or self-consciousness, and was moderately attentive to inner feelings, motivations and mood changes. She indicated that it was partially characteristic of her to be self-reflective and self-analytical.

ii. Public self-consciousness

For *Factor Two: Public self-consciousness*, the breast reconstruction patient indicated being more self-conscious about the way she looked before the reconstruction of a new breast. She also showed she checked on her appearance in the mirror more often prior to surgery for breast reconstruction, and was fairly concerned about what other people thought of her. Post-surgically, the breast reconstruction patient was similarly concerned about what others thought of her, less self-conscious about the way she looked, however more concerned about making a good impression.

iii. Social anxiety

The most notable differences were evident from the scores on *Factor Three: Social anxiety* which appeared to increase for the breast reconstruction patient post-surgically. The breast reconstruction patient indicated attitudes of shyness, getting embarrassed very easily, difficulty in talking to strangers and feelings of anxiety in speaking in front of a group. She also indicated that large groups made her nervous. No further notable differences were observed for the breast reconstruction patient on the self-consciousness scale.

No extremely characteristic or uncharacteristic attitudes dominated for any of the factors for either the mastectomy patient or the lumpectomy patient. As in Questionnaire 3, *Factor One: Personal appearance*, the mastectomy patient indicated being usually aware of her appearance and always checking on her grooming. She indicated being self-conscious about the way she looked (*Public self-consciousness: Factor Two*), however specifically aware of her mood changes (*Private self-consciousness: Factor One*).

Consistent with some items in Questionnaire 3, for example *Factor Three: Conformity* and *Factor One: Concern with personal appearance*, the patient treated for lumpectomy showed little interest in trying to make a good impression, being concerned about what others thought of her or paying extra attention to personal appearance (*Factor One: Private self-consciousness, Factor Two: Public self-consciousness*). Low scores on *Factor Three* seemed to indicate that the lumpectomy patient did not experience above average levels of social anxiety in any form.

7.9.4.5 Questionnaire 5: The IPAT Anxiety Scale (Cattell *et al.*, 1968)

No significant difference was noted for the total A score (that is, covert anxiety) pre-/post-test for the breast reconstruction patient. The pre-test total A score = 16 whereas the post-test total A score = 14. The Total Sten = 5 pre-test which was within the average range for level of anxiety (Cattell *et al.*, 1968). A significant decrease in total B score was observed, which indicated a higher level of pre-surgical overt or symptomatic anxiety; that is, pre-test total B score = 14, post-test total B score = 5 and Total Sten = 3. A sten score of three indicates stability, security and mental health generally (Cattell *et al.*, 1968). The high pre-test B score (overt symptomatic anxiety) appeared to indicate the breast reconstruction subjects' anxiety about a conscious self-sentiment; that is, the loss of a breast and about social approval. In a face-to-face interview with the patient (Durban, May 1994) the breast reconstruction patient expressed anxiety about the surgery and pain and stated that she had been considering surgery for a long time. However, the breast reconstruction patient's attitude toward the prospects of the final results appeared to be positive. Post-operatively, the breast reconstruction patient reported an

improved self-confidence and was very satisfied with the final result of her new breast (Personal communication, Durban, August 1994).

The mastectomy patient showed the highest sten score for anxiety, Total Sten = 6 compared with either the breast reconstruction subject (Total Sten = 5) or the lumpectomy subject (Total Sten = 4). The total B score of 20; that is, symptomatic, overt anxiety, was higher than the total A score (covert, hidden anxiety). This elevated level of anxiety; that is, above the level for the general population appeared to indicate:

- concern with social approval due to the removal of a breast;
- feelings of depression or unworthiness (item 15)(for item descriptions see Annexure 4);
- feelings of fear and frustration;
- lack of control in unsettling situations (item 24).

The indications of higher scores on *Factor Five: Frustration, Tension, ID pressure* item 4, were descriptively expressed by the mastectomy patient's perception of herself as prone to emotionality, tension and irritability.

The level of anxiety for the lumpectomy patient treated for lumpectomy fell within the average range fixed for the general population (that is, Total Sten = 5,5, Cattell *et al.*, 1968). The Total Sten = 4 for the lumpectomy patient, and little difference was noted between the total A score = 12 and the total B score = 11. No further enquiry was necessary into establishing differences between overt symptomatic anxiety issues (B score) or covert, 'hidden' subconscious anxiety (A score). The lumpectomy patient expressed satisfaction in being treated for lumpectomy rather than for mastectomy and did not express over anxiousness about fear of the return of breast lumps (Personal interview, Durban, April 1994).

7.9.4.6 Questionnaire 6, 16 PF (Prinsloo, 1991)

Due to the more mature age group of the oncology patients (n=3) $\underline{M}$ age = 52 years, Table 16 (Prinsloo, 1991) was chosen as a norm for a comparative descriptive analysis of the data observations for measuring personality variables. Table 2, (n=912) (Prinsloo, 1991, p.) was chosen for the cosmetic surgery patients due to the culturally mixed sample and varying age groups, for example, the $\underline{M}$ age for the augmentation mammaplasty patients was 24 years. Many of the patients in the cosmetic surgery (n=25) group were non-professionals and would possibly have had less life changes given the specific mean age groups for each surgical type. Only descriptions of notably varying personality variables are given.

The breast reconstruction subject's score on *Factor B* was elevated, pre-surgically, for breast reconstruction and described a sharper, more abstract mode of thinking or dealing with problems,

than for the three-month period post-surgically. A notable difference occurred for *Factor O* where the pre-test raw score for this factor was 13 and the post-test score was 3. A higher score on *Factor O*, describes a person who is apprehensive, worrying, depressive and troubled. Although not statistically valid, the pre-operative score for the breast reconstruction patient was well above the mean score; that is, $\underline{M}$ = 8,73 for n=221, Table 16 (Prinsloo,1991, p.29). This result, however, gave an indication of the breast reconstruction subject's emotional pre-operative state and was confirmed by scores previously discussed for Questionnaire 5 on the IPAT Anxiety Scale where a total B score = 14 was recorded pre-operatively, idicating an elevated level of pre-operative anxiety compared with a total B score = 5 post-operatively. The post-operative *O* score = 3 indicated untroubled adequacy and was below the norm, 8,73 for the 1989 (n=221) study (Prinsloo, 1991).

A further notable pre-/post-test difference was observed for *Factor Q*, where a low pre-operative score Q_1 = 3 compared with a post-operative score Q_1 = 7 indicated a higher level of conservatism after mastectomy and before breast reconstruction. In the three-month period after surgery for breast reconstruction, the breast reconstruction subject showed tendencies of being more experimental, free-thinking and confident. A decrease in the score post-operatively for *Factor* Q_2 appeared to indicate that with the acquisition of a new breast the breast reconstruction patient felt more at ease in a group situation.

A significant difference was noted for *Factor* Q_4 where the pre-test score was Q_4 = 12 and the post-test score Q_4 = 6. the high pre-operative score indicated high ergic tension; that is, tense, driven, overwrought or distressed, whereas the low post-operative score indicated low ergic tension; that is, relaxed, tranquil and unfrustrated tendencies. No further notable differences were observed on the 16 PF for the breast reconstruction patient (n=1) pre- and post-surgically.

A low score on *Factor C*, C = 10, demonstrated that the mastectomy patient was affected by feelings, and was easily upset, post-mastectomy. This score was lower than the mean on *Factor* C, C = 17,06 for n=221, Table 16 (Prinsloo, 1991, p.27) and, as compared with the breast reconstruction subject, where C = 14 pre-operatively and C = 16 post-operatively. A low *Factor E* score = 10 indicated that the mastectomy subject was more submissive and conforming rather than being assertive, dominant and independent. The $\underline{M}$ average for the 1989 study (n=221) (Prinsloo, 1991, p.27) was reported as 14,98. A lower score on *Factor G* indicated that the mastectomy patient may have had a weaker superego strength rather than being staid or rule-bound. A lower score was recorded for *Factor H* = 12 for the mastectomy patient compared with the $\underline{M}$ = 16,69 for (n=221) Table 16 (Prinsloo, 1991). This score was also lower than the scores for both the lumpectomy subject, *H* = 15, and the post-test score for the breast reconstruction patient, *H* = 15). However, the score for the mastectomy patient was precisely the same as that

of the breast reconstruction patient after mastectomy, $H = 12$. The implications appeared to be that after mastectomy the subjects were more shy, restrained and timid than uninhibited, socially bold or spontaneous. A low score was also noted for *Factor* $Q_1 = 5$ compared with $Q_1 = 12$ for the lumpectomy patient and $Q_1 = 7$ post-operatively for the breast reconstruction patient. A score of $\underline{M}\ Q_1 = 10{,}70$ was reported for the 1989 study (n=221) (Prinsloo, 1991). This seemed to indicate a higher level of conservatism for the mastectomy patient and corresponded with the level of conservatism reported for the breast reconstruction patient after mastectomy and pre-surgically for breast reconstruction. High scores for *Factors* $Q_2 = 16$, $Q_3 = 14$ and $Q_4 = 16$ compared with the $\underline{M}$ scores for the 1989 study (Prinsloo, 1991, Table 16, p.27) which were $Q_2 = 10{,}22$, $Q_3 = 12{,}06$ and $Q_4 = 9{,}31$ respectively, and compared with the post-test for the breast reconstruction subject which was $Q_2 = 6$, seemed to indicate personality variables pertaining to self-sufficiency, self-control and a high level of tenseness or being overwrought or fretful compared with a low ergic tension which is typical of a more casual, relaxed and unfrustrated personality type.

Scores for the subject treated for lumpectomy were either the same or similar to the norms (Table 16, Prinsloo: 1991. p.27). For example, *Factors C,H,I,G,B* (for item descriptions see Annexure 6) indicated a balance in being conscientious, venturesome, and realistic. High scores for *Factors* $M = 17$ and $N = 13$ compared with scores reported in Table 16 (Prinsloo, 1991, p.27) seemed to indicate the lumpectomy subject's perception of herself as shrewd, calculating, worldly and imaginative rather than conventional or over proper (praxernia).

All three subjects showed similar scores for *Factor* Q_3 which indicated subjects' perception of having a sense of self-discipline and a high self-concept control. This may be compared with results on Questionnaire 5: The IPAT Scale for Anxiety (Cattell *et al.*, 1968) and Questionnaire 2: Scale for Measuring Identity (Ochse & Plug, 1983) where oncology patients showed little anxiety for issues dealing with self-worth or self-concept as previously discussed.

7.10 CONCLUSION

A visual representation of pre/post-surgical results for the clinical sample groups follows in Plates 7.1 to 7.5. Overall, the most notable pre/post-test mean differences occurred for the reduction mammaplasty (n=12) patients for the clinical sample, and for the Black fashion group for the non-clinical sample. The implication and integration of these results are discussed in the following chapter.

PLATE 7.1: PRE/POST-OPERATIVE PHOTOGRAPHS OF A WOMAN WHO UNDERWENT A RHYTIDECTOMY

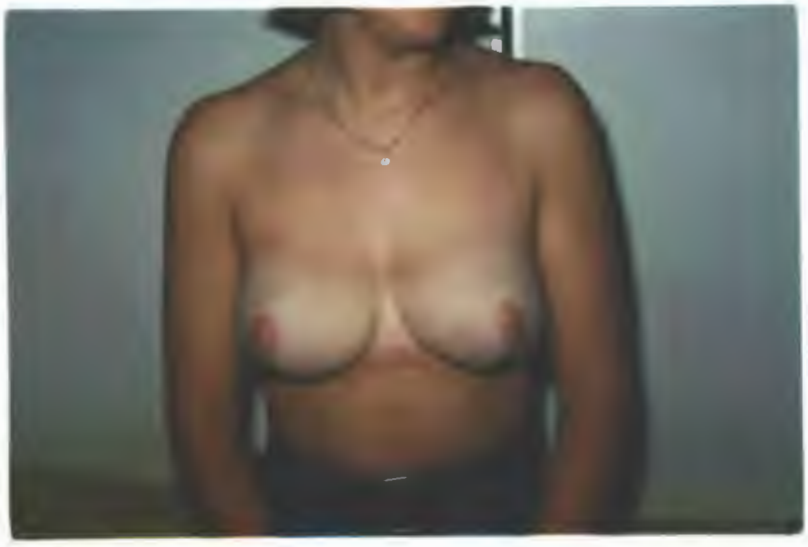


PLATE 7.2: PRE/POST-OPERATIVE PHOTOGRAPHS OF A WOMAN WHO UNDERWENT A REDUCTION MAMMAPLASTY

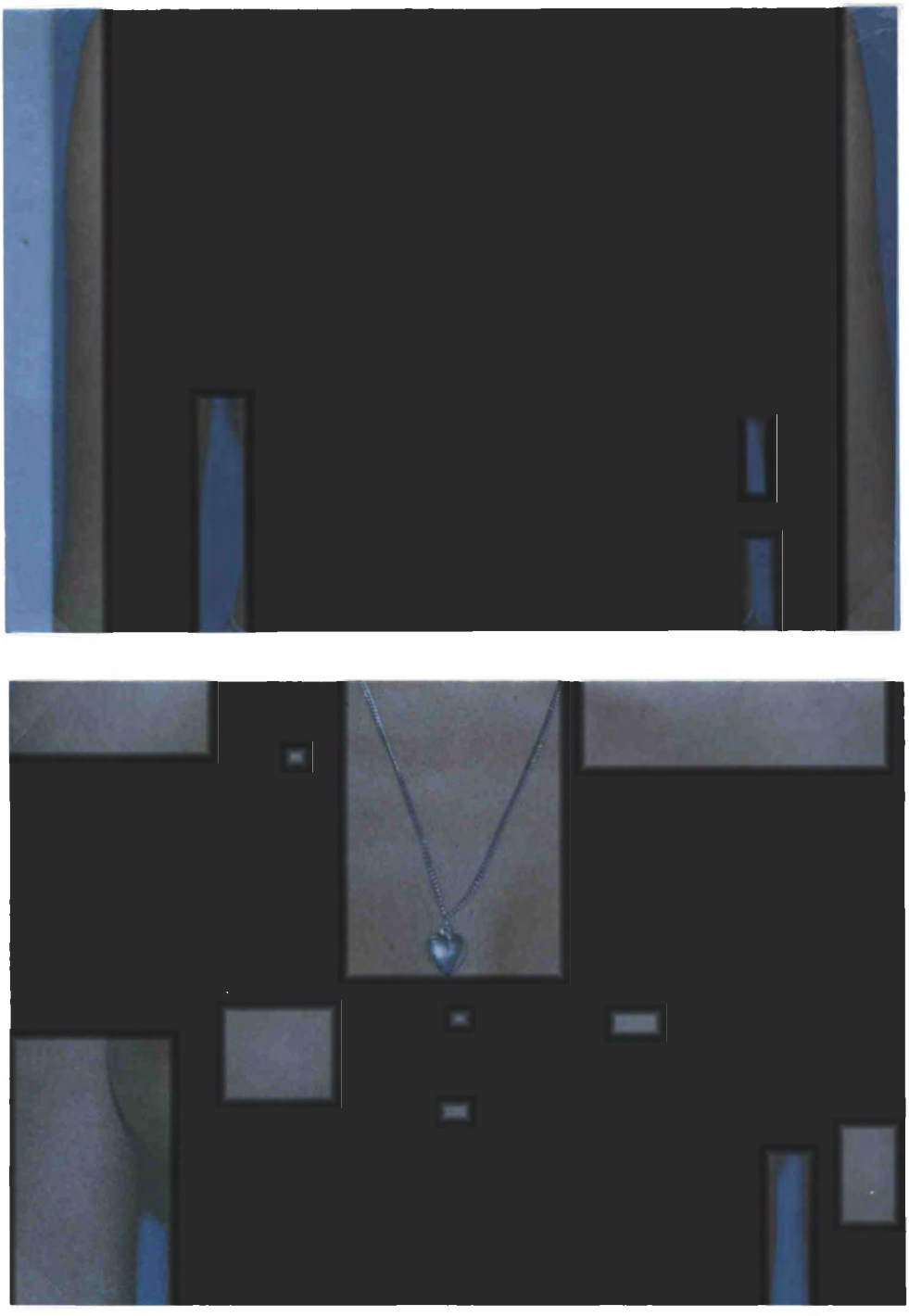


PLATE 7.3: PRE/POST-OPERATIVE PHOTOGRAPHS OF A WOMAN WHO UNDERWEMT AN AUGMENTATION MAMMAPLASTY

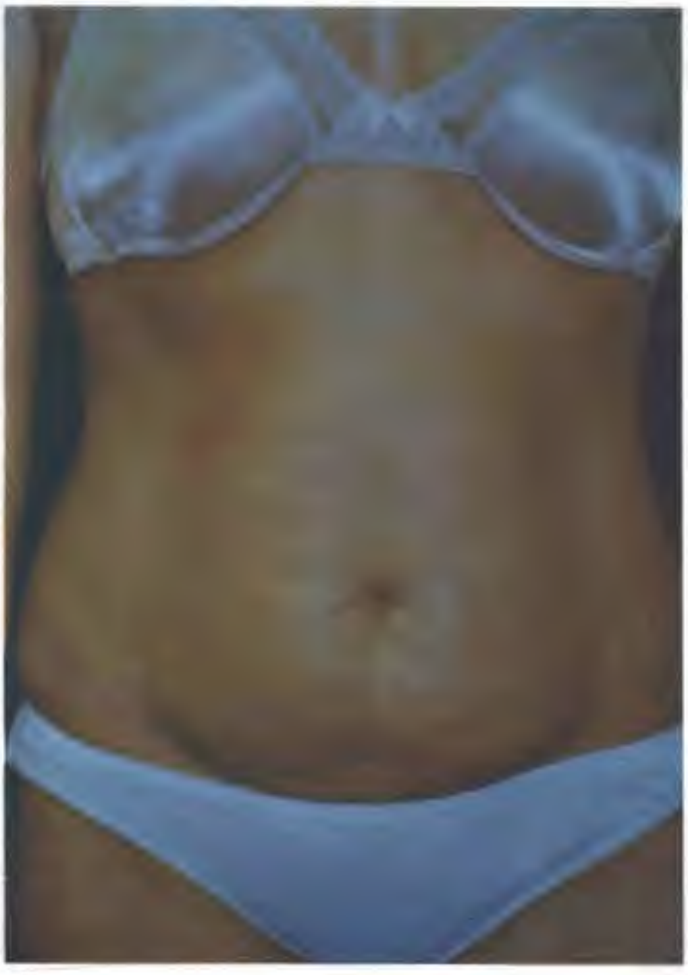
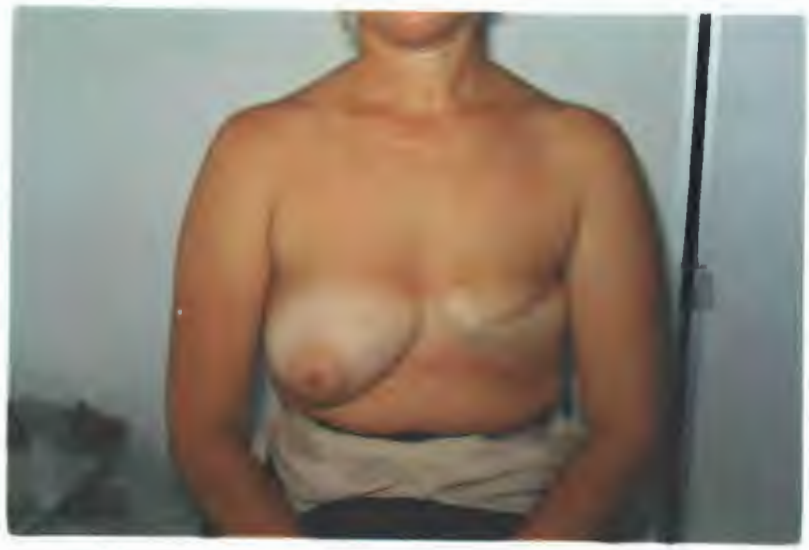


PLATE 7.4: PRE/POST-OPERATIVE PHOTOGRAPHS OF A WOMAN WHO UNDERWENT AN ABDOMINOPLASTY



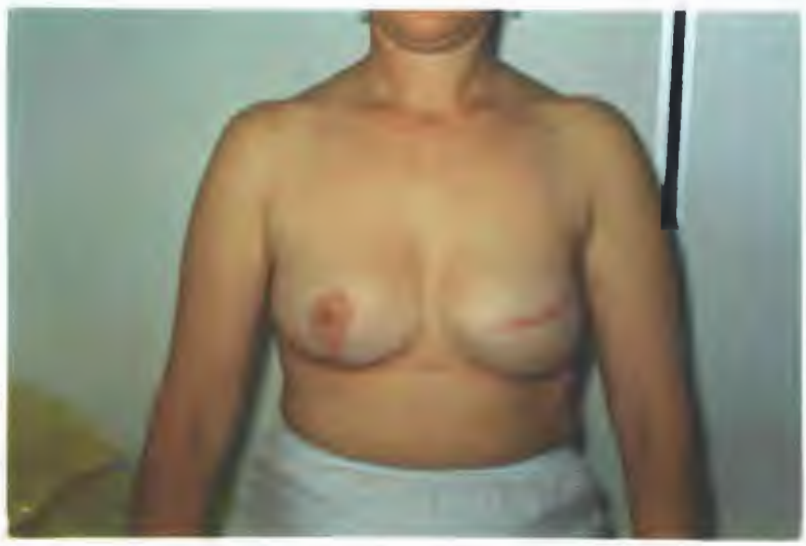


PLATE 7.5: PRE/POST-OPERATIVE PHOTOGRAPH OF A WOMAN WHO UNDERWENT A BREAST RECONSTRUCTION

CHAPTER EIGHT

GENERAL DISCUSSION AND RECOMMENDATIONS

8.1 OVERVIEW

In the previous chapter, the results of the processed data were presented, interpreted and evaluated. In chapter eight the results and findings are integrated and evaluated based on recent research literature. A discussion of the findings follows in order to identify attitudes and perceptions which affect aspects of healthy physical, psychological and social functioning. The research process is reviewed and recommendations for further research are made.

8.2 INTEGRATION OF THE RESULTS

The purpose of this study was to investigate the relationship among the variables, body-image, identity status, clothing behaviour and social acceptance for the selected sample groups (6.3) and within the present South African context of socio-cultural transition and change. The required information needed in order to identify changes or differences in attitudes and perceptions towards the chosen variables (6.1) was collected from the responses to questionnaires as described in chapter six.

The results of the study reported on the differences and changes in attitudes and perceptions of the clinical and non-clinical sample groups towards aspects of physical appearance and clothing behaviour. Attitudinal and perceptual shifts toward these variables clearly illustrate the complex nature of integrated biopsychosocial functioning and the importance of maintaining overall body-image integrity.

The study need focused primarily on the following implications:

- The person who must choose between having elective cosmetic surgery or remain feeling unattractive and socially unacceptable
- Culturally diverse persons who are subject to socio-cultural influences of ideal norms and values other than their own for physical appearance and codes of fashionable dress.

In support of the main foci of the study, consideration was also given to:

- Persons who need to maintain their body image integrity even in the face of life-threatening disease or body-part loss; that is, breast oncology patients

- Suggestions by fashion opinion leaders which may give indications of consumer behaviour and fashion direction.

The impact of these elements are discussed in order to fulfil the aims of this study (1.2) which were to:

- determine and understand people's attitudes towards their body-image and self-identity in relation to their clothing behaviour and the need they may have for elective cosmetic surgery
- determine the level of social acceptance and well-being they experienced after changes to, or due to cultural differences in, physical appearance and clothing behaviour
- understand people's needs in order to anticipate the likely success of changes in attitudes and behaviour toward their physical, psychological and social selves.

An integrated approach was adopted in reviewing the results. Any attempt to isolate physical, social or psychological aspects of the study would defeat the holistic and interdisciplinary approach and compartmentalise the discussion in clean, but unrealistic terms. The discussion is presented in terms of the sequence of the hypotheses and their accompanying variables.

8.3 HYPOTHESIS 1 (5.2.1): THE IMPACT OF COSMETIC PLASTIC SURGERY ON BODY IMAGE PERCEPTION

Hypothesis 1 was accepted at the 0,05 level of significance in view of the positive changes in attitudes towards body image, after elective cosmetic surgery, where significant results for three of the four sample groups, reduction mammaplasty, augmentation mammaplasty and abdominoplasty were shown in Table 7.4. No positive increase in attitudinal change was apparent for the rhytidectomy patients. This suggests that some people experience a definite need to overcome negative body images perception through surgical intervention. The pre-operative level of body images satisfaction for these groups fell below the norm for the Cash *et al.* (1986) study, whereas the Black and White female sample groups, for this study, indicated higher levels of body image satisfaction and their scores were above the average recorded by Cash *et al.* (1986). This group had not requested elective cosmetic surgery, and appeared to have no need to improve their body image through extreme methods of surgical intervention.

8.3.1 The effect of positive body image change on post-surgical body image attitudes

8.3.1.1 Appearance evaluation and satisfaction

Levels of appearance evaluation increased post-operatively for the reduction mammaplasty and abdominoplasty surgery patients. The indications were that after reduction of excess body mass reduction mammaplasty and abdominoplasty patients felt more physically attractive and satisfied with their overall appearance. This implies that pre-operative levels of embarrassment and the discomfort of having oversized breasts or abdomens decreased after surgery. Positive appearance evaluation included patients' satisfaction that their bodies were sexually more appealing and that they enjoyed their physical appearance as they were. Part of post-surgical success, specifically for cosmetic surgery patients, is positive feedback from the surgeon or significant others (Cash & Pruzinsky, 1990); literature review (3.1.3). Patients indicated that they perceived others to consider them physically attractive which was consistent with previous research (Cash & Pruzinsky, 1990; Stark, 1980). This result indicates the interactive process involved in body images perception and change. Patients experienced physical modifications to their bodies. These were evaluated psychologically in terms of positive body image concepts, and positive feedback was accepted with satisfaction from the patient's social world. Overall physical appearance satisfaction was also experienced post-surgically for the augmentation mammaplasty patients. Patients evaluated themselves as more physically attractive and more feminine after surgery for breast augmentation. The need to increase breast size is often accompanied by low self-esteem and a negative body image (Schlebusch & Mahrt, 1993; Cash & Horton, 1983). Underlying expectations for a request for augmentation mammaplasty is that improving one's physical appearance will increase the probability of more positive social and intimate relationships. It is likely that social and psychological changes were implied in the increased post-surgical appearance satisfaction levels experienced by augmentation mammaplasty patients.

8.3.1.2 Body parts satisfaction and fitness orientation and evaluation

Greater body areas satisfaction for the reduction mammaplasty and abdominoplasty patients after breast and abdomen reduction, confirmed their positive attitudes on overall appearance satisfaction. The results on body areas satisfaction implied that reduction mammaplasty and abdominoplasty patients were selectively more satisfied with their other body areas which could have included face, hair, weight and muscle tone. The importance of how positive attitudes to one area of the body can affect overall body image perception and, conversely, how negative

attitudes to one body area can affect the overall self-concept, as well as social relationships, underlies the shift in body image perspective for most patients (Schover, 1994; Cash & Pruzinsky, 1990).

Increased positive fitness orientation and evaluation levels for the reduction mammaplasty patients could be expected. Renewed interest in sport and physical fitness programmes and improving physical skills would not only be practically more comfortable, but are part of an improved body image functioning for reduction mammaplasty patients. Increased physical activity for the reduction mammaplasty patients could be related to the significant decrease in fat anxiety post-operatively. Patients who had breast reductions appeared less anxious about their weight than they did prior to surgery, when they were likely to have felt more restricted with their movements and embarrassed to change in public and take part in sport activities.

8.3.2 The influence of negative body image change, or no change on body image perceptions

8.3.2.1 Restorative as opposed to 'type changing' plastic surgery

The implications of no significant body image change for the rhytidectomy patients (Table 7.4) seems to indicate that, initially, modifications to the face did not have the same impact as the more highly visible changes associated with body-part augmentations or reductions. Rhytidectomy is not type changing but restorative surgery. Patients' underlying expectations are often that a face lift may change their lives or give them a new appearance. However, specific 'type-changing' facial surgery such as rhinoplasty (nose surgery), was not investigated in this study. This means that unrealistic patient expectations and a culturally mixed sample group, could be possible reasons for this unchanged result. However, without a sample large enough to allow for more sophisticated multivariate analysis, the validity of this observation must be treated with caution.

Alternatively, the implications for a positive body image outcome and successful surgical evaluation for rhytidectomy patients, and generally, could improve psychosocial benefits in areas of work and careers and in interpersonal and intimate relationships (Stark, 1980). The goal of successful cosmetic plastic surgery is an integrated development of enhanced physical, psychological and social functioning.

8.3.2.2 Health and illness evaluation and orientation

This study revealed that patients' (other than oncology patients) attitudes to health and illness issues are not necessarily affected by cosmetic plastic surgery. This is shown by the pre-/post-operative results which remained the same for all four sample groups. Patients appeared to rate the time, importance and attention they paid to signs and symptoms of illness equally after surgery as they had prior to surgery.

8.3.2.3 The effect of body image change on levels of acceptance

Although overall body image changes were positive for the clinical sample groups, surgery can either enhance or disrupt, but it always demands a revision or modification of the person's body profile (Gruendemann, 1975).

A psychological adaptation that incorporates the newly manipulated body needs to occur. For this reason aspects of identity, anxiety and personality were considered for the cosmetic surgery patients in this study. Gruendemann (1975) further cautions that for stability and wholeness, it is necessary for a realistic appraisal of actual physical changes caused by surgery. Lack of acceptance of the body as it is, or has become, may manifest with an intense inner struggle accompanied by various degrees of emotionality. Generally the reduction mammaplasty, augmentation mammaplasty and abdominoplasty patients appeared to have adapted well to change. However, the rhytidectomy patients seemed to experience more difficulties with post-operative adaptation to body images change.

From the discussion on the variables implicit in subproblem one, it becomes clear that personal attitudes towards body image and self-identity are related to either; the need a person has to change her physical appearance through surgery, or to the perceived body image changes experienced by the patient post-surgically.

8.4 THE EFFECTS OF CROSS-CULTURAL DIFFERENCES ON BODY IMAGE ATTITUDES

Hypotheses 1 and 2 (5.2.1 and 5.2.2) implied that people may choose different methods in order to compensate for or overcome negative feelings towards their body images and self-identity. Whereas elective cosmetic surgery is chosen by some people with increasing demand, other groups (the Black and White fashion sample, for example) expressed no need to undergo cosmetic

surgery. A discussion on the differences and similarities between these two groups towards their body image perceptions, follows.

8.4.1 Disparity in values toward body image variables

8.4.1.1 Weight

Sharply contrasting values occurred between the Black and White sample groups out of the sixteen factors included in the overall body-image concept (Cash *et al.*, 1986; Cash, 1990)) (Annexure 1). Significant differences between the two groups were observed for the Black sample group on illness orientation, health orientation, weight vigilance, diet, fat anxiety and weight preoccupation. By comparison, interest in 'overall appearance' was a primary concern for the White sample group. These results were highly unexpected given the common misconception that culturally, fatness and a larger breast size, although traditionally more acceptable, were also acceptable to the young urban Black women due to their cultural background.

Although 'weight' is a component of 'overall appearance' and was notably included in negative body image perceptions of the White sample group, mean scores indicating anxiety about being, or becoming fat, was the highest for the Black subjects. The scores for this group were higher than the norms reported by Cash *et al.* (1986) for a non-clinical sample of (n=1070) American women. Thomas (1989) notes that consistent with earlier research results, his study showed a significant discrepancy between women's current and ideal weights, with a thinner figure viewed as ideal (2.2.7.1). With particular reference to Black female studies, Thomas (1989) also reports that a sizeable number of Afro-Americans indicated some degree of body image dissatisfaction due to weight preoccupation. The experimental group of cosmetic surgery patients (8.3.1) also showed that appearance evaluation and satisfaction, body areas satisfaction and fitness orientation, and not fat anxiety, emerged as the most significant concerns, specifically for the reduction mammaplasty, abdominoplasty and augmentation mammaplasty patients. Cognisance needs to be taken that, culturally, 88% of the cosmetic surgery patients were White females. The results of the non-clinical White fashion subjects are remarkably similar to the values placed on body image variables by the cosmetic surgery patients (8.3.1) and differed from those of the Black non-clinical sample.

The question of body images and weight issues is of major physical, psychological and social concern. Obsession with weight issues and subsequent negative body image is reaching epidemic proportions (Bond & Cash, 1992; Kiesouw, 1994), particularly with the emphasis being placed on thinness in Western Society. Extensive research has indicated that a person's body images

include her perceptions of the cultural norm for the ideal female body shape and size. Stereotypical images of the ideal female, promoted by the media, reinforce and exploit these perceptions.

The myth that there is only one way for a woman to look, underlies the current weight, diet and fat anxiety levels notable among Western females. If Black urban females choose, or feel pressurised to accept the ideal of achieving an unrealistically thin standard of bodily appearance, they are likely to become exposed to the eating disorders which characterise obsessive efforts to become and remain thin (Hutchinson, 1989; Bond & Cash, 1992, Jackson *et al.*, 1992; Gehardt, 1993).

Further major body images concerns for the Black subjects were illness and health issues. These results were contrary to the results of both the White fashion subjects and the cosmetic surgery sample who showed no pre-/post-surgical variation between illness, health and positive body image change, where illness prior to surgery was not a specific concern (8.3.2.2).The Black female sample showed not only concern for minor changes in weight and diet issues, but also awareness of even slight changes in their health, reactivity to being or becoming ill, and to the time and investment in improving their life-style. In the context of the South African multi-cultural society where, historically, the opportunities for health improvement were generally inadequate for Black subjects, this result could be expected.

8.4.1.2 Fitness evaluation and orientation

Although there was no statistically significant mean differences between the Black and White samples in fitness evaluation and orientation (Table 7.5), results from the principal components analysis revealed that White subjects placed considerable importance on fitness activities (Table 7.7) in order to maintain a healthy and pleasing appearance. New opportunities for sports activities in Black schools and communities may influence the degree of participation by Black females in the future. Presently, participation in regular sports programmes appeared to be a priority for White subjects only. Results (Table 7.6) indicated a negative score of -0,57 for the Black sample group and 0,68 (Table 7.7) for the White sample for participation in regular sports programmes. Socio-cultural pressure to achieve a thin, healthy body, may influence increased participation in fitness programmes and regular sport by Black females generally.

8.4.1.3 Body areas satisfaction

In addition to their preoccupation with weight and health control (Table 7.6), the Black fashion sample indicated a definite dissatisfaction with their height, their overall physique and to a lesser extent, their facial features. The results (Table 7.6) implied genetic as well as socio-cultural factors which could affect negative body image attitudes and perceptions. In terms of body parts satisfaction, height and weight factors could be modified by an increase in sport and fitness programmes; however, facial features can only be modified to a certain degree through cosmetic plastic surgery (Pierce, 1982). The aforementioned author notes that, in recent years, image awareness has become increasingly related to self-esteem among Blacks in America. With reference to American sample populations, it has been found that Black Americans have been neglected with regard to alternative methods of dealing with body image dissatisfaction, often due to socio-economic factors. This may be compared with the South African context where culturally and economically cosmetic plastic surgery and the less drastic means of physical health education have been restricted for Blacks.

The results (Table 7.6) revealed satisfaction and positive body image perceptions for the Black sample group on their overall appearance, their lower torso; that is, buttocks, hips, thighs and legs, and particular satisfaction with their hair colour, texture and thickness. Hair satisfaction provided an unexpected result, undoubtedly in terms of cultural differences in aesthetic values. Genetically, there is a general lack of hair-type variety within the Black population which may reduce expectations and competitiveness for this variable. Afro hairstyles are also an expression of Black identity status and contribute to the 'Black is beautiful' concept which originated in America in the 1960s, and is currently gaining more ground in South Africa. The media shift in South Africa from a Eurocentric to a more ethnic (Black) based representation of life and culture places emphasis on ethnocentric values. The positive effect of this media influence is shown in the results (Table 7.6), where an increased level of identity integrity, clarity of self-direction, trust and confidence is evident for the Black subjects.

By comparison, the data revealed that the White female sample considered overall appearance as highly important in their overall body image perceptions. White subjects also indicated more satisfaction with their general physical appearance, particularly their height, level of fitness and ability to take control of health issues (Table 7.7). The mean scores for these results were higher than those for Cash *et al.* (1986) and Brown *et al.* (1992). They also perceived their bodies as sexually appealing and gave more importance to this factor than the Black female subjects. Cultural variations in attitudes toward sexuality may explain this difference. Black subjects rated

their bodies as equally appealing; however, this factor was less important relative to the emphasis they placed on weight and health issues.

Negative body image attitudes for the White subjects revealed a high level of dissatisfaction with their hair and facial features (Table 7.7). *Factors Eight* and *Six* showed negative loadings on these items of -0,76 and -0,52 respectively.

It appears that from the results on body image attitudes for the Black and White female sample groups, and the cosmetic surgery patients, that women's satisfaction with their body image is influenced by physical characteristics, by the way others react to them, a comparison of their physique with that of others in their environment and by a comparison to the cultural ideals at the time (Garner & Garfinkel, 1980; Silverstein *et al.*, 1986; Thomas, 1988; Bond & Cash, 1992; Keisouw, 1994).

8.5 THE INTERRELATION OF BODY IMAGE AND IDENTITY INTEGRITY

Hypothesis 1 (5.2.1) proposed that not only body image attitudes, but also a person's perceived level of identity status is relevant in relation to methods chosen to combat negative self perceptions.

8.5.1 The effect of cosmetic plastic surgery on identity status

The data for the clinical sample groups showed that no significant post-operative changes in identity status were obtained for the reduction mammaplasty, augmentation mammaplasty and abdominoplasty patients. An important aspect of identity was found to have been affected by modifications to the face for the rhytidectomy patients (Table 7.8).

Firstly, the implications of no identity change in relation to significant, positive body image attitudes after surgery for the reduction mammaplasty, augmentation mammaplasty and abdominoplasty patients suggested that a person's sense of personal identity is not necessarily related to changes in certain body areas. Gerdes *et al.* (1989) point out that personal identity refers to a person's sense of being the same person over time and through changing experiences and situations (2.2.3). Although the reduction mammaplasty, augmentation mammaplasty and abdominoplasty patients underwent major changes to their physical bodies as a result of cosmetic plastic surgery, their sense of being the same person bound through consciousness and memory, remained unaltered to any serious degree. Individual identity, that is how patients viewed themselves in relation to others, and in their social system, also remained stable after cosmetic surgery for body part augmentation or reduction. It appeared that patients perceived others to

view them similarly, after surgery, as prior to surgery. It is important, however, to take cognisance that for the reduction mammaplasty, augmentation mammaplasty and abdominoplasty body image changes were positive post-surgically.

An inverse relationship on identity status occurred for the rhytidectomy where patients did not appear to perceive positive differences in body image change after surgery to the face (Tables 7.4 and 7.8). The results illustrate the important relationship between body image change and identity, where surgical intervention is perceived to be disappointing. Patients with a negative overall identity, manifest feelings of insecurity about who they really are and how others may view them. They doubt their self-worth and may feel left out in social commitments. In interpersonal relationships the face is the most highly visible area of recognition. Perceived negative changes to this area are likely to cause anxiety and emotional manifestation (Stark, 1980; Regnault & Daniel, 1984). The results for the rhytidectomy patients in this study seemed to be consistent with this previous research. It is important to note that given the small sample size, and lack of complex methodology, interpretations with larger sample sizes may differ.

The role of the face in maintaining identity stability is significant when one considers that surgical changes to other body areas appeared to have improved body image integrity without impairing identity integrity. This point may need to be carefully considered in terms of how ethnic (Black) identity change could be affected by cosmetic plastic surgery.

8.6 THE INFLUENCE OF CROSS-CULTURAL DIFFERENCES ON IDENTITY STATUS PERCEPTION

Hypothesis 2 (5.2.2) proposed that there exists not only cross-cultural differences in body image attitudes but also in a person's perceived level of identity status in relation to the effects of cultural influences. Within the context of the present transitional phase in South African history, the contrasting and even reversed results in terms of previous research (Ochse & Plug, 1986) on White and Black identity integrity are interesting and highly relevant.

8.6.1 Disparity in identity integrity between the Black and White fashion sample (i.e. non-clinical)

8.6.1.1 Trust and identity

Significant results (Table 7.9) were obtained for the Black subjects on issues of trust and identity (Questionnaire 2, Annexure 2) which are closely inter-linked in the following way. Firstly, the

higher levels of trust demonstrated by the Black subjects compared with the White subjects (Table 7.9), were highly unexpected given the past socio-cultural and economic restrictions placed on the Black society in South Africa. However, given the present stage of transition to a more democratic phase of social development, higher levels of trust are understandable, particularly for those who foresee new hope and anticipation for a better quality of life.

The Black female subjects, compared with the White sample, felt more optimistic about the future of people in general, as well as more confident that people could be trusted. The differences between the two groups are worth noting, for example, item 91, *I feel optimistic about my future*. Black subjects scored 0,87 and White subjects -0,72 (Tables 7.9 and 7.10). Black subjects expressed pride at being members of their society and felt their worth was recognised by others. They expressed trust in other people and a sense of clarity about their future direction in life. A sense of confidence in how they perceived others to feel about them was evident, as well as a clear sense of the sort of person they were.

By comparison, the White female sample expressed primarily, feeling depressed, low spirited and unsure how people felt about them. It appeared from the data (Table 7.10) that White subjects experienced a lack of meaning in their lives and felt their lives were being wasted. The findings suggested that the White subjects lacked trust in themselves and others, felt left out in the community, and to some extent, that nobody really cared about them. The disparity in the factor loadings for these items illustrated sharp contrasts in identity-integrity and status between the two groups. For example, item 81, *People can be trusted*, resulted in 0,97 for the Black sample and -0,61 for the White subjects.

According to Erikson (1968), personality develops through a fixed sequence of stages, each stage being critical for the development of a specific bipolar dimension of personality. Aspects of this theory seem applicable to the results on the data for the two culturally diverse groups. Where the Black subjects expressed trust, the White sample expressed mistrust. A pattern of identity satisfaction was apparent for the Black female sample in contrast to a state of identity diffusion, which appeared to be the case for the White female sample.

The results on identity, even though they were marginally significant, presented a startling contrast to previous research for a sample of White and Black subjects by Ochse and Plug (1986). The results obtained by these authors during the time of socio-cultural oppression in South Africa indicated that, by comparison, Black subjects experienced feelings of inadequacy and no self-confidence and uncertainty about life, whereas White subjects reported feeling high levels of self-confidence, satisfaction and optimism and a sense of purpose and achievement.

It is apparent that the aspects of identity integrity and of trust and identity are closely related to psycho-social variables for the non-clinical sample, whereas these factors appeared to be more

closely associated with physical and psychological variables for the clinical sample. What is stressed is the interrelationship among the physical, psychological and social variables for both body image and identity integrity.

8.6.1.2 Social desirability and autonomy

Notable results which were closely related; that is, *social desirability* and to a lesser extent a *sense of autonomy*, showed significant differences or trends between the Black and White sample groups. This disparity for the non-clinical sample group is informative in expressing cross-cultural behaviour patterns, the effects of which need to be carefully interpreted, and understood within a largely Western urban environment.

Significantly high factor loadings and a *t*-test result (Tables 7.9 and 7.10) on the variable, *Social desirability*, seemed to imply that Black subjects were compliant in trying to please people, and that they often behaved in socially correct ways in order to impress others. Further implications included that they absorbed criticism kindly, saw only the good in others and lead people to believe that they were completely honest with everybody. As these factors appeared to be unusually high ideals to achieve, Ochse and Plug (1986) warned that social desirability could be a nuisance variable which indicated the need for social approval rather than being a true reflection of the person's virtues. Therefore, although only marginally significant, the mean score differences between the Black and White subjects (Table 7.9) together with the factor loadings on the principal components' analysis (Table 7.10) tended to suggest that the White subjects behaved in a more autonomous manner than the Black subjects. This suggests that a lower level of autonomy and a high need for social approval expressed by the Black subjects, were related to the need to be viewed positively and to make an impression on others (Pedersen *et al.*, 1976). These factors become more meaningful if they are related to the results obtained by the Black sample for clothing behaviour.

8.6.2 <u>The impact of cosmetic plastic surgery on levels of anxiety and personality integrity for the clinical sample</u>

As postulated in hypothesis 4 (5.2.4), there appears to be a strong relationship between a changed physical appearance and a restored body image integrity, psychologically and socio-culturally. The interactive process of psychological change through changing the body is a key factor in all plastic surgery (Cash & Pruzinsky, 1990; Kaiser, 1990; Pruzinsky, 1991).

Post-surgical results for the reduction mammaplasty patients on anxiety levels and personality traits, indicated the positive effects of successful body image change (Table 6.12). Patients reported increased socially bold, uninhibited and more spontaneous behaviour, post-operatively. These results were above the norm for the same personality variables as reported by Prinsloo (1991, Table 2, p.13). The implications of this behaviour seemed to be that more relief, comfort and less embarrassment about body size and shape were experienced after surgery for the reduction mammaplasty patients. Simultaneously, low anxiety scores, as compared with the means reported by Cattell *et al.* (1968), were in harmony with the personality traits and behaviour expressed by this sample group.

The abdominoplasty and augmentation mammaplasty patients exhibited positive post-operative attitudinal change toward their new physical appearance as well as decreased levels of anxiety. These results, however, although highly congruent in the context of this study, need to be interpreted with caution due to the small sample sizes. Notwithstanding these limitations, the trends shown were compatible with previous research (Cattell *et al.*, 1968; Stark, 1980; Cash & Pruzinsky, 1990; Spalding, 1990; Schlebusch & Mahrt, 1993).

Conversely, anxiety levels increased for the rhytidectomy patients. This result was highly relevant to the previous discussion on negative body image or no change (8.3.2) after facial modifications or alterations. The results for the rhytidectomy patients illustrate the important relationship between body image change and anxiety, where surgical intervention is perceived to be partially successful. According to research (Stark, 1980; Cash & Pruzinsky, 1990), rhytidectomy patients are generally less satisfied than patients where physical changes to the body are more obvious. Higher post-operative anxiety levels could be related to the unrealistic expectations and subsequent disappointment when expectations are not met, after surgery. The debate remains that the patient still has the same face. A careful pre-operative assessment of the patient and good interpersonal patient/surgeon communications are imperative if disillusionment is to be avoided. In the cases of ethnic differences in aesthetic values, rhytidectomy presents a challenge to the surgeon in meeting the expectations of a person from another culture (Cash & Pruzinsky, 1990; Pierce, 1992).

The decreased levels of anxiety noted for the augmentation mammaplasty patients, post-operatively, may be appropriately related to the modified personality changes observed after an increase to breast size. Augmentation mammaplasty patients reported being more serious, inhibited, conservative, shy and anxious prior to surgery (Table 7.12). These patients, together with the reduction mammaplasty patients, had expressed embarrassment prior to surgery in social situations where public change or fitting rooms had to be used, and when choosing garments publicly in stores (Personal communication, augmentation mammaplasty patients, Durban, 1995).

Post-operatively, augmentation mammaplasty patients described themselves as more relaxed, less rigid in their behaviour and more positive in their attitudes toward life in general. Pre-operative negative scores on these variables were below the norms reported by Prinsloo (1991; Table 2, p.13). Variations in personality traits were observed in other research studies where augmentation mammaplasty patients were found to be submissive and dependent. Post-operative test results revealed increased levels of self-confidence and independence (Cash & Pruzinsky, 1990; Spalding, 1990; Schlebusch & Mahrt, 1993).

The close relationship between anxiety and personality traits, to body image perceptions outlined by this discussion, forms the background to further investigations of the socio-cultural variables of clothing behaviour and a person's sense of social acceptance implicit in hypothesis 4 (5.2.4).

In Section 5.2.1 it was hypothesised that personal attitudes toward body image and self-identity were related to the need a person had to change her physical appearance through surgery.

Hypothesis 1 was significant at the 0,05 level of significance and was accepted in terms of the positive changes in body image perception and attitudes experienced by the person post-surgically. This hypothesis was generally accepted in the literature (Stark, 1980; Cash & Pruzinsky, 1990; Price, 1992; Schlebusch & Mahrt, 1993). The differences between body images and identity attitudes and perceptions for the Black subjects and the White subjects revealed that their groups did not require surgery to improve aspects of their physical appearance. Improved physical appearance through cosmetic plastic surgery did not necessarily improve self-identity status where this was found to be stable pre-operatively. However, negative identity post-operatively was found to result where a changed physical appearance had possibly not been absorbed into the self-concept. Positive body image perceptions and identity status were found to be related concepts in terms of the Black and White non-clinical subjects' self-perceptions. Hypothesis 2 was therefore partially accepted at the 0,05 level of significance.

8.7 THE INFLUENCE OF SOCIO-CULTURAL VARIABLES OF CLOTHING AND SOCIAL ACCEPTANCE ON BIOPSYCHOSOCIAL FUNCTIONING

8.7.1 Body image perceptions and clothing behaviour

Hypothesis 2 (5.2.2) implied that a relationship exists between people's body image perceptions and clothing behaviour in terms of their need to change either one, or both, of these variables.

The objectives for changing depended on the level of negativity experiences in order to feel socially more acceptable.

Implicit in this statement is the role of the body as a basic experiential agent in mediating behaviour and modulating psychosocial judgements (Edwards, 1972; Cash & Pruzinsky, 1990). Clothing symbolism together with clothing behaviour forms a vital link in human social interaction (Enty, 1979; Kaiser, 1990). Variations in the data for measuring clothing behaviour indicated significant results in relation to physical changes to the body.

Differences between the Black and White subjects in terms of clothing behaviour also revealed the need for conformity with regard to socio-cultural norms for codes of fashionable dress and for body shape and size. Hypothesis 2 was accepted at the 0,05 level of significance on this basis and in relation to persons not undergoing any form of cosmetic plastic surgery.

8.7.2 The role of fashionable clothes in body image and identity integrity

8.7.2.1 Aesthetics

The aesthetic value of clothing emerged as an important consideration for augmentation mammaplasty and rhytidectomy patients. Patients' answers to the questionnaires (Creekmore Scales, 1971) suggested that they invested more attention to details of the fabric and line of the garment, to colour combinations and accessory co-ordination after changes to physical appearance through cosmetic plastic surgery.

Previous studies on augmentation mammaplasty patients indicated similar results. Schlebusch and Mahrt (1993) reported that post-operatively all patients (n=20) purchased fashion garments more frequently and enjoyed experimenting with a variety of clothing styles in order to achieve a beautiful appearance (Table 7.13). Gurel and Gurel (1979) demonstrated the importance of aesthetic personal appearance achieved through the use of fashionable clothing for a sample of undergraduates (n=55). The highest factor loadings were reported for aesthetics, 0,65; experimentation, 0,68; and for conformity, 0,71 (Gurel & Gurel, 1972, Table 1, p.278).

8.7.2.2 Interest

Patients in all four clinical sample groups for this study, showed stable levels of interest, pre- and post-surgery, in the attention directed at investigating, manipulating or experimenting with clothing.

Behavioural self-presentational skills remained equal pre- and post-operatively for the augmentation mammaplasty, rhytidectomy and abdominoplasty patients. This behaviour implied buying unusual or distinctive clothes in the latest styles, usually with well-known labels.

8.7.2.3 Comfort and conformity

Patients also expressed preferences for comfortable clothes similar to their friends' or to the group's to which they belonged. Conformity appeared to be an important issue which, due to physical differences in shape and size prior to surgery, may not always have been possible for the reduction mammaplasty subjects. A significant post-test result on *modesty* illustrates this point clearly.

8.7.2.4 Conservatism

Unlike the augmentation mammaplasty, abdominoplasty and rhytidectomy sample groups, the reduction mammaplasty patients seem to adopt a conservative, but not necessarily less fashionable, pattern of clothing behaviour after breast reduction. Clothes that were too revealing or tight, conspicuous in colour and design, were avoided initially. The benefits of physical change, although acknowledged, were not necessarily accepted psychologically, in the three-month period after cosmetic surgery, by the reduction mammaplasty patients. The process involved in regaining body image integrity or adjusting to a new physical appearance influences peoples' clothing choices at various stages. Gruendemann (1975) confirms that patients may acknowledge positive change in appearance but are unable to integrate this change into their self-concepts. They continue to perceive themselves as possessing an unacceptable body area. Dissatisfaction with a single symptom or body part may be generalised to become dissatisfaction with other body areas. Eventually the entire self-concept may be affected negatively (Cash & Pruzinsky, 1990). Subconsciously, reduction mammaplasty patients may have been reluctant to draw attention to body areas that were over-conspicuous prior to reduction, which caused them pain and embarrassment.

Ongoing patient assessment would reveal whether these symptoms and the consequent clothing behaviour were permanent or transient. The outcome would add validity to the observations initiated in this study.

By comparison, augmentation mammaplasty and rhytidectomy patients revealed wearing tight fitting and revealing clothes which enhanced their femininity in the three-month period after surgery. Clothing included fashionable sportswear and more attractive swimwear. Impression

management, through the use of clothing, was utilised to attract positive attention rather than to maintain levels of pre-operative conservatism.

8.8 THE EFFECT OF COSMETIC SURGERY AND CLOTHING BEHAVIOUR ON PUBLIC AND PRIVATE SELF-CONSCIOUSNESS

Hypothesis 5 (5.2.5) proposed that changes in body-image perception, level of identity and clothing behaviour affect perceived feelings of social acceptance. Hypothesis 5 was accepted at the 0,05 level of significance in view of the positive integrated effects on behaviour perceptions and attitudes of the abovementioned variable for all four cosmetic surgery sample groups, namely, augmentation mammaplasty, reduction mammaplasty, rhytidectomy and abdominoplasty. It is important to note that the more prominent effects of behaviour and perceptual integration were significant at the 0,05 level for the variables, body images and clothing behaviour. A person's sense of self-identity and of social self-acceptance was not affected to the same degree after cosmetic plastic surgery as those of body image and clothing behaviour.

8.8.1 Social self-consciousness

After surgical reduction of the breasts, self-focused attention decreased for the reduction mammaplasty patients (Table 7.18). Patients reported feeling less embarrassed and more comfortable about the size of their breasts and their general physical appearance. More confidence and an enhanced body image perception contributed to the reduction mammaplasty patients' perceived sense of social acceptance by their peers and within the society in general (Table 6.18) (Personal communication, reduction mammaplasty patients, Durban, 1995).

Social self-consciousness and social anxiety decreased for the augmentation mammaplasty patients (Table 7.17) after an increase in breast size. The results suggested that more self-confidence and less shyness was experienced in the presence of others. Furthermore, patients felt socially more acceptable through feeling physically and aesthetically less different. Enhanced feelings of femininity due to normal breast size seemed to reduce feelings of inadequacy, and increased positive self-appraisal and self-concept (Cash & Pruzinsky, 1990; Schlebusch & Mahrt, 1993).

The symbolic importance of the breasts as part of the feminine concept and the emphasis on clothing styles which focus on the breast may be two reasons for the breast patients' (rather than either the rhytidectomy and abdominoplasty patients'), increased sense of self and social acceptance after the surgical changes to their physical appearance.

What became increasingly evident through this investigation, were the dialectic and symbolic interactional influences of a dynamic, changing biopsychosocial unity.

8.9 THE EFFECTS OF CROSS-CULTURAL INFLUENCES ON CLOTHING BEHAVIOUR AND SOCIAL SELF-CONSCIOUSNESS

8.9.1 Dress and personal adornment

Dress and personal adornment, together with body-image variables such as self-presentation and grooming behaviours, are among the most visible aspects of socio-cultural interaction (4.2).

In multi-cultural, democratic South Africa, cross-cultural influences of clothing behaviour may form an equitable platform for the flow of ideas and the exchange of preferences through which social identity may be modified and accepted.

Ethnic identification, however, for either Black cultural groups or White cultural groups is a socio-cultural process. How a person perceives her ethnic identity is at the core of her self-concept. Clothing behaviour expresses one aspect of ethnic development (Gay & Barber, 1987). Clothing is often chosen for a variety of social, psychological and physical reasons (Cash *et al.*, 1985) and communicates not only the wearer's attitudes, but also her personality.

The effect of these interrelated concepts and influences is evident in the results from the Black and White fashion samples on clothing variables and social self-consciousness (Tables 7.13, 7.17, and 7.18).

8.9.1.1 The concept of fashion paradox

The implications of the results for the Black and White fashion subjects (Table 7.15) emphasised the power of fashion as collective behaviour. The significant mean differences on the unpaired *t*-test (Creekmore, 1971; Table 7.13) for the Black sample group were evidence of the exceptional need of this sample group for approval and attention. The following results exemplify the extent of the need of the Black subjects for recognition for:

- Item 39: *I like to be considered an outstanding dresser by my friends*. The difference between the means for the Black and White groups respectively was $\underline{M}$ ($\underline{SD}$) = 3,21(1,18) and 2.20(1,03), P>|t| = 0,0009.
- Item 46: (*Factor Four: Attention: I wear different clothes to impress people*, $\underline{M}$ ($\underline{SD}$) = 3,82(1,16) and 2,83(1,21) P>|t| = 0,0024.

- Item 51: (*Factor Four: Attention: I wear clothes that everyone is wearing even though they may not look as good on me,* $\underline{M}$ *(SD)* = 4,79(0,50) and 4,30(0,60), P> |t| = 0,0014.

8.9.1.2 The fashion paradox

The implications of these results are closely interrelated to aspects of body images, identity status and sense of social acceptance.

Firstly, as fashion provides a simultaneous means of identification with a group, and differentiation from other individuals, the fashion paradox, (Kaiser, 1985) by dressing like their friends, the Black fashion subjects were able to identify with members in their particular group and at the same time distinguish themselves from members of other groups. At the core of the fashion paradox and as evidenced by the behaviour expressed by the Black fashion sample, is the power of collective behaviour (Roach-Higgins & Eicher, 1992). This power becomes a compelling force in the process of fashion adoption and diffusion (4.4.3.1, 4.5.1), and preferences are often culturally based and highly influenced by media promotion.

8.9.1.3 Pre-encounter, psychologically captive ethnic identity

Significantly high scores for the Black fashion sample on the *Factors of Approval, attention and conformity* highlight the importance of the relationship between clothing variables and identity status. The transition from pre-encounter to post-encounter ethnic (Black) identity is typified by a lack of autonomy, the need for approval, recognition and attention. Pre-encounter ethnic individuals use predominantly Western values as yardsticks for their own sense of what is right and good (Kuper, 1973; 4.6.7). Post-encounter ethnic individuals express their own form of national unity and independence, for example, Afro-Americans in the 1960s and present North African states. In South Africa, however, as an emerging community, the Black urban female sample appeared to prefer Western styled garments based on Eurocentric international trends as opposed to clothes that express their national identity (Table 7.15). Dress which expresses national identity is often seen at public manifestations, usually politically based (TV1, News Services, 1994, 1995, 1996) and where the power of collective behaviour is clearly defined.

By contrast, data results for the White female sample indicated a significant preference for ethnic styled garments which, in relation to their lower sense of trust (8.6.1(i)) in their position and within their own country, appeared to be a strong attempt at gaining identity status as South Africans as expressed through their clothing. The conflict of results for the White female sample group on the unpaired *t*-test (Table 7.15) as compared with inverse factor loadings on the

principal components' analysis (Table 7.17) may be indicative of an inner struggle and conflict of emotions in retaining their own sense of belonging.

8.9.1.4 Comfort and modesty

The Black fashion sample indicated a higher sensitivity than the White sample of finding clothing suitable to the temperature (Durban) although this difficulty was also expressed by the White subjects. This result has implications for fashion manufacturers, together with the fact that the Black fashion sample expressed a dislike for tight clothing and especially clothes that were tight around the upper arm. The data for the White fashion sample indicated their dislike of clothes that revealed too much of the body. This significant difference between the Black and White fashion sample M (SD) = 2,9(1,42) and 3,87(0,78) respectively with $P>|t| = 0,0018$ is interesting. How this result reconciles with current fashion trends such as separates which are transparent, or 'minimal' tops and 'micro' skirts and trousers, lycra fitted sportwear and evening wear and attractive, but very revealing fashionable swimwear, is not clear. The delicate balance between clothes that reveal too much of the body as being interpreted as vulgar, and those that are culturally accepted as fashion norms or trends is difficult to define. Modesty is a sentiment that varies among different countries and during different periods (Polhemus & Procter, 1978). The relationship of modesty to the amount of clothes worn, as evident in many African cultures, is more often obsolete. However, in Western culture where the style and quantity of clothes covering the body was, in the past, closely related to the question of modesty, the 'G'-string and lingerie styled garments such as the bra-top, or bustier, emphasise the disparity between the amount of clothes worn and modesty. Non-verbal messages about what the wearer intends to communicate through her clothing behaviour, and the value of modesty even in Western culture appear to be persistently less related to the amount of clothes worn, but more to 'how' the clothes are worn. Results suggested that Black female subjects (Table 7.13) were more self-conscious about wearing swimsuits in public, specifically for the first time in the season. This result, however, may be due partly to negative weight and body image perceptions (8.6) and to the newness of multi-cultural unrestricted beach facilities, where the body and physical appearance are most exposed. Data results on social desirability (Table 7.9) which suggested the need of the Black female sample for social approval, to be viewed favourably by others, and to belong (8.6.1.1) further explain the interrelationship among body image, identity and clothing variables.

An interesting difference between the two fashion sample groups emerged for the Black subjects (Table 7.15) who seemed to show an intense level of curiosity as to why people chose the clothes they wore, and why some people chose to wear unusual clothes. Understanding why

others wore the clothes they did appeared to have a particular significance for the Black fashion sample; however, the reason is not clear. One interpretation may be that in relation to their need for recognition and approval, understanding why other people chose certain clothes could assist them in their freedom of choice and in their effort to understand their own behaviour.

The Black and White fashion groups showed similar levels of interest in keeping up with the latest trends, reading fashion magazines and gaining media information on fashion. Both groups expressed interest in choosing pleasing colour combinations, and invested time in selecting accessories suitable to the garments they wore. Both groups reported interest in experimenting with new or different hairstyles; however, this appeared to be more important to the Black female sample which was confirmed by the positive result on the body image variable for hair colour and texture (Table 7.6; 8.4.1.3).

Social acceptance, feeling part of the group and dressing like others in the group were important aspects of overall well-being and successful group interaction for both the Black and White fashion groups as suggested by the data (Table 7.14). However, results on the private and public self-consciousness scale revealed the following differences in terms of a person's sense of social acceptance.

8.10 THE IMPLICATIONS OF INTERCULTURAL DIFFERENCES IN PERCEPTIONS OF PRIVATE AND PUBLIC SELF-CONSCIOUSNESS

8.10.1 Self as a social being

Hypothesis 6 (5.2.5) proposed that cross-cultural differences existed between non-surgical modification to physical apearance, choice of clothing behaviour and sense of social acceptance. Hypothesis 6 (5.2.5) was accepted at the 0,05 level of sinificance of the differences between the non-clinical Black and White fashion groups' sense of self-identity and the need for group approval and conformity, specifically in the context of multicultural South Africa. Self-awareness is a central concept in a variety of different approaches to behaviour and life. Self-examination enables the person to recognise unconscious thoughts, motives and defences. A central goal of psychotherapy is increased self-insight (Fenigstein *et al.*, 1975). Self-consciousness is the consistent tendency of a person to direct attention inward, (Fenigstein *et al.*, 1975; Gerdes *et al.*, 1989).

8.10.1.1 Private self-consciousness

An analysis of the data for the Black and White fashion sample revealed that White subjects had a higher tendency for self-examination of their inner thoughts and feelings, analysing their moods, attitudes and behaviour patterns. White subjects also revealed statistically significant negative feelings about the way they looked, concern about what others may think of their looks, feeling more aware of themselves as social objects (Table 7.18) in terms of self-presentation and the effect they have on others. These results are congruent in relation to the negative identity perceptions apparent for the White fashion group, as discussed previously (8.6.1(i)).

No significant differences in social anxiety were noted between the Black and White fashion groups. According to Fenigstein *et al.*, (1975, Table 2, p.523) the White sample group appeared to have simultaneously experienced sensitivity to their social situation without necessarily feeling socially anxious.

8.11 FASHION EVALUATION BY FASHION OPINION LEADERS: THE ROLE OF IDENTIFYING INTERCULTURAL CLOTHING BEHAVIOUR PATTERNS

In subsection one (7.9) fashion opinion leaders were identified as prominent persons in the design field. Their status as opinion leaders was validated through standardised questionnaire responses. The results were discussed in chapter seven (7.9.1).

Hypotheses 2 and 3 (5.2.2 and 5.2.3 respectively) were supported by the opinions of the fashion opinion leaders with reference to a person's need to adopt styles of dress and clothing behaviour which would enhance her physical appearance and sense of social acceptance through consensus of the prevailing fashion norms.

The similarities and differences in clothing preferences, described by the participants in the sample groups, indicated the extent of their involvement with the fashion process. This outcome serves to highlight the pervasiveness of the fashion syndrome and the need people have to conform to fashion norms. The intense interest in fashionable clothes and desire and need for people to express themselves in an aesthetically pleasing manner, extended to those who were candidates for surgery, with no specific involvement in the fashion field, and to those who suffered negative body image perceptions even where a life threatening disease was evident.

8.12 RECOMMENDATIONS

On the basis of the results and the integrated discussion, the following recommendations are made:

1. Medical patients need to be assessed holistically. The results of this study indicated the extent to which variables are related, physically, psychologically and socio-culturally, and what effect this has on a person's attitudes, perceptions and quality of life. It has been shown that psychological adjustment is a key factor in the patient's acceptance of a changed physical appearance. Both these items, together with adequate positive feedback from surgeons and significant others, contribute to the ultimate success of surgery. This was shown to be the case for elective cosmetic surgery patients as well as for those suffering from high risk diseases such as cancer.
2. Emphasis needs to be placed on the strategic role of the surgeon, professional health-care workers and psychologists in formulating and mediating optimum professional and surgeon-patient interaction. Interpersonal communication and adequate information dispersion are factors that will decrease the negative effects of unrealistic expectations for cosmetic surgery and breast cancer patients (Cash & Pruzinsky, 1990).
3. There is a need for specifically trained medical psychologists to form part of a team approach to dealing with medical patients.
4. It is suggested that future research extends beyond the psychosocial effects of aspects of physical appearance and clothing behaviour on quality of life, for cosmetic surgery and breast cancer patients. The effects of surgery on interpersonal relationships, intimate relationships, work and career development, need to be investigated over time. This recommendation is supported by the literature where researchers have commented on the challenging void in studies on the psychosocial aspects of aesthetic and reconstructive surgery (Gruendemann, 1975; Cash & Horten, 1983; Cash & Pruzinsky, 1990).
5. The power and complexity of body image perceptions in mediating all aspects of a person's life, need to be understood. Cross-cultural differences in body image perception need to be assessed in relation to ethnic identity development if cultural harmony is to be encouraged. Understanding people in terms of their needs contributes to healthy socio-cultural interface. The body is the experiential agent that introduces this order and meaning into interaction with others and offers a persistent line of stability for perceptions (Fisher, 1970; Edwards, 1972; Van der Velde, 1985; Cash & Pruzinsky, 1990).

6. Research on methods of countering the negative effects of advertising and multi-media exploitation in portraying stereotypical and unrealistic images of women's physical appearance needs to be instituted and implemented.
7. The over-concern of weight issues for the Black female subjects in this study is indicative of the growing trend in cross-cultural influences of body image distortion. To what extent eating disorders may become prevalent in young urban Black societies is an area of concern in terms of the adequate implementation of preventative strategies.
8. Intercultural influences on clothing adoption and diffusion need to be understood from a physical, psychological and socio-cultural perspective, in order to achieve marketing goals and satisfy a rapidly changing society. The growing recognition of women in business, sport, media and at all levels of government is a vital force in identity formation and social development. Research in this area is suggested as a baseline for future reference on the influences of cross-cultural interaction and marketing strategies. A comparative study between Black and White females would broaden the scope of this assessment.
9. Further research on larger samples of breast cancer patients, within a biopsychosocial framework is recommended. The seriousness of cancer patients' vanity needs, and their need for attractive fashionable clothing and to feel socially acceptable in order to sustain their dignity and maintain their quality of life, merit optimum attention. The paucity of relevant research literature pertaining to Black and White females in South Africa, in terms of cosmetic plastic surgery, breast oncology, ethnic identity development and clothing behaviour, highlights the necessity to develop research resources which are meaningful to the lives of people in this country.
10. It is recommended that tertiary educational institutes such as the Technikon Natal, Fashion Department conduct further research in the area of fashion with specific emphasis on the multi-cultural aspects of the South African population. Involvement by lecturing staff and students for training and for educative purposes could enhance the much needed resource and data base, on a broad spectrum of design, fashion and clothing information, currently needed in this country.
11. It is recommended that established fashion opinion leaders be consulted regularly in order that expert dialogue on fashion directives be available to fashion design students and researchers alike.
12. It is recommended that fashion producers and marketers draw on the integrated knowledge of fashion opinion leaders and researchers in order to gain a more complete overview of the fashionable clothing needs of a full spectrum of the market population.

8.13 CONCLUSION

The results of this investigation provide preliminary evidence of notable relationships between all six variables discussed, body image and identity perceptions, clothing behaviour and social self-consciousness, as well as anxiety and personality variables, which were discussed with particular reference to the clinical sample groups.

The findings of this study cleary demonstrate the effects of positive body images and identity integrity on healthy psychological functioning for the cosmetic surgery sample groups, the Black and White sample groups and the breast oncology case studies.

Efforts to compartmentalise the physical, psycho-social and cultural dimensions of human interactional processes may limit an understanding of holistic, integrated behaviour patterns, the complexity of personality traits and the full range of human emotional responses.

Conversely, efforts to gain insight into and develop sensitivity to a person's core needs may promote the cultural harmony and stability needed for optimum interpersonal and community relationships and subsequent cross-cultural tolerance.

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ANNEXURE 1

THE MULTIDIMENSIONAL BODY SELF-RELATION QUESTIONNAIRE

QUESTIONNAIRE 1

BIOGRAPHICAL QUESTIONNAIRE

Record No.		1, 2
Card No.		3

	Pre	Post	
TEST			4

	YRS	
AGE		5, 6

CULTURAL GROUP	BLACK	WHITE	
	1	2	7

EDUCATIONAL QUALIFICATIONS	LESS THAN MATRIC	MATRIC	CERTIFICATE/ DIPLOMA	DEGREE/ PART DEGREE	
	1	2	3	4	8

OCCUPATION		
		9

HOME LANGUAGE	AFRICAN LANGUAGE	AFRIKAANS	ENGLISH	OTHER	
	1	2	3	4	10

INSTRUCTIONS

The following pages contain a series of statements about how people might think, feel or behave. You are asked to indicate the extent to which each statement pertains to you personally.

Your answers to the items in the questionnaire are anonymous, so please do not write your name on any of the materials. In order to complete the questionnaire, read each statement carefully and decide how much it pertains to you personally, using a scale like the one below.

If you ***Definitely Disagree*** then write **X** in square 1

1	2	3	4	5

If you ***Mostly Disagree*** then write **X** in square 2.

1	2	3	4	5

If you ***Neither Agree nor Disagree*** then write **X** in square 3.

1	2	3	4	5

If you ***Mostly Agree*** then write **X** in square 4.

1	2	3	4	5

If you ***Definitely Agree*** then write **X** in square 5.

1	2	3	4	5

There are no right or wrong answers. Just give the answer that is most accurate for you. Remember, your responses are anonymous, so please be completely honest and answer all items.

THE MULTIDIMENSIONAL BODY SELF-RELATION QUESTIONNAIRE

Please read the following statements. Rate each according to the extent to which you believe that you agree or disagree with the statements. Use the following guide and use a cross for your response.

Scale:
1. Definitely Disagree
2. Mostly Disagree
3. Neither Agree nor Disagree
4. Mostly Agree
5. Definitely Agree

		Definitely Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Definitely Agree	
1.	Before going out in public, I always notice how I look.	1	2	3	4	5	11
2.	I am careful to buy clothes that will make me look my best.	1	2	3	4	5	12
3.	I would pass most physical-fitness tests.	1	2	3	4	5	13
4.	It is important that I have superior physical strength.	1	2	3	4	5	14
5.	My body is sexually appealing.	1	2	3	4	5	15
6.	I am not involved in a regular exercise programme.	1	2	3	4	5	16
7.	I am in control of my health.	1	2	3	4	5	17
8.	I know a lot about things that affect my physical health.	1	2	3	4	5	18
9.	I have deliberately developed a healthy life-style.	1	2	3	4	5	19
10.	I constantly worry about being or becoming fat.	1	2	3	4	5	20
11.	I like my looks just the way they are.	1	2	3	4	5	21
12.	I check my appearance in the mirror whenever I can.	1	2	3	4	5	22
13.	Before going out, I usually spend a lot of time getting ready.	1	2	3	4	5	23
14.	My physical endurance is good.	1	2	3	4	5	24
15.	Participating in sports in unimportant to me.	1	2	3	4	5	25
16.	I do not actively do things to keep physically fit.	1	2	3	4	5	26
17.	My health is a matter of unexpected ups and downs.	1	2	3	4	5	27

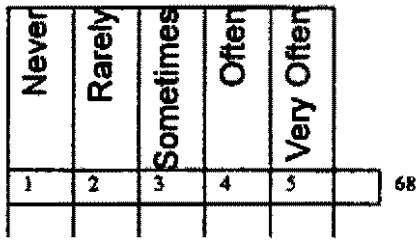
		Definitely Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Definitely Agree	
18.	Good health is one of the most important things in my life.	1	2	3	4	5	28
19.	I don't do anything that I know might threaten my health.	1	2	3	4	5	29
20.	I am very conscious of even small changes in my weight.	1	2	3	4	5	30
21.	Most people would consider me good-looking.	1	2	3	4	5	31
22.	It is important that I always look good.	1	2	3	4	5	32
23.	I use very few grooming products.	1	2	3	4	5	33
24.	I easily learn physical skills.	1	2	3	4	5	34
25.	Being physically fit is not a strong priority in my life.	1	2	3	4	5	35
26.	I do things to increase my physical strength.	1	2	3	4	5	36
27.	I am seldom physically ill.	1	2	3	4	5	37
28.	I take my health for granted.	1	2	3	4	5	38
29.	I often read books and magazines that pertain to health.	1	2	3	4	5	39
30.	I like the way I look without my clothes on.	1	2	3	4	5	40
31.	I am self-conscious if my grooming isn't right.	1	2	3	4	5	41
32.	I usually wear whatever is handy without caring how it looks.	1	2	3	4	5	42
33.	I do poorly in physical sports or games.	1	2	3	4	5	43
34.	I seldom think about my athletic skills.	1	2	3	4	5	44
35.	I work to improve my physical stamina.	1	2	3	4	5	45
36.	From day to day, I never know how my body will feel.	1	2	3	4	5	46
37.	If I am sick, I don't pay much attention to my symptoms.	1	2	3	4	5	47

		Definitely Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Definitely Agree	
38.	I make no special effort to eat a balanced and nutritious diet.	1	2	3	4	5	48
39.	I like the way my clothes fit me.	1	2	3	4	5	49
40.	I don't care what people think about my appearance.	1	2	3	4	5	50
41.	I take special care with my hair grooming.	1	2	3	4	5	51
42.	I dislike my physique.	1	2	3	4	5	52
43.	I don't care to improve my abilities in physical activities	1	2	3	4	5	53
44.	I try to be physically active.	1	2	3	4	5	54
45.	I often feel vulnerable to sickness.	1	2	3	4	5	55
46.	I pay close attention to my body for any signs of illness.	1	2	3	4	5	56
47.	If I'm coming down with a cold or flu, I just ignore it and go on as usual.	1	2	3	4	5	57
48.	I am physically unattractive.	1	2	3	4	5	58
49.	I never think about my appearance.	1	2	3	4	5	59
50.	I am always trying to improve my physical appearance.	1	2	3	4	5	60
51.	I am very well co-ordinated.	1	2	3	4	5	61
52.	I know a lot about physical fitness.	1	2	3	4	5	62
53.	I play a sport regularly throughout the year.	1	2	3	4	5	63
54.	I am a physically healthy person.	1	2	3	4	5	64
55.	I am very aware of small changes in my physical health.	1	2	3	4	5	65
56.	At the first sign of illness, I seek medical advice.	1	2	3	4	5	66
57.	I am on a weight-loss diet.	1	2	3	4	5	67

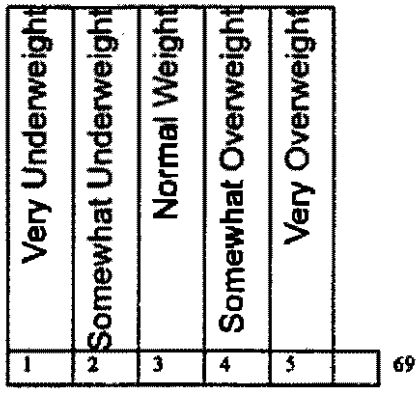
For the remainder of the items use the response scale given with the item

(Continued on the next page)

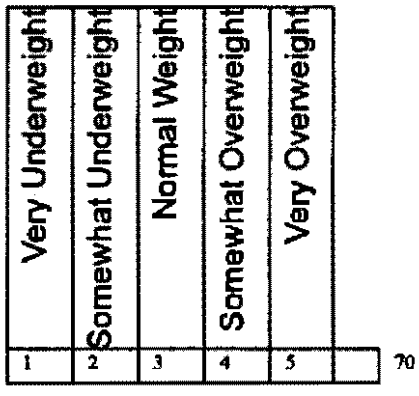
58. I have tried to lose weight by fasting or going on crash diets.



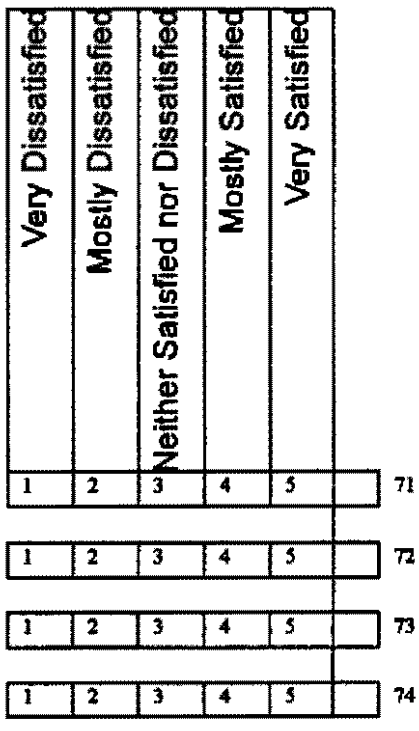
59. I think I am:



60. From looking at me, most other people would think I am:



61-69 Use the 1 to 5 scale to indicate <u>how satisfied you are</u> with each of the following areas or aspects of your body

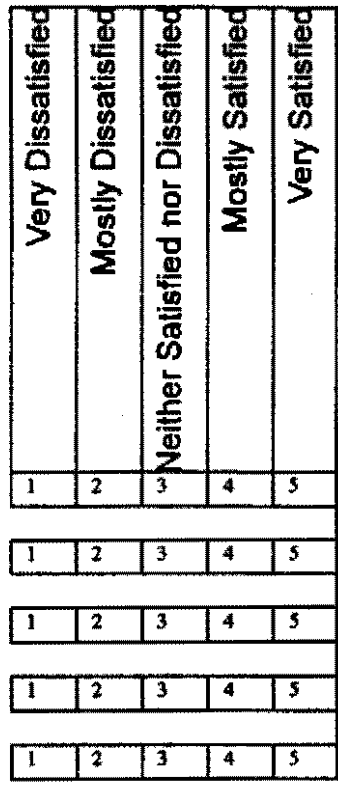


61. Face (facial features, complexion)

62. Hair (colour, thickness, texture)

63. Lower torso (buttocks, hips, thighs, legs)

64. Mid torso (waist, stomach)



65.	Upper torso (chest or breasts, shoulders, arms)	1	2	3	4	5	75
66.	Muscle tone	1	2	3	4	5	76
67.	Weight	1	2	3	4	5	77
68.	Height	1	2	3	4	5	78
69.	Overall appearance	1	2	3	4	5	79

ANNEXURE 2

SCALE FOR MEASURING IDENTITY AS CONCEIVED BY ERIK ERIKSON

QUESTIONNAIRE 2

INSTRUCTIONS

On the following pages are a number of statements.

We would like you to indicate how often each of those statements applies to you by writing **X** in the appropriate square, as shown below.

If the statement *Never* applies to you then write **X** in square 1.

1	2	3	4

If the statement *Seldom* applies to you then write **X** in square 2

1	2	3	4

If the statement *Fairly Often* applies to you then write **X** in square 3.

1	2	3	4

If the statement *Very Often* applies to you then write **X** in square 4.

1	2	3	4

There are no right or wrong answers. We wish to know how people feel - not to judge you as an individual. Therefore the best answers you can give us are those that tell us how you really feel about yourself and the world.

Record No. [ ][ ] 1,2

Card No [ ] 3

QUESTIONNAIRE 2
SCALE FOR MEASURING IDENTITY AS CONCEIVED BY ERIK ERIKSON

Consider each item listed below and write an **X** in the square which best represents your feelings according to the following scale.

Scale:
1 Never
2 Seldom
3 Fairly Often
4 Very Often

		Never	Seldom	Fairly Often	Very Often	
1.	I feel pessimistic about the future of mankind.	1	2	3	4	4
2.	I have a feeling that I would like to "sink through the floor" or become invisible to those around me.	1	2	3	4	5
3.	I hide the fact that I have made a mistake.	1	2	3	4	6
4.	I feel guilty when I am enjoying myself.	1	2	3	4	7
5.	I make the best of my abilities	1	2	3	4	8
6.	I wonder what sort of person I really am.	1	2	3	4	9
7.	I feel that no one has ever known the real me.	1	2	3	4	10
8.	I feel that, in the long run, children are more of a burden than a pleasure.	1	2	3	4	11
9.	I am completely honest with everybody.	1	2	3	4	12
10.	People seem to change their opinion of me.	1	2	3	4	13
11.	I feel I will achieve what I want in life.	1	2	3	4	14
12.	When people try to persuade me to do something I don't want to, I refuse.	1	2	3	4	15
13.	I compare myself favourably to somebody else.	1	2	3	4	16

		Never	Seldom	Fairly Often	Very Often	
14.	I am prepared to take a risk to get what I want.	1	2	3	4	17
15.	When people look at something I have done, I feel embarrassed by the thought that they could have done it better	1	2	3	4	18
16.	I feel certain about what I should do with my life.	1	2	3	4	19
17.	I have a feeling of complete "togetherness" with someone.	1	2	3	4	20
18.	Young people forget what one has done for them.	1	2	3	4	21
19.	I am equally polite to everybody.	1	2	3	4	22
20.	I feel uncertain as to whether something is morally right or wrong.	1	2	3	4	23
21.	When I am looking forward to an event, I expect something to go wrong and spoil it.	1	2	3	4	24
22.	After I have made a decision I feel I have made a mistake.	1	2	3	4	25
23.	I take a dislike to someone.	1	2	3	4	26
24.	I feel hesitant to try out a new way of doing something.	1	2	3	4	27
25.	I lack the energy to get started on something I intended to do.	1	2	3	4	28
26.	Most people seem to agree about what sort of person I am.	1	2	3	4	29
27.	I feel it is better to remain free than to become committed to marriage for life.	1	2	3	4	30
28.	I feel that I have done nothing that will survive after I die.	1	2	3	4	31
29.	I am able to like people who are unkind to me.	1	2	3	4	32
30.	I feel my way of life suits me.	1	2	3	4	33
31.	I feel people distrust me.	1	2	3	4	34
32	I am unnecessarily apologetic.	1	2	3	4	35
33.	I criticise someone behind his or her back.	1	2	3	4	36

		Never	Seldom	Fairly Often	Very Often	
34.	When I compete with others I try hard to win.	1	2	3	4	37
35.	I get a great deal of pleasure from working.	1	2	3	4	38
36.	My worth is recognised by others.	1	2	3	4	39
37.	I share my private thoughts with someone.	1	2	3	4	40
38.	I help people to improve themselves.	1	2	3	4	41
39.	I feel that someone is less worthy than I am.	1	2	3	4	42
40.	I feel freer to be my real self when I am away from those who know me very well.	1	2	3	4	43
41.	I feel the world's major problems can be solved.	1	2	3	4	44
42.	I feel someone will find out something bad about me.	1	2	3	4	45
43.	I have kind thoughts about everybody.	1	2	3	4	46
44.	I am confident in carrying out my plans to a successful conclusion.	1	2	3	4	47
45.	I lose interest in something and leave it unfinished.	1	2	3	4	48
46.	I feel that what I am doing in life is not really worthwhile.	1	2	3	4	49
47.	I feel as though I am alone in the world.	1	2	3	4	50
48.	I enjoy caring for young children.	1	2	3	4	51
49.	I am pleased when people get into the trouble they deserve.	1	2	3	4	52
50.	I feel I fit in well in the community in which I live.	1	2	3	4	53
51.	I feel low spirited (depressed)	1	2	3	4	54
52.	I worry that my friends will find fault with me.	1	2	3	4	55
53.	I see only the good in people.	1	2	3	4	56
54.	I am curious or inquisitive.	1	2	3	4	57

		Never	Seldom	Fairly Often	Very Often	
55.	I feel too incompetent to do what I would really like to do in life.	1	2	3	4	58
56.	I feel proud to be the sort of person I am.	1	2	3	4	59
57.	Someone shares my joys and sorrows.	1	2	3	4	60
58.	I feel my life is being wasted.	1	2	3	4	61
59.	I feel jealous when someone succeeds where I have failed.	1	2	3	4	62
60.	People seem to see me very differently from the way I see myself.	1	2	3	4	63
61.	Iam filled with admiration for mankind.	1	2	3	4	64
62.	I feel frustrated if my daily routine is disturbed.	1	2	3	4	65
63.	I consider others before myself when making a decision.	1	2	3	4	66
64.	I make exciting plans for the future.	1	2	3	4	67
65.	I feel the thrill of doing something really well.	1	2	3	4	68
66.	I feel left out.	1	2	3	4	69
67.	I feel nobody really cares about me.	1	2	3	4	70
68.	I enjoy guiding young people.	1	2	3	4	71
69.	I tell a lie when I want to get out of something.	1	2	3	4	72
70.	People seem to disapprove of me.	1	2	3	4	73
71.	I feel there is something lacking in my life.	1	2	3	4	74
72.	People think I am lazy.	1	2	3	4	75
73.	I am glad when people point out my faults.	1	2	3	4	76
74.	I feel what happens to me is the result of what I have done.	1	2	3	4	77
75.	I avoid doing something difficult because I feel I would fail.	1	2	3	4	78
76.	I change my ideas about what I want from life.	1	2	3	4	79

		Never	Seldom	Fairly Often	Very Often	
77.	When I have difficulty in getting something right, I give up.	1	2	3	4	80
78.	I have a good influence on people.	1	2	3	4	81
79.	I exaggerate when I describe someone's faults.	1	2	3	4	82
80.	I am unsure as to how people feel about me.	1	2	3	4	83
81.	People can be trusted.	1	2	3	4	84
82.	When I disagree with someone I tell them.	1	2	3	4	85
83.	I try to impress people.	1	2	3	4	86
84.	I enjoy competing.	1	2	3	4	87
85.	I feel competent.	1	2	3	4	88
86.	My feelings about myself change.	1	2	3	4	89
87.	I feel embarrassed when people tell me about ther personal problems	1	2	3	4	90
88.	I do something of lasting value.	1	2	3	4	91
89.	I have a sense of accomplishment.	1	2	3	4	92
90.	I feel I am putting on an act of doing something for effect.	1	2	3	4	93
91.	I feel optimistic about my future.	1	2	3	4	94
92.	I take great care of myself.	1	2	3	4	95
93.	I feel proud to be a member of the society in which I live.	1	2	3	4	96

ANNEXURE 3

CREEKMORE SCALES OF EIGHT CLOTHING VALUES

QUESTIONNAIRE 3

INSTRUCTIONS

On the following pages are a number of statements.

We would like you to indicate how often each of these statements applies to you by writing an **X** in the appropriate square, as shown below.

If the statement is ***Almost Always, Very few exceptions*** then write **X** in square 1.

1	2	3	4	5

If the statement is ***Usually True, Majority of the time*** then write **X** in square 2.

1	2	3	4	5

If the statement is ***Sometimes*** then write **X** in square 3.

1	2	3	4	5

If the statement is ***Seldom True*** then write **X** in square 4.

1	2	3	4	5

If the statement is ***Almost Never True*** then write **X** in square 5.

1	2	3	4	5

There are no right or wrong answers. We wish to know how people feel - not to judge you an an individual. Therefore, the best answers you can give us are those that tell us how you really feel about yourself and the world.

Record No. [ ][ ] 1,2

Card No [ ] 3

CREEKMORE SCALES

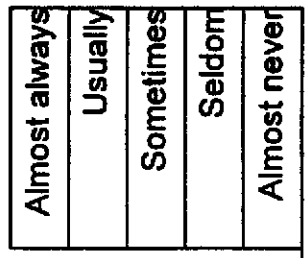
OF

EIGHT CLOTHING VARIABLES

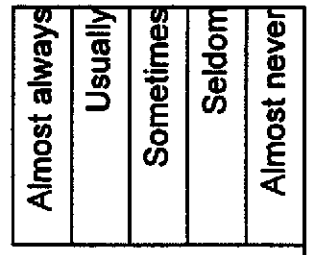
Read the following statements and rate <u>each</u> according to the scale given below. Write an **X** in the square corresponding to your choice.

Scale:
1 Almost Always - Very few exceptions
2 Usually - Majority of the time
3 Sometimes
4 Seldom - Not very often
5 Almost never - Very few exceptions

		Almost always	Usually	Sometimes	Seldom	Almost never	
1.	The way I look in my clothes is important to me.	1	2	3	4	5	4
2.	When I am shopping I choose clothes that I like even if they do not look the best on me.	1	2	3	4	5	5
3.	It bothers me when my shirt tail keeps coming out.	1	2	3	4	5	6
4.	I consider the fabric texture with the line of the garment when choosing my clothes.	1	2	3	4	5	7
5.	I use clothing as a means of disguising physical problems and imperfections through skilful use of colour, line and texture	1	2	3	4	5	8
6.	I wear clothes which have buttons or snaps missing.	1	2	3	4	5	9
7.	I pay a lot of attention to pleasing colour combinations.	1	2	3	4	5	10
8.	I keep my shoes clean and neat.	1	2	3	4	5	11
9.	I carefully co-ordinate the accessories that I wear with each outfit.	1	2	3	4	5	12
10.	I wear the clothing fads that are popular in our group even though they may not be as becoming on me.	1	2	3	4	5	13

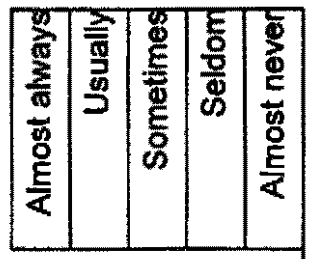


11.	I spend more time than others co-ordinating the colours in my clothes.	1	2	3	4	5		14
12.	I try to figure out why some people's clothes look better on them than others.	1	2	3	4	5		15
13.	I prefer European trends in clothing design e.g. (French Italian) to South African fashions.	1	2	3	4	5		16
14.	My friends and I try each others clothes to see how we look in them.	1	2	3	4	5		17
15.	I enjoy trying shoes of different styles or colours.	1	2	3	4	5		18
16.	I study collections of accessories in the stores to see what I might combine attractively.	1	2	3	4	5		19
17.	I try on some of the newest clothes each season to see how I look in the styles.	1	2	3	4	5		20
18.	I read magazines and newspapers to find out what is new in clothing.	1	2	3	4	5		21
19.	It's fun to try on different garments and accessories to see how they look together.	1	2	3	4	5		22
20.	I experiment with new or different "hair do's" to see how I will look.	1	2	3	4	5		23
21.	I like to know what is new in clothing even if none of my friends care and I probably would not want to wear it anyway.	1	2	3	4	5		24
22.	I try on clothes in shops just to see how I will look in them without really planning to buy.	1	2	3	4	5		25
23.	When I buy a new garment I try many different accessories before I wear it.	1	2	3	4	5		26
24.	I am curious about why people wear the clothes they do.	1	2	3	4	5		27
25.	I prefer wearing ethnic fashions to western styled garments.	1	2	3	4	5		28
26.	The way my clothes feel on my body is important to me.	1	2	3	4	5		29



27.	There are certain textures in fabrics that I like and especially try to buy, for example, soft, fuzzy, sturdy, smooth.	1	2	3	4	5	30
28.	I am more sensitive to temperature changes than others and I have difficulty in being comfortable in my clothes as a result.	1	2	3	4	5	31
29.	I wear my pants or slacks with an easy fit even when tight ones are fashionable.	1	2	3	4	5	32
30.	I get rid of garments I like because they are not comfortable.	1	2	3	4	5	33
31.	I find it difficult to buy clothes suitable to the temperature	1	2	3	4	5	34
32.	I would buy a very comfortable bathing suit even if it were not the current style.	1	2	3	4	5	35
33.	I avoid garments that bind the upper arm.	1	2	3	4	5	36
34.	I am irritable if my clothes are uncomfortable.	1	2	3	4	5	37
35.	I am extremely sensitive to the texture of the fabric in my clothing.	1	2	3	4	5	38
36.	I wonder what makes some clothes more comfortable than others.	1	2	3	4	5	39
37.	When new fashions appear on the market, I am one of the first to own them.	1	2	3	4	5	40
38.	I have clothes that I don't wear because everyone else has them.	1	2	3	4	5	41
39.	I like to be considered an outstanding dresser by my friends.	1	2	3	4	5	42
40.	I try to keep my wardrobe in line with the latest styles.	1	2	3	4	5	43
41.	I go to nearby cities to shop for better fashions.	1	2	3	4	5	44
42.	I try to buy clothes which are unusual.	1	2	3	4	5	45
43.	I avoid wearing certain clothes because they do not make me feel distinctive.	1	2	3	4	5	46

		Almost always	Usually	Sometimes	Seldom	Almost never	
44.	I enjoy wearing very different clothing even though I attract attention.	1	2	3	4	5	47
45.	I try to buy clothes with the best labels.	1	2	3	4	5	48
46.	I wear different clothes to impress people.	1	2	3	4	5	49
47.	I am interested in why some people choose to wear such unusual clothes.	1	2	3	4	5	50
48.	I check with my friends about what they are wearing to a gathering before I decide what to wear.	1	2	3	4	5	51
49.	I would rather miss something than wear clothes which are not really appropriate.	1	2	3	4	5	52
50.	I feel more a part of the group if I am dressed like my friends.	1	2	3	4	5	53
51.	I wear clothes that everyone is wearing even though they may not look as good on me.	1	2	3	4	5	54
52.	I am uncomfortable when my clothes are different from all others at a party.	1	2	3	4	5	55
53.	I try to dress like others in my group so that people will know we are friends.	1	2	3	4	5	56
54.	I get new clothes for a special occasion if the clothes I have are not the type my friends will be wearing.	1	2	3	4	5	57
55.	I have gone places and then wished after I got there that I had not gone because my clothes were not suitable.	1	2	3	4	5	58
56.	I wear what I like even though some of my friends do not approve.	1	2	3	4	5	59
57.	When I buy a new article of clothing I try to buy something similar to what my friends are wearing.	1	2	3	4	5	60
58.	When someone comes into our group dressed unsuitably I try to figure out why she is dressed as she is.	1	2	3	4	5	61
59.	I prefer wearing ethnic fashions which express my national identity.	1	2	3	4	5	62
60.	Unlined sheer dresses or blouses reveal too much of the body.	1	2	3	4	5	63



61.	I select clothes that are conservative in style.	1 2 3 4 5	64
62.	I feel uncomfortable when someone has forgotton to close their zipper.	1 2 3 4 5	65
63.	The first time in the season that I go to a public beach of pool I feel exposed in my bathing suit.	1 2 3 4 5	66
64.	I choose clothing with small prints, even though a larger design looks equally well on me.	1 2 3 4 5	67
65.	I feel embarrassed when I see someone in too low cut a dress.	1 2 3 4 5	68
66.	I select clothes which do not call attention to myself in any way.	1 2 3 4 5	69
67.	I feel embarrassed when I see someone in clothes that are too tight.	1 2 3 4 5	70
68.	I like dark or muted colours rather than bright ones for my clothes.	1 2 3 4 5	71
69.	I hesitate to associate with those whose clothes seem to reveal too much of their body.	1 2 3 4 5	72
70.	I wonder why some people wear clothes that are immodest	1 2 3 4 5	73

ANNEXURE 4

PUBLIC AND PRIVATE SELF CONSCIOUSNESS

QUESTIONNAIRE 4

INSTRUCTIONS

On the following pages are a number of statements.

We would like you to indicate how often each of these statements applies to you by writing an **X** in the appropriate square, as shown below.

If the statement is ***Extremely Characteristic*** then write **X** in square 1.

1	2	3	4

If the statement is ***Partially Characteristic*** then write **X** in square 2.

1	2	3	4

If the statement is ***Partially Uncharacteristic*** then write **X** in square 3.

1	2	3	4

If the statement is ***Extremely Uncharacteristic*** then write **X** in square 4.

1	2	3	4

There are no right or wrong answers. We wish to know how people feel - not to judge you as an individual. Therefore, the best answers you can give us are those that tell us how you really feel about yourself and the world.

Record No. [ ][ ] 1,2

Card No [ ] 3

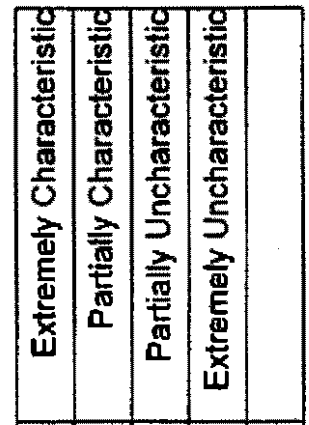
PUBLIC AND PRIVATE SELF CONSCIOUSNESS

QUESTIONNAIRE 4

Consider each item listed below and write an X in the square which best represents your feelings according to the following scale.

1 Extremely Characteristic
2 Partially Characteristic
3 Partially Uncharacteristic
4 Extremely Uncharacteristic

		Extremely Characteristic	Partially Characteristic	Partially Uncharacteristic	Extremely Uncharacteristic		
1.	I'm always trying to figure myself out.	1	2	3	4		4
2.	I'm concerned about my style of doing things.	1	2	3	4		5
3.	Generally, I'm not very aware of myself.	1	2	3	4		6
4.	It takes me time to overcome my shyness in new situations.	1	2	3	4		7
5.	I reflect about myself a lot.	1	2	3	4		8
6.	I'm concerned about the way I present myself.	1	2	3	4		9
7.	I'm often the subject of my own fantasies.	1	2	3	4		10
8.	I have trouble working when someone is watching me.	1	2	3	4		11
9.	I never scrutinize myself.	1	2	3	4		12
10.	I get embarrassed very easily.	1	2	3	4		13
11.	I'm self-conscious about the way I look.	1	2	3	4		14
12.	I don't find it hard to talk to strangers.	1	2	3	4		15
13.	I'm generally attentive to my inner feelings	1	2	3	4		16



14.	I usually worry about making a good impression.	1	2	3	4		17
15.	I'm constantly examining my motives.	1	2	3	4		18
16.	I feel anxious when I speak in front of a group.	1	2	3	4		19
17.	One of the last things I do before I leave my house is look in the mirror.	1	2	3	4		20
18.	I sometimes have the feeling that I'm off somewhere watching myself.	1	2	3	4		21
19.	I'm concerned about what other people think of me.	1	2	3	4		22
20.	I'm alert to changes in my mood.	1	2	3	4		23
21.	I'm usually aware of my appearance.	1	2	3	4		24
22.	I'm aware of the way my mind works when I work through a problem.	1	2	3	4		25
23.	Large groups make me nervous.	1	2	3	4		26

ANNEXURE 5

HUMAN SCIENCES RESEARCH COUNCIL

INSTITUTE FOR PSYCHOLOGICAL AND EDUMETRIC RESEARCH

QUESTIONNAIRE 5

SELF ANALYSIS FORM

NAME ..... **TODAY'S DATE** .....
Surname First Name

SEX ..... **AGE** ..... **SCHOOL/UNIVERSITY** .....
(M or F) (Nearest Year)

OTHER FACTS .....
(Address, occupation, etc, as instructed)

Inside this booklet you will find forty questions, dealing with difficulties that most people experience at one time or another. It will help a lot in self-understanding if you mark **YES, NO,** etc. to each, frankly and truthfully, to describe any problems you may have.

Start with the two simple examples just below, for practice. As you see, each inquiry is actually put in the form of a sentence. By putting a cross, **X**, in one of the three boxes on the right you show how it applies to you. Make your marks now.

		Yes	Occasionally	No
1.	I enjoy walking	☐	☐	☐

A middle box is provided for when you cannot definitely say **YES** or **NO**. But use it as little as possible.

		A	In between	B
2.	I would rather spend an evening: (A) talking to people, (B) at a movie	☐	☐	☐

About half the items inside end in A and B choices like this. B is always on the right. Remember, use the "In Between" or "Uncertain" box only if you cannot possibly decide on A or B.

Now:

1. Make sure you have put your name and whatever else the examiner asks, in the correct place at the top of this page.

2. Never pass over an item, but give some answer to every single one. Your answers will be entirely confidential.

3. Do not spend time puzzling over them. Answer each one immediately, the way you want to at this moment (not last week, or usually). You may have answered questions like this before, but answer these as you feel now.

   Most people finish in five minutes; some, in ten. Hand in this form as soon as you are through with it, unless told to do otherwise. As soon as the examiner signals or tells you to, turn the page and begin.

STOP HERE - WAIT FOR SIGNAL

1.	I find that my interests, in people and amusements tend to change fairly rapidly	True	In between	False	Do not write in this column	
2.	If people think poorly of me I can still go on quite happily and without worrying too much	True	In between	False		
3.	I like to wait till I am sure that what I am saying is correct, before I put forward an argument	Yes	In between	No		
4.	I am inclined to let my actions get influenced by feelings of jealousy	Sometimes	Seldom	Never	Q_3 (-)	
5.	If I had my life to live over again I would: (A) plan very differently, (B) want it the same	A	In between	B	C(-)	
6.	In general, I admire my parents	Yes	In between	No		
7.	I find it hard to "take 'No' for an answer" even when I know what I ask is impossible	True	In between	False		
8.	I doubt the honesty of people who are more friendly than I would naturally expect them to be	True	In between	False	L	
9.	In demanding and enforcing obedience my parents (or guardians) were: (A) always very reasonable (B) often unreasonable	A	In between	B		
10.	I need my friends more than they seem to need me	Rarely	Sometimes	Often		
11.	I feel sure that I could "pull myself together" in an emergency	Always	Often	Seldom		
12.	As a child I was afraid of the dark	Always	Often	Seldom	O	
13.	People sometimes tell me that I show my excitement in voice and manner too obviously	Yes	Uncertain	No		
14.	If people take advantage of my friendliness I: (A) soon forget and forgive (B) resent it and hold it against them	A	In between	B		
15.	I find myself upset rather than helped by the kind of personal criticism that many people make	Often	Occasionally	Never		
16.	Often I get angry with people too quickly	True	In between	False		
17.	I feel restless as if I want something, but do not know what	Very rarely	Sometimes	Often		
18.	I sometimes doubt whether people I am talking to are really interested in what I am saying	True	In between	False	Q_4	
19.	I have always been free from any vague feelings of ill-health, such as funny pains in my head, stomach or heart	True	Uncertain	False		
20.	In discussion with some people, I get so annoyed that I can hardly trust myself to speak	Sometimes	Rarely	Never	A SCORE	

21.	Through getting "worked up" I use up more energy than most people in getting things done.	True	Uncertain	False	
22.	I make a point of not being absent-minded or forgetful.	True	Uncertain	False	
23.	However difficult and unpleasant the obstacles, I always stick to my original intentions	Yes	In between	No	
24.	I tend to get over-excited and "rattled" in unsettling situations	Yes	In between	No	Q_3 (-)
25.	I occasionally have vivid dreams that disturb my sleep	Yes	In between	No	
26.	I always have enough energy when faced with difficulties.	Yes	In between	No	
27.	I sometimes find myself counting things for no particular reason.	True	Uncertain	False	C (-)
28.	Most people are a little queer mentally, though they do not like to admit it.	True	Uncertain	False	
29.	If I make an awkward social mistake I can soon forget it	Yes	In between	No	L
30.	I feel grumpy and just do not want to see people: (A) occasionally (B) rather often	A	In between	B	
31.	I am brought almost to tears by having things go wrong	Never	Very Rarely	Sometimes	
32.	In the midst of social groups I am nevertheless sometimes overcome by feelings of loneliness and worthlessness	Yes	In between	No	
33.	I wake in the night and, through worry, have some difficulty in sleeping again	Often	Sometimes	Never	O
34.	My spirits generally stay high no matter how many troubles I meet	Yes	In between	No	
35.	I sometimes feel guilty or very sorry over quite small matters	Yes	In between	No	
36.	My nerves get on edge so that certain sounds, e.g. a screechy hinge, are unbearable and give me the shivers	Often	Sometimes	Never	
37.	If something bodly upsets me I generally calm down again quite quickly	True	Uncertain	False	
38.	I tend to tremble or perspire when I think of a difficult task ahead	Yes	In between	No	Q_4
39.	I usually fall asleep quickly, in a few minutes when I go to bed	Yes	In between	No	
40.	I sometimes get very excited or "worked-up" as I think about things that have happened recently	True	Uncertain	False	

STOP HERE. BE SURE YOU HAVE ANSWERED EVERY QUESTION

B SCORE

ANNEXURE 6

QUESTIONNAIRE 6

16 PERSONALITY FACTOR QUESTIONNAIRE (16 PF)

PROF RB CATTELL (AMERICAN AUTHOR)

ADAPTED FOR USE IN SOUTH AFRICA BY EM MADGE & L DU TOIT

OBTAINABLE FROM THE HUMAN SCIENCES RESEARCH COUNCIL

ANNEXURE 7

CORRELATES OF FASHION LEADERSHIP
IMPLICATIONS FOR FASHION PROCESS THEORY

HOLLY L SCHRANK, MICHIGAN STATE UNIVERSITY AND
D LOIS GILMORE, OHIO STATE UNIVERSITY

QUESTIONNAIRE 7

INSTRUCTIONS

On the following pages are a number of statements.

We would like you to indicate how often each of those statements applies to you by writing **X** in the appropriate square, as shown below.

If you ***Strongly Agree*** then write **X** in square 1.

1	2	3	4	5

If you ***Agree*** then write **X** in square 2.

1	2	3	4	5

If you are ***Undecided, Uncertain*** then write **X** in square 3.

1	2	3	4	5

If you ***Disagree*** then write **X** in square 4.

1	2	3	4	5

If you ***Strongly disagree*** then write **X** in square 5

1	2	3	4	5

There are no right or wrong answers. We wish to know how people feel - not to judge you as an individual. Therefore the best answers you can give us are those that tell us how you really feel about yourself and the world.

FASHION CONFORMITY

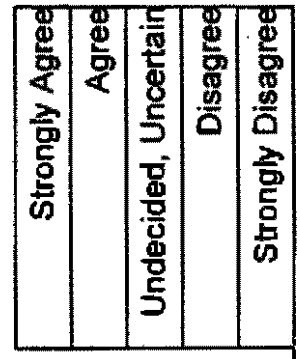
Below are a number of statements about clothing. Several words have been used interchangeably with the word "friends". As you respond to each statement think in terms of your friends or close associates. Rate each statement as to the extent to which you agree or disagree with it. Use the following guide and write an X in the appropriate square.

Scale:
1 Strongly Agree
2 Agree
3 Undecided, Uncertain
4 Disagree
5 Strongly Disagree

Record No. [ ][ ] 1,2

Card No. [ ] 3

		Strongly Agree	Agree	Undecided, Uncertain	Disagree	Strongly Disagree	
1.	It isn't important to wear clothes in the style that is popular with one's crowd	1	2	3	4	5	4
2.	Friends who dress similarly strengthen their friendship ties	1	2	3	4	5	5
3.	One should be careful not to dress too differently from one's friends	1	2	3	4	5	6
4.	When one of my group gets something new in clothing we all eventually end up with something similar	1	2	3	4	5	7
5.	Dressing similarly to others in my group means little to me	1	2	3	4	5	8
6.	It is important to dress like one's friends	1	2	3	4	5	9
7.	Most of my ideas about clothing are quite different from my friends' ideas	1	2	3	4	5	10
8.	It is not worthwhile to make an effort to conform to the clothing standards of one's social group	1	2	3	4	5	11



9.	I don't attend fashion shows even when I have the opportunity	1	2	3	4	5		12
10.	Planning and selecting my wardrobe can be included among my favourite activities	1	2	3	4	5		13
11.	I enjoy window-shopping to see the clothes	1	2	3	4	5		14
12.	I am not clothes-conscious	1	2	3	4	5		15
13.	I would like to be considered one of the best dressed persons	1	2	3	4	5		16
14.	The subject of clothing is uninteresting to me	1	2	3	4	5		17
15.	It is tiresome keeping up with fashions	1	2	3	4	5		18
16.	I do not enjoy shopping for clothing or fabrics	1	2	3	4	5		19
17.	I think clothes are important in expressing one's creativity	1	2	3	4	5		20
18.	I am not too concerned with clothes	1	2	3	4	5		21
19.	I keep my wardrobe in top condition at all times	1	2	3	4	5		22

CORRELATES OF FASHION LEADERSHIP:
IMPLICATIONS FOR FASHION PROCESS THEORY

HOLLY L SCHRANK, MICHIGAN STATE UNIVERSITY AND
D LOIS GILMORE, OHIO STATE UNIVERSITY

QUESTIONNAIRE 7

INSTRUCTIONS

On the following pages are a number of statements.

We would like you to indicate how often each of those statements applies to you by writing **X** in the appropriate square, as shown below.

If the statement is ***Definitely True*** then write **X** in square 1.

1	2	3	4	5

If the statement is ***Partially True, more true than false*** then write **X** in square 2.

1	2	3	4	5

If you are ***Undecided, Uncertain*** then write **X** in square 3.

1	2	3	4	5

If the statement is ***Patrially False, more false than true*** then write **X** in square 4.

1	2	3	4	5

If the statement is ***Definitely False*** then write **X** in square 5

1	2	3	4	5

There are no right or wrong answers. We wish to know how people feel - not to judge you as an individual. Therefore the best answers you can give us are those that tell us how you really feel about yourself and the world.

FASHION INTEREST

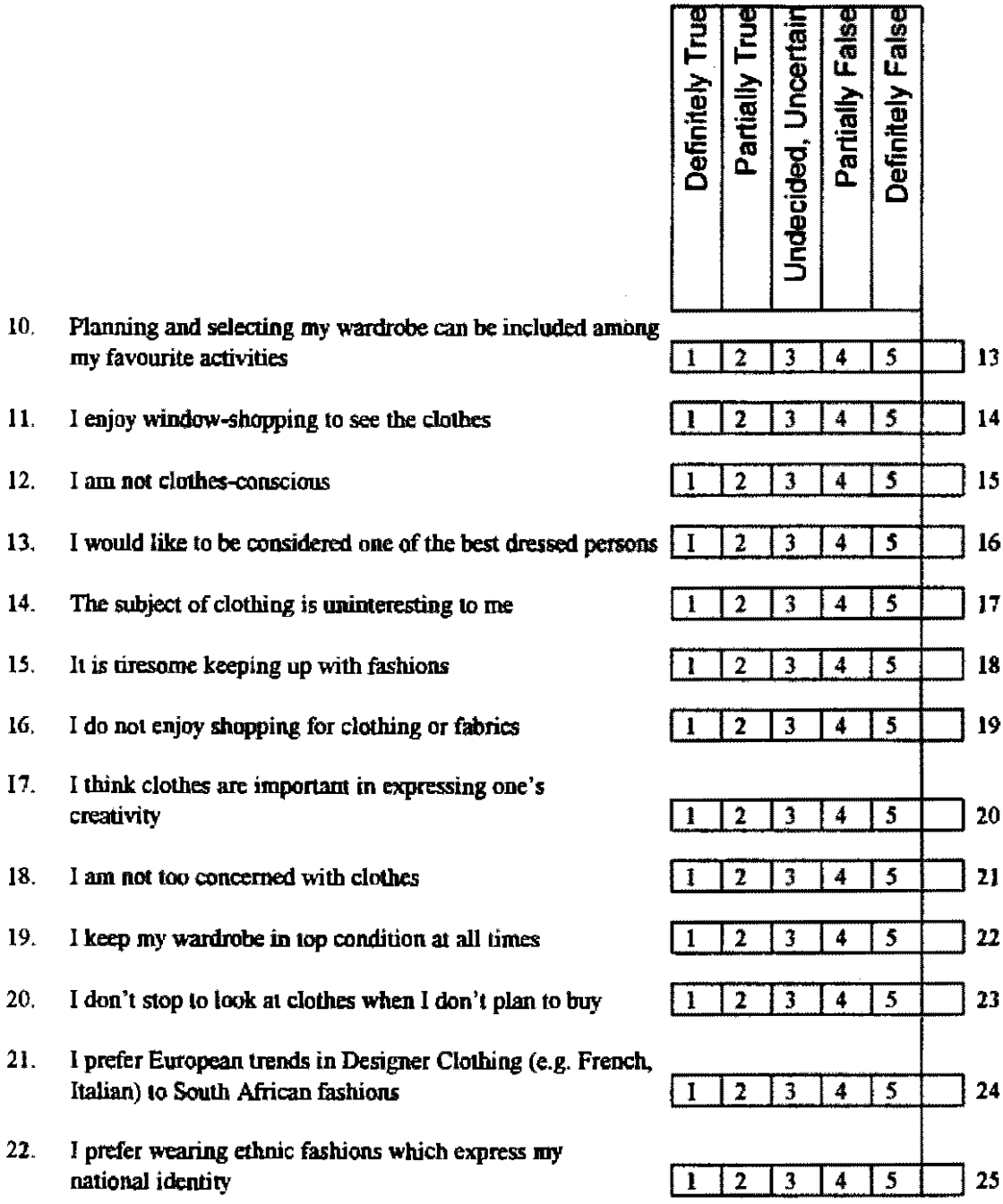
Below are a number of statements about clothing. Several words have been used interchangeably with the word "friends". As you respond to each statement think in terms of your friends or close associates. Rate each statement as to the extent to which you agree or disagree with it. Use the following guide and write an X in the appropriate square.

Scale:
1 Definitely True
2 Partially True, more true than false
3 Undecided, Uncertain
4 Partially False, more false than true
5 Definitely False

Record No. [ ][ ] 1,2

Card No. [ ] 3

	Definitely True	Partially True	Undecided, Uncertain	Partially False	Definitely False	
1. I enjoy clothes like some people do such things as books, records and movies	1	2	3	4	5	4
2. Clothing is so attractive to me that I am tempted to spend more money on it than I should	1	2	3	4	5	5
3. I skip the clothing ads in newspapers and magazines	1	2	3	4	5	6
4. I like to read and study fashion magazines	1	2	3	4	5	7
5. I have no interest in keeping up with the latest fashion trends	1	2	3	4	5	8
6. I would rather spend my money on clothes than on anything else	1	2	3	4	5	9
7. Mass media accounts of what some people in the public eye are wearing are boring	1	2	3	4	5	10
8. I enjoy reading about current fashion trends	1	2	3	4	5	11
9. I don't attend fashion shows even when I have the opportunity	1	2	3	4	5	12


Definitely True
Partially True
Undecided, Uncertain
Partially False
Definitely False
10. Planning and selecting my wardrobe can be included among my favourite activities 1 2 3 4 5 13
11. I enjoy window-shopping to see the clothes 1 2 3 4 5 14
12. I am not clothes-conscious 1 2 3 4 5 15
13. I would like to be considered one of the best dressed persons 1 2 3 4 5 16
14. The subject of clothing is uninteresting to me 1 2 3 4 5 17
15. It is tiresome keeping up with fashions 1 2 3 4 5 18
16. I do not enjoy shopping for clothing or fabrics 1 2 3 4 5 19
17. I think clothes are important in expressing one's creativity 1 2 3 4 5 20
18. I am not too concerned with clothes 1 2 3 4 5 21
19. I keep my wardrobe in top condition at all times 1 2 3 4 5 22
20. I don't stop to look at clothes when I don't plan to buy 1 2 3 4 5 23
21. I prefer European trends in Designer Clothing (e.g. French, Italian) to South African fashions 1 2 3 4 5 24
22. I prefer wearing ethnic fashions which express my national identity 1 2 3 4 5 25

QUESTIONNAIRE 7

FASHION OPINION LEADERSHIP

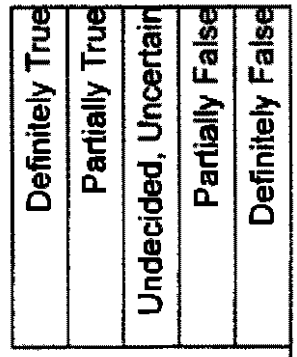
Below are a number of statements about clothing. Several words have been used interchangeably with the word "friends". As you respond to each statement think in terms of your friends or close associates. Rate each statement as to the extent to which you agree or disagree with it. Use the following guide and write an **X** in the appropriate square.

Scale:
1 Definitely True
2 Partially True, more true than false
3 Undecided, Uncertain
4 Partially False, more false than true
5 Definitely False

Record No. [ ][ ] 1,2

Card No. [ ] 3

		Definitely True	Partially True	Undecided, Uncertain	Partially False	Definitely False	
1.	I generally don't pass along fashion information to others	1	2	3	4	5	4
2.	Fashion holds a low priority as a topic of conversation among my friends	1	2	3	4	5	5
3.	Others consult me for information about the latest fashion trends	1	2	3	4	5	6
4.	I believe I am a very good source of advice about fashion	1	2	3	4	5	7
5.	People talk too much about fashion	1	2	3	4	5	8
6.	I never borrow or lend fashion magazines	1	2	3	4	5	9
7.	My friends ask for my opinions about new styles	1	2	3	4	5	10
8.	I am more likely than most of my friends to be asked for advice about fashion	1	2	3	4	5	11



9.	I do more listening than talking during conversations about fashion	1 2 3 4 5	12
10.	When it comes to fashion, I am among the least likely of my friends to be thought of as an advice-giver	1 2 3 4 5	13
11.	It is important to share one's opinion about the new styles with others.	1 2 3 4 5	14
12.	My friends don't think of me as a knowledgeable source of information about fashion trends	1 2 3 4 5	15
13.	I recently convinced someone to change an aspect of her appearance to something more fashionable	1 2 3 4 5	16
14.	I believe in sharing with others what I know about trends in fashion	1 2 3 4 5	17
15.	I enjoy discussing fashion	1 2 3 4 5	18
16.	People bypass me as a source of advice about fashion	1 2 3 4 5	19
17.	I dislike discussing clothes and fashion	1 2 3 4 5	20
18.	I like to help others make decisions about fashion	1 2 3 4 5	21
19.	I am never first to be asked for an opinion about a current style	1 2 3 4 5	22
20.	I enjoy being asked about fashion trends	1 2 3 4 5	23

ANNEXURE 8

211A Marriott Road
Berea
Durban
4001

10 December 1993

Mr .....
Address .....
.....
.....

Dear Mr

Re: Request to Interview Patients

I request your permission to interview a certain number of your patients for research purposes.

As a master's student in psychology and a lecturer in the Department of Fashion at Technikon Natal, I am presently investigating the relationship between the psychology of appearance and clothing behaviour for the require dissertation. The study is entitled "Aspects of Physical Appearance and Clothing Behaviour" and is being done through the University of South Africa. Dr SA Grobler, Department of Psychology, University of South Africa, Pretoria has been appointed Supervisor for this study. Prof. L Schlebusch, Head of the Sub-Department of Medically Applied Psychology, University of Natal, has been appointed joint supervisor for this study in Durban.

The section on physical appearance would require persons undergoing surgery for breast augmentation, breast reduction, cosmetic facial alterations and abdominoplasty to complete a set of questionnaires pre- and post-operatively. A minimum sample of thirty ($n = 30$) persons is required for each group. A smaller sub-group of persons requiring breast reconstruction will also be considered.

All information will be strictly confidential and used for research purposes only.

Please find enclosed:

1. An example of a "Letter of Information" to patients. This is to be handed to patients expressing an interest in participating in this study. I will supply the necessary number of letters for your use.

2. List of Questionnaires to be used.

A copy of the Letter of Approval of the proposed Dissertation by the Post Graduate Committee (Ethics) of the Board of the Faculty of Medicine, University of Natal can be obtained if required.

Thank you

Yours faithfully

Ann-Marie Lo Castro

Tel: (H) 29-4782
(W) 225-2415

Encls.

ANNEXURE 9

ASPECTS OF PHYSICAL APPEARANCE AND CLOTHING BEHAVIOUR

List of tests/scales

to be administered to the clinical and non-clinical sample population groups

Questionnaire No.	Title	
1.	The Multidimensional Body-Self Relations Questionnaire	- 1. Cash, T., Winstead, BA and Janda, LH (1986), Cash (1990) 2. The Great American Shape-up: Body Image Survey Report in Psychology Today, 20(4) 30-37 Adapted for use in South Africa
2.	Scale for Measuring Identity as conceived by Erik Erikson	- R Ochse (1983)
3.	Methods of Measuring Clothing Variables	- Creekmore, A M (1971) Michigan Agricultural Experiment Station Project No. 783 Michigan State University
4.	Public and Private Self-Consciousness Assessment and Theory	- A Fenigstein, MF Scheier and AH Buss (1975) University of Texas at Austin Journal of Consulting and Clinical Psychology, 43, 522-527
5.	The IPAT Self-Analysis Form	- Human Sciences Research Council (1979) Institute for Psychological and Edumetric Research
6.	16 Personality Factor Questionnaire (16 PF)	- Prof. RB Cattell (1957) American Author Adapted for use in South Africa EM Madge L du Toit (1991) Human Sciences Research Council
7.	Correlates of Fashion Leadership Implications for Fashion Process Theory	- Shrank, HL & Gilmore, DL (1973) Sociological Quarterly, 14, 534-543

ANNEXURE 10

DURBAN

15 November 1993

INFORMATION TO PATIENTS

Dear Patient

As a master's student in psychology and a lecturer in the Department of Fashion at Technikon Natal, I am presently investigating the relationship between the Psychology of Appearance and Clothing Behaviour for the required dissertation.

The study is entitled "Aspects of Physical Appearance and Clothing Behaviour" and is being done through the University of South Africa. Dr SA Grobler, Department of Psychology, University of South Africa, Pretoria has been appointed supervisor for this study. Prof. L Schlebusch, Head of the Sub-Department of Medically Applied Psychology, University of Natal has been appointed joint supervisor in Durban.

You are in a unique position to offer the necessary information required to make this effort worthwhile. I would like to appeal to you for your help and co-operation by asking you to answer a set of questionnaires, once before and once after your operation. Without this information the study will not be able to continue. All information will be strictly confidential and will be used for research purposes only.

It is hoped that the results of the study, through the information you are able to provide, will assist in fostering more sensitivity and a deeper understanding among professionals and caring persons with regard to a person's feelings about their physical appearance and clothing behaviour.

Answering the questionnaires should not cause you any discomfort. You are free at any time to withdraw from participating in answering the questionnaires without suffering any disadvantage.

I thank you for the courtesy of your assistance. You may discuss your decision with your Doctor, or contact me at your earliest convenience at the phone number below.

Yours faithfully

Ann-Marie Lo Castro

Tel: (H) 29-4782
(W) 225-2415

ANNEXURE 11

INFORMED CONSENT FOR INCLUSION IN A CLINICAL STUDY

1. I (Name) _____ hereby consent to the following procedure and/or treatment being conducted on myself or the person indicated in the attached letter.

   _____

2. I acknowledge that I have been informed by

   (Name) _____
   concerning the possible advantages and possible adverse effects which may result from the abovementioned procedure and/or treatment and of the ways in which it is different from the conventional procedure and/or treatment.

   I (Name) _____ hereby acknowledge that I understand and accept the "Information to Patients" letter handed to me in connection with this study.

3. I agree that the above procedure and/or treatment will be carried out and/or supervised by

   (Name) _____

4. I acknowledge that I understand the contents of this form, including the information provided in the "Information to Patients" letter and as the SUBJECT/PARENT/GUARDIAN/OTHER (specify) freely consent to the above procedure and/or treatment being conducted on

   (Name) _____

5. I am aware that I may withdraw my consent at any time without prejudice for further care.

   Signed: _____ Date: _____
   Subject/Parent/Guardian

   Signed: _____ Date: _____
   Witness

   Signed: _____ Date: _____
   Informant

   Signed: _____ Date: _____
   Researcher

ANNEXURE 12

DURBAN

26 February 1994

INFORMATION TO PARTICIPANTS

Dear Participant

As a master's student in psychology and a lecturer in the Department of Fashion at Technikon Natal, I am presently investigating the relationship between the Psychology of Appearance and Clothing Behaviour for the required dissertation.

The study is entitled "Aspects of Physical Appearance and Clothing Behaviour" and is being done through the University of South Africa. Dr SA Grobler, Department of Psychology, University of South Africa Pretoria has been appointed supervisor for this study. Prof. L Schlebusch, Head of the Sub-Department of Medically Applied Psychology, University of Natal has been appointed joint supervisor in Durban.

You are in a unique position to offer the necessary information required to make this effort worthwhile. I would like to appeal to you for your help and co-operation by asking you to answer a set of questionnaires. Without this information the study will not be able to continue.

All information will be strictly confidential and will be used for research purposes only.

It is hoped that the result of the study, through the information you are able to contribute, will provide insight with regard to a person's feelings about their physical appearance and their subsequent clothing behaviour.

I thank you for the courtesy of your assistance.

Yours faithfully

Ann-Marie Lo Castro

ANNEXURE 13

Durban

26 February 1994

Mr/Mrs/Ms .....
Address .....
.....
.....

Dear .....

Request to Participate in a Research Project for a Master's Dissertation: Aspects of Physical Appearance and Clothing Behaviour

As a leading personality in the fashion field I would like to request your participation in answering a set of questionnaires.

As a master's student in psychology and a lecturer in the Department of Fashion at Technikon Natal, I am presently investigating the relationship between the psychology of appearance and clothing behaviour for the require dissertation. The study is entitled "Aspects of Physical Appearance and Clothing Behaviour" and is being done through the University of South Africa. Dr SA Grobler, Department of Psychology, University of South Africa, Pretoria has been appointed supervisor for this study. Prof. L Schlebusch, Head of the Sub-Department of Medically Applied Psychology, University of Natal, has been appointed joint supervisor for this study in Durban.

Your expertise could provide valuable information toward attaining the goal of gauging the clothing behaviour of people taken from a sample population. This includes persons undergoing cosmetic surgery for changes in physical appearance (clinical sample) and for persons in the fashion field not undergoing any form of elective surgery (non-clinical sample).

The behaviour of both groups will be assessed in order to establish their current fashion interest and clothing behaviour.

Thank you for your assistance

Yours faithfully

Ann-Marie Lo Castro

Tel: (H) 29-4782
(W) 204-2142

ANNEXURE 14

ASPECTS OF PHYSICAL APPEARANCE

AND CLOTHING BEHAVIOUR

Information given to subjects (Zulu Translation)

Phendula embizo elandelayo izimpendwlo ziyimfihlo futhi zizosetshenziselwa ucwaningo. Izimpendulo mazishaye emhlolweni.

Yiphendule ngokukhululeka lembuzo.

Siza unikeze igama lakho (signature) ngemuya kokuba usukoqonde konke okudingekayo futhi uma uzimisele ukuba ukuzimbandakanye nalolu qwaningo.

Kuyilungelo lakho ukuba uhoxe ekuphenduleni lemibuzo, uma uzwa ukuthi akusahambisani nawe.

Information given to subjects (English Translation)

You are required to answer the following questionnaire.

Your answers to the questions in the questionnaire will be strictly confidential and will be used for research purposes only - Please answer the questions as honestly as possible.

Answering the questionnaire should not cause you any discomfort.

Please give your written informed consent to take part in this research by signing and completing the form provided.

You are free at any time to withdraw from participation in answering the questionnaire without suffering any disadvantage.