

Perceived Foot-Appearance Changes as a Local Component of Body Image: Pathways to Self-Esteem and Social Self-Presentation

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Abstract

Research on body image has developed sophisticated models of appearance evaluation, body appreciation, social appearance anxiety, and psychosocial functioning. Research on foot disorders, by contrast, has largely relied on measures of pain, mobility, footwear, and health-related quality of life. The relationship between perceived foot appearance, body image, and global self-esteem therefore remains conceptually plausible but empirically under-specified. This article critically synthesizes a fixed corpus of 27 verified, openly traceable scientific and methodological sources published between 1965 and 2026, with the principal analytical window covering 1995 - 2026. A structured critical review, evidence mapping, synthesis without meta-analysis, and conceptual modeling were used. Studies were classified as direct evidence, foot- or nail-specific psychosocial evidence, transferable theory and measurement, or methodological/framework sources. The synthesis yields four results. First, direct studies connecting foot appearance with body image or self-evaluation are few and context-bound, whereas most evidence uses quality of life, footwear, social interaction, embarrassment, or function as proxies. Second, the evidence supports an analytical dual-path model: an appearance-social-evaluation pathway and a function-participation pathway may converge on body-image-related quality of life and self-evaluation. Third, no instrument in the reviewed corpus simultaneously covers local foot-appearance appraisal, general body image, global self-esteem, social appearance anxiety, avoidance behavior, and foot function. Fourth, visibility, footwear norms, occupational context, culture, symptoms, and infection-related stigma delimit the model's applicability. The contribution lies in separating construct levels and evidence types rather than asserting a universal effect. The review does not establish prevalence, causality, or a pooled effect size; its model and proposed assessment set require prospective, culturally diverse validation.

Keywords: body image, self-esteem, foot appearance, social appearance anxiety, footwear, stigma, patient-reported outcomes, evidence mapping

1. Introduction

Body image research has rarely treated the foot as a theoretically specific site of self-appraisal. The dominant literature has concentrated on body weight, shape, muscularity, or overall attractiveness, while foot-health research has concentrated on pain, mobility, deformity, footwear, and treatment outcomes. This division matters because the foot occupies an unusual position in embodied self-evaluation: it is ordinarily concealed, periodically exposed, central to mobility, and subject to appearance norms that vary across social settings. A visible change in the foot may therefore be experienced as aesthetically salient without producing functional disability, functionally disruptive without becoming a central appearance concern, or both. A design that collapses these possibilities into a single category of “aesthetic problems” cannot explain when local

dissatisfaction becomes psychologically consequential.

The conceptual distinction begins with the construct itself. Body image is not a single rating of satisfaction but a multidimensional organization of perceptions, evaluations, emotions, investments, and behaviors directed toward the body and appearance [1]. Global self-esteem operates at a different level: it concerns an overall evaluation of self-worth rather than satisfaction with one anatomical feature [2]. Measures of body-image-related quality of life make the intervening level visible by asking how appearance experiences affect social relationships, psychological well-being, and body-management activities [3, 4]. These levels can covary, but they are not interchangeable. A person may dislike the appearance of the toes while maintaining stable global self-esteem; conversely, a relatively minor visible change may acquire disproportionate importance when it becomes a cue for anticipated rejection, shame, or loss of control.

Research on visible difference provides one route for explaining that transition. The psychosocial consequences of disfigurement are heterogeneous: objective visibility does not determine adaptation, and people differ in the meanings they assign to appearance, in exposure contexts, and in available social resources [5]. The sociometer account of self-esteem adds a relational mechanism by treating self-evaluation as sensitive to signals of inclusion and exclusion [6]. Social appearance anxiety operationalizes a related concern - the expectation that one's appearance will be evaluated negatively by others [7]. Applied to foot appearance, these frameworks imply a conditional sequence rather than a direct effect: a perceived difference becomes salient, is interpreted through appearance norms, evokes anticipated evaluation, and may prompt concealment or avoidance. The sequence should remain a hypothesis until its links are measured in the same population.

A second route concerns functionality. Body functionality research argues that what the body can do constitutes a distinct dimension of embodied experience and may buffer or reorganize appearance evaluation [8]. Positive body image likewise cannot be reduced to the absence of dissatisfaction; body appreciation includes respect, acceptance, and protective processing [9, 10]. For the foot, this distinction is especially important because pain, restricted walking, and footwear limitations can alter participation and identity even when appearance is not the principal concern. Cultural norms further shape which features are noticed and which appearance ideals are treated as socially consequential, making unqualified cross-national generalization unsafe [11].

The empirical literature reinforces the conceptual asymmetry. Foot-specific patient-reported outcome measures (PROMs) offer validated domains for pain, function, footwear, and general foot health [12], disabling foot pain and appearance-related concern [13], postoperative walking, pain, and social interaction [14], and impairment, footwear, activity, and participation in rheumatoid arthritis [15]. A case-control study of 498 adults with and without foot problems found differences in foot-health-related quality of life and associated domains, but it did not isolate appearance or global self-esteem [16]. These instruments and studies establish that foot conditions have psychosocial relevance; they do not establish that aesthetic dissatisfaction independently lowers self-esteem.

The object of this study is body image and global self-evaluation in adults experiencing perceived changes in the appearance of a specific body part. Its subject is the set of appearance-related, social-evaluative, behavioral, and functional mechanisms through which the perceived appearance of the foot may become connected to body-image-related quality of life, self-presentation, and self-esteem. The main research question is: Which psychological and social-behavioral mechanisms permit perceived foot-appearance changes to be interpreted as a local component of body image potentially associated with adult self-esteem? Three subsidiary questions guide the analysis: Which outcomes are measured directly and which are proxies? How should appearance-related and function-related pathways be separated? Which visibility, cultural, clinical, and footwear contexts limit the transferability of findings?

The aim is not to estimate a prevalence or pooled effect, because the available open evidence cannot support either. The article instead makes a more limited contribution by (a) ranking evidence according to its proximity

to the proposed relationship, (b) constructing a dual-path analytical model, (c) identifying the measurement gap that prevents direct testing, and (d) specifying boundary conditions for future empirical work. Its theoretical significance lies in embedding local foot appraisal within a layered account of body image without treating one body part as a surrogate for the whole construct. Its practical significance lies in a research-oriented assessment architecture that can distinguish appearance concern from pain, function, and participation. The evidence base comprises openly traceable peer-reviewed articles, validated instrument reports, reviews, and an official functioning framework; no private records, original participant data, or proprietary clinical datasets were used.

2. Literature Review

2.1. From local body appraisal to global self-esteem

The literature supports a layered rather than linear relation between body part appraisal and self-esteem. At the most proximal level, a person notices and evaluates a feature of the body. At an intermediate level, this evaluation affects appearance-related emotion, cognitive investment, and everyday behavior. At a more distal level, repeated consequences may influence body-image-related quality of life or global self-evaluation. The BIQLI and its abbreviated version are useful precisely because they locate body image within psychosocial functioning rather than equating it with satisfaction alone [3, 4]. Yet their generality is also a limitation for the present topic: neither identifies which body feature drives a response. The Rosenberg tradition, in turn, provides a defensible measure of global self-esteem [2], but its level of abstraction makes it unsuitable as the sole indicator of a localized appearance concern.

The distinction has two methodological consequences. First, an association between foot appearance and social interaction cannot be redescribed as an association with self-esteem unless self-esteem was measured. Second, an observed relationship between a foot condition and a global outcome cannot automatically be attributed to aesthetics when pain, mobility, treatment burden, or occupational participation remain plausible explanations. The literature on positive body image sharpens the point: low dissatisfaction and high body appreciation are related but not identical states [9, 10]. An analysis confined to negative appearance ratings may therefore miss acceptance, functionality appreciation, or identity continuity that weakens the proposed pathway.

2.2 Foot-health outcomes: strong measurement, indirect psychological inference

Foot-health research has a mature measurement tradition, but its maturity is uneven across constructs relevant to the present question. The Foot Health Status Questionnaire covers pain, function, footwear, and general foot health [12]. The Manchester Foot Pain and Disability Index incorporates an appearance-related concern within a broader pain and disability instrument [13]. The Manchester-Oxford Foot Questionnaire adds a social interaction domain to pain and walking/standing [14], while the Foot Impact Scale for rheumatoid arthritis organizes the burden around impairments/footwear and activities/participation [15]. These tools capture outcomes that matter to patients and make footwear visible as both a functional constraint and a social practice. None, however, was designed to establish a mediated pathway from local appearance appraisal to general body image and global self-esteem.

The case-control evidence and the mixed-methods review of foot and ankle pain support a biopsychosocial interpretation but also expose a confounding problem. Foot problems are associated with reduced quality of life and limitations in physical activity and footwear [16]. Across the pain literature, psychological constructs are associated with pain and function, while qualitative findings include disruption of self and everyday participation [18]. These findings are relevant to self-evaluation, but the initiating condition is frequently

pain rather than appearance. Treating them as direct evidence of aesthetic impact would convert a functional pathway into an appearance pathway without data.

2.3. Direct evidence and the role of footwear identity

Only a small portion of the corpus addresses foot appearance and body-related self-perception directly. Tutuş and colleagues examined hallux valgus, anatomical parameters, and body-image perception in 158 adults aged 18 - 30 years, 111 of whom were women [17]. The study is valuable because it places a foot deformity and body-image perception within one quantitative design. Its cross-sectional structure, age range, and sex imbalance nevertheless prevent causal or population-wide inference, and the published findings cannot be generalized to nail changes, postoperative states, or appearance concerns without deformity.

Qualitative studies offer richer accounts of mechanism. Interviews with 15 patients after forefoot surgery linked recovery to physical limitations, psychosocial experience, altered body-related perceptions, and restrictions in footwear and clothing [19]. A 2026 study of 27 Turkish white-collar women after hallux valgus surgery identified footwear identity, aesthetic perception, psychological responses, and occupational context as connected themes [20]. These studies show why footwear cannot be treated as a neutral clinical item. It can regulate visibility, signal professional identity, mediate participation, and provide a behavioral means of concealment. Their contribution is explanatory rather than distributive: qualitative themes identify plausible processes, not their prevalence in a broader population.

2.4. Nail appearance as adjacent evidence of stigma and concealment

Onychomycosis research supplies adjacent evidence where foot-specific body-image studies are sparse. A systematic review found that appearance problems, stigma, emotional health, functional activities, and treatment satisfaction recur in onychomycosis quality-of-life research [21]. In a blinded comparison involving 1,017 Hong Kong adults, images of visible nail infection elicited more negative expectations concerning relationships, social activities, comfort in proximity, and career performance [22]. A small Moroccan clinical study described nail-care burden, footwear discomfort, and greater concern with hiding nails among affected patients [23]. An international disease-specific questionnaire similarly incorporated physical and psychosocial consequences of onychomycosis [24].

This line of evidence should not be merged uncritically with structural foot deformity. Infection cues may produce avoidance for reasons not reducible to attractiveness, and studies sometimes combine fingernails and toenails. The data nevertheless clarify two mechanisms that can be transferred cautiously: visible difference may trigger anticipated social evaluation, and concealment can become a behavioral response. The research gap is therefore specific. Existing studies do not jointly measure localized foot-appearance appraisal, general body image, social appearance anxiety, global self-esteem, concealment behavior, pain, function, and visibility context. The present review addresses that gap at the level of analytical architecture, not by claiming that the missing empirical test has already been performed.

3. Materials and Methods

3.1. Review design and corpus

The study is a structured critical review with evidence mapping, synthesis without meta-analysis, and conceptual modeling. It is not presented as a systematic or scoping review. The corpus was fixed before drafting and contains 27 verified sources: 24 substantive scientific sources and three methodological or framework sources. The principal analytical period was 1995 - 21 August 2026; the 1965 monograph on global self-esteem was

retained as a justified theoretical exception, and earlier instrument-development studies were retained when they defined foot-specific measurement domains. Reporting logic was informed by PRISMA 2020 [25], while grouping and transparent narrative synthesis followed the principles of SWiM [26]. These guides were used to improve traceability; they were not used to imply exhaustive database coverage.

The substantive corpus comprises four lines: general theory and measurement of body image, self-esteem, social appearance anxiety, and functionality [1 - 11]; foot-specific PROMs and foot-health studies [12 - 20]; visible nail change, stigma, and onychomycosis-specific quality of life [21 - 24]; and methodological/framework documents [25 - 27]. The International Classification of Functioning, Disability and Health provided the distinction between body functions and structures, activity, participation, and contextual factors [27]. The unit of analysis was an individual empirical finding, qualitative theme, theoretical proposition, or instrument domain relevant to the research questions.

3.2. Search logic and eligibility

The verified corpus was assembled with three search blocks documented in the research package. The first combined foot appearance, foot aesthetics, hallux valgus, foot deformity, onychomycosis, or nail disorder terms with body image, self-esteem, appearance anxiety, stigma, embarrassment, quality of life, or social participation. The second combined body image and self-esteem with visible difference, disfigurement, appearance anxiety, or functionality. The third used instrument names and abbreviations, including FHSQ, MFPDI, MOXFQ, FIS-RA, BIQLI, BIQLI-10, SAAS, BAS-2, and onychomycosis-specific measures. Records were verified against DOI metadata, PubMed/PMC, publisher pages, or official organizational sources.

Sources were eligible when they concerned adults, contained a psychosocial outcome or a relevant validated instrument, and provided verifiable authorship, publication venue, year, and DOI or official URL. Adjacent visible conditions were retained only when they contributed evidence about appearance, stigma, concealment, or psychosocial functioning. Child-only studies, surgical or biomechanical reports without psychosocial outcomes, commercial advice, clinic blogs, social-media material, unverified citations, and treatment studies without relevant outcomes were excluded. Open traceability was required, but open access to every full-text version was not treated as evidence of methodological quality.

3.3. Analytical procedure and interpretation rules

Each source was coded by population, country, condition, study design, construct, instrument, outcome, visibility context, and limitation. Evidence proximity was classified into four levels. Level A contained studies that directly combined a foot condition or foot appearance with body image or self-evaluative experience. Level B contained foot- or nail-specific studies with psychosocial PROMs, social interaction, stigma, concealment, footwear, or qualitative mechanisms. Level C contained transferable body-image theory and measures. Level D contained reporting guidance and the functioning framework. This hierarchy concerns proximity to the research question, not a universal ranking of study quality.

The synthesis proceeded in three steps. First, constructs were separated so that body image, body appreciation, global self-esteem, appearance anxiety, quality of life, social interaction, embarrassment, pain, function, and participation were not treated as synonyms. Second, findings were grouped into an appearance-social-evaluation pathway or a function-participation pathway; mixed findings were allowed to occupy both. Third, recurrent contexts and alternative explanations were used to define boundary conditions. No effect estimates were pooled because designs, conditions, populations, instruments, and outcomes were not commensurable. Directional consistency was described qualitatively, and absence of direct measurement was treated as a measurement gap rather than evidence of no association.

The critical appraisal did not use a numerical quality score, which would imply comparability that the corpus does not possess. Instead, each inference was evaluated against design, sample specificity, measurement validity, evidence proximity, cultural context, and plausible confounding by pain or function. Causal language was reserved for future hypotheses. Results were considered supportable when they could be traced to at least one direct source and a compatible theoretical or adjacent line, or when they described a transparent structural property of the corpus, such as instrument coverage.

4. Results

4.1. Evidence proximity: direct studies are outweighed by proxy outcomes

The first result is an evidence hierarchy rather than an effect estimate. Three publications provide the closest evidence: one cross-sectional study connects hallux valgus and body-image perception [17], and two qualitative studies connect forefoot appearance, footwear identity, psychosocial experience, and self-related meanings in postoperative contexts [19, 20]. Ten sources provide foot- or nail-specific psychosocial evidence through PROM domains, quality of life, social interaction, stigma, concealment, or pain-related identity [12 - 16, 18, 21 - 24]. Eleven sources supply transferable theory and general measures [1 - 11], and three provide methodological or functional frameworks [25 - 27]. Table 1 shows why the existing literature can support a mechanism map but not a pooled effect of foot appearance on self-esteem.

Table 1. Evidence map by proximity to the research question

Level	Evidence type	Source IDs	What it supports	Principal limit
A	Direct foot appearance /body-image or self-related evidence	[17, 19, 20]	Existence of localized appearance and footwear-related psychosocial meanings	Three context-bound studies; no prospective causal test and no standardized global self-esteem outcome
B	Foot- or nail-specific psychosocial, PROM, stigma, concealment, QoL or participation evidence	[12 - 16, 18, 21 - 24]	Patient relevance of footwear, social interaction, visibility, function and stigma	Most outcomes are proxies; pain, infection and function may explain associations
C	Transferable body-image, self-esteem and social-evaluation theory/measurement	[1 - 11]	Construct separation and plausible mediators/moderators	Not validated specifically for perceived foot appearance
D	Methodological and functioning frameworks	[25 - 27]	Transparent synthesis and separation of function, activity, participation and context	Does not provide substantive evidence of the proposed relationship

Source: evidence mapping of the fixed 27-source corpus. Levels indicate proximity to the research question, not a pooled hierarchy of internal validity.

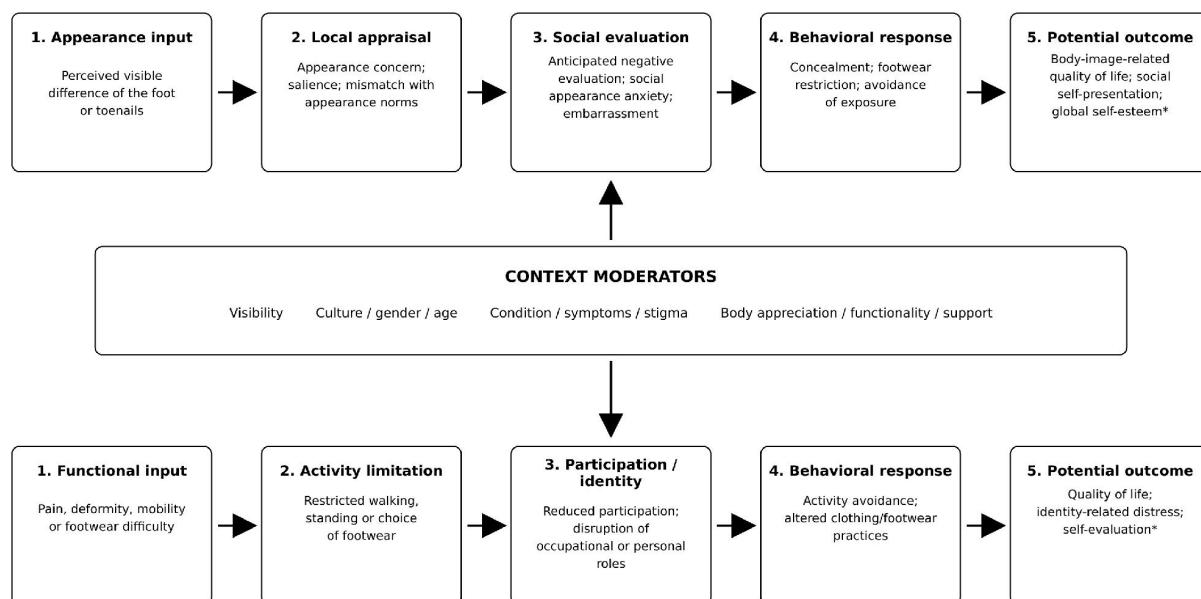
The distribution has two substantive implications. First, the most common outcomes-pain, function, footwear, social interaction, and quality of life-are relevant to psychological functioning but cannot stand in for global self-esteem. Second, the direct studies are too heterogeneous to define an average association. The quantitative study concerns young adults and hallux valgus [17]; the qualitative studies concern postoperative recovery and,

in one case, white-collar women in Turkey [19, 20]. The evidence therefore establishes that foot appearance can enter body-related self-evaluation in particular contexts. It does not establish that it ordinarily does so, nor that the direction and magnitude are uniform.

4.2. Dual-path analytical model

The second result is a dual-path model that separates appearance-related meaning from functional burden while allowing them to converge. In the appearance social-evaluation path, a visible or perceived difference becomes a localized appraisal; appearance salience may then evoke anticipated negative evaluation, embarrassment, or social appearance anxiety. Concealment, restricted footwear choice, and avoidance of exposure are behavioral responses that may carry the effect into social self-presentation and body-image-related quality of life. The sociometer hypothesis and social appearance anxiety research make the evaluative link plausible [6, 7], while visible-difference and onychomycosis studies provide adjacent evidence for heterogeneous adaptation, stigma, and concealment [5, 21 - 23].

In the function-participation path, pain, deformity, mobility limitation, or footwear difficulty constrain walking, standing, activity, and role participation. The psychological consequence may arise from loss of autonomy, altered professional presentation, or disruption of identity rather than from appearance dissatisfaction itself. Foot PROMs, case-control evidence, the pain review, and qualitative forefoot studies support this route [12 - 16, 18 - 20]. Functionality research and the ICF framework clarify why it must be analytically distinct [8, 27]. Figure 1 presents both routes and their shared contextual moderators.



*Source: author's analytical synthesis of [5 - 8, 14, 18 - 23, 27]. The numbered sequence denotes a theoretically coherent pathway, not an estimated causal effect. *Distal outcomes are hypotheses requiring direct prospective testing.*

Figure 1. Dual-path analytical model linking perceived foot-appearance changes to body-image-related outcomes

The model does not assume that the two paths are independent. Footwear can reduce pain, conceal appearance,

or express identity; surgery can alter both function and visible form; and infection cues can combine perceived unattractiveness with fears of contagion. The analytic value of separation lies in measurement. If pain and function are not recorded, an apparent ‘aesthetic effect’ may be functional. If visibility, embarrassment, and concealment are not recorded, a function-only model may miss the social meaning of appearance. The distal link to global self-esteem is deliberately marked as conditional because the reviewed foot-specific studies do not provide a single prospective mediation test.

4.3. Measurement gap across local, general and functional constructs

The third result is a coverage gap across instruments. General body-image tools capture psychosocial impact or positive body image, and the SAAS captures anticipated negative evaluation. The Rosenberg scale addresses global self-esteem. Foot-specific PROMs capture pain, footwear, function, and participation, sometimes with a limited appearance or social component. Disease-specific nail measures capture appearance, stigma, or emotional burden. No measure in the corpus spans all relevant levels. Table 2 makes this gap explicit.

Table 2. Construct coverage of candidate instruments

Instrument / source	Foot appearance	Body image	Global self-esteem	Appearance anxiety	Footwear / participation	Pain / function
Rosenberg self-esteem framework [2]	-	-	●	-	-	-
BIQLI / BIQLI-10 [3, 4]	-	●	●	●	●	-
BAS-2 [9]	-	●	-	-	-	●
SAAS [7]	-	●	-	●	-	-
FHSQ [12]	-	-	-	-	●	●
MFPDI [13]	●	-	-	-	●	●
MOXFQ [14]	-	-	-	-	●	●
FIS-RA [15]	●	-	-	-	●	●
Onychomycosis-specific QoL [24]	●	-	-	●	●	●

Source: instrument-development and validation reports [2 - 4, 7, 9, 12 - 15, 24]. ● primary coverage; ● partial or contextual coverage; - not a designated domain. The matrix evaluates coverage, not validity outside the instrument’s intended purpose.

This matrix alters how a future study should be designed. A single global scale cannot identify the local initiating appraisal; a foot-health PROM cannot determine whether social limitation is attributable to appearance; and an appearance-anxiety scale cannot separate concealment from mobility restrictions. The minimum empirical architecture therefore requires one measure at each level: localized foot-appearance appraisal, general body-image impact or appreciation, global self-esteem when it is the claimed outcome, social appearance anxiety, a foot-specific PROM, and behavior/context items covering concealment, footwear choice, and exposure. This is a proposed coverage set, not a validated battery. Translation, permissions, cultural adaptation, and psychometric testing remain necessary.

4.4. Boundary conditions and contextual typology

The fourth result is a typology of contexts in which the proposed pathway is more or less interpretable. Four types recur across the corpus. Appearance-dominant contexts concern a visible difference with limited

functional impairment. Function-coupled contexts combine deformity, pain, mobility, and restricted footwear. Stigma-prone contexts include visible nail disease, where infection-related meanings may intensify avoidance. Visibility-contingent contexts arise when open footwear, intimacy, communal changing, or occupational appearance codes make the foot socially exposed. Table 3 sets out the evidence and interpretive safeguard for each type.

Table 3. Contextual typology of perceived foot-appearance problems

Context type	Defining condition	Mechanism	Evidence	Safeguard
Appearance-dominant	Appearance salience without dominant pain or mobility loss	Local dissatisfaction → anticipated evaluation → concealment	Visible-difference theory; direct body-image study [5, 17]	Direct foot-specific evidence remains sparse
Function-coupled	Deformity or symptoms affect walking, standing, footwear and participation	Functional loss and appearance concern may converge	Foot PROMs, case-control and pain review [12 - 18]	Control pain/function before attributing outcomes to aesthetics
Stigma-prone	Visible nail change carries infection or hygiene meanings	External stigma and self-concealment	Onychomycosis review, perception survey and clinical study [21 - 24]	Do not generalize infection-related reactions to noninfectious deformity
Visibility-contingent	Exposure depends on footwear, intimacy, occupation or local norms	Context activates or suppresses social-evaluative concern	Qualitative footwear identity and cultural evidence [11, 19, 20, 23]	Visibility and culture must be measured, not assumed

Source: critical synthesis of [5, 11 - 24]. The types may overlap within one person and should not be treated as diagnostic categories.

The typology explains why apparently inconsistent findings need not be contradictory. A condition can be clinically visible but psychologically peripheral when the foot remains concealed and function is preserved. A subtler change can become highly salient when professional footwear, summer exposure, or intimate situations repeatedly activate anticipated evaluation. Conversely, strong body appreciation or functionality orientation may weaken the translation of local dissatisfaction into broader self-evaluation [8 - 10]. The reviewed studies do not allow these moderators to be ranked by effect size; they define variables that should be measured before generalization.

5. Discussion

5.1. What the model changes in the interpretation of foot-related outcomes

The review reframes the relationship between foot appearance and self-esteem as a problem of construct levels and pathways. The familiar statement that an aesthetic foot problem ‘reduces self-esteem’ compresses at least five analytically distinct stages: noticing a local difference, evaluating it negatively, anticipating others’ evaluation, changing behavior, and experiencing a broader effect on body-related quality of life or self-worth. The evidence supports the existence of several stages, but not a universal passage through all

of them. This qualification is not semantic caution alone; it determines what must be measured and which alternative explanations remain open.

The layered interpretation is consistent with multidimensional body-image theory [1] and with the distinction between body-image impact and global self-esteem [2 - 4]. It also clarifies the contribution of the sociometer and social appearance anxiety perspectives. The foot need not be continuously visible for social evaluation to matter. Anticipated exposure may be enough to influence footwear, leisure participation, or intimacy. The Hong Kong nail-perception study demonstrates that visible nail changes can carry social judgments [22], while the Moroccan study and qualitative forefoot work show concealment and footwear management from the affected person's perspective [19, 20, 23]. Yet the gap between anticipated judgment and experienced rejection remains empirically unresolved.

The dual-path model also corrects an appearance-centered bias. Foot conditions are embodied through walking, standing, pain, footwear, and participation. The case-control study and mixed-methods pain review indicate that psychological burden can emerge through function and disruption of self [16, 18]. The ICF framework makes this route explicit by separating body functions and structures from activity, participation, and contextual factors [27]. An article concerned with aesthetics must therefore include function not as background clinical detail but as a competing and interacting explanation.

5.2. Theoretical and practical implications

The theoretical implication is moderate but specific. The article does not propose a new general theory of body image. It refines the application of existing theory to a localized and intermittently visible body feature. The refinement has three elements: local appraisal is distinguished from general body image; global self-esteem is treated as distal rather than automatic; and footwear is conceptualized simultaneously as a functional device, a means of concealment, and a resource for social self-presentation. This account accommodates both qualitative reports of footwear identity [20] and the prominence of footwear domains in foot-health PROMs [12, 14, 15].

For empirical research, Table 2 provides a defensible minimum coverage logic. Future studies should not begin with a single question about satisfaction with the feet and conclude with claims about self-esteem. They should record local appearance appraisal, general body-image impact or appreciation, global self-esteem when relevant, appearance anxiety, pain/function, footwear behavior, concealment, and visibility context. Prospective designs are needed to determine temporal order, and culturally diverse samples are needed because the present corpus spans settings that cannot be averaged without loss of meaning [11, 17, 20, 22, 23]. Qualitative work should remain part of this program because it identifies situational meanings that standardized measures may miss.

For clinical and psychosocial practice, the findings justify attentive inquiry but not screening conclusions. A practitioner may reasonably ask whether a patient avoids particular shoes, social settings, or exposure because of appearance, pain, or both. Such questions can reveal a concern omitted by a purely biomedical assessment. The evidence does not justify assuming low self-esteem from the presence of a deformity or nail condition, nor does it establish that cosmetic correction will improve psychological outcomes. The proposed assessment set is a research prototype, not a diagnostic tool or treatment guideline.

6. Conclusion

Perceived foot-appearance changes can be situated within body-image research, but only if local appraisal, general body image, body-image-related quality of life, and global self-esteem are kept analytically distinct. The reviewed evidence indicates that appearance may become psychologically consequential through anticipated social evaluation, embarrassment, concealment, footwear restriction, and altered self-presentation. In parallel, pain and functional limitation may affect participation and identity through a different route. These paths can converge, yet the available corpus does not establish their causal order or relative strength.

The main scientific result is a dual-path model accompanied by an evidence hierarchy, an instrument-coverage matrix, and a typology of boundary conditions. Together, these results explain why foot-specific quality-of-life findings cannot be translated directly into claims about self-esteem and why aesthetics cannot be isolated without recording function. The framework gives personality and body-image research a more precise way to approach a localized, intermittently visible body feature, while giving foot-health research a clearer account of the psychosocial variables missing from conventional PROMs.

The next empirical step is not a larger collection of unspecific quality-of-life correlations. It is a prospective, culturally sensitive test that measures local foot appraisal, social appearance anxiety, concealment and footwear behavior, pain/function, body-image-related quality of life, and global self-esteem in the same design. Until that evidence exists, claims should remain conditional: foot appearance may participate in broader self-evaluation for some adults and in some visibility contexts, but an aesthetic change is neither a sufficient nor a necessary cause of low self-esteem.

Declarations

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Competing interests. The author declares no conflicts of interest.

Data availability. No new participant-level dataset was generated. The review corpus consists of publicly traceable sources cited in the reference list; the evidence hierarchy, model, and instrument matrix are reported in Tables 1 - 3 and Figure 1.

Ethics approval. Not applicable. The study analyzed published literature and official documents and involved no human participants, animals, or identifiable personal data.

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