Competitive Orientations and Men’s Acceptance of Cosmetic Surgery

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As with women, men are experiencing increased pressure to achieve media-conveyed societal ideals for appearance and their consideration of cosmetic surgery as a means to enhance their appearance for competitive advantage in social and career realms has been increasing. This study considered individual differences in competitive orientations and the acceptance of cosmetic surgery among men. Hypercompetitiveness (psychologically unhealthy) was predictive of acceptance of cosmetic surgery even after age, self-esteem, body mass index, and body dysmorphe were taken into account. Personal development competitiveness (psychologically healthy) was negatively associated with body dysmorphe and was not predictive of acceptance of cosmetic surgery among men. These results for men, along with previous research among women (Thornton et al., 2013), indicate that a hypercompetitive orientation contributes to the consideration of cosmetic surgery independent of body image concerns for both men and women.

Keywords: Appearance; Attractiveness; Body Image; Competitiveness; Hypercompetitiveness; Cosmetic Surgery

Introduction

Physical appearance is well-documented as being an important characteristic for both women and men and has implications for both intrapersonal well-being and interpersonal interactions (Hatfield & Sprecher, 1986; Jackson, 1992; Langlois et al., 2000). Historically, women are presumed to compete intrasexually on the basis of their appearance (Buss, 1989; Darwin, 1871; Fisher & Cox, 2011). As such, it is a woman’s appearance, not her accomplishments, that has been her most valued asset for social and economic survival within a culture (Brownmiller, 1984; Rothblum, 1994; Wolf, 1991).

From an early age women are exposed to the sociocultural expectations with regard to their appearance. These norms are pervasively conveyed in the media and frequently depict unattainable standards for appearance on which a woman’s worth is based (American Psychological Association, 2007). In addition, there is often the not so subtle implication that women must strive to be more competitive through efforts that enhance their attractiveness (Bessenoff, 2006; Derenne & Beresin, 2006).

Not only are these “appearance standards” used to evaluate others, but also they may be internalized and women begin to self-objectify and critically evaluate themselves on the basis of these same standards (Franzoi, 1995; Fredrickson & Roberts, 1997). It is these external and internal pressures that are believed to have resulted in heightened feelings of inadequacy and anxiety among women with regard to their physical appearance and body-image and contributes to the prevalence of body dysmorphe and disordered eating among women (Derenne & Beresin, 2006; Veale, 2004). Appearance concerns also underlie women’s acceptance of cosmetic surgery as a means to boost their self-esteem and enhance their social and career potential (Callaghan, Lopez, Wong, Norcross, & Anderson, 2011; Calogero, Pina, Park, & Rahemtulla, 2010; Henderson-King & Brooks, 2009).

In contrast to the emphasis placed on women’s appearance, a man’s interpersonal and social attractiveness has traditionally relied more on his apparent skills, abilities, and accomplishments rather than physical appearance (Jackson, 1992; Sherrow, 2001). Intrasexual competition among men is based on a display of resource acquisitions (Buss, 1989) and derogation of other men’s abilities and achievements (Buss & Dedden, 1990). However, while objectifying women has had a long history, there has been noted an increasingly obvious trend for objectifying men on the basis of their appearance (Faludi, 1999; Moradi & Huang, 2008; Pope, Phillips, & Olivardia, 2000; Sherrow, 2001). Indeed, just as the media has conveyed the cultural standards of appearance for women, men have been increasingly defined by their looks, particularly a youthful appearance and a lean, muscular body (Faludi, 1999; Moradi & Huang, 2008; Sherrow, 2001).

As with women, men (and boys) may come to internalize these standards and engage in self-objectification (Moradi & Huang, 2008). Although not to the same degree as women, men are increasingly experiencing appearance and body image concerns (Thompson & Cafri, 2007; Thompson, Schaefer,
Menzel, 2012) with implications for diminished self-esteem, depression, body dysmoria, disordered eating, and the unhealthy use of steroids and supplements in order to achieve a lean masculinity (Agliata & Tantleff-Dunn, 2004; Cash, 2000; Davis, Karvinen, & McCreary, 2005; Moradi & Huang, 2008; Muth & Cash, 1997; Pope, Gruber, Choi, Olivardi, & Phillips, 1997).

Men’s appearance concerns also have implications for considering cosmetic surgery to improve appearance and enhance their social and career potential. The American Society of Plastic Surgeons (ASPS, 2012) reported that, of the 20.2 million procedures performed in the United States, 72% were cosmetic surgeries or minimally invasive procedures undertaken to improve one’s appearance, enhance self-esteem, and increase social and career opportunities. Although men are in the minority with regard to undergoing these procedures (9%), the number of procedures among men has increased 22% since 2000. Among the top procedures are those for facial rejuvenation (e.g., facelift, eyelids, botox, skin peel) and achieving a leaner body (e.g., liposuction and breast reduction).

Competitive Orientation and Acceptance of Cosmetic Surgery

Horney (1937) had distinguished between two different types of competitiveness. For instance, hypercompetitiveness was considered a psychologically unhealthy competitive orientation based in neurosis. In contrast, a psychologically healthy competitive orientation, subsequently referred to as personal development competitiveness, reflects less concern with task outcome (i.e., win or lose), but more on the self-discovery, self-improvement, and personal growth and development that can be gained through competition.

Hypercompetitive Orientation. As originally described by Horney (1937), hypercompetitiveness is an indiscriminate need to compete and win at all costs as a neurotic means to maintain and enhance an otherwise fragile self-esteem. Based in childhood experiences, this need stems from having authoritarian parents who are abusive and demeaning, and who strongly emphasize personal success in an achievement-oriented society. Thus, by manipulating, controlling, derogating, or otherwise overcoming others, the hypercompetitive individual is able to deal with feelings of inadequacy. Research has noted that hypercompetitiveness is indeed a neurotic predisposition and associated with low self-esteem, high anxiety, narcissism, the need to control and dominate others, deceitful and unscrupulous behavior, and willingness to strategically manipulate impressions for self-aggrandizement (e.g., Dru, 2003; Ross, Rausch, & Canada, 2003; Ryckman, Hammer, Kaczor, & Gold, 1990; Ryckman, Libby, van den Borne, Gold, & Lindner, 1997; Ryckman, Thornton, & Butler, 1994; Ryckman, Thornton, Gold, & Burckle, 2002; Thornton, Lovley, Ryckman, & Gold, 2009; Watson, Morris, & Miller, 1998).

Personal Development Competitive Orientation. In contrast, a personal development competitive orientation is an alternative psychologically healthy perspective. This is characterized by competition with others, not against others; less interest on extrinsic outcomes (i.e., win/lose), but more intrinsic interest in the task itself and the self-evaluation and personal growth gained through competition. Horney (1937) posited that positive childhood experiences with warm, supportive parents would enable healthy interpersonal relationships and the participation in competitive pursuits with a sense of mutual respect and trust of others. Research has noted that this competitive orientation is related to different psychological and social health indicators, including high self-esteem, achievement and affiliation, empathic, altruistic, and forgiving, but not associated with neuroticism, dominance, and aggressiveness (e.g., Collier, Ryckman, Thornton, & Gold, 2010; Ryckman & Hamel, 1992; Ryckman, Hammer, Kaczor, & Gold, 1996; Ryckman, Libby, van den Borne, Gold, & Lindner, 1997).

Among women, these two competitive orientations have been shown to relate differentially to disordered eating (Burkle, Ryckman, Gold, Thornton, & Audesse, 1999) as well as body dysmoria and the acceptance and consideration of cosmetic surgery (Thornton, Ryckman, & Gold, 2013). In particular, Thornton et al. reported hypercompetitiveness to be positively related to both body dysmoria and acceptance of cosmetic surgery, but hypercompetitiveness proved to be a stronger predictor of cosmetic surgery than body dysmoria. In contrast, personal development competitiveness was negatively related, although not significantly so, to both body dysmoria and consideration of cosmetic surgery. As such, hypercompetitive women may have a greater need to achieve unrealistic standards of appearance in a neurotic striving to overcome feelings of inferiority and gain advantage over female rivals in physical attractiveness; thus, the greater acceptance of cosmetic surgery as a means to enhance one’s appearance for such purpose.

As with women, males today may feel increasingly pressured to achieve media-conveyed societal ideals for appearance and are showing an increased consideration of cosmetic surgery as a means to enhance their appearance, and perhaps their competitiveness in personal, social, and career realms. The present research was conducted to examine the relationship hypercompetitiveness and personal development competitiveness have with body dysmoria and the acceptance of cosmetic surgery among men.

Method

Participants and Procedure

Participants consisted of a nonclinical sample of 131 Caucasian male undergraduates at a public university in the northeastern United States. Their mean age was 24.27 (SD = 6.49); ages ranged from 18 to 47. In exchange for extra credit in their psychology course, the students completed a set of questionnaires for the stated purpose of obtaining baseline data for comparison purposes in subsequent research. In addition to assessments of competitive orientations, body-image, and attitudes toward cosmetic surgery (described below), students provided height and weight with which to compute a body mass index (BMI; mean BMI was 25.08, and ranged from 17 to 31).

Assessment Instruments

Hypercompetitive Attitude (HCA). The 26-item HCA scale is a reliable and valid assessment of individual differences in hypercompetitive attitudes (Ryckman et al., 1990). Sample items are “Winning in competition makes me feel more powerful as a person,” and “If you don’t get the better of others, they will surely get the better of you.” Participants respond to items on a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5). Scores can range from 26 to 130, with higher scores indicating a stronger hypercompetitive orientation. The
internal consistency of this scale in the present study was adequate (α = 0.80).

Personal Development Competitive Attitude (PDCA). The 15-item PDCA scale is a reliable and valid assessment of a psychologically healthy competitive orientation concerned more with personal growth and development than individual attainment (Ryckman et al., 1996). Sample items are “I value competition because it helps me to be the best that I can be,” and “I enjoy competition because it brings me and my competitors closer together as human beings.” Among the men, higher scores on the PDCA scale were strongly associated with a greater personal development competitive attitude (r = 0.23, p < 0.01). Among the women, BMI, and social self-esteem were entered as an initial block to control statistically for individual differences on these variables ($R^2 = 0.12$); $F(3,127) = 5.83$, $p < 0.001$. This was then followed by a stepwise consideration of body dysmorphia, hypercompetitiveness, and personal development competitiveness. Body dysmorphia was identified as the next best significant contributor to the prediction equation ($R^2 = 0.34$, $p < 0.001$), $F(4,126) = p < 0.001$. Hypercompetitiveness was able to contribute further to the regression ($R^2 = 0.38$), $F(5,125) = 15.49$, $p < 0.001$. Personal development competitiveness was excluded from entry as it did not contribute significantly to the regression.

Discussion

Both correlational and regression analyses in the present study demonstrate that the two competitive orientations differ in their relationship to body dysmorphia and attitudes toward cosmetic surgery for men. While hypercompetitiveness was not related to body dysmorphia, it did relate positively with attitudes toward cosmetic surgery. In contrast, personal development competitiveness was negatively related to body dysmorphia, but was not significantly related to cosmetic surgery. Moreover, hypercompetitiveness was found to be a significant predictor of acceptance of cosmetic surgery while personal development competitiveness failed to be of predictive utility in this regard, an outcome that is comparable to previous reports on women (Thornton et al., 2013). Dissatisfaction with one’s physical appearance is typically associated with favorable attitudes toward cosmetic surgery consistent perhaps with a youth-oriented cultural atmosphere.

Acceptance of cosmetic surgery was also significantly related to body dysmorphia ($r = 0.42$, $p < 0.001$), but not BMI ($r = 0.06$). A similar pattern had been observed previously among women (Thornton et al., 2013). Interestingly, both hypercompetitiveness and personal development competitiveness were positively correlated with cosmetic surgery acceptance ($r_s = 0.28$, $p = 0.01$ and 0.17, $p < 0.05$, respectively). The positive relationship between personal development, an otherwise healthy competitive orientation, and acceptance of cosmetic surgery was unexpected.

This is in contrast to a negative relationship reported for women (Thornton et al., 2013) and may be due to a positive relationship between hypercompetitiveness and personal development competitiveness among men in the present study ($r = 0.28$, $p < 0.01$).

Regression Analysis

To consider further the two competitive orientations and acceptance of cosmetic surgery, a hierarchical regression analysis was conducted with attitudes toward cosmetic surgery as the criterion. These results are summarized in Table 2. Men’s age, BMI, and social self-esteem were entered as an initial block to control statistically for individual differences on these variables ($R^2 = 0.12$); $F(3,127) = 5.83$, $p < 0.001$. This was then followed by a stepwise consideration of body dysmorphia, hypercompetitiveness, and personal development competitiveness. Body dysmorphia was identified as the next best significant contributor to the prediction equation ($R^2 = 0.34$, $p < 0.001$), $F(4,126) = p < 0.001$. Hypercompetitiveness was able to contribute further to the regression ($R^2 = 0.38$), $F(5,125) = 15.49$, $p < 0.001$. Personal development competitiveness was excluded from entry as it did not contribute significantly to the regression.

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(Calogero et al., 2010; Slevec & Tiggemann, 2010). Interestingly, Menzel et al. (2011) have reported body dissatisfaction to be a stronger determinant of attitudes toward cosmetic surgery among men rather than women. The present findings with men are consistent with this notion in that body dysmorphism entered the regression prior to hypercompetitiveness, whereas in previous research with women (Thorton et al., 2013), body dysmophia entered the regression following the inclusion of hypercompetitiveness.

The increased emphasis on males’ appearance and the pressure on males to achieve some cultural ideal has been attributed, in part, to the increasing equality between men and women in the workplace (Pope et al., 2000). Women have become more able to compete directly with men for power and resources rather than having to “attract a mate” using their appearance. Traditionally, men could rely on skills, abilities, and a display of status and resources to be competitive in the interpersonal marketplace, however, manhood is becoming increasingly defined by youthful appearance and fitness and conveyed through glamorous depictions that objectify and dehumanize, the same body dysmorphia entered the regression following the inclusion of hypercompetitiveness.

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Body dysmorphic disorder may be an obvious contraindication to cosmetic surgery. Considering the maladaptive nature of hypercompetitiveness, it may also be a personality trait of concern in this regard. With a neurotic need to compete and win at all costs in order to cope neurotically with feelings of inadequacy and feel good about themselves, the appearance domain may be one more arena in which hypercompetitive individuals must strive to best others. With the additional pressure of intrasexual competition among both men and women, a hypercompetitive orientation may contribute further to consideration of cosmetic surgery in order to be more competitive and ultimately “win” in their social and career endeavors. And, like those with body dysmorphic disorder, hypercompetitive individuals may never be satisfied with the results and seek additional treatments in a constant effort to maintain or enhance their competitive advantage through appearance.

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