The experience of female patients seeking elective rhinoplasty surgery: A narrative inquiry

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Abstract

The aim of this research is to understand what motivates patients to have an elective rhinoplasty, taking into consideration any societal, familial, cultural and intrapersonal influences. The research question explored how, if at all, surgery impacts women's embodied sense of themselves and if there is a way of providing psychological support to this patient group. Four female patients were interviewed preoperatively and postoperatively using a narrative inquiry approach. The research offers a detailed qualitative contribution in a field that is predominantly quantitatively studied. The research explored the nuances of why female patients want to have rhinoplasty surgery.

The narratives of the patients showed that the motivation to have surgery is based on external and internal factors. The external factors revealed the following: society's acceptance of cosmetic surgery, the influence of the media, the experience of the consultation and how risk is understood. The internal factors were influenced by the patients' experience of the death of significant family members, a need to separate from patriarchal and matriarchal family members, feelings of body shame, a fear of negative evaluation from others, and objectification of their body in preparation for surgery. Following surgery, a psychological shift was discussed by each patient; this indicates that cosmetic surgery does indeed have a psychological impact.

The implication for practice is that clinicians need to have a better understanding of the motivation of this patient group to be able to offer the appropriate psychological support. Awareness also needs to be raised with surgeons, to help them better understand how the surgery they perform can have a psychological impact. This research showed that patients proceeding with cosmetic surgery could benefit from having specialised psychological support preoperatively and postoperatively. This would contribute to more realistic expectations for surgery and, hopefully, a better outcome for both patient and surgeon.

Acknowledgements

This thesis is dedicated to my husband Des, who has supported me in so many different ways that I never imagined needing. Without his ongoing belief, kindness and care, I would not have reached this point in my career. I would also like to thank my parents, who were always in the background offering me support and encouragement. I am very grateful as well to my supervisor Helen, who was available whenever I needed help. Her prompt feedback has been invaluable, and her help to ground some of my rather grand ideas was most appreciated. Also, my colleagues Rochelle and Georgina, who were always around to talk to and cry with, and who offered me valuable reflection time. Thank you to the plastic surgeon who was so openly prepared to allow me to have contact with the patients he was operating on, and for the genuine interest he showed in my research. Finally, I am most grateful to the four patients who generously gave up their time to participate in my research and shared so much of their individual stories with me.

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1. Introduction

Researcher's relationship to the topic

The connection I have with this area of research began when I was working as a Personal Assistant for a Craniofacial, Reconstructive and Aesthetic Plastic Surgeon. I worked for this surgeon for seven years and spent time with patients preoperatively and postoperatively.

Following their initial consultation, patients would meet with me to book in for surgery. Whilst arranging their surgery, they would often start telling me stories about their motivation for surgery and how long they had been planning it. There seemed to be common factors emerging in their expectation from the outcome and why they wanted the surgery. Some patients said they believed having surgery would boost their self-esteem, improve their relationship with a significant other, or perhaps even help them obtain a specific job. I wondered about this expectation of surgery fixing external and internal issues and whether this was what transpired in reality. There seemed to be a correlation between the patients who expressed the most anxiety about having the surgery also being the ones to have these particular expectations of the outcome; however, these patients were often too afraid to discuss their fears and concerns with the surgeon in case he suggested they should reconsider their decision to have surgery.

Alongside my work as a Personal Assistant, I started training as a Counselling Psychologist and Psychotherapist. Various questions arose in my mind as to what, psychologically, motivates a patient to pursue cosmetic surgery, and whether there is a link to poor self-esteem and to societal pressure to achieve a certain appearance.

I wondered whether providing an open, non-judgemental, safe space for patients preoperatively (for example a psychologically therapeutic space) would help them better understand their reasons for proceeding with surgery.

My personal history also contributed to my interest in this research area. I come from a family of four; two older sisters who are very close in age, and one older brother. In my family, there has always been a certain amount of pressure to maintain your size; ‘being overweight' or ‘looking skinny' were terms we all often used. Undoubtedly, given the fact there were also three girls growing up and developing in the same household, there was unspoken competition between us about who was looking ‘good'. I have often wondered what leads females to be so competitive about their looks and why this becomes an issue for some people and not others.

Clarification of definitions

Patient, client or participant?

In the cosmetic surgery industry, individuals having surgery are referred to as ‘patients'. According to the Oxford Dictionary of Psychology (2002), the word ‘patient' means ‘a person receiving a medical, surgical or other form of treatment for a disorder or illness.’ (p.554) This definition raises a dilemma in my research as to whether to call the participants ‘clients’ or ‘patients’.

A vast amount of advertising in cosmetic surgery talks in terms of surgery being about an individual ‘looking after himself or herself’ and having a ‘normal’ beauty treatment. Surgery is not described as something that is used to treat a disorder or illness. So why then, does the industry call these individuals ‘patients’ instead of, perhaps, ‘clients'? The Oxford Dictionary of Psychology (2002) describes a ‘client' as a person in ‘receipt of a professional service', not necessarily somebody who is suffering from an illness or disorder (p.138).

I am aware that there is a similar dilemma within psychology where the words ‘client’ and ‘patient’ are used interchangeably depending on the treatment sector. Having looked at a wide array of research on cosmetic surgery, one can see why it would be such a dilemma for individuals receiving cosmetic surgery to be called ‘clients', as cosmetic surgery would then be perceived even more as a consumer-based activity. In contrast, many patients will justify their surgery because of the distress they are experiencing and not merely see it as a beauty practice. To clarify; whenever I mention the word ‘patient’ in my research, I am referring to the women/clients/participants who took part in this research. The reason I chose to use the term ‘patient’ is to avoid confusion when discussing participants, as I will be referring to them within the medical, psychological and societal context.

Whenever I use the words ‘surgeon’ or ‘surgeons’, I will be referring to any medical professional from the plastic, reconstructive, cosmetic or other surgical field where cosmetic surgery is performed.

Plastic surgery covers procedures that are also classed as being reconstructive and medically necessary. Cosmetic surgery is not medically necessary. This distinction is essential, as I will be focusing on patients who elect to have a rhinoplasty for non-medically necessary reasons; in other words, they are having cosmetic surgery to reshape their nose. A rhinoplasty is defined as ‘surgery to reshape the nose by increasing or decreasing the size’ *(British Association of Aesthetic Plastic Surgeons, 1982).*

I have chosen to interview patients who are having the surgery for non-medically necessary reasons, as this means it is by choice and not because of physical illness or injury which would be a separate piece of research. I have selected the rhinoplasty procedure for my study due to the psychological aspects attached to our face, and the impact that altering our appearance can have on our psyche (Sarwer et al., 1998).

The pressure on women to conform to prevailing standards of beauty

The pressure on women to conform to society's ideal standards of beauty makes it doubtful whether it is truly a freedom of choice to have cosmetic surgery or perhaps more a reflection of society's dominance on how women's and, more recently, men's bodies should look (Wijsbek, 2000). We cannot overlook the overwhelming pressure on women to conform to a particular beauty ideal that is portrayed by the advertising in magazines and the media. The media plays a very impactful role in the internalisation of beauty ideals. Those individuals who refuse to conform to this norm are often stigmatised (Ibid.), leaving little room for people to be different. Surgery is a coercive paradox, where women feel they are making a free choice but, to some degree, they are being unconsciously coerced by society dictating the norm of beauty in a particular timeframe.

Women are not wholly free agents when it comes to cosmetic surgery, because one cannot ever be completely free or immune to societal influences to maintain certain beauty norms or ideals. It means that taking a position for or against cosmetic surgery is a complex one, especially as to whether it is freedom of choice, when to some degree it can never really be. Beauty ideals pressure women to feel that they must conform to a particular beauty standard (Wolf, 1990); that of thinness, bustiness, blonde hair, dark hair, straight nose, thin or thick eyebrows, and so the list goes on. These ever-shifting standards of beauty mean that there will forever be a category of women who feel they do not fit the norm of society's beauty ideals (Wolf, 1990).

Many women, without support, may never learn to accept their bodies and will tend to 'internalise standards of beauty and judge themselves to the point of self-hatred' (Halprin, 1995, p.42). When there is a felt, embodied sense of not being able to meet society's beauty ideals and to look like the 'norm', body shame and dissatisfaction can be prominent factors contributing to body changes through the use of, for example, surgery (Grogan, 2008).

If an individual internalises the ideals of beauty promoted by the media, society, peers and family, their body image and feelings towards their own body are also dictated by these factors. Thompson et al. (1999) define body image as 'the perceptions and feelings one has towards one's body'. If cosmetic surgery is used as a last resort to achieve the perfect body, it can then be considered invasive surgery to the human body for the sake of fulfilling beauty ideals (Gimlin, 2002, cited in Foo, 2010).

We need to continue campaigning to develop positive body image, especially in today's society where appearance is so heavily invested in, and especially amongst the younger generation. Using psychoeducational interventions and research such as that currently being done by the Centre for Appearance Research (CAR), which every two years arranges a conference focusing on Appearance Matters, we are already beginning to make changes. The conference arranged by CAR focuses on research that explores the impact of the unrealistic images of women's bodies portrayed in the media as being the norm. Conducting this research and organising conferences around the importance of appearance and, in particular, body image, we can begin to take a stance against the internalisation of the perfect body.

2. Rationale and aim of this research

Rationale

Cosmetic surgery has a twofold impact; firstly, on the external part that we show to the world and, secondly, on the internal part, which is the individual's psyche inclusive of their self-esteem and relationship with their body.

Cosmetic surgery research has tended to focus on the outcomes of surgery and whether these have been successful (Rumsey and Harcourt, 2012). Most studies are also undertaken quite soon after patients have their surgery, so the results do not necessarily show how long the effects of surgery last. Quantitative studies will tend to measure the success of surgery in terms of how happy a patient is postoperatively (Ibid.). These measures might help us understand which patients are more likely to have a successful outcome postoperatively, but they do not tell us much about the subtle nuances that contribute to a patient's decision to have surgery. If we can establish these nuances before patients have surgery, we may be better placed to understand what is likely to happen after surgery in terms of patient outcome.

Looking at outcomes of surgery seems counterproductive. What we need to do is to help patients before surgery in a way that enables them to attain the best outcomes after surgery. There seems little point in having a standalone measure that tells a surgeon which patient is likely to have a good result following surgery when we do not know what needs to be changed pre-surgery to impact this outcome. If a surgeon decides that a patient is not a good candidate for surgery, this will not necessarily stop someone having surgery given how accessible cosmetic surgery now is. If the patient is determined enough, they will simply go to another surgeon who is unscrupulous and willing to operate on them. If we can help patients understand the psychological reasons why they may not be good candidates for surgery, we will be better placed to help these patients in the long run.

Aim

This research aims to explore the motivation of four female patients as they go on their journey through rhinoplasty surgery, while bearing in mind any societal, familial, cultural and intrapersonal influences. By carrying out this study, I hope to address part of the gap in the literature available on cosmetic surgery. I intend to show how we can better prepare patients before surgery by helping them articulate why they want to have the surgery. This will hopefully enable patients to separate out the historical and psychological factors interlinked with their desire for surgery. Another outcome from the preoperative interviews will be further understanding of the patient's mental health before they proceed with major surgery.

Research questions

What motivating factors, from society to family to culture, underlie a patient's decision to have cosmetic surgery? Is there a shift in patients' embodied sense of themselves after their surgery? What psychological support would be helpful for this patient group?

Contribution to counselling psychology and the medical field

This research intends to inform not just psychologists, but also psychiatrists working with patients who seek cosmetic surgery as a solution to their body image challenges. Specific areas in the plastic surgery industry are incorporating psychological services (Dittmann, 2005). We therefore need research that helps us to understand what specific psychological support is helpful for this patient group.

At present, only a handful of hospitals in the United Kingdom offer psychology services to patients struggling with appearance concerns (Rumsey and Harcourt, 2012). There is a need for more evidence indicating how a psychological approach can be useful for treating these concerns in order to increase the number of services available (Hansen and Butler, 2012).

Evidence from this research will further inform surgeons about the reasons why patients pursue surgery and whether patients' expectations are realistic and attainable by having surgery. Honigman, Jackson, and Dowling (2011) have suggested that practitioners will be able to improve the quality of care provided to patients if they encourage them to receive preoperative counselling. Preoperative counselling could also increase patients' satisfaction after surgery by identifying their motivation for pursuing the surgery.

Psychologically supporting these patients could help the cosmetic industry understand the reasons why people have non-medically necessary surgery. It could broaden the field of counselling psychologists. It could benefit cosmetic surgery practices by identifying patients with underlying appearance issues who may not be suitable for surgery. From a sociological and psychological perspective, it could also inform society in general as to why women seek cosmetic surgery and, specifically, rhinoplasty surgery.

3. The context of this research

To contextualise this research, I will briefly mention the historical development of cosmetic surgery and, specifically, the rhinoplasty procedure. I will then discuss the statistics for cosmetic procedures performed in both the United Kingdom and the United States.

In reviewing the literature, I will discuss the relevant quantitative and qualitative studies. I will explore the feminist positions on surgery and indicate where further research will aid a fuller understanding. I will then expand on the motivating factors by looking at how society, family and the medical profession influence a patient's decision to pursue surgery. I will indicate how my research can contribute to a gap in the literature. To conclude, I will explain why a narrative inquiry is an appropriate approach to use for this study.

Brief history of the rhinoplasty procedure

The historical development of plastic surgery can be traced back as early as 600 BC in India (Gilman, 1999 and Parker, 2009). Restoration of the nose and earlobes were the first plastic surgery procedures recorded. These procedures came about due to previous amputation as a form of punishment (Ibid.). As a result, ‘Plastic surgery was initially understood as surgery of the nose.’ (Parker, 2009, p.15)

In the 16th century, Gaspare Tagliacozzi, a surgeon in Bologna, was the first person to make a distinction between reconstructive surgery using skin grafts and beauty surgery (Parker, 2009). Cosmetic surgery appeared in the 19th century, when surgeons realised they could help those whose appearance did not ‘pass' in society to look more pleasing (Parker, 2009, p.15). After the First World War, when plastic surgery and cosmetic surgery were defined, the demand for cosmetic procedures gained further momentum (Gilman, 1999).

Statistics for the United Kingdom and the United States

I will refer to various quantitative and qualitative studies from the United Kingdom and the United States; therefore, the statistics from both countries are relevant. The figures are for the period 1997 to 2016. I have shown the figures for this period because prior to 1997 statistics were not recorded in such a formal way.

Figures taken from the United States Cosmetic Surgery National Databank are as follows: (https://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf) . In 1997, 900,933 procedures were recorded. In 2016, 1,979,595 were recorded, a staggering 120% increase over a 19-year period in the annual number of procedures being carried out. Of the total recorded in 2016, 148,143 were rhinoplasties. To put this into perspective, in 2014, $12 billion was spent on various cosmetic procedures. In 2015 and 2016, $13.5 and $15 billion was spent, respectively, on procedures. At the time of this research, the statistics for 2017 were not yet available. By showing the latest statistics and comparing them to those from 1997, one can begin to see how rapidly the industry has developed and how much demand there is for cosmetic surgery. Table 1 below shows the number of rhinoplasty surgeries by age category. These figures are from the United States Cosmetic Surgery National Databank (ASAPS, 2016).

(https://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf).

Table 1: Total number of rhinoplasty surgeries recorded for 2016 for both men and women

Procedure	Age	Number
Rhinoplasty	18 under	11,059
	19-34	71,007
	35-50	44,182
	51-64	18,561
	65 +	3,334

This table indicates that a high proportion of rhinoplasties are requested by patients in the 19-34 age range, suggesting that individuals in this age group focus on their appearance and accordingly their demand for surgery is higher.

The statistics available from the British Association of Plastic Surgeons (BAAPS) https://baaps.org.uk/baaps_annual_audit_results_.aspx show that in 2016, 2,703 men and women had a rhinoplasty procedure out of a total of 30,750 cosmetic surgical procedures performed. Statistics in the United Kingdom are not as clearly recorded and do not cover as long a period as the data from the United States.

Gimlin (2012), a sociologist based in the United Kingdom, looked at the differences in how cosmetic surgery is viewed in the United States in comparison to the United Kingdom. She interviewed 40 British women and 65 American women. Her focus was a cross-cultural analysis, and her research helps understand why there is such a discrepancy in demand between these two countries.

Gimlin discovered that cosmetic surgery is funded and viewed differently in each country. In the United States, women justify cosmetic surgery as a financial investment in their physical attractiveness and wellbeing. In the United Kingdom, women stress emotional turmoil as being the reason why they seek surgery. In the United States, some healthcare systems will pay for specific procedures provided that a surgeon writes a letter explaining why the patient needs the procedure. Gimlin considered the general impact of political and structural pressures inherent in patient decisions in each country, but not on the individual stories of the patients.

Review of the relevant literature

As this research will show, it is too simplistic to imply that proceeding with cosmetic surgery is purely freedom of choice. The decision to have cosmetic surgery has a number of motivating factors. This research hopes to uncover some of these factors and look at how this information can be used to inform the cosmetic surgery industry, not only to support patients psychologically through their journey, but also to understand what it is that patients seek when they are altering their bodies.

Motivating factors

I will discuss two specific pieces of relevant research exploring the factors that motivate patients to have surgery. The first is an older piece of research carried out by a group of psychiatrists, in America, in the 1960s. The second is a much more recent study conducted in France by Locatelli et al., in 2017.

The group of psychiatrists in America analysed qualitative preoperative and postoperative interviews with 30 female patients to understand what motivated them to have an elective rhinoplasty (Meyer et al., 1960). It appears to be the only piece of qualitative research that has focused on the unconscious factors influencing a patient's decision to pursue rhinoplasty surgery.

Findings from this research indicate that women patients' motivation for surgery can be understood by looking at the following three factors:

1. The conscious factor, which they list as being culturally implicated, i.e. realistic wishes for beauty and attractiveness influenced by society.
2. The preconscious factor, i.e. preconscious awareness of relatively rigid, restrictive, parentally-acquired attitudes towards sexuality.

This awareness can have a domino effect on the person's ability to express basic emotion and could lead to a secondary result of shame, guilt and anger. The surgery can then act as a means of taking control or breaking away from the rigid parental structure.

3. The unconscious factor, which involves deeply-rooted ambivalent identifications with one or both parents. The person unconsciously feels that their body is the same or similar to that of a parent, and often this can be the parent with whom there might be difficulties in the parent/daughter relationship, and the result can be a denial of affect identification. Surgery serves the purpose of trying to liberate the person from this struggle.

Meyer et al.'s (1960) paper focused on establishing which of the 30 patients interviewed indicated some form of mental health issue. The emphasis was to categorise the women as histrionic, obsessive or neurotic to identify who would have a better outcome following rhinoplasty surgery. Some patients acknowledged that the shape of their nose resembled that of their father, and for a small number, their mother. This research was limited, as there was little focus given to the women's embodied experience of themselves; for example, how did they feel about their appearance post-surgery, what if anything had improved following surgery, and were their expectations from the outcome of surgery met?

The focus of Meyer et al.'s study was more in line with some of the current quantitative studies of Picavet et al. (2011), Castle, Honigman and Phillips (2002), and Sarwer et al. (1996). These studies help to identify which patients are more likely to be satisfied postoperatively but do not necessarily provide much information about how patients feel about their bodies pre-surgery and/or post-surgery.

Locatelli et al. (2017) aimed to identify the factors that motivate patients to have cosmetic surgery, to provide insight for surgeons, psychiatrists and psychologists in their preoperative assessments. They did in-depth preoperative interviews with 35 patients undergoing various cosmetic procedures. The difference in my research is the inclusion of both preoperative and postoperative interviews, and the focus on patients having just one specific rhinoplasty procedure meant that it allowed for a more in-depth analysis with a specific patient group.

Locatelli et al.'s (2017) research identified two particular macro factors driving individuals to seek surgery; these were recent events that had taken place in the patients' lives and, secondly, their psychological needs.

Three specific recent events were identified:

1. Relationship changes - loss/separation and being with or meeting someone new.
2. Body changes - perceived risk to physical safety and the fear of dying.
3. Other changes - change of school/job and close friends, and/or family having had cosmetic surgery.

Locatelli et al.'s model showed 'how recent life events can trigger and/or strengthen patients' particular psychological needs' (p.92); patients stated they were undergoing surgery to meet these psychological needs.

<u>In the Locatelli et al. model, six psychological needs were identified:</u>

1. Coping with the past, and with change, by erasing the past or finding a 'former' self; accepting a new self/integrating the past.
2. Reconciling conflicting identities by reducing the discrepancy between self-image and ideal image.
3. Finding or regaining a positive self-image by being able to express a positive self-image for the first time.

4. Altering the way others see you by changing your physical appearance.
5. Defining oneself in relation to others – being more like others or being different or separate from others.
6. Pleasing others or oneself.

The results from this study showed that loss and separation had an impact on 60% of participants. Body changes was another factor indicated by 60% of the participants. Locatelli et al. see the request for cosmetic surgery as a form of coping mechanism to deal with psychological needs and life events.

According to Locatelli et al., using surgery to integrate a better version of one's self seems more appropriate than using it to erase markers from the past (asserting individuality in relation to someone in the family by changing a hereditary trait, i.e. similar nose to father or mother). They feel this latter reason is bound to fail because surgery leaves behind a trace, i.e. a scar.

Locatelli et al. found that a large number of patients refused to participate in their research. I too had difficulty recruiting patients, and this may well indicate a general resistance amongst this patient group to analyse their requests for surgery. This could pose a risk factor for dissatisfaction post-surgery, as surgeons may not know the full expectation of their patients' requests for surgery. In agreement with Locatelli et al., we need to understand cosmetic surgery as being more than just a technical act; the whole psychological wellbeing of the patient is just as important and should be taken into account. This would mean a more 'comprehensive, conscientious and responsible' (p.102) care pathway for the patients. Locatelli et al. stated that a surgeon should determine a patient's need for surgery by looking at the psychological effect of any recent life events. This will help them to understand how the surgery fits into the patient's life history and the real reason that surgery is being requested.

Quantitative studies tend to use measures such as the body image questionnaire, acceptance of cosmetic surgery, and the body image and eating disorder measure (Soest et al., 2007; Castle et al., 2004; Kisely et al., 2002; Sarwer et al., 1998; Rankin et al., 1998). These studies measure the psychopathology of patients preoperatively against the level of satisfaction postoperatively (Rumsey and Harcourt, 2012). These quantitative studies help to identify which patients may be suffering from body dysmorphic disorder (BDD). According to the American Psychiatric Association (2013), BDD is classified by a preoccupation with an imagined defect in appearance: a) if a slight defect is present, the person's concern is markedly excessive, b) the preoccupation must cause significant distress or impairment in social, occupational or other areas of functioning.

In one of the studies by Sarwer et al. (1998), 100 cosmetic surgery patients were interviewed about their body image and it was discovered that 7% of the group was confirmed as suffering from BDD. Another research study, carried out by Picavet et al. (2011) with 226 participants, explored the prevalence of BDD in patients requesting rhinoplasty surgery and this study showed that a staggering 33% of patients had moderate to severe BDD. There are now numerous other studies available that help us to see that BDD is very common in patients who request cosmetic surgery (Honigman, 2004; Castle, Honigman and Phillips, 2002).

The results from these studies show that patients suffering from BDD are more likely to be dissatisfied postoperatively; therefore, surgery is often contraindicated for this patient group because, in some cases, the mental health of this patient group can deteriorate after surgery (Cook, Rosser and Salmon, 2006; Castle et al., 2004; Castle, Honigman and Phillips, 2002; Kisely et al., 2002; Sarwer, 2002 and Sarwer et al., 1998). These findings help identify the patients who will have a better outcome post-surgery and those who perhaps are not good candidates for surgery. However, the research appears limited in aiding understanding of the individual nuances that influence a patient's decision to have surgery.

Thorpe et al. (2004) carried out an interpretative phenomenological analysis (IPA) study in which they interviewed seven female patients postoperatively following elective cosmetic surgery. Three themes were identified in this study: age appropriateness, body image, and wanting to look normal. Their study was useful to see how these women made sense of how they felt they looked. Thorpe et al. considered their study to be limited because it failed to explore the psychological and emotional outcomes of surgery. Due to the limitation of their research, they were unable to see if patients' views of themselves had changed as a result of surgery as they did not have any preoperative interviews to give a comparison. This study helps us to see that qualitative preoperative interviews could add to the existing knowledge in the field.

The surgeon and patient

Parker (2009), a sociologist based in Australia, carried out a notable piece of research which has helped unravel some of the factors that motivate patients to have surgery. Parker looked at the motivations for surgery from both the surgeons' and the patients' perspective. As part of her research, Parker interviewed 32 women who had undergone a cosmetic procedure. She also interviewed 19 medical practitioners who carried out cosmetic procedures and asked these practitioners why they thought patients elected to have cosmetic procedures and how the practitioners decided which patients to operate on. Parker also asked what their reasons were for choosing a career in cosmetic surgery.

All 19 of the practitioners interviewed mentioned that they understood their patients' motivation for surgery as being linked to psychological factors; however, only one doctor reported that they referred their patients to either a psychiatrist or psychologist preoperatively. The others stated, 'I used my judgement to ascertain whether a woman had a psychological disturbance' (Ibid. p.86).

Surgeons have been heard to say that they are ‘psychologists with scalpels in their hands’ (Mendelson, 2013 p.174) and acknowledge the potential psychological impact they have on their patients. Mendelson (2013), a practising plastic surgeon, describes facial plastic surgery as being ‘surgery of the emotions’, which essentially is ‘psychosurgery', asking patients the frequently used question in therapy of ‘why now?' (p.182). Viewing cosmetic surgery as a tool to help psychological disturbance is not a new phenomenon (Haiken, 1997); however, if surgeons do believe that they are treating psychological problems and wish to offer their patients competent care, it might be worthwhile for them to consider working in tandem with mental health teams (Parker, 2009).

Parker noted that surgeons decide who they will operate on based on risk factors. The surgeons understood risk as the following: the medical risk of something physically going wrong; the risk that a woman might have unrealistic expectations in terms of the outcome of a procedure; and, the motivation behind the reasons for the patient seeking surgery.

Parker (2009) found a contradiction in the interviews with practitioners. On the one hand, they talked about wanting to operate on women who were seeking to look ‘normal' and who were ‘healthy and stable' (p.177), yet, they believed that cosmetic surgery was a ‘curative option for psychological distress.’ (Ibid.) The surgeons were quite clear that they did not want to operate on a woman whose surgery expectations were unrealistic.

It is not clear how the term ‘unrealistic’ should be defined when the patient may be requesting surgery for reasons that are not just about achieving physical perfection, whereas, for the surgeon, the outcome depends on how successful the physical side of the surgery is (Ibid.).

Parker (2009) added to the debate by looking at social and cultural aspects that influence patients to have cosmetic surgery. She identified broad motivating factors including the need to fit in and wanting to feel less self-conscious, while some patients were having surgery due to ageing. Her findings indicate that women's motivations were 'internally generated but with external influence.' (p.100)

Parker looked at motivation from the doctor and patient perspective; looking at the discourse between patient and doctor and the understanding of risk between both parties. The postoperative interviews from her study gave a good perspective on the social and cultural factors influencing patients, but perhaps preoperative interviews may have developed this understanding further.

Parker (2009) stated that her study did not look at whether BDD may be a prevalent factor, or the individual psychological reasons why women decide to undergo surgery. This area is where I see the preoperative interviews from my research being able to add to existing knowledge in the field.

The societal and cultural influence

I will expand on the factors mentioned above by looking at the current literature with regards to how society views cosmetic surgery. Over time, society's position on cosmetic surgery has shifted, historically, women, especially those having facelifts, would go to great lengths to hide their surgery (Northrop, 2012). They were often quite adamant that they did not want others to find out they had had surgery and would be encouraged by their surgeons to alter their hairstyle before surgery (Ibid.). That way, if anyone commented on a change in their facial features, the women could refer to their new hairstyle as being the reason for looking different.

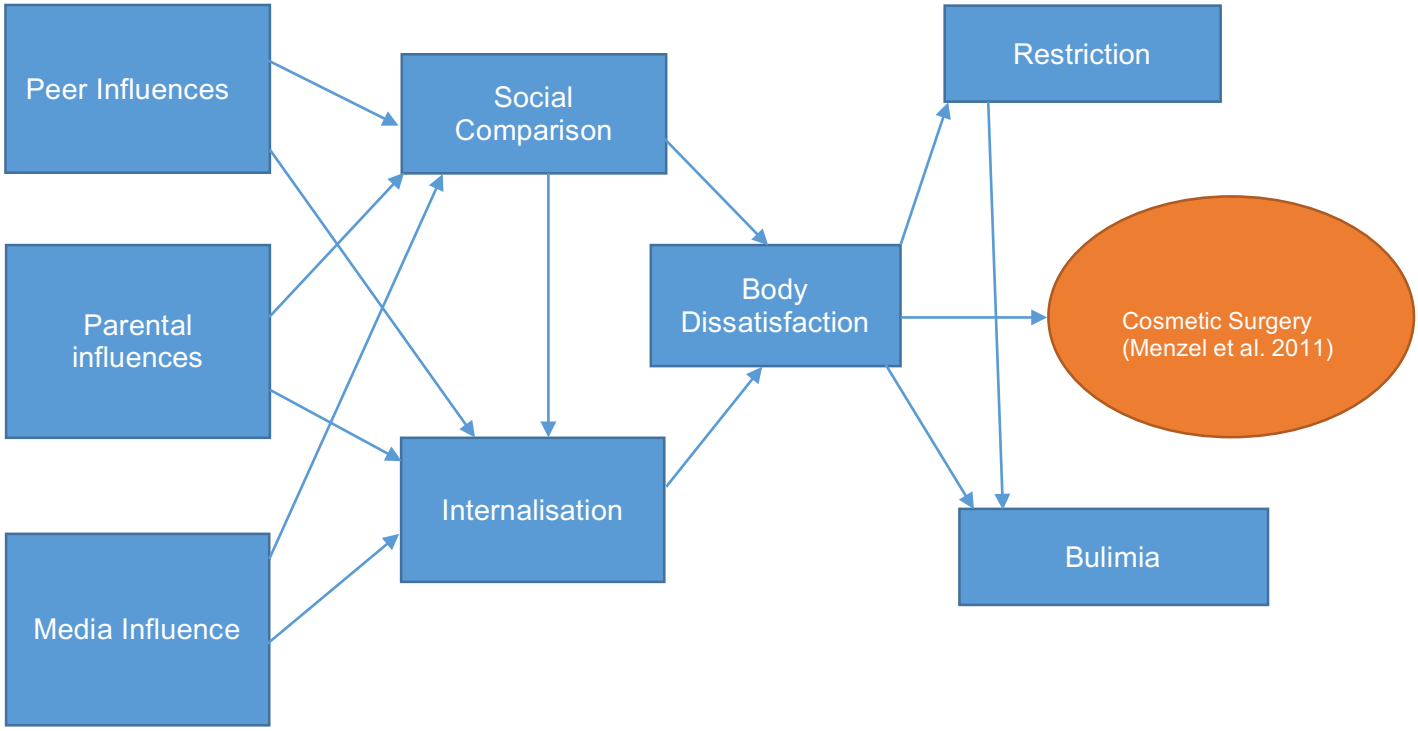
Cosmetic surgery is now much more accessible and accepted, and this means there are fewer hurdles for patients to overcome (Gimlin, 2012). Hopefully, with time, this openness and acceptance will enable people to start exploring why they actually want to have surgery, and not be afraid of negative judgement or that others might try and convince them not to have surgery.

The media portrays cosmetic surgery as 'life changing, become the person you always wanted to be.' (Mendelson, 2013: p.203) This completely downplays the seriousness of invasive surgery, giving individuals the impression that surgery is a simple fix for self-esteem and body image issues (Parker, 2009). Cosmetic surgery is thus sometimes positioned as a suitable way in which to achieve self-love and minimise the discrepancy that may exist between self and body image (Northrop, 2012).

BAAPS (2009) is starting to put limitations in place on how cosmetic surgery is marketed. CAR has also been key in raising awareness of how the media and society can influence individuals to have surgery. Quantitative studies, like those of Slevec and Tiggemann (2010) and Crockett et al. (2006), do assist in recognising how the media can influence individual attitudes towards cosmetic surgery.

Using the Tripartite Influence Model of Body Image, we can begin to understand how much societal pressure there is on people to look a certain way. The original Tripartite Influence Model of Body Image from Thompson et al. (1999), as shown in the diagram below, was used initially to understand what factors contribute to the development of eating disorders. In the original model (Thompson et al., 1999), the focus was on three primary sociocultural influences (peers, parents, and media) and two proposed mediators (social comparison and internalisation of appearance ideals) as the potential causes of body dissatisfaction and eating disturbance.

Tripartite Influence Model of Body Image (Thompson et al.,1999, p.320)



The Tripartite Model is useful in understanding motivations for cosmetic surgery, as it focuses on the endorsement of societal values regarding appearance (Menzel et al., 2011). Menzel at al. (2011) adapted the original Tripartite Model of Thompson et al. (1999), and in their adapted model, cosmetic surgery follows as an outcome of body dissatisfaction. They found that perceived pressures to undergo cosmetic surgery were directly and indirectly related to positive attitudes towards cosmetic surgery.

Their study found that perceived sociocultural pressure from peers, parents, media and others were all positively correlated with an increase in body dissatisfaction, causing a more favourable attitude towards cosmetic surgery. These pressures work indirectly to create more positive attitudes towards cosmetic surgery by increasing the internalisation of media ideals of appearance and increasing body dissatisfaction.

The findings suggest that the 'Tripartite Influence Model of Body Image may be a useful framework to examine the sociocultural and intrapersonal factors that influence cosmetic surgery attitudes in both women and men.' (p.476)

The aim of Menzel et al.'s (2011) study was to detect the relevant psychological factors that need to be considered by clinicians during the preoperative stage to determine a patient's suitability for surgery. Menzel et al.'s adapted model could help explain the increasing rate of cosmetic surgery as a result of cosmetic surgery being portrayed by the media as a realistic way to meet society's standards of appearance ideals. With more people engaging in cosmetic procedures, there are also going to be more favourable attitudes towards surgery. Menzel et al. hypothesized that one could use an adapted version of the original Tripartite Influence Model of Body Image to gain a better understanding of the motives for cosmetic surgery; however, a limitation in their study is that they did not look at the appearance comparison factor that is part of the original Tripartite Model.

Sharp, Tiggemann and Mattiske (2014) expanded on Menzel et al.'s (2011) model, by looking at the factor not explored in Menzel et al.'s research; that of appearance comparison in relation to requests for cosmetic surgery. Sharp et al.'s (2014) study helps us to understand attitudes towards cosmetic surgery from the sociocultural framework. It also elaborated on the Tripartite Model of Thompson et al. (1999) to apply it to explain attitudes towards cosmetic surgery.

Based on the Tripartite Model of Thompson (1999), and the adapted model of Menzel et al. (2011), Sharp et al. (2014) formulated a structural model with two predictors for surgery: conversations with friends and media exposure. These predictors then lead to internalisation of beauty ideals and body image comparison, and both of these factors (internalisation and comparison) cause body dissatisfaction which, in turn, leads to a favourable attitude towards cosmetic surgery.

Sharpe et al. also investigated a specific type of peer influence; namely, conversations with friends. They found that conversations with friends positively correlated with a more favourable attitude towards cosmetic surgery. This is because the conversations focus attention towards appearance issues, reinforcing the importance of appearance and advocating for appearance ideals; however, frequent appearance-related conversations with friends have also been associated with elevated body dissatisfaction (Clark and Tiggemann, 2006).

Sharp et al.'s (2014) proposed model showed that continued exposure to cosmetic surgery in the media leads to more favourable attitudes towards surgery. This makes sense, because the media normalises cosmetic surgery as being an 'acceptable' way to improve the appearance of our bodies.

The media, and in particular 'television programmes, influence women's attitudes towards cosmetic surgery by affecting the level of body dissatisfaction.' (Sharp et al. 2014, p.482) They found that when women compare themselves to idealised images in the media, 'they will almost always find themselves lacking and become dissatisfied' and this increased body dissatisfaction (p.483).

Sharp et al.'s (2014) study showed that the viewing of cosmetic surgery-related programmes is positively correlated with an interest in obtaining cosmetic surgery procedures. In Sharp et al.'s research, friend conversations strongly predicted internalisation and comparison, whereas media exposure only predicted internalisation.

Feminist perspectives

The feminist critique of cosmetic surgery is going some way to help us explore cosmetic surgery from a qualitative psychological standpoint. These studies tend to focus on women's decision to pursue surgery as being due to low self-esteem and conformity to what is seen to be the beauty norm, and narcissism (Northrop, 2012 and Davis, 1995); however, these studies are limited in their ability to help us understand women's lived experience in their bodies (Davis, 1995). In other words, how women decide to have cosmetic surgery, and how they understand their actions after surgery.

I hope that, by carrying out preoperative and postoperative interviews, this gap in the literature can be minimised. I agree with Parker (2009) that there is not enough empirical research into cosmetic surgery to help us understand why people pursue it.

There are also conflicting positions in the feminist theory on cosmetic surgery. Davis (1995), for one, looked at cosmetic surgery as being about women exercising freedom of choice. The aim of Davis' research was to understand how women's involvement in 'cosmetic surgery can be understood within the cultural context of femininity and the beauty system without attacking women for having it done' (p.13).

Davis looked more at the cultural factors influencing women's decisions, and not necessarily the intrapersonal factors that may also be present in their stories. In opposition to Davis, writers like Blum (2003), Morgan (1991), Wolf (1990), and Chapkis (1986) see a decision to have cosmetic surgery as being made against a backdrop of objectification of women's bodies and a cultural norm which does not allow for variation regarding beauty.

Blum (2003), a cosmetic surgery patient herself, takes an ethnographic position in her book. She views cosmetic surgery as the ‘oppression of women’ and sees women as victims (p.48). She draws from interviews with surgeons and some patients with whom she had conversations while they were undergoing surgery. In her book, Blum (2003) gives a detailed account of her experience of being in the operating theatre witnessing various cosmetic procedures, giving a real insight into the physical process of surgery. Where Blum’s (2003) research differs from my own, is that she does not include any interviews with patients postoperatively to hear how they felt about themselves following surgery. She also does not make much reference to herself and how she feels about her own body following surgery. My hope is that the postoperative interviews in my research will add to this existing literature.

Morgan's (1991) paper ‘Women and the Knife' draws heavily from newsprint articles in the Toronto Star, a Canadian online newspaper. She provides some useful analysis on how the media portrays cosmetic surgery and what gets left out of the messages that are communicated to the public. Morgan highlights that the media is quick to suggest surgery as an option to help with body dissatisfaction, but what is not mentioned in the advertising are the medical risks inherent in cosmetic operations; however, she also has no first-hand accounts of interviewing women who have had cosmetic procedures. If Morgan had been able to include this information, her work would have provided a more balanced view of how the media impacts upon women and whether the impact is to the extent that she claims in her paper.

Blum (2003) and Morgan (1991) feel quite strongly that women should be discouraged from having surgery and are quick to disagree with writers like Davis (1995) who are trying to further our understanding of why females pursue cosmetic surgery. Blum (2003) and Morgan (1991) feel that to hold an inquiring position, like that of Davis (1995), goes against what being a feminist stands for; that of opposing the oppression of women. They believe that women should be discouraged from having surgery.

But, they are not the only writers to oppose cosmetic surgery. Both Young (1990) and Bartky (1990) have stated that we cannot consider women's reasons for undergoing cosmetic surgery as serious, and they are quick to dismiss struggles with appearance as frivolous.

Blum (2003) and Morgan (1991) provide useful insights into how the media portrays cosmetic surgery and how surgeons view their role in the delivery of surgery, although I found both these accounts to be limited in building an understanding of women's feelings about themselves post-surgery. What appears to get lost in this position are the subtle nuances of how women actually feel about their bodies and how hard it can be to exist in a body that does not feel like the norm or right.

These writers seem to overlook the fact that cosmetic surgery sits within a tension; on the one hand, it empowers and helps women renegotiate a relationship with their bodies but, on the other hand, has a disempowering effect on women when the norm of beauty is dictated by mostly male plastic surgeons (Northrop, 2012 and Davis, 1995).

We now live in a consumer-focused society, where one's appearance assumes more importance than ever. Cosmetic surgery, and especially procedures like the use of Botox, have become too much the norm of everyday beauty practice for surgery simply to be discouraged.

If we take the position of Blum (2003) and Morgan (1991) that cosmetic surgery is about historical patriarchal oppression and we discourage or negate cosmetic surgery, we are taking away an individual's freedom of choice. We are then causing oppression in another way by continuing to dictate what people can and cannot do with their bodies.

I do not feel it is helpful to hold such a binary position, stating that I am either for or against surgery. It is more useful to acknowledge that patriarchal oppression may well be present as an unconscious factor in female patients' decisions to pursue surgery. However, there are other factors, including the search for identity in an ever-changing society, an expression of freedom of choice by being able to do what one wants with one's body, and the physical challenge of living in a body that an individual may feel is unacceptable.

Instead of dividing the field further, I hope to begin to integrate these various perspectives, incorporating what the existing research from the feminist, sociological and quantitative studies tells us about cosmetic surgery.

The power of the surgeon

Medical professionals are often considered to be at the top of the hierarchal order of society through title and profession (Schon, 1983). Historically, the relationship between doctors and patients has taken on the Parent-Child transaction style, where the 'doctor knows best' and the patient accepts the doctor's response as a given (Jones and Chawathey, 2014).

The transactional analysis model first developed by Eric Berne in 1964 can further explain how this occurs. According to Berne, three ego states exist in everyone: Parent, Adult, and Child. At any moment, we can respond and behave from a different ego state.

The Parent model will come from the experiences we have of being parented. The Child, from our early infant and childhood experiences and the Adult develops as we grow and develop the rational part of our minds. These experiences act as a blueprint for how we interact with various people. Transactions between two people can at any moment in time be Parent - Parent; Parent - Child; Child - Child or Adult - Adult (Ibid.).

Depending on our life experiences, we will also respond differently to people with authority (doctors, nurses, teachers and surgeons); hence why this model is often used to help GPs understand how best to communicate with their patients, because ideally what is required is Adult - Adult communication. This is where the patient takes ownership for their care and wellbeing with additional help from the doctor, not the doctor being in charge (Jones and Chawathey, 2014), and this position is more likely to occur if both parties are responding from an Adult role. The ability that surgeons possess, to make a visible difference to an individual's appearance, increases the likelihood of this hierarchical authority as is shown in the research studies discussed below.

Blum (2003) interviewed patients undergoing surgery, asking them how they felt about the surgeons who were operating on them. She found that what surgeons say to their patients preoperatively can significantly influence the patient's decision to proceed with surgery. Sometimes, the result is that patients are convinced to have further surgical procedures that they did not think of before the initial consultation (Blum, 2003). Parker (2009) also found that the women she interviewed were impacted positively and negatively by what the surgeon said. She noted that women's feelings about their experience through surgery were influenced by the entire practice staff; from the receptionist, to the nurse, to the surgeon.

Northrop (2012), a sociologist based in the United Kingdom, carried out in-depth interviews with 30 women who had engaged in some form of cosmetic surgery or enquired about surgery. Two of the patients she interviewed were told by the surgeon that surgery was not advisable. The patient who wished to have a breast augmentation was told by the surgeon her breasts 'were beautiful and he was not prepared to operate on them' (Ibid. p.93). The second patient, who wished to have an abdominoplasty correction, was told that she would not get a better outcome by having further surgery. Both patients accepted what the surgeon said to them and decided not to proceed with surgery.

We need to consider the fact that most women having cosmetic surgery are operated on by a male surgeon, and what norm of beauty is then being consented to by these women. According to ASAPS (2017), only 14% of cosmetic surgeons are female. Women who feel that cosmetic surgery is empowering for them, underestimate the impact of the power that is present within the medical profession, and the patriarchal social order that is present in the medical field (Davis, 1995; Mendleson, 2013; and Schon, 1983).

Research from Blum (2003), Northrop (2012) and Parker (2009) shows how influential the discourse with the surgeon is; the surgeon's word is often taken as a given because he holds the knowledge and authority. This then raises the question of how consent is understood in terms of cosmetic surgery, when patient decisions are more complex due to external influences not just from society but also from interactions with their surgeon.

Familial and intrapersonal factors

I will now explore how the interaction with caregivers impacts on our body image development, and how this can sometimes lead to the development of body shame resulting in patients seeking surgery as a means of relieving some of these shameful feelings.

Attachment history

Early attachment experiences contribute to the development of an individual's body image (Mollon, 1993). We develop a sense of our body through imagining ourselves in the eyes of the other (Gerhardt, 2004). An infant's face tends to be the feature that is most commented-on and related-to in the early years of its life, and our face also tends to be the part of ourselves that we are most conscious of when we age. Infants develop a relationship with their body through the physical interactions they have with their caregivers.

How infants are responded to through mirroring, skin-to-skin contact and affect regulation all impact on their body development (Schore, 2000; Stern, 1998 and Gerhardt, 2004). The infant's experiences will sort into pleasurable and unpleasurable memory traces through the sensory information received from the caregiver (Lichtenberg, 1975; Lichtenberg et al., 1992).

Physical interactions between an infant and caregiver will impact the organising principles of the infant (Stolorow et al., 1995; Fonagy, 2001). These principles are shaped by how others viewed, listened, responded to, validated or invalidated the infant (Woolfe et al., 2010). Feelings that originate in and on the surface of the infant's body contribute to a body image; in other words, the way a caregiver physically interacts with the infant helps it to establish a sense of its own body, where it stops and the other starts (Lichtenberg, 1975).

If a caregiver consistently misattunes to an infant, research shows that there is a strong possibility the infant will adapt to whatever the caregiver can offer regarding physical contact, affect regulation and care (Gerhardt, 2004; Mollon; 2002 and Little, 1995). In adapting, the infant may unconsciously split off, disengage or fragment from the part of them that is not responded to.

Research on shame indicates that when an infant is consistently misattuned to by a caregiver, the part of them that gets split off is internalised as unacceptable and becomes an inherently unlovable part of themselves (DeYoung, 2015; Gilbert and Miles, 2002; and Sanderson, 2015). If the infant does not see love, but instead sees humiliation, anger or disapproval, the body then becomes something about which to be ashamed (DeYoung, 2015), and shaming could then become overemphasised as a developmental influence (Mollon, 2002). Ongoing misattunements leave an infant susceptible to developing chronic shame (DeYoung, 2015).

Chronic shame is a form of relational shame, and relational shame impacts an individual's ability to be in a relationship with another person and will have a lasting effect on the individual's attachment. Shame can be deeply-rooted in body-based experiences; hence shame attaches itself to our body image and appearance. How one is responded to by a significant caregiver in early childhood sets up our development as adults.

How we think we should look is intra-psychically connected to how we feel about ourselves, and if there is a mismatch it can cause distress in an individual (Thorpe et al., 2004). Body image is not static, and shifts and changes over the course of our life. It is on a spectrum from healthy to unhealthy, and a person can be at any point on this spectrum; however, an unhealthy body image leaves a person susceptible to external influences on their sense of self, and with a fragile self, there is the potential for a narcissistic trait to develop to protect this fragility (Northrop, 2012 and Pines, 1993).

Body shame

I will discuss how shame and body image connect with our attachment history, showing how these factors act as unconscious factors motivating patients to pursue surgery. Many factors will influence the image that is reflected back when we look in the mirror; from family, society or culture, and depending on whether these factors are negative or positive influences the reflection we see of ourselves.

Shame provides a framework against which we can compare ourselves and make decisions about our acceptability (Northrop, 2012). Shameful feelings can create a narcissistic presentation; however, to date, there is little research linking narcissism and body shame (Lewis, 1971). The hope is that my research will provide additional literature on our understanding of body shame and the connection with narcissism.

Body shame can be very disabling (physically and emotionally) for both men and women. An individual's demeanour portrays shame; hunched shoulders, eyes looking down, hollowed chest or flushed face (Davis, 1995). Without needing to be linked to a specific event or act, shame can lead to reactions of silence, hiding and avoidance (Gilbert and Miles, 2002). Lewis (1971) identified shame and guilt as developing through a complex interaction between social and psychological experiences. She felt that something was amiss in the current psychoanalytic understanding of the relationship between shame and guilt. Even though a gap in the literature was identified in 1971, to date there is still little research in this area and, in particular, how to work with body shame and guilt from a clinical perspective.

Differentiating between shame and guilt is essential. Both are about something, but only guilt has an object; for example, someone could say 'I am ashamed of…' whereas 'I am guilty of…' has a different experiential feel (Mollon, 1993, p.43). Something that is shameful about an individual is not separate to the person as in the case of guilt; shame is linked with our perception of ourselves and this is why it attaches itself to our body image.

Gilbert and Miles (2002) have written extensively on shame, but also make a point that 'body shame is a relatively new concept which is yet to be defined and properly understood.' (p.3) How then do we begin to understand such elusive, deeply-buried feelings if, 47 years on from Lewis's work in 1971, we are still struggling to make sense of these feelings and their impact on our body image? The mere fact of admitting that one feels shame about one's body can lead to embarrassment. It is not often that someone will say 'I feel ashamed of this or that part of my body'; instead, people tend to say, 'I feel self-conscious'. To admit to feeling ashamed is almost counterintuitive to our desire to want to belong, when belonging is interpreted as fitting in and not being different.

People with a high level of shame tend to feel inferior in the gaze of others (Gilbert and Miles, 2002). Body shame is a feeling that others look down on you because of your appearance, and external shame develops because of what we think is in the minds of others (Ibid.). Shame emerges in the gap between how we view ourselves and how we think we should look (Kaufman, 1996; Gilbert and Miles, 2002), and a fault line starts to develop which creates the feelings of shame (Northrop, 2012). To rid themselves of shameful feelings, some patients may invest heavily in body image and its transformation (Lemma, 2010).

Shame and cosmetic surgery

Evidence shows that people who are seeking some unconscious attention or acceptance from early caregivers continue to seek this into adulthood, and have possible identification issues later in life which lead them to seek cosmetic surgery (Lemma, 2010 & 2009; Meyer et al., 1960; Erikson, 1956; and Lee, 1968). To be seen and liked, the adult self of the patient is left looking for a way in which to make themselves into the perfect person.

People seek cosmetic surgery due to an unconscious belief that if they make themselves appear a certain way, the lacking or void they have from early infancy will be resolved (Lemma, 2010).

> *The body develops through our early relationships with other people; its modification invariably expresses something about the quality of internalised relationships, and impacts on both internal and external relationships.' (Lemma, 2010, p.4)*

Hardit and Hannum (2012) added to the original Tripartite Influence Model (Thompson et al., 1999) by investigating mother and father criticism and parental attachment on body dissatisfaction, attachment anxiety and body shame.

Research from Cheng and Malinkcrodt (2009) found that anxious attachment style is associated with body dissatisfaction, and therefore more internalisation of media influence and the media's portrayal of beauty ideals. According to Hardit and Hannum (2012), higher attachment anxiety means that an individual is more likely to internalise the beauty ideals portrayed in the media, and also leads a person to be more 'other' orientated and thus susceptible to negative influences from the social environment (Ibid.).

Cash and Henry (1995) found that teasing severity was correlated with a negative body image and that individuals who had reported being teased by family and/or peers reported significantly higher levels of body dissatisfaction. Therefore, lower attachment anxiety or a more secure attachment is likely to buffer individuals to some degree against the idealised images of beauty and sociocultural influences (Hardit and Hannum, 2012). Whereas, higher attachment anxiety or anxious attachment may exacerbate these influences on a woman's body dissatisfaction (Ibid.).

The cosmetic industry portrays itself as something that helps people love themselves again. The industry unconsciously taps into the individual's shame, and the individual begins to feel that cosmetic surgery is the way in which to change what it is they feel ashamed of (Northrop, 2012). Assuming others are judging you as offensive or unacceptable may give rise to feelings of shame; however, whether shame becomes an embodied feeling will depend on the fragility of one's sense of self and body image. It is important to recognise when a patient may have experienced shame in their childhood, as this may be a critical factor in their decision to pursue surgery.

Attachment history impacts whether someone develops a secure sense of self and positive self-esteem or whether they have an insecure sense of self and low self-esteem (Gerhardt, 2004; Gilbert and Miles, 2002; and DeYoung, 2015). This impact leads to some individuals being more vulnerable to the impact of media and societal pressures to look a certain way (Thorpe et al., 2004).

Research shows a correlation between those who have the most complex social situations also undergoing the most surgery (Lemma, 2010); a link I witnessed in my role as a personal assistant. There is evidence from Davis (1995), Blum (2003) and Northrop's (2012) research, indicating that patients who have a poor body image continue trying to manage their struggle by having cosmetic surgery.

How a narrative approach adds to existing research

The expectation that patients have of the surgical outcome needs to be explored, as this expectation impacts how satisfied they will be postoperatively (Rumsey and Harcourt, 2012; and Castle et al., 2002). If patients have a realistic expectation, that is a conscious factor (Meyer et al., 1960), it is more likely to be fulfilled.

One can only explore the subtle nuances behind patients' expectations by performing a qualitative study using a method such as narrative inquiry. I also agree with Thorpe et al. (2004), Dittmann (2005) and Sarwer et al. (1998, 1997) that there are far more questions than answers regarding the psychological effects of cosmetic surgery; carrying out preoperative and postoperative interviews will provide a fuller account of patients' experience.

Qualitative research is under-utilised in the plastic surgery industry; ironically, a sector where subjective outcomes (i.e. patient opinions) are more critical than traditional outcomes measured by quantitative analysis (Schauver and Chung, 2010). Quantitative methods do not seem to allow for exploration of why patients feel a particular way about their appearance, and using a method such as narrative inquiry provides the opportunity to explore the complex issues involved in patients' decisions to pursue elective surgery (Schauver and Chung, 2010).

Notable researchers in the field, such as Northrop (2012), Gimlin (2012), Parker (2009) and Davis (1995), have all used a narrative-type approach to understand society's impact on women's decisions to pursue surgery, indicating that this is a suitable method to use when analysing patients' decisions to pursue cosmetic surgery. A narrative approach lends itself well to gaining an understanding of the patients who pursue cosmetic surgery.

Stories are the nearest we can get to someone's experience, and a story has a sense of coming out of the individual's personal and social history (Clandinin and Connelly, 2000). This study will add further research to this area by building a fuller picture of patients' experiences leading to the point of their surgery and providing an opportunity to see if their narratives change postoperatively. In talking to patients in the past, it is apparent to me that they have a desire to tell the stories connected to their decisions to pursue surgery, and a narrative study provides patients with this opportunity. If we can understand the stories that lie behind patients' decisions to proceed with surgery, we can begin to understand what motivates these patients to have the surgery (Parker, 2009).

In Summary

The focus in this chapter was on the relevant qualitative and quantitative research that has contributed to our understanding of what motivates patients to seek cosmetic surgery. Statistics were included for cosmetic procedures done in the UK and the USA for the period from 1997 to 2017, to indicate just how much the demand for cosmetic procedures has increased. The contribution of quantitative research showed the prevalence of body dysmorphic disorder amongst cosmetic surgery patients. Two significant pieces of qualitative research were discussed; that of Locatelli et al. (2017) and Meyer at el. (1960).

Locatelli et al.'s study highlighted what motivates patients to seek cosmetic surgery; their findings showed recent life events as triggering psychological needs within patients which cause them to seek out surgery to meet those needs.

Thompson et al.'s (1999) original Tripartite Influence Model of Body Image was discussed and expanded on through the inclusion of the research of both Sharp et al. (2014) and Menzel et al. (2011). Both these studies adapted Thompson et al.'s (1999) original model, applying it to further our understanding of the factors that influence patients to have cosmetic surgery. Their adapted models showed how society impacts on body dissatisfaction through the way that media portrays beauty ideals, peer influence (friend conversations about appearance and surgery), and parental influences through comments and/or criticism. The internalisation of these beauty ideals was further explored in relation to how we develop a body image, how early attachment impacts on this development and the potential development of body shame. The link between body dissatisfaction and a more favourable attitude towards cosmetic surgery was shown.

The feminist studies discussed indicated how writers in this field will take a particular stance on cosmetic surgery as either being for or against it. The studies highlighted how strongly some writers feel that cosmetic surgery is another form of oppression against women, and hence should be completely stopped. The review also highlighted the power dynamic that is at 'play' between a surgeon and patient; this dynamic was shown to further influence whether or not a patient proceeds with surgery, and how many procedures a patient may have. The literature review was concluded by providing the reasons as to why a narrative type approach is appropriate to use for this particular study.

3. Methodology

Personal choice of narrative

Since the start of my training in counselling psychology and psychotherapy, I have felt that there is a divide between the personal self and the academic pieces that one is expected to deliver. The 'academic world' has felt like a place where I am supposed to use jargon-filled language and codes to discuss people's lived experiences. I have tussled with this, as I feel it does little justice to individual stories if they are reduced in this way.

Finding a research approach that would enable me to bridge the divide between the academic and personal self, felt crucial to the outcome of my research, not just to maintain sincerity and transparency (Bochner, 1997), but also for congruency within myself.

I wanted to ensure, whichever approach was used, that it would allow space to incorporate the personal stories within the academic context. A narrative approach has felt to be the least deductive and reductionist of all the approaches, and has 'sat' most congruently with me as a practitioner, person and researcher. I did not want to force the patients' stories into theoretical constructs; rather, I wanted to look at what emerged organically from their stories and use what developed as the codes to form the basis for my analysis (Bochner, 1997).

Knowing that I wanted to work organically with my data, I had not recognised how personally challenging this would be. My challenge has been to think alongside the stories of the patients and not deductively turn the stories into data and codes just to test my pre-held theoretical position (Ellis, 1995). My aim was not to give a historical reconstruction of the patients' lives, but instead to provide a story of how each patient sees themselves physically and psychologically at this point in their life.

The objective of doing in-depth preoperative and postoperative interviews was to learn about the patients' reality, meanings and interpretations of their decisions to pursue surgery at this particular time in their lives, aligning with the social constructionist position (Rubin and Rubin, 2012).

As an Integrative Psychotherapist and Counselling Psychologist, it is essential to understand a patient and their presenting issue as existing within a complex context, whereby factors from childhood, culture, society and adulthood influence who is present and sitting in front of me in the therapy room. I wanted to see the women I interviewed as individuals with their own story.

Philosophical stance

A social constructionist position is in line with this research, because there is a focus on the patient's journey through their surgery, and taking this approach means that there is scope to acknowledge the impact of society on the patient's decision to pursue surgery. The basis of knowledge stems from the reality around us, and what we know in life is given meaning by our surrounding context (Ritchie and Lewis, 2003).

The development of this research is seen as taking place through shared culture, self, history and dialogue (McNamee & Gergen, 1992). This philosophical position aligns with my ethos as a Counselling Psychologist and Psychotherapist as being a co-constructed relationship (Woolfe et al., 2010). Many factors will influence the lens through which I interpret the data; from my own culture, history, life experiences and educational understanding of the field, as well as the bias that I bring to the research (Denzin, 1992).

Bochner (1997, p.425) states that 'knowledge is not neutral; it can never be disinterested.' To manage this reality, I have kept a reflective journal throughout my research, noting down my thoughts and feelings throughout the process; an excerpt is shown in Appendix 7.

I also conducted a self-interview with a colleague, to better understand my values and judgements on cosmetic surgery. This self-interview proved crucial in helping me to make sense of how my family history and life experiences would impact on the position I took in this research.

The social constructionist perspective means that narrative sits at the intersection of the patient's history, culture and society and that of the researcher (Hunter, 2010). 'The social researcher is concerned to explore and understand the social world using both the participant' and researcher's understanding (Snape and Spencer, 2003 p.16-17)'. Narrative is co-constructed, and therefore my moral and ethical stance will influence the research; it can never be judgement or value-free (Hunter, 2010). According to Finlay and Ballinger (2006), there needs to be an emphasis on transparency and reflexivity throughout the research process.

Narrative inquiry

Narrative inquiry starts from the position that, in everyday life, people organise their understanding of reality in the form of narratives (Harper and Thompson, 2012). It looks at an individual's story, and through their story how they make sense of the world. How do they tell their story? For example; where and what do they emphasise, what language do they use, and who is or is not present in their account? (Clandinin and Connelly, 2000)

Narrative inquiry is appropriate to use when people are discussing major life events and life experiences (Riessman, 1993); all the patients interviewed felt their surgery would be life-changing in different ways. Narrative can also be used as a metaphor for understanding both self and identity in psychotherapy and research (Ritchie and Lewis, 2003). Our sense of self is interpreted as being socially constructed, but also continually evolving (Polkinghorne, 1995); therefore, a focus in the preoperative and postoperative interviews resulted in patients organically exploring how they felt surgery was impacting their sense of self and identity.

Using a narrative approach has enabled me to explore with patients whether any significant events in their lives contributed to their decision to pursue surgery. My choice to use narrative instead of another approach like IPA was to gain some understanding of how patients decided to proceed with surgery and not just the meaning of their particular experiences. Narrative inquiry shares with discourse analysis how culture, values and life experience all impact on the language used by an individual (Potter and Wetherell, 1987).

I hold a position that language is a tool; it is not neutral as it has the power to name things (May, 2011). We learn language through interaction with others, most notably our early caregivers. Language is the means by which we express ourselves, and make sense of our lives (Heidegger, 1978; Howard, 2000). Describing ourselves is then filled with emotional undertones from early experiences (Lemma, 2009 and 2010). Using a narrative approach allows for exploration of patients' stories to help understand their motivation for surgery and how early interactions contributed to their present sense of themselves and their body image (Lemma, 2010 and Davis).

In narrative inquiry, an important part is the collaboration between researcher and patient. It involves a process of interactive storytelling and, as the research progresses, it is crucial to construct a relationship in which my voice, as well as the patient's, could be heard (Connelly and Clandinin, 1990).

'Frame' setting for the interviews

Narrative inquiry tends to take shape as a form of therapy; therefore, any questions I asked were posed therapeutically to be sensitive and not intrusive or judgemental (Blanche, Durrheim and Painter, 2006). To understand the lens through which I have asked interview questions, and interpreted and discussed the data, it felt vital to conduct a self-interview before commencing any of the interviews with patients.

I asked a colleague to explore my views and opinions regarding the similar sorts of questions I would be asking the patients; this approach helped me understand my position on many factors, including cosmetic surgery, body image and appearance.

I recognised from my self-interview, that to start the patient interviews by asking patients how they felt about their bodies could potentially feel an intrusive question to answer. I therefore started each interview by asking the patient some general questions about how they were feeling about the interview, checking whether they were comfortable for me to start recording, and reiterating that at any time the interview could be stopped.

I realised that, for some individuals, talking about their body might be difficult and trigger feelings of shame and/or humiliation (De Young, 2015); therefore, it became apparent that I would need to establish a degree of trust between myself and the women I was interviewing. This would enable them to feel comfortable to talk about a part of themselves they may feel ashamed of, or dissociated from. My focus was on helping them to begin, informally and comfortably, talking about how they decided to have surgery (Northrop, 2012).

Northrop (2012) and Davis (1995) both used a form of narrative inquiry to explore patients' experiences before and after cosmetic surgery. Reading their findings was useful to understand what would be helpful or unhelpful concerning the interviews I was carrying out, and how best to support the patients who decided to take part.

I asked patients to tell me about themselves and their journey to date in deciding to proceed with surgery. I stayed alongside the patients, only asking questions to encourage them to go on if they became stuck (Rubin and Rubin, 2012). This interview approach lends itself well to narrative inquiry (Clandinin and Connelly, 2000). I explored the relationship that patients have with the people in their lives and the chronological organisation of events as their story unfolded (Polkinghorne, 1995).

Creating the right conditions for an interview meant that I needed to remain flexible and empathetic and adjust where appropriate to what the patients might need in different situations (Riley and Hawe, 2005). For example, for one of the patients, changing the field conditions to a video Skype interview was deemed appropriate; this change was needed because the patient had constraints on her time but was very keen to take part in the second interview. Within my reflections on the patient summaries, I had discussed the impact of using Skype and the behavioural difference of this patient from when she was in the face-to-face interview.

Recruitment

After the patients' initial consultations with the surgeon, they were approached by the surgeon's secretary and asked if they would be interested in participating in my research. If they expressed interest, they were given the recruitment letter as shown in Appendix 1, containing details of the study, and asked if their contact details could be passed to me. Once a patient's details were forwarded to me, I waited at least a week before contacting them to arrange an informal discussion about the study. This delay gave them time for reflection after the initial consultation; for most patients, meeting their cosmetic surgeon for the first time can be both exciting and daunting (Mendleson, 2013).

I contacted each patient via email, and we arranged a time to discuss my research over the phone. In the interim, I sent them the information sheet and the participant form. The documents contained detailed information about the study; the method, risks, and benefits as shown in Appendix 2. I reiterated that participation was entirely voluntary, and I also informed patients of their right to withdraw at any point. Once we had talked over the phone, if the patient wanted to participate in my research we arranged a convenient time and place to meet for the first interview.

Sampling

I recruited four female patients, who were between the ages of 18 and 45 years old. I did not specify an upper age limit, culture, or employment. Rubin and Rubin (2012) believed that to obtain in-depth data a smaller sample size should be used, as this approach allows more time to be spent with each patient and provides a fuller picture of the patient's journey through surgery. I interviewed each patient before surgery following their initial consultation with the surgeon, and then again, a minimum of one month postoperatively, to allow patients sufficient healing time before the second interview. This timeframe was discussed with the surgeon.

Exclusion

The nature of the project dictated the exclusion criteria; only female patients who were having a non-medically necessary rhinoplasty were asked to participate. In the consent form, I advised patients who had a current or prior psychiatric issue to have a further discussion with me before taking part. I did not interview anyone under the age of 18, due to the ongoing ethical debate around age appropriateness for cosmetic procedures (BAAPS, 2017).

I recruited patients from the practice where I had worked as a Personal Assistant; the surgeon's letter of consent to this is shown in Appendix 4. I reflected on my recruitment decision with colleagues, to see if there were any ethical issues to consider, and we agreed that I should keep a clear boundary between my previous role as PA and my role as researcher. I only interviewed patients I had never previously met; any patient I had supported in my capacity as PA was excluded from this research.

Limitations

A potential shortcoming in using this approach was my ability to become too subjectively involved in patients' stories; hence, it was important for me to remain reflective of my impact on the interpretation of the stories.

There is no standard set of research procedures in narrative research, and the text alone, by its nature, is linguistically subjective (May, 2011). Acknowledging this approach is co-constructed, and therefore the research will be impacted by my values and subjectivity, keeping a reflective journal during the entirety of the research project has been vital.

Data collection

In narrative inquiry, there are various methods of collecting data, including field notes of shared experiences, journal records, storytelling, and letter writing (Connelly and Clandinin, 1990). I chose to carry out unstructured interviews with each patient (Schauver and Chung, 2010).

I interviewed each patient twice, once preoperatively and once postoperatively, and each interview lasted up to 90 minutes. Narrative inquiry helped to explore the patients' stories and look at what, in their narrative, may have influenced their decision to pursue surgery. By interviewing patients postoperatively, I could investigate whether the patients' expectations for surgery were met, and if their view of themselves was different following surgery. Carrying out two interviews with each patient also allowed the opportunity for further exploration of some of the issues mentioned in the first interview (Ziebland and McPherson, 2006).

After each interview, I wrote down reflective notes about how I was feeling and what central themes were mentioned (Etherington, 2004). I listened to each of the preoperative interviews before the second, postoperative interview, to note any aspects that needed to be revisited.

The postoperative interview was slightly more structured, in the sense that we would explore some of the issues the patients had asked to revisit from their first interview, to gain greater depth. The patients were keen to use the second interview as an opportunity to compare how they felt post-surgery. 'Depth implies searching in a way that goes beyond the superficial, beyond the first response to a second and third level, and maybe more.' (Rubin and Rubin, 2012, p.131)

The second interview also provided an opportunity to ascertain that what patients said in one part of their story did not contradict another part or, if it did, to have a chance to explore this further with them (Atkinson, 2002).

Recording and storage of data

I recorded the interviews on two Dictaphones. To ensure confidentiality of the recordings, I did not save any details of the transcripts under patients' names but instead used a coding system that I stored separately. I also refrained from writing the patients' real names on any documents. I kept the recorded interviews and data in password-protected files on a locked computer to which only I had access.

Ethical considerations

I have adhered to the Metanoia Institute, Middlesex University and British Psychological Society guidelines on ethics. The Ethics Approval letter is shown in Appendix 3. In the information sheet shown in Appendix 2, I explained that if during the interview process it became apparent that a patient appeared unsure or unsettled about their decision to proceed with surgery, I would encourage them to discuss their concerns further with their surgeon and a therapist to help them better understand their decision. I also made patients aware that the final research would be going into the public domain.

I was mindful at the start of the interviews that, as a Psychotherapist, I can enquire in a way that could result in an individual talking about topics or feelings they had not anticipated mentioning (Dickson-Swift et al., 2007).

A challenge for psychotherapists carrying out qualitative research can be managing the difference between a research interview and a therapy session (Etherington, 2004). In therapy, we sometimes explore anxiety present in the room, but as it was not therapy, if patients showed signs of anxiety or distress I asked them if they wished to continue, take a break or perhaps explore something else.

Due to the sensitive nature of the material that emerged in the interview process, I used my knowledge as a therapist to remain aware that specific issues might stir up strong feelings for the patients. I endeavoured to keep their wellbeing in mind throughout their participation; I offered time to debrief following the interviews and allowed space for the patients to process and ask any further questions regarding anonymity and confidentiality that may have become important due to the material they had discussed (Ritchie and Lewis, 2003).

There was also the possibility that, following the preoperative interview, a patient might decide they no longer wished to proceed with surgery. I had taken this into account and agreed with them, should this situation arise, that they should have a further discussion with the surgeon; the surgeon was also in agreement with this course of action. I also included the contact details of a local therapist who was willing to work with the patient if issues that warranted further exploration arose from the interviews.

I explained to each patient that I would use a pseudonym when writing up the results to protect their anonymity and confidentiality; however, all four patients were keen to use their real names in the write-up.

I recognised that this could potentially be an ethical issue, and agreed with each patient that we would have a further discussion on anonymity once they had read the summary of their interviews; this approach also gave us an opportunity to explore how they felt about what they had shared. In the interim, I was fortunate to attend Kim Etherington's one-day seminar on narrative inquiry at the Metanoia Institute. This seminar helped me recognise why these patients would want to keep the story under their own names, and just how attached patients are to their personal stories. In narrative inquiry, an ongoing collaboration with the patients is such a big part of the outcome of the research (Etherington, 2004).

After completing the interviews, I also attended a webinar on ethics at Middlesex University, and this provided me with an opportunity to discuss with a senior lecturer the ethics of my research. The lecturer helped me understand how maintaining anonymity is vital to protect the wellbeing of the patients; moreover, it is compulsory that patients' names are changed to maintain confidentiality, given the nature of my research and its use of verbatim accounts.

I was then in a dilemma regarding how I could relay the importance of anonymity to the patients, without the patients feeling as though I was 'telling' them they could not keep their stories under their real names. I decided it would be of greatest benefit to have this discussion with the patients once they had read through their summaries.

Once a patient had read through their summary, I spoke to them about using their real name. It had come as a surprise to each of them how much they had talked about their family relationships, and after reading their summary and seeing how much personal information they had shared, they all agreed that they would feel more comfortable using a pseudonym. To honour each story, I asked the patients whether they would like to choose a pseudonym for themselves. Initially, two of them could not think of a name and asked me to choose one, then, after our conversations, all of them contacted me telling me that they had come up with a name they would like me to use.

This approach enabled us to co-construct a safer framework in which to hold their detailed personal summaries, while still honouring who they were and what they had been through to reach this point in their lives.

Interpretation of data

Narrative relies on more than just validity, reliability and generalisability criteria (Connelly and Clandinin, 1990 and 2000), it also uses alternatives such as trustworthiness, authenticity and transparency (Loh, 2013). Rather than looking for statistical validity (Schauver and Chung, 2010), it is more important to judge the rigour with which the study is performed.

The rigour of a study can be measured using the following criteria mentioned by Lincoln and Guba (1985):

- Transferability - how can my research be used in other clinical settings or fields, as is shown in the contribution section.
- Dependability - being transparent, clear and thorough in terms of discussing my data collection, how it is stored and how accurate it is.
- Credibility - in the form of prolonged engagement with the interview transcripts, peer debriefing after the interviews, and member checking.
- Confirmability - which includes an audit trail of my data collection as shown earlier, analysis of data, findings and recommendations, and using a reflexive journal throughout this process to monitor my subjectivity.
- Plausibility - which can be seen as an account that in some way rings true; for example, one might say ‘I can see that happening’ (Connelly and Clandinin, 1990, p.8). This is shown in the narratives in Chapter 4.

Transferability

Clandinin and Connelly (1990) mention that a vital criterion to judge value in narrative research is how 'real and alive' the research is; this is dictated by the ability to transport the reader directly into the study, its verisimilitude. Since a narrative study will look at the interpretation of personal reality, it is important that my study meets the verisimilitude criterion (Loh, 2013).

Utility is another aspect that addresses the usefulness of my study (Riessman, 2008). Will it be useful to the research community to which it is addressed; that is, to counselling psychologists, psychotherapists and plastic surgeons? Does it become a basis for other work?

Internal consistency

By carrying out a preoperative and postoperative interview with each patient, not only did it provide a fuller, deeper account of their experience, but it also verified internal consistency (Mischler, 1990) as the second interview provided an opportunity to explore with the patients any contradictions that may have emerged from their preoperative interview (Atkinson, 2002).

Dependability

It was naive of me to think that my position as researcher would not be impacted by my experience of working as a personal assistant for a plastic surgeon. I am aware that the initial driving force behind this research was to provide a platform for patients to rethink their decision to pursue surgery; however, now that I am aware of this, I can hold a more inquiring position and interest in the patients' stories. Shifting the focus of my research to narrative inquiry enabled me to become more personally interested in their stories.

Knowing that my position on cosmetic surgery was going to impact my study, I have reflected continuously on my feelings and thoughts throughout the process (Riley and Hawe, 2005). Towards the end of the patient interview process, and as I was commencing the transcribing, I met with my supervisor to discuss how I felt during the interviews as the material had evoked a strong reaction in me which I wanted to reflect upon. I noticed that my position towards cosmetic surgery and plastic surgeons had shifted.

When I started this study, I did not anticipate moving from holding plastic surgeons in high regard and seeing them as talented individuals, to questioning how they can perform surgeries that have such a big impact on women's psyche. I still view them as talented surgeons, but I struggle ethically with the morality of cosmetic surgery. In undertaking this piece of research, I am aware that my agenda is to help women explore the meaning of surgery and whether it is perhaps a search for acceptance.

With narrative, one of the outcomes could be what is termed 'narrative smoothing', especially during data collection and writing up, where the notion of 'everything works out well in the end' (Spence, 1986) comes into play. The way to be alert to this issue was to allow myself to be open and transparent and to acknowledge the stories not told, as well as the stories that were told (Kermode, 1981).

Creditability

In narrative, member checking has significant functions (Loh, 2013). It involves sending the transcribed data and summaries back to the patients, and this helped to keep my biases in check when interpreting the data (Ibid.). Member checking is the way in which I ensured trustworthiness and validity as well internal consistency (Loh, 2013, Creswell, 2009, and Fielding & Fielding, 1986). It is also ethical to allow patients to see their data and the interpretations derived from it (Etherington, 2004 and Loh, 2013).

Following each interview, I transcribed the tapes and then listened to each one again to check the accuracy of the transcriptions and ensure I had captured the intonations and meanings in what each patient had said. I then sent a copy of each transcribed interview back to the patient for checking (Lincoln and Guba, 1985 and Loh, 2013).

Confirmability (analysis)

Once the checked transcriptions had been returned to me, I began the process of analysing the transcripts; see Appendix 5 for an excerpt from a transcript.

According to Chase (2005), there are five interconnected lenses used in analysing narratives: uniqueness of human action; the narrator's choices; how social circumstances constrain the narrative; how the narrative is socially situated; and the interactions between both researcher and participants. These so-called 'lenses' have formed the basis for my coding.

Narrative does not look for 'cause and effect' or one 'truth', but more a search for the nature and meaning of a phenomenon (Connelly and Clandinin, 1990, p.7-8 and Hunter, 2010). By recognising and connecting with a story, one can imagine the particulars in the scenes described; it is these particulars that provide authenticity and plausibility to the narrative (Rosen, 1988).

I started the analysis process by familiarising myself with the data and immersing myself in the interviews. I read and re-read the transcripts to begin identifying recurrent themes (Riessman, 1993 and Smith and Firth, 2011; Ritchie and Lewis, 2003 and Pope, Ziebland and Mays, 2000). By re-reading the transcripts, I was able to create a chronicled account of the information contained in both sets of interviews for each patient.

With each transcript, I focused my analysis on the patient's decision to pursue surgery by looking at where family relationships, society, and culture may have impacted their decision (Hunter, 2010). I looked at how the patients told their stories (Riley and Hawe, 2005). An essential difference between story and narrative is that people tell stories, but narrative comes from the analysis of the stories (Riley and Hawe, 2005). I focused on who was present in each patient's story, but also who was absent, the role they might have played, and the timings in the patient's story of particular events; Gergen and Gergen (1984) describe this as looking for the 'supporting cast'. This resulted in emergent themes of loss and transgenerational body image.

I then proceeded to create a summary for each patient containing the main themes identified from the analysis. During this process, I re-listened to the tapes to ensure I was capturing the essence of individual stories and also referred back to the notes I had made after each interview. I recorded my insights, thoughts and feelings about each summary, and made notes linking my reflections to the particular patient or perhaps just the process as a whole.

My reason for preparing a summary is due to the amount of data collected from the interviews. For one patient alone, the total word count from her interviews was 25,000. In order to ensure I captured as much of the story as possible, I chose to create a six- to seven-page chapter for each patient that would represent the data collected, but in one summary.

I was keen to represent the patients' experiences along their entire surgery journey, not fragmented in the way that it is in quantitative studies which routinely separates the before and after results of surgery (Rumsey and Harcourt, 2012; Sarwer, 2002). In the summaries, I used themed titles, but not overarching themes as would be the norm in a thematic analysis (Riley and Hawe, 2005); instead, I chose to stay as close to the original story by using individual titles that emerged organically from the patient's story.

Each summary was returned to the patient for member checking. Initially, I struggled to return the summarised transcripts; however, I worked through this with a colleague and identified that I was afraid I might in some way offend or anger the patients due to the language I had used. I had become so absorbed in looking at the language used by each patient during their interview that I worried about finding the 'right' words to honour their stories. I am aware that I have a need for perfection, and began to recognise how this had played into trying to find the 'perfect' words for the patients' stories, paralleling the patients' need for perfection in their body image.

Returning the summaries to the patients meant exposing them to reading something that might evoke strong reactions. In my email to each patient, I was very clear that the summary was attached, and that it was advisable to ensure they had a suitable time and place to read it. I also offered to discuss the summary with them afterwards.

Rachel, Kerry and Sarah were happy with the way I had written their summaries and felt they captured what had been discussed with me; however, Gemma wanted me to remove some of the verbatim from her summary because she did not like reading how depressed she had felt during the first interview.

I wanted to ensure that the patients felt their stories had been honoured and respected in a way that was true and authentic (Cresswell, 2009). This process was an opportunity for the patients to add anything additional that they felt important; 'another valuable source of insight and data' (Fielding and Fielding, 1986, p.43).

Once the checked summaries had been returned to me, I started to analyse and identify the main themes talked about by each patient. The sense-making for each of the patients was contextualised by focusing on the person telling the story and by identifying the common themes across all four narratives which would later form the basis for the discussion section.

I used thematic coding to identify the key themes mentioned across the narratives (Ritchie, Spencer and O'Connor, 2003). I did not use specific codes, as this would mean moving away from the patients' stories and the narrative approach; instead, I used themes looking for particular events in the patients' lives, any relevant activities mentioned, the meaning-making of their decision to pursue surgery, the different relationships they had with people, and the cultural and contextual view (Clandinin and Connelly, 2000).

I tend to work best by seeing things visually, working from each patient's summary, I decided to prepare a conceptual diagram in the form of a mind map, as shown in Appendix 6 (White, Woodfield and Ritchie, 2003; Lofland and Lofland, 1995). This enabled me to see how and where the core themes from each summary connected, and the diagrams helped make sense of the themes that emerged from the data and to check their credibility.

This approach involved reading through each summary and noting down on a separate sheet of paper all the main issues mentioned by each patient (Ziebland and McPherson, 2006). I was then left with a single sheet per patient, identifying the core themes mentioned in their summaries, and used these single sheets to identify common themes across all the summaries.

I then created a chart listing the main themes and concurrent themes with their relevant pieces of verbatim; an excerpt from this chart is shown in Appendix 7. The broad sub-themes that emerged were; society, discourse between patient and surgeon, family (loss and separation), culture, and intrapersonal factors of shame and adolescent experiences. I also sent a copy of the final summaries to a colleague, as a form of peer validation (Mischler, 1990) to check the validity of the themes identified (Loh, 2013). My colleague blind-coded the summaries to validate the themes; this approach provided corroboration for my analysis of the data and helped me identify where my blind spots were (Hunter, 2013 and Etherington, 2004).

My colleague helped me identify where my 'lens' may have impacted the themes I chose, ensuring that I remained open and aware of what I had perhaps left out of the stories and why. An important aspect noticed by my colleague, which I had not initially been aware of, was that in the discourse of the patient, the surgeon non-verbally takes on the role of the caring Parent.

Analysing the data in this way has meant reflexively acknowledging how my social background, assumptions, positioning and behaviour have affected the research process (Finlay and Ballinger, 2006 and Etherington, 2004), and also meant providing a transparent methodological account which is so crucial to narrative as well as exploring the co-constructed meaning-making between the patients and myself. Once the list of themes was returned from my colleague, I compared it to my list and discussed any discrepancies. The final list of themes has been used as the base for my discussion (Ziebland and McPherson, 2006).

Researcher reflexivity

Throughout my data collection and analysis, I found myself shifting between writing reflective pieces to working on the discussion section, to collaborating with the patients. I noticed (and this is something discussed by Connelly and Clandinin, 1990), that various documents throughout the research journey became relevant. At the start of the analysis, I struggled with just how iterative this process can be; I wanted something more structured with a more precise layout. However, as I engaged more with the patients' stories, I am pleased that I persevered and allowed the emerging data to be more organic and far richer in depth than anything I could have anticipated.

I have had an immense amount of support academically and emotionally from a fellow student from my training institute. I met her the year before submission of this research. She was also in the process of conducting her research, and both of us found this part of our journey isolating, so we decided to arrange a weekly catch up; doing so helped each of us stay on track and gave us a sense that we were not alone in this process, and her support has proved pivotal throughout this last year of my writing-up. We would agree on a goal for the week and talk about what we struggled with if we did not achieve it.

This ongoing reflection has proved crucial for my research, because often, when I would get 'stuck' with something, it was due to the nature of what I was trying to analyse, write about or understand. One particular piece that was very challenging to work through was starting the discussion write-up on body image and shame. While writing this section one Friday, I discovered myself feeling powerful emotions of shame within my own body and recognised through reflection with my colleague just how embodied my research is, and that there was intense transference occurring during my write-up. Understanding this helped me appreciate how difficult this area is to work with from a clinical perspective.

4. The Narratives

It is not a surprise that the age demographic, as shown in Table 2 below, of the patients who agreed to participate are in line with those recorded on the ASAP's Cosmetic Surgery National Databank (ASAP, 2016). This particular age demographic on the ASAP's Databank showed the highest demand for cosmetic procedures.

Table 2: Demographics of the patients

	Rachel	**Kerry**	**Sarah**	**Gemma**
Age	21	27	37	41
Nationality	Mother Maltese Father British	Mother British Father Maltese	Both parents are British	Both parents are British
Occupation	Graduating medical student	Works for the emergency services	Legal secretary	Full-time mother
Age when first became aware of disliking her nose	Around 9	Around 13	Around 9	Around 15

Researcher's position

As mentioned in the literature section, there is a debate for and against cosmetic surgery as being disempowering for women, but the position taken within this research is not exclusive to either position. I hold a position that allows me to incorporate both the literature from the feminist and the psychological perspectives, without dismissing one over the other. Cosmetic surgery is both problematic and desirable for women. It is a complex issue with multiple layers of ethical dilemma. I agree with Davis (1995, p.181) that we need to 'learn to endure ambivalence, doubt and discomfort'; this is an important prerequisite to help us better understand the motivation that drives females to pursue surgery. This stance has enabled me to listen to the patient's stories and take them seriously, but not necessarily agree with what they say. It has helped me to explore their suffering with their bodies and think about what defences and or coping mechanisms they develop to help them manage their body-based difficulty.

Rachel

Rachel is 21 years old. She has recently finished a Master's Degree in Biomedicine. Her father is British and her mother is Maltese; she has one sister who is two years younger than her. When we meet for Rachel's preoperative interview she had already had her initial consultation with the surgeon. She was scheduled for surgery two months after the interview.

Generational challenges with appearance

Rachel's nose looks similar to both her grandmother's and her mother's and neither of them like their noses. Her grandmother said that she believes 'I was at the back of the line when looks were being given out.' Rachel says her nose came from the Maltese side of the family. Both her mother and grandmother have a 'bump' on their nose the same as Rachel. She feels she got the 'worst of the looks from my parents.' She says her father's nose has a hook on it.

Rachel wants to have the surgery because she does not want to 'waste these years that are supposed to be the best years of your life.' She also wants the surgery because she cannot 'hide' her nose, 'it is in the middle of my face'. Rachel says her sister, has a 'normal' nose and she 'envies it'. Rachel's parents have paid for her surgery so she said they will need to do something 'equally as big for my sister' because her sister always wants what Rachel gets.

Judgement based on appearance

Rachel started discussing her nose, and it transpired that she felt most self-conscious about it on meeting new people. She felt people would have a 'bad impression or judge' her because of her nose and how she felt it made her look.

When I asked Rachel why she wanted to have the surgery now, she said because she is 21 years old and she has had time to think about it, she is more mature, she has stopped growing and feels the bump has become more noticeable. Her mother said her nose got worse as she got older and Rachel is worried this could happen to her. She says her nose was not as bad her mother's and grandmother's as 'they are older; theirs has had more time grow.'

Her parents are supportive of her having the surgery, because they know how much she struggles with the issue and they want her to be happy. She feels she does not look good in photos; she says, 'I cannot do my hair and make-up well like other people.' She decided not to have any photos taken of her at her Prom because she felt she was not as 'transformed as everyone else'.

Using makeup and piercings to change

Rachel has piercings in her nose and septum and has had them since she was 19 years old. She feels that they 'improve my appearance'. She said: 'as I do not like my nose, I might as well decorate it'. She started 'experimenting with make-up' at around the age of nine, and it was around this time that she started becoming more 'aware' of her nose. She feels she looks 'worse' if she does not have make-up on. She noticed the 'bump' on her nose from around 11 years of age, but she feels it has become 'worse' since then.

Rachel says she has become 'harsher and more critical' of herself. Some people in school were not very nice to her but she does not feel she was bullied. She said she was shy when she was younger and quiet and did not want to talk to new people. She did not mind school but felt that she was not necessarily somebody who was 'noticed'.

Rachel feels she was ‘quite shy’ and would avoid getting noticed, ‘keep under the radar’ and ‘hated getting into trouble’.

> *I don’t know, I don’t know if it was an appearance thing or whatever or because I just wasn’t that confident and I was quite shy when I was younger so it might have been that as well. I hate getting into trouble, the teachers would shout at you and whatever I would just hate it yeah so I just try and keep under the radar.*

Surgery journey

Rachel feels the surgery happened very quickly and she did not have much time for the reality to ‘sink in’. She said her father was most worried because he had paid for her surgery and would blame himself if something went wrong. He felt the surgery carried more risk than Rachel thought it did. On the day of her surgery, her family felt it important that she had somebody accompany her, so her grandmother attended the hospital with her.

Rachel had surgery on the Tuesday and, while at home recovering, she decided she would bake something for her father as a thank you because she felt ‘bad’ that he had spent a long time driving to pick her up from the hospital. She says she did not feel nervous when she was due to have the splint taken off her nose because she felt ‘anything would be better’ than what she had previously. She was pleased she did not look ‘weird’ after surgery, and the bump was gone which she was very happy about.

The change since surgery

Since the splint has come off her nose Rachel says she has felt a lot better about herself; previously she would struggle to leave the house without first putting on makeup. She feels her nose does not look as ‘bad anymore and it looks nicer’.

Rachel was surprised that she had changed so much in terms of how she feels about her appearance that she forgot to put on makeup for her graduation.

> *(…) I don't worry too much anymore and like I kind of forget that I like when I drove up for graduation we stopped at the service station, and I realised oh no I am not actually wearing any makeup, like kind of gave myself a shock that I forgot I didn't have any on, kind of thing.*

Rachel feels that in the past, that would never have happened, as she would not have felt able to leave the house without makeup. She was 'shocked' that she had forgotten, but she still feels that she looks better with it on; she said 'I just don't care as much anymore.'

Sense of self

Rachel feels she does not get as nervous when she meets new people. In the past, she worried that if people saw a picture of her before they met her, they would be like 'oh, she doesn't look so kind of nice in person as she does in the pictures' because you cannot see the 'full extent' of her nose in pictures. She used to worry because she felt that in pictures she would look 'nicer' than in person, whereas in person 'they just see you'. Now, she feels there is not as big a discrepancy between what she looks like in person and what people see in photographs.

> *I don't get as nervous when I meet new people, I don't worry what they will think as much because my nose was the main issue I used to worry about anyway, because I used to think if they have sort of seen a picture of me before they meet me, I am worried they will be like oh cause you can't really see the extent of my nose and they would be like oh she doesn't look kind of, so nice in person as she does in the pictures.*

Well like before I think I was a bit worried because obviously pictures look slightly different you can select pictures that obviously you look nicer in, but obviously in person they just see you as you are, and I used to worry about my nose mainly so its just like you know if I do look different it is not as bad as I did before.

When I met Rachel for the first interview, she had quite a few facial piercings; she had to remove the piercings for surgery due to infection risk; she was not sure she would be putting them back. She felt it was not 'worth' getting them re-pierced as she no longer felt such a 'need' to have them. She feels her nose looks more 'subtle' after surgery and 'does not come up on my face as much.'

Rachel wanted to have her surgery before her graduation and summer holiday in order to be able to 'have a nicer experience at both of them.' She said the surgery had made her feel less 'self-conscious' and not as 'bad' about her appearance. Because she felt better about the way she looked, she did not feel the need to wear as much makeup on holiday.

Rachel does not want to have further surgery because she does not feel it is worth the risk. However, with her nose she felt the risk was low because 'anything would be better and could not look any worse.' After her surgery, Rachel discovered that a cousin on her mother's side also had a 'nose job' because of a bump on her nose. Rachel was surprised and found it 'weird' when she heard this, as she did not expect anybody else in her family to have cosmetic surgery.

Being in debt leads to guilt

Rachel's parents paid for her surgery as her birthday present. She feels guilty about this and feels that she needs to 'repay' them in some way. She hates the idea of being in debt to anybody; it makes her feel 'bad'.

Yeah, I do feel guilty like, one day I want to like obviously pay them back, but I would love to do something really nice for them when I have the money but that could take ages, but I will one day I will do something nice for them, because I don't like people buying me things, like I do feel bad.

She is worried her father may have sold his motorbike in order to have the funds available to pay for her surgery; he said he did not, but she is not entirely sure, so this adds to her feeling of guilt. If somebody does something nice for Rachel, she feels it is important to repay them in some way. She feels 'guilty' accepting presents from people and feels conflicted because not to accept the gift, she feels would be 'rude'.

It's you kinda like, you feel guilty but you know it's, it's rude to say no, kind of like you don't want throw it back at them and stuff yeah (laughs) it is difficult but its ok.

She said she had decided to participate in my research because if she ever needed to apply for participants for her studies later on she would then not feel guilty asking people to take part.

No longer feeling the need to cover up

Rachel said she no longer feels as 'insecure or worries' as much about her appearance. She still finds it difficult when other people take photos of her, 'because I am not in control and find it harder to pose.'

Rachel said she feels slightly more confident when meeting new people because she no longer 'second guesses myself as much as I used to.' She feels she 'comes across more well', in the past, she would worry about giving a 'bad impression' or saying 'something stupid'.

I have not met that many new people since surgery, but I think I am more confident I don't sort of like sort of second guess myself, but you know sort of talk a bit more, come across well. You know, you don't want to give a bad impression, and like say something stupid and I think oh I shouldn't have said that or come across in a bad way now yeah, I…(..)

Rachel was concerned that her nose impacted on the 'first impressions' people would have of her. She feels this dictates her 'personality' too. She feels the combination of 'not coming across well and not looking nice, made it worse.'

I don't (laughs) I guess just I don't know obviously like first impressions or appearances say something about the personality so the combination of both like not coming across well and not looking that nice could be worse than if you were just kind of like I don't know (laughs) I don't even know what I was thinking…

Rachel believes that the worry about her looks held her back. She felt that her face 'exposed' her 'because you can't hide behind anything.' Now, she no longer feels her nose 'grabs people's attention'.

Kerry

Kerry is 27 years old and works for the ambulance service. She has wanted a rhinoplasty since puberty, around the age of 13. She contacted the surgeon two years previously for an initial consultation. However, due to finances, she delayed her surgery until October 2016. We did her first interview later on in the day after her second preoperative consultation with the surgeon. I met face-to-face with Kerry for the first interview. We struggled to find a time and place that was convenient for her second interview as she works shifts for the ambulance service. She was keen to do the second interview as soon as possible, so we agreed the best option would be to use Skype.

Why surgery?

Kerry feels she had a 'button' nose before the onset of puberty and 'it was lovely'. She does not remember being bullied about her nose, more that it was the way she felt in herself. Kerry feels her nose is 'wrong' for her and she started to notice it changing when she saw photos of herself. She does not like the profile view because she says you can see a 'bump' on her nose. She also feels it looks uneven from the side.

> *Well because I hated it before, I hated the way I looked, I hated it, it was always there, like I say it was always on the forefront of my mind.*

When Kerry saw the surgeon for the initial consultation, he took some preoperative photos of her nose. Since seeing these photos, she says she has become more aware of how 'wide my nose is'. In her head, she had not imagined it being that 'wide'. Kerry feels she has been 'obsessed' with looking at the morphed pictures taken by the surgeon, so much so she wanted to try and make it a screen saver on her phone, because 'I love them' and 'I look at them every day'.

Family History

Kerry started to notice the changes in her nose around the same time that she was beginning to 'clash' with her father. I asked her if she felt the two were connected. She said no, just that she used to be a 'daddy's girl' until around the time she started secondary school, then 'I developed a mouth' and she feels her father did not like that she started to answer him back. Kerry describes her relationship with her father as being 'strained'. When she was younger, they used to 'clash a lot'. Kerry will often try to avoid her father as she finds he is the only person 'that can get to me in that way'. If something goes wrong or missing in the house, Kerry is the one to be 'blamed' by her father.

She feels her father is 'old fashioned and believes the man must be strong and should look after the woman'. She says her father earns enough money that her mother does not need to work. However, her mother enjoyed earning her own money as she does not like to rely on her husband 'because we all know what he is like when you ask him for money, so we don't ask.' Kerry once borrowed money from her father and he 'hounded' her for it, so she made a promise to herself never to ask him for any ever again. Rather than ask her father for the money to pay for her surgery, she feels it is easier to pay interest on borrowed money from the bank.

She feels her father's 'perception' of her is a 'reckless teenager' even though she was never in trouble. She felt her father thought she was the 'devil' compared to him at her age.
Kerry says that as a teenager all she wanted from her father was to know that he was proud of her, but she says he never showed that he was. She said whatever she did or achieved was never 'good enough' for him. She 'hates' having to rely on other people, so she has made it her 'mission' to ensure that she is 'independent'.

Kerry describes her nose looking quite similar to her father's.

> *(…) I'm the only one with the nose like my dad, my little brother hasn't and my sister hasn't. My brother looks like my dad um, but he doesn't have the nose, but he's got the Maltese genes, the dark skin, the dark hair, whereas all the girls in my family, we've got the English side, so the pale skin, the ginger hair so we've all got red hair, from all of us, all the girls, my sister is a bit in the middle, she's a, she's I don't know if you put us all together you can tell we are siblings, but she's got more of my mum's features um than my dad's, whereas I have got my dad's whereas my brother's got a bit of both and I'm the only one that's got an issue with it so.*

Losing those you love

Kerry's grandfather died when she was 13. She described him as 'my best friend'. Her aunt died when she was 17, and her grandmother died two years previously. All were family members on her father's side.

> *Yeah and its all been one side of the family as well, so my granddad when I was 13, Margaret (her Aunt) when I was 17, and my nan was 2 years ago, um, but yeah they all hit me differently because like I say my granddad was like my best friend, but, I was very young then, so that affected me differently, so then when Margaret died, that was different because, because at that point when she died, it is not that we weren't close, but we weren't as close as what we was prior to before my mom and dad had fallen out with her, because I hadn't had seen her, because when they had the falling out, I had wanted to keep seeing her and they wouldn't let me because they had this falling out (…)*

Kerry says she is often compared to her aunt and grandmother because they were 'mouthy and independent'. She likes being told she is similar to her aunt 'because she was strong and did well for herself.' Kerry was tearful when talking about her aunt's death, which she feels contributed to her decision to have a different relationship with her father. She feels she has re-evaluated what is 'important in life' and that it is not 'worth it' to 'constantly' argue with him.

The challenge of social situations

Kerry feels her nose is 'the first point of vision' on her face. Therefore, it will always be the first thing she will look at, and this has been the case since around the time she turned 13. Kerry says her nose impacts how she feels in social situations, so she will make sure she has put on makeup before she leaves the house, it makes her feel more comfortable and confident. When she was a teenager she would also put on makeup before going to bed. When she goes out and drinks alcohol she finds that it helps her to 'forget' about her nose, until she goes into the toilets and then feels she needs to 'touch up' her makeup just to make sure her nose 'looks alright'.

She worries when meeting new people that the first thing they will look at is her nose and she has had the occasional comment from 'strangers' about it.

> *I always felt like a lot people look at people's lips didn't they, they look at them when they are talking they look at lips, they look at eyes and whatever and obviously you see it when other people are looking at you, I always felt the first thing they are going to look it is my nose um… whether it is or not I don't know, because even it is the first thing they are never going to tell me anyway.*

She says she was bullied in school but not about her nose; she feels very sure that she is having the surgery for herself and wanted to be clear that it is not for anybody else.

Expectation from surgery - connecting body image and confidence

Kerry feels the surgery will help to increase her self-confidence. She feels her weight and nose have always been two ongoing issues on her body that are holding her back, especially from being in a relationship.

Kerry does not want to get involved with someone because she feels she will be 'putting these issues onto them'. When people give her compliments; she struggles to believe they are 'genuine'. She feels she needs the surgery to help her feel more confident in herself; she can then make the other changes she wants too, like losing weight.

Originally, Kerry wanted to lose weight before having the surgery and 'be completely new afterwards'. At the time of the interview, Kerry felt she was 'just making do with my appearance' but she hoped that after surgery she would be able to like her appearance.

> *(….) when I look at myself in the mirror, if I am getting ready to go out, I can look at myself and be like ok, I don't want to do that I want to look at myself and be like, alright, I quite like it, um, you know I don't wanna just make do, and that's what I feel like I do, make do, because I have got no other option at the moment um and that's what I feel like I have done so far is just make do, because that's what I have had to do, I have no choice but to, its either that or go the complete opposite way and do nothing for myself and just kind of go into a bit of a pit(….).*

Kerry expects that the surgery will change how she feels about herself, 'so that I can look in the mirror and my nose not to be the first thing that I look at.' She is hoping it will increase her confidence, 'because you cannot hide it under clothes like you can other parts of your body.'

(...) I will look in the mirror and be like ok, but I'm hoping to look in the mirror and be pleased with what I see, for once, yeah it would be quite nice, because I am always like nip tucking and everything, like I am literally pulling it, pushing it like just to see what I don't like about it, um…but yeah definitely, I am hoping that it does increase my confidence, because you know its your face its different, if it was hidden somewhere under clothes it's horrible, but at least it's hidden.

Meeting the surgeon

Kerry decided on the surgeon she wanted to use after watching a documentary about cosmetic surgery called *Botched up Bodies* which featured this particular surgeon.
Kerry says she was 'instantly at ease' with the surgeon from the 'minute I walked in for the first consultation even though it was only 15/20 minutes.'

Kerry felt it was important to her to find a surgeon whom she felt she could trust.

You are never going to please everyone, but if I can sit there and say that I feel comfortable and that's what he makes me feel, comfortable, he makes me feel at ease, I feel quite calm when I am sitting with him, like he has kind of got this like, I don't know what he does, he has kind of got this like thing about him where he does just make you really calm and um if I can sit there and feel that, and be happy with that, then I can trust someone like that to do that, and as I say, maybe it has taken me, maybe it has got to this point where I have had to find someone like that, for me to kind of go ahead with this, yeah maybe, I never really looked into it before, I looked into surgeons before, not in depth and I have never met any of them before either, he was the first one I met.

So you knew instantly?

Yeah, yeah, completely there was nothing about him that put me off, not one thing! the minute I stepped into that office, because when I was sitting in the waiting room I was a bit like, really did not know how it was going to go, what he was like, but literally the minute I got in there, and yeah, he was, you know, he was honest with me and said yeah we can do something with this, and he explained what he wanted to do and everything, took pictures and that and yeah I was just really happy with everything, everything that happened.

When Kerry saw the surgeon for the first consultation he made some further surgical suggestions of her nose that Kerry had not considered, he said 'they would improve my nose further'.

So I knew that was obviously what I wanted to go, the bump, but I didn't want that to go and then me have like a really long nose, now I didn't even really think of that, before I went into him, all I had in my mind was that was all I needed to have done and he was saying about taking it in at um the top there as well (shows me on her nose) and then pushing the tip up ever so slightly and for me its like I don't want, I don't, I am not saying I want the perfect nose, but I don't want a miss piggy nose and I don't want a witch nose do you know what I mean, a decent nose, nice and straight, you know, um so when he kind of said about pushing it up, I was kind of like ah alright, but then actually when he was talking about it, in the second appointment he was like it's just um a very, a very minor push like a 1 mm or 2 like nothing major at all, just to make sure that when he takes that away (shows me on her nose) it doesn't kind of dip as such.

Oh, ok

Um, so that I wasn't expecting, so that bit there I wasn't expecting either to narrow it down there (points on her nose) kind of thing and give it a bit more definition, um and he said something in the last appointment, about that people, when people have that like kind of curvy bit there (shows me on her nose), if that makes sense, he said that I don't really like have that, so it is to try and make it look like I do kind of thing,

so yeah, there was a few things in there that I wouldn't really have expected as I was saying, the main thing I went in there for was the bump, it wasn't really until he started doing what he was doing, that I was like oh yeah, ok, and like I say I trust him enough to let him do what he needs to do.

Kerry cried when she saw the morphed photos because she was so happy with them.

I cried when I saw the pictures, I cried my eyes out, absolutely cried my eyes out, I was blown away, completely blown away, I love them, I loved the pictures, like I am always looking at them, always showing people

Post-operative interview done via Video Skype

Throughout the course of the second interview, Kerry kept looking at herself on the small camera on her screen and shifting her face in out of focus to look closer at her nose. When I asked her how she felt about being interviewed via video Skype, she said:

Yeah, good (laughs) because I can show off my new nose (moves her face towards the screen to bring her nose more central)

On the day of her surgery, she was very nervous and tearful, mostly about the anaesthetic. She was afraid of 'not waking up' and the 'unknown of it all'.

She said she has a habit of rubbing her nose when she is sleeping, so to avoid possibly pulling out her stitches, she decided to sleep with her hands tied behind her back for four days after surgery until her stitches were removed.

After surgery, Kerry decided to dye her hair blonde which she felt was a ‘massive change’ in comparison to the surgery. Deciding to make such a ‘massive difference’ to her hair, felt a bigger deal to her than surgery because she always knew she would have the surgery. She never questioned whether she was going to get her nose done. Regarding her hair, she never felt that ‘adventurous before’ so the change was more of a surprise. She said she had mentally prepared herself for her nose changing, but not necessarily the change in her hair colour.

Change in perception

Kerry feels the surgery has changed her perception of herself. She finds it ‘odd and weird’ that she can longer find any pre-operative photos of herself that she likes; ‘the old pictures are horrible, that’s how much of a change it’s made.’ Previously, she would have gone through the photos and thought that some were acceptable, but now she does not like any of them. She thinks photos of her before her surgery are ‘horrible’.

In the past, Kerry felt she could not look in the mirror without her nose being the first thing she would focus on. Now she says she rarely thinks about it. One of her main issues was feeling ‘self-conscious’; following surgery, she says no longer feels that way. She feels the surgery has made a ‘dramatic change, the difference is absolutely amazing’ and she thinks it is a ‘fantastic’ result. Her nose no longer feels like something that is ‘going to hold me back anymore’. She feels the difference in her appearance is ‘unbelievable’. Kerry said that the difference in how she feels about the way she looks is so dramatic for her that she was surprised because she did not expect it to have such an impact on her perception of herself.

Kerry feels she has received good feedback from friends and family. People keep saying to her ‘Kerry, you look lovely, you look like you are glowing’. She feels it is ‘nice’ that people have noticed the change in her.

After surgery, her father commented that ‘you look like you, but you don’t look like you and you no longer have a nose like mine’, to which Kerry responded, ‘that is the result I was hoping for’. Kerry feels there is a part of her that wanted to look different after surgery. She feels she now accepts that she will never be 100% happy; ‘I want the weight off now, with the new nose and the platinum hair like Barbie’.

Change in belief

Before surgery, when friends or family told Kerry they could not see a problem with her nose, she struggled to believe they were telling the truth. However, the fact that some people had not noticed the change in her nose following surgery, made her begin to wonder if they were, in fact being truthful; she was very surprised by this.

> *(…)But in my mind I suppose I don’t quite believe it, if that makes sense, in my mind I am thinking how do you not notice, come on now, don’t be stupid, but then obviously when people are seeing me afterwards and not realizing, I’m thinking, was there so much of a difference? Like I know there was a difference, I can see it, physically I can see it, when you, especially when you see the before and after shots, you can see it like, when people do see that, they are like oh yeah, I can see what you mean now, because, because, before I suppose they just knew me as me and did not see that about me if that makes sense, but I did, I always did, no one ever really looked as far as I am aware what everyone tells me, no one ever looked at me and looked at my nose. It was not the first thing that they looked, whereas as it was the first thing for me so I don’t know like…it’s quite like, I suppose it’s quite nice in a way because it says to me that maybe they weren’t lying, maybe they did not really notice before, um…*

Her surgery appears to have exceeded her psychological expectations; she did not realise she was going to like it or herself as much as she does now.

Quietening of a voice

Kerry feels that before surgery, her thoughts would often be about her nose, and she struggled for it not to be the only thing she would see and think about, especially when looking in the mirror.

> *(…) there isn't this big honking thing in my face that is constantly talking to me going look at the size of you, do you know what I mean? It's quite nice to have that voice go away, its lovely.*

We explored why Kerry felt the surgery had such a big impact on her confidence, and she believes because 'I hated the way I looked and it was always on the forefront of my mind.' She does not remember a time when she would look in the mirror, look at photos or be talking to someone and her nose not be the first thing she looked at or thought about.

Kerry feels that because she has lost quite a few family members her nose should not be such a significant issue compared to other things and people in her life. She feels that any change to her nose would be better than what she had before. Now she feels able to be happy with what she has got. If she could not have had the surgery, she feels she would just have made the best of what she had, but to know there is another option is 'fabulous'.

Sarah

Sarah is 34 years old. She works as a legal secretary and has one half-brother.
Sarah was keen to participate in my research as she felt it would be useful to have a record of how she felt through her surgery journey. Sarah believed that the surgery was going to change her 'physically and psychologically' and she wanted to remember how she felt through the process. I met with her following her second preoperative consultation with the surgeon.

Family History

Sarah's mother died of cancer the previous year, and this was the 'definitive moment' when she decided she wanted to have a rhinoplasty. She feels she lost some of her 'confidence' after her mother died, and she wants to make her life 'better' now.

> *I was always fully independent, I was always taking care of me, when something like that happens (her mum dying) although you are so independent, your anchor goes like something, that something that holds you together is gone um, I am going to cry, so yeah, something just goes, it's coming back, it's coming back.*

When Sarah was nine years old, her grandmother died. It was around this time she remembers children at school starting to make comments about her nose like 'you've got a big nose' and since then, she has wanted to have a 'nose job'.

She cannot remember telling anybody like her teachers or mother about the comments the children were making because she felt she needed to be 'independent' and felt her mother was not 'really there, she was all over the place'.

Sarah said she remembers another time at school when she was around the age of ten; the teacher asked the children to draw a silhouette of their profile. She remembers drawing the silhouette and then using scissors to 'cut off the tip' of her nose from the picture 'so it wouldn't look so pointy and long.'

Sarah does not like photos of herself because she thinks her nose looks 'quite bulbous' at the bottom. She will only have photos taken if she is doing a 'specific kind of face'. Sarah thought her mum had the 'cutest nose'. She thinks her aunt's nose is 'horrible and dodgy like my granddad on my mum's side.' Sarah is very sure her mother would have had a facelift if she could afford it. However, she did not like the idea of her mother having any surgery.

Sarah found it 'strange' to hear herself say this when she herself is having it done. When I asked her why this was, she said she thought her mother was 'fine' the way she was. She said she feels 'hypocritical' hearing herself say that, because she believes her mother would have said the same to her, that she was fine and did not need surgery. Sarah started talking about her postoperative care and mentioned that she thinks she will be a 'right mess and I won't even have my mum there to look after me.'

Consultation with the surgeon

Sarah was so excited at her initial consultation that she 'kept whacking the surgeon on the knee with excitement.'

> *It felt like, I just felt so excited yeah it felt I felt like this guy could actually change my life, mm (starts thinking about this)*
>
> *What do you mean by change your life?*

Well just make me have, that's a good point actually, what do I mean by change my life… maybe I should not have said that, it's too to, maybe that's too dramatic, just make me feel more confident because sometimes like, I don't like my profile, or so.

I think if I am having, I think when you go through a grievance everything… is different … and I think to get a little bit of me back… could be the wrong reasons why I am doing it, but to get a little bit of me back… and to do something for myself. Yeah and the reason being is because um I think because I don't have a, a dad so, it literally was just me my mum and my little brother and… I think that the whole of the time she was really ill cause it was really aggressive um… I was there looking after her, looking after my brother, holding down a full time job um managing staff, it was, just drained and there us not a lot of me left, yeah I am slowly feeling, I think, I think a part of you changes forever, but I am slowly feeling better

The surgeon asked Sarah what she did not like about her nose, and she said the 'bump and length of it'. She said she had not realised how much it her nose 'dips' until the surgeon pointed it out. Sarah commented that 'he (the surgeon) has noticed more than I did'. It was important to Sarah that she felt she could trust the surgeon she chose. The photographs the surgeon will morph of what her nose will look like after surgery need to reflect what she wants as it will indicate that the surgeon had 'picked up what I want'.

The family association

During the interview, some questions were raised in Sarah's mind as to whether she was just having the surgery for superficial reasons. She felt the interview was prompting her to think 'deeper' about why she was having the surgery and that perhaps it had a greater meaning than just her not liking her nose. She had also started to wonder if the reason she did not like her nose is because it is like her grandfather's and 'I don't like him, he is a horrible man'.

(Surprised) … let's put it this way, he was not, he was alright when I was younger I didn't have much to do with him, because he divorced my nan umm well I think even before I was born and um… they didn't have a great relationship, he used to physically abuse like my mum and her siblings then um… they were put in care because when he left my nan, my nan couldn't cope with five kids, um and then like my nan sorted herself out got the kids back, but he um…he didn't have a relationship with my mum at all so when my mom got ill that's when he reappeared on the scene

Sarah talks about the time following her mother's funeral. Sarah feels she has worked very hard not to be like any of her mother's family because she does not agree with their 'morals'. She was quite surprised to realise that this was perhaps one of the reasons she wanted surgery.

I was exhausted and then we got to my mum's house, and my aunt who was there moved my cousin into our house and he takes drugs and was sleeping in my brother's bedroom, so there was no, there was lots of stuff going on and that's why I think I have kind of like disassociated myself with my mom's family, I've got no interest their morals are just like urgh.

Shift in excitement

Sarah feels her excitement for surgery has dissipated because the reality that she is having an operation on her face had started to 'settle in'. She was anxious about not waking up after the anaesthetic, which she thought was 'ridiculous because he (the surgeon) is just so calm about it.' Sarah said when she saw the photographs of her nose on the surgeon's computer, she did not think her nose looked too bad.

She feels this is because her face looked bigger on the screen, so her nose looked more in proportion. The surgeon commented that she did not have a ‘bad nose; it just protruded from my face a bit.’

> *When I walked in the room actually my normal nose to me at that point didn’t look so bad I think because my face is on a big screen it looked bigger so I was actually like my nose isn’t actually that bad um and he said to me you know, your nose isn’t that bad you don’t have a bad nose it just protrudes you know, he said a bit too much for your face.*

Sarah was disappointed with the morphed photos; she was hoping to see more of a difference with her nose. When the surgeon pointed out the changes he had made on the images, she was able to see the difference more clearly.

The surgeon warned Sarah that her nose would not be 100% symmetrical after surgery, but the asymmetry would not be visible to anyone else, only Sarah, because she is ‘naturally’ more critical of her appearance.

Expectation from surgery

Sarah believes that when she meets people for the first time, they will look at ‘my dodgy nose’. Her expectation from surgery is that she will no longer worry about people looking at her nose. The possible benefits of surgery far outweigh the risks; this was the same for Sarah when she had the breast reduction.

Prior to her breast reduction, she would wear tops much larger than her size in order to disguise and hide her breasts to avoid ‘unwanted attention’.

How I felt about my breasts as well, I think I had so much insecurities back then being 15, I used to wear tops that were a size 14 um Deborah, to stop attraction, like… people staring and… the attention… and when I had it done it was like the best thing I have ever had done, the best thing, and the risks were your nipples could fall off, you might never be able to breast feed, they could potentially go back to the same size, I saw horrific, horrific photos and I was like I don't care it is worth the risk, everything was fine like the scarring is prefect and um I made that decision at the age of 15, and that is, I am uncomfortable with this um…and I don't like this attention.

Sarah says it is important to her that people notice the difference in her nose after surgery; she will be upset if they do not. She also wanted to have the surgery to ensure that if she ever decided to get married, she will have the 'perfect profile pictures'. She feels there is particular focus on your wedding day 'because that's when you will be photographed the most, like the photos are going to be in your house.' Marriage is important to her, because she wants to have children but would not have them out of 'wedlock'.

Postoperative interview

Before the postoperative interview, Sarah chose to go shopping and was therefore 15 minutes late arriving. She said she was not feeling good about herself because her nose was still very swollen.

Um and I am going on holiday in a few weeks so I thought I would pick up a little, it's only a little address it is only 50 quid (laughs) and then I've got to go home otherwise I will spend a fortune (laughs) but yeah that is because usually with like shopping, it's a pick you up and I know that because I had a really bad break up years ago and I used to, became addicted to shopping because it made me feel good, I never wore half the things I bought and then I realised pretty quickly that actually this is only a minute fix….

Loss of relationship

Sarah seemed more subdued in her postoperative interview. When I asked her if she was ok, she said she had fallen out with her brother and he was not speaking to her. They used to have a close relationship but he 'absolutely hates me for whatever reason.' She feels very hurt by her brother and the way he has behaved towards her.

She feels her brother has put her 'off wanting kids because I could not give myself so fully to somebody like your child and they turn around at 15 and hate you anyway.' She feels she has done a lot more for her brother than he has done for her, especially when their mother was ill. She said 'I was just thinking, there was no one out there looking out for me at the time.' Sarah feels the rhinoplasty is something she has done for herself.

> *So now do you understand why I have done the nose, I have done something for me I have done everything for everyone else and this is for me.*

Postoperative process – feeling cared for

Sarah said in the lead up to her surgery and especially on the day, she was tearful because she was so 'scared' of the anaesthetic; 'it terrified me'. The reason the anaesthetic worried her, is she was scared of 'going in so deep, I would see my mum and I would not want to come back.' She said she was worried that 'seeing her, and wanting to be with her, would be more than me wanting to come back.' She said she was so 'terrified' prior to the anaesthetic she was 'shaking'. Sarah feels that 'if there was an opportunity to have a moment with my mum, why would I not take it.'

Sarah's friends came around to her house after her surgery and did various things to help look after her, which she really enjoyed.

One of them had to wash my hair, other people came around cooking for me, I loved it, I am going to have a nose job all the time just to get the care.

Psychological and physical preparation

When patients have a rhinoplasty, they will have a cast on for about one week to help set the nose in the right position. Sarah's cast came off in just under a week, but she said she did not feel ready to have it taken off.

She would have preferred to have it on for another week. When the surgeon first took the cast off, she did not want to see her nose because she was worried she would not like it. She felt the whole process from the anaesthetic to her splint coming off, happened very quickly, and she did not have much time to prepare herself mentally.

> *I really was not ready for it to come off, I had not prepared myself enough to see it, I was not quite ready to see it.*

Sarah has been worried that because she found the surgery so easy, 'that something must be wrong or it will look bad.' She is finding it difficult being patient and waiting for the swelling on her nose to settle down because she worried 'people might look because my face looks funny.' She said my 'face is like a balloon, so swollen and hard' and she was worried about it 'dipping'. When Sarah saw some recent photos of herself, she thought she looked like she had 'an elephant's nose' due to the swelling.

The surgeon told her it will take three months for the swelling to settle and six months for the tip definition to show. At the moment, she describes the tip of her nose as being 'blunt and like a blob'. However, even with all the swelling, Sarah feels it looks better than it did before. Sarah did not anticipate her nose would take as long as it has to settle down.

She feels she did not understand what the surgeon meant when he said the ‘tip of my nose would be blunt for around six months.’ She did not understand what this ‘bluntness’ would look like on her nose, till she saw it postoperatively; ‘there is no definition it is just a blob.’

Sarah says she can still see the ‘imperfections’ in her nose. She wants it to settle down ‘a bit more’ for her to be happy with it. Even though the surgeon told her it would take six months to settle fully, she feels ‘you really have no idea how long it takes you know, its patience which I don’t have.’ She feels it would be helpful if surgeons could be more specific with patients about the postoperative process, in particular, the healing and swelling.
She thinks this would help to better prepare patients. She also feels patients need to be prepared in terms of ‘the fact that it gets worse before it gets better.’

Sarah says she was so excited at the time she had her cast off, she did not ask the surgeon the ‘right’ questions about her postoperative healing.

> *Um… I didn’t anticipate how long it would take, and like they can tell, I can sit there and sit there and say Sarah it will take about 6 months it will look really blunt…and you think ooh what does blunt mean, what does a blunt tip mean, and like yeah whatever it will heal really well (laughs) and then you wake up the next day and you like oh my god it’s worse (laughs) and then, then you see this that it’s just, there is no definition there, it’s just a blob (laughs), then you’re like oh that’s what he means, and then you can feel that there is so much more healing to be done, …*

Change in self and identity

A colleague said he could see the difference straight away, especially in her profile. Other people have also commented that her nose looks very different, which she is very happy about.

Sarah feels there is a ‘massive difference’ when looking at the before and after pictures. She says her nose was ‘huge and hideous’ before the surgery and ‘triangular’. She now feels it is more ‘subtle and feminine, kind of softer, it was so hard before.’

Sarah describes her grandfather on her mother’s side as a ‘horrible man’, and she feels they had similar noses. She is relieved she is changing and moving further away from her mother’s side of the family, who she is not in contact with and does not like. She is physically cutting off any connection; ‘we don’t have the same surname and now we don’t even have similar features.’ She now feels she has a ‘lady’s nose’

> *A lady’s nose different to my grandfather whose nose was bloody horrible, yeah mine was too crooked, too bulbous at the bottom, but now look before and after*. (Sarah shows me photos of before and after surgery pictures that she has on her phone).

Reflecting on the surgery process

Sarah says she still has physical healing to do, but also internally she feels she needs to ‘heal’. She is pleased with the result, but she feels the process was all-consuming.
We discussed how Sarah felt having been involved in my research because she had said it had a really important impact on her, so we looked at why.

> *I am pleased with the results um I am actually sad that the whole process is done, because it’s taken up so much time, like, it’s consumed so much energy, the thoughts you know, the process, all the appointments, and now its just like it, you are left, all these like medical professionals are just leaving me now (laughs). I am going to miss all of you, that have been involved in my care.*

You made me think, because I had to talk about it, rather than just with my friends, who say, we love you, we will support you…your kind of … planting the seed (laughs) that makes me think about why, rather than me just, oh I don't like my nose, I've never liked my nose, because I lived up until 33 years of having this nose now if it really did affect me when I was younger, I could've gone to doctors I could either of had it done on the NHS or I could've saved sooner.

Gemma

Gemma is 41 years old; she is married and has two girls who are aged 12 and 8. She is a full-time mother. She has one older sister and an identical twin sister. I met with Gemma for her first interview on the day of her second preoperative consultation. Due to the surgeon's waiting list, Gemma was only having her surgery six months later. We met for her second postoperative interview two months after her surgery.

Family history

Gemma remembers her nose starting to 'bother' her from around the age of 15. She feels her mother has a 'nice pointed nose' but her father has a 'big round nose', the same as Gemma's. Growing up, Gemma used to look at people's noses and think 'I want that one'.

Gemma and her twin sister both had a 'bobble' on the end of their nose. However, Gemma thinks her sister's is 'cute and not like my dad's, a lot nicer.' Her older sister has a similar nose to both her and her father, and she 'hates it'. She feels people tend to focus on whatever area of your face might not be in line with what is the 'norm'. In her mind, her nose is so 'highlighted' she feels that other people will automatically focus on it. She feels like a part of her nose is on show, a part that people should not 'normally' be able to see (due to her deviated septum). She does not like the shape of it because she feels there are 'lumps and it's horrible'.

Gemma says she has not had a good relationship with her father. She describes him as 'old-fashioned, he's very strict but is also very funny.' Her grandfather on her father's side died when her father was very young; this meant that her father went out to work at a very young age of 12 and worked in a metal factory for most of his life, a job he said he hated. She thinks he has probably suffered from depression for most of his life. Her father tells other people he is proud of his daughters but will not say it to them directly.

She feels her dad is ‘very set in his ways’ and used to put her off buying things like a car or flat because she feels he was ‘over-cautious’ and would worry that she could not afford it. She feels he put up ‘barriers’. Growing up, she wished her father would take her to places like she would hear other fathers doing with their children. Gemma feels she is very different with her own children; ‘I ferry my kids everywhere’.

The impact of the brain tumour

In 2015, doctors discovered Gemma had a benign brain tumour. At the time, it was pressing on a facial nerve and caused one-sided facial paralysis. Gemma’s face was still paralysed after the surgery and she says she just felt ‘miserable’. She became more focused on her nose, because ‘I had a massive scar and my hair was shaved.’ She also lost her hearing on the left side. Due to feeling ‘miserable’ Gemma says she started to ‘eat’. She gained three stone in weight, and she feels her nose got bigger and became more of a focus for her. The change in her face following the tumour ‘knocked my confidence’.

Gemma feels that at the moment nothing fits her body; ‘my body is horrid and I hate it’. She feels her face is never going to be the same again. Due to the tumour removal, her left eye is smaller than the right one. As a result, she will avoid making eye contact with people, so they do not look at her eye. She is worried people might look at her and think ‘ooh what is wrong with her face’ and then also notice her nose.

When Gemma tells people, she had the tumour removed they have said they wondered what was wrong with her face. This, she says, makes her feel ‘awful’ because it confirms her belief that people might think she is ‘ugly and that I look strange’. When her face was paralysed she felt she did not have any control over when it would settle down. She feels having the surgery on her nose is something she can control and change.

Gemma will try to avoid attending social events. If she has to attend she says, 'I will wear black and try and find a table that is situated in the dark' so she can hide herself away. She says the weight she has gained has resulted in her feeling that her face has 'melted, it is so fat, it's horrible'. She does not feel like her body is hers; she sees it as 'this fat thing is telling me it needs feeding'.

The surgery to remove the brain tumour took around 12 hours, so her and her family see the rhinoplasty as just a 'nip and tuck, this is a walk in the park'. Gemma's family have been supportive, saying that if she wants to have the surgery she must go ahead and do it. She feels confident about the surgery and is not worried about it. Gemma believes that even if she had not had the tumour, she would still have wanted to have the rhinoplasty. When she watches the cosmetic surgery shows, she starts to think about her nose and wants to have the surgery.

Gemma shared with me that since the age of around 17 she has suffered from depression. Her family have said she should have the surgery if it will make her happy and 'bring the old Gemma back'. She feels there is no way out of her depression, so she says she just has to live with it as 'this is as good as it gets'. Gemma believes people will often think she is 'happy and confident' when inside she feels quite different. She does this because she does not want people to think she is 'miserable'. She is looking forward to her surgery, and she said it feels like for the first time, in a long time, she has something to be excited about.

Expectation from surgery

Gemma hopes that having the rhinoplasty will make her feel 'better and normal' and motivate her to get herself 'back in shape and go out again'. She is hoping that after surgery she can look in the mirror and say, 'this is a new start, now you can get yourself sorted' and will like what she sees.

She believes the surgery will make her feel more confident and then she will feel better about herself and begin to accept the way she looks. Gemma is hoping they will go ‘hand in hand so I look better, I feel better, let’s get on with things, let’s go out’. At the moment, she would rather stay at home and hide away from people.

Gemma sees the surgery as an opportunity for her to get her body back, not just being a mother; once again feeling like a female. She is hoping the surgery will ‘kick start’ better thinking about herself. She does not feel able to change the way she feels about herself without having the surgery; ‘how can you make this work (points to her body) without that (her nose).’ Gemma feels that because her nose is always at the forefront of her mind, even if she lost the weight, she would still want to have the surgery. Her nose makes her feel like she is ‘on show’ because it is what people will look at when they meet her for the first time.

Finding the surgeon

Gemma first saw the surgeon on a TV documentary called *Botched up Bodies*. She thought to herself, ‘if only I can get him’. The results of the surgeries that she watched on the documentaries made her decide that he was the right surgeon for her. She felt ‘confident he could improve my nose’. He does charity work, so she felt he was a kind, genuine person and not just in it for the money; ‘he has a gift and is good at it’. Watching the programmes reassured her that he would be able to help her.

When she had her first consultation she was ‘excited and star struck’ to meet the surgeon, but also worried that he would see her request for a rhinoplasty as something ’superficial’. This did not happen; instead the surgeon said to her ‘yes we can do that’.

At this point, Gemma wished she had decided to do it sooner.

> *(…) so, when I said this and maybe this (points to the area on her nose) I felt like it was being a bit superficial, but he said yeah we can do that we can and it was like yeah you can do like exactly what I want obviously within reason, and he does all that charity work and you just think wow you must be such a genuine person*

Postoperative interview

Gemma was able to get a much earlier date than originally planned for her surgery. She feels the whole process happened 'really quickly' and she decided 'to just do it' and 'I ain't got to worry about it then.' The most stressful part was waiting around in the hospital before surgery. She started to think: 'oh my god am I doing the right thing?' She was surprised how easy it was, and she had no pain after surgery and no bruising. The main difference for her was that her septum was no longer deviated and she did not have a bump on her nose.

When Gemma went to see the surgeon, and have her splint removed she said, 'I was so nervous; I didn't want to see it'.

> *It looked totally different in the splint, it was a bit of a shock, because it felt smaller than I had hoped, but it wasn't it, it was just the initial reaction, so I was… I was just shocked it was such a shock, I didn't think it would be that much of a shock but it was.*

I asked her why she did not want to see it and she said because both the consultant and the nurse were present at the time. She said she just wanted to get out of the surgery 'to look at it on my own'. Gemma was worried that if she did not like it, she would feel bad saying that to the surgeon. When we met for the second interview, one of Gemma's daughters was being bullied in school. She was worried about her daughter, and a lot of what her daughter was going through reminded her of her own experience at school. Gemma said her depression started when she was at school, so she knows the impact this could have on her daughter.

Meeting Expectations

Gemma feels her nose is 'tilting' on the one side and is still quite 'solid'. Everyone, meaning her sisters, said her nose looks much better and overall, she is happy. However, 'it's just a tiny little thing' which she is not happy about, that is the 'slight tilting'. She was worried about going back to the see the surgeon for her second postoperative consultation. She felt she would need to tell the surgeon that she was not entirely happy with the outcome.

> *But I think that as well, with the surgeon and the aftercare, I think that's really important, I don't think unless you've had the surgery, you don't, when you are hoping to have the surgery, I don't think you care what happens afterwards, you just can't wait to have the surgery but at the end of it, the way I feel, I am nervous to ring them up to go back because obviously, if I did mention that I weren't happy slightly, I would hate him to think, well … that's as good as it gets, or think I don't care what you think or anything you know, I am not saying that he would say that, but I know that I've still got healing to do as well so I am thinking ah should I go back and I think yeah.*

> *I think oh would I mention it, but then in my head I would think I have to mention it because I would be unhappy with it going forward, if I mentioned it, and he said look we have tried and it wouldn't go straight, or this is cause of this, and its been bent for all of them years or whatever, then I would think ok well that's fine he has explained why it is like that, but cause I say its only a tiny little bit that's, I do think how would they respond to that and that's quite another stressful part of it thinking, if I wasn't 100% happy, I am never going to be 100% happy anyway, I am a lot happier than I was, so that's the main thing, but you just think to yourself, I have gone through this thing and I just want it to be as perfect as much as it can be for me.*

Gemma felt that surgeons could perhaps be more 'sympathetic' to their patients.

> *Yeah and that is only thing, I just want them to be a bit more sympathetic to how it will affect the patient (…) it would be nice for them to say yeah don't worry, or they can take your concerns on board and not dismiss them like straightway.'*

She is hoping the swelling will settle the way she wants because she feels she put a lot of trust in the surgeon and spent time choosing a 'good one,'

> *Sometimes you think oh I put so much, like it had to be perfect, of course nothings ever gonna be perfect, they ain't inside your head, are they? But, you just think, going to a really good surgeon, you just think that it would be the way you want, but as I say, its not over yet, I am hoping that it will just heal down a little bit and … then it will be fine.*

Side effects from the tumour overshadowing her rhinoplasty

When Gemma smiles, she feels her eye tightens from where the nerve in her face was damaged following the tumour removal. She will only be in family photos that she knows will not be posted on any social media because she thinks her face looks 'weird'. I asked her why she did not want photos of herself on social media and she said because she is worried that people might look at her and go 'what's happened' because she was 'one of them girls that was in lots of photos you know; I would get in all them photos.' Gemma believes if she did not have the problems with her eye, she would be in every single photo.

> *The thing on my face (her eye) it's like um …. I don't know, its, its like a big, like a big birthmark on my face that everyone can see you know.*

Gemma believes that if she never had the tumour and still had the nose surgery, she would 'be really happy with myself'. She is aware that, unless pointed out by her, others are unlikely to see the difference in her eyes. She feels she is 'overly obsessive' about her eye, because it is 'different' and it will take her time to get used to it. She wishes that the tumour had happened on some part of her body that is 'hidden'. She feels 'when things are fixed (corrected) you find something else to focus on'. She feels that the tumour 'knocked' her and now she does not 'look as nice' so she has to 'get up to a better stage where I feel happy with myself.'

Gemma thought that over time her face would 'go back to normal'. However, the consultant who removed the tumour has said:

> *That's as good as it's going to get, and you are lucky, you are one of the lucky ones, some people's faces are really bad'. Gemma said to me 'no one's ever gonna be happy, I think if you are taking away someone's, if you are making someone's face uglier than it was before obviously it is a problem isn't it.*

Noticing and not noticing

Gemma believes that even if she did not have the tumour she would still have wanted the surgery because she felt that the deviated part of her nose was getting worse over time. However, she was not entirely sure it was changing. Nobody had said that it had changed; it was just her perception that it had. She was planning to see a group of her friends soon, and she wanted to show them before and after pictures from her nose so they could see the difference. She says her friends have not noticed that she has had surgery and when she recently attended a family event, nobody 'noticed/decided not to say anything, bring it up in case it's embarrassing for me.' She feels 'fine' about this because it was something that 'upset me not them, so why would they notice'.

Gemma said before her surgery she had never shown her friends the part of her nose that she did not like; it was only recently and her friends said they had not noticed her deviated septum.

> *I've only just started showing umm friends this part of my nose, the bit that goes to the side, and they go I didn't even notice it was doing that because obviously they are not looking at them, they might be looking at something else, lets just say you don't walk around like that (puts her nose upwards).*

Motivation following surgery

If Gemma looks in the mirror, she now likes the image she sees, especially since losing weight. She has lost two stone and five pounds since we met for the first interview. She feels the rhinoplasty surgery 'kick-started' her into thinking:

> *Come on now, let's get back to normal…. feel a lot better, face is a lot slimmer, clothing is fitting better and into smaller sizes…. I have got me nose done, I feel a lot better, I am on better medication now, so yeah, I do feel more comfortable with myself yeah.*

Because she found the surgery 'easy' she felt she could 'give it a go with the weight, it all sort of comes together.' Losing weight felt like something she could control, and she said, 'that's it now, you have done that part (surgery), get on with your part (losing the weight).' She felt she had been given a 'head start with the new nose' and it was something to look forward to. Gemma feels she is on the home straight now and feels a lot better with new medication, weight loss and new nose: 'Something different when I look in the mirror.'

> *Yeah uh, I don't know, you just think to yourself I couldn't have got any bigger, I was so uncomfortable in myself, the way I sat, the way it was like urgh, tired and everything else, so I thought, when I had it done, I was pleased that I had it done and I weren't in pain and it was sort of like that was easy, (…) so I think seeing …the surgery was easy you feel like okay we will give it a go with the weight it all sort of comes in together.*

5. Discussion

Reflecting on the interview process

I started each preoperative interview by giving the patients a brief background to my research. I also said it was entirely up to them to decide what was relevant for them to talk about during the interview. This form of interviewing is standard procedure for narrative, and assumes that if the interviewer intervenes less, the patient is more likely to talk freely about their experience and in an order that is relevant to them in terms of priority (Denzin, 1992 and Davis, 1995). This style of interviewing resulted in narratives I could never have predicted.

I asked the patients how they felt talking about their noses, and all of them said they were 'fine' because they felt I was there out of interest and they did not fear scrutiny or judgement from me. All the patients were surprised how open they had been when they read their summaries.

Kerry was surprised, not only when she read her summary but also during her interview, to find herself talking as much as she did about the feelings she has towards her father and the guilt she still feels about her aunt's death. Kerry had talked at length about her relationship with her father and how he used to continuously 'make fun' of her as a teenager, 'which really got to me'. Gemma started off the first interview saying she did not feel there was anything significant to talk about; however, towards the end of the interview, when I asked if there was anything else she wanted to share before we finished, she had talked at length about her depression. She had spoken about how long she had been depressed and how much it had affected her life. Gemma was 'shocked' when she read her summary at how 'depressed' she was at the time we did her first interview. Gemma's journey through surgery and participation in the research was slightly different to the other three women.

The first interview with the other patients took place around a month before they had their surgery. The gap between Gemma's first interview and her surgery was much longer as she had to wait six months for surgery due to the surgeon's availability. To help 'bridge' the gap, and refresh Gemma with regard to what she had discussed in her first interview, I sent her a summary of the first interview.

The difference with the other three patients was that they had received one summary of both their interviews, and so Gemma and I had an opportunity to talk face-to-face about how she felt about what she had shared in the first interview in a way that had not occurred with the other three patients. Being able to compare what she had said and how she had felt at the time of the first interview, in comparison to how she was feeling at the second interview, highlighted to Gemma just how depressed she was at the time of the first interview.

In the first interview with Sarah, she was very anxious about the surgery because of the anaesthetic and, also, something potentially going wrong. She had raised these concerns with the surgeon, but it is interesting that at no point did the surgeon ask her if she would rather not go ahead with the surgery. Sarah had decided to go shopping before the second interview because she was feeling low about the situation with her brother, and was worried about the interview because she was feeling upset. She said she chose to go 'shopping, it picks you up'; this meant she was then ten minutes late for the interview.

This paralleled my difficulty when I did the self-interview. I also went shopping beforehand and arrived late, because there was part of me that anticipated the interview being an exposing process and shopping was a distraction. Having the time and opportunity to reflect on this experience with a colleague before starting any of the patient interviews was so useful as it helped me understand how difficult it can be for people to talk about their body image.

I recognised a need to be in front of a mirror, on my own, that gave me an opportunity to first scrutinise my reflection before sitting with someone else to discuss the relationship I have with my body. The fear of the external gaze of the other person is a powerful force and, recognising that this process had perhaps happened for Sarah, I was mindful not to be intrusive in the interview and gave her space to discuss the anxiety the interview may have triggered for her.

A way in which these patients all possibly avoided any shameful feelings concerning their decision to have cosmetic surgery was to make it an interactive event, telling friends and family that they were having the surgery. Both Sarah and Kerry said they told all their family, friends and most of their work colleagues about their surgery. Kerry thought it was 'ridiculous' that some people said they could not see what the problem was with her nose and why she wanted to have the surgery; however, talking to others about their decision to have surgery also gave them an opportunity to gauge how people might respond to them postoperatively.

A decision to have surgery is not made lightly or without years of deliberation. At the start of the first interview, all four patients were quite reserved in their responses, perhaps because of an unconscious fear that if they talked too much they might dissuade themselves from having the surgery. By the end of the interviews, they were significantly more open and descriptive in what they shared. A patient's decision to proceed with surgery seems to be a well-defended decision; this may mean that helping patients to reflect on this decision prior to surgery and understanding why they are protective of their decision is important for therapists to consider when offering therapeutic support.

A narrative approach requires building a rapport with patients so that they feel able to trust the researcher to tell their story. One way in which to 'build rapport' is to spend more time than just one interview with each patient (Lapum, 2009, p.80).

Building an alliance with these patients clearly resulted in an element of trust developing between myself and the patients as they were all more relaxed in the second interview; they also went into greater depth about their desire to have the surgery and their hopes and expectations of the outcome.

I found, just as Davis (1995) did, that there is a release that happens for these patients once they have had surgery and they can talk about what they previously felt they needed to keep 'hidden'. Both Gemma and Kerry talked about 'physically' hiding themselves from others. The parallel here is that these patients buried the feelings, thoughts or physicality that they feared would be negatively judged or criticised by others, and the relief experienced by each of them in their second interview is palpable.

The interviews seemed to function as an opportunity for the patients to talk openly about something that for so long had been a carefully 'guarded secret' (Davis, 1995, p.96).

A good example of the openness that occurred in the second interview was Sarah feeling comfortable enough to tell me her reason for being frightened of the anaesthetic. Sarah was afraid that while under the anaesthetic she might 'see' her dead mother, and this would be hard for her because she did not know whether she 'would have wanted to come back'. In the first interview, Sarah kept saying that she feared the anaesthetic but did not know why; however, in the second interview, she said she was very aware of why she had been so scared but had not wanted to say for fear that she would sound 'stupid or silly'. Sarah's narrative indicates two important themes; firstly, how psychologically impacting surgery is and, secondly, how patients can sometimes feel too afraid to discuss their true anxieties in relation to surgery, especially pre-surgery.

Each patient told a story about their childhood history, some in more detail than others. However, what was apparent from each of their stories, was how some of them had suffered the significant loss of important figures in their life (grandparent, aunt and mother), and that the losses occurred at turning points in their lives when they had become aware of a dislike of their nose.

Adolescence for all of them was a key moment when they had become aware of the shape of their nose; this is not surprising given how much the nose tends to grow and take shape around this time of life. Each of them discussed having a similar nose to a family member; Rachel said it was both her grandmother and mother, Gemma and Kerry said it was their father, and for Sarah it was her grandfather.

The patients in this research lessened their anxiety about the risks of surgery by saying 'it can't be worse than it already is'. Each patient insisted that I be clear that they were having surgery for themselves and wanted to ensure that I understood how unhappy they were and therefore needed the surgery. Gimlin (2012) found that patients in the United Kingdom justified their decision to have cosmetic surgery based on the emotional and/or physical distress their particular issue caused them.

At one point, Sarah said to me 'now do you understand why I want to have the surgery?' Hearing this made me wonder about the fear of judgement these women anticipated experiencing from me in the interviews. It seemed that they needed to prove their surgery was warranted, even though, at the start, each of them said they were not concerned about judgement from me.

Telling their stories about why they wanted surgically to alter their bodies provided these patients with an opportunity to reflect on their decisions to pursue surgery.

It allowed them to look at the events that may have contributed to their decision and understand how these events may have impacted them, possibly giving coherence and understanding to their choice. Their stories took on a 'before and after' aspect, and surgery was viewed as a turning point in their lives; however, what was very clear from these narratives is that clinicians who work with this patient group need to recognise how attachment history and shame impact on body image development and may be underlying reasons why patients seek cosmetic surgery.

It is evident from this research that cosmetic surgeons need to be much more aware of the psychological impact of surgery and how best to support their patients.

Narrative themes

The narratives of each patient revealed four overarching themes which will be discussed using the relevant subthemes that emerged (see Appendix 6 for themes with extracts of verbatim accounts).

1. **Societal factors** - acceptance of cosmetic procedures, media influence, the consultation, power of discourse and the understanding of risk.
2. **Familial factors** - loss and patriarchal separation.
3. **Cultural factors** - intergenerational body image.
4. **Intrapersonal factors** - adolescence as a primer for shame, body shame, shyness and guilt, fear of negative evaluation, the mirrored reflection, objectification of the body, and the psychological shift following surgery.

Societal Factors

Acceptance of cosmetic procedures

The findings from my research contrast with the studies of Davis (1995) and Northrop (2012) by showing how society's position on cosmetic surgery has shifted. In the past, surgery was something to hide; now, it is a more accepted way to improve your body. When Davis (1995) interviewed patients proceeding with breast surgery, all the women she talked to felt that cosmetic surgery would not be seen as acceptable and these women would have to do a lot of justifying; most of them had also tried to keep their surgery hidden from family and friends.

All four of the patients I interviewed had spoken to family members and friends about their decision to have surgery. Rachel's father was supportive but concerned about her having the surgery; he was paying for it, and he worried that he would feel guilty if anything went wrong. Kerry's father was unsure about why she wanted to have the surgery but did not try to stop her. Gemma's family were supportive and said, 'if it makes you happy, you should have it done.' Sarah's brother did not have much, if any, reaction to her deciding to have surgery. None of the patients worried about being negatively judged or feeling in any way that their decision would be seen by family members as unacceptable.

It is no longer difficult for an individual to find a surgeon who is willing to operate on them. In the past, the surgeon would decide whether the individual's appearance warranted surgery (Davis, 1995); however, now the decision whether or not to have surgery is more in the control of the patient, surgery is far more accessible.

Society's impact can be quite difficult, on mothers especially. For some mothers, what they find acceptable at home regarding their appearance they feel is not acceptable at work, and they begin to feel a strong pull to change their bodies before going out to work (Northrop, 2012).

What Gemma found acceptable at home, she would not consider acceptable in public, to the extent that she would cover herself in a coat to avoid any form of observation when doing the school run. Gemma felt that she could not allow herself to pursue any other interests outside the home; for example, the photography classes she was interested in taking. She felt that to continue living in her body the way it was, was not an option she could consider. Surgery felt to her as the only way forward to alleviate the 'disgust' she felt towards her body.

History has also had an impact on women's position in society, and this has changed significantly over the years. Following the two World Wars, there has been a distinct shift in women's roles and functions. Women went from being mothers and wives to being mobilised to keep the industrial production lines going while their husbands and sons joined the armed forces (Northrop, 2012 and Orbach, 1986). Following the end of the wars, with this newly-acquired wealth, status and responsibility, the majority of women did not wish to return to their lives as purely wives and mothers (Ibid.).

Media Influence

Advertisers play a dominant role in determining how topics are portrayed, shifting opinion in one direction or another depending on the economic need of the advertisers, glamorising what the economy needs at the time. Women's magazines have also been shown to be potent agents in shifting women's position in society (Wolf, 1991).

Sharp et al.'s (2014) adapted model of the original Tripartite Influence Model showed that continued exposure to cosmetic surgery in the media leads to more favourable attitudes towards surgery. This makes sense, because the media normalises cosmetic surgery as being an 'acceptable' way to improve the appearance of our bodies.

The media, and in particular ‘television programmes influence women’s attitudes towards cosmetic surgery by affecting their level of body dissatisfaction’ (Sharp et al., 2014, p.482). Sharp et al.’s study showed that the viewing of cosmetic surgery-related programmes is positively correlated with an interest in obtaining cosmetic surgery procedures; this was the case for both Gemma and Kerry who would watch surgeons on television programmes and feel motivated to have cosmetic surgery.

The discourse used by the media and various advertising campaigns for cosmetic surgery minimises its seriousness. Terms like ‘nip and tuck’, ‘boob job’, ‘nose job’, and ‘freshening up’ (for facelift and eyelid surgery) seem rather benign, but what they do is minimise the perceived risks of surgery so that individuals are unaware of the invasive nature of some procedures; hence, the government is asking organisations like CAR and BAAPS to look at advertising standards for cosmetic surgery and implement stricter guidelines.

Depending on the positioning of society at a particular time, body change can be viewed as mutilation, decoration, bizarre or ordinary (Davis, 1995). Gemma and Kerry both watched makeover television programmes and would then start thinking about going ahead with surgery and feeling more motivated to pursue it. Gemma commented about the difference it made to people’s lives and this made her want to have it done even more.

The media seems to act as a portal for patients to find or choose a surgeon. Gemma and Kerry had seen the reconstructive surgery work of their surgeon on television (he reconstructed disfigured children for a charity), and this immediately made him seem trustworthy; ‘he is amazing, the work he does for others, he is so talented’. They also saw him on the documentary *Botched up Bodies*; the surgeon would reconstruct women’s noses when their original surgery, carried out by a different surgeon, had not been successful.

All the patients I interviewed said that being able to trust the surgeon who was going to operate on them was hugely important. There is a parallel process in therapy. A significant factor for the success of therapy is whether there is a good enough working alliance established, and this is one of the main reasons why therapy is successful (Safran and Muran, 2003).

Most people seeking treatment of any kind, including therapy or cosmetic surgery, usually want to see somebody who has been recommended to them (Huis in't Veld, Canales, and Furnas, 2017). Trust is placed in someone by recommendation; something about familiarity, no matter how distant through the media, establishes an initial sense of trust (Ibid.). Sarah and Rachel had both been recommended to their surgeon; Rachel by a family member and Sarah by a friend.

The consultation

How surgeons and patients interact plays a vital role in patients' likelihood to go ahead with surgery. When I worked as a personal assistant for a plastic surgeon, I often heard patients come out of their consultation very surprised at how kind and supportive the surgeon had been towards the ongoing struggle with their bodies. The surgeon had offered them a solution to their problem in a reassuring and trustworthy way. Gemma felt the surgeon was a 'kind, genuine person who was not just in it for the money because of the charity work he does; he has a gift.'

Kerry said when she saw the surgeon for the initial consultation, 'he made me feel at ease; he has this quiet calm about himself, he was honest with me.' When she saw the morphed photographs of her nose on the surgeon's computer she was 'blown away, absolutely cried my eyes out, I love the pictures.'

When I talked to the patients in my research about the consultation process, they all said the surgeon focused on their medical history, i.e. were they physically fit enough for surgery, not necessarily psychologically fit. None of the patients I interviewed were asked about their psychological history and whether they had ever suffered from a mental health issue. Where the mental health of a patient is in question, surgeons feel they can gauge whether a patient should go ahead with surgery (Parker, 2009); thus the consultation between patient and surgeon will mostly be about the physical alteration that the patient is seeking and not necessarily the psychological shift they also want.

What appears not to be part of the consultation is the patient's motivation to have a result that means they will find their reflected image acceptable. All the patients I interviewed said they hoped to be able to look in the mirror after surgery and like what they saw; however, to fulfil this criterion with surgery, one needs to understand what is being used to measure whether the reflected image will be acceptable post-surgery, especially if acceptance is impacted by early attachment experience (Gerhardt, 2004). Acceptance is not just about a physical attribute; Gemma and Kerry had wanted to change their noses that looked like their fathers' noses, and both had difficult relationships with their fathers.

As discussed in the literature review (Parker, 2009 and Mendleson, 2013), there are many surgeons who feel that they are performing psychosurgery. They believe they are making changes to the body that will also influence patients psychologically; however, it does not appear, as part of standard practice, that surgeons employ the services of mental health teams.

The power of discourse

Historically, the relationship between doctors and patients has taken on the role of 'Parent-Child', where the 'doctor knows best' and the patient accepts what the doctor says (Jones and Chawathey, 2014).

This relationship sometimes results in a patient approaching a surgeon with one procedure in mind but agreeing to have further procedures suggested by the surgeon to get an optimum result (Parker, 2009, Northrop, 2012 and Blum, 2003). This discussion could lead to somebody feeling even more flawed than they did before, and the expertise of the surgeon can be a persuasive force; women in particular are likely to accept the surgeon's judgement (Parker, 2009 and Blum, 2003). The surgeon takes on a non-verbal position of becoming the critical parent with the expertise and knowledge, and potentially increasing the criticised child part of the patient (Berne, 1964). If the surgeon remains in the parent state, and the patient in the child state, the surgeon can be seen as holding the authority on what is right for the patient.

Sarah approached the surgeon because she was unhappy about the shape of her nose; especially the 'bump and length of it'. The surgeon pointed out that her nose was not 'symmetrical' and he suggested she should have this straightened. Sarah then started to focus on the fact that her nose was not symmetrical, and said she had not realised this before seeing the surgeon. When a surgeon points out further defects, it is potentially very damaging to some patients and it results in the surgeon having an enormous amount of unconscious power, deciding what is acceptable in terms of appearance.

The surgeon in the transference can become the critical parent and, if the patient is responding from a child state of consciousness, crossed transactions between the patient and surgeon can occur.

Understanding this issue with reference to Berne's (1964) Parent-Adult-Child model, if the surgeon remains in the 'parent ego' state and the patient continues in the 'child ego' state, crossed communication takes place and neither the patient nor the surgeon will be communicating from their 'adult' state.

This issue then brings into question consent, and whether patients understand what they are consenting to if their thought process at the time of the consultation is from a ‘child ego’ state; this point brings to light just how impactful the initial consultation can be for some patients.

The surgeon also induces the idea that an element of perfection is possible in surgery; this sits at odds with the reality of being left with a scar following most surgical procedures which one could argue is far from perfect.

It then becomes clear why Sarah would still proceed with surgery even though, on seeing the photos of her nose on the surgeon’s computer, ‘I did not think my nose looked that bad’. In response to this statement the surgeon said, ‘no your nose isn’t that bad, it just protrudes a bit too much for your face.’ At no point did the surgeon ask Sarah if she wanted to reconsider her decision to have surgery, and at no point did Sarah entertain the idea that she could change her mind. The patient could also be caught up in an unconscious process of wanting to please the parent-part of the surgeon, and so the option to no longer proceed with surgery is not considered for fear of disappointing the parent. Once you go past a certain point in deciding to have surgery, there appears to be no going back, no option to reconsider.

When a surgeon agrees to operate, they increase the power of the critical part of the patient by stating unconsciously ‘yes, your belief that you are not acceptable is correct, and so I will operate to fix it.’ (Jones, 2008; Jones and Chawathey, 2014) This point again shows how discourse between a patient and the surgeon can take on the role of the critical parent-child; however, where cosmetic surgery is concerned, a better outcome is likely if a dialogue takes place between adult-adult ego states (Ibid.). Ensuring that both parties are in an adult state will improve communication between a patient and surgeon; this is something that Parker (2009) also highlighted in her research, in that all the patients she interviewed mentioned the fact that communication with the medical team as a whole could be improved.

In Gemma's narrative, we can hear how her trust is placed in the surgeon, that he would be able to know 'exactly' what she was expecting from her surgery. But, after surgery, she then realises that this is impossible when she says 'they ain't inside your head are they?' She is hoping the swelling will settle the way she wants because she feels she put a lot of trust in the surgeon and spent time to find a 'good surgeon'.

> *Sometimes you think, oh I put so much like it had to be perfect, of course, nothings ever gonna be perfect, they ain't inside your head, are they?*
> *But, you just think, going to a good surgeon, you just think that it would be the way you want, but as I say, it's not over yet I am hoping that it will just heal down a little bit and … then it will be fine.*

Following her operation, Sarah was concerned about the shape of her nose. She said the surgeon came out of another surgical procedure specifically to see her and reassure her she had a 'nice nose'. This is an important theme; having a surgeon tell you that your 'defect' is now fixed and is now 'nice' postoperatively, instils the idea to the patient that they can begin to accept themselves.

In the discourse of the patient and the surgeon, the surgeon plays to the narcissistic injury, by reassuring the patient that their nose looks 'nice' after surgery. Psychologically interpreting this, 'you are now acceptable and can allow yourself to be happy again', but if you are not happy, there is something wrong with you and not wrong with the surgery.

Once again, we have the surgeon positioning themselves as the caring parent who reassures the anxious child in the patient (Jones and Chawathey, 2014). This is helpful to settle a patient's anxiety, but the adult part of the patient is not given an opportunity to express exactly what it is they are unhappy about; rather, this gets overlooked and the patient is told they have a 'nice nose'.

Surgeons start to be seen as ‘gods, transforming plain to beautiful, ordinary to celebrity, unacceptable to socially acceptable.’ (Northrop, 2012, p.173) A comment from one of the patients in Northrop’s book (2012, p.173) highlights this point when she said, ‘I would love to go into my doctor and say: “My body is a blank slate, what would you do to it?” And see what he says’. She indicates how power is handed over to the surgeon to decide how she should look. Surgery then becomes the way in which a body part is changed into something acceptable. The hope is that, following the change, the self can then look at the reflection and like what it sees and thereby accept this part again, and ultimately integrate it back into the psyche.

The surgeons interviewed by Parker (2009) stated that when patients were unhappy with the surgical outcome, the surgeons labelled these patients as having ‘psychological issues’, especially if the surgeon deemed the outcome a good result. If patients are suffering from body dysmorphia, they will often be unhappy postoperatively (Cook, Rosser and Salmon, 2006; Castle et al., 2004; Castle, Honigman and Phillips, 2002; Kisely et al., 2002; Sarwer, 2002 and Sarwer et al., 1998).

When the outcome is an unsuccessful one, psychologically, the responsibility is not necessarily returned to the surgeon for operating on this patient in the first place. What instead appears to take place is that the surgeon puts the onus back on the patient by stating that they have a mental health issue, and this is the reason they are not happy postoperatively (Parker, 2009). If surgeons do believe they are performing psychosurgery, and as BDD is classified as a psychological disorder, then technically one would expect an improvement in the mental health of this patient group following surgery not a potential decline.

Investing in cosmetic surgery to create a cohesive sense of self can be a risky strategy if the agenda of the patient and surgeon are different. One of the barriers to achieving a shared understanding is that surgeons do not seem to understand fully the patient's motivation to begin with (Parker, 2009).

Understanding risk

In cosmetic surgery, risk is not just about the physical risks of undergoing an operation, but also the psychological risks that underlie a patient's motivation for surgery (Parker, 2009). Culturally, cosmetic surgery is referred to as an individual exercising freedom of choice (Davis, 1995); however, understanding the narratives of the four patients alongside their motivating factors, this is no longer just freedom of choice. As stipulated by Gemma, it becomes a matter of necessity to find some acceptance and happiness with her body. All the patients I interviewed stated that 'the benefits of surgery far outweighed the risks'. Gemma and Kerry said they were not worried because they felt anything would be better than the way their nose currently looked.

For Gemma and Kerry, it was not an option to continue without the surgery because of the way they felt about themselves. Rachel thought she was 'wasting the best years of my life', and because she felt so 'self-conscious' she could not enjoy or participate in life the way she wanted. 'The risk of doing nothing has to be balanced against the risk of undergoing a surgical procedure.' (Parker, 2009, p.153)

Gemma said that to 'bring the old Gemma back' she needed to have the rhinoplasty; she believed that having the surgery would motivate her to lose weight and result in her feeling more confident and comfortable in herself to start going out again and socialising. Gemma felt her body was 'horrible', 'this fat thing that needs feeding', and said that if she must go out of the house, 'I will wear black and find a table in a dark corner' so that she can 'hide' herself away.

She felt ‘trapped’ in her body after the tumour, and surgery felt to her as a way of ‘taking back control’ of her body. Gemma described the surgery process and weight loss as being connected; ‘they go hand in hand, I cannot have one without the other’.

As discussed by Locatelli et al. (2017) patients have surgery due to psychological needs which get triggered by life events. In Gemma’s case, the life event is the change in her body following the tumour, which then triggers a psychological need, as mentioned by Locatelli et al., to try and reduce the discrepancy between the self-image and the ideal image. This shows how Gemma has internalised the beauty ideals that lead to her feeling dissatisfied in her body, because to her it no longer fits the norm of society.

An important question raised by Davis (1995, p.117) is:

> *To what extent does an individual’s suffering eliminate her ability to rationally assess the advantages and disadvantages of surgery? Given the enormous pressure on women to meet the prevailing standards of beauty, can we ever speak of consent that is freely given?*

Kerry felt the same way as Gemma, in that she also stated that she needed to have the rhinoplasty and would then feel motivated to lose weight. Kerry wanted the ‘bump’ gone from her nose. She felt it was obvious in profile, and this made her ‘self-conscious’; it was ‘holding me back’. Kerry believed that the feelings about her nose and her weight prevented her from being able to be in a relationship. To be with somebody now, she said, she would be ‘putting these issues’ about herself onto them, and she did not feel that would be fair. If a woman thinks her appearance is not acceptable, she might decide that she cannot participate in what is referred to as the dating game (Cooley, 1927 and Blum, 2003).

Rachel also felt her nose exposed her; ‘you cannot hide it under clothes like other parts of your body.’ Rachel said, 'I want to have surgery now because these are supposed to be some of the best years of my life, and I do not want to waste them.’ She also said she was ‘shy and quiet, I try to pass under the radar’, but felt that because of her nose she could not do this. She worried about the impression she would give people because she felt she did not look as ‘nice in person as I do in photos, you cannot see the full extent of my nose on the photos.’ Rachel felt this issue affected her personality, and she thought people judged her negatively because she was ‘shy and quiet’.

In Rachel’s narrative, we can hear how she feels that there is a discrepancy between her self-image and the image others perceive. As mentioned by Locatelli et al. (2017), this is one of the psychological needs that drives patients to have surgery. In relation to Rachel, the recent event that has triggered this need is the fact that she has finished studying and is beginning to look for work.

Sarah also hoped that the surgery would make her feel ‘more confident’, as she felt she lost confidence in herself following her mother’s death the previous year. All the patients wanted to have the surgery to feel less self-conscious; to no longer be the object of the gaze of another (Parker, 2009). Instead, the aim was to blend in or, as Rachel said, ‘pass under the radar’.

In the narratives, the idea of informed consent is shown to be a complicated issue. Using surgery, these patients attempt not only to physically remake their bodies but also, to some extent, to transform themselves, indicating how connected appearance is with a sense of self and identity (Davis, 1995).

There is a wealth of difference in the information provided to patients when it is a non-cosmetic operation; surgeons will spend far more time explaining the risks and possible adverse outcomes (Parker, 2009). Patients who are not consumers seem to be better informed than cosmetic surgery patients, and this was the case in the research of both Northrop (2012), Parker (2009), and in my findings. Surgeons will justify this difference by saying they do not want to alarm the patient or make them anxious before surgery (Ibid.).

This is a reasonable argument, but what is missed is that patients cannot give informed consent to an operation if they do not have a full understanding of what they are undertaking. Currently, cosmetic surgery patients do not have any form of non-judgemental, unbiased space to explore their feelings about their bodies (Parker, 2009). They are not supported in looking and thinking about the risks of surgery, and the information provided by surgeons is on a 'need to know' basis (Davis, 1995). The discourse that surrounds cosmetic surgery, by the way it is conveyed in the media, downplays the associated risks (Parker, 2009).

Familial factors

I will now discuss how various familial factors mentioned by each of the patients, from loss to attachment with parental figures, plays a role in motivating them to seek surgery.

Secure attachment styles are associated with higher levels of self-esteem and more positive attitudes towards others, and comfort with both closeness and separation in relationships (Bowlby, 1988). Whereas research from Cheng and Malinkcrodt (2009) found that an anxious attachment style is associated with body dissatisfaction and therefore more internalisation of media influence and the media's portrayal of beauty ideals. Evidence from the research study indicates that neither Sarah, Gemma nor Kerry have particularly secure attachments with their primary caregivers; therefore, one can assume that their attachment, especially in Sarah' and Kerry's case is likely to be higher on the anxiety level.

Hardit and Hannum (2012) state that higher anxiety means that an individual is more susceptible to internalising the beauty ideals portrayed in the media, and to negative cultural, parental and peer influences, as was also discussed in Menzel et al.'s (2011) study. Higher attachment anxiety also leads a person to be more 'other' orientated, and thus susceptible to negative influences from the social environment and especially family (Ibid.).

Loss

Sarah and Kerry had both suffered significant losses throughout their life and felt this had contributed to their decision to proceed with surgery.

Sarah was nine years old when her 'Nan' died, and she had found her death particularly hard to deal with because her grandmother had been taking care of her at the time because 'my mum was all over the place'. It was around this time that she remembers the comments starting at school that she had a 'big nose'. Sarah said she did not have anyone to talk to about this; 'I needed to be independent and deal with it myself.' One way to deal with the issue was by cutting off the tip of her nose from a picture, 'so it wouldn't look so pointy and long'.

Sarah had also lost her mother; she had died of cancer one year before Sarah decided to have surgery. It was after her mother's death that she made the decision to go ahead with the rhinoplasty. She said the surgery 'was doing something for myself', because throughout her mother's cancer treatment Sarah had looked after her mother on her own, and she felt she needed to have the surgery 'to get a little bit of me back'. Understanding Sarah's decision as a way of protecting her fragile self, it is an attempt to reconcile the effects of the separation from another, in particular her mother, and the attempt to re-establish a coherent sense of identity (Northrop, 2012). Sarah said she no longer felt the same about herself as she did before her mother died and she was hoping the surgery would help her regain some of her confidence, 'feel like my old self again', and make her feel better.

Kerry's paternal grandfather died when she was 13. She described him as 'my best friend'. It was around this time that her relationship with her father became difficult and she remembers starting to dislike her nose. She was also being bullied at school. When she was 17, her aunt, who she was close to, passed away, then two years ago, her grandmother died. All these losses have made Kerry decide she no longer wants to wait to have the surgery because 'life is too short'.

For some women, surgery is a way to rebuild the self and social identity, especially following loss (Northrop, 2012). Body image is dependent upon the integration of one's life experience, which includes the knowledge we acquire through physiological, psychological and sociological processes (Schilder, 1935 and Northrop, 2012). It makes sense that patients would then link specific events and/or deaths to their relationship with their body.

Patriarchal separation

Puberty can be a challenging time for females in their relationship with their father figure. Whether their identity is supported and encouraged by the male figure in their life, or whether it is discouraged, is going to affect how they will feel about themselves, and often this can be linked to their appearance (Parker, 2009).

Kerry said she had had a 'button' nose before puberty and it 'was lovely', but when she started puberty her feelings about her nose began to change and she felt her nose was 'wrong' for her. She had been close to her father as a child – 'a daddy's girl' – until she started secondary school and they started to 'clash'. Kerry said she became a 'mouthy teenager who would answer back.' I asked Kerry if she thought the dislike of her nose and the change in her relationship with her father were connected and she said, 'no I don't think they are.'

Kerry feels her father is the one person who ‘can get to me’. She says that growing up she was never in trouble, but feels her father viewed her as a ‘reckless teenager’. Kerry said, ‘my father thought I was the devil compared to him at that age.’ Whatever she achieved ‘it wasn’t good enough for him’ in comparison to her brother who was the ‘golden child’. All she wanted was for her father to ‘be proud of me’. Kerry’s father also held a view that men should be the ones to go out to work and wives should stay at home and look after the children. Kerry said she worked very hard to be different to her father’s view of women and ‘be independent’, i.e. earning money and owning her flat were important to her.

This is an indication of a narcissistic father, struggling to see his daughter’s separateness and accept her development into adulthood. Parental narcissism is a failure of the parent to notice the separate identity of the child (Freud, 1957). Enmeshed family systems and blurred boundaries between self and other are often present in narcissistic family systems (Brisch, 1999 and Bowlby, 1988). It would seem then, that narcissism and shame start to become self-fulfilling prophecies; the boundary between self and other is very permeable, and the self can struggle to stand firm if shame and narcissism are in the frame (Mollon, 1993 and Northrop, 2012).

Gemma also describes her relationship with her father as being ‘strained’; he is ‘old-fashioned, over-cautious, stuck in his ways, feels women should be taken care of by their husbands.’ As a teenager, she often felt that whatever she did was not ‘good enough’ for him. Her paternal grandfather had died when her father was very young, so from the age of 12, her father had had to go out to work and ended up working in a metal factory for most of his life, in ‘a job he hated’. Gemma believes her father was depressed for most of his life but never actually spoke to anyone about it. She feels their relationship is strained and often wished her father ‘would take me places like my friend’s dads did for them.’

She said her father would come home from work, never spend much time with the family, and on weekends he would go to the pub. Gemma feels she holds different views to her father and is more engaged in her children's lives than her father has been in her life.

Gemma remembers the dislike of her nose starting around the age of 17, at the same time there was also an important shift in her relationship with her father. She had finished school and her parents expected her to 'sign on' because they needed the money; however, Gemma did not want to do this and wanted to have a different life for herself, so she went out to find work. For Gemma, there was a desire to be different from her 'common' parents, by changing the way her nose looked, and going out to work instead of 'just signing on' as her parents had assumed she would do.

Both Kerry and Gemma said their noses looked very similar to their fathers' noses. Orbach's (1993) work on eating disorders, and in particular anorexia, states that sometimes individuals seek to maintain the body shape and size of a young child to continue receiving the care they may have felt at that stage of their life.

There are different perspectives from which to view Gemma's and Kerry's decisions to pursue surgery. One is that they are trying to change their nose back to how it looked before they started puberty, wanting to get the prepubescent look back, possibly feeling that this might also improve their relationship with their father (Orbach, 1993). The other position, more relevant to the narratives of these patients, is that they want to change their noses to look different to their fathers, with whom they have a challenging relationship.

For Sarah, it was her grandfather that she wanted to distance herself from. Sarah's mother is one of five children, and Sarah's grandfather used to abuse her mother and her siblings physically and then her grandmother decided to separate from him. Her grandmother was unable to look after all the children on her own and Sarah's mother was taken into care.

Sarah had a strong desire and awareness that she wanted to change the shape of her nose so that it would no longer resemble her grandfather's. She became aware of this connection in the first interview and was quite taken aback by this realisation; however, after realising the connection, she still wished to proceed with surgery.

Sarah's desire to separate herself from her grandfather has been a focus in all areas of her life. She never took on her grandfather's surname and has now changed her physical features. Sarah felt that changing the shape of her nose was the last thing that connected her to him because 'he is a horrible man, I don't agree with his morals.' He was 'nasty' to her at the time of her mother's funeral, and it was not long afterwards that she made the decision to proceed with the rhinoplasty. Again, an event and interpersonal interaction with a significant other proves to be the deciding factor for an individual to go ahead with surgery.

Northrop (2012) found that quite a few of the women she interviewed had left domineering husbands or partners and surgery was an act of defiance against them; however, in my research, the findings have been about women separating from father, grandfather, mother and grandmother, and the procedure to change the look of the nose becomes more about separating (by cutting/changing) from the part of themselves (father/mother similarity) that they are unable to accept. Dissatisfaction with the body then stems from the lack of validation and acceptance of this part of themselves.

Regarding Gemma's, Kerry's and Sarah's narratives, there is an evident desire for separation from a patriarchal family member and, for Rachel, it was the opposite; it was separation from the appearance of her matriarchal family members.

Kerry said, 'I have made it my mission to always ensure I am independent, I hate relying on people', so much so she felt it would be easier to borrow money from the bank and pay interest than to ask her father to lend her the money for her surgery.

Sarah was relieved she was now physically distancing herself from her grandfather by no longer having the same facial feature. However, there is a contradiction in these patients' pursuit to separate from their patriarchal figure. All the patients I interviewed were operated on by a male surgeon. So, in trying to separate from a father figure, they indirectly give that power to another male to decide what their appearance should be. We then understand why some feminist writers view cosmetic surgery as a form of non-verbal patriarchal oppression (Blum,1993 and Morgan, 1991).

Kerry said the reason she waited so long to have her surgery is because she needed to find somebody she could trust. The feeling she has when she is with the surgeon contrasts with how she feels with her father, who she expects to criticise her. The surgeon in the transference becomes the good object, and the father remains the bad object (Klein, 1946). Kerry described how she felt when she met the surgeon for the first time and immediately thought she could trust him:

> *If I can sit there and say that I feel comfortable and that's what he makes me feel, comfortable, he makes me feel at ease; I feel quite calm when I am sitting with him.*

There is a split that happens with these patients in the relational aspect of being with the surgeons. The surgeon is put on a pedestal, held in high regard as 'such a kind, lovely, gentleman' most likely very different from their fathers. As part of the separation process, the good object may be idealised, making it more comforting and in contrast to the bad object, their father or grandfather, who makes them feel uncomfortable (Klein, 1946).

My research findings are in line with those of Locatelli et al. (2017) that patients seek surgery for certain psychological needs which are triggered by recent life events, be that loss, separation, body change or other life changes.

As confirmed by the discussion above, for Sarah, the psychological need to regain some sense of herself had been triggered by the loss of her mother. For Gemma, the psychological need was to regain confidence in herself and get her image more in line with how she felt, which had also been triggered by a recent life event that of the tumour removal in the year prior to her surgery. For Rachel, the psychological need was also to gain a positive self-image, and this was triggered by the life event of change; she had graduated university and was due to start a job and thus a new chapter in her life. For Kerry, it was also about regaining a positive self-image, which was triggered by the loss of her aunt and her desire to want to meet a partner.

Cultural factors

A coincidence occurred in the demographics of two of the patients who participated in my research. I did not stipulate a cultural background on the recruitment letter (see Appendix 1), yet two of the patients came from a Maltese background. Both described their noses as something that was due to their Maltese origin, i.e. the size and shape of their nose being the way it was due to their Maltese heritage.

Rachel's mother and grandmother are Maltese, and Kerry's father is Maltese. According to Parker (2009), changing the shape of the nose is to some extent disavowing one's cultural identity and family heritage. When Kerry looked at her father, it was a constant reminder that unless she did something her nose would remain like his. Following surgery, Kerry's father said, 'you no longer have my nose', to which Kerry responded with, 'well that was the point'. Analysing the discourse of what this means, Kerry is saying 'I wanted to look different to you'.

When Rachel looked at her mother and grandmother she felt afraid that if she did not do something, her nose would keep getting 'bigger' because that has happened with both of theirs; 'they are older, theirs have had more time to grow'.

Intergenerational body image

Rachel said that when she was a teenager, her nose started to look more like those of her grandmother and mother. Neither her mother nor her grandmother liked their noses, and her grandmother went as far as to state, 'I was at the back of the line when looks were being given out.' Hearing this, and given the fact that Rachel felt she was starting to look more like her grandmother, the unconscious message is that the way you are beginning to look is not acceptable, as it was not for her grandmother, who is an important figure in Rachel's life.

They are a close family, with her grandmother living nearby and being regularly involved in their lives; her grandmother was the one who accompanied Rachel on the day of her surgery. The dissatisfaction with this body part is then transferred from grandmother to daughter, to granddaughter. Rachel's mother said she would also have had a rhinoplasty if she had had the money, but now she felt it was too late in her life. This is an example of the intergenerational impact of caregiver's feelings towards their bodies being passed on generationally.

Parents start out as the custodians of children's bodies (Northrop, 2012; Schore, 1994; and Gerhard, 2004). During the process of caring for their children, they start to socialise their child about what social rules (interpersonal, embodiment, and cultural values) surrounding appearance are acceptable (Northrop, 2012). Parents do this in the belief that they need to help their child fit in, to make the child's life easier.

The grooming practices they teach will often also be performed to love, care and protect their child. However, because the cultural norms that govern appearance are communicated from very early in an individual's life, it is no wonder that if a parent feels ashamed of a body part, for example their nose, this feeling can be unconsciously passed on through the generations to the child.

If parents struggle to separate themselves psychologically from their children, their child's body can then become an extension of themselves (Northrop, 2012). It becomes more of an issue when the child is born with a body part similar to that of their parents, as with Rachel. If the parent does not like this body part on themselves, this dislike may consciously or unconsciously be communicated to the child; that the child's body part is not acceptable. This feeling is further exacerbated when parents support their child in having surgery to change their body part; they give the idea that it is not acceptable the way it is.

Intrapersonal factors

The nose has been a symbol to represent Western history with aesthetic surgery (Gilman, 1999), and can be directly linked to the individual's desire to erase markers linked to possible shame-related experiences that are betrayed by its shape (Northrop, 2012). Historically, rhinoplasty surgery was used to reconstruct noses that had been amputated as punishment for a crime, so shame relating to the nose dates back to 600 BC (Gilman, 1999). Individuals can be prone to experiences of shame at times when they are emerging from identification with another, i.e. separating themselves from a parental figure (Mollon, 1993).

Adolescence as a primer for shame

Adolescence is a time when children are most vulnerable to experiencing shame (Kaufman, 1996). Significant changes occur within the body, and children start to become more aware of themselves. It is then no surprise that each patient I interviewed remembered the focus on their nose developing when they started puberty. Puberty is a significant stage when an individual is beginning to develop his or her identity and seek more independence; this is most likely the reason Kerry started to 'clash' with her father at this time. Adolescents will talk about feeling 'exposed, scrutinised and judged' (Kaufman, 1996: p.42). They also feel that others can see their 'faults and defects' as clearly as they do themselves (Ibid. p.42).

Gemma said her eye, after the tumour removal, was ‘like a big birthmark on my face that everybody can see.’ Sarah said her nose was ‘this big honking thing on my face.’ These patients describe their bodies in ways that an adolescent might do; this indicates that shame is a likely undercurrent to these feelings, as the dissatisfaction with the particular body part occurred at a time in their development when they were most prone to shame.

Shame disturbs the development of an individual’s identity, and fragmentation of identity can occur after the breakdown of a serious relationship (Lewis, 1971); this was the case for all four of the patients. The feeling of not being ‘good enough’ in the eyes of a significant other can lead to high levels of shame and, in particular, external shame (Gilbert and Miles, 2002). The experience of shame is understood as the viewing of oneself as being a failure of some kind; when one is condemned as inadequate by a significant caregiver, one then sees the defect in oneself as magnified (Pines, 1990).

Gemma and Kerry both felt that whatever they did was never ‘good enough’ for their fathers. They both wanted their fathers to be proud of them; however, neither of them ever felt that this was the case. The shame experienced by both these patients is external shame, i.e. judgement from another as not being good enough (Gilbert and Miles, 2002). External shame develops out of what we believe the other thinks of us. If what we can offer is ‘not good enough’ we can then feel shame (Ibid.). It is human nature to want to belong and be in a relationship with another; if you then feel that how you look is not acceptable to another, and especially a parental figure in your life, this is likely to have a residual effect on your sense of secure attachment within that relationship.

As discussed in the Tripartite Model (Thompson et al.,1999), peer and parental influence impacts on the development of body dissatisfaction and these are important factors that must be acknowledged when looking at a patient’s request for cosmetic surgery.

Research done by Locatelli et al. (2017), Menzel et al. (2011), and Sharp et al. (2014) found that parents, peers, media and life events trigger psychological needs in patients that they then try to meet by having surgery.

Body shame

Hardit and Hannum (2012) added to the existing Tripartite Model of Influence (Thompson et al., 1999) by investigating mother and father criticism and parental attachment on body dissatisfaction. Parents indirectly/directly, through teasing or verbal commentary, foster internalisation of beauty ideals, and this becomes more heightened if the child experiences ongoing comments that result in shameful feelings (Ibid.). A child persistently teased or criticised, be it directly or indirectly by a parent and or peers, is unlikely to have a secure attachment and high self-esteem.

An individual with low self-esteem is more susceptible to internalising beauty ideals, being impacted by conversations with friends and family about their body and the media's normalisation of cosmetic surgery (Menzel et al., 2017). These factors then have a further impact by causing a favourable attitude towards having cosmetic surgery (Ibid.)

As is shown in the findings of my research, Rachel had conversations about surgery and her appearance on an ongoing basis with both her mother and grandmother. Kerry was constantly teased and felt criticised by her father, and therefore is unlikely to have developed a secure attachment with him and more likely to have experienced shame-based feelings. Sarah describes an anxious attachment style and early development of body dissatisfaction. Gemma was also bullied in school, which links with the peer influence on her level of body dissatisfaction. These findings show that all four of the patients had direct and indirect peer and family influences on their development of body dissatisfaction.

If an individual feels ashamed of their body, this impacts on all areas of their life; it attacks the very core of the vessel that we need to be able to exist. If significant others do not find you acceptable, it will be hard for an individual to feel differently about themselves. When someone has an ongoing need for admiration from others, they can develop narcissistic traits to protect a somewhat fragile identity to avoid them experiencing overwhelming feelings of shame (Davis, 1995).

The narcissistic structure is there to protect what is often a very fragile self (Mollon, 1993). If we acknowledge that the fragile self is also made up of body self, and for some individuals the body is unacceptable, we begin to see how shame-based feelings can develop and become interlinked with body image, cosmetic surgery and self. The observing part of our self-objectifies the part that is felt to be a failure. Narcissism develops to protect this very injured part of the self (Mollon, 1993). As discussed earlier, a loss can contribute to the fragility of the self, as in Sarah's case, where she mentioned losing confidence in herself after her mother's death and feeling like her 'anchor' was gone. Shame heightens the awareness of the self (Mollon, 1993 and Kaufman, 1996) so it mobilises narcissism to repair a struggling self-esteem (Northrop, 2012).

Shame has the power to evoke silence, hiding and evasion (Davis, 1995). It can be seen in body language, where the head hangs, eyes lowered, gaze averted (Sanderson, 2015; Kaufman, 1996). This very action is what Gemma describes doing in trying to avoid being looked at or seen, a clear indicator of shame. Paradoxically this very action heightens attention on the face, increasing visibility (Ibid.). To avoid this attention, Gemma goes to the extreme of 'hiding' herself under coats when doing the school run and sitting in dark corners when attending social events. If Gemma does talk to people she says, 'I will avoid eye contact, hoping that they do not see my eye and think 'what's wrong with her face?'

A child well-rehearsed in experiencing shame will be familiar with feelings of shame and humiliation (Pines, 1990). Kerry's interactions with her father when she was a teenager will likely have been very shaming for her. She talks about her father provoking her to become angry; 'he knew which buttons to press to make me angry, and he would think it was funny and laugh at me.' The anger she felt has contributed to her motivation to split off from the parts that are associated with him, and the shame that most likely accompanies those feelings.

Shyness and guilt

Shyness is shame, just in a different context; this tends to result from the activation of feelings of exposure which then bind to the individual sense of self (Kaufman, 1996). Shyness is a way to avoid feeling exposed or noticed. Rachel said, 'I would hate getting into trouble, the teachers would shout at you and whatever, I would just hate it, yeah, so I just try and keep under the radar.'

Rachel felt she needed to have the rhinoplasty to 'help my confidence to come across more well when meeting new people' and 'not be so shy and quiet or worry about saying something stupid.' Rachel felt there was incongruence between what she looked like in person and what she looked in photos.

Rachel was worried that if people saw a photograph of her before meeting her, they would not think she looked as 'nice' as she did in photographs. In Rachel's narrative, the real (physical) self, has been substituted by the false (photo) version as being the more acceptable self to present. Rachel separates herself from a body part that, in her family (mother and grandmother), is not accepted.

Rachel also described feeling a lot of ‘guilt’ whenever someone would do something nice for her. Her father paid for her surgery, and she said, ‘I feel guilty and want to repay him some day or do something equally as nice’. Guilt can be connected to shame and is a form of ‘moral shame’ (Kaufman, 1996, p.25).

How we view ourselves in the context of others forms our identity. Cosmetic surgery is a way in which to have control, and the ability to change the body parts we may find unacceptable.

Controlling the body, and especially the way it looks, gives these patients a sense of power and control of over what may feel to them as an insecure environment (Davis, 1995 and Foucault, 1988). Surgery becomes a way in which to ‘cleanse and control’ a body that is viewed as ‘unacceptable’ (Northrop, 2012 p.98).

The cosmetic surgery industry gains access to the psyche by playing on the part that is rejected, by saying ‘we can help you accept that part and integrate it back into your subconscious’, therefore tapping into the familiar shamed parts (Northrop, 2012, p.28). It is a way in which a woman who feels trapped in a body that may not fit with her sense of herself, can then try and escape it by changing the way it looks.

Fear of negative evaluation

A body that feels ‘not right’, or not the ‘norm’ of society, can contribute to a host of female body issues such as anorexia nervosa, obesity, agoraphobia, frigidity and depression, which then further contribute to feelings of shame and guilt (Davis, 1995).

The success of the cosmetic surgery industry relies on its ability to mobilise shame within individuals (Northrop, 2012), and it maintains a lot of control over this area by defining what is classed as acceptable or normal in today’s society regarding appearance.

Each patient justified their surgery as being more than just a 'normal' difficulty with appearance and, for them, this meant it was not 'frivolous or superficial'. We can then begin to understand cosmetic surgery as being viewed as a solution to a problem.

The fear of negative evaluation led all the patients to use some form of camouflage to change or conceal their appearance: Gemma felt the only option was to 'hide' herself away and not have any photographs taken; Sarah would only have certain profile photographs; Rachel would not have profile photographs taken and used makeup and facial piercings to distract from her nose; and, Kerry would use alcohol to help her 'forget' about her nose and use makeup to camouflage it.

It is the loathing that people have with their body that appears to seek resolution through surgery. The patients then view the operation (physical) as a solution to reintegrating that part of themselves that they currently see as unacceptable (Mollon, 1993). Cosmetic surgery will only remain viable if it continues to be easily accessible and a socially-acceptable solution to body dissatisfaction. These patients are looking for something or someone who can help put them back together (psychologically). The surgeon addresses this 'psychic injury' by surgically managing the individual's appearance concern (Northrop, 2012, p.179).

If patients are struggling to integrate a part of themselves that they find unacceptable, and a highly trained professional says he can change their view of their body with surgery, patients are understandably going to be persuaded by the lure of surgery resulting in self-acceptance. If all these factors, including loss, separation and fear of negative evaluation, are underlying a patient's motivation for surgery, the surgical process and interaction with the surgeon become a compelling engagement. Cosmetic surgery becomes a 'struggle for one's self' as it is not just about beauty but also more specifically an individual's identity (Davis, 1995, p.133).

A significant alteration to the face, like rhinoplasty surgery, will also affect an individual's sense of self, because there is a strong correlation in the Western world between the face and a person's sense of self and identity (Schore, 1994 and 2000). Embodied identity is 'an outcome of the individual's interaction with her body and, through her body, with the world around her' (Davis, 1995. p169). If cosmetic surgery is connected to identity, we start to realise how deeply psychological the impact can be.

'Mirror, mirror on the wall who is the fairest of them all' (Disney, 2001)

It is not just our reflection that can result in potential shame-based feelings, but also the imagined effect that our reflection has on another (Cooley, 1902). We develop our self-concept by having an imagined inner dialogue with those around us (Cooley, 1902). We try to imagine what others think of us, how they might judge us, and how they might view our appearance. This is what gets played out when we seek the opinions from others on how we look; this gauging of reaction is the very behaviour that individuals use in trying to assess how their appearance will be perceived by another.

Hepworth (2012: p.46) states: 'looking into the mirror is an interactive process through which connections are made between the personal subjective self of the viewer and the external world of other people.'

All the patients interviewed wanted to feel happier about their reflection after surgery. Kerry said she did not want to look in the mirror and her nose be 'the first thing on my mind', Gemma wanted to be able to look in the mirror and like what she saw; they were both unable to recognise that it is themselves who are in control of how they feel about that very image. The surgeon and surgery gain power and authority to dictate how they will think about themselves - external locus of control instead of internal locus of control.

The image reflected back to us by a mirror is also a view of the self that has, in effect, been flattened and distilled at the moment when we view ourselves (Hepworth, 2000). We place so much emphasis on this image to dictate how we will feel about ourselves; it is most likely because of what we use the mirror for, and this is to assess how we look to another, be that acceptable or unacceptable. The mirror is the ultimate tool for our self-surveillance (Northrop, 2012), and invariably the reflection we see is going to be impacted by our history. The perception of our self in the mirror is constructed symbolically by meaning and experiences we have throughout our life.

Gemma and Sarah said they asked family and friends how they looked and what they thought of their noses. All of them were given the same response of 'it looks fine, you don't need surgery', or 'I don't think you need it' – however, none of them believed what people told them and they both felt that family, especially, were just being polite by saying they could not see the problem. Gemma and Kerry were then surprised when their friends did not notice any change in their noses after surgery.

Kerry was 'shocked' that people did not notice, and this made her consider that they were telling the truth when they said they could not see a problem with her nose. Gemma and Kerry both felt it necessary to show their friends the before and after photographs from the operation, so that they could see the difference in their noses. This indicates that these patients needed to justify their surgery to themselves, ensuring that others could see what difference the surgery had made by displaying the before and after photographs.

Sarah said that she would be upset if people did not notice the difference following her surgery as it felt important to her that there was enough of a change in her nose for others to see. This finding shows that some women tend to view their bodies as if from a distance, through the critical eyes of another.

Lacan (1977) highlights the mirror stage of development as a time of inner tension between the psyche and the body image. The mirror confuses the natural development of the self and perhaps, to some extent, disregards the social impact on self and body image development (Ibid.). If we are dissatisfied with our appearance, mirrors give us the opportunity to separate the self from the reflected body image 'by repositioning the reflected body image as an object detached from the self.' (Northrop, 2012: p.78)

With this point in mind, we begin to see how and why patients find it easier to proceed with cosmetic surgery; the body becomes like an object that can be changed and modified to the needs of the mind.

Objectification of the body

Psychological preparation takes place before surgery by separating the unwanted part of the body. Instead of integration, patients psychologically reject the body part that they find unacceptable. The body part is objectified and, as an object, it is no longer something someone is attached to; it is, therefore, easier to surgically modify. The disembodiment that occurs in the process of cosmetic surgery, whereby women's feelings and experiences remain separate to what is happening on their bodies, most likely makes it easier to proceed with surgery.

Cosmetic surgery can thus be viewed as a transformation of the body as an object and not as self (Davis, 1995). In the discourse of these patients, objectification of the body is emphasised; all of them disliked the profile view of their nose but would describe the issue with their profile in different ways. Sarah, Kerry and Rachel said they did not like the 'bump' on their nose, whereas Gemma said she did not like the 'bobble' on the end of her nose. Their discourse indicates the similar but also different ways in which they make sense of the issues they have with their noses. Referring to body parts in these terms indicates the relationship they have with their bodies.

Gemma and Sarah used some strong words to describe their feelings about their noses and bodies. Gemma said, it is 'horrible, this thing that needs feeding, weird'; she describes her face as 'having melted, it's so fat, it's horrible'. Sarah says her nose is 'too pointy, long, bulbous, too crooked'. It is as though they are describing their body part as something that is monstrous and witch-like from movies and not a human body part.

The change after surgery

Each patient described how differently they felt about themselves after surgery.

Rachel said, 'I do not look as bad any more, it looks nicer,' and said she does not get as nervous when she meets new people because she feels her nose is not as different on photographs as it was before. Rachel no longer had her facial piercings because 'it is not worth getting them re-pierced as I don't feel I need them anymore'. Surgery had made her feel 'less self-conscious and not as bad about my appearance,' and she was surprised she no longer felt as dependent on makeup as she did before the surgery.

Kerry's postoperative interview took place via video Skype. Throughout the interview, she was distracted by looking at her nose on the camera on her computer; she would move her face in and out of focus to look at her nose. When I asked her if she was comfortable doing the interview via Skype she said, 'yeah, good, I can show off my new nose.' Kerry was 'shocked' at the shift in the perception of herself following surgery; she no longer felt as self-conscious, and the difference is 'amazing, dramatic change'. Kerry no longer feels her nose is going to 'hold her back anymore' or that it is at the forefront of her mind as it was in the past:

> *(…) There isn't this big honking thing in my face that is constantly talking to me going, look at the size of you, do you know what I mean? It's quite nice to have that voice go away, its lovely.*

Sarah said she thought there was a ‘massive difference’ in her nose. It was no longer ‘huge and hideous’, it was more ‘subtle, feminine, kind of softer; it was so hard before’. She was relieved that the surgery meant she was moving even further away from her grandfather’s side of the family.

Sarah felt the process of surgery was ‘all-consuming’ and she still had a lot of healing to do ‘internally and physically’. Out of all the patients interviewed, Sarah was the least satisfied post-surgery; interestingly, she was also the only one who said, ‘surgery will change my life.’ This raises the question of whether her expectation was met with surgery.

Both Gemma and Sarah were worried about how their noses would look once the swelling had completely settled. Sarah feels that surgeons should prepare patients better for the postoperative process. Sarah’s surgeon told her the tip of her nose would be ‘blunt’ for around six months, but she did not really understand what he meant by ‘bluntness’ and did not feel comfortable asking him. She only fully understood when she saw her nose after surgery and was quite shocked at how it appeared.

Sarah had formed an attachment not just with myself but also the team of people (surgeons, secretary and nurses) who were involved in her surgery, and she was struggling to imagine that we would no longer be there to support her. She said to me: ‘Now my surgery is over, you are all just leaving me, I am going to miss all of you.’

This feeling is not unusual for patients having surgery, and something I also witnessed happening with the patients I interacted with in my role as a personal assistant. They seem to experience a loss, especially if they feel they were being ‘cared for’ by another who then once again leaves their life. This feeling does not seem to be currently acknowledged by surgeons when patients undergo cosmetic surgery.

The surgeon is unconsciously placed in the caring parent position, but when this happens the patient then experiences a loss when they no longer require medical care. Sarah felt this particularly strongly because her friends had rallied round to look after her post-surgery, cooking for her and washing her hair; she said, 'I am going to have a nose job all the time just to get the care.'

Gemma said she could 'now see something different when I look in the mirror.' She had also lost a significant amount of weight since the preoperative interview. She said she was feeling a lot better and on new medication for her depression, but now that she had had the surgery and lost weight, she said her focus had changed to be more about her eye. She said, 'when things are fixed, you find something else to focus on.' When we met for Gemma's second interview, she had not been to see the surgeon for her three-month follow-up consultation. She was very anxious about the follow-up. She was worried about telling the surgeon that she was not entirely happy with the outcome, as she thought her nose was not as symmetrical as she had hoped it would be. She feared he would 'not care what she thought' or just tell her 'that is the best he could do'. Her nose had become an object, something separate to her and remodelled by another who might then disregard her concerns.

> *(…) I am nervous to ring them up to go back because obviously, if I did mention that I weren't happy slightly, I would hate him to think, well … that's as good as it gets, or think I don't care what you think or anything you know,(…), if I mentioned it and he said look we have tried, tried and it wouldn't go straight or this is cause of this and it's been bent for all of them years or whatever, then I would think ok well that's fine he has explained why it is like that, but cause I say it's only a tiny little bit that's I do think how would they respond to that and that's quite another stressful part of it thinking, if I wasn't 100% happy, I am never going to be 100% happy anyway, (…)*

The narratives of all four patients indicate that cosmetic surgery is having a psychological impact, and that surgery is sought out for this psychological purpose even if it is not directly named as such. Surgery functions as a journey for the patients seeking a coherent sense of self by integrating the past unacceptable self into a new more acceptable self (Northrop, 2012). Whether this change actually occurs, and especially long-term, remains to be seen, and requires research where patients are followed up at least a few years after surgery.

The discourse used by the patients is about a psychological change when they say, 'I no longer feel as self-conscious, don't need to hide myself away, I like what I see when I look in the mirror, it is no longer in the forefront of my mind, I feel more confident.' It is fair to say that surgeons are performing psychosurgery, but this means they perhaps need to consider using psychological support services as standard practice in their clinics.

Areas for future exploration

I am aware there are different positions I could have taken in how I analysed and listened to the narratives of the patients who were involved in this research. Many complexities arose in the narratives, but it would have been impossible to analyse each one given the word limit of this project. It means that somebody with a different background to my own, analysing these transcripts, may well have come up with a very different set of themes. This very subjectivity is what occurs through narrative, and why it was so crucial for me to check the validity of my findings with constant reflections, member checking, and having a colleague interview me and blind code the summaries. I am aware that there were other choice points for exploration. For example, Gemma mentioning that she did not like the fact she sounds so 'common'. What does this mean for her and why does she feel so uncomfortable about this? However, this is not something that, within the remit of the chosen methodology or word count, I was able to explore.

It would have meant moving away from the narrative approach to a more structured type of interviewing, which I was keen to avoid. I did not want the interviews to take on a Questions and Answers shape, as a surgery consultation may do.

A follow-on piece of research would be an in-depth case study with perhaps one patient who is having more than one cosmetic procedure. The would provide an opportunity to explore more nuances in the discourse of the patient. On reflection of this research process, one area I feel could warrant further exploration is the impact I may or may not have had on patients in what they discussed or did not discuss in the interviews. How did I, as researcher, influence their decisions of what they disclosed to me? It would be useful to carry out a follow-up piece of research, which would lend itself well to providing further information, not only on the effect of discourse between myself and the patients, but also on how much impact the surgeons may perhaps have through the discourse they use with patients.

Further research will help us understand the impact of computer imaging in morphing patient photographs. These images are useful for assisting patient and surgeon to agree on an outcome following surgery, but these images show what is possible not what is necessarily achieved. How does this create an idea in the patient's mind of what their nose could look like after surgery, and does it perhaps give false hope? Currently, there is no real understanding of the impact of these images (Parker, 2009).

A further piece of research would be to look at how male patients decide to proceed with surgery and whether there is similarity or difference in their narratives in comparison to the women I interviewed. A limitation I found with my research is the timeframe I had in which to complete it, which means that I have not been able to interview these patients as long after their surgery as I would have liked, i.e. a year or two later.
Such interviews would provide an opportunity to analyse whether the initial psychological impact of surgery is long-lasting (Parker, 2009).

Research conference

In September 2017, I made a poster presentation at the UKCP (United Kingdom Council for Psychotherapy) Research Conference. I presented my findings on an A1 poster with a small mirror in the middle of the poster and the text surrounding it, as shown in Appendix 10. I then placed the poster in the conference hall and waited to see who would be interested in reading it. What I noticed was that people would come up to the poster and stand to the side, as if to avoid the mirror.

On reflection of this experience at the conference, what this highlighted for me is just how difficult we may find it, to look at ourselves in the presence of others. We appear to want to do so in private, in much the same way that Gemma and Sarah both wanted an opportunity to scrutinise their noses in a mirror on their own, away from the surgeon and nurse, before deciding if it was acceptable or that they were happy with it. It seems we first want to view ourselves before we present to others.

The mirror on my poster, being in such a public place, was potentially too exposing and risky even though, interestingly, it was psychotherapists attending the conference. It shows that the relationship we have with our body is not just challenging for patients but perhaps also for practitioners. Clinically this is important, especially regarding how we work with body shame.

6. Implications for practice

Findings from this research show that shame is an under-researched area. It is not often that the word shame is brought into the work of counsellors, psychologists or psychotherapists, especially body shame (Sanderson, 2015); this is potentially due to the embodied shame that may be present for both clinician and patient. Clinicians need to learn about their own body shame to be able to bear witness to it and hear stories of shame; how it develops and the impact it has (De Young, 2015; Sanderson, 2015 and Gilbert and Miles, 2002).

Understanding how our shame is triggered in the therapy room is a crucial factor in helping us stay alongside our patients; otherwise, it will remain as an unconscious process with patients seeking alternative ways of dealing with these feelings through means such as cosmetic surgery.

What I learnt from my experience in the early parts of the first interview with Kerry, is that shame can lead to powerful enactments. I initially experienced Kerry as withdrawn and very guarded, as though I might verbally 'attack' her in some way; however, as Kerry shared more about her history, and the criticism, belittlement and teasing she experienced from her father, I recognised how her critic was on high alert for any possible attack. As Pines (1990) suggests, when working with patients who have a traumatic history in relation to shame, one needs to be even more available to look beyond the defence and see the injured self that may lie beneath the defended narcissist.

What helped in the interview process was allowing Kerry to take the lead in where the discussion went; this is also in line with the narrative approach. This approach enabled Kerry to talk about issues concerning her family system that she had never before been able to voice, and she said she had not talked about 'this stuff with anybody'.

Shame is a wound that happens on the inside; this not only makes it difficult to recognise and work with clinically, but also leads to division and separation from ourselves and others (Kaufman, 1996). This separation affects an individual's interpersonal relationships and ability to be in a relationship with another. In agreement with Northrop (2012), 'shame suffers from collective neglect' (p.192). It is a complex paradox because shame often develops around the part of ourselves that we try to fragment from and, in essence, neglect by keeping it hidden. The challenge then is to re-engage this part so that it can be reintegrated, possibly without pursuing surgery.

I agree with Gilbert and Miles (2002), that shame operates on the threat system of the body leading to a hyper-aroused autonomic nervous system (ANS); this is because it carries the risk of abandonment, exclusion, and separation from others. Clinicians working with shame need to be able to recognise if a patient is in a hyper-aroused state, especially if they have experienced chronic shame. External shame often causes people to function from a heightened level of arousal (Ibid.). Helping patients learn to regulate their ANS means they will be more able to function from the drive area and make use of the calming/soothing parts of themselves (Rothschild, 2017). Teaching patients how to breathe to bring down their arousal is a key part of this work; it can slow down the patient's system and help the patient feel more in control of their thoughts and feelings.

The two-chair technique used in Gestalt work can be helpful with people whose critical part of themselves attacks their body image; this intervention can be especially useful with patients who have BDD (Gilbert and Miles, 2002). If using the two-chair technique as a therapy intervention, the clinician needs to pay close attention to the differences in body language, depending on who the patient is role-playing at the particular time; the critical or compassionate part of themselves (Gilbert and Miles, 2002).

The criticising part of the individual has no ability for compassion because it stems from the fear part of the brain mentioned earlier (Ibid.); it comes from the 'threat system' and has no empathy. In the fight or flight response, people cannot think rationally; they are unable to be compassionate towards themselves. It is essential to follow up this intervention by exploring what insight the patient has gained.

Gilbert and Miles (2002) help us understand how to work with shame, but their work could perhaps be enriched by exploring the interpersonal aspect of shame, with which most patients who experience body shame have difficulty. It will be hard for an individual to find themselves acceptable enough to be in a fulfilling relationship if they constantly criticise themselves. Finding compassion for the self helps to shift this process, but does not, in my view, go deep enough to alter a very malignant shame-based system. We need to develop a more relational way of working with shame-based systems.

From this research, it is very evident that surgery has a psychological impact. Rumsey and Harcourt (2012) identified a need for plastic surgeons to have much greater awareness of the psychological impact of cosmetic surgery. Currently, this impact appears to have little focus in the preparation of patients before their cosmetic surgery.

Using the findings from this research, I hope to raise awareness with the surgeons of the psychological impact of cosmetic surgery. Both Gemma and Sarah discussed how they felt surgeons should consider the emotional impact of surgery on their patients, especially if something does not feel right postoperatively.

> *More sympathetic to how it will affect the patient, it would be nice for them to say, oh don't worry, or they can take your concerns on board and not dismiss them like straight away.*

Sarah felt surgeons should better prepare patients for the postoperative process. Her surgeon had told her the tip of her nose would be 'blunt' for around six months, but she did not understand what he meant by 'bluntness' and did not feel comfortable asking him. She only fully understood when she saw her nose after surgery and was quite shocked at how it looked. Sarah had also felt particularly attached to the medical professionals that had been involved in her surgery journey and said, 'now my surgery is over, you are all just leaving me now, I am going to miss all of you.'

Contribution

The clinical contribution in the practice of both psychological practitioners and surgeons will be further informed through the delivery of the following:

- Workshops for psychological practitioners
- Seminar for surgeons
- Online hub
- Dissemination through publications – Body Image Journal, and Therapy Today

Dissemination

My abstract has been accepted for a poster presentation at the Appearance Matters Conference in Bristol in the summer of 2018. A future plan is to take my findings to the British Association for Plastic and Reconstructive Surgery (BAPRAS) conference, also in 2018, and to look at getting a paper published in the Body Image journal.

Workshop for psychological practitioners

Using the findings in this research to raise awareness of how shame undermines how we feel about our appearance and ourselves, will give us the opportunity to clinically help people develop resilience against it (Northrop, 2012).

I plan to prepare a workshop that will help psychological practitioners clinically think about shame and how it connects with body image and appearance. These workshops would also focus on helping practitioners understand the needs of patients who struggle with body image and appearance issues.

Focus points for the workshop

- Help clinicians to **sensitively** name and talk about shame (Pines, 1990).
- Use a **narrative-type approach in therapy**, as this can help open a dialogue between a patient and the practitioner in a less intrusive way (Etherington, 2004).
- Help patients to **develop assertiveness** against those they feel have been critical to them in the past and the present (Gilbert and Miles, 2002).
- Ensure the **patient takes the lead** when discussing shame, especially when talking about the body. This helps to create a sense of control in what can often feel overwhelming to talk about. Helping patients to be **more in control of their autonomic nervous system** by regulating their arousal level (Rothschild, 2017).
- **The two-chair technique used in Gestalt work** can help open a dialogue between the critical and the compassionate parts of the patient.
- Gaining an **understanding of a patient's early attachment experiences** and how the shame-based system may have developed will be important for how to work with the client and, also, to understand how it may have impacted on their decision to pursue surgery (DeYoung, 2015).
- Attachment history, especially an anxious attachment style, will negatively impact on body dissatisfaction and could be a factor causing the internalisation of appearance ideals, and a more favourable attitude towards cosmetic surgery (Hardit and Hannum (2011 and Menzel et al., 2011).
- Further clinical understanding of the psychological motivations that contribute to patients' decisions to pursue cosmetic surgery and how to explore this with patients.

- Provide clinicians with understanding of how psychological support can be of benefit, and at what stage in the patient's surgery journey.

How can psychological support be of benefit?

As cosmetic surgery is not medically urgent, patients need to be helped to make a responsible decision and not make a choice that is driven by distress and/or confusion (Locatelli et al., 2017). If decisions are being made under these circumstances, the question of patient capacity is in the frame; capacity, in terms of the patient's ability to 'understand information given to them and to weigh up the information (including the risks) available to make the decision' (MCA, 2005). Patient capacity should be the first point of assessment before any decision to proceed with surgery can be made.

By giving patients time and space to think out loud with a psychologist their more personal reasons for requesting surgery, patients can be helped to make more realistic decisions in relation to surgery. In some cases, this might mean that a psychologist helps the patient understand why surgery may be contraindicated due to their psychological wellbeing and, therefore, by having surgery they may well aggravate their psychological wellbeing and not resolve it with surgery (Locatelli et al., 2017).

Pre-surgery therapy can help clarify patient motivation, aims and expectations from surgery (Bradbury, 2013) and, if necessary, the safeguarding of a patient's psychological wellbeing can be put in place prior to surgery. However, only pre-surgery therapy is going to provide the scope for this. For example, Gemma, who has a longstanding mental health issue, that of depression; if psychological support had been put in place during her surgery journey, this would have helped ensure she remained well throughout her surgery.

Gemma was started on new antidepressants following her surgery, and therefore one can only wonder if the medication alongside psychological support had been in place pre-surgery, whether she would have felt as compelled to proceed with her surgery.

The surgeons should advise patients to take time to think about their decision (Locatelli et al., 2017). Providing patients with time to discuss their motivation out loud gives them a chance to make more realistic decisions about surgery. As shown in the research of Locatelli et al., (2017) the more clear and explicit the patient's motivation for surgery, and also the more physically-orientated the expectation from the outcome, the more likely the outcome will be a successful one. However, a challenge for mental health professionals working in this area may be around getting patients to speak openly about their real reasons for wanting surgery. Therefore, the more knowledge and understanding the surgeon has of how and where psychological support can be helpful for their patients, and the clearer they are in their referral, the more likely it is that patients will agree to this support in an open, engaging frame of mind. If the surgeon endorses something, the patient is more likely to agree.

Using the Body Image Disturbance Questionnaire (BIDQ, Cash et al., 2004), and the Brief Fear of Negative Evaluation Scale (Leary, 1983), as well as holding in mind the Tripartite Influence Model of Body Image (Thompson et al.,1999), mental health professionals can explore with patients their motivation for surgery. They can explore the impact of peers, media and parental influence on the patient's decision to have surgery. They can look at what recent or major events have occurred in the patient's life, and what impact these events have had on the patient. Based on these assessments, the mental health professional can then decide whether ongoing therapy during surgery is required, whether the patient needs to delay surgery for now, or perhaps that surgery is contraindicated based on the information shared during the assessment.

Any patient seen by a psychologist pre-surgery should be seen post-surgery for at least one follow-up session. This is to reassess the patient's psychological wellbeing post-surgery and also to consider whether ongoing psychological support is indicated based on what the patient shares and how they feel about themselves post-surgery. It would also be very helpful for psychologists working in this area to have some level understanding of the different types of cosmetic procedures; from outcome, risk and healing periods, and what the actual patient experience of a procedure is likely to be (Clarke and Rumsey, 2018).

Post-surgery therapy can help patients who may not have had the outcome they hoped for. The psychologist can help the patient process their understanding of what went wrong, and they can discuss the options of corrective procedures with the psychologist and the surgeon (Bradbury, 2013).

In agreement with Bradbury (2013), the cost implications of any psychological support should be made separate from the surgery and paid for by the patient. It should be suggested as an addition to the surgery, not instead of, or part of a surgery package. This ensures that the patient, as far as possible, can feel they are receiving an independent opinion. The psychological support should ideally also be offered in a different location or room to where the consultations with the surgeon occur. Maintaining this boundary is important, not just from a confidentiality perspective, but also to enable the patient to experience the psychological support as different to the consultation and not part of the same process.

A seminar for surgeons

I am going to use these findings and discuss them at conferences and independent practices. Parker (2009) stated that there is a need to understand what takes place in the dialogue between a patient and surgeon to gain an understanding of how communication can also be increased.

Discussing directly with the surgeon how they understand the impact of surgery on patients will aid the development of a specific psychological support service for this patient group. Surgeons should invest time to understand their patients and their reasons for seeking surgery. As stated by Parker (2009), patient and surgeon communication greatly influences the outcome and postoperative satisfaction, and this is due to the initial relationship the surgeon builds with their patient.

Surgeons should avoid suggesting add-on treatments simply because the 'perfectionist' in the surgeon is seeking a better result by doing more. This will help patients who are later dissatisfied postoperatively, because they will be able to acknowledge that the surgery was based on their own need. Cosmetic surgery marketing needs to be managed to ensure that a patient's vulnerabilities, for example those with low self-esteem and poor body image, are not exploited.

Cosmetic surgery is a technical act that is performed to make physical changes as well as psychological ones. But, as surgeons are technically trained and not necessarily psychologically trained, what is important is to provide surgeons with the tools to be able to identify patients who need a referral for psychological support.

Surgeons should consult a mental health practitioner who has experience working with this patient group and has some level of understanding of cosmetic procedures. The SIG (Special Interest Group) currently being organised by Dr Alex Clarke and Professor Nichola Rumsey, as mentioned in the recent BPS Journal (Clarke and Rumsey, 2018), will be of use.

Surgeons should build-up a contact list of professionals that they can refer their patients to, for example, psychiatrists, psychologists and psychotherapists with specialist training in working with cosmetic surgery patients.

This is where my online hub will be of benefit. I plan to create an online portal that lists the contact details of suitably qualified psychiatrists, psychologists and psychotherapists who have knowledge and understanding of this patient group. This could be for both preoperative and postoperative support, and will be disseminated to plastic surgery practices for surgeons to use as a referral base, for patients to be able to contact professionals directly, and for patients to access further information about how, when and where psychological therapy can support them, before, during and after their surgery.

The online hub will have a main contact to provide assessments of patients and then forward the patients on to the relevant healthcare professional, i.e. psychiatrist, psychologist or psychotherapist. Having a main assessment provided by a suitably qualified psychologist means that if a surgeon is unsure who the patient needs to see, they can forward the patient directly to the service for an initial assessment with a psychologist.

How do surgeons identify which patients who need psychological support?

As shown in my research, cosmetic surgery has a twofold impact, physically and psychologically. Ideally, all patients should have psychological support as part of their care pathway (Clarke and Rumsey, 2018); however, as this practice is still in development, it would be more pertinent and helpful to think about how we can get surgeons to refer on patients who are most in need of psychological support.

Those who present for surgery with an existing psychological issue, that means surgery could potentially be harmful for them, can be identified by the surgeon and then referred on for psychological assessment, support and/or psychotherapy. There is an existing screening tool designed by CAR in conjunction with the Royal Free Hospital to help surgeons identify those patients most at risk.

The psychological screening tool ‘RoFCAR’ (developed by researchers and clinicians at the Royal Free Hospital London ‘RoF’ and the Centre for Appearance Research ‘CAR’) is intended to be used preoperatively in addition to an extensive consultation, and postoperatively to collect outcome data (Paraskeva, Clarke and Rumsey, 2014, p.29). The RoFCAR was specifically designed to identify psychological factors which are likely to increase the risk of a poor psychological outcome post-surgery (Ibid.); however, this does not appear to be sufficient, as was discussed by surgeons at the recent Appearance Matters Conference in June of this year (2018). http://www1.uwe.ac.uk/hls/research/appearanceresearch/newsandevents/appearancematterconference.aspx

Both surgeons involved in a panel discussion at the Conference shared their concerns about patients becoming angry with them, when the surgeons recommended that the patients were seen by a psychologist or that the surgeons were not prepared to operate on them.

Surgeons often come across as receptive to involving psychological practitioners in their patient care, as was indicated by the panel members; however, some surgeons worry about raising the subject with their patients and how they would do so. For a patient to engage in psychological services, surgeons need to be explicit about their reasons for the referral and the help that the psychologist can offer to the patient; however, in order for a patient to believe it would be helpful, the surgeon must be confident in the benefit and be able to explain it to a patient.

According to Bradbury (2013), there are three broad categories that can assist surgeons in referring a patient to psychological services:

- Be clear about the referral and what is being asked of the mental health professional.
- Be accepting of the role of the mental health practitioner in the patient's journey and gain knowledge of the psychological issues that may be a contraindication for surgery.
- Communicate openly and honestly with the patient and encourage him/her to attend the psychological service.

Offering mental health training to surgeons will assist them in being able to communicate with their patients clearly, authentically, and in a helpful way why the surgeons may not be prepared to operate on the patients, or why they are recommending a particular patient for psychological support. As was discussed by the panel, if psychological support was automatically part of the process of cosmetic surgery, patients would see it as the norm and not feel they were being singled out or feel stigmatised that they had a mental health issue preventing them from having surgery.

Mental health training for surgeons

Mental health training would focus on helping surgeons find the language to communicate with a patient any concerns they may have, and how best and where to refer patients they may be concerned about. It would also provide an opportunity to look at the protocols that surgeons currently have in place to psychologically support their patients. Training would help to raise awareness with surgeons that some patients may feel quite attached to the medical team involved in their care and that, post-surgery, some patients can feel a sense of loss or abandonment.

If surgeons can consider identifying this issue with their patients, it will help to increase awareness in patients of the psychological impact of their surgery. It could also help surgeons identify those patients indicating attachment issues that could cause challenges for these patients postoperatively when their medical care stops. As indicated by Morioka and Ohkubo (2015), patients with a borderline attachment presentation should receive psychological support as part of their surgery care pathway.

How to help surgeons identify patients who are at psychological risk

There are particular presentations that surgeons can use as a guide as to their patients' mental health. This guide can also be used by psychologists to help them understand which mental health issues pose a potential problem in the consideration of cosmetic surgery.

When would surgery be contraindicated?

If the patient is suffering from a severe mental health issue, for example borderline personality disorder (BPD, APA, 2015), BDD (APA, 2015), a depressive episode or an eating disorder. This part of the mental health training is important because surgeons need to be able to identify these patients in order to confidently refer them on when appropriate. A further contraindication is a patient who has unrealistic expectations of the surgery and/or outcome (Bradbury, 2013).

If the patient's life event is indicating a harmful impact on the patient and triggering a psychological disturbance, i.e. shown in the way they are perhaps processing it, then cosmetic surgery may not be the way in which to try and resolve this for the patient but instead may aggravate things, then surgery may be contraindicated (Locatelli et al., 2017).

According to Morioka and Ohkubo (2015), BPD (APA, 2013) is a contraindication for cosmetic surgery. Their review of the literature revealed that individuals with BPD seek treatment from plastic surgeons for two distinct reasons: as a form of self-injury, and/or an insatiable desire for aesthetic procedures (Ibid.), and these patients may continue requesting surgery to different body parts in order to avoid abandonment by the surgeon.

This was something discussed by Sarah, if only in jest, when she mentioned wanting to have ongoing rhinoplasty procedures in order to continue getting care from the medical professionals. In agreement with Morioka and Ohkubo (2015), psychological treatment should be offered to minimise the impulsivity of this patient group and help them process their fear of abandonment. Surgeons need to be sensitive to the nuances of BPD in order not to miss the proper timing for psychiatric/psychological support (Ibid.).

Other areas are not as explicitly obvious as contraindications for surgery, and it is these areas that make it complex for the surgeon to decide whether or not to operate and whether instead to refer the patient on for psychological support. In such cases, the surgeon being able to identify why they have concerns about their patient having surgery, and recommending that psychological support is part of the patient care pathway, would mean that these concerns can be explored with a suitably trained psychologist.

The more complex areas

One such complex area, is if the patient is showing signs of low mood or disordered eating that is not severe enough to be classed as a disorder. Gemma was depressed at the time of her preoperative consultation, so much so, that when she read her first interview summary she was ‘shocked’ to hear how depressed she actually was; however, the surgeon did not know about this as Gemma had not been asked any questions about her mental health.

Another example is the patient overtly anxious about surgery or other life events (Bradbury, 2013). Sarah felt very anxious about the anaesthetic but the surgeon did not explore why; instead, he reassured her that 'anaesthesia was nowadays safer than crossing the road'.

Another area is patients suffering from social anxiety. Gemma especially was experiencing social anxiety, not wanting to go out, and if she had to go out, finding ways to hide herself away or sit in dark corners.

A further area is patients going through a life crisis such as divorce, loss of employment, or in a state of distress which would mean that rational decision-making is impacted (Bradbury, 2013).

If the patient is having difficulty identifying the exact aims, motivations and expectations from surgery, these are clear indications that further analysis of the motivation for surgery should be explored before proceeding. If the patient's decision to have surgery appears to be made impulsively, or on a whim, or perhaps through pressure from peers and/or family, this is another indicator that the patient should be referred for psychological assessment and support.

Another area is if the patient is overvaluing the importance of their physical appearance, and they are assuming that others are critical of them based purely on the basis of supposed or actual flaws in their appearance (Bradbury, 2013). This was a finding with Rachel; she felt that because of her appearance, people would judge her 'negatively' and she felt this impacted on her personality.

Other psychological traits that a patient may be presenting with, but not necessarily as a disorder, are perfectionism, externalisation of beauty ideals, and external locus of control, i.e. using the mirror to confirm the acceptance of their appearance.

All four of the patients in my research were exhibiting quite high levels of external locus of control, and the likelihood is that given the results of my research, had they been seen by a surgeon using the suggested screening tool, they would potentially have been referred for an initial psychological assessment.

Patients undergo cosmetic procedures in response to a life event (Locatelli et al., 2017, Bradbury, 2013 and Sarwer, 2007). This was a finding in my research too: Sarah, feeling her 'anchor' was gone after her mum passed away and she saw surgery as one of the ways she could get this back; Gemma, following the benign tumour removal, had been feeling so depressed that she did not want to leave the house and see or do anything, and surgery for her was also seen as a way to get back to her 'old self'.

These patients believe that cosmetic surgery is going restore their confidence and lift their mood; however, the internal struggle is rarely, if ever, resolved by cosmetic surgery, and an external fix to cure an internal issue is unlikely ever to be successful.

The mental health training would also focus on psychological screening tools that surgeons can use, for example, RofCAR (Paraskeva, Rumsey and Clarke, 2014). Some surgeons may be comfortable using these tools in their practice but, if not, they should have a list of standard questions that they ask all patients in order to obtain information about their mental health, their motivations, and any current life situations that may impact the patient's ability to give informed consent; this would help the surgeon determine if a psychological referral is required. This list of questions could be provided by the psychologist who the surgeons are comfortable referring their patients to, and this would mean that a collaborative approach is being taken in the patients' care pathway.

A potential screening tool that could be used by surgeons should include the following factors:

1. Anxiety level in relation to surgery.
2. Depression.
3. De-personalisation/dissociation/personality disorder.
4. Recent life event – divorce, loss, change in body, relationship changes, life changes.
5. Mental Health Capacity – listing the four conditions (as a guide for surgeons not for diagnosis).
6. Difficulty identifying exact aims, motivations and expectations from surgery.

There would need to be a rating scale on the screening tool. If there are high marks on all six factors, surgery is contraindicated. If there are high marks on any one of the factors, the patient is referred for further psychological support and assessment; however, the difficult area for making a decision is when the patient's scores are within the lower range. Having a list of further questions, especially in terms of recent life events, would help the surgeon to explore the patient's decision further and decide whether psychological support would be helpful (Locatelli et al., 2017).

By using the Mental Health Capacity Act as the foundation, the screening tool is based on clinical evidence that can be used to support the surgeon's and psychologist's assessments. The Mental Health Capacity Act 2005 (MCA, 2005) has a two-stage functional test of capacity:

Stage 1. Is there an impairment of, or disturbance in, the functioning of a person's mind or brain? If so, look at Stage 2.

Stage 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

1. **Understand information given to them.**
2. Retain that information long enough to be able to make the decision.
3. **Weigh up the information available to make the decision.**
4. Communicate their decision – this could be by talking, using sign language, or even simple muscle movements such as blinking an eye or squeezing a hand.

The main focus in terms of cosmetic surgery is on Numbers 1 and 3; 'Understand information given to them', and 'Weigh up the information available to make the decision' (MCA, 2005). These items relate to informed consent and, as discussed earlier in the research, depending on the level of distress that a patient's body disturbance causes them, the impact of a recent life event or a comorbid mental health issue could mean that, to some degree, these patients are not able to thoroughly weigh up the risks of surgery and fully understand the impact of their decision. This means that their capacity is being impacted.

Another helpful tool for surgeons would be to create a concise leaflet for patients, providing further information on how and where psychological support can be of benefit to them in their journey. It would explain what impact involving psychological support could have on their experience through surgery versus not having the support; for example, a finding from my research is that the patients stated how a psychological interview raised questions they had not previously thought about in relation to surgery. This does not need to be frightening for patients, or a reason not to have psychological support, but instead these reasons can be explored in a safe, non-judgemental environment to look at what they mean in terms of the connection with the patient's decision to have surgery. This helps to ensure that expectations and motivations for surgery can be met. An information leaflet for patients would help to normalise the reason for the referral. See Appendix 9 for a potential patient leaflet.

Reflections

When I started this research journey, I found little evidence to support the case that cosmetic surgery patients should, as standard practice, have psychological support incorporated as part of their care pathway. Therefore, when doing the preoperative interviews with these four patients, even though certain aspects of what they talked about did cause some concern about whether they should be proceeding with surgery at this time, there was little, if any research that could support my clinical thinking regarding my concerns.

My research journey shows how large the gap is between psychological support and cosmetic surgery. The clinical knowledge and understanding I have gained through this research study has helped me to appreciate the complexity that is involved in a patient's decision to have cosmetic surgery, and, it is evident not just from my own research, but also that of Locatelli et al. (2017); Sharp et al. (2014); Parker (2009) and Gimlin (2012), that all cosmetic surgery patients should have psychological support as part of their care pathway.

What I have learned and now understand - and given the information that was shared by the patients in their preoperative interview - if I was doing these interviews now, it is highly likely I would be strongly recommending that the patients have a further discussion with their surgeon about their expectations and aims for surgery. I would also have made a further recommendation that at least two of them (Gemma and Sarah) have psychological support preoperatively. This research has enabled me to find my authority as a psychologist through the knowledge, understanding and findings that have emerged, which will support me to have a voice in the medical field of cosmetic surgery that is struggling to find a way to incorporate psychologists as part of their practice in a collaborative, helpful way.

7. In Summary

This research aimed to better understand female patients' experience as they proceed through their cosmetic surgery. By understanding their experience, we get a sense of what motivates patients to surgically alter a healthy body part. As indicated by this research, the psychological motivation for cosmetic surgery is deeply rooted.

I realised, in the write-up, how embodied is this piece of research. When I was writing the section on shame, this had a profound impact on me. Throughout the day, and over the following few days when I was writing this piece, every time I made a personal decision or gave an opinion on something, I worried it was the wrong one and then became embarrassed (ashamed) about it. This unease continued for a few days, and I struggled at first to recognise the feelings I was experiencing as transference from my research. When I reflected on this with my peer review research group, I managed to get a perspective on the feelings I was experiencing. I also explored my reaction with my clinical supervisor, who is a body psychotherapist, and she helped me to recognise that such transference with research means that I need to be mindful that I do not become biased in my approach when looking at my results.

I also discovered that I was not alone in experiencing these strong transferential body-shaming feelings. Northrop (2012) comments that she too found herself criticising and analysing her own body while immersed in her research. It made me realise just how contagious body image is, especially amongst the female population. We are to some extent always scrutinising ourselves.

I became preoccupied when I discovered the writings of both Davis (1995) and Northrop (2012). My relationship to this project and the literature had triggered my narcissism. Davis (1995) and Northrop (2012) have written extensively about cosmetic surgery and explored their findings using narrative inquiry, and it worried me that their research would in some ways overshadow the uniqueness of my own. What I had not recognised, until I reflected with my research supervisor, was that my own narcissistic trait that drives my need for perfection, was fuelling this concern. What I had become concerned about was that my research would not be inspirational!

Narcissism is incredibly seductive and takes away perspective and the ability to see reality, and I was worried that I had started to hold a narcissistic position towards cosmetic surgeons. I decided to re-look at the original transcripts to see how I was positioning myself concerning the data. This proved very helpful in showing me where I might have become biased in my discussion.

It is important to acknowledge what is expected of surgeons in the industry of plastic and cosmetic surgery. Some surgeons will operate for around 12-14 hours at a time, especially if they are performing a major reconstruction. It is not an option to stop and close the patient up and carry on at a later stage, and neither will surgeons allow another surgeon to come in and take over their operation.

Technology has moved on so much, that what surgeons can now reconstruct is just phenomenal. But, as technology improves and surgery improves, what seems to be forgotten is that it is still a human being performing the operation and not some robotic narcissist. This is fascinating from many perspectives. Why will surgeons not share their surgery? It is likely that there is also the narcissistic part of the surgeons that unconsciously communicates with the narcissistic part in the patients, and both get entwined in a very complicated self-serving process (Blum, 2003).

In interviewing these four patients, I cannot reduce their reasons for surgery as being due to patriarchal oppression or freedom of choice (Morgan, 1991 and Northrop, 2012). It would be naïve of me to dismiss the pain felt by these women concerning their body dissatisfaction; their surgery was more of a personal process than just being about oppression, but we also cannot deny that this was a contributing factor in some of their decisions. In the narratives, there was a sense of loss of a significant other in their lives and a generational lack of acceptance in the way they looked. This shows how our body image connects to the psyche through attachment history and life experiences.

This research indicates that perhaps there is room for further exploration to see if and where, working with body shame from an attachment perspective, could help patients better understand why they are seeking surgery. A secure sense of self is mostly written about as being connected to early attachment history. How the self develops in relation to the body will undoubtedly also be influenced by one's attachment (Gerhardt, 2004). The psyche develops through social construction, and body image is a social phenomenon informed by our sensory perception and emotional experiences from early childhood (Schilder, 1935); therefore, body image is constructed and deconstructed by various interpersonal and intrapersonal interactions.

Body image is not 'static' (Schilder, 1935: p.241.), as one can hear in the narratives of the four patients, yet we invest so much in the static images we see in the mirror and photographs. Surgery is a way in which individuals try to bridge the gap between how they feel about themselves and how they think they should look according to their inner dialogue on what they believe the other wants to see (Budgeon, 2003). The patients who participated in this research all expected that surgery would change their minds' position on their reflection. We can understand then, why Mendleson (2013) who is a plastic surgeon says that plastic surgeons are essentially psychologists with scalpels in their hands; however, the surgeons are on not working on the mind, but instead working on the body to shift the mind.

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9. Appendices

Appendix 1: Participant recruitment letter

Research exploring the experience of female patients seeking elective rhinoplasty surgery

Participant Recruitment Letter

Have you ever been curious about the psychology behind cosmetic procedures in particular rhinoplasty surgery? If yes, then please read on.

I am carrying out a study to explore the stories of a small number of female patients as they proceed with their rhinoplasty surgery. By exploring your story with you, I hope to gain some understanding of your experience as you go through your surgical journey. As part of the study I will conduct two interviews one following your initial consultation with the surgeon and one after your surgery. All information that is collected about you during the course of the research will be kept strictly confidential.

This project is the research portion of my professional Doctorate in Counselling Psychology and Psychotherapy (DCPsych). This is a joint programme at Metanoia Institute and Middlesex University, London.

Please consider the following questions:

- Is this your first rhinoplasty surgery?
- Have you wanted to have a rhinoplasty for a year or more?
- Is your decision to have the surgery only for cosmetic reasons and not for any underlying medical condition?

If you answered yes to all the questions and would be interested to participate, please let your surgeon's secretary know. The secretary will then will pass on your contact details to me and I will call you to discuss the project.

If you prefer, you can contact me directly: debbieauer1@gmail.com or 07825 236616.

Thank you for taking the time to read this letter, please feel free to keep this copy.

Kind Regards

Deborah Auer, PG Dip, BA(Hons), MBPsS and MBACP(Accred.)
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Appendix 2: Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

Participant Information Sheet

The experience of female patients seeking elective rhinoplasty surgery: A Narrative Inquiry

You are being invited to take part in a research study. This study is being conducted as part of a Doctorate in Counselling Psychology and Psychotherapy. This is a joint programme at Metanoia Institute and Middlesex University. This study will be carried out by a 5th year doctoral trainee researcher supported by a research supervisor.

Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Research has shown that cosmetic surgery has been found to have a twofold impact on individuals. The one is the physical result and the other the psychological impact. Most research explores the impact of the physical change following surgery. However, there is limited research exploring the psychological impact of surgery. By exploring the experience of patients as they move through the various stages of their rhinoplasty surgery, the hope is that they will have a better understanding of the psychological impact of this particular cosmetic procedure and their individual motivation for surgery.

Why have I been chosen?

As you are considering rhinoplasty surgery I have been given permission by the practice to ask if you would be interested in taking part in this study. As part of the study four female patients will be interviewed.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

If you agree to take part I will be interviewing you on two occasions for around an hour or so at a time. Your involvement in the study will take around 2 hours of your time and we will agree to meet at a time and place that is convenient. The first interview will be after your initial consultation with the surgeon and the second interview will be around six weeks after your surgery. The purpose of the interviews is to find out more about your experience of proceeding with rhinoplasty surgery.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

What do I have to do?

If following our conversation, you would like to take part we will agree a time and place for the first interview. You will not need to do any form of preparation prior to the interviews.

What are the possible disadvantages and risks of taking part?

There is a risk that during the interview you may become unsure/unsettled about proceeding with surgery. If this happens I would encourage you to discuss it further with your surgeon and if need be a psychological therapist. In the information pack you will find relevant contact details. Any counselling or support information provided will be by qualified staff who are not members of the research team. Due to the nature of the research it is advisable that if you have any prior or current psychiatric issues you do not partake in this research please do feel free to discuss this with me further.

What are the possible benefits of taking part?

- I hope that by participating in the study your decision to have surgery will be further informed.
- To provide information to psychologists and psychiatrists working or looking to go into the field of cosmetic surgery patients.
- The information obtained may help future patients with their decision to pursue surgery.

However, these benefits are not guaranteed.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

To ensure confidentiality and in accordance with the UK Data Protection Act I will not save any details of transcriptions or audio recording under your name. Instead I will use a coding system that I store separately and refrain from writing your name on any documents. I will also ensure that at all times the information is securely stored on my computer which only I will have access to.

What will happen to the results of the research study?

The results of this research will be written up as part of a Doctoral dissertation and possibly at a later stage in professional publications and meetings. It will be held in the Middlesex University Repository. If you wish to access a copy of the published results you can contact Middlesex University. As mentioned previously all identifiable information will be removed.

14. Who has reviewed the study?

This study has been reviewed and approved by the Metanoia Research Ethics Committee.

15. Contact for further information

If you would like any further information about this research you can contact the researcher or supervisor below.

Researcher: Deborah Auer
Supervisor: Dr Helen Molden
Metanoia Institute
13 North Common Road
London
W5 2QB
Tel: 020 8579 2505
Email: debbieauer1@gmail.com

16. Contact for psychological support

Georgie Bainbridge
Psychotherapist
Wimpole Street Therapy
85 Wimpole Street
London
W1G 9RJ

Tel: 07875 409036

A copy of the information sheet and signed consent form will be given to you to keep.

Thank you for reading this information sheet.

Appendix 3: Consent Form and Ethics Approval Letter

CONSENT FORM

Participant Identification Number:

Title of Project: The experience of female patients seeking elective rhinoplasty surgery: A Narrative Inquiry.

Name of Researcher: Deborah Auer

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐
3. I understand that my interview will be taped and subsequently transcribed. ☐
4. I agree to take part in the above study. ☐
5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Debbie Auer
DCPsych programme
Metanoia Institute

16th April 2015

Ref: *9/14-15*

Dear Debbie

RE: *The experience of female patients seeking elective rhinoplasty surgery: a narrative inquiry*

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Institute Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Institute Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Research Subject Specialist, DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Appendix 4: Letter of consent from Surgeon

Mr Niall Kirkpatrick BDS MB BS MD FRCS FRCS(Plast)
Consultant Plastic, Craniofacial and Aesthetic Surgeon

20th March 2015

To Whom It May Concern,

I Niall Kirkpatrick give permission for Deborah Auer to ask my patients if they would be willing to participate in her doctoral research study. Research Title: The experience of female patients seeking elective rhinoplasty surgery: A Narrative Inquiry.

With best wishes

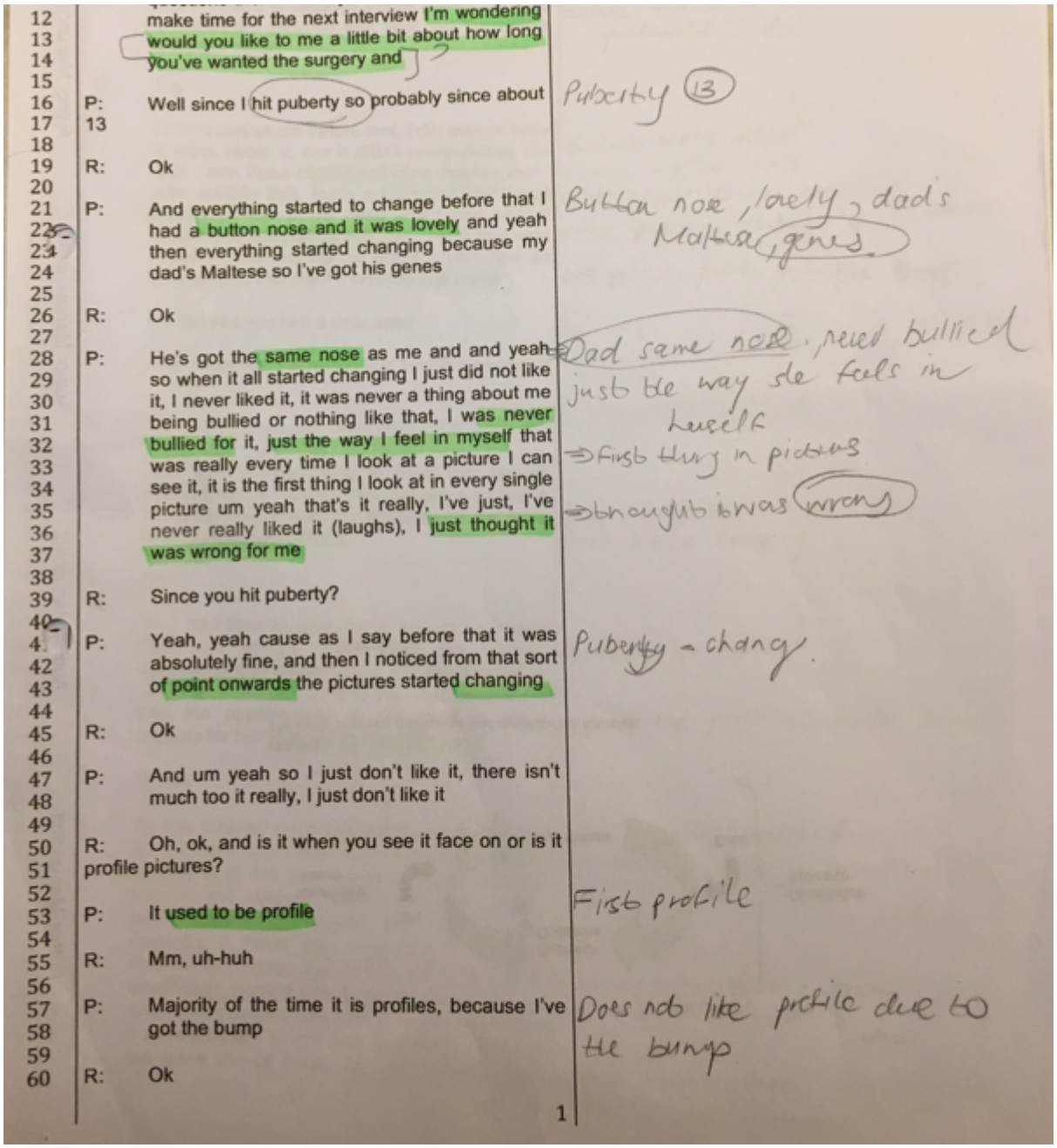
Yours sincerely

Mr Niall Kirkpatrick BDS MBBS MD FRCS FRCS(Plast)

WNA Kirkpatrick Limited
The Consulting Suite 82 Portland Place London W1B 1NS
Email:niallkirkpatrick@theconsultingsuite.co.uk
Tel: 020 7927 6512 Fax: 020 7927 6511
GMC Number: 3460409

Registered Office: c/o Sandison Easson & Co. Rex Buildings, Wilmslow, Cheshire, SK9 1HY
Company Number:08345422

Appendix 5: Transcript from 1st Interview



make time for the next interview I'm wondering would you like to me a little bit about how long you've wanted the surgery and

P: Well since I hit puberty so probably since about 13

R: Ok

P: And everything started to change before that I had a button nose and it was lovely and yeah then everything started changing because my dad's Maltese so I've got his genes

R: Ok

P: He's got the same nose as me and and yeah so when it all started changing I just did not like it, I never liked it, it was never a thing about me being bullied or nothing like that, I was never bullied for it, just the way I feel in myself that was really every time I look at a picture I can see it, it is the first thing I look at in every single picture um yeah that's it really, I've just, I've never really liked it (laughs), I just thought it was wrong for me

R: Since you hit puberty?

P: Yeah, yeah cause as I say before that it was absolutely fine, and then I noticed from that sort of point onwards the pictures started changing

R: Ok

P: And um yeah so I just don't like it, there isn't much too it really, I just don't like it

R: Oh, ok, and is it when you see it face on or is it profile pictures?

P: It used to be profile

R: Mm, uh-huh

P: Majority of the time it is profiles, because I've got the bump

R: Ok

1

Puberty 13

Button nose, lovely, dads Maltese, genes.

Dad same nose, never bullied just the way she feels in herself

→ First thing in pictures

→ thought it was wrong

Puberty - change.

First profile

Does not like profile due to the bumps

P: So any side view you can see how uneven it is um, and as time sort of gone on it is front as well so if I look at any pictures of myself or look in the mirror it looks absolutely wide as well as having the bump it was mainly just the bump to begin with, but it is sort of everything now

side view, uneveness now front view to pictures/mirror absolutely wide now everything

R: And why do you think its changed from being just the bump to being about the width too?

P: Well, I see it is because I think mainly because (laughs) the pictures that Niall did the before and after shots

Before and after consultation pictures "shots"

R: Yip

P: I didn't realise um before that, I did always have a thing about it, but it didn't really bother me until I saw these before and after pictures that I was actually that, that's a lot wider than I had expected, than in my head until I saw what it would look like afterwards um... and that was mainly it and that started about a year ago so and up until that point it was just the bump

didn't really bother before + after pics also wider than expected. after pictures skewed up wideness till that point just the bump.

R: So did you see him a year ago?

P: Well I saw him I think the first time in November 16

R: Ok

P: And then, I was going to have my second appointment in January, my surgery was going to be booked in April but because of the price of it I had to push it back

due to price push back surgery

R: Ok

P: So I had time to save for it, so um I emailed Sam um in so I cancelled the second appointment in January and she rebooked it in for September so I said to her that because, I had the appointment so far apart is there anyway for her to email me the pictures?

secretary to email

asked for pictures to be email

R: Oh, ok

P: So she emailed me the pictures and ever since then I have been obsessed, literally everyday looking at it, like people cause I talk about to people and certain people that don't really know (clears her throat) like have I told anybody, I have told everyone I am that excited, everybody that knows me knows how long I have wanted this. Even my mum, like my mum hates surgery any kind of surgery whether it be necessary or not she absolutely hates it but even she is happy for me, because she

since pictures emailed obsessed looking everyday

told everyone excited everybody knows how I have wanted this

mum happy, even though she hates surgery

knows how long I have wanted this and how bothered I am about this

R: So she has been as supportive as she can

P: Yeah definitely, definitely, the only person that hasn't is my dad but that's only because of the money, because he is cheap (laughs)

R: Is that the only reason he doesn't want you to have surgery?

P: Yeah, yeah I think so, I don't know he doesn't really talk to me much, but like when I talk to him about it he says there is nothing wrong with it, but then he would because he has got the same nose and he has not had a problem with it, but like I say he is quite tight so (laughs)

R: So does his nose look the same as yours?

P: More of less yeah more or less... I'm the only one with the nose like my dad, my little brother hasn't and my sister hasn't

R: So they look more like your mum?

P: My brother looks like my dad um but he doesn't have the nose, but he's got the Maltese genes, the dark skin, the dark hair whereas all the girls in my family we've got the English side, so the pale skin, the ginger hair so we've all got red hair from all of us, all the girls, my sister is a bit in the middle, she's a, she's I don't know if you put us all together you can tell we are siblings if you put us all together you can tell we are siblings ,but she's got more of my mum's features um than my dad's whereas I have got my dad's whereas my brother's got a bit of both and I'm the only one that's got an issue with it so

R: And what's your relationship like with your dad

P: Mm that's a question...(laughs) um strained, strained, not all the time, not so much now, when I was younger really, really hard, we just didn't get on, we clashed all the time, because we are both just as stubborn as each other, so that's another thing I get from him, we had a very strained relationship when I was a teenager and then I moved out um... when I was 18 and then... it just kind of got better over time so now I found that if I am not with him that much it's fine

R: OK

P: If we are together too much, it, it becomes a problem and we start to clash again about

anything, he says things to wind me up on purpose, and I know he does and I can't help but retaliate my mom always tells me not to retaliate but I cant help it its habit I cant let him win (laughs)

R: So he knows which buttons to push

P: Oh completely yeah, he knows exactly how to get to me, exactly but um yeah so its not so bad now, we just don't, if it comes to a point now where we I kind of know it is going that way I just sort of I just agree with him and let him get on with it as I can't be bothered with the arguing if I argue with him he wont stop neither will he so I just leave him be

R: So it's a complex relationship (smiling)

P: (Laughs) it is yeah, yeah it's just as I say in certain ways we are both very similar so that clashes and then there's other ways in which we are completely different and it's those ways about him I don't like I'm not that kind of person and he is, so yeah it's ok, it's not too bad now since cause my nan passed away a couple of years ago, his mum and um... we kind of not like bonded over it we kind of drew a line really and it hasn't , hasn't been as bad , since I moved out, I have lived away from home now for nearly 10 years

R: Ok

P: So in the first few years it was still quite... volatile but I've just avoided him at all costs because he was the only person he was actually out of everyone I know, he was the only person that could get to me like that, and that could upset me, my mom never even in as much as me and my mum argued it never upset me whereas my dad, my dads thing for him I suppose its like proudness for me, like every kid wants to make their parents proud

R: Uh-huh

P: And my dad kind of never showed that with me, so like everything I did was never good enough, my mom always says to me, that he does it to push me further which in a way has helped in another away not so much because as a teenager all I wanted was...

R: Approval

P: Yeah, that's all and it has taken a long time to get over that um

R: Well it instils this idea that you are never good enough

P: Yeah, like, not so much not good enough, but like, like I could always do better, like but like my GCSE's it was kind of like one of the big ones for me,

R: Uh-huh

P: I got average GCSE's you know I didn't fail, but I didn't like get exceedingly good kind of thing, but it still wasn't good enough for him

R: Were you happy with them?

P: Yeah, I was fine with them

R: OK

P: My little brother he has just turned 16 last year and he has just had his GCSE results but obviously he is a complete brain box like A stars and all of that, like I am so proud of him, but like I said to my brother that he made his father like so happy that at least he has got one of his kids that have got like outstanding results, but it's, its always been stuff like that or like if something goes wrong like 9 times out 10 it is my fault, like there is thing about from when I was a baby probably before that, he has made videos over the years

R: Uh-huh

P: And some of them went missing, they moved from my childhood home to the house now and some of them went missing, and that was my fault because I used to like to watch them when I was kid, I must of took them with me, but my mom, obviously my mum was kind of on the fence, when was arguing when I was kid I always thought as a kid that she was on his side

R: Mm

P: So we used to argue because of that, um but, actually I look back it now you know she is in the middle of both us, she would always choose us, if there was ever a choice, but as a teenager you don't see that do you, you only see it as you get older and you are like ah alright ok, um but she was kind of in the middle of everything, even the video tapes that wasn't an old thing that was a fairly recently, probably the last five years um because obviously I moved out when I was 18

R: So they think you took them with you?

P: Well dad did, um...mum sort of asked me about it, and I said to her I didn't and she just sort of like said do you mind if I come and have a look in your boxes and stuff, and I said yeah that's fine look as much as you want, she looked she didn't find anything, she has told him and he still doesn't believe it even to this day, me and mum still have conversations about it, he will bring it up every so often with her, he never brings it up with me, he will bring it up with her, and then it will cause an argument with them, because she is sticking up for me but yeah

R: What's it like for you to have him not believe you?

P: I don't care anymore (laughs)

R: Ok

P: I used to, it used to bother me a lot about everything, everything that used to happen, always used to get to me so much, and that kind of made me not care because I kind of got to a point where I was like well why am I letting this one person, fair enough he is my dad

R: Uh-huh

P: He will always be my dad, but why am I letting this one person upset me like this, nobody is worth being miserable for, not one person in this entire world I don't care who it is and... yeah, I just decided to stop doing it and that's why I have stopped engaging with him when he used to try and pick at me because, I knew the minute I started biting, I would be the one who was upset, not him, he would find it funny and I would be the one that would get upset, he would forget all about it and I would stew on it for ages... and so yeah I just decided I didn't want to be like, I didn't want to dwell on things like that, that its not worth it, its not worth it, because I've had family members that have um...died and that and I think it was ever since that I just couldn't see the point because my aunty, his sister um she died um what year are we, 10 years, yeah 10 years this year so 2006 she died and she was 39 and had leukaemia she died within 4 months of being diagnosed

R: Wow very quick

P: (voice changes to quite tearful) And I think she was the main one, because my granddad passed away before ¾ years before her um and then my nan passed away a couple of years ago, but it is all from one side of the family my aunty was the main one, I think

because her, I am always being told all the time that me and my Aunty are very similar, she used to have me with her all the time when I was a kid, like I would go around with her, she has nose jobs, she had two (laughs)

R: Were you very close to then?

P: Yeah, we was growing up, I was yeah and then my mum and dad had a falling out with her and my Nan so they didn't speak for about four or five years

R: So this was your aunt on your dad's side, your dad's sister?

P: Yeah, they didn't speak for about four or five years, um when I was growing up and then my granddad was ill and they started speaking again and um then three years later she passed away from the leukaemia

R: Gosh

P: But I think with her, it's the main one because of her age, she was 39 do you know what I mean

R: Yeah

P: Like she was so young, she didn't have kids of her own, she had a stepson, but she didn't have any kids of her own, that's what she was on her way to doing and I think with her, I kind of just decided that it just wasn't worth it, worth constantly arguing with my dad about it, because even as much me, my dad grinds on me like no ones business, he is still my dad and you know one day he is not going to be here (crying)

R: How are you doing talking about this?

P: I am fine, no, I just don't like thinking about it

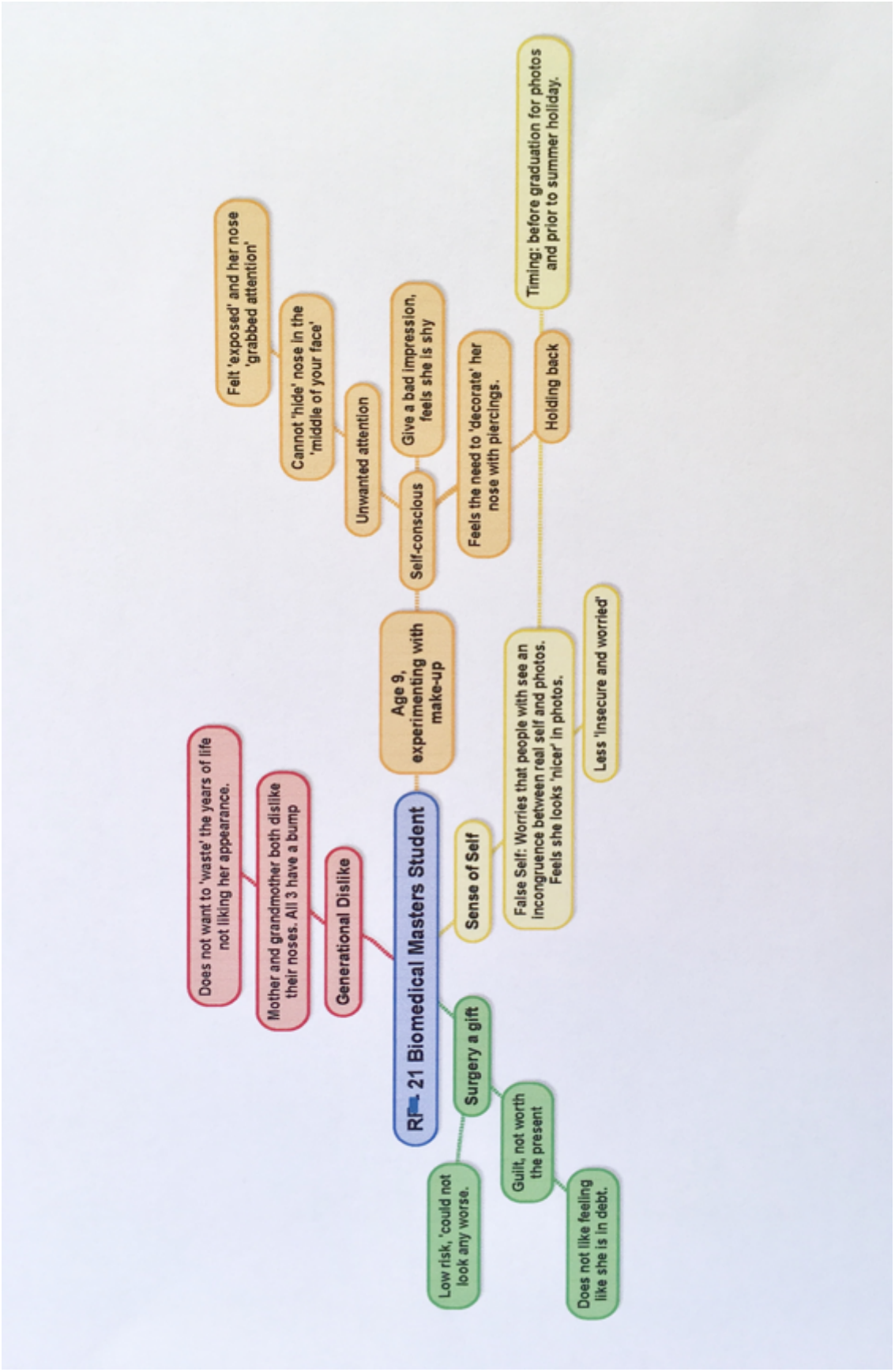
R: Mm, are you surprised to find yourself talking about this?

P: Yeah, (laughs) yeah, no I am fine, but I just don't I know that, that's going to happen one day, and as much me and my dad don't get on he is still my dad

R: And you want to make the most of it

P: Of course and that's why I try even now, in as much I don't care as much what he thinks, and I really don't... I just want to have a good relationship with him, I know he is never going to change, I know that, I am very aware of that

Appendix 6: Mind Map



Appendix 7: Overarching Themes

Themes	Relevant text	Reflections
Societal factors Acceptance of cosmetic procedures Media Influence The consultation The power of discourse Understanding of risk	**RACHEL** Feels the surgery risk is minimal, because 'it could not look any worse'. Rachel feels the surgery happened very quickly and she did not have much time for it to 'sink in'. (contemplation time/stage?) She was not nervous. She said her dad was most worried, because he had paid for her surgery and would 'blame' himself if something went wrong. Surgeon was colleague of family friend. **SARAH** Fear of not waking up after the anesthetic. Seeing her mum whilst under and not wanting to come back. The possible benefits from surgery far outweigh the risks; and this was the same for her when she had her breast reduction. Surgeon - Felt it important that it was somebody she could trust. ***Discourse*** The surgeon asked Sarah what she does not like about her nose and she said the 'bump and length of it'. The surgeon said to her that her nose 'dips', she said, she had not realised how much it 'dips' until the surgeon pointed it out. (What are the surgeons doing? (Impact/damage of initial consultation) Sarah commented 'he (the surgeon), has noticed more than I did'. Surgeon told her, her nose is a 'bit big'. – confirms her belief that she is not normal. **KERRY** She was most afraid of the anaesthetic and 'not waking up'. Very nervous and tearful on the day of surgery. Saw the surgeon on a TV documentary, felt reassured 'he must be good'. Also, important that she felt she could trust him **GEMMA** Saw the surgeon on a TV documentary and felt he was 'gifted' and also felt reassured. She wanted somebody she felt comfortable with.	There is an important similarity of the patient's need to feel that they can trust their surgeon and feel safe with him, all the literature for therapy shows that a successful therapeutic outcome is more based on the relationship between a therapist and client

	The surgery to remove the brain tumour took around 12 hours, so her and her family see the rhinoplasty as just a 'nip and tuck, this is a walk in the park'.	
Familial factors Loss Patriarchal Separation Timing of surgery	**RACHEL** Prior to graduation – does not like photos of herself anyway and especially social media. Summer holiday She is 21 she has had time to think about it, is more mature, has stopped growing, feels the bump has become more noticeable. Mum said was also got worse as she got older! Wanted to have the surgery now, prior to her graduation so that she might be able to feel happy about her graduation photos. Also wanted to have the surgery at this time because it was just prior to her summer holiday and she felt she would enjoy it more if she had it done now. ***Reason*** Does not want to 'waste' these years of her life worrying about her nose. Felt her nose and the way it made her feel 'held my back'. **SARAH** Sarah feels she lost some of her 'confidence' after her mum died and she wants to make her life 'better' now. (Age, deciding moment, confidence) Feels her mum dying the previous year has motivated her to want to do something for herself. *I was always fully independent, I was always taking care of me, when something like that happens although you are so independent, your anchor goes like something that something that holds you together is gone um, I am going to cry, so yeah, something just goes, it's coming back, it's coming back.* ***Reason*** To get her confidence back. Separating herself from her grandfather, changed her surname and will no longer have similar features. ***Family relationships*** Finding it difficult with her brother not wanting to talk to her at the moment, this was her main preoccupation in the 2nd interview, it appears that she finds it very difficult that somebody might not like her at a particular time.	For Sarah it was difficult for her to feel she was being rejected in anyway. – attachment style, insecure attachment fears rejection, also does not believe in being held in mind. Insecure attachment according to Paul Gilbert, is a predisposing factor for developing strong external shame.

	KERRY Kerry has wanted surgery since puberty and it was around the age of thirteen that she believes everything started to change. She feels she had a 'button' nose prior to the onset of puberty and 'it was lovely'. She does not like the profile view, because she feels you can see a 'bump' on her nose. She also feels it looks uneven from the side. Aunt dying from cancer, firstly questioning existing relationships, no longer wants to be worrying about her nose. ***Family relationships*** Kerry started to notice the changes in her nose around the same time as she was beginning to 'clash' with her dad. She does not feel that the two are connected. She feels it has more to do with the fact she used to be a 'daddy's girl' till around the time she started secondary school 'I developed a mouth' and she feels her father did not like that she started to answer him back. Kerry describes her relationship with her dad as being 'strained'. When she was younger, they used to 'clash a lot'. ***Reason for surgery*** To 'increase self-confidence', then hopefully be able to lose the weight she feels she needs to. Feels her nose is stopping her from losing the weight the she feels she wants to. Once she feels more confident following surgery, she feels she will be able to lose the weight and she also then wants to have a relationship. But does not want to have one, till she 'sort these issues'. **GEMMA** In the past, she was afraid of the surgery going wrong, but now following the brain tumour removal, she feels this surgery is just a 'nip and tuck' and she is less fearful. ***Reason*** Hopes the surgery will make her feel 'better and more confident'. 'Motivate' her to get back into shape. She feels her body is 'horrid' and she 'hates' it. Since having the brain tumour, she feels she has focused more on her nose.	

	Control over one's body Gemma felt when her face was paralysed she did not have any control over when it would settle down. She feels having the surgery on her nose is something she can control and change. ***Family relationships*** Gemma feels her dad is 'very set in his ways' and used to put her off buying things like a car or flat because she feels he was 'over cautious' and would worry that she could not afford it. She feels he put up 'barriers'. Growing up, Gemma wished her dad would take her places like she would hear other fathers doing with their children. She feels she is very different with her own children, 'I ferry my kids everywhere'. When she finished school, she decided she wanted a different life to her parents and not just go on the dole as they expected.	
Cultural Factors Intergenerational body image	**RACHEL** Rachel said her nose has a 'bump' on it, the same as her mother and grandmother, both of whom do not like their noses. Her father and her both have a 'hook' on their nose that she also does not like. On the day of her surgery her family felt it important she has somebody to accompany her and so her grandmother attended the hospital with her. Rachel feels this was good because her grandmother can be 'quite a worrier' so by attending she could see that Rachel was ok after surgery. (How integral the family are in the process her surgery) Rachel feels her nose came from the Maltese side of the family. Both her mother and grandmother have a 'bump' on their nose the same as Rachel. Rachel feels she got the 'worst of the looks from her parents'. She says her father's nose has a hook on it. **SARAH** Mum had 'massive' breasts, down to her knees'. Her mum didn't like her own breasts. Mum had 'goofy teeth and always wanted a facelift'. ***Internal dissonance*** Sarah is very sure her mum would have had a facelift if she could afford it. Sarah didn't like the idea of her mum having any surgery.	There is also a theme here, about self-worth, I wonder how hard it might for this young girl to believe in herself and especially her appearance, given the fact that she had both grandmother and her mother disliking their appearance and she looks like both of them. Her internal critic would have developed in such a way as to tell her that she is not acceptable they she is, especially given the fact that neither her mother nor her grandmother accepted themselves. Sarah did not see the parallel that the very similar features her mum did not like about herself, she has not liked or already changed about herself. – this makes me wonder about their attachment, especially given her mum's attachment being taken into care and abused by her father. Then raising two children on her own.

	Sarah found it 'strange' to hear herself say she did not want her mum to have cosmetic surgery when she herself is having it done. Sarah feels 'hypocritical' hearing herself say that, because she believes her mum would have said the same to her, that she was fine and did not need surgery. **KERRY** Father's nose also has a bump on, which she does not like. **GEMMA** Her nose is similar to her twin sisters.	
Intrapersonal Factors Adolescence as primer for shame Body shame Shyness and guilt Fear of negative evaluation – defenses, coping strategies The mirrored reflection Objectification of the body The change after surgery	**RACHEL** Decorate or distract/disguise attention away from her nose, because of the piercings you could not see her nose, piercings in her nose and septum and has had them since she was nineteen years old. She feels that they 'improve my appearance'. She felt that as she does not like her nose, 'I might as well decorate it'. started 'experimenting with make-up' (defences/coping strategies) at around the age of nine (age at onset is a factor) and it was around this time that she started becoming more 'aware' of her nose, feels she has become 'harsher and more critical' of herself since then. Does not like photos, felt that she was not necessarily somebody who was 'noticed'. She feels she was 'quite shy' and would avoid getting noticed 'keep under the radar' and 'hated getting into trouble'. (another defence/coping strategies) ***Change after surgery*** She feels slightly more confident when meeting new people because she no longer 'second guesses myself as much as I used too'. She feels she 'comes across more well'. She previously worried about this because she did not want to give a 'bad impression' or say 'something stupid'. Rachel feels her nose looks 'nicer' now and more 'subtle'. No longer had the piercings as she does not think she needs them. **SARAH** Around 9, 'comments made at school, big nose'. Nan died around the same time. Sarah believes that when she meets people for the first time, they will look at 'my dodgy nose'. Her expectation from surgery is that she will no longer worry about this. For Sarah, (In relation to her nose). Prior to her breast reduction, she would wear tops much larger	Interesting parallel between Sarah choosing to go shopping prior to her interview, I did the same prior to myself interview, we talked about this in my self-interview, as result I recognize just how hard it is to talk about body image issues, so we both went shopping.

	than her size in order to disguise and hide her breasts to avoid 'unwanted attention'. *but yeah that is because usually with like shopping it's pick you up and I know that because I had a really bad break up years ago and I used to, became addicted toshopping because it made me feel good, I never wore half the things I bought and then I realised pretty quickly that actually, this is only a minute fix, so yeah, I know, I know* ***Change after surgery*** Sarah feels her nose looks more 'subtle, feminine, and softer – a lady's nose'. Still feels there are 'imperfections'. A colleague said he could see the difference straight away especially in her profile and other people have also commented that her nose looks very different. Sarah feels it is important that surgeons communicate more with patients about the process especially how long the healing process takes. Perhaps add into clinical considerations, that should surgeons be writing to patients after their initial consultation outlining their process of surgery????Sarah feels it would helpful if surgeons could be more specific with patients about the postoperative process, in particular the healing and swelling. She feels this would help to better prepare patients. (again preparation) She also feels patients need to be better prepared in terms of 'the fact that it gets worse before it gets better'. She didn't really understand what this 'bluntness' would look like on her nose, till she saw it postoperatively 'there is no definition it is just a blob'. *Um… I didn't anticipate how long it would take, and like they can tell, I can sit there and sit there and say Sarah it will take about 6 months it will look really blunt…and* you think ooh what does blunt mean, *I really was not ready for it to come off, I had not prepared myself enough to see it, I was not quite ready to see it.* **KERRY** Around 13, also around this time started to 'clash' (connection to sexual development) with her father, whom previously she had a good relationship. 'I started puberty and developed a mouth'. Kerry feels her nose impacts on how she feels in social situations.	External validation is a very strong theme for all the participants but especially for Sarah, - wedding photos, profile, others noticing the change. Sarah talks about mentally preparing herself, but then in the postoperative interview she talked about not feeling she had enough time psychologically prepare herself. The medical professionals become internalised good objects, hence why they probably given so much power, don't want to disappoint those we feel positive regard from. Sarah says it is important to her, that people notice the difference in her nose after surgery. This verbatim brings into question of what do patients actually to consent/ understand the full extent of what they are undertaking???

	She will also make sure she has done her make-up before she leaves the house. Feels it is the 'first point of vision', wore make-up to ensure it looked 'alright'. (drinking alcohol and make up both coping strategies) She used to put on make-up prior to going to bed as a teenager (this makes me wonder if it was too difficult for her to even see herself naked on her own?) When she goes out and drinks alcohol, she forgets about her nose till she goes to the toilet when she then checks her makeup- and will also touch up her make-up around her nose – **external validation** ***Change after surgery*** Detachment from self-prior, 'Hates' pictures prior to surgery. Feels more confident, existing beliefs about people challenged as some did not notice the change in her. Kerry feels she has received **good feedback (external validation)** from friends and family. People keep saying to her 'Kerry, you look lovely, you look you are glowing'. **GEMMA** Around the age of 15, 'my nose started to bother me'. Only certain angled pictures are acceptable. Hide one's self from the public eye Gemma will try, whenever she can, to avoid attending social events. However, if she has to attend she says 'I will wear black and try and find a table that is situated in the dark' so she can hide herself away. Bullying: Gemma says her depression started around the age of 17 this is also when she was being bullied in school, but there was never any mention of this in the initial interview, in her first interview, she said she was not bullied. Due to the fact she has a deviated septum, she is worried that people can see a part of her nose, 'that you should not normally be able to see'. As a teenager, she felt people were looking more at her teeth because she felt they weren't straight. She has since had her teeth straightened. Gemma feels people will tend focus on whatever area (social world) of your face might not be in line with what is the 'norm'. In her mind, her nose is so 'highlighted' she feels that other people will automatically focus on it.	I wonder if Gemma has a tendency to dissociate from parts of herself that she does not like and experiences and that she has found difficult??? This is an ongoing theme, Gemma regularly has different expectations of to what happens in her life, for example she assumed her eye would return to normal after the paralysis went away, she did not expect to hear yourself being as depressed in the interview summary, she did not expect her nose to look the way it did after surgery.

Appendix 8: Journal Excerpts

First

I have found it challenging transcribing Gemma's interview as I found it difficult to stay focused with what she was saying. She has a number of co-morbid issues which she mentions towards the end of the interview, however, now that I am transcribing it with these issues in mind I recognise I am feeling distracted by how she feels about herself, seems to have layered meanings in terms of her body image and the impact this has on how she lives her life.

When I met with Gemma to do second interview, she said she was 'shocked' when she read her summary from the first interview. Firstly, she had not realised how depressed she was at the time of the interview and secondly because of the amount of personal information she had shared with me. Hearing her recognise how depressed she was feeling, I started to recognise why I had found her first interview so hard going when transcribing and re-listening to it. I felt so weighted down by something and found myself taking frequent breaks and only being able to do small amounts at a time.

Second

It is interesting how two of the research participants (Gemma and Sarah) were very giggly at the start of the interviews and then as it continued, they became more sullen, one of them even crying during both interviews. My wonder if whether the laughter marks the sadness that lies beneath, there may also be a mixture of anxiety resulting in the laughter but I wonder if it is more to do with hiding the sadness and possibly from me for fear that if I hold power can I then dictate whether or not their surgery goes ahead based on their mental health? Perhaps when feeding back the narratives could explore this especially with the last patient.

Third

I found myself shifting position in terms of how I feel towards the surgeons who perform these surgeries. When I was working for a surgeon as his PA, I held him in high regard and was in awe of the work that I saw him do, but as I have journeyed through my research I felt myself shifting position regarding cosmetic surgeons. I still think they are very talented at what they do, but wonder about their morals and ethics in terms of deciding to become cosmetic surgeons operating on people who essentially do not have anything medically wrong with them on a physical level, but more psychological. Once my research is complete I would really want to approach a surgeon and have a discussion about how and why they end up in this field.

This research journey has been challenging for me on a number of different levels, I regularly found myself experiencing feelings in parallel to the patients in terms of a search for perfection. I am researching about a search for perfection; I have a tendency to want perfection, so undoubtedly this gets entangled in my research process and how I do the work.

Appendix 9: Leaflet for patients

Common questions about psychological support and cosmetic surgery

Why am I being referred to the psychological services team?

Try not to be concerned at this time, a referral to the psychology team does not mean your surgeon is not prepared to operate, it only means that he/she feels that for any of the following reasons (loss, trauma etc.) seeing a mental health professional as part of your surgery journey would ensure an integrative approach to your care where your psychological and physical wellbeing through surgery are being looked after.

Does this mean I am going to be told that I should not have surgery?

In some cases, it may be advised that you perhaps delay your surgery or do not have surgery. However, if this is the case, it will be discussed with you to ensure you feel that you have fully understood the reasons for this decision.

How will it help me with the surgery to see a psychologist, psychiatrist or psychotherapist?

If you have been referred to the psychology team, this will be because your surgeon feels that time with a psychologist will help to ensure your journey through surgery looks after both your physical and psychological wellbeing. The surgeon may feel this would be helpful due to that the fact that perhaps you have recently suffered a bereavement, significant relationship breakdown be that partner, child or parent. A mental health issue for example battling with an eating disorder, depression or severe anxiety. Or perhaps, there have been other major life changes for example a traumatic experience, which mean that normally it would be advised that at this particular time, making any life altering decisions (major surgery being one of them) is not recommended.

How will my surgeon know whom I need to see?

Based on the information you share with your surgeon in the initial consultation process, either the surgeon will decide which mental health professional would be most helpful for you or alternatively you will be seen by the lead psychologist for an initial assessment session, which can be done via phone or face to face.

Appendix 10: UKCP Research Conference Poster

The experience of female patients seeking elective rhinoplasty surgery: a narrative inquiry

Deborah Auer, Psychotherapist, UKCP; BACP (Accred.)

Doctorate in Counselling Psychology and Psychotherapy

WARNING

Reflections in this mirror may be distorted by socially constructed ideas of beauty

INTRODUCTION

This research explored the experience of four female patients' motivation to have rhinoplasty surgery, taking into account societal, familial, cultural and intrapersonal influences. We develop a relationship with our bodies through the physical and psychological interactions we have with our caregivers. These will naturally be influenced by the cultural and societal context within which we develop (Northrop, 2012).

How are our bodies being portrayed in the media and is this contributing to our on-going need for the perfect body.

The body that is seen as 'not right' or the 'norm' of society can contribute to a host of female body issues for example anorexia nervosa, obesity, agoraphobia frigidity and depression which then also contributes to feelings of shame and guilt (Davis, 1995).

AIM

To understand how preoperative and postoperative psychotherapy can support cosmetic surgery patients.

We need suitable research to identify what patients would find helpful from a psychological perspective (Dittmann, 2005).

This study could raise awareness of patient's mental health prior to proceeding with major surgery. It will help surgeons be better-informed about the patients' decisions to pursue surgery and whether their expectations are obtainable by going 'under the knife'.

From a sociological and psychological perspective it could inform society in general as to the reasons why women in particular seek cosmetic surgery and more specifically rhinoplasty surgery.

FINDINGS

The findings indicate that patients seeking surgery are likely showing symptoms of body dysmorphia. The literature around the area of body dysmorphia and body dissatisfaction states that cosmetic surgery has a poor outcome ratio for this patient group and for some it can even worsen their preoccupation with their body. (Castle et al, 2004).

The findings show that for all the patients a motivating factor for surgery was to have a different nose to either their father or grandfather. Three out of the four patients interviewed also mentioned having a difficult relationship with their fathers, indicating that family relationships impact on patients decisions to pursue cosmetic surgery.

It is vital for therapists, to have knowledge and understanding of how to work with this client group, as talking about body dissatisfaction can be felt as a very shaming experience for some individuals

Shifting beliefs

'Most people said before I had it done, most people said to me they don't understand why I am having it done, there is nothing wrong with it, all that stuff and obviously I felt differently, but to me what they were saying, did not make any difference, but in my mind, I suppose, I don't quite believe it, if that makes sense in my mind I am thinking how do you not notice, come on now, don't be stupid, but then obviously when people are seeing me afterwards and not realizing, I'm thinking, was there so much of a difference?'

'A lady's nose different to my grandfather whose nose was bloody horrible, yeah mine was too crooked, too bulbous at the bottom, but now look!'

Expectation from surgery

All four patients were expecting surgery to make them feel more confident in themselves and more comfortable when meeting new people.

'The surgeon could actually change my life and make me feel more confident, get a little bit of me back'.

'I know it's not something that is going to hold me back any more, I know it is something I am not going to have to constantly worry about it in any situation now, you know.'

METHODOLOGY

A narrative inquiry methodology was chosen for this study as it is appropriate to use when people are discussing major life events (Riessman, 1993). All the patient's interviewed felt their cosmetic surgery would be life changing in different ways. The decision to use narrative is to gain some understanding of how individuals come to the decision to proceed with surgery and not just the meaning of particular experiences.

Four female patients were interviewed preoperatively and postoperatively using unstructured interviews.

Mirror, Mirror on the Wall,
who
is the Fairest of them all?

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