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Shame and the Body

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Submitted in fulfilment of the requirements for the degree of:
Doctor of Psychology

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November 2010

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Acknowledgements

To the participants, thank you for your generosity and courage.

To my supervisor, Dr Jacqui Farrants, thank you for your interest, enthusiasm and for always asking me the important questions.

To my family, partner and friends, I could not have done this without all of your unwavering support and patience, thank you.

Preface

This thesis is primarily concerned with aspects of theory and practice in Counselling Psychology, with a focus on the issues of shame and the body. I will start by outlining the sections of the portfolio, and will move on to discuss the evolution of it as well as some of the threads which weave throughout the different sections. I will end by reflecting on professional issues which have been realised for me in the writing of the thesis.

i. Sections of the portfolio

- Section A: Firstly I will present the research study which explores the lived experience of a changing body. This is investigated specifically in the context of individuals who have lost significant amounts of weight and have had the resultant excess skin removed by plastic surgery.

- Section B: Secondly I will explore the factors and processes which enable resilience and positive adjustment in individuals living with a visible difference. This exploration takes the form of a critical literature review.

- Section C: Thirdly I will present a clinical case study. This study considers professional aspects of clinical practice throughout work with a particular client. Key aspects in this clinical piece of work resonate with issues which arose from the analysis of the research study and the critical literature review.

ii. Evolution of the portfolio

The term 'evolution' relates to the organic and dynamic nature of the development of this portfolio. Rather than embarking on a portfolio entitled 'shame and the body', this title has emerged from the analysis of the research and the synthesis of these pieces of work. Whilst the research questions in both the research study and literature review were explicitly formed, the centrality of shame and the deepening consideration of embodied existence emerged from the findings.

When considered together these pieces of work illustrate my allegiance to the scientist-practitioner role of a Counselling Psychologist. I suggest that their coherence and

connectedness is evidence of the iterative and multidirectional relationship between theory and practice that I have experienced in my training. As is described below, whilst my research was inspired by clinical experience, my research has gone on to both inform and inspire clinical work.

The seeds of my interest in the experience of adjustment to a change in appearance started to flourish when working in the psychology team in a plastic and reconstructive surgery department of a London hospital. I worked there firstly in a research and later in a clinical capacity. I became fascinated in the breadth and variety of clients' experience of this adjustment process and became increasingly curious about the factors and processes which determined this. I wrote the first version of the critical literature review exploring this in 2007. This has since seen extensive revision, in both updating the literature as well as the refocusing on aspects of resilient and positive adjustment. This focus was inspired, not just by my experiences in that department, but my experience of awe at the resilience, strength and determination I have, and continue to witness in my clients in all the contexts I have worked.

Whilst in this department I became particularly interested in the bio-psycho-social experiences of individuals who were previously classified as obese, who had lost a lot of weight and were applying to have their resultant excess skin removed by plastic surgery. My fascination with this population is likely to have been influenced by my witnessing the experiences of my sibling, who also lots a significant amount of weight over a short period of time. When meeting with these individuals clinically I was struck by the level of their distress and their belief that further physical change would soothe it. I then decided to embark on a research project to investigate it. I conceptually embarked on my doctoral research in 2008, collecting my data in 2009 and analysing and writing it up in 2010.

My motivation to present the case study stems from connections I experienced in the case, that link to both my research findings and also aspects of the critical literature review. In addition I found the work inspiring and fascinating. This clinical work took place in my final year placement in a Community Mental Health Team from the end of 2009 to 2010. These dates have been presented to contextualise the pieces of work. It seems important to reflect on the fact that whilst I was engaged in this piece of clinical work I was also interviewing and transcribing interviews for the research study.

In presenting the research project first I hope to use the opportunity of a critical literature review and a case study to continue to reflect on and contextualise some of my research findings. In addition, I hope to illustrate the iterative relationship between theory and practice.

Whilst it is traditional for academic pieces of writing to be presented in the third person, I have chosen to write this thesis in the first person. My experience as a practitioner and a qualitative researcher has informed my critical realist epistemological standpoint. My interest is in how individuals subjectively make sense of their experiences. I believe that as soon as I try to make sense of this, I am immediately and inextricably bound up in the work myself. I find this to be the case when reviewing, collecting and analysing data, as well as in therapeutic encounters. It would therefore seem incongruent to present the work in a way which implicitly distances me from it.

iii. Themes permeating throughout the Portfolio

The body has been a central and evolving theme in this thesis. Initially my interest was in the experience of a change in appearance, which influenced both the research study and critical literature review. It became immediately obvious that participants were experiencing far more than a change in appearance. It seemed they were in fact adjusting to an embodied shift which affected not only how they looked but their entire embodied existence. This realisation led to a refining of the research question and a broadening and deepening of my consideration of the experience of a changing body.

In a cultural moment when it seems increasingly impossible to escape the fierce and exacting messages about how are bodies should be, it is unsurprising that the client in my case study as well as the participants in my research seem to have been touched by this. Resiliencies that my client discovers and builds on in our work connect to some of the factors and processes enabling resilience and positive adjustment illuminated in the critical literature review.

Shame is another theme which is woven throughout the portfolio. In the case study shame evolved as a central aspect of my client's experience and therefore was implicated in our working formulation. As discussed in the critical literature review, the experience of shame in individuals with visible differences is widely reported. Shame also emerged as a central theme in the analysis of the research project. This has been considered in the cultural context discussed above.

Over the course of my clinical training I have grown to consider my compassion as my primary therapeutic tool. This is highlighted in my clinical work in the presented case study. No doubt informed by my clinical theoretical orientations, I have discussed the potential helpfulness of compassion focussed Cognitive Behavioural Therapy interventions with the participants in my research study. This inclusion of a case study evidencing the processes and effects in this kind of work hopes to provide the reader with further insight into my suggestions.

The process of adjustment is a central theme to this portfolio. Adjustment to living with a visible difference and to a changed body following weight loss and plastic surgery are two of the adjustment processes more explicitly considered. In the case study, the process of my client's adjustment to adopting a more compassionate stance towards herself is a central aspect of the work. In addition, adjusting to the experience of an alternative relationship with me, and therefore adopting an alternative position herself is implicated.

iv. Theory and practice of Counselling Psychology

My personal and professional commitment to the underlying humanistic principles of Counselling Psychology has informed the positioning of clients and participants at the centre of this portfolio. Whilst theory has been drawn from and personal interpretations have been made, it is hoped that the importance of the voices of the individuals who have participated in the research and clinical practice are heard.

The development of this thesis has been both a clarifying and a blurring experience in relation to the boundaries of Counselling Psychology. Whilst in some ways I have felt clearer about my professional values and commitments, I have been reminded of the blurred and broad boundaries of the profession. This latter realisation has strengthened my commitment to resist the temptations of narrowness, complacency and elitism and to continue to remain open to critical and broad ranging considerations.

I have specialised in the theory and practice of CBT over the course of my training and this will inevitably have influenced the methods of making sense of the data, as well as my suggestions of clinical implications throughout the thesis. Over the course of my training I have practiced in a variety of other therapeutic models, including systemic and psychodynamic. My choice to specialise in CBT, like my decision to conduct

phenomenological enquiry, has been informed by my wish to achieve congruence between my personal perspectives and standpoints and my professional approaches to both research and practice.

I have found the process of compiling this thesis a challenging, fascinating and inspiring one, which also reflects my experience of my professional training. I have found it a helpful tool in refining my professional commitments and values through the in-depth reflection on both my scientist and practitioner role and, of course, their interconnectedness.

Section A: The research Study

A changing body: The experience of women who have lost a significant amount of weight and had resultant excess skin removed by plastic surgery.

Abstract

This study explores the experience of women who have lost a significant amount of weight which has resulted in excess skin and who have subsequently undergone plastic surgery to remove parts of this excess skin in a London National Health Service hospital. It aims to shed light on the lived embodied experience of a changing body.

The research took the form of a qualitative, idiographic inquiry. Due to the relative dearth of literature and strong potential for 'anti-fat' bias in this area, it was deemed important to remain rooted to the participants' experience.

Eight previous patients of the Plastic and Reconstructive Surgery Department of a London Hospital took part in in-depth, semi structured interviews one year post plastic surgery to remove the excess skin around their abdomen, following weight loss.

Participant interviews were transcribed and analysed using Interpretative Phenomenological Analysis. The overarching theme of 'Destabilised Embodiment' emerged with two inter-related constituent themes: 'Turbulent past experiences of embodied existence' and 'self-acceptance in continued flux'. Each of these consists of several sub-themes. The results of the analysis represent my interpretation of participants' interpretation of their own lived experience.

These findings are considered in relation to the wider literature and links are made with theoretical models regarding shame and lack of acceptance. Discourses relating to the body are also considered. Clinical implications of the findings are discussed.

1.0. Introduction Chapter

1.1. Introduction

"A search for contentment focussed around the body is a hallmark of our times" (Orbach, 2009, pp 13).

Western culture's preoccupation with beauty and thinness exists alongside a fixation with an obesity 'epidemic'. The Department of Health estimated that 22.1% of men and 24.3% of women were obese in 2005 (Department of Health 2006). Despite the apparent prevalence of obesity, it is not accepted in a culture that designates the obese body as out of control and 'rapacious' (Orbach, 2009). It is therefore not surprising that at any one point in time one in four women, and one in ten men are estimated to be dieting to lose weight (NICE, 2006).

The number of people requesting cosmetic surgery to alter their appearance is rapidly increasing (Sarwer, Pertschuk, Wadden & Whitaker, 1998). A recent audit by the British Association of Aesthetic Plastic Surgeons reports that despite the recent recession, the amount of cosmetic surgery procedures rose by a further 6.7% between 2008 and 2009. Whilst men are undergoing more and more procedures, of the 36, 400 procedures 32, 859 were performed on women (BAAPS, 2010). In a cultural moment in which so many are encouraged to transform their bodies (Orbach, 2009), it seems pertinent to consider the psychological experience of body transformation.

Excess skin is a frequent result of significant weight loss and has been suggested to cause discomfort and significant appearance related distress (e.g., Boccheieri, Meana & Fisher, 2002). It is predicted that as more obese people lose significant amounts of weight, the demand for cosmetic surgery to remove their resultant excess skin will increase substantially (American Society of Plastic Surgeons, 2003). However the psychological experience is relatively unknown.

This chapter will consider the existing literature and ways of conceptualising the lived experience of people who experience a changing body following significant weight loss and subsequent plastic surgery to remove the resultant excess skin. First I will consider adjustment to a changing body and appearance. I will then review findings relating to obesity, weight loss and plastic surgery. Because of the multiple fields of research

which are relevant to this title, I will briefly review the relevant findings within them and then go on to discuss the research studies relating to the specific experience of plastic surgery following weight loss in more detail. Studies published in the last five years will be attended to with deeper consideration than those that are less recent. There continues to be a paucity of qualitative research in this area. For this reason, and because it allows for an alternative form of knowledge production, it will be paid particular interest throughout the review. I end by summarising what we know so far and introducing the current study.

1.1.1. A note on language:

The loose skin remaining post weight loss is referred to in different ways by the researchers in this field. This ranges from 'skin redundancy' (Sagrillo and Kunz, 2004) to more charged and potentially offensive terms such as the 'saddlebag deformity' (Hurwitz, Rubin, Risin, Sajjadian and Sereika, 2004). Individuals I have encountered who have lived through this experience preferred to call the loose skin 'excess skin' and referred to the skin around their abdomen as 'abdominal overhang'. These terms will therefore be used throughout this thesis.

The terms used to describe people with an above average body mass index (BMI) range from the offensive to the cruel. Participants in this study referred to themselves before they lost the weight as 'big' or 'obese'. These are therefore the words I will use to describe this population.

1.2. A changing body (and appearance)

Evidence of human's interest and concern with appearance can be dated back to 30, 000 years ago, when it is recorded that people in Africa decorated their faces (Bates and Cheese, 2001). As Rumsey and Harcourt (2005) list, as long as records have existed, there has been evidence from all parts of the world, that humans have invested in their appearance; from neck lengthening in Thailand, to lip insertions in tribes in Africa and South America, to foot binding in China, to the insertion of the toxin Botox to smooth wrinkles in contemporary western society. Today's western society now offers a phenomenal number of ways to 'enhance' one's appearance, including dietary restrictions and, more and more commonly, undergoing major and potentially life threatening cosmetic surgery procedures. The world- wide cosmetics business is now

estimated to have reached 160 billion dollars a year, which, Orbach points out (2009) equates to a third of the world's steel industry.

As it is often the first source of information to a person perceiving us, potent cues for identity and recognition are provided by our physical appearance. Dion, Bercheid & Walster (1972) and Eagly, Ashmore, Makjihani and Longo (1991) have provided evidence suggesting that judgements of personality and morality are made from people's appearance.

Rodin, Silbertstein and Streigel Moore (1985) termed the phrase 'normative discontent' when describing levels of appearance dissatisfaction in contemporary western society. However researchers in the field of appearance dissatisfaction (e.g., Thompson, Heinberg, Altabe and Tantleff-Dunn, 1999) stress that whilst this discontent may be normative, it is certainly not benign.

Harris and Carr (2001) conducted a survey of more than 1200 adults and found that 25% of women and 19% of men who were found to be concerned with aspects of their appearance, indicated significant behavioural dysfunction and psychological distress. Many of them had levels of distress as severe as patients with objective visible differences. Difficulties included social avoidance, difficulties in intimate relationships, beliefs they were unlovable and physically unattractive and feelings of isolation (Harris and Carr, 2001). Whilst a meta-analysis of 222 studies concluded that higher levels of body dissatisfaction are continually measured in women than men (Feingold and Mazzella, 1998), dissatisfaction in males is rising.

Body Dysmorphic Disorder (BDD) is a psychiatric diagnosis characterised by the DSM-1V-TR as a pre-occupation with an imagined 'defect' in appearance. If the concern does centre around an aspect of appearance that is different from 'normal', the individual's concern would need to be perceived as 'excessive' to render a diagnosis (DSM-1V-TR, 2000). It is a diagnosis that, according to Castle, Rossell and Kyrios (2006), sits 'uneasily' subsumed under somatoform disorders. They discuss BDD's substantial overlap in symptomology with obsessive compulsive disorder and social anxiety disorder. Sarwer et al (2008) report studies which have indicated that between 5 and 16 percent of plastic surgery patients meet the diagnostic criteria for BDD (e.g., Sarwer, Wadden, Pertschuk and Whitaker, 1998). Plastic surgery has been found to contribute to worsening of symptoms of body dysmorphia, and is therefore contraindicated in these cases (Crerand, Franklin and Sarwer, 2006). As Sarwer et al

discuss (2008), because the bodily 'deformities' experienced by post weight loss plastic surgery patients are not 'slight 'or 'imagined', their concern about their appearance does not meet the criteria for a diagnosis of BDD. They state that whilst this is the case, the level of preoccupation with their appearance can be of a similar degree with patients with a diagnosis of BDD (Sarwer et al., 2008).

Body change occurs to everyone, to differing degrees throughout their life time. We all experienced bodily change in childhood and adolescence, and will all continue to experience it until we die. Bodily change can stem from human development (e.g., adolescence), various life stages (e.g., pregnancy), our behaviour (e.g., weight change) or medical conditions (e.g., Cancer). Other changes require people to negotiate sudden and sometimes considerable changes to their body and subsequently, their appearance. They can occur from events such as burns, paralysis, surgery, trauma and disease (Clarke, 1999). It is important to bare in mind that the change in appearance that is the subject of this thesis is driven by the individual, who hopes to lose weight and undergo plastic surgery.

Research into the appearance related distress experienced by people who do not have a visible difference falls predominantly within the wealth of 'Body Image' literature. The term 'Body Image' has been used to describe a number of psychological constructs, including attitudes towards appearance, body weight, body size, body competence and gender-related aspects of the body (Thompson and Kent, 2001). Research concerned with the process of adjustment to a change in appearance falls mainly within in the body of literature on visible differences, however, as previously mentioned, these are not the only experiences of adjustment to change in appearance. Rumsey and Harcourt (2005) state that drawing a line between what does and does not constitute a visible difference is not a straightforward task. Whilst obese participants typically drive their change in appearance through weight loss, their resultant excess skin tends to be an unwanted change in appearance. Excess skin following weight loss has been described as 'disfiguring' by some (Bocchieri, Meana and Fisher, 2000).

In their review of the literature Thompson and Kent (2001) conclude that adjustment to a visible difference is a multifaceted process, including intra-personal, inter-personal and societal factors. Rumsey, Bryon-Daniel, Charlton, Clarke et al., (In press) recently conducted a national study funded by 'The Healing Foundation' investigating the psychological factors and processes contributing to a successful adjustment to a range of conditions with a visible difference. A large scale cross-sectional questionnaire-

based study involved 1265 participants with a range of visible differences. The questionnaires measured the cognitions, emotions and behaviours of those living with a visible difference and also included free text questions which were qualitatively analysed. They also conducted two longitudinal studies using the same measures, with a nine month interval follow-up on 360 participants. Qualitative interviews were conducted with 26 participants relating to stability and change in the adjustment process.

Findings confirmed that adjustment is a multi-faceted process affected by multiple factors. Characteristics found in those who were positively adjusted included cognitive factors, for example lack of fear of negative evaluation and increased perceived social acceptance, as well as dispositional factors such as optimism. Authors state that adjustment is also a dynamic process and that fluctuations can be triggered by a variety of events, including developmental milestones and life events. Appearance related distress was found to be higher in women but the differences were small and many men were significantly distressed. In addition, whilst appearance related distress was found to decrease with age, large numbers of older people were distressed about their appearance. Results confirmed previous findings that the extent of a visible difference did not predict the amount of distress experienced, and that living with a minor disfigurement could significantly impact on a number of psychosocial aspects (Rumsey et al., 2010). This study provides a large amount of data that is considered in a variety of different ways and offers important, innovative and promising findings relating the experience of living with a visible difference. It also focuses on the development of employable recommendations for intervention. This is a welcomed focus on linking research findings directly to practice. Further analysis of this study and the process of adjustment to a visible difference is in the Critical Literature Review.

How do people adjust to change in body and appearance which is not one that determines them visibly different or is related to illness, but that is a part of usual development such as ageing? Tiggemann (2004) conducted a review on the experience of body (dis)satisfaction across the adult female life span. Much of the research she presented concludes that women tend to experience relatively stable body dissatisfaction across their life span, despite their body moving further from the ideal body later in age. She states that the importance of body shape, weight and appearance tended to decrease with age. This finding underscores importance of the distinction between an individual's evaluation of their appearance, and the importance they place on appearance (Tiggemann , 2004).

Another female experience of marked body and appearance change is that of pregnancy. This experience is likely to differ substantially from the weight loss and excess skin removal experience. However, the literature provides some interesting insights into the area of body change and associated psychological processes.

Quantitative studies conducted up to over thirty years ago suggest that women's attitudes to their bodies worsen in pregnancy as their body moves further away from their ideal body shape, and that this becomes progressively worse as pregnancy progresses (e.g., Strang and Sullivan, 1985; Moore, 1978). In stark contrast, more recent studies suggest that women are more satisfied with their weight and shape during pregnancy and after (e.g., Wood Baker, Carter, Cohen & Brownell, 1999). Clark and Ogden's (1999) findings suggest that women who are pregnant experience less body dissatisfaction that non-pregnant women. On the one hand pregnancy appears to be an antagonist for body dissatisfaction and on the other it seems to serve a protective function against it. Researchers examined factors which might explain this contradiction. Copper, DuBard, Goldenberg and Oweis's (1995) findings suggest that thinner women were more positive about weight gain in pregnancy however this finding was contradicted four years later by the findings of Williams and Potter (1999). They found that body image was more likely to improve in women who were overweight before pregnancy (Williams & Potter, 1999).

As stated by Johnson, Burrows and Williamson (2004), it appears that the predominantly positivistic approach taken, which generally assumes that there are underlying laws about human experience to discover, has fallen short of providing useful findings that can be applied to the care of pregnant women. In response to this, Johnson et al. (2004) provided a qualitative approach to exploring the meaning of bodily change in first time mothers to be based, instead, on the assumption that psychological and social life is the outcome of human interaction. They interviewed six women in the latter stages of pregnancy. Their analysis drew from both Interpretative Phenomenological Analysis (IPA) and Foucauldian discourse analysis (FDA). In doing this they hoped to both illuminate the individual lived experience and to reveal the discursive resources involved in constructing this experience. Three themes were identified in the IPA; 'the dynamic nature of body satisfaction during pregnancy'; 'the varied impact of pregnancy on perceptions of the body' and 'the changing boundaries surrounding the body'. I am immediately struck by the complex and dynamic nature of these themes which could explain some of the contradictions in the previous quantitative findings. It seems that the experience required a richer description than the

polarized variables of body satisfaction vs. dissatisfaction could offer. In addition, bodily changes were not all related to external aesthetics but were also experienced in internal sensations, disrupted boundaries and restriction of movement. These were novel discoveries that were not previously measured in the quantitative research.

Three discourses were identified in the FDA, which all were located within a wider discourse of femininity. These were, 'pregnancy as transgressing dominant ideals for feminine beauty', 'pregnancy legitimising the transgression of idealized feminine beauty' and 'contexts and positioning'. This linking of IPA and FDA enabled an insightful exploration and the production of meaningful and thought-provoking findings. It also illuminates the usefulness of qualitative inquiry in enabling the complexity and rich nature of human experience to become visible.

Research seems to suggest that psychological experience of appearance often causes significant psychosocial distress and that the experience of appearance change is a complex, multifaceted and dynamic process.

1.3. Obesity

When considering the experience of body change I believe it is pertinent to reflect on the experience of the body before it changed. For this reason I will now briefly review literature relating to the experience of having an 'obese' body.

Mitchell and de Zwaan (2005) describe obesity is a public health problem that has reached epidemic proportions in much of the developed world. No country has managed to reverse the trend (Department of Health, 2006). The 2007 health profile of the United Kingdom by the Department of Health found that whilst other health risks (like smoking) were successfully being reduced, obesity rates continue to rise and to be the highest in the European Union (Department of Health, 2006). The cost of currently obese people on the NHS has been estimated at 3.2 billion pounds (Allender and Rayner, 2007).

Severe obesity is associated with significant health problems including cardiovascular disease, certain forms of cancer and diabetes to the extent that severe obesity is associated with a twofold increase in total mortality (Sjostrom, Larsson, Backman, Bengtsson, Bouchard, et al., 1992). However health problems appear to be only part of the burden of distress for obese individuals in today's society. Sawer, Thompson,

Mitchell and Rubin, (2008) report that many obese individuals seek bariatric surgery for its anticipated psychosocial effects. Halmi, Stunkard and Mason (1980) found that for 70% of patients, improving body image was the primary motivation for undergoing bariatric surgery for weight loss. In their extensive review of the literature Herpertz, Kielmann, Wolf, Langkafel, Senf and Hebebrand (2003) concluded that psychosocial status (e.g., employment opportunities and social relationships) as well as mental health improve for most who have bariatric surgery to lose weight. This further implies that, along with health problems, obesity brings with it a significant appearance dissatisfaction and psychosocial burden.

Much of 'Obesity Research' has considered links between childhood abuse, psychiatric diagnoses and eating disorders in the population. An association has been documented between childhood abuse and obesity (e.g., Williamson, Thompson, Anda, Deitz and Felitti, 2002). A higher prevalence of axis 1 psychiatric disorders, most commonly anxiety and mood disorders, is also suggested (Sarwer, Cohn, Gibboms et.al, 2004; Rosenbergerm Henderson & Grilo, 2006). However these findings vary greatly. Earlier studies suggested that up to half of patients displayed binge eating disorder features (e.g., Mitchell, Lancaster, Burgard et al., 2001, & Wadden, Sarwer, Arnold, Gruen & O'neil, 2000). Allison, Thomas, Sarwer et al's (2006) more recent study into both night eating and binge eating disorder appeared to follow the diagnostic criteria with rigour. In stark contrast, their results suggest that the prevalence could be as low as five percent.

It has been repeatedly stated that obese people are the last socially acceptable targets of discriminations (e.g., Kilbourne, 1994; Faulkner, French, Jeffery, Neumark-stainer, Sherwood and Morton, 1999). Puhl and Brownell reviewed information on discriminatory attitudes and behaviours against obese individuals (2001). They concluded that clear and consistent stigmatisation, and in some cases discrimination, is documented in three major areas of living; employment (e.g., Pingitoire, Dugoni, Tindale and Spring, 1994), education (e.g., Crandall, 1995) and health care. Schwartz, Chambliss, Brownell, Blair and Billington (2003) investigated the level of anti-fat bias in health professionals who specialise in obesity by identifying personal characteristics which correlate with implicit and explicit bias. An implicit and explicit associations tool was used. Whilst the results unsurprisingly illustrated a significant pro-thin and anti-fat implicit bias, it also illuminated that participants significantly endorsed the implicit stereotypes of lazy, stupid and worthless in relation to obese people. They argue that this illustrates a powerful stigma. Phul and Brownell (2001) state that this stigma leads

to a reluctance in some cases for individuals to seek medical care, especially for their obesity.

In this cultural context, which rewards thinness, it seems unsurprising that Sarwer, Gibbons and Wadden (2004) identified a positive correlation between body mass index and body image dissatisfaction. Obese people have been found to experience significantly higher levels of appearance related distress than controls (Adami, Gandolfo, Campostano, Meneghelli, Ravera & Scopinaro, 1998). Many studies have included all female participants, and the results of these have indicated that body image dissatisfaction in obese women is often co morbid with decreased self esteem as well as depressive symptoms (Schwartz and Brownell, 2004; Grilo, Wilfley, Brownell & Rodin, 1994; Sarwer, Wadden & Foster, 1998).

1.3.1. The Obesity debate

The 'Obesity epidemic' is not an uncontested phenomenon. A minority of researchers suggest that the numbers of overweight and obese individuals are hugely inflated, due to the crude measurement of BMI. Paul Campos (2004) states that because the BMI measurement is not adjusted for those who are extremely fit and muscular, they are often included in the statistics for the overweight and obese. He states that according to the BMI measurements Michael Jordan would be classified as overweight and George Clooney would be 'Obese'. Botterill (2006) challenges several propositions that are made by those intent on reducing the numbers of obese people. This includes her challenging of the validity of the 'proven' link between individual weight gain and increased disease. She interrogates the suggestions that if we do not act now, that public health systems in the developed world will collapse due to the strain laid on them by the obese. She challenges the often assumed notion that weight loss itself is risk free, and suggests that it is not possible to state confidently that scientific evidence relating to obesity is objective and free from bias (Botterill, 2006). To this end she calls for the values that underpin public health proposals to be transparently articulated. She states that moral panic and hyperbole (e.g., use of term 'epidemic') 'add more heat than light' (Botterill, 2006, pp.500) and that they do not lead to sensible debate about policy.

The majority of research in the field of obesity is quantitative in nature and contains little of the reflexivity and transparency called for by Botterill (2006). A minority of

researchers have adopted a qualitative methodology in exploring individuals' experiences of obesity.

Grant and Boserman (2005) considered how individuals make sense of being 'fat' using a qualitative hermeneutic analysis of adults' explanations for obesity. They explicitly state that their interest in this subject comes from their own personal experiences with obesity and weight loss. This is a welcomed statement which transparently introduces the concept that researchers are not void of personal motivations and interests relating to their topic. Critically it then opens up the possibility of reflexivity to enable a reduction of the effect of this on their research. 11 participants were interviewed who had a BMI of 40 or higher.

They state that patterns of eating and relationships with food were developed in childhood and revolved around family interactions and tacit rules. They state that half of their participants reported abuse during childhood, which supports previous correlations in the literature (e.g., Williamson et al., 2002). One sub-theme is named 'tensions and contradictions'. An example of this is the tendency for participants to assign blame internally for their lack of control over food, whilst also stating that food was in control of them. The authors highlight the importance of early childhood experiences of food, and the damaging consequences of parental use of food to exert control over the child.

In a narrative analysis of a television talk show discussing obesity, David Giles (2003) discusses the medicalisation of identity in obesity and weight loss (e.g., 'obesity sufferer', rather than 'a big man'). He discusses the fact that obesity is a contested illness in the world of psychology, however in the television programme it was frequently referred to as an illness. This is in contrast with other pervasive discourses relating to blame and accountability in obesity. It seems that this discursive confusion is likely to contribute to the difficult position that these individuals find them self in. Giles suggests that this could be informative when considering psychological treatment. Authors of both of these studies suggest how their findings could inform psychological or psychotherapeutic intervention with this population.

Research in the field of obesity suggests that existence is rife with psychosocial, as well as health problems. Strongly convergent arguments exist relating to the extent of the 'problem' and it is suggested that western society's anti-fat bias is shaping the knowledge that is produced.

1.4. Weight loss

The weight loss industry has flourished alongside the widespread desire and pressure in westernised cultures to achieve slimness (Bidgood & Buckroyd, 2005). In the light of the literature describing the position of the 'obese' in this un-accepting society, it is not surprising that many individuals are motivated to lose weight.

Tinker and Tucker (1997) investigated motivations for weight loss and behaviour change strategies associated with 'natural recovery' from obesity (positioning obesity firmly within the illness discourse). Participants in the study had maintained weight loss for a mean of 4.5 years. Motivations were reported as 'largely negative' and reflected appearance and psychosocial problems. Only 25% of participants cited concerns about their future health as one of a number of motivators. The retrospective nature and recalling motivations in the hindsight of weight loss success could have implications for the validity of these findings. Bidgood and Buckroyd (2005) interviewed eighteen obese men and women from a public sample who had attempted weight loss programmes but had not had lasting success. They reported participants' desire to reduce their BMI was largely motivated by body dissatisfaction which was seen to increase with BMI (Bidgood & Buckroyd, 2005).

Some individual research studies have shown that behavioural interventions can produce significant initial weight loss and some satisfactory maintenance (e.g., Perri et al., 2001). However Brownell and Wadden's broader analysis of the effectiveness of these programmes yields less optimistic results. Their results suggest that the average weight loss during the weight loss programme is 0.5kg per week and that roughly 60-70% of the weight lost is maintained in the first year Brownell & Wadden, 1992). Weight appears to be regained back to the baseline weight in three and five year follow-ups (Brownell & Wadden, 1992; Wadden, 1993; Wilson, 1995).

For this reason, bariatric surgery (*or 'weight loss surgery'*) is increasingly used as a treatment option for morbid obesity (Department of Health, 2008) and much of the literature on 'significant' weight loss falls under bariatric surgery research. The surgery is typically offered to people with a body mass index that is greater than 40 kg/m2 (Mitchell & Courcoulas, 2005). The most common procedures are the gastric bypass and the gastric band. Both are designed to restrict the amount of food that can be ingested, and the bypass also affects absorption (Mitchell & Courcoulas, 2005).

Wadden, Sarwer, Womble, Foster, McGuckin and Schimmel (2001) illustrated a decreased quality of life (QOL) as a result of obesity. Comprehensive reviews have concluded that weight loss is associated with improvements in multiple health problems that are co morbid with obesity, such as hypertension and type 2 diabetes (e.g., Buchwalk, Avidor, Brayunwald et al 2004). QOL measures have been shown to improve following weight loss (Mitchell et al; 2001, Tolonen and Vicorzon, 2003; Dymek, le Grange, Neven, & Alverdy, 2001; Fontaine, Barofsky, Bartless, Franchkowiak & Anderson, 2004), and these changes are mainly accounted for by improvements in physical health (Swan-Kremeier, 2005). The impact of weight loss on psychosocial factors, often the primary motivation for weight loss, is less clear.

Boccieri et al., (2000) reflect on the fact that little is known about interpersonal experiences following weight loss. They suggest that sudden social acceptance and being related to positively because of weight loss might not be experienced as positive. They question whether the paucity of research on these potential negative outcomes of weight loss are related to an anti-obesity bias, in which non-obese researchers might struggle to consider any negative social outcomes of weight loss (Boccieri, et al., 2000). Rand, Juladau and Robbins (1982) reported a higher divorce rate in couples following bariatric surgery. On closer examination it appears that bariatric patients were more likely to leave poor relationships when they had lost weight. It has been hypothesised by Sarwer et al (2008) that similar changes could occur in the relationship dynamics of those who have undergone plastic surgery post weight loss.

Appearance dissatisfaction has been found to be the primary motivation for seeking weight loss surgery in between 32% (Libeston, Dixon, Lauries and O'Brien, 2004) and 70% of participants (Halmi, Stunkard and Mason, 1980) but the relationship between weight loss and body image appears to be a complicated one.

Guisado and collegues (2002) reported greater weight loss was strongly correlated with lower levels of body dissatisfaction. These findings suggest that body image and body dissatisfaction are connected to the success of weight loss and the maintenance of it. In contrast Hotter, Mangweth, Kemmler, Fialia, Kinzl, and Biebl (2003) report that whilst some participants showed 'normalisation' in their levels of body dissatisfaction post weight loss, others continued to experience significantly impaired levels of body dissatisfaction. Adami et al (1998) illustrated that post obese participants with adult onset obesity were have been found to have similar measures of body image to controls whereas post-obese participants with childhood onset of obesity reported

abnormally low measures of body image. Sarwer et al., (2008) make the point that much of the literature reporting improvements in body image following weight loss only investigate changes in the first or occasionally the second year of weight loss (e.g.,Foster, Wadden & Vogt, 1997; Neven, Dymek, leGrange, Maasdam, Boogerd and Alverdy, 2002) and that for this reason long term effects cannot be inferred. In a three year follow-up of participants after bariatric surgery and weight loss, Adami, Meneghelli, Bressani, & Scopinaro (1999) found that whilst measures of body disparagement and salience of shape had improved they remained significantly different to that of controls (Adami et al., 1999).

Much of this research is carried out by bariatric surgeons and is of more positivist, quantitative persuasion, although a growing minority of research has been qualitative. Followell (2009) engaged in a qualitative enquiry to investigate the meaning of the experience of bariatric surgery. She interviewed women two to four years postoperatively. She reports the emergence of eight main themes: relationships with food; interpersonal relationships; relationships with self; living with excess skin; food intolerance; treatment from society; concern with ageing and support systems. She reports that all the themes revolved around the communicated need to be better prepared for bariatric surgery and for continued support after it.

In 2006 Ogden, Clementi and Aylwin conducted a qualitative investigation into the experience of obesity surgery. They interviewed 15 men and women who had undergone obesity surgery in the past four years and analysed the data using IPA. The authors report that a central theme of control permeated all emergent themes. The state that the imposed control of the obesity surgery on their ability to eat appeared to enable participants to feel a renewed sense of control in their relationship to food. They have termed this the ‘paradox of control’. In addition four broad themes emerged. These were ‘personal weight histories’, ‘the decision-making process’, ‘the impact of surgery on eating behaviour and their relationship with food’, ‘the impact of weight loss on health status, self-esteem and relationships with others’.

The final theme appears to illuminate the experience of body change. Participants reported positive change in confidence, body image, energy and general quality of life, health status and relationships, which confirm other quantitative findings. In addition some participants discussed their experience of weight loss as a form of ‘rebirth’. It appears that in these cases body transformation bought about a sense of personal transformation. Other participants described a sense of returning back to ‘normal’ again.

A continued sense of surprise when they looked in the mirror was also reported, suggesting a continued adjustment to their new appearance. One female participant reported feeling pleased with her new body but that she had betrayed herself by opting for the surgery which 'mutilated' her body, as this went against her values and belief system. These findings highlight the largely positive but complicated and multifaceted meaning making experience of significant weight loss. The experience of excess skin after weight loss is not reported in this study.

In the context of extreme weight loss it is common for patients to experience body dissatisfaction in weight loss due to the "frequent" resultant excess skin on ones abdomen, arms, face and thighs (Swan-Kremeier, 2005, p. 112). Kinzl, Traweger, Trefalt and Biebl (2003) found that in their sample of morbidly obese patients 87% of participants were happy with the amount of weight they lost following gastric banding. Notably, the patients who were satisfied with their appearance following weight loss had lost significantly less weight than those who were unhappy with their appearance. The negative consequences for appearance following weight loss were attributed to "flappy skin" (53%) an abdominal overhang (47%) and pendulous breasts (42%). 70% of participants considered that excess skin was a negative consequence of weight loss (Kinzl et al., 2003).

Boccheieri et al., (2002) state that the commonality of clinical reports of distress at the 'disfiguring' effect of this excess skin is not at all reflected in the literature, with no studies on body image and weight loss looking directly at the 'skin problem'. They call this a "curious omission" (Boccheieri et al 2002 p. 160) suggesting it may be due to a bias of obesity research to ignore negative outcomes of weight loss. It illustrates that there is still much of post weight loss life that is not known about.

1.5. Plastic Surgery

Sawer et al (2008) describe the continual rise in the popularity of plastic surgery in recent years as an 'explosion'. The number of cosmetic procedures, both surgical and non-surgical have increased five hundred percent in the United States in the last ten years (Sarwer, Infield, Baker, Casas et al., 2008). In the United Kingdom plastic surgery has risen from 10, 700 procedures in 2003 to 36,400 procedures in 2009

(BAAPS, 2010). The worldwide cosmetic surgery and facial cosmetic rejuvenation market was valued at 14 billion in 2007 (Testa, 2007).

Susie Orabach speaks of the normalisation of cosmetic surgery and the societal change that has meant that bodily transformation is no longer linked to social rituals but is an individual's striving to produce what is deemed to be an acceptable body by today's society (Orbach, 2009). She criticises the "rhetoric of empowerment" (Orbach, 2009, pp. 83) that suggest that not opting for such things would be a sign of personal neglect and the fact that people do not recognise themselves as victims of an exploitative beauty industry. Meridth Jones discusses cosmetic surgery as the most provocative and controversial aspect of the new 'make over culture'. She describes this current culture as one that demonstrates 'fixing' of the body as the suggested way to uncover true identity and improve lifestyle (Jones, 2008). It seems important to hold this cultural trend in mind when considering individuals who have significantly transformed their bodies.

Orbach also includes the distressing quote from Dr D'Amico, the president of the American Society of Plastic Surgeons as describing the post-pregnant body as one that is 'in need of restoration' (Orbach, 2009). This appears to normalise plastic surgery whilst *abnormalising* the post partum body. This rhetoric is found in the literature relating to the post weight loss body. The term 'saddlebag deformity' (Hurwitz, et al., 2004) constructs excess skin as something that is defective and in need of fixing. In addition, calls from other surgeons (e.g., Chandawarkar, 2006) for post weight loss patients to commit to two to three years of body contouring surgery[1]could be seen as colluding with framing excess skin as a problem that cannot be lived with.

Psychology has made attempts to conceptualise the motivations of people seeking plastic surgery. Edgerton and McClary (1958) suggest that women requesting breast enlargement are being related, unconsciously, to sexual and affectionate feelings towards the father and the resulting guilt and the subsequent interpreted punishment of having small breasts. Psychiatric diagnoses have also been used to describe the neurosis of these individuals. Breast augmentation patients have been described as 'impulsive' and 'hysterical' (Edgerton, Meyer and Jacobson, 1961) and rhinoplasty patients as 'obsessive and schizoid' (Meyer, Jacobson & Edgerton, 1960). These

[1] Body contouring refers to all plastic surgery procedures which re-define the body's contour, in this context, after weight loss.

pathologising generalisations unsurprisingly fail to encapsulate the complexity of the behaviour.

Burk, Zelen and Terino (1985) conceptualise the female cosmetic surgery patient within a self-consistency approach where she is a normal woman, with average levels of self-esteem who is attempting to resolve her conscious awareness of a disparity between her general and specific-body part esteem.

Kisley, Morkell, Allbrook, Briggs and Jovanovic (2002) compared new referrals to their plastic surgery clinic who were requesting cosmetic surgery with those who were requesting 'medically explained symptoms'. Participants completed a general health questionnaire and a dysmorphic concern questionnaire. Participants in the 'cosmetic' group were 13 times more likely to be female. In relation to dysmorphic concern, a UK study found that 75% of body dysmorphic patients were female (Veale, Boocock, Gournay et al., 1996) but studies in the United States (Phillips, 1998) and Australia (Oosthuizen, Lambert and Castle, 1998) suggest males and females were equally affected by dysmorphic concern. Patients who scored highly for dysmorphic concern were thirty two times more likely to have a psychiatric co-morbidity. Dysmorphic concern emerged as the only independent predictor of psychiatric co-morbidity in a multivariate analysis. This study relies heavily on the measures it employs to make these statements by making psychiatric diagnoses from the results of the general health questionnaire alone which is a limitation. Whilst the interesting relationship between psychological distress and concern about appearance is illuminated it requires further more rigorous attention.

As Sarwer et al., (2008) discuss in their review of the literature, several factors are currently considered to play a role in individual's decision to opt for plastic surgery. These include dissatisfaction with appearance (e.g., Cash, 2006) and a general investment in the importance of appearance (e.g., Sarwer, Cash, Magee et al., 2005). Considering the unattainable and exacting body ideals in our culture and the extent to which the importance of appearance is paraded in the media, it is not surprising that the popularity of plastic surgery seems to be continually rising.

In an empirical study Sarwer, Alison, Baker et al., (2008) reported on two-year follow up findings in a prospective, multi-site investigation of postoperative 'psychological status' and satisfaction with surgical outcome in the USA. Participants completed a set of quantitative measures psychological status and rated their perceived attractiveness

and satisfaction with the surgical outcome at 3, 6, 12 and 24 months post surgery. The participants had undergone a variety of procedures, which did not include abdominoplasty. At all points of time, 89% of participants reported being at least 'somewhat satisfied' with their surgical results. Participants rated their attractiveness overall and the attractiveness of their particular feature that had been operated on as significantly different at 3 months post operative to pre-surgery. This rating did not significantly change over the following twenty one months. The initial change in perceived overall attractiveness at three months is much smaller than that change in the rating of attractiveness of the feature alone. No significant change in the orientation towards appearance was reported at any point in the process. Preoccupation with overweight did not have any significant changes at any stage although the results did increase over the two years. No significant change was found in scores of self-esteem and depressive symptoms or in body image quality of life (Cash, 2001).

The researchers discuss their efforts to retain participants in this study and report "repeatedly contacting study participants" (Sarwer et al., 2008, pp. 250) to remind them about participating in the study. These actions could have influenced how participants completed the measures. In addition, ethical questions should arise from this since participants may have felt harassed and disconnected from their right to withdraw from the study if they wished.

Past studies' findings of changes in body image quality of life have been equivocal (Bolton et al., 2003., & Rankin, Borah, Perry and Way, 1998). Sarwer and colleagues (2008) attribute this to the multidimensional nature of the construct of quality of life and question whether certain procedures are more likely to impact this body image quality of life than others. They could not investigate this in their own sample as it was too small.

The research field of plastic surgery has also been dominated by quantitative research methods. There appears to have been a heavy reliance on specific measures. A number of similar factors appear to have been examined (e.g., body image) whilst others have been ignored (e.g., impact of social support).

I will now turn to examine the more specific experience of undergoing plastic surgery post weight loss, to remove excess skin.

1.6. Plastic surgery following weight loss

Excess skin following weight loss can form an abdominal overhang that can cause hygiene problems, rashes and difficulties with mobility (Song et al., 2006). It is reported that in the USA in 2003 52,000 post-bariatric weight loss patients underwent surgery to remove their excess skin (Song et al, 2006). Song and colleagues (2006) comment that this population are scarcely investigated, particularly in relation to their body image and quality of life. Excess skin tends to be more notable when weight is lost quicker, and when the individual is older (Chandawarkar, 2006).

Excess skin is removed from post weight loss patients using a variety of different plastic surgery methods. Excess skin is typically removed from the abdomen (abdominoplasty/ tummy tuck) thighs (inner thigh lift), arms (Brachioplasty), back (backlift) and breasts (breast lift) (Taylor and Shermak, 2004). These procedures are grouped together as 'body contouring' procedures (Taylor and Shermak, 2004). Of the 3403 abdominoplasty procedures that were reported by the British Association of Aesthetic Plastic Surgeons in 2009, 3268 were performed on women (BAAPS, 2010).

Mitchell, Crosby, Ertelt et al., (2008) considered the prevalence of the desire for body contouring surgery following bariatric surgery. 33 of the 70 participants who had undergone a gastric bypass 6 – 10 years previously, reported undergoing 38 body contouring procedures. The most common was the abdominoplasty (24.3%) followed by breast lifts (8.6%) and thigh lifts (7.1%). They report that participants were not 'uniformly satisfied' with their body contouring surgery, stating that the affected area was 'unattractive'. They also report that the majority of participants expressed a desire to have body contouring surgery on several parts of their body. Of note, researchers used a measure that was developed for this study and so had not been validated. In addition, less than one third of people who were mailed the questionnaires responded. The authors recognise that they are therefore unable to comment on whether the respondents were an atypical group or not. The findings suggest that a significant subgroup of people who have lost weight wish to and do undergo body contouring surgery.

Several recent quantitative studies have investigated psychosocial outcomes of body contouring surgery. Whilst surgeons have documented the "tangible changes in appearance" (Song et al., 2006 p. 1626) experienced by this population, the psychological experience is less clear.

Bolton, Pruzinzky, Cash and Persing (2002) followed 30 female abdominoplasty patients prospectively; pre-operatively and post-operatively. They employed measures of body image, investment in appearance and general psychological functioning (self-esteem, social anxiety and satisfaction with life). The authors had hypothesised that the sample would have a higher investment in appearance than normative samples; however the findings did not suggest this. Significant improvements in body image were reported two months following abdominoplasty surgery. As the authors hypothesised, participants reported reduction in avoidance of body-exposure during sexual activities. No changes were found concerning participants investment in appearance or their general psychological functioning.

At two months post surgery, when participants completed their post operative measure, it is likely that they were still experiencing post operative pain and healing. Because these questionnaires were completed so close to the event of surgery, one cannot infer whether the changes would be enduring, or indeed whether the aspects which remained stable would in fact change over time.

In 2006 Song, Rubin, Thomas, Dudas, Marra and Fernstrom carried out a prospective study administering quantitative measures to 18 bariatric weight loss patients before surgery to remove excess skin and at three and six months following this surgery. Significant improvements were found in measures of quality of life and body image. However, in line with Bolton et al (2002), no changes were reported in mood. In addition, participants ascribed thinner silhouettes to their current appearance following the surgery. Interestingly, participants also ascribed thinner silhouettes to their ideal appearances following surgery. The authors discuss the potential tendency for body contouring to trigger dissatisfaction with other parts of the body. This is reflected in other studies in the area which found that many patients undergo multiple body contouring procedures. They suggest that this is due to the shifting of body ideals towards a more exacting nature and thinner ideal. This study follows up patients at six months. Whilst this is longer than Bolton et al's study (2002), six months is also a relatively short period of time, and a further follow up, one year later, might provide important information on the longevity and stability of these findings.

Pecori, Cervetti, Marinari, Miglior and Adami (2007) investigated the attitudes to weight loss and body image in a cross-sectional study of groups of women at various stages in weight loss and after cosmetic surgery. 20 morbidly obese women prior to their bariatric surgery, 20 post-obese women following their bariatric surgery, 10 post obese women

following bariatric surgery who were described to be 'requiring' cosmetic procedures, 10 women after their weight loss and cosmetic procedures and 20 healthy weight controls completed the "Body Uneasiness Test" questionnaire. This is designed to assess concern with physical appearance body image, body dissatisfaction and to elucidate body parts that contribute most significantly to body dissatisfaction. This test has been shown to be a reliable psychometric instrument and has been tested on Italian populations (Cena, Toselli, and Tedeschi, 2003, Ravaldi, Vannacci, Zucci et al., 2003). Whilst the post-obese group scored lower than the obese patients on body uneasiness, the group requesting cosmetic procedures showed similar scores of dissatisfaction to the obese group. The authors suggest this could mean that the body image construct has remained relatively unchanged despite the body change. Interestingly the group who had undergone cosmetic procedures following the weight loss had similar scores to those who had lost weight and were not requesting cosmetic procedures. It is suggested that this disparity can be accounted for by the difference in the relationships between distress about appearance and physical morphology. They state that in the group requesting cosmetic procedures, body dissatisfaction was less accounted for by real anatomical conditions. This appears to relate to findings in the disfigurement literature which suggests a lack of relationship between severity of disfigurement and level of distress (e.g., Ong, Clarke, White, Johnson, Withey and Butler, 2007). The authors propose that the distress could therefore reflect a form of psychological distress which is independent of obesity. They make the point that in the group not requesting surgery, body dissatisfaction is more related to somatic morphology. Whilst body contouring surgery following weight loss does tend to improve body satisfaction, "aesthetic operations following weight loss could have complex and still unknown psychological meanings" (Pecori et al., 2007, p.72)

I think that the suggestion that "inner feelings" are separate from participant's experience of body change could be inaccurate. It should be taken with caution as it may serve to discount the importance of the subjective experience of the patient. As noted by the authors, this is a cross-sectional study and therefore the phenomenon could be chance and may be related only to these separate groups.

Stuerz, Piza, Niermann and Kinzl (2008) investigated the psychosocial impact of Abdominoplasty in an Austrian sample of 34 people (30 women, 4 men) who underwent abdominoplasty in a prospective study. Participants were interviewed before and one year post abdominoplasty surgery using a series of instruments assessing body perception, satisfaction of life and anxiety and depression. These results were

compared to weight loss controls who did not undergo surgery to remove their excess skin. Abdominoplasty patients were also administered a general surgery questionnaire post operatively. A significant postsurgical improvement was found in the subscale for attractiveness/ self esteem and body image in the surgery group. Scores in the control group were found to decrease and then rise after the second follow-up. It is important to consider that the mean self confidence/ attractiveness for the control group at the first point of measurement was considerably higher than that of the group electing for surgery, and only just lower than the mean score for the surgery group postoperatively. No change was found in anxiety and depression or life satisfaction in either group. The authors have therefore suggested that, whilst abdominoplasty could be seen as an effective way to reduce body image distress, expectations of improvement of life satisfaction and other measures of general psychological functioning, might be too much to expect from the cosmetic surgery procedure.

Results from the general surgery questionnaire imply that the main reason for undergoing plastic surgery, in 80% of participants, was because they felt unattractive. Eight patients reported discomfort and ten reported that problems with clothing were their main motivators. Crucially, every participant who underwent surgery stated that they would recommend it and would undergo it again. By the second follow-up over a quarter of the participants had undergone a second plastic surgery operation for removing excess skin. 87.5% of patients stated that their abdominoplasty operation had 'intensified' their desire to have further plastic surgery procedures. It appears that whilst changes were not experienced in anxiety and mood, the changes that were experienced were satisfactory enough for participants to not regret the decision. It might be pertinent to consider alternatives to this explanation in the light of the tendency for participants to request more plastic surgery. Theories of cognitive dissonance[2] (Festinger, 1957) might suggest that because patients had invested so much in undergoing surgery, it would be psychologically less difficult to consider it a good decision to have made, even if their expectations had not been met.

Cintra, Modolin, Gemperli, et al., (2008) investigated quality of life after abdominoplasty in 16 women who had previously undergone bariatric surgery in Brazil. Quality of life was assessed by a psychologist employing the 'Adaptive Diagnostic Scale' which is

[2] Leon Festinger's (1957) theory that which states that individuals are motivated to reduce internal inconsistency (dissonance), where 'cognitive dissonance' is an antecedent condition which leads to activity related to reducing dissonance.

designed to measure affectivity, relationships, productivity, social and cultural performance and somatic and organic health and had been adapted for Brazilian patients. The interview was conducted between one and three years post abdominoplasty. This is a relatively large range of time following the procedure. It could be that the post-operative time could account for some of the variation in the results but this is not explored.

The domain of cultural and social adaptation rendered the best results, with 81.3% of patients showing the highest level of adaptation. In the other three domains (affectivity, relationships and productivity) 62.5% of the tests displayed the highest value of adaptation and 'few complete failures' (Cintra et al., 2008). Given the positive results that were presented I was struck by the much less positive results appearing in the results table, which are not discussed in the findings. The highest level of adaptation is termed 'good adaptation', with levels 2 to 4 ranging from 'mild' to 'very severe maladaptation'. The authors illustrate an overall percentage of 43.8% of participants having a 'good adaptation', leaving 56.2% with mild to very severe maladaptation. This presentation of results appears worryingly misleading. They go on to state that patients rarely complain about multiple interventions or extensive scars to surgeons and are typically 'ready for more' plastic surgery. It is inferred by Cintra et al., (2008) that because people want more plastic surgery and do not complain to their surgeons about their outcomes, that they are happy with those outcomes. I would suggest that this is a plausible explanation but only one of many. Due to the inevitable power dynamics present in a surgical consultation, many patients might not voice their concerns. It could be the case that requests for further surgery do not correspond to an enjoyment or appreciation of it, but could indicate that their psychosocial needs were not met by the previous procedure. Song et al., (2006) discussed the tendency for requesting more surgery after an initial procedure. Their explanation was that the closer participants came to their body ideal, the higher their expectations became. Again, this is one possible explanation, but it could also be the case that when they undergo another procedure and are still left feeling dissatisfied and distressed patients look for another procedure to meet that need. These suggestions merely aim to highlight the myopic considerations of the motivations of this population.

Lazar, Clerc, Deneuve, Auquit-Achbur and Millez (2009) systematically reviewed the medical notes of 41 patients (32 male and 9 male) who had requested and undergone abdominoplasty after weight loss in France. They also administered two un-validated scales. The first was a three item scale which was designed by the plastic surgeons to

evaluate most problematic areas of the body, the areas of life that their excess skin was affecting and then asked them to rank the effectiveness of the abdominoplasty on reducing these difficulties. In addition patients underwent separate examinations with a psychologist and a surgeon. The data was collected after an average follow-up period of 57.7 months.

The psychological evaluation rendered retrospective accounts of some positive effects of abdominoplasty with the 'large majority' reporting improvements in current life, dressing, aesthetics, sexual relations and psychological status. 59.3% stated that they liked their new appearance. Similarly to the findings of Stuerz et al (2008), 96.1% of participants stated that they would undergo the procedure again. In the psychological evaluation, 26.9% of patients had negative opinions of their abdominoplasty. They report that 34.6% reported feeling "bad" because the surgery did not heal their "psychological narcissistic wounds" (Lazar et al., 2009, pp. 1073). The psychologist is reported to have stated that, after the long duration of suffering because of their obesity and the success of slimming methods, their major morphologic repercussions are difficult to accept. They also report that the new body image can become a source of deep shame, humiliation and deception. In line with this, 61.5% of participants retrospectively declared that life would have been 'unacceptable' without abdominoplasty and that it could be to blame for nervous breakdown or suicidal ideation. The authors report that plastic surgery appears to be the best approach to recovering a 'good-looking' body. They appear to have recognised that a good looking body does not necessarily render psychological wellbeing. They report that 39% of participants underwent another plastic surgery procedure following abdominoplasty.

This study requires retrospective reflection and uses un-validated scales. The use of psychology evaluation offers a new dimension adding depth to the results. The psychologist's reflections appear to be anecdotal and to summarize their meetings with patients, rather than draw on qualitative data.

Due to the little empirical attention that this patient group have drawn to date, Sarwer, Thompson, Mitchell and Rubin (2008) use the more established body of plastic surgery literature on breast reduction surgery to make their suggestions for the assessment of post weight loss body contouring patients. They argue that the development of a new sub-specialty often requires reliance on existing and related areas to guide both clinical and empirical development. They infer similarities between the two groups of patients in relation to impaired quality of life, self esteem and body satisfaction, and increased

symptoms of depression and anxiety. They report that the vast majority of women who undergo breast reduction are satisfied, reporting one study which found that 94% of patients indicated that they would have the surgery again (Godwin, Wood and O'Neil, 1998). They state that it is not yet known if satisfaction and associated psychosocial improvements occur with body contouring patients following weight loss and make calls for researchers to focus on this growing population.

Sawer et al (2008) underscore the importance of psychosocial assessment prior to plastic surgery to remove excess skin following weight loss, as with all plastic surgery procedures. Drawing from previous papers investigating psychosocial aspects of plastic surgery (Sarwer, 2001 & Sarwer, 2006) the authors suggest three main areas of importance in assessing this population: motivations and expectations, appearance and body image concerns and psychiatric status and history. They suggest that a patient with realistic expectations and an understanding of the risk of complications of the procedure are more likely to benefit. They highlight the importance of the patient understanding that this surgery will not transform their bodies to a perfect body shape, and that there will be large, visible scars and some residual 'deformities' in body shape (Sarwer et al., 2008). They also suggest that patients who think about their appearance for more than one hour a day and whose concern about their appearance is leading to significant disruption to their daily activities should undergo a psychological consultation before they undergo plastic surgery. In relation to ongoing psychiatric problems, the authors encourage communication between the plastic surgeon and any mental health professionals who might be working with patients when they are undergoing plastic surgery. They discuss "untoward psychological outcomes" (Sarwer et al, 2008, pp. 429) of body contouring surgery and refer to the common disparity between what the surgeon refers to as good surgical result and the patient considers to be an unsatisfactory one. They propose that, like bariatric surgery, body contouring surgery should lead to improvements in body image and quality of life, whilst acknowledging that little is empirically known about this.

This paper appears to be written for plastic surgeons and is published in the journal of Plastic and Reconstructive Surgery. Its emphasis on the importance of psycho-social factors in this process is welcomed. The language used in the review implies a subscription to a strongly medicalised and illness discourse in relation to psychological experience, using terms such as 'psychological abnormalities' and 'physical deformities'. I think that these terms could be regarded as offensive by the patient group. The authors communicate in language that is likely to be familiar to surgeons.

However, I argue that papers relating to psychosocial aspects of experience have an opportunity to model the use of sensitive language for those who read it. The authors recognise that the patient's subjective perception of their post-operative result is fundamental in all areas of plastic surgery. They do however make several suppositions regarding the experience of abdominoplasty patients from findings from both bariatric and breast reduction literature. Whilst this is a necessary, pragmatic and useful start to considering this subject, it is clear that research in this area is required to focus on the unique experience of this population to develop an understanding specific to them and their lived experience. In addition, the comparison with breast reduction could be in danger of further alienating men from this experience.

Chandawarkar (2006) recommends that the post weight loss patient requires a further two to three years of commitment towards body contouring procedures. He states that the aim is to 'restore body image through reshaping procedures' and states that this should be an integral part of the treatment of weight loss patients.

It is clear that in recent years, the calls for more investigation into the experience of excess skin and its removal after weight loss have been answered, in line with the increasing popularity of these procedures. Typically Body Image appears to have been improved by the post weight loss plastic surgery (Bolton et al., 2002; Song et al.,2006; Pecori et al., 2007; Stuertz et al., 2008; Lazar, et al., 2009). Measures of Quality of Life have also typically improved post surgically (Song et al., 2006; Lazar et al., 2009; Cintra et al., 2008). Self esteem has been shown to not improve (Bolton et al., 2002) and anxiety and depression have appeared to remain stable (Bolton et al., 2002; Song et al., 2006; Steurtz et al., 2008).

1.7. The story so far

Taking into account the broader fields of enquiry as well as more specific findings, the literature relating to the experience of people who lose weight and then have their resultant excess skin removed by plastic surgery paints a complex picture. It appears that functional and psychosocial improvements are likely to be experienced, but that these are limited and are likely to vary from person to person. The studies into this experience have only been of a positivist, quantitative nature with much of it being conducted by plastic surgeons rather than psychologists. Whilst these findings provide us with interesting insights, their quantitative nature means that only specific variables have been considered (e.g., body image). In addition, some of the interpretations of

results appears to be relatively myopic and has triggered for me further questions relating to the complexity of this experience, which are seemingly difficult to answer with quantitative research alone.

It will have been obvious that much of the research in this area relies on the psychological construct of 'Body Image'. Gleeson and Frish (2006) have considered '(De)constructing' Body Image, seemingly in a challenge to the pervasive positivistic approach to literature in this field at present. They state that body image has been a powerful and central concept in health psychology. They make the point that in research it is usually referred to as a relatively fixed schema which influences people's behaviour. Their article attempts to elaborate on the assumptions which underlie the construct of 'body image'. The assumptions that they expand are; that body image 'exists', that body image is a product of 'perception', that body image is 'internal' and therefore 'of the individual', that although a hypothetical construct, body image can be treated as real and accurately measured and that when responding to body image measure, people are neutrally providing information about an image that is held in their heads. They suggest that body image, in the schematic and individualised form in which it is currently constructed, could narrow the focus of researchers, down play the contextual nature of body image and de-emphasize the discursive production of body image. In addition they state it is in danger of eliding the social nature of perception, distracting from the dialogic nature of body image and encouraging researchers to individualise body concerns. They call for a replacement of the static notion of body image with *body imaging* with a focus on the process, rather than the product.

The authors state that the limited but growing numbers of studies which employ reflexive and qualitative paradigms are beginning to develop concepts of body image that are more complex and dynamic. Whilst momentum has picked up on the number of qualitative studies in the reviewed surrounding research fields (e.g., obesity), the full potential of qualitative enquiry in this area has yet to be met. Seminal pieces of literature relating to visible difference have illustrated the power of personal narratives (e.g., Partridge, 1990).

1.8. **Introduction into the current study**

In reviewing the literature, the absence of the voice of the individuals who are experiencing this body transformation has become apparent. It also seems that there is a tendency for researchers in these fields to focus on particular constructs (e.g., body

image, self esteem) and to rely on constructed quantitative measures. As has been mentioned by Boccheiri et al (2000), it could be the case that the pervasive nature of anti-obesity bias has led to only certain questions being asked. It seems that more consideration is needed of this potential anti-fat bias on the part of researchers in this area and its possible impact on the knowledge that is produced and published.

For these reasons, I believe that a qualitative enquiry into this field would be timely. It would return the voice to the individuals who live the experience, and as a result would hopefully distance itself from pre-existing theories about benefits of weight loss and from the possible anti-fat bias. It could also enable a broader approach to the experience, remaining open to novel findings.

When considering the current literature on the hardships of living with an obese body in today's western society, the difficulty in losing weight, adjusting to a considerable change in body size and shape as well as the distressing experience of resultant excess skin, the question of how this population experience their body is a fascinating one. Their distress at the excess skin was significant enough to motivate them to undergo major and potentially life threatening surgery to have it removed. Critically, in many cases it appears that individuals would be prepared to repeat the experience. It seems important that a better understanding of the experience of these individuals is developed to enable consideration of the best way to support them. With many government initiatives around the world encouraging weight loss, it seems imperative that empirically supported interventions and support for the people who experience this process are developed.

For these reasons I will conduct a qualitative study which explores how women experience their bodies having experienced significant changes in them. Post-obese women who have lost weight through either diet or bariatric surgery will be interviewed. All participants will have applied for plastic surgery following weight loss in the NHS because they were distressed by their resultant excess skin. All participants will have had at least one surgical procedure to remove excess skin around their abdomen following weight loss.

1.9. References

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2.0 Methodology Chapter

2.1. Introduction

This chapter aims to provide a description and explanation of the way that I have attempted to answer the research question; How do people experience change in body following weight loss and subsequent removal of excess skin? I pass from my broader epistemological assumptions to detailed procedural descriptions and include the steps that have been taken to ensure this is a valid, high quality and ethically committed piece of research.

Throughout the planning and execution of this study, issues of quality and validity were emphasised. In particular Yardley's (2000) sophisticated and insightful four principles of evaluation of qualitative research ('*Sensitivity to Context', 'Commitment and rigour', 'Transparency and Coherence'* and *'Impact and Importance')* were kept in mind. These issues will be discussed in detail in the Discussion Chapter (Chapter 4).

2.2. Epistemology, Methodology and Method.

As Cardinal, Hayward and Jones (2004) outline, 'Epistemology' ('theory of knowledge') is committed to describing ways in which humans have tried to make sense of the world around them and how we come to know things or believe them to be true. Silverman (1993) has helpfully differentiated *Methodology* (the general approach to studying research techniques), and *Method*, (the specific research technique used). The former, as Willig (2001) highlights, is most directly connected to the epistemological position held. In this section the epistemological position will be presented and the Methodology and Method that have been employed will be described, with a view to answering the aforementioned research question.

2.2.1. Rejection of the positivist position

This study takes an alternative position to the dominant epistemological position in psychology, which is *positivism*. Positivism typically assumes a quantitative research design and stipulates that it is possible to directly describe the 'truth' and 'reality' of the world and the people in it and that this is, as Kirk and Miller (1986, p.3) state,

independent of the 'process or circumstances of viewing it'. It has been acknowledged among contemporary positivists that humans observe and experience the world 'selectively' (for discussion see Gazzaniga, Ivry and Mangun, 2002). It is argued that human perception is therefore at best 'partial' and consequently dependant on the 'observer'.

As Willig (2001) states, Karl Popper's hypothetico-deductivism relies on the existing system of thought to make its deductions and fails to acknowledge the role of historical, social and cultural factors in the very formation of this knowledge. As Willlig goes on to highlight, feminist scholars in the 1960's and 1970's pointed to the danger of relying on existing systems of thought stating that womens' relative absence in social scientific work allowed the male dominated research 'findings' to perpetuate existing gender inequalities in society.

As is evident in the review of the literature (see Introduction Chapter), the positivist position is taken by the vast majority of researchers in the fields of 'Body Image', 'Plastic and Reconstructive Surgery', 'Weight loss' and 'Bariatric surgery'. Quantitative research, by its nature, only gets responses to the questions it asks. It is suggested that because only a number of variables have been considered in relation to this experience, a qualitative methodology could enable a broader and deeper insight into the experience.

2.2.2. Acceptance of qualitative methodology

As discussed, there is a lot that is not known about the experience of people who have lost weight and had their excess skin removed by plastic surgery. It therefore seems desirable to remain rooted to participants' experience and to learn from this. I believe that investigating the subjective experience of these individuals is likely contribute to a different, poly-dimensional and empowering insight into this area (Stiles, 1993). The present research therefore aims to advance understanding of the experiences of the described population through a qualitative research design. My training as a Counselling psychologist is reflective of the importance I place on subjective human experience. This aligns me naturally with a qualitative research design. In addition, the humanistic theoretical basis of Counselling Psychology underscores the value of an idiographic approach to human experience. It seems that employing a research design that fits with one's worldview is likely to promise production of a higher standard of research.

This research is also politically motivated to embrace an inductive model of knowledge formation. It is suggested that the participants who are female and have lived proportions of their lives clinically obese are a subjugated group in today's society. It is hoped that this research will return some of the power of knowledge formation to these participants.

There are a variety of epistemological positions taken by qualitative researchers, making different knowledge claims on the basis of their research. Willig (2001) reminds us, however, that all qualitative researchers are interested in how people experience events and make sense of the world.

2.2.3. Critical Realist position

This study intends to produce *Critical Realist* knowledge. As Willig (2001) states, it is useful first to consider the assumption that you make about knowledge in relation to the spectrum which has *realism* at one end and *relativism* at another. An extreme *realist* approach is rejected because it is argued that whilst actions and events occur in *reality*, it is not possible for these to be accurately and honestly described by participants as they only have access to their own subjective experience of reality. In addition, it is proposed that in the process of analysis, it is not possible for the me, the researcher, to produce accurate knowledge about the participant's account without imposing my own experiential views on the data.

An extreme *relativist* position is rejected because, despite the participant's account being mediated through culture, language and politics (Pilgrim and Rogers, 1997), it provides us with access to their experience of an actual *reality*, not one purely constructed by language. It is argued that participants are describing their experiences of *real* events. A principal and persuasive argument for this is that when we are born into the world, we do not yet have language however we do have embodied experiences (e.g., hunger, pain). Therefore, experience exists before and without language and is not socially constructed by it. This study is principally interested in the embodied experience of the participants. For further discussion of human perception in relation to the social construction relativist position see Burkitt (2003). In turn, during the analysis, it is suggested that whilst I am not able to produce an accurate description of the participants' subjective experiences, some insight will be offered into how they each experienced their own reality.

The analysis will therefore be considered to be an account of me making sense of the participant making sense of an actual reality and thus 'critical realist knowledge'.

2.2.4. Method: Interpretative Phenomenological Analysis

Transcribed interviews will be analyzed using Interpretative Phenomenological Analysis (***IPA***) to make sense of the subjective accounts of the participants. IPA is a qualitative approach, founded by Jonathan Smith (1997) that is rooted in phenomenology and so is concerned with the ways in which humans experience and gain knowledge of the world around them (Willig, 2001). As Larkin, Watts and Clifton (2006) state, the phenomenological commitments of IPA 'give voice' to the concerns of the participants, whilst the interpretative aspect allows for the researcher to 'make-sense' of and contextualize these experiences from a psychological perspective.

In summary, Larkin, Watts and Clifton (2006) state that IPA has its epistemological roots in 'minimal hermeneutic realism'. This does not deny the presence of an objective reality (thus avoiding relativism) but accepts that reality is dependent on context (contextual and 'critical'). It therefore corresponds with my epistemological position, providing a coherent methodological approach, the importance of which is underscored by Yardley (2000).

Husserl, who first proposed the founding principle of phenomenological enquiry, stated that we do not experience the world and its properties in their objective state, but:

"..we grasp the corresponding subjective experiences in which we become 'conscious' of them…" (Husserl, 1927, p. 1).

He states that instead of focusing on the activity itself – taking a 'natural attitude' we need to make a reflexive shift and focus on the subjective experience of the activity – the 'phenomenological attitude' (Smith et al., 2009).

In line with the method of IPA an *interpretative* approach will be taken to the data generated in this study. Husserl advocated that purely *descriptive* methods aim to describe the experience as it presents itself in the data. He discussed the importance of 'bracketing off' this natural attitude and adopting a purely 'phenomenological attitude' when looking at our perceptions and experiences of the world. As previously discussed,

it is deemed impossible to do this without, even unwittingly, imposing one's own biases and emphases on the data. This too was the argument of Heidegger, a student of Husserl who, as outlined by Smith and colleagues (2009), questioned the possibility of any kind of knowledge outside of the *interpretative stance*. He moved away from Husserl's transcendental project towards a more ontological question of existence itself and therefore introduced a more hermeneutic (the theory of interpretation) and existential emphasis to the world of phenomenology (Smith et al., 2009). When articulating his case for a 'hermeneutic phenomenology', he stated that:

"An interpretation is never a pre-suppositionless apprehending of something presented to us' (Heidegger, 1962/1927:191-192).

Significantly informed by this argument of Heidegger's it is suggested that one's access to the lived personal world of the participants is complicated by one's own conceptions, but that these conceptions are vital to interpreting and making sense of the data.

Whilst I am committed to being a reflexive researcher and hope to reduce, as much as possible, my impact on the data, I am more comfortable taking a more humble position. I would rather use my 'humanness' and previous knowledge of human experience and the surrounding literature to move beyond the data in the hope to make further sense of the participants' accounts.

IPA is becoming increasingly established as a method in Health Psychology (for review see Brocki & Wearden, 2006) and continues to develop in the fields of Counselling, Clinical and Social psychology (Smith et al., 2009). IPA draws from the writings of Merleau-Ponty (1962), who suggested that our body is interwoven into our sense of self and our life world. Merleau-Ponty described the *embodied* nature of our relationship and interaction with the world around us stating that:

"All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view…." (Merleau-Ponty, 1962, p. 4)

He suggests that as humans we see ourselves as different from the world around us and that we are engaged at looking at the world, and not just being in the world. He positions humans as 'body-subjects'. This is particularly well illustrated when considering interacting with another person. Merleau-Ponty suggests that whilst we are able to observe others and experience some level of empathy, we can never share

another person's experience because it is owned by their own embodied position in the world around them (Smith et al., 2009). The current study places an emphasis on the embodied experience and meaning making of the 'body' and is therefore strongly informed by the work of Merleau-Ponty.

In their latest book Smith et al., (2009) provide examples of IPA research they have conducted in four areas; 'health and illness', 'sex and sexuality', 'psychological distress' and 'life transitions and identity'. The current study could be placed within all of these topic areas. I therefore see this as an affirmation of the appropriateness of this method for this study.

2.3. Research Design

As discussed, informed by the epistemological position, a qualitative design is being employed to attempt to answer the above research questions. Eight one-to-one semi-structured interviews were conducted with individuals who, at least one year ago, had excess skin removed by plastic surgery following significant weight loss. Interviews took between 50 and 80 minutes. I conducted the interviews, which were digitally recorded, and then transcribed them.

2.3.1 Semi structured interviews

Interviews are flexible and individually focussed tools to enable a "conversation with a purpose" (Smith et al., 2009, p.57) to illuminate the participant's experience and are the most widely used method of data collection in qualitative research in psychology (Willig, 2001). Eatough and Smith (2008) stated that they offer a context in which the participant is positioned as the expert on their experience and the researcher is able to facilitate the participant in exploring their lived experience. Interviewing was therefore deemed an effective way to access the lived experience of the participants in this study.

As a trainee Counselling Psychologist I have experience of having meaningful one-to-one conversations with people and elucidating meaning in a professional context. It was felt that my skills in listening, facilitating meaning making and remaining curious best fitted with the semi-structured interview process.

Whilst recent studies using diaries as a method of data collection have produced inspiring and rich data (e.g., Boserman, 2009) this method was not employed. This was

in part informed by an ethico-political position regarding the exclusion of participants due to their educational level. In agreement with Boserman, I suggest that to get rich written data, participants should be confident in their ability to write their reflections and descriptions. I challenge, however, her statement that University level education is 'crucial to the ability of expressing oneself through writing' (Boserman, 2009, p. 432). I would argue that there is an existing problem in that much research in psychology recruits middle class participants (e.g., use of undergraduate students). I would challenge the apparent assumption made by some IPA researchers (e.g., Boserman, 2009) that people require a certain level of academic experience to make in-depth descriptions of their experiences. It seems to me that producing knowledge about the subjective experience of the middle classes is too restrictive. The use of diaries could exclude potential participants as it is more likely to trigger anxieties about school/ homework etc. This was another reason why interviewing was chosen as the method of data selection.

Finlay (2006) discusses the importance of the embodied experience in phenomenological research interviews. Drawing primarily from the work of Merleau-Ponty she argues that the researcher should attend reflexively to both the participants and their own body during the interview. Specifically she states that *bodily empathy (*attention to the participant's demeanour and movements), *embodied self-awareness (*attention to researchers embodied responses) and *embodied inter-subjectivity (*attending to what is 'in-between' the researcher and the participant) should all be reflected on. Finlay's argument that there is rich experiential data in the embodied experiences in the interview that is too often omitted is convincing. Due to the centrality of the body in the present research, efforts have been made to reflect on the three outlined aspects of embodiment in the interview. Reflective notes were made after each interview, taking these points into consideration. It is suggested that this process served to heighten the 'sensitivity to the context' of the research, the importance of which is stressed by Yardley (2000).

The development of the Interview Schedule (See Appendix F) was an iterative and inductive process that was guided by the conceptual framework. Once formulated, it was principally used as a guide. Many participants covered areas in the schedule before they were asked about them.

2.4. Reflexivity

Reflexivity in this context is conceptualised as:

"...the processes in which researchers are conscious of and reflective about the ways in which their questions, methods and very own subject position might impact on the psychological knowledge produced in a research study" (Langdridge, 2007, p. 58).

As a Counselling Psychologist I place high importance on reflexivity and am aware of the crucial impact it has on my clinical work, and my professional and personal life. I believe the same level of attention to reflexivity should be paid to research. Langdridge (2007) concurs with researchers in IPA that it is vital for the researcher to consider their standpoint and to take steps to make explicit what it is that the researcher is bringing with them into the research. I do not imply that in making these aspects explicit they will not impact on the research but that my heightened awareness of them will help me to be thoughtful about their influence on it. Langdridge (2007) also highlights the increased importance for the researcher to be reflective if he or she has not experienced the 'issue' themselves, which applies to me in this instance.

Willig (2001) argues that what we bring into analysis with us are in fact the 'necessary preconditions' for the researcher making sense of the participant's experience. I believe that this is this is the case for the whole research process, not just analysis. She goes on to state that these should not therefore be perceived as 'biases' that need to be eliminated but aspects to be exploited.

To this end I have engaged in three reflexivity interviews to 'make explicit' some of the features I have bought into the research with me. In each instance I was interviewed by a university colleague and the interviews were digitally recorded. To illustrate the process, I describe below some of the aspects which I have re-visited over the course of my research to promote continued reflection to illustrate the process.

2.4.1. Reflexivity interview 1 (Langdridge Reflexivity interview)

Langdridge (2007) provides a list of pertinent questions to encourage a reflective approach to research. Three aspects that emerged are:

My position as an outsider: I am an outsider to the experience of the participants in this research. My weight has always fallen within the 'normal range' for my height and age. I have, therefore, never experienced noteworthy changes in weight. I have never

experienced other kinds of drastic change in appearance, other than expected developmental changes. I have also not undergone plastic surgery. I am certain that my being a slim woman impacted on my participants when we met. I recognise that if I were overweight or obese, my appearance would have had a different impact. The fact that I am slim, and also middle class, however, raises issues of power to be reflected on. In our society 'slimness' is celebrated and 'fatness' is shamed (Orbach, 2009). I therefore tried to be mindful of possible heightened power differentials in the interview process. I hope to use the fact that I have not experienced this experience personally to enable an approach that is as open and curious as possible. This does not mean that by being an outsider I do not approach this research with my own assumptions and expectations.

A personal connection to this subject is that my only sibling, having been obese, lost a significant amount of weight over a short period of time. I was acutely aware of and fascinated by their wide range of experiences following this dramatic change in body size and appearance. My subsequent Counselling Psychology training and clinical work at the plastic surgery department has led me to think in a more psychological way about their experiences. Being very close to my sibling, I believe that whilst I am an 'outsider' I am closer than the average 'outsider' to this experience. An example of a specific expectation that I have from the experience from my sibling is that of the difficulty experienced in not being recognised by other people. I have listed the other expectations I might hold but I do not provide these for reasons of confidentiality.

Impact of researcher as feminist: I feel it is also important to make explicit my position as a feminist. It is my personal belief that the current cultural importance of ascribing to an exacting and unattainable appearance serves to demoralize and weaken people's self belief and subsequently their strength in society. In addition, the likelihood that they will spend extremely large amounts of money in order to 'reach' their desired appearance is increased.

Impact of the literature and previous clinical work: The introductory chapter illustrates that I am familiar with current relevant literature. The main assumption from this is that of the importance of appearance and the subsequent belief that a considerable change in appearance and body will have a significant impact on someone. I am therefore trying to be 'open' to the fact that it might not have been an important experience for people.

When I worked clinically as a trainee Counselling Psychologist in the plastic surgery department of the Royal Free Hospital, I was imbedded in general discourses relating to change in appearance. For example, it was generally accepted amongst the staff in the department that the aesthetic and psycho-social 'expectations' of plastic surgery were very important in relation to people's experience of the outcome of surgery.

In addition, I met with clients who had lost weight and were highly distressed at the presence of excess skin and were struggling with adjusting to their change in body size and appearance. I became particularly familiar with the experiences of one client of mine, and so decided to embark on a second interview to explore further ideas I formed as a result of my work with her.

4.2.2. Reflexivity Interview 2 (Answering interview schedule as old client of mine)

This interview highlighted several ideas that I hold about what might be important in this experience. Two predominant themes are, 'the significant of the change in appearance on sexual relationships' and 'the sense of disgust at the excess skin before its removal'. More detail is not given due to issues of confidentiality.

4.2.3. Reflexivity Interview 3 (Answering proposed interview questions about my appearance)

In concordance with Finlay (2006), I believed that my embodied experience was important to illuminate before I conducted the interviews. I therefore answered my own research questions, relating to what it felt like to 'live in my body now' and about the ways in which I felt about my body and appearance 'impacted various aspects of my life'. I hoped that this would better enable to me engage in the embodied experience of the interviews, increase my levels of self awareness and allow me to reflect on the influence of my own embodied experience on how I make sense of participants' accounts. This experience highlighted for me the surprisingly significant role that my experience of my body has in my life, which has, in turn, helped me to empathise with the experiences expressed by the participants.

2.5. Ethics

'Ethics' has been defined by the British Psychological Society as 'the science of morals or rules of behaviour' (BPS 2009, p6). As a scientist practitioner and member of the

British Psychological Society, I place the upper-most emphasis on ensuring that this study tightly and thoughtfully adheres to the ethical guidelines outlined by the British Psychological Society. I hope a 'transparent and coherent' account of the ethical commitment, in line with Yardley's (2000) guidelines, is presented. Firstly the four general principles described in the British Psychological Society's Code of Ethics and Conduct which influence the researchers day to day clinical practice were considered at every point of the research. These are 'Respect', 'Competence', 'Responsibility' and 'Integrity'. Following the 'essential principle' outlined by the BPS (2009), insofar as is possible, care has been taken to consider all aspects of the study from the standpoint of the participant. More specifically the 'Ethical principles for conducting research with human participants' (British Psychological Society, 2009) were followed closely and are outlined below.

Consent

Informed, written, consent was obtained prior to contacting the participants by telephone (Form of interest, Appendix C) and before the research interview (consent form, Appendix D).

Deception

I was open and honest about the aims of the research from the first contact (Information sheet, Appendix B) and did not withhold any information that might have caused distress to the participants' in debrief.

Debriefing

Considerable effort was made to ensure that participants had an accurate understanding of the research. Participants were given information regarding support services available to them whether or not distress was picked up on in the interview (Debrief sheet, Appendix G).

Withdrawal from investigation

Participants were made aware at every stage that they were entitled to withdraw from the study at any time (including during interview) without giving a reason and without there being any effect on their care.

Confidentiality

Participants were assured of their right to anonymity and of the efforts that were taken to protect their confidentiality. To preserve the confidentiality of the participants, all

transcriptions were stored anonymously. Any information linking the participant to her transcript was kept securely on a computer in the Royal Free Hospital and destroyed at the end of the analysis process. With participant consent, excerpts from the transcripts will be included in the presentation of the research findings, however all identifying material will be omitted.

Before the start of the interview participants were informed of the limits of their confidentiality. Participants were made aware that if I was to hear anything that made me concerned about their safety or the safety of people around them, I would be duty bound to inform relevant services due to my professional code of conduct (British Psychological Society, 2006) in relation to protecting participants.

Protection of participants

Extensive thought went into protecting the participants. The risks of psychological distress were kept to a minimum. However, it was possible that in being provided with a safe, empathetic space to articulate their experiences, participants may have reached new understandings and may have experienced some psychological distress. I felt skilled and equipped to discuss these issues in a sensitive and empathetic manner, and to contain distress that may be triggered by the interview process. In addition, in the case of distress, I was equipped to signpost participants to relevant sources of support.

Giving advice

Whilst this did not occur with any of the participants in this study, I was prepared to let the participants know if I became aware of any physical or psychological problems that I was concerned about during my interactions with them. To this end, all participants were informed that distress could arise after the interview had finished. They were given the 'debrief sheet' to provide them with information should they want any advice about finding support. This included the details of the psychology team at the plastic and reconstructive surgery department who had agreed to meet with participants experiencing appearance related distress following the interview; the details of the Samaritans phone line; my contact details and advice to go to their GP to discuss any distress. In addition, the GP of each participant was aware of their involvement in the study (Letter to GP, Appendix H) and can be involved in any required referrals to other services.

2.5.1. Obtaining ethical approval from appropriate sources.

Ethical approval for the study was granted by City University.

Due to the relative specificity of my inclusion criteria and my previous links with the Plastic Surgery Department of the Royal Free Hospital I agreed with the Consultant Clinical Psychologist to recruit participants from their department. I was therefore required to gain ethical approval from a centralised National Health Service Research Ethics Committee and local research and development approval from the Royal Free Hospital.

Whilst this was a lengthy procedure, I found that the increased level of detail required in completing the extensive forms led to an increased consideration, and as result clarity, of my research design and procedure. I believe that this put me in a stronger position to start my data collection from the moment Ethical and Research and Development approval was granted. I met with the Riverside Research Ethics Committee at Chelsea and Westminster Hospital on 3rd August 2009. For an outline of the points discussed in the meeting and the subsequent minor amendments made please see Appendix I.

2.6. Pilot

A pilot study was conducted, primarily to evaluate the effectiveness of the proposed interview schedule in accessing the lived experience of the participants and to develop my skills as a qualitative research interviewer.

Participants

One male and one female participated. These participants were both known personally to colleagues of mine. They were both informed that a preliminary interview about 'change in body' would be conducted to inform the development of a doctoral research project. They both identified as having recently adjusted to a different appearance having lost a 'significant[3]' amount of weight having been previously obese. Neither participant had undergone surgery to remove their excess skin following their weight loss but both stated that they lived with some 'loose' skin. I accepted that it would be difficult to find participants for the pilot that would be precisely the same as those I

[3] 'Significant weight loss' was not objectively defined but both participants subjectively identified as having lost a 'significant' amount of weight.

would recruit for the main study and believed these participants to be appropriate because their experience of change in appearance related to weight change.

Data collection

Both participants were interviewed by me. The first interview was over the telephone and the second was face to face at the house of the participant. Both lasted approximately fifty minutes. Questions regarding experiences of plastic surgery were excluded because neither reported having undergone any plastic surgery.

After the interview the participants were asked for feedback on their experience of participating on the interview, the questions, and experience of me as an interviewer.

Summary of feedback and outcomes

Both interviews were successful in that they accessed rich descriptions of participants' subjective lived experience. Both participants stated that the interview was an interesting and relevant experience that was not emotionally disturbing. I also found that I was more comfortable than I had expected in the role of 'researcher' rather than 'therapist'.

One participant reported difficulty in answering questions on how it felt to live in his body in the present. As a result I noted that these questions should be positioned towards the end of the interview in the hope that participants would be more accustomed to thinking and talking about their bodily experiences at that point, and that a more trusting relationship would have been established. I also felt that the process of participants attempting to answer these challenging questions would be an important one to consider.

I found the telephone nature of the one interview frustrating as I was not able to interact and observe the embodied experience of the participant. The argument articulated by Finlay (2006), regarding the importance of the embodied experience in the research interview resonated particularly strongly with me following this experience.

2.7. Data Collection

2.7.1 Sample Size

IPA's concern with the "detailed examination of personal change" (Smith et al., 2009, p. 164) means that it takes an idiographic position in relation to knowledge formation. Therefore, the importance of depth and detail are fore fronted in the analysis. In addition, as described by Smith et al (2009) there is a commitment to understanding how an experiential phenomenon is understood from the subjective perspective of particular individuals in a particular context. For this reason a small and relatively homogenous participant group is required to shed light on this phenomenon.

Participants were recruited in a purposive sampling manner. I aimed to recruit eight to ten participants. There are no formal guidelines on sample numbers in qualitative research (Smith et al., 2009). The range of eight to ten was arrived at after weighing up two commitments I had to answering the research question. First, I wanted to hear as many different subjective perspectives as possible, to provide insight into the phenomenon. Second, I hoped to maintain an idiographic approach and be able to devote appropriate resources to allow in depth analysis of each of the interview transcripts in the time frame available. Smith et al., (2009) state that it is harder to meet the commitments of IPA with a sample size that is too large, rather than one that is too small. When planning for time, I felt that ten was the maximum number possible.

2.7.2 Inclusion/ Exclusion Criteria

40 patients of the Plastic and Reconstructive Surgery Department of the Royal Free Hospital who were identified on the hospital's records as having undergone a plastic surgery procedure to remove excess skin from the abdominal area, following weight loss, at least one year ago were invited to participate in the study.

Through discussions with surgeons and psychologists in the department, it was decided that one year post-operation was the best time to meet with participants. This point in recovery best met the needs of the study to have the participants sufficiently close to the experience of change in body following plastic surgery that they could recall their experiences in detail, ensuring the suitability of their accounts, as discussed by Willig (2001). In addition, after one year, patients are all likely to have fully recovered physically from the operation and the scars would have healed and stopped changing in appearance. The latter was deemed important as the appearance of the scar will remain mostly stable from this point forward, and that participants would most likely be out of the 'recovery' period of their surgery.

During the period of data collection I was contacted by a friend of one of the participants, who had also recently undergone plastic surgery to remove her excess skin following weight loss. She expressed extremely high levels of distress relating both to the aesthetic outcome of her surgery and the psychosocial ramifications that she attributed to it (e.g., she stated her partner had left her stating her body following the surgery was 'disgusting'). I expressed to her my concern about her level of distress and, with her permission, I contacted a psychologist in plastic surgery department at the Royal Free Hospital. The psychologist contacted this individual that day. They went on to engage in a psychological therapy contract to address her distress. This individual did not meet the inclusion criteria as she had had her surgery two months previously. For this reason, after discussions with my research supervisor, I did not arrange to interview her and this reasoning was explained to her clearly.

Patients who met with me in a clinical capacity during my first year trainee placement at the Plastic Surgery Department were excluded from the study. This was primarily informed by my 'sensitivity to context' of the potential participants (Yardley, 2000). I believed it was important for the participants to understand clearly that their participation in this study was separate from their clinical care from the Royal Free Hospital. I worried that, if they had met with me clinically, the boundaries of our research relationship may be confused by the previous and different boundaries of our therapeutic relationship. In addition I hoped to avoid the potential for participants to feel pressured into participating due to the potential influence I might have on them as their previous therapist.

Only patients who had undergone surgery to remove excess abdominal skin *following weight loss* were invited to participate. One participant, who appeared to fit the inclusion criteria for the study on the database search stated in the interview that she had never considered herself to be overweight and that her 'excess skin' was a 'post-partum' abdominal overhang resulting from three caesarean sections of her three daughters. I had previously decided that these participants should be not be included in the study because the experience of bodily change after pregnancy was likely to bring with it qualitatively different meaning making process to that following obesity. I discussed this with the participant. We agreed to continue the interview as both of us had cleared the time and she was keen to discuss her experience of adjusting to life since the plastic surgery. Following a conversation with my supervisor and the participant it was decided not to include this participant's interview in the study.

2.7.3 Participant identification and invitation

Participants were identified using a search of the Plastic surgery department's electronic surgical record system for individuals who had undergone surgery to remove excess skin in the abdominal area since weight loss.

Participants were identified by members of their care team to protect patient hospital record confidentiality. The letter of invitation was signed by the Consultant Clinical Psychologist within the department. It was hoped that this would both increase participants' confidence in the study and reduce anxiety regarding being contacted by an unknown person, thus reassuring participants that their confidentiality was being respected.

Individuals who had had their surgery between October 2008 and October 2007 were shortlisted. Their addresses were identified by the secretary to the consultant psychologist of the department. An invitation pack was sent to 15 potential participants on the 17th September 2010, including:

- Invitation letter (Appendix A) – sent from the consultant psychologist of the Plastic surgery department
- Information sheet (Appendix B, version 2[4])
- Form of interest, consenting to be contacted by the researcher via telephone, (Appendix C) to be returned to the researcher at the hospital.
- Stamped addressed envelope to return the consent to be contacted form to the researcher at the hospital.

In the invitation letter, potential participants were invited to contact me, the Consultant Psychologist in the department or my research supervisor via telephone or email if they had any queries or were interested in participating in the research.

The information sheet was written with the aim of providing the participants with the most information possible, being transparent about the genuine aim of the

[4] Version 2 of the information sheet was the version with the amendments made which were stipulated by the Research Ethics Committee.

study and in language that aimed to be clear and understandable. I hoped that participants would be giving their fully informed consent if they chose to participate. Contact details were also provided to offer those who were not comfortable reading the whole information sheet an opportunity to be provided with the same information.

Potential participants were invited to communicate their interest in participating in the research project by returning the 'Form of Interest' in a provided stamped and addressed envelope. They were encouraged to read the information sheet thoroughly before doing this. It was recommended that they take at least twenty-four hours to consider their decision before agreeing to participate. By recommending this, I hoped to avoid any potential coercion that might take place if the participant was to be directly approached by any member of the research care team.

My contact telephone number was a mobile phone number that was used only for the purposes of this research study and is only used by me. No names or numbers of participants were recorded on the mobile phone. If I did not answer the participant's call, the participant was redirected to an answer phone message asking them to leave their contact details and a convenient time for them to be contacted.

Six participants responded to the initial batch of invitation packs that were sent out. Four returned the invitation letter slips and two contacted me on the mobile number provided.

Two more batches of six invitation packs were sent out and three more interviews were arranged through returned 'Forms of interest'.

On receipt of contact from the participant (either by post or telephone message) I contacted the participant by telephone. Participants were asked if this was a convenient time to speak, and in all cases the participants said 'yes'. I then introduced myself and offered the participants the opportunity to ask any further questions. I checked with them that they had read the information sheet and offered to go over it on the phone with them. All participants stated they had read and understood the information sheet. All participants stated that they were still interested in participating in the study. We then collaboratively

arranged the most convenient time and meeting place suitable to the participant that I was able to accommodate. Four interviews took place at homes of the participants, two at the participants' places of work, one was arranged at the hospital and one at City University.

Eight female adults participated in this study. Interestingly, whilst males were invited, only females responded to the invitations. Of the sample who were invited only three were men and 26 were women, which reflects the unequal gender distribution in people requesting this particular surgery on the NHS. Figure 1 displays the demographic information collected from the sample. This information was gathered to enable a description of the population. Three participants lost their weight through changes to lifestyle (diet and exercise) and five underwent bariatric surgery. Five participants had undergone Abdominoplasty surgery, whilst two had an Apronectomy and one underwent a Circumfrential Body Lift. These are different Plastic Surgical procedures which all remove excess skin from the abdominal area using different methods and to different extents.

Introducing the participants

The participants pseudonyms were selected by picking the first name that appeared for consecutive alphabetical letters in order of who was interviewed first (e.g., 1st woman to be interviewed- Abi). Below I will outline some information given to me by participants to help contextualise them.

Abi

I met with Abi in her home. Abi underwent surgery to remove her abdominal overhang one year ago. She told me that she had lost a 'significant' amount of weight from cutting out bread from her diet and stopping drinking alcohol. She said that she had been distressed that her abdominal 'pouch' which had existed since the birth of her daughters ten years ago became empty and dropped down between her legs. Through consultations with her GP she applied to have this removed and for the surgery to be funded by the NHS. She was concerned about the sides of her abdomen protruding after the procedure and had asked for liposuction to 'correct' this however this was declined and she was told that she would not be offered any further surgery. She is not awaiting or applying for any further surgery.

Babette

I met with Babette in her home. Babette underwent surgery to remove her abdominal overhang one year ago. She told me that her trigger for weight loss was a consultation with her GP who discussed with her the health risks of remaining at the weight she was at. She said she lost weight by cutting out cakes, crisps, chips and chocolate. She had an operation that removes the lower part of the abdominal overhang. She reported more weight loss since this procedure and continues to be distressed by her 'upper abdominal overhang'. She is currently applying to have this removed in a second procedure. She also discussed potentially applying for a thigh lift in the future.

Callie

I met with Callie at her home. Callie underwent surgery to remove her abdominal overhang one year ago. Callie underwent gastric bypass surgery three years ago after years of failed attempts to lose weight. She lost weight very quickly and continues to be distressed about the excess skin on her thighs and arms, and her neck. She is applying to have a thigh lift funded by the NHS and said that she might apply for an arm lift following that.

Daisy

I met with Daisy at City University. Daisy had undergone bariatric surgery three years ago and had a gastric band fitted. She reported losing a lot of weight and was distressed about the resultant abdominal overhang. Daisy underwent surgery to remove her abdominal overhang one year ago. She is distressed about the asymmetry of her scar and the 'puckering' at one side, which she hopes will be 'corrected'. She is also distressed about parts of her body that have been revealed by removal of her abdominal overhang. She is considering having plastic surgery to address this.

Edana

I met with Edana in a clinic room at the Royal Free Hospital. Edana underwent surgery to remove her abdominal overhang one year ago. Edana said she had weighed 27 stone. She underwent gastric bypass surgery and lost weight very quickly. She is applying to have a thigh lift and hopes that this will be the last procedure she undergoes to remove her excess skin.

Fae

I met with Fae at her workplace. Fae underwent surgery to remove her abdominal overhang one year ago. She has also already undergone a second 'upper' abdominal overhang removal, a bilateral thigh lift and bilateral arm lift. Fae underwent gastric bypass surgery and lost fourteen stone quickly having weighed 27 stone. She said that the trigger for her weight loss was a rude comment by a little boy on the beach on holiday. Fae now states that she does not want anymore surgical procedures and that she has 'reached the end of her journey'.

Gabby

I met with Gabby at her work place. Gabby underwent surgery to remove her abdominal overhang one year ago. Gabby lost weight by increasing her exercise and monitoring her diet. She told me that she made a new year's resolution in January 2000 to change her body. She lived with her abdominal overhang for several years before her GP commented on it in a consultation about an unrelated complaint. She had not been aware that it could be removed and funded on the NHS. She is applying to have liposuction on her 'sides' as she states that they are still protruding following her previous surgery.

Habiba

I met with Habiba at her home. Habiba underwent surgery to remove her abdominal overhang one year ago. She had an operation that removes the lower overhang and continues to be distressed by her 'upper abdominal overhang' and is currently applying to have this removed in a second procedure. Habiba lost weight quickly after undergoing a gastric bypass procedure. Habiba is distressed about her prominent 'podgy fanny' which has been revealed since the removal of her lower abdominal overhang. She reports distress about her 'dog ear' (puckering at one side of her plastic surgery scar) and would also like a new belly button as her previous one was removed in her previous operation.

Age	Occupation	Family status	Ethnicity
50	'Housewife'	Living alone	White British
47	'Home care worker'	Married	White British
50	'IT trainer'	Married	White British
54	'Project Manager'	Living with relatives	Greek Cypriot
60	'Teacher'	Living with relatives	White Polish
54	'Admin Manager'	Married	White British
29	'Deputy Manager'	Living with friend	White British
34	'Nanny'	Living with partner	White British

Figure 1, Table displaying demographic details of the participants[5].

2.7.5 The Interview

The following procedure was replicated irrespective of where the interview took place:

After I had met the participant, given them the opportunity to ask any questions, and answered any questions to the best of my ability, I went through each point of the consent form with them to ensure that the consent given by the participant was fully informed. Two copies of the consent form were signed by the participant and me, so that one copy remained with the participant. The participants were then asked if they were comfortable, and were reminded that they should let me know if they wanted to terminate or take a break from the interview at any point, and were given the opportunity to ask any further questions.

[5] 'Occupation' was completed as 'the occupation they identify as'. Not all participants were currently employed in their stated occupation at the time of interview.

With the permission of the participant, the digital recorder was then switched on and I re-stated my aims of the interview, informing the participant that it was their personal experience that was important and that my questions were just a guide. I stated that if their thoughts led them away from the question then this was fine and important to follow. This was intended to position the participant as the expert on this experience (Reid, Flowers & Larkin, 2005) and to ensure this remained an inductive process. The interviews ranged from fifty minutes to seventy minutes.

When the interview took place in the Hospital, a quiet consulting room was booked out in preparation, in the Plastic Surgery Department or the Royal Free Hospital. At City University a room was booked. When the interview took place at the home or workplace of the participant, we agreed in advance that it would be important for us to meet in a private, quiet place. This was to protect the participant and reduce distractions. In addition, I set up the necessary safeguards for my personal safety. These included carrying a rape alarm and providing a colleague with the address of my participant and asking my colleague to telephone me on my 'research phone' 90 minutes after the start of the interview. In all but one case, I telephoned my colleague before the 90 minutes had passed to let them know that I had left the house and was safe.

I transcribed each interview after the interview personally which enabled me to get to know the data. Interview transcriptions included all spoken words, pauses, false starts and other aspects worth noting (e.g., laughter) as suggested by Smith et al., (2009).

2.8. Analytical procedure

One advantage of using IPA as the analysis tool is that procedures for the process of analysis have been clearly illustrated by Smith and his colleagues over the years. In addition I welcome the openness and transparency of the analysis process. Whilst the body of literature does not prescribe one specific method of analysis, various outlines have been provided. My analysis is primarily influenced by the most recent and thorough guidelines to date, outlined in the 2009 collaboration from Smith, Flowers and Larkin. I appreciated being provided with a detailed and clear set of guidelines which have been born from years of experience engaging in IPA whilst being tentative enough to allow

for and encourage individual ideas and creativity. I was also informed by a helpful list of questions for the researcher, provided by Larkin (2004, p. 8) at several stages during the analysis. An example question is 'what do these experiences mean for the participant?'

Broadly speaking IPA analysis is a process which continually moves from detailed description of the text to interpretation, and from looking at the particular lived experience, to the shared. To this end it has been described by Smith (2007) as an iterative and inductive cycle. Six stages of the analysis were engaged in which are outlined in Chapter five of Smith et al., (2009) book. Below I will describe how I engaged with the data in all six of these levels. The stages are described transparently and explicitly and exemplars relating to the stages are presented in the appendix (Appendix J – L) to illustrate my 'commitment and rigour' with the intention of producing valid and high quality findings (Yardley, 2000).

1. Reading and re-reading

The importance of 'immersing' oneself in the data is repeatedly highlighted in the IPA literature (e.g., Smith et al, 2009; Langdridge, 2007; Willig, 2001). Eatough and Smith (2006) state that each reading helps the researcher to become more responsive to what is being said. To this end I transcribed the data myself, listened to the interview once more whilst reading the transcript and then read through the transcript once more. I found that listening to the tapes alongside reading the transcripts helped me to re-familiarise myself with the experience of the interview and helped me to consider the process issues relating to the interview itself. I carried out this process for each individual interview before analysing it individually. This afforded me engagement with and knowledge of the text which helped me to view it as a whole when I moved on to the next level. As suggested by Willig (2001) I recorded my thoughts and observations in response to the text in my research diary.

2. Initial noting

I then engaged in individually and thoroughly examining the transcript on an exploratory level. I made efforts to remain open minded and note anything of interest that arose in the transcript. As suggested by Smith et al., (2009) I made

three distinct types of comments, focussing on three aspects of the text, which I noted in different colour pens in order to maintain their differentiation. These were *descriptive*, *linguistic* and *conceptual*.

The *descriptive* comments comprised the content described by the participant. They hoped to highlight the 'things which matter to the participant' (Smith et al., 2009, p. 84). I tried to ensure that these notes remained as close to the text as possible, with the least influence from my own knowledge and ideas.

My *linguistic* comments noted the ways in which participants presented the content when describing their lived experience (e.g., repetition, laughter).

As suggested by Smith and colleagues (2009) my *conceptual* notes took a more interrogative and conceptual form. I noted interesting features of the accounts and questions it raised for me, in the knowledge that some questions would lead nowhere whereas others would lead me back to the data or towards a more abstract level of analysis (Smith et al., 2009). These comments drew more on my own professional and experiential knowledge, using these to tentatively inform my newly emerging understandings of the lived experience of the participant.

These notes were all made by hand, as this is how I prefer to engage with text. This was a lengthy process in which the three types of noting were made in parallel as I worked my way through the narrative of the text. I found making three different types of notes helped me to be disciplined about exploring different aspects of the text.

3. Development of emergent themes

My principle and simultaneous aims of this stage were to reduce the volume of detail of the notes whilst maintaining the complexity and richness of the material. My preliminary notes therefore became the focus of the analysis and I focussed on discrete chunks of the notes, whilst keeping the content from the whole of the transcript in mind (Smith et al., 2009). The transcript is therefore momentarily fragmented into parts, in the hope that it will be bought back together in a 'new whole' at the end of the analysis which, as Smith et al., (2009) point out, represents a manifestation of the hermeneutic circle.

I listened to my first recorded reflexivity interview (Langdridge, 2007) to ensure that I continued to be thoughtful about what I was bringing to the analysis and that the analysis at this stage remained closely connected to the text.

The emergent themes are intended to capture what was important in the comments attached to a specific part of the transcript, with a succinct and pithy statement. Consequently they reflect not only what is spoken by the participant but also my own interpretations. For an example of stages two and three of the analysis process, please see the exemplar in Appendix J. For the purpose of this exemplar a word document example is presented.

4. Searching for connections across emergent themes

Emergent themes from stage three were ordered chronologically, as they occurred in the transcript and I looked at them in relation to each other. These were typed up into a table and cut out on to separate pieces of paper. A large floor space was then used so that I could observe the themes together and consider how they might relate to each other. This is one of a number of methods suggested by Smith and colleagues (2009) and best fits with my personal methods of using spatial methods to make connections.

I then labelled the resulting clusters of themes. The label intended to capture the essence of all the themes within it. A summary table containing the cluster themes, and subordinate themes that shed light on the phenomenon under investigation for each transcript, alongside citations representing these themes in the text (Willig, 2001) was constructed. I discussed some of the clustered theme titles with my supervisor with a view to checking and validating my analysis process. For a copy of an exemplar table of stage 4 please see Appendix K.

5. Moving on to the next case

Due to the idiographic nature of IPA, I engaged with each interview individually using steps one to four. Once I had done this for one transcript, I moved on to analysing the next case in its own terms; to the best of my ability 'bracketing' the ideas that had emerged from previous transcripts. I held in mind that this

was another individual's subjective experience and therefore it was important for me to take this at its own face value and allow myself to be surprised by it.

6. Looking for pattern across cases

When all transcripts had been analysed using steps one to four I considered the cluster themes from the different transcripts in relation to each other to form master themes as described by Willig (2001). Due to concerns of mine about the associated meaning of the term 'master' I am calling these themes 'super-ordinate themes'. Cases were integrated in a cyclical manner, meaning that when broader, higher level themes were reached, they were required to be grounded in the text of the transcript. In order to do this, I printed out summary tables, cut out individual rows of cluster themes, and the emergent themes within it, spread them out on a floor space and considered them in relation to each other.

A table illustrating how emergent themes are grouped under super-ordinate themes, quotes and references of where this super-ordinate theme is expressed from the participants' transcripts was constructed. This process led to the re-labelling and reconfiguring of themes. Once again the aim was to produce over-arching themes that captured both the individual lived experiences of each participant whilst representing higher order theoretical ideas. As suggested by Smith et al., (2009), the recurrence across cases was taken in to account when grouping and naming super-ordinate theme. This is discussed in the Analysis Chapter. Subsumation and polarisation are examples of the methods employed when developing super-ordinate themes. These are all described by Smith et al., (2009) in Chapter 5. To see an exemplar of stage six please see Appendix L.

2.10. Methodological and procedural reflexivity

During the process of data collection and analysis I was aware of the relationships that formed between me and the participants. All participants engaged in the process and were remarkably trusting and open. I felt that because the participants were real people to me, they bought the phenomenon into meaning. My awareness of our relationship led to my consciousness of the interview being a product of our interaction. It is not suggested that their experience did not exist outside of our interaction, but that in the interview it was

presented in a particular form. To this degree I was reminded of the reality of my impact on the phenomenon both in data collection and analysis. This confirmed to me my epistemological position, that whilst their experience occurred in reality, the interview was the product of their making sense of their experience in a particular context with me.

During data collection and transcription I kept a diary in which I noted thoughts and feelings I had about the interviews, comments made by participants when the tape was switched off that I thought were interesting and notes relating to the embodied experience of the interview (Finlay, 2006). I also made notes relating to the impact of my 'outsider' status to the experience on the process of the interview. One situation of note was a comment made by Callie at the end of the interview, after I had turned off the tape. She stated that I must have found 'all this absolutely disgusting' being that I was 'so lovely and slim'. This seemed to be an illuminative and powerful communication regarding her experience of her body.

After the first and second interviews I met with my supervisor to discuss my concerns that I was not reaching the 'depth' of experience that I had anticipated. This conversation helped me to challenge my expectations and think more carefully about the data that I had. I also reflected that I had perhaps been too wedded to the interview schedule. In later interviews I focussed less on the schedule and more on illuminating each specific participant experience, which I believe had a beneficial impact on the data. I think that my training and experience as a Counselling Psychologist enabled me to make this shift and that it was my anxiety about being a 'researcher' (and not a 'therapist') in the conversation that led me to start off the interviews anxious and keen to follow the schedule.

After the first two interviews I changed the title of the study. My outsider status, and relative naivety, had led me initially to entitle the research 'change in appearance'. I soon learned that whilst some of the experiences related to how participants looked, much of the data related to their embodied experiences, and how this felt emotionally and physically. The title was there for changed to 'changes in body'.

My experience of surprise in the interviews reassured me throughout the data collection process that whilst it was impossible for me not to influence the data, the context allowed for the possibility for new and novel data to be formed.

2.11. Cost

My travel to participants' houses (petrol and public transport)- £60
Participants' reimbursed travel to hospital - £10
SIM card for mobile telephone – £30
Postage - £40
Total cost - £140

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3.0. Analysis Chapter

3.1. Introduction

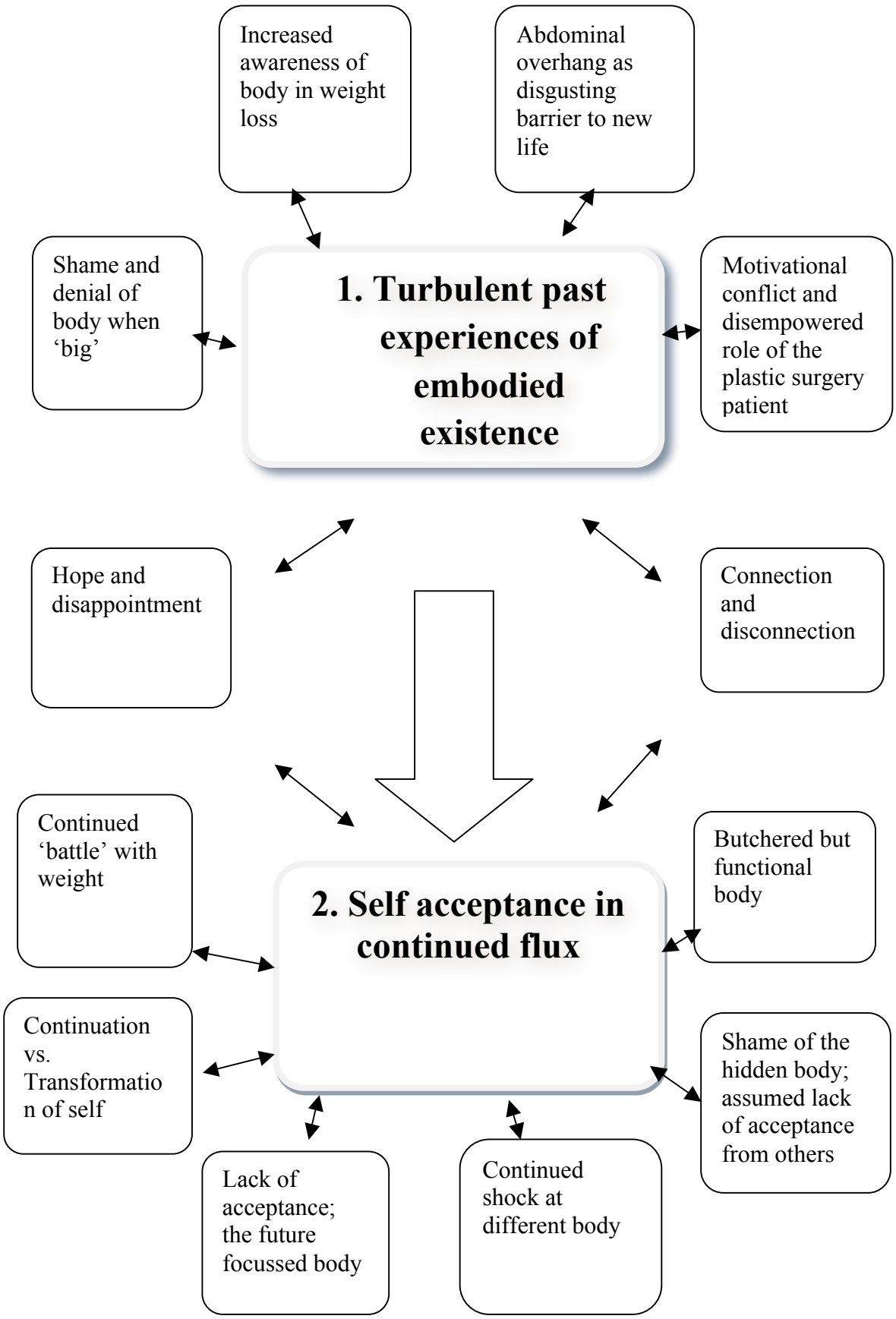
This chapter presents one over-arching theme with two inter-related constituent themes derived from interpretative phenomenological analysis. The presented themes aim to provide a rich and illuminative insight into the complexity of the lived and embodied experiences of these women. What is presented in this analysis is my interpretation of participants' interpretation of their own lived experience.

The over-arching theme is 'Destabilised Embodiment'. The two inter-related constituent themes are listed:

1. Turbulent past experiences of embodied existence
2. Self acceptance in continued flux

Please refer to the diagram below to consider the themes in relation to each other and their sub-themes. As is evident from the diagram, the sub themes of 'hope and disappointment' and 'connection and disconnection' refer to both of the constituent themes. They will therefore be presented in between the presentation of constituent themes.

DESTABILISED EMBODIMENT



As is evident in the diagram, themes one and two have a number of sub-themes. Whilst the super-ordinate themes were expressed by all participants, not all of the subthemes apply to all participants. See Appendix M for a table of appearance of themes for each participant.

Theme two describes the lived experience of the body in the present. As this is the phenomenon under investigation, this theme and its sub-themes will be paid most attention in this chapter. It feels important also to consider theme one, as the past turbulent embodied experiences are likely to have considerably influenced the present experience of the body. This first theme sets the context for the present experience and it will therefore be presented first. I will start by outlining the over arching theme and will refer to this again in the summary. I will describe both constituent themes by detailing their sub-themes and providing quotes to illustrate how these themes were communicated.

Throughout data collection I made notes about the embodied experiences in the interviews. These reflections will be presented in italic font throughout the chapter.

3.2. Overarching theme

Destabilised Embodiment

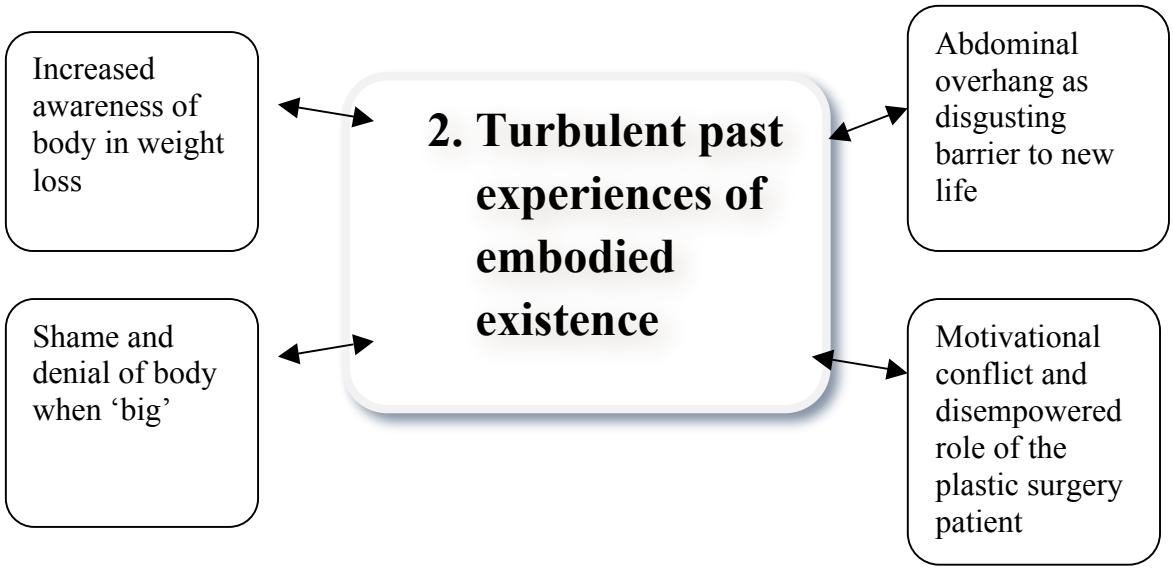
'Destabilised Embodiment' is the over arching theme that appears to encapsulate the variety of lived experiences of the women who participated in this study. It is discussed that the current sample have experienced such significant, and in many cases ongoing, changes in their body and that the experience of relating to their world through their body has been destabilised as their body has changed. These changes are experienced both within the self and in relation to others. Below I will present my experience of the descriptions of the participants' experience of living in their body-in-the-world.

As discussed, the sample was not homogenous in that participants did not all identify as being at the 'end' of their 'journey' of body change. Six were still applying for more procedures and one who was not had already had four plastic surgery procedures. This is a pertinent and symbolic indication of the embodied

and lived worlds in which these participants inhabit. I believe that destabilised embodiment is best communicated by describing the themes that are embedded in it:

3.3. Constituent theme 1.

Turbulent past experiences of embodied existence



Participants described their experiences of their past body at different stages; when they were big, when they lost weight, living with their abdominal overhang (before its removal), and their experience of plastic surgery. The phenomenon under exploration relates to the experience of the body in the present and it is therefore important to spend some time considering how past embodied experiences might inform the present.

3.3.1. Shame and denial of body when 'big'.

Participants discussed their difficulty with living in a bigger body. They vividly described feelings of shame and disgust towards their bodies as well as the functional difficulty of living in a body that was so big. Some participants described themselves as being in denial about their body at this time. This appears to be a reflection only gained with hindsight.

Callie names her experiences as 'humiliation':

"...a life time of being overweight and humiliation." Callie 36/25[6]

She goes on to recall a specific event in which her husband 'humiliated' her in public by drawing attention to her and her size:

> "He goes 'the fat bird, she can't get the thing [aeroplane seat belt] around her' and I just sit there and look at him and think; 'why have you just done that. I am sitting here and everyone can see the top of my head and they all know where I am'. And they were, they were walking up and down the aisles looking down and I said 'look see, cos you live with it and you don't think about it, it's something you don't want to broadcast more than they can see". Callie, 37/6.

Here it seems as though Callie did not want to be seen and was more comfortable when hiding in public. Her last sentence acknowledges that she could not hide herself totally, and that her inevitable visibility was distressing in itself. There appears to be an intense sense of shame in Callie's experience here, and a frustration at the lack of understanding from her husband. Interestingly Callie reported that she continues to hide her body in the present, both from herself, her husband and others. It could be the case that a 'lifetime of being overweight and humiliation' has rendered her unable to feel comfortable being noticed in the body she has hidden for so long.

Callie moved about a lot in our interview, changing her seating position regularly. At the time I understood this as discomfort, possibly nervousness, in the interview.

Habiba discusses her limited functionality and subsequent embarrassment in her body when it was bigger:

> "And saying to people at the hospital and the psychiatrist, saying 'look my husband is my husband, not my carer but he is having to wash, you know, wash my backside properly because I can't reach it' and I said 'it's, you know, quite embarrassing you know''. Habiba, 19/12

Explicitly Habiba is explaining the difficulty of assuming a dependent patient role rather than the role of a wife, due to her body size. It appears that Habiba had a

[6] Quotations are cited with the participants pseudo name and the page/line number of the quote from the transcription.

different relationship with her body to those who are smaller and able to reach all parts of their body. This in turn affected her relationship with her husband. This altered relationship with the body could have important implications for the present embodied experience as it is likely that she is now able to reach all parts of her body.

It is important to reflect on the tone with which Habiba made this statement; it was with a jokey tone, making comical faces as she went. This, alongside her use of the term 'quite embarrassing', leads me to believe that these are distressing memories of an upsetting time, which she is belittling by laughing off. This approach to recalling distressing material was adopted by many of the participants. It seems that humour was used to create distance from the difficult feelings surrounding these memories.

Habiba was physically communicative in our interview, showing me her scars and clutching the excess skin that she wanted removed. She was energetic and dynamic and, despite my hypothesis about her use of humour, she made me laugh.

Participants discussed their tendency to use humour as a strategy when they were big:

> "And I kind of, afterwards I kind of feel sorry that I missed out on my teenage years, doing, you know, missing out on stuff like that cos I wouldn't do things. And I would sit there mocking myself so that other people didn't have to. And I didn't realise that until I look back." Gabby, 10/16.

Gabby mentions her sense of loss for herself as a teenager. She also states that in hindsight she is able to identify her protective strategy of humour. This humour may have helped to distance and protect herself from the experience of loss she described at the time. Her acknowledgement of life being harder when she was big than she admitted at the time, is representative of other participants' accounts.

Babette discussed her recently identified strategy in which she would 'put things to the back of her head'. This seemed to represent a protective strategy of denial where she would deny that she was distressed about her body when she

was big. She explains below that in hindsight she wonders if she was distressed the whole time:

> "Stupid. Why didn't I come to my sense before? And now, I shouldn't do, but when I go on a bus and a see a big person I now I always think 'you are wasting your life'. Because deep down I am sure they are not happy. I said to everyone, 'I am erm, I am alright'. But I wonder, I don't know, I don't know. I put a front but I don't know if I really was, I don't know." Babette, 20/13

At the start of this excerpt I think that Babette communicates anger at herself for not changing her body sooner. Her statement implies that she now believes that she was not in her 'right mind' when she was big. She describes how her insight into her own experience influences how she experiences big people in the present. She describes the 'front' she used to put on and her doubt, in hindsight, of whether she was in fact 'alright'. This recognition of a previous denial or having a defensive 'front' when bigger was a common theme. This implies that participants are now in a different and potentially less defensive state in which they are more able to connect with what they actually do feel about their bodies.

Having recognised that they used to deny their body and their distress about it, hide and feel ashamed of their bodies, and laugh off their difficult experiences, it would seem that participants are likely to have a complex way of relating to their embodied experience in the present. It is also important to consider that many participants inhabited a 'big' body for up to forty years.

3.3.2. Increased awareness of body in weight loss

Participants described the experience of weight loss differently. For some it was characterised by adjusting to life post-bariatric surgery. In relation to the body changing in size and shape, an increasing awareness of the body was frequently described. This appeared to have come from both an increased intrapersonal and interpersonal awareness. The women described being more aware of their bodies because they experienced a change in how it felt to be in them, and because they were aware of changes in how others interacted with their bodies. This theme is particularly illuminative of the changing body bringing about a qualitative change in embodied experience.

Gabby talks about experiencing herself as increasingly looked at by others as well as becoming more conscious of her body:

> "I remember being more conscious of people looking at me and maybe a bit more of a, I can't remember before when I was big how people used to look at me but I was more conscious of myself when I had lost weight. It should have been the other way around I would have thought: You know when I was really big people looking at me and then I lost weight and I was happy for people to look at me but it was the other way around." Gabby, 5/32

Gabby describes her surprise and confusion at becoming more conscious of herself when losing weight than she had been when she was big. It seems an interesting paradox that when she was reducing in size she was becoming increasingly aware of being noticed by others. This is open to varying levels of interpretation. It might be the case that others looked at her more, which led to increased self consciousness. It is also possible that her increased self consciousness led her to be more aware of people looking at her. It could be that when she was bigger, given that she described feeling ashamed of her body, she did not allow herself to notice how people looked at her as a protective strategy. It sounds as though Gabby experiences the way people looked at her as different, and as if they make her feel more exposed. It could be that she was more aware of people looking at her with sexual interest and that this experience was an uncomfortable and exposing one which led to increased self consciousness. This perceived change in the way she was viewed by others appears to have unsettled her embodied experience, and potentially her view of herself.

Gabby held her arms across her stomach and kept her coat on throughout the interview. I experienced this as self consciousness.

Daisy also describes her experience of being looked at more and her disbelief that people might have been looking at her because they were attracted to her:

> D[7]: It was just the fact that I noticed people looking at me a lot more but I don't know why. I have always been the worst person to accept compliments, I find it very hard.

[7] Initial of pseudo name of participant.

> R[8]: If you were to try to make sense of why people were looking at you more what would be your thoughts?
>
> D: At that point, the only thing I could think of was, 'Oh you are looking better, so maybe they are just looking thinking that you look better', but that was after a lot of 'oh why are they looking at me?' I would look behind me. Daisy, 20/22

For Daisy as well as Gabby this change in experience of being perceived by others seems like a significant shift and appears to coincide with viewing oneself differently. It is clear that there is still a sense of flux where these women are continuing to adjust to their new bodies and how they are related to by others. Daisy's statement that she would 'look behind' her suggests that a part of her still does not believe that she is found attractive.

This theme illustrates the complexity of the lived experience in body change and the discrepancy between participants' expectations and their reality.

3.3.3. Abdominal overhang as disgusting barrier to living new life

All participants discussed the excess skin remaining post weight loss as a disappointing barrier that stopped them from living the life they had hoped to live when they had lost weight. Given that most hopes and expectations were psychosocial (e.g., to have more confidence), it appears that it was a physical barrier to the psychological shifts they had longed for. This theme relates closely to the theme 'hope and disappointment'. All participants referred to the overhang as a disappointment, complication, or unwanted result of weight loss. Here Daisy describes her contrasting experiences of the skin.

> "And I was feeling absolutely amazing, I was feeling really motivated, feeling great and I was going and buying clothes and the same time I had this hanging tyre. Everything I put on there was this hanging tyre, you know boobs you can put into a bra and pull up, saggy arms, no way I am exposing them, which I haven't done ever, you know your legs are all saggy and I was like, 'oh my god, reality, I am doing all this and I feel bloody awful. I look awful. I don't feel sexy; I don't feel like a woman, like I should feel." Daisy, 9/1

[8] 'R' introduces something said by the 'researcher' to the participant.

Daisy describes the shock of the 'reality' in which it appears her expectations and hopes of feeling 'sexy' and 'like a woman' had not been met. Daisy's reference to the skin as a 'tyre' is representative of how the excess skin was discussed by all participants. The language used constructs it as objectified, de-humanised and detached from the body itself. Given that the abdominal overhang caused distress for all the participants, the function of this narrative might have been to distance the displeasing object from the self. Participants expressed strong hatred and disgust towards their excess skin. It could be that it is easier to direct these negative feelings towards an external object, rather than towards a part of one's self.

Callie describes 'the skin' as another inanimate, separate object:

> "The thing with losing the weight is you are conscious beforehand but you are even more conscious with the skin because people are staring. So you are still limited to what you can wear and do and it is a hindrance because it is weight. It hangs and it gets in the way. Like cleaning my floor on my hands and knees, it was like playing football with the stomach because you had to kick the stomach when you, I know it sounds awful, when you are lovely and slim like yourself (laugh) but it is, this excessive skin that just hangs." Callie, 1/25

It seems that for Callie, her abdominal overhang felt like an object that was separate to her body. Her describing it as 'like a football' appears to be related to the physical actions she had to perform on it being similar to that of a football; it would not move without her kicking it. It seems as though this part of the body was not just constructed as separate from the body, but that it also felt separate from the body. It appears to be passive and not to move with the rest of the body.

Callie appears to imagine that I would be experiencing disgust in hearing her talk about her skin, and comments on her experience of my body. This is an illuminative comment which serves to separate me from her experience as well as highlight her assumption that others will be disgusted by her body.

I was aware in our interview of Callie looking at my body. Alongside her comments about my body, this led me to feel more self conscious. It highlighted to me a potential attentional bias she might have relating to body shape and size.

Gabby describes her hatred and disgust for 'the skin':

> "Umm, I hated it and I would stand there for hours in front of the mirror and kind of going (grimaced face) just disgusting. Didn't have any relationships because I was too conscious. Yeah it was horrible, I hated it. And in the bath was gross. I would just sit there playing poking.....I would pull it and prod it and kind of, I know it sounds awful but be horrible to it. You know, its discussing. Yeah horrible. Could quite happily have cut it off myself. Urg." Gabby, 17/20

It seems as though Gabby used to take out aggression and hatred of the skin on it physically by abusing it. Her bullying of the skin, which, in reality was a part of her, is a distressing and important reflection of the extent of her hatred for it. Her statement that she could have 'happily' have cut it off herself reflects the extent of her desperation to be rid of it.

Gabby's expressed disgust for her skin came across very strongly and I was struck in the interview by her expression when talking about it. Her face looked as though there were a rotten smell in the room. It appeared hard for her to think of the skin without grimacing. This level of disgust at one's own body is likely to have a considerable impact on how the body is experienced in the present and the future.

Gabby's meaning making of the skin offers more insight into her hatred for it:

> "That was my memory of me being big, although I had forgotten what it was like to be big. That was almost like my scar, that was what I deserved because I was like that." Gabby, 18/16

The overhang appears to have been positioned as her deserved punishment for being big. Gabby has positioned herself as being persecuted for her behaviour (overeating) and appears to direct her own self persecution directly and 'horribly' onto her own body. It appears as though much of Gabby's anger at herself for being overweight in the first place, and all the related distress, has been transferred on to her excess skin.

Edana articulates her disgust toward her abdominal overhang and the strategies she employed to live with it:

R: When you used to look at the skin, and see it, what did you think of how it looked?

E: Disgusting. I try to don't' look. I tried to avoid it as much as possible. Uh, I tried to not ok,

R: You tried to not look at it?

E: I tried to not look and I didn't want to accept that I have it. Edana, 15/15

Edana appears distressed by my question which asked her to think back to her experience of looking at the skin. Both the memory and the reality appears to distress her significantly. She states that she employed the strategy of avoidance because she did not want to accept the skin. It seems that she believes that if she looks at and engaged with this part of her body she might have to accept that it was just that; a part of her own body. Edana also uses language that constructs the skin as an 'it' and separate from herself.

All participants explained that they still have excess skin on their bodies. Very strong negative emotions were directed towards their abdominal overhang (excess skin on their abdomen). It is interesting to consider where these emotions have gone now that the overhang has been removed. Has it disappeared? Has it been displaced on to the other parts of their bodies that still have excess skin and on which many of the women are applying to have further plastic surgery procedures?

3.3.4. Motivational conflict and the disempowered role of the Plastic Surgery Patient

This theme will be presented in two parts, both of which relate to the complex experience of being a plastic surgery patient. The first relates to the motivational conflict experienced and the second describes the disempowered and disregarded role experienced by the participants.

Motivational conflict

'Motivational conflict' describes the conflict which emerged from being a 'plastic surgery patient' and the implicit links this has to vanity. All participants were keen to distance themselves from concerns about appearance and emphasised

health motivations for plastic surgery. As has just been illustrated, participants' hatred of their abdominal overhang did not appear to exclusively relate to functional problems, and often related to disgust at the appearance and feel of it. It is important to note that applying for plastic surgery on the NHS required the adoption of a medicalised discourse relating to their experiences of excess skin. Patients are required to illustrate that health benefits would be brought about by the removal of the skin and this is likely to have influenced their discourse around their motivations considerably, especially when talking to me, who contacted them through the NHS plastic surgery department. It is also important to note that participants did experience pain, sweating and infections under the overhang, and found that it hindered their movement. It seems there were definite health motivations. However, I would suggest that there were also aesthetic motivations, which seem harder for most to communicate.

Babette stated that she recovered from her plastic surgery on a cancer ward:

> "...because the ward I was in was a cancer ward and I felt out of place. Because, back of my mind, the operation was for me. All these people in the wards, they have got, had their breast removed because of cancer and they have had this removed because of cancer and I did not want anyone to know that I was in it, perhaps people thought I was in it to make myself more pretty or something like that" Babette, 5/10

Here Babette appears to be articulating her experiences of shame and guilt relating to being a plastic surgery patient in a cancer ward. The idea of engaging in surgery for reasons of vanity appears to be a shameful one and causes her considerable distress. Babette discharged herself from hospital early because she found this context hard to bare.

Babette appeared highly anxious when talking about this experience, shuffling in her seat and tapping her hand on her lap. I experienced her as much less comfortable when we talked about her motivations for surgery and it seemed that this was an area that had a lot of strong emotional content bound up in it.

It seems as though Babette also experienced self-questioning regarding how deserving she was of having surgery and being in the hospital. This theme is described in more detail later.

Daisy articulates her motivational conflict as well as describing her sense of urgency to 'live her life':

> "So I am thinking no no, I have to have it now; I have got to live this life now. Umm, and it's not about... there is a slight vanity thing in it. Cos I did say this to Mr –[9] [plastic surgeon]. I did say 'oh it's not a vanity thing, and then went 'actually it is'. It's not all about vanity but there is the vanity aspect in there because I want to look nice." Daisy, 15/1

Her broken speech appears to reflect her ongoing meaning making and conflict regarding her motivation. Daisy stops herself as she is about to deny the presence of vanity as a motivator, just as she did in her consultation with her plastic surgeon. It seems that she is less ashamed of wanting 'to look nice' than Babette. Her first sentence implies that she did not feel able to live her life until her skin had been removed, which has interesting implications for the fact that she is currently applying for further surgery which she also hopes will help allow her to 'live her life'.

Disempowered and disregarded role

The disempowered and disregarded role of the plastic surgery patient refers to the experiences of the lack of personal agency, disregard and disempowerment described by all of the participants in their experiences of the processes leading up to surgery and of surgery itself. I was struck by how the participants took meaning from their encounters with surgeons and their surgical outcome. Here Habiba describes how she made sense of her consultation with her 'rude' Consultant surgeon:

> "It's as if 'you are fat, you shouldn't be having the surgery anyway'. Do you know what I mean? 'We're doing you a favour'." Habiba, 33/26

It seems that Habiba interpreted her surgeon's manner as indicative of his belief that she was not deserving of the surgery because she was 'fat'. This sense of un-deservedness is echoed regularly throughout the transcripts and I believe it is this that contributes significantly to the disempowered position they experienced. It could be that her sense that the surgeon believes this reflects

[9] I have left out names of surgeons to protect anonymity of participants.

her own doubt in how deserving she was of the surgery. Because these participants were deemed 'cosmetic' patients, on the lead up to their surgery many had their surgery date postponed due to an 'emergency' case coming in. This could have been emergency surgery for someone who had been burned in an accident. Abi described being 'humbled' by this. Many others referred to their being very understanding of this process, alongside feelings of gratefulness at being able to have this surgery on the NHS. It could be that experiences like this served to reinforce this sense of grateful un-deservedness.

Daisy articulates her meaning making from her asymmetrical surgical scar (which is understood within the department to be a relatively normal outcome after such a procedure, and which patients are routinely warned about in the assessment process (personal communication), based on similar assumptions of lack of self importance and deservedness:

> R: What does it mean to you that it is not even?
>
> D: They did it, it's like I am only half done. Was I not worth doing properly? Did I not deserve that? Why didn't they take into consideration....did they not think, did they think 'oh it doesn't matter what she is going to look like because nobody is going to look at her? I felt a bit like that, oh now she is not thin, I still wasn't thin when I did it but for me I really was a lot thinner. But it was like, oh well it's not important, you know, she is flabby all over the place anyway, having a flat tummy is like, yea whatever, it doesn't really matter what she looks like as she is not going to be exposing her body anyway. Daisy, 27/5

Daisy has interpreted her surgical outcome to mean that her surgeons held total disregard for the importance of her having a good aesthetic outcome. This echoes Habiba's sense of being undeserving of the surgery.

Gabby earlier described her persecutory stance towards herself, implying that she 'deserved' the punishment of the excess skin because she had got 'big' in the first place. It seems as though there is a strong sense of shame experienced by these women in relation to what they have done to their bodies. They seem to experience a sense of disregard of the self and a begrudging attitude by the health professionals who work with them. As previously mentioned, participants' meaning making and their assumptions about what the surgeons believe could be very telling of how they feel about themselves at times. It could sadly also be the case that the participants are picking up on a

reality in which society (health professionals included) holds discriminative beliefs towards people who are or were big. They are likely to have experienced years of discriminatory behaviour and could be sensitively attuned to peoples' prejudiced attitudes.

Abi articulates her gratefulness towards the NHS and the difficulties of not being able to afford to pay privately for the plastic surgery:

> "You know, so there are things to consider with this and really you've got to be really thankful for you what you get. And it's very difficult if you can't afford it. If you can't go private for it in actual fact you have got to go the NHS and the after care is a lot better." Abi, 13/35

Abi's statement raises the issue of socio-economic disempowerment. All participants referred to feeling disempowered when applying for their surgery and it could be the case that they would have felt more empowered if they had had the money to pay for the surgery privately. It seems as though participants experience guilt associated with their gratefulness for using NHS resources and this could contribute to their troubled sense of self.

Gabby said that when she came round from surgery the top of her leg was hurting. This was not an area that was involved in her surgical procedure. Gabby's surgical story represents both the 'disregarded' and the 'disempowered' experience:

> G: I read it on a piece of paper when it came back later. You know the suturing thing, they had left it on and it had burnt the top of my leg as well [laugh] so umm, I had two holes at the top of my leg. Cos it was such a superficial thing that really hurt. This [abdominal scar] was numb but that really hurt.
>
> R: So they had left something on your leg and it had burnt?
>
> G: Yeah [laughter]
>
> R: You are laughing
>
> G: Yeah well, what can I do? You know it wasn't major and everyone makes mistakes and well, I know it's not good but... Gabby, 26/10

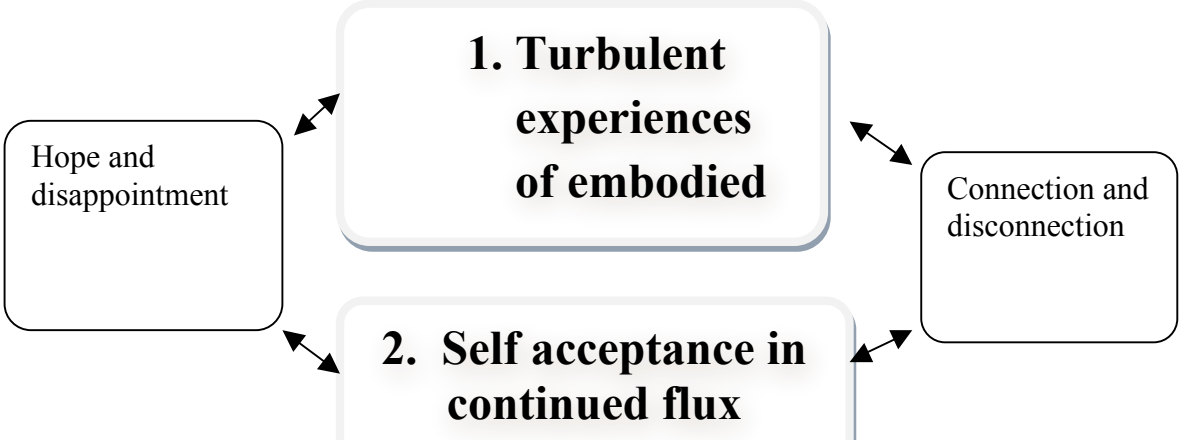
Gabby does not explicitly describe a sense of feeling disregarded and instead has excused the event as a mistake. This appears to enable Gabby to be light hearted about what happened, however I wonder whether she found this more distressing than she is reporting. She appears to have adopted an accepting role which appears to come from her sense of disempowerment and powerlessness; 'what can I do?' It seems as though laughter is one of the few methods she has to help her process or manage this situation.

The quote from Daisy below is later highlighted in the theme relating to feeling 'butchered'. Here she describes what she perceives to be a disregard of her body by the surgeons, likening herself to a lifeless piece of meat:

> D: You are not taking me into consideration, I am a piece of meat on your table and you have to remove that piece of flesh and you are just doing it. That is how I felt
>
> R: Like a piece of meat?
>
> D: Oh there is another big blubber, come here, flesh hanging down, we have got to cut it off, let's do it the best way we can do it. Daisy, 23/17

She discusses her belief that she was immediately categorised as 'a big blubber' and was therefore not considered as a woman, but a piece of meat. This sense of having been unimportant to the surgeons could considerably influence the embodied experience in the present. Having surgery is an interesting experience when considering embodiment. It is a time when your body is handed over to other people in an explicitly unbalanced power dynamic. This sense of objectification and separation from embodied experience is likely to contribute to the overarching theme of destabilised embodiment.

3.4. Sub themes, relating to both constituent themes.



3.4.1. Hope and disappointment

Many participants' narratives appear to be shaped by cyclical experiences of hope followed by disappointment. This arose in various aspects of their 'journeys' with unmet hopes from weight loss and plastic surgery. Disappointments ranged from disappointment with the aesthetic outcome of weight loss or plastic surgery, to disappointments with psycho-social expectations.

Retrospectively, all participants described the disappointment which dashed hopes of decreased body distress when they became aware of the excess skin following weight loss. This is clearly articulated by Abi:

> "... When I saw the result of the weight loss and everything coming off it was not, I just felt fantastic until I looked at my stomach and then I just felt awful. So even though I was thin, I was still depressed." Abi, 23/38

This polarised and split experience of the body as 'fantastic' and 'awful' could considerably contribute to a confused and unstable sense of one's embodied existence.

Gabby describes the discrepancy between her expectations and her reality:

> "Oh yeah, I expected to feel brilliant. But then I expected myself to just lose weight and from going from big to thin with no other complications. There is a big psychological process of it all. And the whole thing, that you don't just go from big to small without everything dropping [Laughter]". Gabby, 7/15

Gabby describes the skin as a 'complication' of weight loss which appears to draw from medicalised discourse of weight loss. She refers to 'psychological processes' without going into detail. It appears that she has an understanding that these play an important role in relation to achieving 'feeling brilliant'. Gabby laughs at the end of this description. As previously noted, it was common for her to make light of seemingly emotionally charged aspects of her experience. She identified in her interview that her laughter was a response when she feels powerless in a situation. In this instance her laughter could reflect her difficulty with her lack of control over her body and 'everything dropping'.

Callie articulates her experience of hope followed by disappointment below in relation to applying for plastic surgery:

> "It's been a long fight. That is, it's the disappointment. It's pulling the hope up. I have never taken somebody's word for it because as I said, that one percent makes a big difference so you always live in the shadow of one percent". Callie, 4/27

She describes her experience of applying for plastic surgery as a 'fight'. This is a discourse drawn on by other participants in relation to this process. The 'fight' discourse positions the patient as an active agent which differs from some of the less empowered narratives which emerged in relation to plastic surgery. It suggests that Callie has a sense that the *system* is not necessarily willing to help her if she does not fight.

Callie appears to be mistrusting of the *system* and goes on to describe an interesting metaphor. The shadow metaphor might refer to the percentage likelihood of surgical complications, but might also be about the chance that she will not be offered the surgery. Either way this provides an interesting insight into Callie's psychological processes. It would appear that if something positive was 99% likely to happen and 1% likely not to happen, Callie would be more preoccupied with the chance that it would not happen. She says that 'you' always live in the shadow of 1%'. It seems as though she means 'I'. Callie often spoke in generalised terms in her narrative, using the plural, third person 'you' rather than 'I'. I have considered that this is a functional strategy, creating distance between her and her experiences by generalising them.

The repeated and seemingly cyclical nature of hope and disappointment is likely to have considerably affected participants' embodied experiences. This connects with both the inability to accept the body in the present and also to the turbulent past experiences of the body. It seems as though they all experienced unmet expectations. When looked at alongside the theme of 'lack of self acceptance, the future focussed body', it appears that ideas and hopes about the body in the future might be setting individuals up for disappointment.

3.4.2. Connection and disconnection

Participants discussed their experiences of either connection and support or loneliness and isolation in their experiences.

Edana describes her sense of isolation when she was big:

> "Because you haven't got much contact and your friends back up from you because of your size. Even, umm, very good friends, some of them I haven't seen for long. And they back up out of shame". Edana, 7/3

She appears to believe that people avoided her because they were ashamed of her. This way of making sense of her experience might reflect how she felt about herself at this point. She is also talking in generalised terms, using 'you' rather than 'I' here. This could be a functional narrative, avoiding stating 'people were ashamed of me' which might be a more emotionally charged statement.

The following interaction displays how Callie experienced loneliness and isolation through not being understood by her husband:

> "C- ...I looked at him and thought, you have got no idea have you? He can't understand why it's such an issue.
>
> R- If you think about what you said before about being understood, I wonder what it feels like to not feel understood.
>
> C – Umm, it's hard because it does cause arguments because the more you try to explain to somebody the more they'll say 'but blah blah blah' but you are totally missing the point". Callie, 27/10

At various points Callie described her husband's lack of understanding and lack of sensitivity to her self consciousness of her body in public. Callie described a close relationship with her husband and talked about him a lot in the interview. She describes her attempts to explain her experiences and feeling that her husband 'missed the point'. This sense of loneliness and isolation in this lived experience came across strongly in her narrative. All of the participants, including Callie, were very keen to know about other women's experiences in this process when we met. It seemed as though all participants wanted to feel connected in their shared experiences with other women.

Below are some examples of experiences of connection in this process:

Abi and Fae described experiences of connection and support with people in their life. Interestingly these are the participants who were not applying for further surgery, implying a higher degree of acceptance of the present body.

Fae described her libido becoming negligible after the plastic surgery due to all the numbness she experienced around her scars on her thighs and lower abdomen. She stated that she and her husband were no longer sexually active as a result. This highlights an experience of physical/ sexual disconnection. However she goes on to explain how they have remained connected in spite of this experience:

> "I think talking about it and talking about the whole sort of process of the operations that I have had done and at first my husband wasn't agreeable to the operation but then he knows that I am quite strong willed person and that I was going to go for it and then he supported me so I think if you have got the support from you partner or your husband, whoever it is..." Fae, 22/15

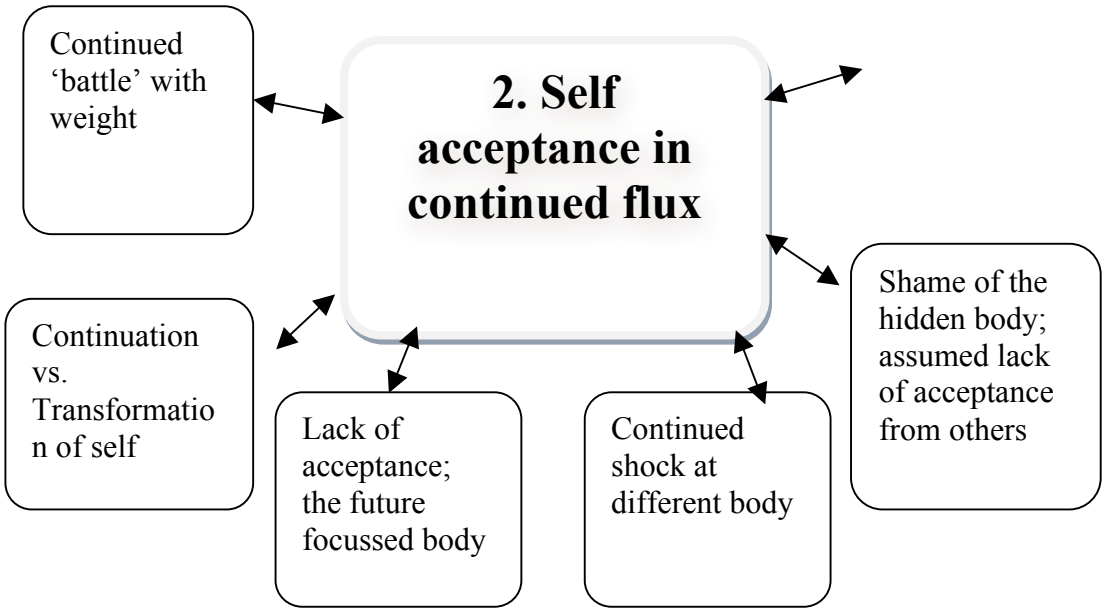
She appears to be highlighting the importance of support at the end of her statement here. Within her description she points out times of disconnection; when her husband did not agree with her having the surgery, and then connection; when they had talked about it and he went on to support her.

Abi describes her partner's expression of unconditional acceptance and love for her:

> "...my partner, he doesn't, he's not into that, he says 'I love you if you're naked, you're in your pyjama's, if you are in your Basque...nothing, it doesn't bother me, I love you". Abi, 8/32

It would appear that there were quite polarised experiences of either connection or disconnection by the participants which relate to both previous turbulent experiences and present embodied experience. It is likely that feeling disconnected and lonely when experiencing body change would have a different impact to feeling supported and connected throughout the process.

3.5 Constituent theme 2.
Self acceptance in continued Flux.



This theme relates to the difficulty expressed by all participants in accepting themselves in the present. This constituent theme describes the state of flux which participants appear to inhabit in relation to self acceptance. This theme has six sub themes which will be described below to illustrate the lived experience. Several participants articulated the fact that they saw the end of their journey as 'self acceptance'. It is interesting that what they were aiming for was not a physical change but a psychological one. Gabby articulates her goal succinctly:

' (To) Accept me for who I am and allow other people to accept me for who I am'.

3.5.1. Continuation vs. Transformation of self

Participants varied greatly in their discussions of the relationship between the past 'self' at varying stages in body change and the current 'self'. This variance was evident both between and within individual transcripts. Interestingly they were always discussed in quite polarised narratives; that they had stayed totally the same, or were a completely different person. It could be the case that this categorical approach to what has happened to the self in body change could be contributing to the state of confusion that appears to be rife in all participants.

Below is an example of the contradictions that are evident in most of the participants' transcripts, relating to their continuation or transformation of the self in body change. Firstly Habiba describes her rejection of men that she had previously found attractive and who had ignored her when she was 'big', but then made sexual advances after she had lost weight:

> "And they would come over to me and I would be like 'fuck off' you know, who do you think you are you know? I am the same person as when I was fat. I said 'nah' you know some times. That was nice you know as in 'yeah on your bike mate, no change' as in, I was still the same person. You could have been with me and gone thought that you know journey." Habiba, 18/20

Habiba appears to have experienced anger at people not having noticed Habiba the 'person' when she was big. It seems she experienced increased sexual interest from others post weight loss and feels angry at the superficial nature of these oversights. She describes an enduring sense of self whilst the body, and subsequently the way one is perceived by others, has changed.

Later on in the interview, however, Habiba describes herself as a totally different person, and attempts to make sense of this change in her 'self':

> "Well, I am a totally different person, do you know what I mean? Not like, you know, I am more confident. Like erm, I mean I was always, I mean when I was big I wore a bikini because I just thought, people stare for a couple of days and that's it. As in now I still wear a bikini and I just hate that flappy bit ['puckering' on her hip post plastic surgery], not that I have got a belly button but people keep looking at my flappy bit." Habiba, 43/28

In the first sentence she makes a clear statement about being different, but then appears to move away from this generalisation, stating that a more specific aspect of her 'self' has changed; her confidence. She chooses to articulate this change by describing her experience of wearing a bikini. Whilst it seems she is using this example to illustrate a change, she actually describes a continued act of wearing a bikini and her continued awareness of other people staring at her body, both in the past and the present. One difference appears to be that her self consciousness and 'hate' now appears to be directed towards 'that flappy bit'. The implication here is that she was previously conscious of, and 'hated', the whole of her body.

Taken together, there seems to be a conflict for Habiba about what has happened to herself in this experience. This might be partly explained by the fears and expectations of her loved ones that she might lose her 'self' in her body change:

> "And then a lot of people were frightened that I was going to lose my personality and go into myself being so thin but because I hated being big I think I became more cocky, do you know what I mean? Being thinner. But then I did find it hard because I fitted in. I would have to be even louder now cos it's like 'oi hello!" Habiba, 11/15

A discourse drawn on by some of the participants suggested a belief held by them or others that they might lose their personality if they changed their body size. This appears to suggest a fear of a transformation of the self, and a loss of more than just weight in the weight loss process. The implication of this fear is that a thin person has a more introverted personality, whilst a larger person is more extraverted. Habiba explains that, contrary to this, because she hated being big, she became more confident and therefore more extravert and 'cocky' when she was thinner. She discusses what could be discordance between her smaller body and her identity as having an effervescent and bold personality. She implies that her bigger body reflected her personality whereas her smaller body might not, and that she feels she now has to shout and be louder to get noticed.

Fae describes holding a related belief:

> F- I think if I lose a lot more weight then I would go too skinny and that's not me. I think my personality could change. Whereas it hasn't changed since I lost the weight.
>
> R- What do you think might happen to your personality if you were to go 'skinny'?
>
> F- How can I say? I think I would be a different person. I don't think I would be the same sort of happy go lucky person that I am or have been. I think I could change quite dramatically and I don't think I would like to be that person. Fae, 8/15

Here Fae discusses her fear that she might lose her personality if she loses more weight. Fae reports having lost 14 stone and states that she is the same person. It appears that she is worried that losing another stone or two might

mean that her personality would change, implying a threshold below which it would be impossible to continue to be the same person. This belief could be serving a functional role as it allows her to be accepting of her current weight and to stop 'battling' to reduce her body size further, which most of the other participants continue to do.

It is clear that Fae is experiencing difficulty in articulating her embodied experience and what has happened to her 'self' during this body change:

> F- "So it is difficult, and it's difficult to really put it into words because I haven't changed the person that I am but you have changed in a way really.
>
> R- So part of you has stayed the same but part of you has changed?
>
> F- Yeah because you look different, you know, you do look different." Fae 21/15

At first she highlights the continuation of the self despite the body transformation, but moves on to recognise a change in self because of looking different. Fae shifts her language in this statement, moving from speaking in the first person ('I haven't changed'), to using a generalised, plural 'you' ('you do look different'). It could be that Fae is more comfortable believing that her sense of self is the same. Her change in language could distance herself from the possibly threatening experience of having changed as a person.

Fae appeared at ease in the interview and seemed generally light hearted throughout it. When talking about her continuation vs. Transformation of self, however, she appeared uncomfortable, becoming restless and pausing more in her speech. At the time this communicated to me that she was making sense of this for the first time and that it was triggering some potent thoughts and feelings.

It might be the case that Habiba and Fae hold on to the construction of the enduring self in order to protect themselves and others around them from the fear that they have lost a part of their character through weight loss. It might be easier to consider the self as separate from the body so that the self is believed to be able to endure considerable changes in the body.

Gabby presents an alternative experience, in which she believes she has changed as a person. Below she discusses her experience when looking at photographs of herself when she was big:

> G- "I hate them [photographs). And then I look at them and feel a bit sad. Not me back then of the person back then. It's like a different person. It's not me. I feel sorry for the girl that is in that photo.
>
> R- And that girl is?
>
> G- Not me. No. I know it's me. In my head it's me but my heart, its someone else. And I do feel really sorry for her and for everything she went through, if you see what I mean. Maybe I kind of detached myself from that person." Gabby, 11/1

Here Gabby appears to recognise that she might have detached herself from her previous, bigger self. She has created distance between her past self and the difficult experiences associated with that time. It is likely that this serves a protective function in that feeling sad for a separate person might be a less painful alternative than feeling sad for yourself. It seems as though Gabby prefers to consider herself as having changed totally.

Gabby describes experiencing something in her heart and something else in her head. This draws on a split discourse between thoughts and feelings. Interestingly Gabby locates both acts as embodied experiences.

Edana discusses her sense of having lost a part of her 'self' in plastic surgery:

> "It's something taken from me, something cut, something I don't know how to explain to you properly in English. I am not 100% woman. Do you understand? I am half something. To make me to do better for walking or something." Edana, 28/1

It appears that she experienced a loss of something very deep and central to her identity in the act of having flesh cut away in surgery. This suggests an experience of a self that is inextricably bound up in the body and that a removal of part of the body means that part of the self has been removed as well. She highlights the sense of womanhood being removed. She describes herself as 'half something'. It makes me think about the fact that she has lost over half of her body weight over the course of this experience and it is interesting that this appears to be mirroring a sense of loss of her 'self' as well. Edana goes on to

affirm that she believes she has changed the person that she is through her change in body:

> "I can tell you that I am not the same person that I was before, do you understand? It's different for me. .....I am not the same. I am not the same person as I was. Do you understand? You take something and you lose something. That's the way it is." Edana, 29/2

I think Edana's constant checking- 'do you understand?'- relates to an anxiety about whether she is articulating her point in a clear way. I think this is related to the fact that English is not her first language. Ironically I experienced Edana's descriptions as one of the most evocative and illuminative. Her difficulty in describing her embodied experience is representative of every participant's difficulty in articulating their embodied experience.

Daisy describes her embodied change when her body changed:

> "My whole persona changed. My body language changed, my posture changed. My kind of, I mean I have got, I have always had a confidence about me but it depends what situation I am in. But I took on this air of total and utter blissness and calm, that just kind of taking a deep breath and just thinking, yeah, it's going to be alright." Daisy, 19/2

Here Daisy does not distinguish between herself and her body. She describes an embodied change that incorporates physical and non physical changes in response to a change in size. Her 'air' of 'calm' appears to be an embodied experience that is felt inside the body and would also be visible outside the body. She does not describe herself staying the same or changing, rather a transformation in the lived experience of the body. This felt change appears to provide Daisy with an incredibly positive experience.

The theme 'Continuation vs. transformation of self' relates to the overarching theme (Destabilised embodiment) in that it appears that the confusion and conflict that is apparent in the transcripts regarding the relationship between the self and the body reflects a turbulent and destabilised embodied experience. Participants generally discussed their motivations for this body change as both health related and psychological. All described a wish to be more confident and less ashamed of their bodies. Whether or not these expectations have been met,

there appears to be an understanding that our psychological experience is related to our physical experience and a hope that by changing the body, psychological shifts will take place.

3.5.2. Lack of self acceptance; the future focussed body

This theme describes the tendency for all participants to talk about their hopes for their bodies in the future, even when asked a question about their body in the present. As previously discussed, all but one participant reported applying for further cosmetic surgery. In addition, most expressed hopes for further weight loss. It appeared that it was difficult for the participants to inhabit their own body in the present, which would require a degree of acceptance. Rather, all participants appeared to prefer to consider their body in the future once it had been 'improved'.

Below is an example of a typical interaction:

> R- If you think of your body now, maybe unclothed, what does it get you thinking, what comes up for you?
>
> D- That I want to take those two stone off and get back so I can wear those clothes that made me feel a lot better. But also, I want this corrected. Daisy, 23/10

Here Daisy responds to my question about her body in the present with a set of aims and improvements for her body in the future. This is reflective of most other participants. It seems that it is difficult for her to consider her body in the present when she sees it. This suggests a strong sense of a lack of acceptance of the body in its present state. Her language also suggests that her body is still faulty as she describes her wish to have her body 'corrected'. Below is an example of her describing this in more detail:

> "I am waiting for some more correction because they somehow did it completely skew whiff (right). I really love my one side but I have an overhang on the left, so I have to go back and get that corrected." Daisy, 1/18

I am struck by the repeated use of the word 'corrected' but also her experience of the strong *need* to be corrected ('I have to...'). This suggests a refusal to even attempt acceptance of her body, and instead a determination to change it

physically. In reality it is not certain that she will have this 'corrected' by the NHS. Her positioning of the 'overhang' as the problem could have serious implications for her feelings about her body in the future.

I observed Daisy as a physically expressive person. She moved around in the interview, acting out stories physically and dynamically. She confidently engaged in eye contact from the start of the interview and maintained it throughout. She communicated strong senses of anger and frustration regarding her treatment by health professionals and also towards herself when discussing weight gain. This was communicated by her raising the volume and sharpening the tone of her voice.

Babette answers a similar question of mine with her thoughts about her present body, however appears to be equally as un-accepting:

> R: What comes up for you...Right now, if you picture yourself?
>
> B: Ugly, because I have still got the excess skin. I look in the mirror and I think to myself, yeah you are alright from the bottom half down but it's just this [points to stomach]. Babette, 21/32

She appears to attribute the 'ugliness' she sees to her excess skin. She describes a form of acceptance of part of her body (the bottom half). It is possible that it is functional to focus on and externalise the 'ugliness' to a specific and objectified body part; the abdominal excess skin. It seems as though Babette is also looking in the mirror and noticing what she does not like and what she wants to change. Babette is currently applying to have a second procedure removing more excess skin from her abdomen.

Gabby discussed an increase in confidence but appears to be considering a future in which she hopes to be more confident:

> "But yeah I am more confident now. Once I have had this other surgery now hopefully I will be totally totally confident. Cos that is one thing, I have got a nice flat stomach and I can put on a top and that bit looks really nice but I have got these bits that don't look nice so then I have to put a cardigan over the top and things like that. So to me I am near the end of my journey but I am not quite there." Gabby, 34/28

Gabby is expecting that a physical change will bring about significant psychological shifts. It seems that so far Gabby has experienced that with body change also come some psychological changes, as she reports improved confidence. Gabby clearly identifies self acceptance and self confidence rather than physical change (e.g., body shape, weight) as the end point of her journey.

Gabby also tended to discuss her body in the context of the future. Below she appears to recognise that the operation will do only part of the work in helping her to reach her psychological shifts:

> G - "Yeah, and maybe even when I am feeling perfect myself that [self consciousness] will still be there. Maybe that is something that would take years to get rid of. But I am pleased I had it [first plastic surgery procedure] done and I do want this other surgery just to finish everything off. And then it's my choice how I, not my choice, it's up to me then how I deal with it. You know everything has been done that can be done and it will be up to me to deal with it. It might take six months, might take a couple of years, I don't know.
>
> R - And when you say deal with it...
>
> G - Deal with it as in accept me for who I am now. I have got, you know I have accepted that the scar and everything. That's fine, it doesn't bother me, and hopefully I will do the same with this. Just be for me to deal with it. Accept me for who I am and allow other people to accept me for how I am. Cos I don't do that." Gabby, 35/20

Gabby's statement that her aim is self acceptance implies that she does not feel that she is self accepting in the present. Her understanding of the psychological aspect of self acceptance sets her apart from many of the other participants who appear to continue to locate the problem of lack of acceptance in a problematic body. Crucially Gabby hopes to accept herself, not her body, which indicates her global lack of self acceptance and thus the extent to which her view of herself is bound up in the appearance of her body.

Gabby's expectations continue to appear very high as she talks about 'feeling perfect'. This is an interesting phrase that underscores her psychological rather than physical goals, as she is not stating that she wants to look perfect, but to 'feel perfect'. Gabby adds that she hopes to allow others to accept her. This implies that she currently does not feel accepted by others, but that this is her

responsibility and that others would accept her should she give them the chance. This also sets her apart from many of the other participants who fear that others would reject them if given the opportunity.

Babette describes her expectations of her next procedure:

> "I know the operation is not one that is going to be a miracle but it will be a lot better than what I am now". Babette 22/4

She appears to be most focussed on it being an improvement rather than 'the end', as Gabby does. It seems as though her expectations are more measured that Gabby's, and appear to remain rooted in her body change. Interestingly, Babette talks about her *self* being improved by the surgery, not just her body; 'better than what I am now'. This again suggests an inextricable link between the perception of the body and the perception of the self.

Below Callie articulates her non-acceptance of her body. She describes her consideration of her body in the future and the possibility that she will undergo the plastic surgery procedures that she wants to have:

> "I have got no idea about that, that is something that is put on a different shelf. It's not like you can go and buy one get one free [Plastic Surgery procedures]. You can't. That's a different issue. That is something that I am learning to cope with. Not live with but cope with. There is days when you think 'oh blow it' but then as you think you are going on great something will happen and you think, no." Callie, 33/2

Callie describes the psychological processes involved when she considers her body in the future. She uses the metaphor of a shelf as a place to leave something that is problematic, potentially implying it is too distressing to consider fully now.

Callie states that she is learning to 'cope' with the uncertainty of whether she will be offered further plastic surgery on the NHS. She clarifies that she cannot 'live' with this uncertainty and doubt. It appears that she does not feel able to 'live' in her body as it is. Perhaps she feels that life would only be a matter of coping whilst she inhabits the body she has. It seems as though she is far from accepting of her body and does not believe that she can be accepting of it

without further physical change. She goes on to describe the fluctuation in feeling able to cope with her body in the present.

Looking at this theme in relation to the overarching theme it appears that participants are predominantly future focussed in relation to their bodies and this lack of acceptance of the present and subsequent position of flux appears to contribute to the overall destabilised embodiment. Participants appear to find it difficult to consider their embodied experience in the present and instead hope for a future in which they might experience self acceptance, and possibly a more stabilised embodiment.

3.5.3. Shame of hidden body; assumed lack of acceptance from others

A common theme in participants' accounts related to a long history and a current behaviour of hiding their bodies. It appeared that this came from a concern of lack of acceptance by others of their body, and an associated sense of shame. An example of the lack of acceptance of the body in the present and the assumed lack of acceptance from others is provided by Callie below:

> C- "See, clothes I can hide everything but unclothed no. I haven't got a full length mirror in the house. I wouldn't have a full length mirror.
>
> R- What would that be like for you to have to look at yourself in a full length mirror unclothed?
>
> C- No, no. I wouldn't. No. That's why I don't like my hubby seeing me. I have only got to look down at it and I am looking at a different angle, not full on." Callie, 25/13

It seems as though Callie feels unable to even contemplate looking at herself naked in the mirror. She appears to be fearful of what she might see in the reflection, how it would make her feel, or both. She repeats the word 'no' four times in her last two sentences. I believe this serves to underscore the strength with which she refuses to consider her body naked. She does not answer my question and her refusal to answer it speaks volumes in illuminating her experience of her body. Her resolution to avoid seeing her body could represent a very cut off, separated relationship with her body.

Callie's lack of acceptance of herself appears to be transferred on to her husband, as she assumes that he would not accept her either. It is likely that avoiding exposing her body to her husband removes any opportunity for her to experience possible acceptance from him, which could in turn serve to help challenge her own ideas about her body. Callie describes her feelings towards her husband seeing her naked:

> C- "Even now, if he was to open the door to the bathroom, he'd think nothing of the way I look now but I would break his nose with the door with the way I slam it. You know it does cause problems.
>
> R- So after the apronectomy it means a lot for...
>
> C- Yeah because it's exposed other areas... yeah, yeah, that I couldn't see because it was under my stomach." Callie, 16/7

There appears to be a conflict here for Callie about whether her husband would be accepting or not of the appearance of her body. She appears to believe that he would 'think nothing of it' and yet she would take extreme measures to hide her body from him. It could be the case that she has an underlying belief that her body could not be accepted by anyone, and that whilst her husband might have reassured her, she cannot believe that he would not experience the same shame and disgust that she reports.

Callie goes on to describe the fact that since her abdominal overhang was been removed, other areas have become visible to her that she was previously unaware of. This infers that there were parts of her body that she was not aware of, which has interesting implications for the embodied experience and the separateness that she might feel from her body, or parts of it. In addition, the hope for surgery to help her relationship with the body is complicated by its revealing new 'problematic' areas. It seems as though the removal of the overhang has provided an exposed feeling and the arrival of other reasons to feel ashamed of her body. Others have described a fatty protruding pad sitting on their pubic bone, which was revealed after the removal of their abdominal overhang. It is possible that Callie is referring to this.

Callie goes on to explain what she imagines other people would think of her body:

R-"What do you think they might think if they saw it?

C- Gross.

R- Gross?

C- Yeah, yeah, gross. It's not smooth hanging skin, it's horrible hanging skin." Callie, 12/25

She uses the word 'gross' which communicates a disgusted response from others. This, in the context of her avoiding seeing her body, could go some way to describe some of her own experience of her body.

Callie goes on to describe a humiliating event in which her body was revealed to others in the work place:

> "I bent down to get the milk out of the fridge and two of the technicians were standing at the door and it wasn't until I went to pick the milk up and I noticed something here and I thought it was my hair and as I have looked down I have noticed that it wasn't, it was my wrinkly boobs and they were standing there looking and never said a word. I have got to face them every day now and the minute I look at them I see my boobs that will never ....and I was adamant that is not funny, that is humiliating. Do it at home and there is no one to see that hasn't seen it before but at work, that is, you know, you think, oh they've gone away and I bet they are talking to everyone else now." 33/15, Callie

She reports feeling humiliated. It seems likely that many people would experience embarrassment if their breasts were revealed at work however there is a very high level of distress in this description. It could be that because Callie's body has been hidden from herself and others for many years that there is a hyper-sensitive response to it being exposed to anybody. In addition her beliefs about her body might lead her to predict that others would be disgusted by it. This would be likely to contribute to a sense of shame in this experience.

When Callie told this story she covered her face with her hands. At the time I experienced this as a communication of the shame she felt in just re-telling the story.

When considering Callie's embodied (or disembodied) experience it is striking that she first experienced the feel of her breasts on the skin of her cheek as her hair. It is likely that Callie has some empty, excess skin around her breast tissue due to her weight loss, however this confusion of two very qualitatively different body parts suggests quite an extreme disconnection with the body.

Here Abi describes her comfort with her body when dressed in contrast to her not being as happy when undressed.

> "I would say I am a hundred percent happy with how I look when I am clothed. I am not as happy when I am undressed and, um, although I can get past that because there is no one that really sees me undressed anyway, so." Abi, 5/6

It is likely that in Western Culture many people do not feel 'as happy' and comfortable when naked as when clothed. Abi states that this does not have an impact on her life because no one sees her undressed. Abi told me that she is sexually active with her partner, and this statement implies that he does not 'really see' her 'undressed' which might indicate that Abi attempts to conceal her body in sexual encounters.

Gabby describes what she thinks other people might feel in response to seeing her:

> R- "What are you thinking other people might think [about your body if they saw it]?
>
> G- Just looking at how disgusting I am. How disgusting. But when people know me like my partner now, he knows what kind of, I know it sounds like a bit of a cliché, but what's inside." Gabby, 38/15

Gabby states that people would find *her* disgusting and Abi states that no one 'really sees' *her,* rather than *her body*. She uses this embodied and connected language to explain that when someone knows *her* that they will accept her appearance, implying that they are the same thing. It seems, however, as though she believes that they would not accept her if they were just to see her body. This implies a more secure sense of self, but a continued distress in relation to her appearance. She goes on to explain her acceptance of her continued hiding of her body from others:

> "I am not confident enough for other people to accept it [my body]. You know, umm, yeah. But we wear clothes every day, when would you not? I am not going to be running along a beach in a bikini. You know I wouldn't. I wouldn't have done that when I was big, I won't do it now, even after my surgery. I think even if I looked perfect I wouldn't do it now. Because I have lost that kind of, umm, I have still got inhibitions. I have lost that kind of freedom if you see what I mean. But I have put that on myself." Gabby, 37/2

Interestingly Gabby is now referring to her body in a more distanced and objectifying manner; as 'it' not 'me', drawing from a dualist discourse. Whilst she rationalises the unimportance of not showing her body, she describes a strong sense of loss, which she blames on herself. She talks about losing 'a kind of freedom'. I think that this is a very poignant point which appears to encapsulate the experiences of all the participants; that because of their previous size, they have lost the opportunity to live in a body without such restrictive 'inhibitions'.

Gabby's motionless and protective posture in the interview communicated to me a socially inhibited and self conscious state.

Edana articulates her concerns about showing her body in public:

> E- "I don't think I would allow anyone to see it [current body]. To tell you the truth, it's not fair for the other people because other people on the beach will be sick.
>
> R- You think other people might have been sick if they saw it?
>
> E- Yeah, I think so, or it would put them off, you know, something. So I had to avoid, you know, any public, going to the swimming pool. You know, London, you go to swimming (pool). I don't go. People say maybe you wear some shorts or something you will be ok. No, because I don't want to upset the other people. Not because I would be upset if somebody see me but I think they would be upset. It's much work for people. If they see me it might put them off, do you see? I don't think it's very fair...some people, I don't know, it's like they can't take it [seeing my body]. I can't take it. For example, if I saw somebody like that coming and I was normal, I don't think I could take it. I would be the same you see." Edana, 16/27

This is an illuminating description of the beliefs that Edana holds about her body and the subsequent impact her body would have on others. She appears to believe it would make others 'sick' and 'upset' them, and that it is therefore not fair for her to inflict her body on others. She explains her attempt to empathise

with others, who she refers to as ‘normal’. Edana states that she ‘cannot take it’ when referring to her own body. This not only suggests a lack of acceptance from the self and others but a total rejection of her body. It appears that Edana experiences a strong sense of disgust towards her own body.

Later in the interview I asked Edana what she imagined someone might think if they saw her body. She responded*:*

> “I don’t, I am a monster and I am cut into pieces. Maybe they make funny comments. I don’t think I could accept, do you understand?” Edana, 24/15

Edana seems to believe that people would think of her as un-human; as a monster. This may be representative of her own perception of her body. It would seem that she experiences her body as not human and feels that she has been cut into pieces. Edana suggests that she would struggle to hear comments about her body, implying that she feels vulnerable in relation to this.

Edana communicated disgust at her body in her facial expressions when she described it. She also sat very still in the interview, and did not physically draw attention to any parts of her body when she spoke.

Daisy had expressed that she was distressed by the fact that her plastic surgery abdominal scar was asymmetrical. I asked her what this meant to her and she responded:

> “They did it, it’s like I am only half done. Was I not worth doing properly? Did I not deserve that? Why didn’t they take into consideration...did they not think, did they think ‘oh it doesn’t matter what she is going to look like because nobody is going to look at her? I felt a bit like that, oh now she is not thin, I still wasn’t thin when I did it but for me I really was a lot thinner. But it was like, oh well it’s not important, you know, she is flabby all over the place anyway, having a flat tummy is like, yea whatever, it doesn’t really matter what she looks like as she is not going to be exposing her body anyway” Daisy, 27/5

Daisy’s meaning making about her surgical response highlights some of her beliefs and attitudes regarding other people’s perceptions of her, and possibly her perceptions of herself. She believes that the surgeons would have immediately categorised her as a ‘blubber’ (as she previously mentioned), and subsequently would have disregarded any aesthetic outcome due to having

placed very little importance on her appearance. It is not surprising that Daisy is very distressed about the asymmetry of her scar if it is loaded with such strong and negative meaning. It could be that Daisy believes that no matter how much surgery she has, it will not change the fact that she is 'flabby all over the place anyway'. It appears that Daisy experiences extreme disregard and categorisation from others. Whilst some of this might come from her own beliefs it is important to consider that in a culture that does discriminate against big people, she, along with the other participants, has experienced a reality in which she is not accepted by others.

This theme relates to the lack of acceptance of the body by others (imagined or real) which I believe is connected to the lack of acceptance of the body by the self. When a body is hidden it is less likely that the individual will be able to experience acceptance of the body by another and thus the shame of the hidden body is likely to pervade. It is important to underscore the fact that western society, with its negative appraisals of overweight people, suggests that there might be some reason for these participants to believe that their bodies would not be accepted by others. I believe that this state of lack of acceptance from the self and other individuals leads to a continued sense of flux and a destabilised embodiment where people perceive that their body, the very means by which they communicate with the world around them, will be not accepted by that world.

3.5.4. Butchered but functional body

Every participant told me that they did not regret having plastic surgery and outlined to me the functional benefits of living without their abdominal overhang. They all said that they could move better, that they had less pain and sweating in that area and that it was easier to find clothes to fit them. Frequently referred to, however, was a body that was no longer natural, womanly and in some cases human. The participants seemed to be describing a trade off that they had made, in which they had gained a functional body but had lost a natural and human one.

Daisy provides an introduction to the term 'butchered' as she describes feeling like an ignored and disembodied piece of lifeless flesh on the plastic surgeon's table. She describes how she felt towards the surgeon:

> D- “You are not taking me into consideration, I am a piece of meat on your table and you have to remove that piece of flesh and you are just doing it. That is how I felt.
>
> R- Like a piece of meat?
>
> D- Oh there is another big blubber, come here, flesh hanging down, we have got to cut it off, let’s do it the best way we can do it.” Daisy, 23/17

Daisy describes her sense of being categorised as ‘another big blubber’ and being treated like a ‘piece of meat’. This striking description is echoed in descriptions by others where surgeons are positioned as brutal butchers and participants are positioned as disempowered and disembodied mounds of flesh. This experience is likely to contribute significantly to the (dis)embodied experience of the participants.

As discussed earlier Daisy was distressed at the asymmetry of her surgical scar, and she developed a hypothesis that her surgery was done by two surgeons. She goes on to explicitly name one of her surgeons a butcher:

> “Cos whoever did this side was excellent, whoever did this side was like a bit of a butcher.” Daisy, 24/5

She goes on to describe the brutality of the surgical procedure and her subsequent anxiety about opening up:

> “I was all like,’ I have been cut from here’. I hadn’t even looked at it. There was no way, I was like this, ‘oh my god is it going to split open?’” Daisy, 25/25

This experience of her body as potentially splitting open could reflect Daisy’s sense of fragility following this procedure. Observing the language she has used, it seems likely that she felt objectified and ‘butchered’ in her surgery and she appears concerned that she might fall apart as a result. She goes on to describe feeling non-human and like a stitched, non-living object:

> “So I would rather be a patchwork quilt than having that big tummy. I did look at and think oh patchwork; oh I am marked for life. But I was just really angry that they didn’t get it right but my anger was with that.” Daisy, 28/6

She is describing her present body as improved from the previous body however describes it as an inanimate object. Her statement that she has been 'marked for life' appears very poignant and open to varying levels of interpretation. It could be that she feels 'marked for life' by the scar, which represents a reminder of the fact that she was once overweight, however she does not appear to blame herself. Daisy places herself in a passive position, inferring that the surgeon has marked her for life. It might be the case that she holds anger towards both the surgeon and herself for leaving herself with this 'mark for life'.

Implicit in this theme is the immense power differential that takes place in surgery, which was reflected in all participants' narratives. This has been explored in more detail in the sub theme relating to the 'disempowerment of the plastic surgery patient'.

Below Edana talks about her experience of her body as 'butchered' by plastic surgery as well as its functional improvement:

> "Mmm, can't believe it. I think I am cut like the pig. I feel like I am cut like the pig, like a pig. I always say I am like Frankenstein. I have a piece here, a piece there, do you understand? Umm I don't like my body, even with the scar. I don't like my body, but it make me walk, make me feel better and that is the main thing. But I don't like my body." Edana, 24/2

Edana repeats the word 'pig' three times. Her use of the metaphor of the pig could be understood on a number of levels. One possibility is that it is communicating her experience of her body as a dead animal being brutally butchered. Another might relate to discourses that connect overweight people's lack of control over their eating with that of pigs. This could relate to her view of herself as well as her imagined view that others (e.g. the surgeon) have of her.

Edana goes on to describe herself as like Frankenstein due to parts of her body having been moved around in surgery. She experiences her body as 'a piece here, a piece there'. Frankenstein is man-made and it is possible that it is this aspect that Edana is relating to; that her body's form is no longer natural and how it was born, but altered by man. Frankenstein is also a frightening character, and her use of this comparison possibly echoes her concerns about

people's responses to her body if she were to show it. In the theme 'Shame of the hidden body; assumed lack of acceptance from others', Edana describes her cautiousness in baring her body in order to protect others from the distress that she expects they would experience on seeing it. Edana described herself when she was big as a 'monster'. It seems that she experiences her present body, as she has experienced her past body, as frightening and starkly different from other 'normal' human bodies.

Edana goes on to describe the trade-off of this man-made body for a body that is functional and she positions this gain as 'the main thing'. This was a common narrative theme, in which participants would describe their distress at their bodies and then end with confirmatory statements about not regretting their surgery.

As mentioned earlier, Edana had referred to her previous and current self as a 'monster' throughout the interview. I reflected that she had used the word monster again and she replied:

> "Yeah, that is what I feel. I am sorry. I don't think I am... it's something taken from me, something cut, something I don't know how to explain to you properly in English. I am not 100% woman. Do you understand? I am half something. To make me to do better for walking, or something." Edana, 28/1

Edana appears to be describing her sense of loss of something in her pursuit of a more functional body. She appears to be describing feeling non-human and unwomanly and that in the surgery more than just flesh was removed; she lost something relating to her sense of self. The self seems to be experienced as inextricably bound up with the body; when a part of the body is removed, so too is a part of the self. It is also important to remember that Edana has lost half of her body weight. This grief response from plastic surgery implies that the trade-off in plastic surgery is a significant one for Edana. When she describes being 'half something', it could reflect a mirroring of the internal loss alongside a loss of weight.

Abi also connects her appearance to that of Frankenstein:

> **"**I felt a bit like Frankenstein." Abi, 2/19

She also describes the brutal reality of plastic surgery:

> "I look at it [surgical scar] and think oh, it still looks like I have been chopped in half...." Abi, 6/4

In her attempt to communicate the brutality of the surgery to me Abi lifted her top and showed me her scar. I understood this as a frustration of the difficulty of describing the embodied experience of this without me seeing the scar itself.

Habiba said she was distressed about the loss of her belly button in her surgical procedure. She describes the responses she got from the children she works with, about it:

> "They find it amazing that I don't have a belly button, you know 'only aliens don't have belly buttons.'" Habiba, 38/4

Here the role of the belly button as something that differentiates us as humans and mammals from other types of living creatures seems key and Habiba's lack of one appears to place her outside of that 'humanity'. Habiba later described a distressing embodied experience when she was showering and had an urge to clean her belly button. When she went to clean it, she was reminded that it was not there. This experience seems to illuminate discordance in the felt sense and the objective reality of the body and this was experienced as distressing for Habiba.

As stated above, the improved functionality, both from weight loss and plastic surgery, was greatly appreciated by the participants. Below are two celebratory accounts of the improved functionality of the body:

> "I could do much more and I was much more outgoing and probably more fun to be around to be honest. I would go paintballing, I would go ice skating, I would do all of that. And I kind of, afterwards I kind of feel sorry that I missed out on my teenage years doing, you know, missing out on stuff like that..." Gabby, 10/8

Gabby makes a connection between being able to do more and being 'much more outgoing'. It might have been the case that in engaging in activities that she would have previously avoided, she might have disproved beliefs that she had previously held about herself. This in turn may have helped to develop her

confidence. Alongside this, Gabby also experiences loss and appears to be grieving for what she missed out on in her 'teenage years'.

Daisy describes her enjoyment of having more space in her world once she had lost weight:

> "Getting on the plane after the first time after I had the operation, instead of the table being like (half way down) ....it was like bam (flat down) and I have got space... I could cross my legs on the plane. And getting up and going to the...all these things that other people take for granted." Daisy, 18/5

Daisy describes the difference between how it used to be getting on to a plane and how it is now. This downward comparison appears to provide her with a reflection that she previously found things that other people take for granted uncomfortable or difficult, and that now she does not. Her description suggests that Daisy continues to notice these new abilities, celebrating and appreciating them.

This theme highlights the changes in the way the body is experienced by these women. They describe vividly and evocatively how their bodies feel different, unnatural and cut up. Whilst they discuss some distress with this change in body (which manifests itself in sensation as well as appearance) all confirm that they do not regret their decision because they now have a more functional body. It seems that weight loss and plastic surgery may have enabled improved relations between individuals and the world around them, but that the way they relate to their embodied existence appears to have remained strained and uncomfortable.

3.5.5. Continued "battle" with weight

Many participants communicated anxiety about gaining weight again and their continuing strategies and difficulties with maintaining or losing weight. I was struck by the apparent close connection between participants' perceived weight and their self esteem and mood. This is articulated by Habiba below:

> "I have put on a bit of weight and that has really really dented my confidence cos I was really peed off that I had put on weight." Habiba, 14/30

She appears to attribute her 'dented' confidence to her anger towards the weight gain, rather than the weight gain itself. Gabby discusses her weight within a popular weight control discourse; in terms of goals and vicious circles. It is likely that she will have picked these up in her multiple engagements with diet services:

> "Yeah, really difficult because I achieved my goal and now I have kind of gone backwards, vicious circle, but I will lose it cos I will. I will do it. I will. But also, sorry, at the end of it I kind of wanted to be more relaxed around food. I wanted my battle with food to be over. And this was the last point for me." Gabby, 42/18

It seems that what Gabby desperately wants is for her 'battle' with food to be over. She holds expectations that relate to psychological shifts, and is hoping to achieve them through a physical change. This appears to be reflective of the process of all participants. Clearly, for Gabby, this 'battle' is not over and this appears to have considerably disappointed her. This also relates to the constituent theme of 'hope and disappointment'.

I am struck by her repetition of the term 'I will' which sounds like a self motivational talk. Gabby lost her weight through a self managed diet and exercise programme, and it is therefore likely that she developed effective strategies of self encouragement. She is focussed on the attainment of a positive outcome. In contrast Daisy appears to have a different focus and repeats a phrase that emphasises the avoidance of a negative outcome:

> "I mustn't put on weight. I mustn't put on weight because I can't have that again. I can't allow that area to stretch again. To protrude of to start having, that's when I start panicking and I check, you know, I put on 3 stone and it showed." Daisy, 30/4

Daisy underwent bariatric surgery. She appears to be fearful of repeating the process of gaining weight, stretching the skin and then having excess skin if the weight is lost again. Her fear highlights the difficulty that she, and, it seems, the other participants, have experienced in this process.

Babette describes her continued struggle with food and her fear of her lack of control over her eating:

> "It's not been easy. No way has it been easy. And I know the diet people will say, all the experts say you shouldn't deprive yourself of anything, but I do. It's been four years now and I have not touched a bit of chocolate, chips, cakes or potatoes or anything like that. Cos I am scared. If I had that first little bit of chocolate or that first bit of cake then I am going to go back and there is now way, hope in hells chance that I am going back." Babette, 22/17

Babette articulates her resolution to not 'touch' any of the foods which she believes would lead to her gaining weight again. This is motivated by fear. This could be seen as connecting to Gabby's earlier reflection that she has lost a 'kind of freedom' in relation to her body. It seems as though Babette is afraid that if she allows herself freedom, she will lose control totally and that this would result in her 'going back' to being big. Babette's fear of 'going back' suggests that her experiences of being big were very negative.

Participants' continued battle with weight relates to the overarching theme 'Destabilised embodiment' in that they continue to be in an un-stabilised position in relation to their experience of their bodies. Fear of gaining weight and continued anxiety relating to food and control over food appears to add to this state of flux in which it is hard for the person to be embodied in the present.

3.5.6. Continued shock at different body.

This theme describes the experiences articulated by some of the participants in which they are continually shocked by their new and different body.

Babette describes her confusion with her reflection in the mirror and the use of external objective measures of size to remind her that she has changed:

> "Sometimes I don't recognize what I see in the mirror and then sometimes I still see a fat person. Especially with my clothes off, I still see a fat person because of all the skin, the excess skin. It's not until I put my clothes on and it's a smaller size of clothes that I do reality that I am back to reality again, that I have lost the weight." Babette, 12/21

Babette is talking in quite categorical terms using the term 'a fat person'. This also communicates a sense of distance created between Babette and her reflection, as she describes 'a fat person' rather than herself as fat. Implicitly the opposite category is 'a thin person'. Given that Babette has lost over 10 stones

it is very interesting that, using this categorical thinking, she sees a 'fat person' in the mirror.

The use of clothes as a way of reminding her that she has lost the weight highlights her difficulty believing her body's change. It would seem that if she still sees a 'fat person' that her expectations of weight loss have not been met in reality. It could be that whilst her thinking remains so categorical, it will continue to be hard for her to see the change that has happened to her body, and that a more graded way of thinking might allow her to see variation on a continuum of size.

Below, Gabby articulates the 'weirdness' of being shocked by her own reflection:

> "But like walking through the shopping centre and catching sight of yourself and thinking, oh, that's me. That's really weird, but good. Good weird." Gabby, 3/20

Gabby has specified a situation in which she is not prepared to see her reflection. It is interesting that when she is not primed to expect herself to reflect in the mirror, she is shocked by what she sees. This could be interpreted by considering that at an unconscious level she has not fully adjusted to her new body, and that it has not yet assimilated fully into her sense of herself. There appears to be a moment when Gabby sees what looks like another person and then realises that it is her. This clearly displays the overarching theme of de-stabilised embodiment. If we are our bodies, then what does it mean to not recognise our own body?

Many of the participants use the word 'weird' quite frequently when attempting to explain their embodied experience. I think that the use of this word highlights a difficulty in expressing their experience and the potential for language to fall down in its ability to adequately communicate the embodied experience.

3.6. Summary

This chapter has presented an interpretative phenomenological analysis of the interview transcripts of eight women. The over-arching theme of 'Destabilised Embodiment' includes two super ordinate themes of 'Self acceptance in continued flux' and 'Turbulent experiences of embodied existence'. It appears

that the wide ranging and extreme past experiences of the body have influenced the participants' difficulty in accepting their bodies in the present. The construction of the body as problematic and something to be fixed appears to have had a significant impact on how participants relate to themselves and the world around them, and has served to continually destabilise their embodied existence in the world.

4.0. Discussion Chapter

4.1. Introduction

In this, the discussion chapter, I will start by reviewing a summary of the findings of the analysis in relation to the initial research aims. The findings will then be considered in the context of the wider literature. I will reflect on the quality of the research study by considering the strengths and limitations of the design and analysis method, further avenues of research and the impact of the myself, the researcher, on the study. The clinical implications will then be discussed followed by conclusions.

4.2. Research aims and summary of results

This study aimed to illuminate the lived experience of women who have lost weight and had their resultant excess skin removed by plastic surgery. It hoped to shed light on the embodied experience of a changing body. Results suggest that this is a complex experience, in which the way that an individual relates to their body undergoes significant and multiple shifts and appears to be in continued flux. Whilst the focus of the study was the embodied experience in the present moment, it became clear that the way that the body was experienced in the past continues to play a central role in how it is experienced now. The present experience is characterised by a continued sense of flux, in which embodiment is destabilised and the relationship between the self and the body is confused. Considerable distress continues to be experienced in relation to the body, including feelings of shame and disgust which affects not only the relationship with the self, but also restricts relationships with others. The body is not accepted and is predominantly considered in a future context, following additional improvement. Previous experiences of 'improvement' have been characterised by cycles of hope followed by disappointment.

4.3. Discussion of analysis in context

4.3.1. 'Outcomes' of surgery

No participants said that they regretted losing weight or undergoing plastic surgery to remove their abdominal overhang which confirms previous findings (Stuerz et al., 2008; Lazar et al., 2009). Participants conceptualised most improvements as relating to functional improvements, both in relation to their health and being less restricted by their bodies and so able to engage in more activities (e.g., going to the cinema). This seems to correspond to previous findings suggesting an improvement in quality of life measures following weight loss (Mitchell et al; 2001, Tolonen and Vicorzon, 2003; Dymek, le Grange, Neven, & Alverdy, 2001; Fontaine, Barofsky, Bartless, Franchkowiak & Anderson, 2004), most of which are said to be accounted for by improvements in physical health (Swan-Kremeier, 2005). In addition, overall quality of life after the removal of excess skin has previously been reported (Song et al., 2006; Lazar et al., 2009; Cintra et al., 2008). Self esteem was not measured but women appeared to be continuing to experience relatively low self esteem. This was also found by Bolton et al., (2002) who found no improvement in measures of self esteem pre and post body contouring procedures. Bolton et al., (2002), Song et al., (2006) and Steurtz et al., (2008) reported no change in measures of mood and anxiety following removal of excess skin. Participants in this study did not explicitly report any improvement in mood or decrease in anxiety however they did describe finding it easier to buy clothes and experiencing less anxiety about people noticing their abdominal overhang following its removal. Most participants did report an improved body image, in particular less distress and disgust related to their removed abdominal overhang. Improvements in body image measures were found in previous quantitative studies (Bolton et al., 2002; Song et al.,2006; Pecori et al., 2007; Stuertz et al., 2008; Lazar, et al., 2009). Although an improvement in this construct was reported, I was struck by the intensity of the continued distress most participants communicated regarding their bodies and their complex ways of relating to their body. In addition plastic surgery appeared to add the dimension of the 'butchered' body, which, for many, contributed towards their body distress. It does seem that for most participants, their bodies are perceived as much more functional which has improved quality of life, however their psychosocial functioning does not seem to have transformed in the way that they had hoped it would. Stuerz et al., (2008) conclude in their study that whilst plastic surgery post weight loss can reduce body image distress, it should not be expected to improve other areas of psychosocial functioning. They stated that 34.6% of their participants reported feeling 'bad' because the surgery did not heal their "psychological narcissistic

wounds" (Lazar et al., 2009, pp. 1073). Because of the small scale of this study generalisations cannot be made, but many participants in the present study articulated disappointment in their continued experiences of body dissatisfaction and general psychological dysphoria.

Previous studies found that participants were keen to undergo further body contouring procedures following their first one and this was reflected in the present study. As is discussed in the analysis chapter, all but two of the participants in this study were still hoping to undergo more procedures to remove their excess skin on other body areas. Of the two who were not continuing to apply for NHS funding for more procedures, one had applied but had been told that she would not receive any more funding. The other had already undergone four body contouring procedures. Cintra et al (2008) suggest that this is due to the positive effects and experience of the procedures. From the findings in this study, I suggest an alternative explanation for this (see lack of acceptance).

Stuerz et al., (2008) reported that 61.5% of participants retrospectively declared that life would have been 'unacceptable' without abdominoplasty and that it could be to blame for nervous breakdown or suicidal ideation. A similar experience was echoed by the participants in this study, with Callie stating that she could sometimes 'cope with' but not 'live with' her excess skin, and Gabby saying that she would have cut it off herself had she not been funded for the surgery.

To avoid repetition of the analysis chapter, rather than run through the themes again, the conceptual and theoretical themes which permeated the analysis will be considered in relation to the wider literature. Three overarching and interconnected themes will be discussed; 'De-stabilised embodiment', 'Shame' and 'Lack of acceptance and flux'. All three of these domains will be examined in relation to theory and to each other. These themes will be predominantly underpinned by theoretical proposals by Susie Orbach (2009) and Paul Gilbert (2002, 2010).

4.3.2. 'Destabilised Embodiment'

I was immediately struck by how participants described their bodies in relation to themselves. This ranged from constructing the body as a separate objectified entity to the body being an integrated part of the self. The theme of 'continuation vs. Transformation of the self' highlights this. As is illustrated in the analysis chapter, participants varied greatly in their explanations of the relation between the 'self' that was obese, and the current self. This variation was both within and between participant transcripts. The conflicting and confused nature of the construction of the body and self represented an interesting conflict relating to the body, mind and self. I will now consider how some of the conflicting ways the body has been conceptualised within philosophy and psychology were seemingly drawn from in the transcripts.

4.3.2.1. Dualism

Descartes stated that the human being was comprised of two separate entities; the body, which is solid and extends in space, and the soul/ mind, which thinks. He proposed an interactionist dualist perspective, in which he recognised a cause and effect relationship between the mind and the world around it (Kirk, 2003).

Participants' descriptions of an enduring sense of self in body change, such as Fae's, could ascribe to a dualist mind/body discourse in which enormous amounts of change can happen to the body but because of the separateness of the mind, one's self remains unchanged. However, even Fae communicated some conflict relating to this as she considers the effect of looking different and whether this means that she is in fact different herself[10].

Participants discussed objectified separation from their bodies at various points of their bodily change process. Some participants discussed their separation from and lack of awareness of their body in obesity. Most participants discussed their experience of their abdominal overhang as an alien, separate 'thing' rather than a piece of their body. Participants also tended to describe their body in an objectified way in relation to undergoing surgery. Post plastic surgery, participants talked about feeling like a 'patchwork quilt' or 'Frankenstein'. It

[10] Refer to quote in analysis- Fae 21/15.

might be the case that at times of extreme distress in relation to the body (e.g., 'obese body', abdominal overhang, 'butchered body'), it is easier to consider it as separate from the other aspects of the self (i.e., the mind). At these times, drawing from a Cartesian dualist discourse could have had a protective function. It is discussed in the analysis chapter that participants discussed becoming more aware and conscious of their bodies as they lost weight. This could be for a variety of reasons, one being that the body transiently became perceived as more acceptable and less shameful, and that it was therefore less painful to consider it as a part of the self.

Gillies, Harden, Johnson, Reavey, Strange and Willig (2004) conducted an in-depth qualitative enquiry into women's collective constructions of embodied practises, including sweating and pain, using the method of memory work. Their findings suggest that Cartesian dualism is central to women's accounts of their embodied experience. They highlight the functional and restrictive aspects of the use of a mind/body split approach, stating that the Cartesian dualist construction of pain enabled participants to attempt to cope with and control their pain. Conversely the separation of the pain from the self sets up the body as something to be controlled. As a result they state that when people lose control of their body (e.g., experience pain) they can experience a sense of failure (Gillies et al., 2004).

4.3.2.2. Embodiment

An alternative construction of the body is provided by French Philosopher Maurice Merleau-Ponty in his book 'The Phenomenology of Perception' (1962). 'I am my body', he declared, arguing that our bodies are fully implicated in processes which make up our lived experience of the world, such as sight and motion.

Amongst others, the eminent neuro-scientist Damasio (1994) argued against Cartesian dualism, stating that the body and mind are one 'indissoluble organism'. He used the term 'ensemble' to describe this oneness and the way that bodily responses and mental phenomena are inter-connected.

Recent developments in neuroscience appear to suggest that the body and mind are inseparable. Panksepp's work (2006) into the neuroscience of

emotions indicates that it is not just conscious cognitive processing which dictates the responsiveness of our emotions, but that, separate from the control of the mind, the body can also house emotional processing of its own. Neural substrates such as opiods or oxytocin have been found to effect emotional responses such as fear and lust. Panksepp states that these are read out of not only cognitive but also by primitive emotional consciousness which lies in the limbic region of the brain, below the cortices. Neuropeptides[11] are carriers of emotional life and receptors from these neruopeptides are found throughout the body. Panksepp (2006) states that this accounts for the ways we can physically experience emotion, for example in our stomach.

Participants who described a strong sense of personal transformation alongside their bodily transformation could ascribe to a more embodied consideration of the body and the self. It would suggest that because our existence is so inextricably bound up in and mediated by our bodies, that if our bodies significantly change, so too would our experience of ourselves and the world around us.

Fae, who discussed an enduring sense of self, and ascribed to a more dualist discourse, also communicated anxiety regarding changing as a person and a determination to hold on to her character. She also discussed close family relationships and her loved ones' anxieties that she might change as a person. For her it might be less distressing to believe that she has not changed as a person.

Conversely, Gabby describes feeling detached from the person she sees when she looks at old photographs of herself when she was big. This could serve a protective function for her. Due to the negative associations with her life when she was big, it might be less painful for her to feel pain and loss for a person who feels separate and distant, rather than for herself. In addition, it could be important for her current self esteem to distance herself from someone who felt so negatively about herself.

[11] Neuropeptides are short protein molecules which control the sensitivity of neurons (Panksepp, 2006).

Edana discusses the loss of tissue cut away in surgery corresponding to a deep sense of the loss of part of her. This suggests an experience of a self that is inextricably bound up in the body, and that a removal of part of the body means that part of the self has been removed as well. This does not fit with the dualist idea of the mind being separate from the body, but suggests they are inextricably linked in the way that Merleau-Ponty (1962) and Damasio (1994) suggest.

Susie Orbach states that our sense of our bodies is fundamentally shaped by our "specific cultural moment" (Orbach, 2009, p. 134). This specific cultural moment has appeared to witness a growing alienation between mind and body. Laing (1976) discussed the growing alienation between mind and body in Western culture when he discussed the 'unembodied' self. He used the term "body vacuity" to describe how we are unable to integrate the body experience with our mental processes. Young (2006) has gone on to consider some of the many ways in which objectification and alienation of our bodily experience has taken place in past and contemporary Western culture. She lists forms that the body has taken such as 'the disgusting sex object'; 'the disposable asset for military use'; 'something to be perfected or controlled by diet and exercise' (Young, 2006). Micheal Soth states that the way we relate to the body reflects our experience of it and proposes that our culture suffers from an underlying pervasive disembodiment. He suggests that one can only manipulate one's body with such an objectifying nonchalance if they are not connected with it (Soth, 2006). This could relate to the functional aspects of the Cartesian dualist approach to the body. Perhaps one could not opt for such a dramatic and invasive action as plastic surgery, if they were strongly connected to their body as an integrated part of themselves.

Orbach argues that current cultural discourses on the body have led to a 'new epoch of body destabilisation' (Orbach, 2009). I make the suggestion that both Cartesian dualist and 'make over' transformation discourses do contribute to a confused and destabilised sense of embodied experience.

As Laing, Young and Orbach suggest, this inability to feel embodied and comfortable with one's body affects much of the population and not just this sample. Perhaps the 'normative discontent' discussed by Rodin, Silbertstein and Streigel Moore (1985) relates to a heightened consciousness of the body

which disables individuals' ability to simply 'be' in their bodies. Feminists, including Rosalyn Diprose, argue that social injustices against women originate from social assumptions about sexual difference and how these constitute women's embodied existence as secondary to men and improper in themselves (Diprose, 1994). It is proposed that the participants in the study, who are influenced by current cultural discourses as well as having experienced vast bodily change, continue to be unable to experience a fully embodied existence. For this reason, they experience a destabilised embodiment in which they are unable to accept their body, and continue to feel ashamed of it. It is hoped that in describing concepts of 'shame' and 'lack of acceptance' below this proposition will be explained in more detail.

4.3.3. Shame

4.3.3.1. Body Shame

"Millions, literally millions struggle on a daily basis against troubled and shaming feelings about the way their bodies appear. It is not a trivial problem just because it is a personal struggle which might be expressed as, and is sometimes mistaken for, an issue of vanity." (Orbach, 2009, pp12).

The psychologist reporting in Lazar et al.s' (2009) study stated that after the long duration of suffering because of their obesity, the new body image can become a source of deep shame and humiliation. Shame has received increasing research and theoretical attention as both an intrapersonal experience, which relates to negative thoughts and feelings we experience about ourselves (e.g., Gilbert & Andrews, 1998), and an interpersonal experience, as a result of being shamed and stigmatised by others (e.g., Crisp, 2001).

John Paul Sartre (1956) states that our perception of ourselves develops from our understanding of the perceptions others have of us:

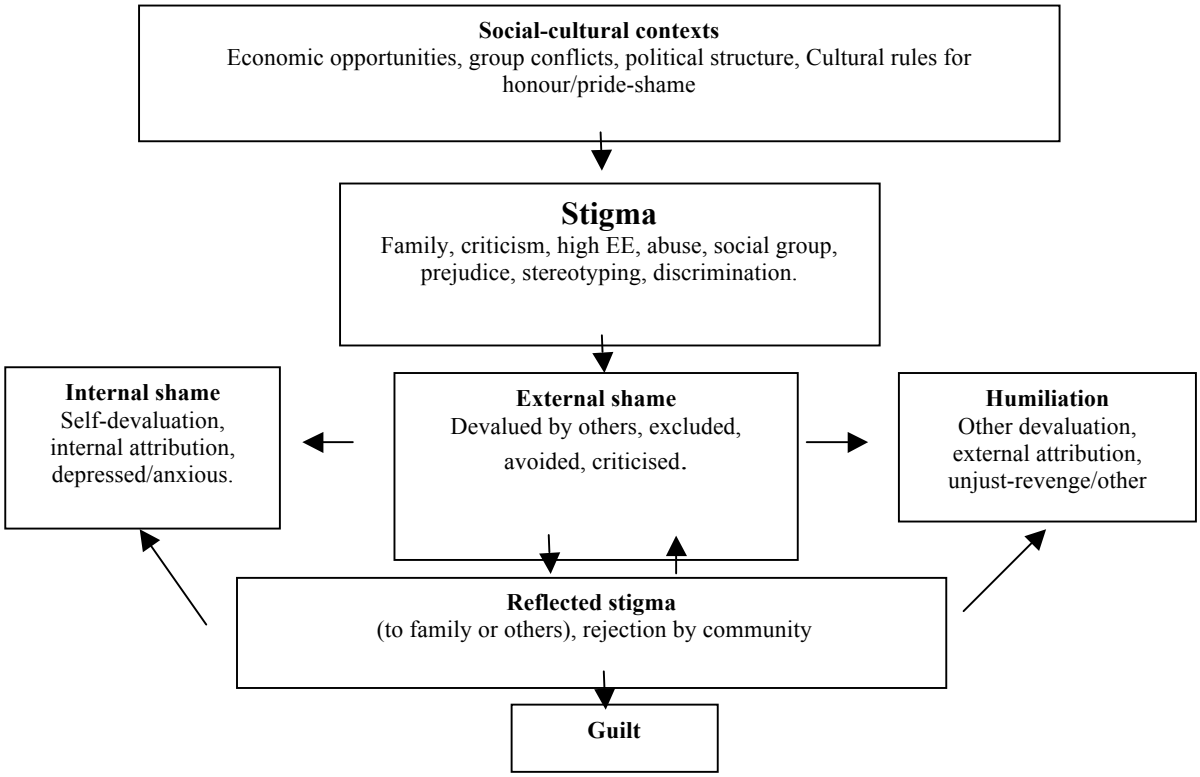
"By the mere appearance of the Other, I am put in the position of appraising judgment on myself as on an object...I recognize that I *am* as the Other sees me" (Satre, 1956, p.222)

The women in this study described a long history of shame in obesity. This seems to be an understandable response to a society that appears to discriminate against obese people. As described in the introduction, individuals have been found to be treated with a negative bias due to being obese throughout education (e.g., Crandall, 1995) in employment (e.g., Pingitoire, Dugoni, Tindale and Spring, 1994) and in health settings (e.g., Schwartz, Chambliss, Brownell, Blair and Billington, 2003). It seems that most participants hoped to put an end to their body shame through their body transformation, however most seem to have been disappointed by their reality as it appears that many participants continue to be ashamed of their body after surgery. Having already changed considerably in body shape and size, and yet still be experiencing shame, I suggest that this body shame is unlikely to reduce as a results of more body change, and that it might be dealt with more effectively through psychological interventions. The potential clinical interventions related to this will be discussed later on in the chapter.

Paul Gilbert suggests a bio-psycho-social conceptualisation of 'body shame' (Gilbert, 2002). He describes shame as a multifaceted experience with five experiential components. The first listed is the social cognitive component. Evidence of this was rife in all the interviews. Examples include Daisy's assumption that her surgeons disregarded her because she was 'a blubber' and Gabby's prediction that if people saw her body they would think she was disgusting. Second is the internal self-evaluative component, an example being Edana's belief that she is a monster who has been cut into pieces. Thirdly is the emotional component, illustrated in Babette's anger at herself for becoming overweight in the first place. Fourthly, the behavioural component is evidenced in Callie's determination not to have her body revealed to her husband or to herself. Lastly is the physiological component. This was less explicitly discussed but was inferred in Gabby's physical unease at being looked at by sexually interested men after weight loss. Gilbert (2002) highlights the fact that as with all emotions, whilst some people are able to tolerate it without acting out defensive behaviours, others find it intolerable and go to great lengths to avoid the emotion as well avoid situations that might induce it. This avoidance is evidenced both in participants' reported behaviour of continuing to hide their bodies out of fear of disgusting and upsetting others, and in their avoidance of acknowledging their body in the present.

The model he suggests is presented below, figure 1 (Gilbert, 2002, pp. 35). He highlights the vital role of social and cultural contexts which provide the "threads from which shame and stigma are woven" (Gilbert, 2002, pp35). Gilbert highlights the fact that in a different context, such as being a sumo wrestler, being 'bigger' would have very different associated meanings and subsequently different implications for the stigma and shame attached to it. Orbach comments that in today's cultural moment, failing to get one's food and size right can signify failure, rejection of societal values and, of course, shame (Orbach, 2009). The role of 'self control' in relation to stigma is also discussed by Gilbert (2002), and seems particularly relevant to the present sample. Rozin et al., (1999) investigated a theory regarding the different emotions that are evoked from a variety of different 'violations'. They state that losing control over one's body and desires (e.g. food) tends to elicit disgust. Some participants vividly described their sense of disgust at their bodies. This manifested itself in beliefs that the sight of it would make others physically sick (e.g., Edana) and an avoidance of seeing or even thinking about seeing the body themselves (e.g., Callie). It seems likely that this sense of disgust at one's own body could be connected to the sense of shame. It could be that participants are assuming that how they feel about their body (disgusted) is how others would also feel.

External shame relates to instances in which an individual feels devalued or criticised by others. These experiences were reported particularly in relation to obesity, an example being Edana's experience of social isolation and being avoided by her friends when she was obese. Internal shame is conceptualised as involving a constellation of negative feelings and thoughts about oneself, for example Edana considering herself as a monster. Reflected shame relates to the shame and stigma which falls on someone as a result of other people's stigmatisable or shameful behaviour. An example of this is that Fae discussed deep concern that her daughters were bullied as a result of her body size. Humiliation refers to being devalued by others, for example Callie's husband shouting 'fat bird' when she could not do up her seat belt on an aeroplane.



As illustrated above, Gilbert's conceptualisation of body shame does describe aspects of the experiences of the participants in the study to a certain extent, however further complexities related to experiences of shame arose in the analysis. I will now describe these and make links back to this theoretical framework.

4.3.3.2. Shame as creating distance between the self and the body.

It could be the case that the avoidance of the experience of shame (discussed by Gilbert, 2002) could motivate people to become distanced from their bodies. This is likely to lead to a multidirectional relationship. It seems as though avoidance of shame inducing experiences has invariably led to the avoidance of acknowledging the body in the case of certain participants. This is likely to lead to a less embodied and more objectified and Cartesian approach to the body. It is also likely that this will disrupt the ability to be self accepting. This avoidance, disgust and shame of the body has also been illustrated in the experiences of post surgical women with ovarian cancer. Schaefer, Ladd, Lammers and Echenberg (1999) conducted a qualitative enquiry into the experiences of ovarian cancer patients and reports that participants described an avoidance of their bodies. One avoided seeing her new 'emaciated' body and the 'puckering flesh' around her new scar (pp, 235).

As previously discussed, participants communicated a remembered sense of denial of their bodies when they were big. They also discussed intense experiences of shame at this time. It could be that shame had a part to play in the functional denial of their bodies. Participants discussed an increasing awareness of the body when they were losing weight which could suggest that as the body became an object which induced less 'shame', it was less dangerous to engage with. As discussed above, some participants tended to create distance between themselves in the present and themselves when they were big. This could have been motivated by an avoidance of shame. Gilbert (2010) states that because shame is related to threat and punishment, individuals tend to deny feeling that they have done anything to feel ashamed about to protect their self esteem. Babette describes her reflection in hindsight of how she used to pretend that everything was alright but that she now knows that it was not. Potentially she is describing this process.

Shame was also discussed in relation to the excess skin. It was conceptualised as a shameful reminder of the participants' obesity, which was to be hidden. Interestingly, the shame attached to the excess skin was also accompanied by a hatred and disgust of it. The skin, typically, was constructed by language as something separate that did not belong to the person. It might be that shame leads individuals to disassociate themselves with parts of their bodies because it is too painful to accept that they are, in fact, ashamed of themselves.

4.3.3.3. Shame as creating distance between the self and others.

Participants expressed fear and concern regarding the evaluation of others. Fear of negative evaluation is a cognitive factor that was identified in the Rumsey et al., (In press) study. They found that high levels of 'fear of negative evaluation' were associated with a poorer adjustment to living with a visible difference. The women in this study seemed to experience that it was that it was very difficult to stop being concerned with how others perceived them.

In the theme 'connection and disconnection', it seemed that those who described most 'connection' to others felt the least ashamed of their body (Fae, Habiba and Abi). In contrast Edana, Callie, Babette, Daisy, and Gabby all described their experience of disconnection from others and also described high

levels of bodily shame. It is proposed that this association is multidirectional. Those who gain positive affirmation that other people, including loved ones, are not disgusted by their bodies, may feel less ashamed by their bodies. However, individuals who feel strongly ashamed of their bodies are less likely to reveal them and are therefore unlikely to gain this experience of acceptance.

4.3.3.4. Shame of plastic surgery

Participants also communicated experiencing shame due to their undergoing of plastic surgery. This experience is not documented in the plastic surgery research and is an interesting new finding. In the Ogden et al., (2006) qualitative investigation into the experience of bariatric surgery, they report that one participant felt that she had 'betrayed' herself by 'mutilating' her body. They state that undergoing surgery went against the values and belief systems of this participant. It would seem that something similar was experienced by the participants in this study. Babette, for example, discussed external shame, in the form of concern that her family would think she was trying to be 'like a movie star' when having plastic surgery. She also described avoiding her internal shame when she discharged herself from hospital early because she felt so uncomfortable about the elective nature of her surgery when recovering in a ward with patients with cancer.

Kent and Thompson (2002) discuss the development and maintenance of shame in visible difference and I think that their conceptualisations have strong links to the experience of the participants in this study. They state that experiences of stigmatisation regarding visible differences can develop a 'self-schema' which is associated with increased anxiety about social encounters, concealment and sensitivity to further rejections. This response to past obesity stigmatisation appears to be reflected in the current experiences of participants in this study, which suggests that they too might have developed a similar 'self-schema'. Kent and Thompson suggest that as a result of repeated stigmatisation a schema is developed. This suggests that the way of thinking about the self is considerably changed due to how one is treated in relation to their physical appearance. Beck (1964) describes schemas as relatively entrenched cognitive structures in the mind. I propose that individuals who have been obese and have experienced such stigmatisation develop entrenched internal shame and ways of thinking about the self, as well as external shame,

and ways of thinking about interactions with other people. Kent and Thomson (2002) state that medical treatment of a visible difference, which is designed to improve physical appearance, can often only help in a superficial way and does not address 'underlying precipitating and predisposing psychological factors' (Kent and Thompson, 2002, pp, 109). It could be the case that when people lose weight and then undergo plastic surgery, they are only superficially addressing their negative experiences of their body, and that to address them at a deeper level would require psychological work.

4.3.3.5. Shame and social anxiety:

Appearance anxiety (termed by Dion, Dion and Keelan, 1990) has been indicated to operate in a similar way to social anxiety. Newell and Marks (2000) present findings in which people with disfigurements score similarly to those with social phobia on the 'Fear Questionnaire'. Kent and Thompson (2002) state that appearance and social anxiety involve similar beliefs and cognitive distortions. They give the example that an individual being ashamed and anxious about a visible difference could lead to conclusions that others will reject them. They may also minimise compliments and over-personalise staring. Kent and Thompson (2002) also state that individuals with other types of body anxiety might engage in similar avoidance and concealment behaviours. The suggested similarity might pose interesting treatment implications as much research has investigated the cognitive model of social anxiety proposed by Clark and Wells (1995).

4.3.3.6. Shame and self discrepancy theory:

In his discussion of the experience of shame in individuals with a diagnosis of Body dysmorphic disorder (BDD) Veale (2002) discusses self discrepancy theory (Higgins, 1987). Self discrepancy theory suggests that the discrepancy between three domains, set up by the 'self' or the 'other' perspective, can dictate one's vulnerability to negative emotional states. These are the *actual self* (individual representation of the attributes that someone (self or significant other) possesses, or that someone else believes they possess), the *ideal self* (individual representation of the attributes that someone (self or significant other) would ideally possess) and the *ought self* (individual representation of the attributes that someone (self or significant other) ought to possess as a sense

of obligation). Individuals with BDD diagnoses have been found to have high discrepancies between their *actual self* and their *ideal* and *ought* selves (Veale, 2002). Because BDD individuals were found to have no discrepancy between their *self actual*, *other actual*, and *other ideal* states, Veale (2002) suggests that for these individuals internal shame is often the most pervasive problem, in which they struggle to live up to their internal aesthetic standards, rather than being punished for meeting aesthetic ideals set by others.

Self discrepancy theory suggests that those who experience high discrepancy between *actual* self and *ideal* self are likely to experience dejection related emotions such as sadness, where one's hopes and aspirations are unfulfilled. In an *actual-self* and *other-ought* discrepancy (where the self is perceived as different from what you perceive others think you ought to be) individuals are suggested to experience anxiety resulting from the idea that they have not met standards set by others and so are vulnerable to punishment (Higgins, 1987). It seems that participants in the present study experience both of these, as, in contrast to some individuals with BDD, they have described experiencing external shame. There is clear evidence of dejected disappointment and sadness in not having achieved the aesthetic and psychosocial attributes that they had hoped to achieve thought weight loss and plastic surgery. In addition there is much evidence of individuals experiencing anxiety stemming from a fear of punishment (e.g., rejection) by others due to their bodies not being how they 'ought' be. It seems plausible that both of these states could trigger a sense of shame about the self. In the context of this study, it could be pertinent to consider that the 'significant other' who also sets standards to be attained could be western contemporary society, rather than another person. In this context, when the body of an individual is perceived as different from their *ought self* set by another (thin and young body, stipulated by the media) anxiety is experienced due to fear of lack of acceptance and disgust from others influenced by the same cultural media messages.

4.3.4. Lack of acceptance: future focussed body

Whilst all participants stated repeatedly that they were pleased to have lost weight, evidence of continued flux in a variety of different contexts appeared throughout the analysis. This flux was evident in peoples' hope and disappointment throughout the process, their continued 'battle' with weight and,

most potently, their lack of acceptance of their body and their focus on it in the future. The overarching theme 'destabilised embodiment' also alludes to these dynamic processes.

4.3.4.1. Flux and the transformation culture

As reported in the introduction, commentators on the current 'cultural moment' have been discussing our 'transformation culture' (e.g., Orbach, 2009; Jones, 2008). Meridth Jones (2008) refers to the 'make over culture' which positions the body as something to be 'fixed'. The theme 'lack of self acceptance; the future focussed body' seems to fit in with these ideas. It appears that because of the participants' particular ideas and hopes of the bodies they had wanted the future, they were unable to 'be' in their bodies in the present. This idea could go some way to explain the puzzling findings that whilst all participants discussed improvements in their quality of life since weight loss (e.g., buying 'normal' clothes), their dissatisfaction with their bodies, and seemingly their mood, had not improved as they would have liked.

The seemingly cultural nature of this problem leads me to ask the question; how realistic is it to expect anyone to accept their body when contemporary discourses revolving around continual transformation and improvement are so pervasive? It could be that as long as there are products and procedures designed to improve our bodies, it will be a challenge for many individuals to be accepting of their own body.

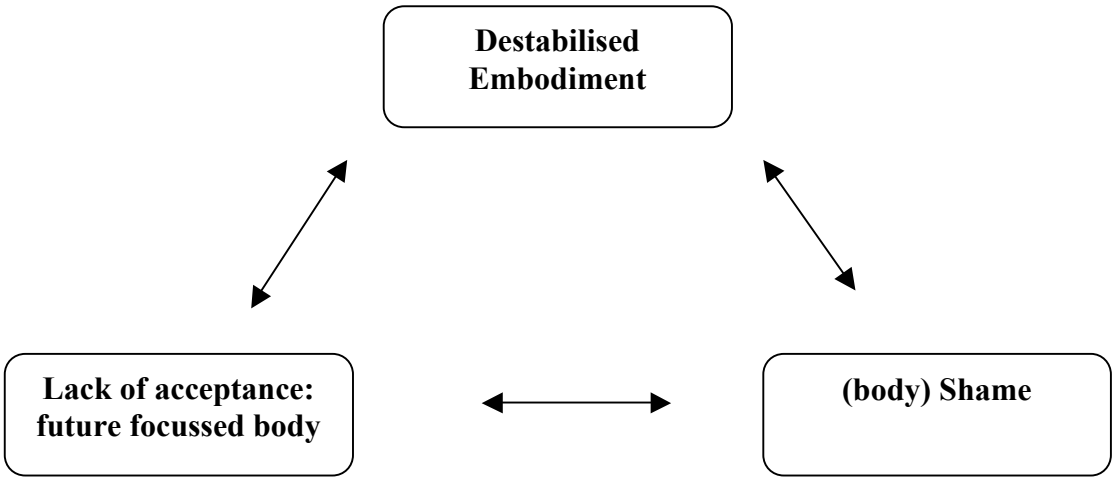
Many participants voiced concern that they would not get funding for the next procedure they wanted because they were unable to afford it privately. Interestingly Abi, who was told that she would not be offered any more surgery appeared to find this helpful in enabling her to be more accepting of her body in the present. It could be that the mere option of plastic surgery makes acceptance of a body harder to achieve.

Previous researchers in this field suggest that the tendency to seek further plastic surgery after the initial procedure was due to participants' happiness with the service they received (Cintra et al., 2008), their initial procedure 'intensifying' their desire for plastic surgery (Stuerz, et al., (2008) and their initial procedure triggering dissatisfaction with other areas of their bodies (Song et al.,

2006). I think that the findings from this analysis suggest an alternative explanation. It appears that participants' continual desire for more surgery is born out of continued disappointment as a result of particular needs not being met by the surgery, and the continued hope that it will be the next procedure that enables the psychosocial shifts they have been hoping for. When considering the motivational conflict that all participants communicated, it seems that opting for more surgery is not taken lightly and is a cause for much internal conflict. This could be seen as evidence of the high level of distress and strength of the hope and determination that the participants have in order to make changes to their lives.

4.3.5. Connections

I propose that the 'future-focussed' approach to the body is closely linked to the experience of destabilised embodiment and shame. Their interconnectedness is illustrated below:



Shame and lack of acceptance both influence each other in that shame may prevent the body being accepted. In turn, the continued future focus on the body and how it 'should' be places the body in the present as not how it should be, and therefore as shameful. The lack of acceptance of the body brings about a destabilised sense of embodiment in which one does not inhabit the present body that one is in now because one is focussed on the body one wants to have. Finally, shame of the body is connected to the destabilised sense of the body in various ways, one of which is manifested in the distance that is created between the body and the self to avoid the sense of internal shame.

4.4. Reflections on quality and avenues for future research.

Assessing the quality of qualitative research is a contested issue. Whilst researchers do not want to impose qualitative rules, guidelines for quality control are agreed to be important. Yardley (2000) has outlined four characteristics of good qualitative research, which have been considered throughout this research as discussed in the Methodology chapter. These are 'Sensitivity to context', 'Commitment and rigour', 'Transparency and coherence' and 'impact and importance'. These guidelines set out by Yardley (2000) have been considered as I believe them to be sufficiently flexible to be adapted to this specific study. I also appreciated their emphasis on the impact of research, as I consider this to be an ethical matter. I will briefly summarise and discuss these characteristics in relation to the study.

The review of the broad spanning fields of literature on the phenomenon ensured an initial sensitivity to context. This not only enabled me to be versed in the current conceptual ideas in the area, but also to engage with the discourses and rhetoric which appear to permeate the worlds of obesity, weight loss and plastic surgery. My work in a plastic surgery department of an NHS hospital also facilitated an introduction to the clinical context of this study. Through personal reflection I endeavoured to remain aware of the social context of the relationship between myself and the participants. Ethical issues have been considered to ensure that this study is sensitive to the experiences of the individual participants and protects them. As encouraged by Yardley (2000), in this chapter further scholaristic tools, such as philosophical theory, have been drawn from in order to address findings in a wider context that make the analysis more profound and far reaching.

Evidence of 'commitment and rigour' is provided throughout this thesis, particularly in the Methodology chapter. This has primarily been evidenced through the in-depth engagement with the topic, the reviewing of literature, and an in-depth engagement with the phenomenon both in interviews and particularly during analysis. In addition, the rigour and commitment with which the themes remained rooted to the texts of the participants is illustrated in the close analysis of said texts in the analysis chapter. The prioritising of the well being of the participants throughout the data collection process is evidence of the commitment to professional and ethical standards. To increase the rigour with which the analysis was completed, supervision took the form of

triangulation. I met with my supervisor on several occasions throughout analysis and explained my process of getting to the themes I had arrived at. My supervisor interrogated these processes and provided feedback on the labelling of the themes. Although the supervisor had an awareness of the topic, she was not up to date with all the current literature in this particular field and had not engaged fully with the transcript. I believe that this has given her an alternative and outsiders perspective which I found valuable in this case.

Coherence is evidenced in the clear fit between the theory and method that were implemented in this study and the presentation of clear arguments for them. The transparency of the analysis process is illustrated in the methodology and analysis chapter and in the presentation of the exemplar. I have stated, reflexively, the thoughts, feeling and predictions I held coming into this research with the aim of being transparent and explicit about what I have bought to the research. It is hoped that this would enable the reader to read the analysis in the enlightened context of my position.

The impact and the importance of this study has remained a key aspect of the research. The participants in this study not only gave me their time, but also provided open and in-depth data which required courage and generosity. Ensuring that this research produces clinical implications to improve the quality of care of service users in a similar position in the future is believed to be an ethical matter. It is hoped that articles will be published in plastic surgery and bariatric journals, as well as psychology ones, for this reason. The clinical implications will be outlined later in the chapter.

4.4.1. Reflections on Design and Future Research

One notable limitation of the study is the small scale of it. It is suggested that due to the courage, openness and trust of the participants, this sample provided a rich quality of data despite its small size. The determination to complete rigorous and in-depth analysis of every transcript meant that quality was not sacrificed for the generation of more data. It is important to consider that many individuals were invited to be interviewed that did not participate. It might be that they had different stories to tell and that the study attracted a particular, and possibly more distressed, group of participants.

All participants interviewed had applied for and had undergone their plastic surgery in the same NHS department. It may be the case that experiences differ in different departments, different trusts and with different protocols. Whilst this could be the case, and it would be interesting to look at this in a further study, it was not the aim of this study to generate generalisations about the experiences of plastic surgery patients across the United Kingdom.

Although invited, no men participated in the study. The British Association of Aesthetic Plastic Surgeons reported that of the 3403 tummy tuck procedures carried out in Britain in 2009, 3268 were performed on women (BAAPS, 2010). It has also been a problem recruiting men into weight loss programmes and research studies (Wolfe & Smith, 2002). Because so much of the research in this area has been with female participants, insights influencing interventions could be further alienating men from participating. Whilst it might be a challenge to recruit for, it is suggested that it would be important to carry out a similar study to this one with male participants. It would be interesting to compare similarities and differences between their experiences with those of women. A larger scale study across a range of plastic surgery departments could provide insights into a wider range of experiences including male participants, and therefore account for these limitations.

Given that the results of this study pointed to an explicit experience of disempowerment as a plastic surgery patient in the NHS, it might be interesting to explore the experiences of a similar participant group who paid for their plastic surgery privately. The motivational conflict reflected in the emphasis on pain and discomfort as motivators, de-emphasis on the importance of appearance, as well as experiences of shame and gratefulness, might be a result of the stigma related to having elective plastic surgery funded by the NHS. In addition there might be a different area of meaning attached to the personal financial cost of the surgery.

I am strongly motivated to carry out similar in depth interviews investigating the embodied experiences of individuals who have excess skin after weight loss but do not opt for plastic surgery to remove it. The recent turn towards considering individuals who cope well in appearance psychology (Rumsey et al., in press) has provided invaluable findings about protective factors, which can inform interventions. It could be that these individuals have found ways to live with their

excess skin and learning about the processes that enabled this could considerably inform clinical work with individuals who find it impossible to live with.

The findings of this study suggest that it would be pertinent to consider a broader range of measures in future large scale quantitative studies. Measures considering factors such as shame, social support, disgust, intimacy, acceptance and self efficacy could provide important findings in large scale studies of this population.

Smith et al. (2009) call for relatively homogenous samples. The sample in this study was homogenous in respects of shared experience of weight loss and plastic surgery, however the participants were heterogeneous in many ways. Firstly, some had lost weight by undergoing bariatric surgery whereas others had lost weight through modifying their diet and exercise behaviour. It did not seem to be the case that variation in experiences was accounted for by whether participants lost weight independently or through bariatric surgery. The Ogden et al., (2006) study suggests that undergoing bariatric surgery impacts meaning making and the experience of weight loss. As this study was looking into the embodied experience post weight loss, and not the experience of weight loss, this was not considered to be a problem. A larger scale investigation could compare these two groups when considering the meanings participants make of their new bodies.

The use of the interview was found to be a satisfactory tool for data collection. It not only enabled me to hear about participants lived experience, but also enabled me to meet and experience them first hand. As the knowledge that I have produced was aimed to be my subjective experience of participants' subjective experience, I suggest that my experience of the participants as people enabled me to add texture to the analysis. Sitting with the participants also enabled me to experience them physically and consider them as an embodied individual, which was crucial for this particular study. Finlay (2006) suggests that embodied experience in phenomenological research interviews is very important, as discussed in the Methodology chapter. Reflections on the experiences of the participants' embodied experience have been included in the analysis chapter. Sandelowski (2002) argues that qualitative researchers should act against cultural trends which separate body and mind and elevate mental

processes over corporal ones. She suggests that we use observation in research, not by merely looking at participants, but using all of our senses to engage in the embodied experience in the room. It is suggested that this shift in focus could be very interesting in investigating experiences such as body shame and health issues, where the body plays such a central role in the lived experience.

I felt that as the interviews progressed the participants became at ease and were very forthcoming with their experiences. I believe that we developed a rapport characterised by trust and compassion in the interviews which helped facilitate this. This drew from my skills as a practitioner and I consider it to be a strength of the study.

Reflections on Analysis

As described in more detail in the Methodology Chapter, IPA was used because it was felt that it would best enable the answering of the research questions, and would generate the type of knowledge that I hoped to produce. This was a critical realist epistemological perspective, hoping to produce an account of my meaning making of the subjective experiences of individuals located in a 'real' world. IPA is understandably and healthily challenged and contested in the field of qualitative research.

Willig (2001) lists three major challenges to IPA. These will be listed and responded to in relation to this specific study. Firstly she highlights the assumption of the representational validity of language made by IPA researchers; that language does indeed provide participants with the tools to conceptualise and describe their lived experience. Taking this further, it also assumes that language equips the researcher sufficiently for them to capture the experience. Interestingly, as other researchers have commented when discussing descriptions of embodied experience (e.g., Gillies et al., 2004), language did seem to fall short of communicating the embodied experience at times. This was evidenced in the interviews by participants showing me photographs and their bodies to communicate their experiences. It seemed that this was because it was difficult to conceptualise their experience in language. The inclusion of unspoken aspects of the interviews hoped to go some way to account for this, as it is believed that they communicate their own meanings,

and in the very least highlight the difficulty of describing embodied experience with language. The development of more creative and imaginative methods of including non verbal data in analysis would be welcomed. Social constructionists argue that language constructs reality rather than describes it, implying that the description will add meanings to the experience which make the real lived experience inaccessible. In relation to this study, interview transcripts are seen as subjective accounts of experiences embedded in the personal experience of the individual. The meanings that are attached to the experience are therefore seen as vital aspects of the analysis.

Willig (2001) goes on to discuss the challenge of the suitability of participant accounts and their ability to communicate the rich texture of their experience to the researcher. She argues that individuals who are not practised in expressing their emotions, thoughts, perceptions and sensations might not be able to communicate the texture of their experience. She discusses the limited application of the method due to the sophisticated use of language required to communicate their experience. The participants in this study ranged in educational level and none claimed to have a particularly literary background. I was continually struck by the vivid, in depth and emotionally charged descriptions of experiences communicated by individuals.

Willig (2001) ends by raising the debate between description and explanation, highlighting the role of phenomenology as uncovering *how* we experience things, and its lack of an attempt to answer the *why.* She makes the point that to move beyond sharing experiences with participants and clients into understanding them, we need to become aware of conditions which give rise to the experience. This is not something which phenomenology claims to address. I propose that gathering insight into an experience teaches us a great deal about it and enables us to interrogate it through interpretation. Through using conceptual and theoretical frameworks to take the analysis further, as has been done in this chapter, one can attempt to move beyond a description and consider clinical implications.

Being that it was the first time I had engaged in IPA, I found the analysis of the data a pleasingly organic and natural experience. I believe that this was facilitated by the fit between IPA and my own personal epistemological standpoint. I was aware of using the guidelines for the method of analysis as a

guide and not an instruction book as suggested by Smith et al., (2009). I adapted it to my personal preferences in making connections between themes by cutting out words and spreading them out over the floor. I found that the more and more I read the individual transcripts, the more interrogative of the meaning of the experiences I became. The iterative nature of the process came much more naturally than I expected. My determination to produce themes that were reflective of how I understood the transcripts led me to engage in systematic and constant checking back of theme labels and representative quotes in the data.

4.4.2. Reflections of impact of author on research

The three main themes that emerged from my reflexivity interview (see methodology Chapter) are listed below. They were all indeed pertinent areas of consideration:

My position as an outsider

I am certain that my position as an outsider to the experience of my participants influenced both data collection and analysis. In some sense I believe that my distance from the experience enabled me to have a genuine open curiosity that might have been more difficult to harbour if I had personal experiences more similar to the participants. This could have benefited both my interview style and my interrogation of the transcripts throughout analysis. Conversely my appearance as a slim woman could have had a number of effects on the data that was collected. One possibility could be that participants felt that I could not understand their experiences. Some participants may have had ideas that I had also been previously obese and had lost weight. In considering this I have wondered what the impact of my body could have been if I were overweight myself. In this sense it could have made it more difficult for individuals to express their relief at being no longer obese. It seems that whatever form it takes and however it manifests itself, researchers impact their results. Therefore, rather than naming the impact as negative or positive, because it has been thoughtfully considered, I position it as an important part of the findings.

Impact of me as a feminist

It is likely that my position as a feminist has impacted the research, in particular the analysis. I found that during the analysis process I was becoming angered and upset by the extent to which participants felt ashamed of their bodies and themselves. I believe that my feminist persuasions are an important part of my identity as a practitioner and a researcher and that they helped to inform the way that I conducted my research. Due to the rigor with which I conducted the research, I do not think that my feminist beliefs fostered findings that were not in the transcripts. I do, however, think that they have influenced how I have made sense of participants' accounts of their experiences, but just as any other values and beliefs that I, and any other researcher hold would have.

4.5. Clinical Implications

4.5.1. Bariatric, weight loss and plastic surgery services

As previously discussed, Kent and Thompson (2002) suggest that medical treatment for disfigurements only address problems with appearance superficially. I believed that to a large extent this is also the case for participants in this study. In some cases whilst underlying psychological processes and factors in relation to appearance are not addressed it might be difficult to achieve self acceptance. Many researchers acknowledge that the initial aims of weight loss are psychosocial and not just aesthetic (e.g., Tinker and Tucker, 1997).

Sarwer et al., (2008) state that Plastic Surgery is contraindicated for patients with diagnoses of Body Dysmorphic Disorder (BDD). It seems that this is due to an assumption that their problems are psychological and are therefore unlikely to be solved by plastic surgery. One could suggest that the difference between participants in this study and patients with BDD is that the participants have a noticeable difference in appearance. Sarwer et al., (2008) state that the levels of distress appear to be similar and psychological distress does not appear to be being solved by surgery alone. Whilst this is the case, it seems grossly unethical to be putting individuals through the emotional and physical turmoil of invasive surgery if it is not likely to achieve their goals. It is proposed that obesity, bariatric, weight loss and plastic surgery services should consider

developing services which place more of an emphasis on a psychological approach to meeting these needs than there is at present.

Participants in this study were very interested in whether their experiences were shared and were excited to hear about experiences of others who had had excess skin removed following weight loss. This suggests that there could be an important role for groups, whether support groups or therapeutic groups in supporting these individuals.

4.5.2. Prevention

It is proposed that alongside the many government interventions promoting weight loss, interventions regarding the prevention of appearance related distress and the promotion of positive self esteem could be helpful. It seems that there is a role for the Counselling Psychologist in the prevention, as well as treatment of the psychological distress which permeated the analysis. Psychologists, such as Kagan (2007), have been encouraging the development of an increasing ecological and community consideration and role for psychologists. Kagen comments that psychological resources are always scarce and that collaboration and working at the 'edge' between disciplines can generate greater richness of perspectives and opportunities for learning and development (Kagan, 2007).

It can be a mistake to allow the continuation of the internalisation of blame and failure in relation to distress about ones body. In a society with such a specific homogenous cultural ideal of beauty, it seems like a natural response to suffer reduced self esteem, distress about appearance, shame, lack of acceptance and distancing of the 'self' from the body. Due to the 'narrowness' of the bodies that are deemed to be acceptable, it would make sense that the vast majority of individuals would experience this dysphoria. It therefore seems that this is a social problem, not an individual one. If we only direct our interventions at the individuals, the implication is that they are the problem, which could be inaccurate.

Due to the central role of stigmatisation in the development of body shame and social anxiety in disfigurement, Kent and Thompson (2002) emphasise the importance of community level interventions to prevent individuals with

disfigurements from becoming shamed by others in the first place. The situation seems to be similar for obese individuals. Several studies have carried out interventions to reduce the negative attitudes and bias regarding obesity, however many have been unsuccessful (e.g., Anesbury and Tiggeman, 2000), showing that anti obesity attitudes are deeply engrained in society and difficult to change. Puhl and Brownell (2003) have reviewed this literature and report disappointing findings resulting from many of these efforts. They suggest a 'social consensus' approach through encouraging valued in-group members, rather than disliked out-group individuals to attempt to change attitudes. It is clear that more work needs to be done to find more successful forms of attitude change toward the obese.

Another method of encouraging acceptance of different body types is through the promotion of more heterogeneous body types in the media. An example of this at work is the 'Campaign for real beauty' in Dove's advertising campaign which started in 2003. This uses women of different ages and different sizes proudly exposing their bodies. 'AnyBody' is an example of another campaign which is currently lobbying for more of this (http://anybody.squarespace.com/). It seems that psychologists are well placed to offer inter-disciplinary contributions in such campaigns.

Psycho-education about the reality of the media and its effects on dissatisfaction with appearance could also be helpful. In her qualitative interviews with people who were satisfied and dissatisfied with their appearance, Liossi (2003) found that those who were satisfied were more cynical about the media and its portrayal of the body ideal. It seems that the ability to reject the implicit messages from the media serve to protect individuals from body dissatisfaction. This is discussed in more detail in the Case Study chapter.

4.5.3. Psychological Intervention

Whilst prevention is important, there are many people experiencing shame and distress relating to their experience of their body who require intervention. Cognitive behavioural interventions have been shown to be effective in addressing Body Image dysphoria, anxiety and depression (Cash and Levellee, 1997; Buttes and Cash, 1987; NICHE, 2007a; NICHE, 2007b). In addition CBT models, for example Gilbert's (2002) model of body shame, appear to explain

the experience of participants in this study well. CBT interventions will be considered because of this evidence base, the fit of the data with CBT models of body shame and the fit with my theoretical orientations as a practitioner (See case study for more detail). In addition I propose that the collaborative nature of the therapeutic relationship in CBT (Waddington, 2002) could be a helpful intervention in and of its self for clients who have experienced plastic surgery. Participants described difficulty with their sense of powerlessness in the lead up to, and their experience of, plastic surgery. The women's sense of powerlessness and dependence on others to help them (by removing their excess skin) could be contributing to their continued application for further procedures and lack of acceptance of themselves. Empowering these individuals to find their own solutions to their difficulties would be an invaluable process which could promote pride and self-reliance in the place of shame and powerlessness.

Thomas Cash (1997) has developed an eight step program for working with individuals who have body image problems drawing from traditional second wave CBT principles. Primarily he recommends a comprehensive body image assessment and employs a number of standardised assessments. In step two he recommends clients keep a diary to help both client and therapist identify problem areas. The aim of the third step is to desensitise the client to both body areas, and situations which cause them distress. This is done through systematic desensitisation exercises paired with relaxation techniques. Steps four and five involve the identification and challenge of appearance related assumptions. Step six aims to reduce engagement in unhelpful safety behaviours and step seven promotes engagement in positive behaviours. Step eight addresses the maintenance of positive body image (Cash, 1997). These steps have been presented in a user friendly way and can be completed independently in the form of self help. The outcomes of this work book have not been systematically researched however Newell and Clarke (2000) present findings which suggests that self help can be beneficial. When considering experiences of individuals in this study, I believe that this programme would be very helpful. Findings from the research, however, suggest that because of participants' long history of body shame, their continual avoidance of their present body and their destabilised embodiment, they might benefit from some additional consideration with regards to intervention.

Findings from the analysis suggest that both internal and external shame play an important part in maintaining the negative experience of the participants in this study. In addition they appear to be struggling towards being self accepting and tend to focus on the future or the past, rather than the present. In the last decade third wave developments in CBT have skyrocketed. Mindfulness and acceptance have been radical additions to behavioural traditions. In the cognitive field more importance has been placed on the present moment and the function, and not just the form, of cognitions (Hayes, 2004).

The explicit influence of the Buddhist concept of Mindfulness on Western psychology has exploded in recent years in the form of mindfulness based interventions (O'Driscoll, 2009). Mindfulness has been described as paying attention on purpose, in the present moment, and non-judgementally to the unfolding of experience (Kabat-Zinn, 1994). It is now suggested that mindfulness is a core therapeutic process, present in both psychologist and client in an effective therapeutic encounter (e.g., Geller & Greenberg, 2002). Critically, mindfulness encourages a non judgemental, accepting focus on the present moment. This could provide individuals in this study with the skills and processes to remain connected to the present (rather than remaining fixated on the future and past body), to be more accepting of the present moment (including being accepting of themselves, including their body). The development of a less judgemental approach to one's self and one's processes could also help to reduce the experience of internal shame.

In Paul Gilberts (2010) recent book 'The Compassionate Mind' he articulates the role that compassion can have in the development of self acceptance, happiness and well being. He defines compassion as "a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it." (Gilbert, 2010, pp xiii). He talks about the striving nature of today's Western Society, which has obvious links to the 'transformation culture' already discussed above (Orbach, 2009; Jones 2008) and the tendency to remain focused on the future and what one can attain. He states that this culture tends to see compassion as a weakness, and that fear, hostility, self criticism and striving seem to come more naturally. He suggests that the development of compassion can in fact subdue our anger and increase our courage and resilience to problems such as depression and anxiety. Gilbert (2010) promotes

the development of mindfulness skills as part of the behavioural development of a compassionate mind.

In addition, and focussing on cognition, Gilbert (2010) discusses the unhelpfulness of shaming forms of self-criticism and self-attacking. He calls for the development of a form of compassionate self correction in place of these, which can be harboured by a number of therapeutic techniques. Firstly the individual is encouraged to empathise with their own distress. When alternative thoughts are considered, a compassionate and warm approach is encouraged. I experienced compassion from all of the participants, both in their behaviour towards me and in the stories they told of other people in their lives. The lack of compassion when the women were talking about themselves and their internal worlds was very apparent. It seems that the development of self-compassion and self-acceptance, alongside mindfulness skills, would benefit these individuals no end. In particular, problems of lack of acceptance can be formulated in the context of a typically striving culture, and can be addressed directly.

Gilbert (2010) refers to self discrepancy theory when he links concepts of shame and disappointment. He states that we feel shame when we are disappointed with our perception of not reaching our ideal self, thus becoming the 'undesired self'. He says that when this happens we tend to respond in non-compassionate ways such as attacking ourselves and giving up. He proposes harbouring a compassionate response to disappointment through understanding the importance of dealing with disappointments throughout life. He says that it is helpful to be accepting of the anger that arises in this situation but to move on to being kind and supportive to the self and acknowledging the disappointment (Gilbert, 2010). This is another example of ideas that could be helpful when working with the shame and the disappointment experienced by the participants.

4.5.4. Bringing the body back into therapy

For the participants in this study, the body plays a central role in their experiences and distress. Having considered the 'normative' discontent (Rodin et al., 1985) with body and appearance it would seem that the body plays a central role for many others as well. It seems important, therefore, to work with

clients in an embodied way in order to effectively address these concerns. To avoid the perpetuation of the dualistic mind/body discourse, the term 'bodymind' will be used. This is used by Soth (2006) to communicate working with an embodied client.

Alongside two university colleagues I co-authored a presentation for the British Psychological Society Division of Counselling Psychology annual Conference in 2010 regarding 'bringing the body back into psychological therapy'. All three of us had been struck by the centrality of the body and embodied experience in our research and developed ideas that could help inform more embodied clinical practice (Nelson, Smith and Nicholson, 2010).

The tendency in contemporary western culture to objectify the body, constructing it as something to be controlled, perfected and often exploited has been discussed. Together my colleagues and I reflected that it is important to be mindful of the fact that psychological therapies are not free from these cultural disembodying and objectifying trends. The psychoanalytic couch for example sets up the room so that the therapist cannot have a full view of the client's face, the client cannot see the therapist and their difference in positioning makes an equal embodied experience in the room impossible. In addition second wave traditional forms of CBT tend to emphasise the role of the thinking mind and position it as the means with which to control ones experience (Padesky and Greenberger, 1995). Radical constructivist therapeutic approaches tend to overlook materiality and embodiment completely and instead focus on the discursive constructions of lived experience (Nelson, et al., 2010).

We reflected that many psychological therapists place an emphasis on working with the therapeutic process. There appears to be a great deal of opportunity for therapists to make use of our embodied experience relationally. Attending and responding to bodily forms of communication (e.g., posture) is a vital part of empathy and attunement. In addition to this, therapists can attend with their body rather than just to the body of the client. Gendlin (1988) uses the term 'felt sense' to name sensations that constitute the clients experience but that are difficult to articulate with words. We could attempt to use this 'felt sense' to deepen and broaden understanding of our clients' experiences, thus enabling a

more potent level of empathy. This could enable a different relationship between the client's sense of self and their body (Nelson et al., 2010).

We considered that another way to work with an embodied client is to consider carefully how the body is constructed by the client. Drawing from this analysis, it seems it would be important for the therapist to consider how the 'bodymind' is discussed and experienced by the client by paying close attention to their language. If the client is subscribing to a dualist mind/body split it would be important to consider whether this is functional or restrictive. As discussed earlier, Gilles et al., (2004) highlighted both the functional and restrictive aspects of the dualist discourse. They argue that when the body and mind are seen as separate, the body is often constructed as something to be controlled. Subsequently, if we lose control of the body (for example if we feel pain) we are likely to experience a sense of failure. It might be that during a particularly acute period of time when distress about a body part (e.g., excess skin) is so extreme that it is functional to consider it as separate. It would be important in therapy to consider the costs of this way of experiencing the body and whether anything could be gained from attempting to integrate it back into the sense of self. We suggested that if the therapist was not mindful of the way that the client talks about their body, they could un-helpfully collude with a restrictive discourse. This obviously requires mindfulness and reflexivity on the part of the therapist in relation to their experience of their own body.

If it is felt that the dualist discourse is restrictive for the client then it might be helpful to consider how the therapist could facilitate the reconstruction of a more productive and embodied paradigm for the client to work within. One method that we suggested to achieve this, and is in keeping with the theoretical orientations above, is the use of mindfulness. The focus of mindfulness on paying attention to the *entirety* of experience brings the body and its present lived experience into the fore. Mindfulness meditation could provide an effective way to facilitate a more embodied experience of the body.

4.6. Reflective statement

I have found that engagement in this research topic has had a number of personal effects on me. My own embodied experience unsurprisingly came into my conscious experience to a much greater degree over the course of the

research. I found that at first this led to a more confused and slightly more challenging and destabilised experience of my body. Having reflected on this experience and addressed it in personal therapy, I have subsequently been able to experience my own body in a more embodied and accepting way.
In the past few years I have, much like the participants in the study, been future focussed and striving with regards to my career and qualification as a Counselling Psychologist, rather than accepting of my present situation as a trainee. I think that this has contributed to experiences of self-criticism, anxiety and frustration. This understanding has helped me to consider the importance of the present moment on my journey and the potential dangers in continually focussing on the future. In addition, I have learned from my participants' experiences of hope and disappointment that alongside a future focus and high expectations can come disappointment. I have therefore attempted to manage my expectations of post qualification life.

This research study has also lead to professional developments. I have been struck by my enjoyment of the qualitative research process, in particular IPA. I hope to develop my future career in a way that allows space for research as well as clinical practice. I have also been reminded of the importance of attending to the body in therapy, and believe that this has enabled me to feel more connected to my clients. I hope to develop this further in my clinical practice. I have also repeatedly been reminded of the importance of compassion, both in relation to others and to myself.

4.7. Conclusions

Despite having gone through a tremendous amount of body change, participants seemed to be in a continued state of flux in relation to their bodies and themselves. How they relate to their bodies appeared to be confused and destabilised and they communicated high levels of internal and external body shame. Connected to this was a tendency to only consider the body in the future after further potential transformation and to avoid considering it, let alone accepting it, in the present. It is proposed that these aspects of experience are interconnected and maintain each other in their development. These findings offer new and interesting insights into bodily experience and have enabled important considerations for interventions with this population as well as wider therapeutic implications. Whilst participants have gone about changing

themselves physically it seems that what they have truly been seeking can be summed up in the words of Gabby:

"[To be able to] accept me for who I am and allow other people to accept me for who I am".

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Section B

5.0. Critical Literature Review

Resilience and Positive adjustment to visible difference: the role of the Counselling Psychologist

5.1. Introduction

This review will critically consider current literature regarding adjustment to living with a visible difference. It will pay particular attention to the factors and processes involved in positive and resilient adjustment and will consider these findings in relation to a potential role for Counselling Psychology. In connection to the research study previously presented in this thesis, adjustment to change in body and appearance remains the focus of my interest. In a cultural moment where the importance of appearance is increasingly emphasised, having a visible difference presents immense challenges to individuals. Researchers in the field have begun to highlight the fact that despite this, many individuals adjust positively, displaying remarkable resilience. I think that a focussed consideration of the processes and factors that enable resilience and positive adjustment could broaden our understanding of the processes of adjustment to visible difference.

As discussed by Rumsey and Harcourt (2005), terms in this area typically stem from a problem focussed medical approach and use negative language (e.g., disfigurement, deformity). This language is considered unhelpful and limiting by some (e.g., Eiserman, 2000; Rumsey and Harcourt, 2005). Rumsey and Harcourt suggest the use of the term 'visible difference' and this term has been adopted for this review. It is recognised in the literature that drawing a line between what does and does not constitute a visible difference is not a straightforward task. This review will adopt a definition of visible difference adopted by several other researchers: "a difference from a culturally defined norm which is visible to others" (Rumsey and Harcourt, 2005, p. 88).

A change in appearance is something that is experienced by everyone, to differing degrees throughout life (e.g., pregnancy, ageing and changes in

weight). The change in appearance experienced by participants in my research study was one that they had been motivated to achieve. In contrast, this review will consider changes in appearance which are generally understood to be 'un-wanted'. Changes arising from burns, paralysis, surgery, trauma and disease (Clarke, 1999) require people to negotiate sudden and sometimes considerable changes to their appearance. In addition individuals live with congenital visible differences which can develop at different stages of life.

Rumsey and Harcourt (2005) make the point that appearance related research falls into two distinct bodies; those living with a visible difference and those who are not. This follows an assumption that the needs for those with a visible difference are different to those without one. However, when reviewing the literature, the variability in adjustment and the psychological factors involved illustrate that these are not separate homogenous groups and that the variation within the groups is similar to the variation between them. For this reason this paper will draw selectively from findings in the vast body of 'body image literature' to inform understanding about the processes that might be implicated in adjusting to a visible difference.

This review does not wish to simplify adjustment by categorising 'good' and 'poor' adjustment. Moss and Rosser (2008) conceptualise adjustment as a continuum which seems to be a more helpful and less constricting conceptualisation. Differences between 'good' and 'poor' adjustment are not finite, and vary both within and between people. In this review 'adjustment' denotes the extent to which psychological distress is experienced, where poorer adjustment is associated with greater psychological distress.

Partridge (1999) states that a focus on resilience, and a move away from the traditional focus on the 'defect' could provide rich insight into this research topic. 'Resilience' will be defined as "dynamic processes encompassing adaptation within the context of adversity" (Luther, Cicchetti and Becker, 2000, p543). The focus on resilience comes from my motivation, along with other researchers in the field, to move away from the previous focus on distress and suffering and towards a more holistic understanding of the wide range of responses in people living with a visible difference. By exploring the processes by which people manage to negotiate this effectively I hope that this review will provide both an alternative focus and a greater understanding of some of the processes which

appear to help individuals adjust positively. As stated by Eiserman (2001), it is important not to swing in the other direction towards an exclusive emphasis on resilience and positive adjustment and this is certainly not suggested in this review. The change in focus is merely suggested to underscore the importance of an aspect of the literature which is too easily overlooked.

Woolfe, Dryden and Strawbridge (2003) state that the theory and practice of Counselling Psychology differs from Clinical Psychology and Psychiatry in its emphasis on well being and personal development as opposed to sickness. Bearing this in mind, it would seem that Counselling Psychology could be particularly well placed to bring a new, perspective which learns from the skills and abilities of those who adjust positively.

The cultural context in which this research is situated is considered. Following this some myths in relation to visible difference are addressed. Factors and processes related to appearance dissatisfaction are then examined, drawing from visible difference and body image literature. The review then turns to consider studies in the area highlighting positive adjustment and resilience. The role of Counselling Psychology is considered. The scientist-practitioner role exemplifies the need to gather information from shared experiences in the field, whilst appreciating the uniqueness of individual experience to inform evidence based practice. This appears to mirror a dilemma in this research field. It is hoped that being able to draw on research findings about positive adjustment to visible differences will further help to inform practitioners in the construction of individually tailored client formulations and plans for psychological work.

5.2. Setting the cultural context

“A search for contentment focused around the body is a hallmark of our times”. Susie Orbach (2009, p 13).

Most of the research reported in this paper occurs in contemporary western culture and it is important to highlight the cultural context in which the majority of participants are embedded. Today’s western society sees increasing levels of preoccupation with appearance. As discussed by Meredith Jones (2008), people are going to greater and more severe lengths to ‘improve’ their

appearance. She makes the point that in our 'make over' culture, the 'fixing' of the body has become the suggested way to uncover true identity and improve lifestyle. The term 'normative discontent' has been used to describe levels of appearance dissatisfaction in western society (Rodin, Silbertstein and Streigel Moore, 1985). Many researchers in the field agree that whilst this discontent might be normative, appearance dissatisfaction is far from benign (e.g., Thompson, Heinberg, Altabe and Tantleff-Dunn, 1999).

Given the importance placed on appearance in western culture, where beauty ideals are becoming ever homogenised and unattainable (Orbach, 2009), it is perhaps not surprising that having an appearance which considerably deviates from this is a challenging experience. Staring, unsolicited questions and audible comments are frequently experienced by people with a visible difference (Rumsey, 2002b). Research investigating the psychological impact of visible difference has reported a wide range of negative responses including anxiety and depression (Rumsey, Clarke, White, Williams and Garlick, 2004) feelings of shame (MacGregor, 1990; Kent and Thompson, 2002; Coughlan and Clarke, 2002; Gilbert, 2002) and negative views of self and reduced self- esteem (Moss and Carr, 2004). Many individuals are reported to experience social anxiety and social phobia which introduces further restriction to their lives (Rumsey and Harcourt, 2005). Individuals respond to a visible difference in many ways and this variation does not appear to be explained by severity of location of the visible difference.

5.3. Dispelling myths: Severity and Location

5.3.1. Severity

Whilst it appears to be intuitive that the severity of a visible difference would be a vital factor in adjustment, research within the visible difference literature suggests this is not the case. Whilst poorer social adjustment has been illustrated in adults with more visible burn scars (Andreasen & Norris, 1972; Browne, Byrne, Brown, Pennock, Streiner, & Roberts, 1985) and extent of visibility is associated with more body disturbance in children (Abdullah, Blakeney, Hunt, Broemeling, Phillips, Herndon & Robson, 1994) the vast majority of studies suggest that severity of the change in appearance does not

predict psychological distress. This has been demonstrated in many conditions including those with burns, (Orr, Reznikoff, & Smith, 1989), vitiligo (Thompson, Kent and Smith, 2002), craniofacial visible differences (Sawer, Whitaker, and Bartlett , 2001) and psoriasis (Fleischer, Feldman and Rapp, 1996).

Ong, Clarke, White, Johnson, Withey and Butler (2007) have provided the most recent evidence for this phenomenon. They used standardised quantitative measures at six month intervals to investigate the relationship between subjective and objective measures of appearance and psychological adjustment in patients (N=51) undergoing a synthetic filler treatment to reduce the noticeability of facial lipoatrophy[12]. Participants' appearance was assessed 'objectively' through clinical assessment and the use of a 'laser surface scanner'[13]. Participants completed three subjective measures, all demonstrating high levels of reliability and validity, measuring appearance related distress, anxiety and depression and self esteem. The study conducted a within subjects design using repeated measures of laser scanning, clinical grading and psychological change from the baseline at 6 months post treatment and at 12, 18 and 24 months follow up points. Analysis of the results yielded a predictive relationship between subjective measures of appearance and psychological distress. No significant relationship was found between objective ratings of appearance and psychological distress.

This prospective longitudinal study uses robust measures in a sample followed up for 2 years and its results are consistent with the large body of findings. It cannot however be assumed that measures of 'psychological well-being' relate to appearance related concerns. Self-esteem, anxiety and depression are all measures that could be heavily impacted by a myriad of factors including other life stressors, including a positive HIV status. In using the laser face scanner the researchers have developed a more objective technique of measuring variance from 'normal' appearance than studies using surgeon's perspectives, however it is important to consider that this is only measuring one very specific aspect of appearance.

[12] Lipoatrophy syndrome is a significant risk in patients treated with highly active antiretroviral therapy, to control HIV infection. Whilst it has no functional impairment attached to it, it has a marked impact on peoples' appearance. Facial Lipoatrophy is sometimes called 'facial wasting'.

[13] Digitally records three dimensional volume changes.

5.3.2. Location

It may also be presumed that a person who has a visible difference on a part of their body easily covered by clothing (e.g., abdomen) might find it easier to adjust than someone with a facial visible difference, however research suggests that this is not necessarily the case. Carr, Moss & Harris, (2004) reported findings stating that levels of distress did not differ between the two groups. This has been explained in part by models of secrecy (e.g. Smart & Wegner, 1999). Moss and Rosser (2008) suggest that in the case of a visible difference that is visible to others daily, experience is gained of a predictable social world that 'deals with' this difference (Moss and Rosser, 2008). However concealed visible differences, that will eventually be revealed, can cause extremely problematic effects on adjustment, both through not experiencing this social 'acceptance' and the avoidance of intimacy (Moss and Rosser, 2008).

The general consensus in the field is that severity and location are unable to account for the variety in adjustment to living with a visible difference. This phenomenon appears to resonate with findings in my research project. Participant's expressed disappointment at their continued distress and shame relating to their bodies, despite their belief that their bodies had 'objectively' been improved. This suggests that the variation in individuals' experiences of adjustment to their change in appearance is largely accounted for by individual factors and processes. This presents an exciting opportunity for the central role psychologists can play in considering interventions with individuals who adjust less well.

5.4. Appearance dissatisfaction

As discussed, levels of dissatisfaction with appearance have been recorded as very high (Rodin et al., 1985). Appearance dissatisfaction will now be considered in order to illuminate some of the factors and process which appear to contribute to resilience and vulnerability for experiencing distress regarding appearance. Findings are drawn from research involving participants with and without a visible difference. This is in line with suggestions in the literature that it is not helpful to consider them entirely separately (e.g., Rumsey & Harcourt, 2005).

5.4.1. Participant's without a visible difference

Liossi (2003) conducted a mixed methods study investigating the extent and correlates of appearance related distress in young adults. The sample used adds considerable insight into the area due to its inclusion of people both concerned and not concerned with their appearance, both male and female, and a student (N=125) and a community sample (N = 175) in a cross-sectional survey. Participants whose quantitative scores suggested they were the 'most self conscious' (N=8) and the 'least self conscious' (N=8) were interviewed. Interviews were analysed using Interpretative Phenomenological Analysis (IPA).

A multiple regression of the questionnaire data yielded appearance schemata as the most significant predictor of appearance dissatisfaction in individuals concerned about their appearance. In support of this the qualitative interviews illuminated 'preoccupation' with appearance as a central theme amongst highly self-conscious participants. In contrast, 'accepting self with faults' was a central theme for subjects who were less self-conscious. This group also appeared to make sense of staring by attributing the problem externally, whilst the more 'self-conscious' group displayed much internal attribution of staring and interpreted this as something 'wrong within them'. This suggests that psychological processes making sense of external information contribute highly to resilience from appearance related distress.

Whilst not being a predictor of psychological distress, self-esteem was found to be a moderator in the relationship between appearance schemata and psychological distress (Liossi, 2003), where individuals placing high significance on appearance were less emotionally distressed if they had high scores for self-esteem. In a possible implication for the role of perfectionism in appearance dissatisfaction, Liossi observed that the women and men who were concerned about their appearance tended to be more goal directed, setting higher personal standards than those in the other group.

Self esteem (Cash, 2004; Liossi, 2003; Harter, 1999 Ben-tovim and Walker's, 1991) and perfectionism (Flett, Hewitt, Endler & Tassone , 1995; Shafran and Mansell, 2001; Blatt, 1995; Slade, 1982) have been implicated in providing potential resilience and vulnerability respectively to appearance related

concerns in research on people without a visible difference. It could be that high self-esteem provides a buffer against appearance dissatisfaction problems for those with a visible difference. It seems perfectionism could be related to the setting of high and often unattainable standards to validate peoples' self esteem, resulting in a lowered resultant self esteem.

In addition, lower levels of social support arose as a predictor for appearance dissatisfaction in Liossi's (2003) study. Those who scored highly on measures of appearance concerns and social support had lower levels of social avoidance and social anxiety. The results suggested that even in the presence of dysfunctional appearance schemata an interaction of social support and higher levels of self-esteem appeared to provide participants with resilience regarding levels of distress.

The Appearance Schemas Inventory (Cash and Labarge, 1996) measure used in this study had not yet been widely applied and so did not have well established community norms. It has since undergone further scrutiny and a subsequent extensive revision (Cash, 2004). For this reason it may have been vulnerable to extremity bias. In this light, Liossi's claims about the existence of appearance schemata determining a 'feeling state' are questionable, and this study would benefit from being repeated with validated measures. None the less, this study offers extensive and interesting insight into the processes and factors involved in appearance dissatisfaction and, as described later, many of the findings are echoed in research with individuals with a visible difference.

Thomas Cash, whose research is predominantly with individuals who do not have a visible difference, has implicated particular cognitions which appear to contribute to vulnerability to appearance dissatisfaction. He found that women who endorse more traditional gender attitudes in their relationships with males invest more importance in their physical attractiveness, have more internalised cultural ideals and standards of beauty and generally had more maladaptive beliefs about body image. It is suggested that, if 'schematic'[14] for appearance one would preferentially attend to and process information relating to

[14] A cognitive schema is defined as "Cognitive generalisations about the self, derived from past experience, that organise and guide processing of self relation information contained in an individual's social experience". (Markus, 1977, p. 64).

appearance (Cash 2004, Cash and Pruzinsky , 2002). This has been illustrated in a number of other studies, including Papadopoulous, Bor and Legg's (1999b) observations of high appearance-related negative thoughts in their study of Vitiligo sufferers. As is discussed above, in a culture which places such importance on appearance it is likely that many, many individuals are currently 'schematic' for appearance.

5.4.2. Participant's with a visible difference

Moss and Carr (2004) performed a quantitative study investigating appearance related distress in a cross sectional study on participants (N=70) recruited from self-help organisations and a burns unit. They considered the role of the self-concept in this adjustment process (Moss and Carr, 2004). 'Self-concept' was conceptualised from a social-cognitive perspective (Markus and Wulf, 1987) as a dynamic, hierarchical and multifaceted information processing network that guides behaviour through self-regulation.

Questionnaire data was collected using measures of appearance related distress. The first regression analysis demonstrated that appearance related adjectives were rated as more central to poorer adjusters than good adjusters and that poorer adjustment was associated with high compartmentalisation of appearance and non-appearance adjectives within the self concept. The second regression demonstrated that a higher complexity of the self-concept was associated with poorer adjustment. This association was not moderated by the centrality of appearance related self-aspects. This provides further evidence to suggest that the importance of appearance is a vulnerability factor for poorer adjustment to a visible difference.

It seems important to note that because the first task comprised of questions relating to concerns about appearance, participants may have been primed to provide more appearance related information than is truly representative. In addition, only 70 usable responses were collected out of 264 sent out booklets. This implicates the sample of those already seeking help as a specifically highly motivated sample which may have implications for the generalisability of these results.

Self esteem, perfectionism and social support have all been implicated in appearance dissatisfaction. In addition, how individuals interpret the behaviour of others seems important. Most strikingly the importance placed on appearance seems to play a vital role.

5.4.3. Body shame

Findings suggest that the experience of appearance dissatisfaction is not entirely remote from Paul Gilbert's (2002) bio-psycho-social model of body shame; where experiences are characterised by both negative views of the self (internal shame) and perceived or real negative views from others (external shame). If a lot of importance is placed on appearance, it seems likely the interpretation of external information will be heavily affected. In addition, ascribing to more traditional ideals of appearance, alongside a visible difference, could lead to further internal shame, through increased perceived self discrepancies. Kent and Thompson (2002) discuss the role of body shame in individuals with a visible difference where internal and external shame schemas promote cognitive distortions and unhelpful coping strategies (e.g., avoidance of social contact). Whilst this is a clear and interesting model, it appears to be exclusively focussed on pathology and could be broadened through the addition of resilient and positive factors as possibilities in the experience.

5.5. A turn to Resilience

In recent years there have been several calls from researchers in the field to take notice of and learn from those individuals who do cope well with adjustment to living with a visible difference (e.g., Rumsey and Harcourt, 2005, Partridge, 1999). Eisermann (2001) goes as far as to state that it is unethical not to consider the positive aspects of visible difference and to exclusively focus on pathology.

One of the difficulties facing researchers investigating resilience is that there is continued debate regarding the construct of resilience itself. Cooper (2000) defines resilience in relation to visible difference as "the ability to develop the self confidence to withstand the social and psychological pressures" (Cooper, 2000, p.31). In the last twenty years research on resilience has turned away from a focus on individual factors that are thought to be 'protective' and towards

understanding the underlying processes that contribute to resilience. The charity Changing Faces, who also call for more research on resilience, divide resilience with visible differences into three areas; behavioural, cognitive and emotional resilience.

Findings suggest the presence of resilience and positive adjustment in individuals with a visible difference. For example, Rumsey, Clarke, White, Wyn-Williams and Garlick (2004) report that the majority (between 50% to 70%) of individuals with a visible difference (N=650) did not report significant levels of distress. Resilience, strength and an increased sense of well-being appeared to stem from placing less importance on appearance and positive perceptions of social support (Rumsey et al., 2004). In a study with participants with vitiligo, Thompson et al (2002) reported that some individuals displayed evidence of developing coping strategies themselves which are similar to those promoted in treatment.

5.5.1. Positive Adjustment

It seems that some individuals recognise that they have gained as individuals from living with a visible difference. Eiserman (2001) conducted a mixed methods study looking at unique outcomes and positive contributions of a cranio-facial disfigurement (CFD). 11 affected adults and 11 parents of children with CFD's completed a questionnaire with both open (qualitative) and closed (quantitative) questions. Participants were explicitly informed that the study was focussing on the positive ways in which their CFD had impacted their life and the positive nature of the findings should therefore be interpreted in this context. Qualitative findings included an 'appreciation of an enhanced set of communication skills', due to a perceived need to compensate for their difference in appearance. In line with this, another theme related to the development of 'acute observation skills'. It seems that whilst these skills arose from challenges in life, they are now an appreciated positive personal attribute. Another theme was entitled 'a commitment to service'. This related to participants' sense of societal injustice with regard to appearance, and their commitment to challenge it. An 'orientation to question society's myths' was another theme which highlighted the participant's taking on society's distorted view of the importance of beauty. These themes suggest an appreciation of being politicised against unjust aspects of society through their adjustment to

their visible difference. Of note, half of the affected adults and half of the parents of affected children said that they would not remove their CFD if they were given the option. Whilst it is important to note that participants were primed to focus on the positive aspects of their CFD, this is an illuminative finding and provides insight into the strength of the positive factors of living with a CFD.

5.5.2. Resilient factors

Myerson (2001) reports findings which suggest a variety of resilient factors. Determination, a sense of self, humour, family support and faith are reported to contribute to resilience in adjustment for participants with Moebus syndrome[15]. Participants were interviewed over the telephone and their responses were written down by the interviewer. The resulting data was treated as survey data and not formally analysed. Whilst this study provides interesting insights, the results should be interpreted with caution due to the informality of the data collection and analysis process.

Carr (2004) drew from trait personality theory to describe a 'resilient personality'. He proposed four aspects; self-efficacy and self esteem, functional coping strategies, adaptive defences and future orientated perspective on life.

Eiserman's (2001) aforementioned study also yielded themes relating to an 'inner strength', a 'valued social circle' and 'the perception of CFD as one of life's normal hardships' as resilient factors. The latter of which implicates a role for the meaning making of a visible difference.

5.5.3. Meaning making of a visible difference

Wallace, Harcourt and Rumsey (2007) investigated the adjustment to the appearance related changes resulting from the potentially fatal disease;

[15] Meobus syndrome is characterised by congenital facial paralysis involving cranial nerves and some oral and limb malformations (Meyerson, 2001).

Meningococcal Septicaemia[16] (ms). Eleven semi-structured interviews were conducted with adolescents (female=7, male=4) between the ages of 10 - 20[17]. IPA was used to analyse the transcripts of these interviews, with the aim of exploring participants' personal views on the experience. The major themes that emerged from the research were 'pre- and post-ms changes: before and after', 'Facing death, re-evaluating life', 'Relationship with scars/altered appearance' and 'Health care provision'. The appearance related changes were found to be central to the experience and the emotional and psychological recovery. Whilst this was found to be something that participants' struggled with, researchers suggest that participant's illustrated an 'astounding' level of resilience (Wallace et al., 2007).

The theme referring to the 'near death' experience of ms sheds light on this concept. It would appear that this experience acted as a 'protective' factor to the adjustment to the changes in appearance by facilitating a re-evaluation the importance of appearance, in the face of mortality. These results provide further support in the form of qualitative data, suggesting that the 'importance of appearance' is a key factor in the adjustment to a disfigurement. In support of other findings, social comparison was also implicated, in the form of a shift from upward (less helpful) to downward comparisons (more helpful). It seems that cognitive processes involved in making meaning from the changes in appearance are a vital process in predicting resilience or vulnerability in adjustment to a visible difference.

Claims are made about the homogenous 'adolescent' sample however the age range (10 – 20) encompasses a vast range in developmental terms. Comparisons between the younger and older participants would have been interesting due to their different life stages.

5.5.4. Coping strategies

[16] Meningococcal Septicaemia Inflammation of lining surrounding the brain and spinal cord; of viral or bacterial origin. Often results in gangrene in extremities and subsequent skin necrosis and the need for amputations.

[17] Authors used the World Health Organisation definition of adolescence.

Saradijan, Thompson and Datta (2007) interviewed 11 males with a unilateral upper limb amputation and prosthesis. They used IPA to analyse the data. They report the emergence of several master themes. One of which relates to 'Coping style facilitating adjustment'. Here a 'positive attitude' and an 'engagement in life and openness to experience' appears to help facilitate a pride in positive coping and a regaining of self worth. It is reported that a minimisation of the sense of difference in appearance and ability also helps to regain a positive self worth. The importance placed on the success of minimising the difference is in contrast to findings where a sense of acceptance of difference (e.g., Harcourt & Rumsey, in press; Liossi, 2003) is implicated. It might be that this relates to the central role of impaired functionality in this particular sample. The authors state that the findings can be understood theoretically within the framework of Gilbert's (2002) bio-psycho-social model of body shame, previously mentioned. The prosthesis is conceptualised as a defensive behaviour against the experience of external shame, where other people would notice their difference.

'Emotion-focussed coping' is one general conceptualisation of a coping method which is frequently investigated in behavioural health literature. It proposes that to cope with emotions some people take an avoidant 'mentally disengaged' approach (motivated by controllability) whilst some extensively process material, 'venting their emotions' (primarily motivated by unpredictability)[18].

Fauerbach, Heindberg, Lawrence, Bryant, Richter and Spence (2002) assessed these two types of 'emotion focussed coping methods' in participants (N=78) with a burn injury in a prospective, longitudinal design. Participants completed questionnaires during acute hospitalisation (baseline) and at one week and two months follow up. Participants using high levels of both mental disengagement and venting emotions are claimed to have experienced the most psychological distress. This is explained by the frequent use of opposing methods resulting from ambivalence in terms of motivation which may result in the incomplete processing of aversive stimuli, and the subsequent promotion of increased sensitisation and perpetuation of severe symptoms. There was no significant difference between using either one or none of these methods and psychological distress. These findings seem to suggest that the use of one or

[18] For more details on the Mental Control Model see Wegner (1994) and Fauerbach,et al., (2002).

none of these methods may facilitate helpful coping and that the use of both is unhelpful. This is an important consideration for clinicians who might be encouraging a 'venting' approach as it seems that this could be harmful if the client is engaging in any form of 'disengagement' concurrently.

A prospective longitudinal design is welcomed in this area, however, when considering the healing period for burn scarring and the likely length of time to psychologically adjust, I would argue that a two-month follow-up may not be long enough into the adjustment period. It seems that this is likely to have measured the acute experience, much affected by the means by which participants acquired their burns (e.g., accident, attack). In addition, this study is only able to make claims about the coping mechanisms that it has chosen to measure. With a complex concept such as 'coping', causal relationships regarding motivations cannot be made, due to the likely presence of other coping mechanisms as well as many other confounding variables.

5.5.5. Rumsey et al., (In press).

I will now consider a recent and extensive study in the area in relation to previous findings. Nicola Rumsey and colleagues (in press) have engaged on an ambitious project to identify the psychosocial factors and processes contributing to the successful adjustment to visible differences from a range of conditions, embarking on several related studies. Due to the recency of this research the findings are not yet published in academic journals, however the final report submitted to 'The Healing Foundation' presents the findings.

A large scale questionnaire based cross-sectional study included 1265 participants with a rage of visible differences, both from hospital and community settings. The measures were validated and considered cognitions, emotions and behaviours of people living with a visible difference. The questionnaire battery also included free text questions which were qualitatively analysed. The questionnaire batteries were repeated after a 9 month interval by 360 participants. Other smaller scale quantitative and qualitative studies were conducted.

Results from the large scale quantitative study suggest that participants displayed a wide range of profiles of adjustment and distress, revealing

characteristics of both 'more and less well adjusted people' (Rumsey et al., in press). Interestingly the researchers state that high levels of distress were found in both samples seeking and not seeking intervention and say that this indicates unmet needs in the community. The authors conclude that adjustment is multi-factorial. They list the cognitive processes contributing to adjustment as; fear of negative evaluation, interpretation of responses of others, perceived social acceptance, satisfaction with social support and appearance specific cognitions, such as salience, valence and appearance related self discrepancies. These echo the cognitive processes implicated by Cash (2004) and Cash and Pruzinsky (2002) in body image literature. Rumsey et al., (in press) also implicate the contribution of dispositional style (pessimism/optimism) in the process of adjustment.

Whilst other studies have illustrated that comparisons with others can impact how individuals feel about their appearance (Grogan 1999; Gibbobs, 1999; Stormer and Thompson, 1996; Liossi, 2003; Van den Berg and Thompson, 2007), Rumsey et al (in press) state that findings regarding social comparison processes were contradictory in the various sub studies of the project. They also report that this was the case for the issue of the visibility of a disfigurement to others. This sheds some doubt on previously 'established' findings and suggests that further research is required.

A qualitative study was conducted by the same team (Rumsey et al., in press) investigating the dynamic nature of adjustment. Findings suggest that changes in both the impact and salience of appearance concerns are dynamic. Events including developmental milestones, signs of ageing, life events and the cumulative impact of daily stressors (e.g., reactions of others) appear to trigger changes in coping. It appears that even for those who experience themselves as 'positive adjustors', coping with a visible difference can be an ongoing strain on personal resources (Rumsey et al., in press). Qualitative research has been shown in this instance and others (e.g., Johnson et al., 2004) to illuminate the dynamic nature of adjustment in a way that quantitative studies have struggled to do. In earlier literature adjustment has been discussed as a static process once it is 'achieved', and this finding has helpfully opened up this conceptualisation. This is particularly helpful when considering long term support of individuals with a visible difference.

In another sub study of the broader project, Harcourt and Rumsey (in press) interviewed participants whose results in the cross sectional questionnaire study indicated that they had felt they had adjusted positively. Three focus groups and four interviews were conducted with 12 participants who had a variety of visible differences. Inductive thematic analysis was used to analyse the data.

Four main themes emerged from the analysis. The first was 'importance of appearance'. Participants reported placing little importance on appearance and more importance on other characteristics. This finding appears to support much of the previous literature suggesting that those who place a higher importance on appearance experience more appearance distress (e.g., Cash, 2004; Liossi, 2003; Papadopoulos et al., 1999b).

The second theme was termed 'personal growth'. Participants reported becoming more resilient, resourceful and taking up new interests and opportunities as a result of the challenges faced when living with a visible difference. This also echoes previously discussed findings regarding positive aspects of adjustment (e.g., Eiserman, 2001).

The third theme was 'relationships with others'. This relates to some participant reports of being helpfully treated no differently by family and friends. Other participants discussed appreciation of support they had received. This finding implicates the importance of person centred and tailored social support and echoes earlier findings relating to the role of social support (e.g., Liossi, 2003; Meyerson, 2001; Eiserman, 2001). Harcourt and Rumsey (In press) also stated that participants discussed the benefits of support from and being able to talk to those who have had shared experiences of visible difference.

The final theme is termed 'coping'. This refers to participants strategies employed when times were difficult. The authors state that responses ranged from use of humour, positivity, determination, dealing with things daily and acceptance. Participants also described how they chose to confront their difficulties and to make the best of them. Another strategy related to contextualising their visible difference by placing more importance on other aspects of their lives and making downward social comparisons. Participants also reported techniques including distraction, practical solutions, treating themselves and drawing from senses of faith and spirituality. The qualitative

nature of this research allowed for novel findings in relation to coping methods, and could perhaps provide impetus for future research examining these methods of coping, just as Fauerbach et al (2002) conducted when considering the role of emotion focussed coping.

This broad ranging study offers many opportunities for insight into resilience, as well as considering more dynamic aspects, because of the inclusion of a qualitative dimension. Most research in the area understandably recruits participants from clinical samples which could be seen to negatively bias results. This study's inclusion of community samples, as well as hospital ones, enables insight in to people who are not currently receiving treatment.

5.6. The role of the Counselling Psychologist.

It seems that Counselling psychologists would benefit from paying due attention to individuals who are adjusting well. These individuals appear to be a potential invaluable resource to psychologists, individuals who are struggling to adjust and to each other.

5.6.1. Support groups

Findings from this particular review suggest that support groups could be a particularly powerful and effective area of support for individuals with a visible difference. Participants in Harcourt and Rumsey's (in press) qualitative enquiry reported the helpfulness of talking to others who have had similar experiences with visible difference.

Counselling Psychologists could adopt a facilitative, non expert role in support groups. Roles for individuals who identify as 'positive adjusters' could be defined; they could run some groups, workshops or make presentations on their experiences and their effective ways of coping. The involvement of these individuals could also increase the uptake of the groups, due to their perceived understanding. It could be a reciprocal, empowering, hope inspiring and affirming experience for all involved. Through due consideration and reflection on safety, care and support for all of those involved, the Counselling Psychologist would need to take the responsibility for ensuring that all individuals involved gained from, and did not suffer from, the experience. In

addition, due care would need to be taken to ensure that a value judgement was not placed on any particular way of coping. The construction of one universally desirable method of adjustment would be constraining and unhelpful, and the appreciation of individual needs and methods should be emphasised.

5.6.2. Moving away from a deficit focus clinically

Meyerson (2001) reports comments by participants that in psychological counselling settings "too often the deficits provide the only focus". Eiserman (2001) stated that the participants reported finding participating in a study in which they were forced to focus on what had been positive about their condition was a positive experience. Eiserman (2001) recommends the use of the positive in therapeutic encounters with individuals with CFD. It seems that exploring the positive aspects as well as those which are challenging could offer many therapeutic opportunities.

One theme of findings in this area appeared to be the appreciation of enhanced skills (e.g., communication skills) that were developed due to the challenges that are faced when living with a visible difference (Harcourt & Rumsey, in press; Eiserman, 2001). It would seem that exploring and emphasising these could be an important way to both validate and enhance participant's individual coping skills, strengths and resilience's.

5.6.3. Cognitive behavioural Interventions

It seems that appearance specific socio-cognitive cognitions play an important role in adjustment to a visible difference. These include the interpretation of the behaviour of others, importance placed on appearance and meaning making processes relating to visible differences. It would seem that there was a role for cognitive techniques, in challenging some of these cognitive processes and constructing alternatives offering more opportunities.

Liossi (2003) reported findings suggesting that participants who were more concerned about their appearance often used avoidance and concealment to manage the impact their appearance has on others. This is consistent with literature on visible difference, social anxiety and body dysmorphic disorder (Learly and Kowalski, 1995). These findings also resonate with results from the

research in this portfolio. It could be that behavioural interventions promoting exposure through systematic desensitisation could serve to facilitate more situations in which individuals could challenge unhelpful cognitions. This could reduce the socially limiting aspect of life with a visible difference described by Rumsey and Harcourt (2005). As suggested by Coughlan and Clarke (2002) it is not helpful to make these changes in isolation. For example, it is not therapeutic to encourage an individual to give up social isolation as a coping mechanism without considering, cognitively, how to put both oneself and others more at ease with their visible difference (Coughlan & Clarke, 2002)

Kent and Thompson (2002) implicate Paul Gilbert's (2002) bio-psycho-social model of body shame in the dealing with negative views of others (external shame) and negative views of the self (internal shame) in relation to a visible difference. This model takes into account the role of objective discrimination and prejudice and how the likelihood and the impact of it can be reduced.

In Harcourt and Rumsey's (in press) qualitative study it seemed that participants who adjusted well were able to be kind and compassionate to themselves. For example, one strategy they discussed was that of 'treating themselves'. They also discussed being accepting of their condition. Concepts of 'Compassion' and 'Acceptance' are playing an increasingly central role in third wave CBT models, with the introduction of mindfulness based CBT (Crane, 2009), Acceptance and commitment therapy (Hayes, 2004) and Gilbert's (2010) Compassionate Mind work. It seems that many individuals who show resilience in adjustment are employing these processes to positive effect. Having observed that these strategies appear to be helpful when employed by 'positive adjusters', it could be the case that these therapies can offer particularly effective interventions working with individuals who are struggling to adjust.

5.7. Future Considerations

Research has provided much insight and guidance in working with people adjusting to a visible difference, however some conceptual and methodological issues are worth commenting on.

Conceptual issues include further definition of keys terms such as 'resilience', and 'adjustment'. For example 'adjustment' it is presently defined in terms of

emotional wellbeing, however there have been calls for measures of adjustment to include behavioural and cognitive dimensions (Thompson and Kent, 2001). In Rumsey et al.'s (In press) study adjustment is suggested to be far more dynamic than otherwise considered.

Whilst many of the measures used have been found to be empirically robust, those relating to 'Body Image' and used with populations without a visible difference are generally based on student samples (Thompson and Kent, 2001). A review of these measures through widespread applications of the measures across different cultural and socio-economic backgrounds could further validate the use of these measures.

Many quantitative studies use a similar batch of measures looking at similar constructs (e.g., body image, self esteem, anxiety and depression). In quantitative research, one only finds answers to the specific questions they ask. The widespread reliance on particular measures runs the risk of not exploring different aspects of the experience. New aspects of adjustment have been identified in more recent qualitative studies, and some seem to overlap in multiple findings (e.g., acceptance). The development and implementation of measures relating to these findings could enable broader scale quantitative investigation in to these aspects across a range of participants and contexts, enabling more generalisations.

The vast majority of research in this area recruits western, Caucasian samples. Greater consideration of the role of various contexts including culture, sexuality, ethnicity and religion on meaning making of a visible difference is required and could shed further light on the factors and processes involved in adjustment.

In addition it is important to recognise that visible differences do not occur in a vacuum and are often accompanied by significant factors, including experiencing trauma (e.g., illness). Whilst it has been beyond the scope of this review to take these factors fully into consideration, it seems that more research investigating the meaning making of the visible differences in relation to how it was acquired could provide additional and important insight.

5.8. Conclusions and reflections

The findings in the literature regarding the lack of predictability provided by severity and location of visible differences highlights the potential centrality of the role for psychological consideration and intervention. It seems that an individual who places little importance on appearance, has high self esteem, is not perfectionist, values the development of personal strengths through adversity, appreciates social support, experiences social acceptance, rejects societies pressure to look a particular way, does not fear negative evaluation and has a generally optimistic disposition is likely to adjust positively and resiliently to life with a visible difference. In addition, the use of humour, positivity, determination, downward social comparisons, one or no method of emotion focussed coping and addressing issues 'face on' are reported by individuals who adjust positively.

It seems that there is much scope for the role of the Counselling Psychologist in promoting resilience in individuals living with a visible difference. In using its scientist/ practitioner role Counselling Psychology appears to have a rich resource of expertise to guide psychological intervention in positive adjusters to visible difference. Roles have been implicated in using the strengths of service users in support groups and specific theoretical suggestions for interventions have been made in connection to research findings.

In focussing on findings relating to the strengths and resiliencies of individuals with a visible difference I have found myself up-lifted, humbled and excited about the possibilities for psychological work in this area. My research project, into the experience of body change in women who have lost significant amounts of weight and had their subsequent excess skin removed by plastic surgery, highlighted considerable and continual psychological dysphoria related to the body. Having engaged in this review, I feel strongly motivated to conduct research with individuals who have not sought plastic surgery to remove their excess skin, but have found ways to live with it. It would seem that the factors and processes involved in enabling some individuals to live with and possibly accept their excess skin after weight loss could provide vital knowledge that could help those who find it hard to live with their excess skin. It seems that promotion of resilience in adjusting to life with excess skin could be a more likely way to achieve 'self acceptance' than plastic surgery.

5.9. References

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Section C

6.0. Case Study

"Towards Compassion: A Case Study "

6.1. Introduction to the therapeutic work

6.1.1. Introduction

I have chosen to present my work with Lilly[19] because I found it an exciting piece of work that raised and affirmed important professional issues for me, in relation to my identity as a Counselling Psychologist specialising in Cognitive Behaviour Therapy (CBT).

My work with Lilly is particularly informed by some of the theory which I have suggested might be helpful in clinical work with the participant group in my research study. I think it would be helpful for the reader to contextualise this work and see evidence of its effectiveness in practice. In addition, aspects of my work with Lilly resonate with ideas that have appeared in my previously presented IPA findings (e.g., shame) and my critical literature review (e.g., resilience factors in appearance distress). I believe that these interactions illustrate the reciprocal nature of the scientist-practitioner role in Counselling Psychology.

After introducing the case I will discuss the development and beginning stages of the therapy. I will then discuss a particular conversation, to illustrate some of the micro processes which were present in our encounters. I will go on to discuss the middle and end stages of therapy and then present the therapeutic ending and my evaluation and reflections on the work.

6.1.2. Ethics

After I had explained the potential uses of the recording, including the use of some anonymised recordings in my academic assessment, Lilly considered and signed the consent form. Because of the potential for this portfolio to have

[19] All names and identifiable details have been changed to protect the identity of the client.

public access and for it to be published, I felt that it would be inappropriate to include any full transcripts of my therapeutic work with Lilly in this report. Transcripts are, however, available to examiners on request.

1.c. The context of work

This work took place in the Assessment and Treatment team within an urban Community Mental Health Team.

6.1.3. The referral and convening the first session

Lilly had been referred to the team by her GP. The GP described years of difficultly with mental health problems including diagnoses of Depression and Generalised Anxiety Disorder and 'horrendous' bullying at school. He reported that her mental health had recently deteriorated since being made redundant from her job. Lilly had been working in an environmental awareness charitable organisation. Lilly met with a psychiatrist who reviewed her medication, and, due to their concern about her low mood, increased her dosage to 60mg of Citalopram. Lilly had initially been referred to a 'depression group' running in the CMHT. Whilst she had attended the first session she had not returned. It was then decided by the multidisciplinary team that Lilly would benefit from engaging in one to one CBT.

6.1.5. The presenting problem

Lilly stated that being made redundant from her job for not being 'reliable and punctual enough' had had a negative impact on her self-esteem and that she was subsequently struggling more with her low mood and anxiety.

6.1.6. Summary biographical details of client

Lilly is a 25 year old woman of white, British ethnicity. She is the middle of three daughters. She lived with her sisters and parents, both medical doctors, in a London suburb until they moved to a northern English town when she was eight. She moved back to London to go to University aged 19, and has lived here since. She currently lives with her partner of four years who works as a civil servant. When we met, Lilly was receiving job seekers allowance.

6.1.7. Summary of the theoretical orientation

"At its core, CBT focuses on how we attend, interpret, reason, reflect and make sense of inner and outer events" (Mansell, 2009, pp. 19.).

CBT posits that thoughts, emotions, behaviour and physiology form a unified system and that changes to a part of the system will have knock on effects for the other areas (Curwen, Palmer and Ruddle, 2000). Over the past decade new ideas borrowing from a diverse range of theoretical and philosophical approaches (Mansell, 2009) and highlighting the importance of the *function* of events (Hayes, 2004) have developed. This emergent and strengthening CBT movement has been named the 'Third Wave'.

Third wave ideas of Compassion, Mindfulness, Metacognition, and Acceptance described by Gilbert (2010), Kabat-Zinn (2003), Harvey, Watkins, Mansell and Shafran (2004) and Harris (2006) respectively were employed in this case, alongside more traditional second wave principles such as Socratic Questioning (Padesky, 1993).

CBT literature which underscores the importance and advocates the explicit use of the therapeutic relationship influenced the therapeutic work (e.g., Gilbert and Leahy, 2007). In CBT, the therapeutic relationship is characterised by its collaborative nature in which the client is positioned as the expert in their own experience. The therapist is positioned as a containing guide who draws on their theoretical knowledge and therapeutic skills to help the client reach their goals (as outlined by Westbrook, Kennerly and Kirk, 2007).

My supervisor and I collaboratively considered how best to draw from the body of available CBT theory in order to ensure my ethical practice was in the service of Lilly's specific needs at this time. For a copy of the therapeutic plan see Appendix O).

My rational for drawing on these particular aforementioned theoretical constructs were:

- Lilly experienced vicious, 'bullying' thoughts about herself, informed by self-critical core beliefs. I hoped these would be reduced by promoting a more compassionate approach to the self.

- Lilly had become terrified of her internal experiences and was engaging in avoidant behaviours (e.g., use of cannabis) which were exacerbating herself critical thoughts. I hoped that through developing a more accepting stance towards her internal experiences she could experience them as less threatening, and therefore be less motivated to avoid them.

- Mindfulness has been shown to be helpful with the treatment of depression and anxiety (see Baer, 2003 for review). I hoped that the development of skills in mindfulness meditation (Kabat-Zinn, 2003) would provide Lilly with a helpful coping mechanism and form of emotional regulation.

- I believed that by making positive changes to Lilly's self-critical thinking and avoidant behaviour, she would experience welcomed knock on effects that would influence the rest of the distressing cycles of thoughts, feelings, physiology and behaviour that she experienced (Curwen et al, 2000).

- Lilly was able to access and articulate her cognitions (Safran and Segal, 1990).

- The National Institute of Clinical Excellence recommends CBT for addressing anxiety and depression (NICE, 2004).

6.1.8. Initial assessment and formulation of the problem

On meeting Lilly I was immediately struck by the incongruence between how 'noticeable' she was and how 'noticeable' she seemingly wanted to be; Lilly is a tall, striking woman with brightly dyed hair, black clothes and multiple piercings, but she sat in the corner with her shoulders hunched and her head hung low. Lilly greeted me warmly but sheepishly and shuffled into the therapy room smiling nervously.

Lilly and I collaboratively developed a 'case level formulation' (Persons and Davidson, 2002) highlighting the impact of her previous experiences and subsequent beliefs on her current everyday experiences. Please see Appendix

N for the copy of the diagram version that we used in our sessions (adapted from Westbrook, Kennerley and Kirk, 2007).

Lilly stated that her physical and emotional bullying started at the age of eight when her family moved to a North England town, from the south. She reported being bullied at school for 'standing out'; having a middle class 'southern' accent and for her appearance. Aspects of her appearance that attracted unwanted attention were her being tall and wearing 'stupid' clothes bought by her mother. Lilly described her mother as 'clueless' and that she dressed her children and herself in bright clothes from charity shops that did not match. Lilly's sisters went to different schools in the area and appeared to adjust to the move with relative ease, making lots of friends.

Lilly's teachers and family, in particular her mother, told Lilly that if she was 'strong' the bullies would not get what they wanted and would stop bullying her. Lilly's 'failure' to do this, her struggle to hide her fear and distress when being bullied and her experience of escalating frustration from those around her led her to internalise the blame for her bullying and develop the belief that her 'weakness' made her a deserved target. She developed core beliefs such as 'I am weak and pathetic', 'I cannot cope' and 'I need to be treated harshly to force me to be strong'. The well meant advice from those trying to help her appeared to place the fault and responsibility for change within the victim rather than the problem, which was external. Lilly stated that she had experienced her four previous 'failed' attempts at therapy, as re-enactments of this process, in which she experienced frustration from her therapists and felt anger at herself for not 'pulling herself together'.

Being made redundant because of her lack of reliability and punctuality appeared to have triggered and reinforced Lilly's beliefs about her inability to cope. She was experiencing distressing self critical thoughts (as described by Gilbert, 2010) which we named 'bullying thoughts' (as they were similar in content and tone of the bullying she had experienced at school). Her thoughts (e.g., 'I am weak and pathetic') were triggering feelings of frustration, shame, despair, low mood and anxiety which led to unpleasant and worrying physiological responses (e.g., heart racing). Lilly would typically then engage in behaviours to avoid these internal experiences (e.g., smoking cannabis,

cancelling appointments) which would serve to exacerbate her beliefs that she could not cope.

Lilly stated that this cycle was particularly likely to be triggered if she was required to be somewhere at a particular time. As a result she was avoiding these situations and stayed in the house as much as she could. This served to trigger more thoughts about her inability to cope and she experienced higher levels of anxiety when she did have to leave the house. Lilly stated that her recent increase in smoking cannabis had reduced her motivation and ability to concentrate on applying for jobs which in turn made her feel frustrated and despairing with herself at the end of every day.

Due to her experience of low mood and hopelessness we carried out a suicide risk assessment (Peruzzi and Bongar, 1999). Whilst Lilly reported fleeting thoughts about death as an end to all of her distress, she stated that she never paid attention to them because of all the people in her life that love her and her inability to cause them pain. Lilly reported a supportive and loving relationship with her partner, her immediate family and some friends. I viewed these as strong protective factors for Lilly. Lilly expressed future plans and good problem solving skills which reassured me that she was not at high suicidal risk.

The formulation diagram we used in our sessions (Appendix N) was based on one presented by Westbrook et al., (2007). Due to Lilly's strong protective factors, and my developing motivation to pay attention to positive factors in therapeutic work, we included these in our diagram. I believe it is important to include factors relating to the resilience, skills and positive factors of the client to encourage their sense of agency, offer a sense of hope and to recognise the potential resources to draw on in therapeutic work. These ideas have been discussed further in my Critical Literature Review.

Our collaborative formulation assisted both our understanding of Lilly's problems and helped to guide our therapeutic work. It was continually and collaboratively refined over the course of our sessions.

6.1.9. Negotiating a contract and therapeutic aims

We agreed to meet weekly for 20 sessions. This was deemed an adequate length for us to work towards Lilly's goals given the entrenched nature of her beliefs and the constraints of the service.

Using the 'SMART' framework, as suggested by Westbrook et al., (2007) to ensure they were specific, measurable, achievable, and realistic within the timeframe, Lilly and I collaboratively agreed on her therapeutic aims, which were to:

- Increase her repertoire of coping mechanisms for her anxiety and low mood
- Decrease her engagement in coping mechanisms which fuel the 'bullying thoughts' (e.g., cannabis smoking)
- Move from 'self-critical' thinking towards a more compassionate approach to the self (hopefully increasing self-esteem).
- Increase Lilly's (perceived) ability to meet the requirements of full time employment

6.3. The Development of therapy

After Lilly and I collaboratively decided on our therapeutic goals, I outlined a therapeutic plan which was later approved by my supervisor. Please refer to this in Appendix O.

6.2.1. Beginning stages of therapy (Session 1-5)

Lilly responded well to psycho-education about her low mood and anxiety and the Cognitive Behavioural framework (Addis and Carpenter, 2000; Curwen et al., 2000). Her understanding of the CBT model and the potential for change within it appeared to enthuse and provide hope for Lilly, the importance of which is discussed by Snyder, Michael and Chearvens (1999). The process of normalising her experience also appeared to reassure Lilly and her understanding of her difficulties appeared to give her an increased sense of control over them, the benefits of which are discussed by Frank (1971). We started by developing a situational conceptualisation using the 'Hot cross bun model', suggested by Greenberger and Padesky (1995), to help her to begin to

differentiate between and examine the causal relationships between her thoughts, feelings, behaviours and physiology in particular situations in which she felt overwhelmed. For a copy of this diagram as used in a later session please see Appendix P. We continued to use this skill throughout the course of our work when addressing challenging situations.

Lilly was quick to understand the link between behaviour and mood and was shocked at the 'emptiness' of the first daily activity schedule she completed. Lilly began to engage in more activities which bought her pleasure (e.g., going for a bike ride) and a sense of achievement (e.g., cleaning the kitchen) and both (e.g., walking her friend's dog) as is suggested by Leahy and Holland (2000) in the treatment of depression. As one of Lilly's aims was to perceive herself as more able to meet the requirements of employment we agreed that it would be helpful to work towards getting up everyday at a certain time and showering and getting dressed. She reflected that her increased activity and time spent out of the house led to a decrease in her cannabis use which decreased the bullying thoughts and subsequent low mood regarding this behaviour. We conceptualised her changes in behaviour, including coming to therapy, as being more compassionate towards herself.

Lilly and I also worked on the development of mindfulness and relaxation skills to provide new coping mechanisms for her distressing internal experiences and to develop her ability to witness her experiences in a non-judgemental way (as suggested by Kabat-Zinn, 2003). Lilly downloaded Mindfulness Meditation MP3s and used these to develop her practice between sessions. She also kept a diary on how this was going to encourage her to bring any difficulties back to the sessions.

The development of our relationship and Lilly's trust for me was well illustrated by her early pattern of attendance. Lilly attended the first session twenty minutes late and was either late or cancelled the following three sessions. I was mindful of possible parallel processes that might have been present alongside her difficulty in leaving the house on time as an aspect of her presenting clinical problem.

It appeared that once Lilly was attending regularly and appeared to trust me, she began to work very hard in our sessions and attend on time. Sometimes

she would appear distressed, frowning and rubbing her forehead. She would report that this was when she was experiencing her 'bullying thoughts' that were overwhelming her.

6.3.2. The fifth session: a turning point

In our fifth session I experienced a turning point in our therapy, in which Lilly was able to access a deeper level of her processing facilitated by our developing therapeutic bond and after which she engaged fully in our work. I will describe parts of our conversation where I believe particularly important aspects of our work were facilitated to illustrate some of the micro therapeutic processes at play in our encounters.

Lilly had recently started a voluntary job. This formed part of our behavioural activation work as well as her preparation for re-entering back into employment. Lilly came into the fifth session very distressed, stating that she had found it hard to get dressed that morning because of anxiety about what to wear given that she was due to go to her voluntary job after our session. We discussed her anxiety about her appearance being a central problem relating to her leaving the house in the morning and subsequently her reliability at work. Lilly recalled a poignant experience; she was walking home from school having been verbally and physically attacked by her 'bullies'. She was very distressed and tearful. She passed another girl from school who shouted across the road that she looked like a "fucking bag lady". Lilly said that she learned in this moment that:

"...however overwhelmed I was by things that were going on people were still judging me by my appearance".

As previously noted when I first met Lilly, I was struck by the incongruence of the way she dressed (which made her stand out) with the way she held herself (which appeared to want to hide). I learned in this session that Lilly's dressing like a 'goth' had in fact provided Lilly with another way to hide herself from people as well as a sense of group membership. That because she had "pre-arranged" how she looked, she felt in control and prepared for comments about her unusual clothes and avoided comments more painful to her (e.g., her size):

"The comments that would hurt the most weren't the ones I got".

We collaboratively constructed a situation level hot-cross bun cycle of her thoughts (e.g., I cannot cope), feelings (e.g., anxiety), behaviour (standing still stunned) and physiology (e.g., heart beating fast) of when she was struggling to get dressed. We had used this method previously to increase understanding, reduce its overwhelming nature and also model the helpfulness of breaking down experiences like this in the future (see Appendix P for a full copy of this diagram). This is an example of how we used specific situation level formulations alongside our broader case level formulation (Appendix N).

Rather than challenging her cognitions we discussed links between her past and present. This was informed by my concern about remaining exclusively focussed on her intra-psychic experience and responsibilities. In helping her to see the potential causes of her self-criticism I hoped that she could develop a more compassionate (Gilbert, 2010) and accepting (Harris, 2006) stance towards herself. Gilbert discusses the importance of understanding the origins of self critical thinking (Gilbert, 2010). In agreement with Gilbert (2010) and other third wave authors, I believe that labelling thoughts as 'faulty' can reinforce self-criticism. I therefore prefer to consider 'balancing thoughts' rather than 'correcting' them.

As the conversation continued I was struck by Lilly's stuck patterns of self blame. I desperately wanted her to see that her being bullied and its impact was not her 'fault'. This led me to feel frustrated. As suggested by Safran & Muran, (2000) I allowed how I experienced Lilly to inform me about her interpersonal behaviour and wondered whether I was experiencing a similar desperation for Lilly to 'change' as her mother did when she was being bullied at school. I found that reminding myself to be compassionate to the part of Lilly that is finding it very hard to change, rather than being instructive, as her mother had been, helped me to feel closer to her again.

Lilly told me that people found anything she wore 'funny' and drew unwanted attention to her. When Lilly said the word 'funny' her head dropped and I could hear a quiver in her voice. Lilly looked as if she was back at school being laughed at with her head hung and her eyes brimming with tears. Her vulnerability triggered a strong sense of protectiveness in me. I became aware that I might be being positioned again into a maternal role. I asked her how she

felt when people laughed at her. This was motivated by my sense that there were painful emotions underlying these memories, my continued wish to guide Lilly in her own discovery (Padesky, 1993), and my aim to ensure that our relationship remained collaborative.

Lilly immediately responded with the word 'shame'. I believe that Lilly was able to answer so quickly, unlike her usual deliberating manner, because she was so connected to this experience in the moment.

Lilly's identification of shame felt very significant. We felt very strongly connected at this moment. She looked up at me with an intense stare and I felt overcome with sadness for her. I responded by reflecting the word back to her with a lump in my throat. I wanted her to hear it again and to know that I had heard and felt the magnitude of this feeling. I also hoped to promote and validate awareness and acceptance of this difficult emotion, as encouraged by Fuzzetti, Shenk, Mosco and Lowry (2003) and Greenberg (2007).

This identification informed our working formulation; According to Gilbert's Compassionate Mind theory (2010) Lilly is experiencing high levels 'internal shame' and is engaged in 'shame-based self criticism'. Gilbert describes two types of 'shame based self criticism', the first relating to what is happening in the minds of others and the second being about our own thoughts. Lilly described both of these forms in our sessions. As Gilbert (2010) states, when both our own minds and the minds of others are perceived as hostile this leaves no safe and compassionate place to go.

I sensed that Lilly then tried to pull away from the identification of 'shame' as she talked about something else. My decision to bring her back towards it was informed by the magnitude of emotion that was evident in her when she identified it, my faith in the strength of our therapeutic bond and my ability to contain her distress, evidenced in previous sessions. I asked Lilly whether the shame was still around. I hoped to make links between the past and present as well as informing our understanding of her current distress. As articulated by Gilbert (2007) I was acutely aware of my role as a guide and support for Lilly through feared experiences that she had found ways to avoid. Lilly appeared totally engaged in this moment, maintaining strong eye contact. She said that 'shame' was 'nearly always around'.

It seemed as if identifying shame had enabled Lilly to process her inner experiences at a deeper level, as she went on to link shame with anger. Lilly recognised that she had placed the blame on herself and that had made her feel worse. I felt that this displayed a firm understanding of the impact of beliefs about the self on her feelings. I felt heartened to hear this evidence of Lilly's model of aetiology of her problems, which Addis and Carpenter (2000) state is an overarching purpose of CBT. They agree with Frank (1971) that this is the first step to gain control over problems. I felt hopeful that she is starting to see the negative impact of her frustration and criticism towards herself.

I asked Lilly what she thought might happen to the shame if she located a little bit less blame to herself for everything. I introduced the idea of change at this point by asking Lilly to picture a future in which she is not bound by her self-criticism. As suggested by Mooney and Padesky (2000), it can be preferable to focus on the construction of new possibilities and ways of being, rather than on correcting 'dysfunctional' patterns of thought with people who experience recurrent problems (like Lilly). I wanted to explore her thinking about the relationship between shame and blame further and to continue to facilitate her shifting thinking.

In response to my question Lilly sat in silence. She appeared distressed and overwhelmed by her internal experiences. I felt tempted to break the silence and rescue her. Newman (2007) discusses the importance of therapists being aware of their own dysfunctional thoughts so as not to respond in ways which fuel unhelpful cycles of the client. I am aware of my tendency to fall into the 'rescuer' role both personally and professionally and considered that it was particularly important to avoid reinforcing Lilly's beliefs about her being 'weak' and so continued to leave the silence.

Lilly broke the silence a minute later and stated that she was struck by the newness and significance of identifying 'shame'. Whilst listening to Lilly I tried to communicate acceptance, using encouraging and empathetic utterances, both in aid of our therapeutic relationship, as suggested by Gilbert and Leahy (2009), and to further model an accepting appraisal of her cognitions (Harvey et al., 2004). Her confirmation of the importance of this discovery seemed to provide

further evidence of our therapeutic bond as she echoes my thoughts about the poignancy of what she has just uncovered.

Lilly stated in the following session that she was now ready to 'try this compassion thing'. In the fifth session Lilly both assimilated the CBT model and our working formulation to understand her problems which enabled her to move towards her therapeutic goals. Most critically, in this session we identified an emotion that became central to our collaborative formulation: shame.

6.2.3. Middle stages of therapy (6-15)

Lilly and I continued to shift her thinking and behaviour from being self-critical to compassionate. Whilst Gilbert (2010) discusses the 'bullied' going to on bully others, Lilly recognised that she had become a bully, but only towards herself. This was both an important and deeply upsetting realisation for Lilly however, as suggested by Gilbert (2010), understanding the origin of her self-critical thoughts provided an important step for her to moving towards compassionate thinking.

Initially it was hard for Lilly to give up her self-criticism. Gilbert (2010) discusses the importance of noticing blocks to letting go of self-criticism and so we moved to identifying Lilly's metacognitive beliefs. I am persuaded by Harvey et al.'s (2004) explanation that it is often our appraisal of thoughts, rather than the thoughts themselves that can affect psychological dysphoria. Lilly believed that her 'bullying' thoughts were functional in 'getting her off her arse'. Through guided discovery Lilly identified that the perceived function of these thoughts was not effective. She reflected that her internal and external bullying at school never helped her to become 'stronger' or to 'take action'. Conversely effective psychological movement (e.g., ability to be confident of her body sexually) had come from a compassionate and nurturing approach by her partner. This conversation appeared to significantly increase Lilly's willingness to develop alternate and more compassionate and encouraging ways of being.

As much of Lilly's low self-esteem centred on concerns about her appearance we had a conversation acknowledging society's pressure to look 'a certain way'. Lilly became very animated in this conversation. I was struck that her anger was outward facing, towards an unjust society, rather than locating the problem in

and subsequently her anger towards herself, as she usually did. When I reflected this process back to her she joked that she had 'forgotten that she was a feminist'.

Susie Orbach (2009) discusses the ever mounting pressure experienced in today's western society to appear in an unattainable and increasingly homogenised way. Lilly reflected to me a further motivation to dress 'alternatively' was to reject this pressure. In a study including participants who were self conscious and those who were not self conscious about their appearance Liossi (2003) reported that individuals who were less self conscious about their appearance tended to explicitly reject society's pressure to look a certain way. In addition Cash (2004) and Cash and Pruzinsky (2002) report findings which suggest that women who have more internalised cultural ideals and standards of beauty generally have more maladaptive beliefs about body image, making them more vulnerable to body image distress. Because of my research interest and familiarity with this literature, I was particularly heartened to hear Lilly describing her use of these identified protective processes against appearance dissatisfaction.

In the Socratic dialogues that followed Lilly increasingly engaged in her feminist beliefs and joined a feminist activist group with her friend. Subsequently her ability to reject the pressures that society placed on her and her appearance appeared to decrease her anxiety about how she looked. Lilly's ability to place the 'blame' for her distress outside of herself, into her unjust society, appeared to empower her and reinforced our work as it enabled her to be more compassionate towards herself and others in society. In addition it contributed to the development of a more evaluative stance towards events; for her to consider what she thinks of situations in relation to her beliefs and values before leaping to blaming, and shaming, herself.

In addition Lilly's maintenance of a more active and structured lifestyle appeared to improve her self-esteem, motivation and energy levels. Alongside the development of her Mindfulness meditation skills and emotional regulation, Lilly reduced her cannabis intake to weekly or fortnightly, at social gatherings, in line with her original goals. Lilly stated that her success in reducing her cannabis smoking and her increased sense of control over her engagement in this behaviour made her feel better about herself. It seemed that this increased

self belief was triggering a more positive cycle of thoughts, emotions, behaviour and physiology that had typically occurred (Curwen et al., 2000).

Lilly and I developed and maintained a strong therapeutic bond. From the fifth session Lilly had a high level of attendance and punctuality for our sessions, contrasting highly with her history of not engaging with therapy and her difficulty with punctuality in general. Lilly recognised that her reliability and punctuality to the sessions was evidence of her ability to be the same way in the work place. Lilly told me she appreciated the newness of someone trying to help her without demanding things of her that she felt she could not deliver (as was the case when she was being bullied and with past therapists). I believe this was predominantly facilitated by the compassionate and collaborative nature of our relationship as well as my mindfulness of the potentially unhelpful dynamics in the relationship that could have been re-enacted.

As our sessions continued Lilly expressed notably less self attacking language and appeared calmer and more at ease experiencing her internal processes. She also continued to respond quicker to my questions, having less of an 'inner battle' beforehand. Sessions seven to ten were characterised by Lilly being very tearful stating that she felt very sad for herself as a young girl. This shift from anger and hostility to sadness and compassion to herself as a young woman was a significant movement towards her therapeutic goals.

Following our conversations regarding her feminist beliefs Lilly became strikingly animated and assertive in her communication. This was evidenced in her appearance (e.g., straighter posture) and her speech (louder and more assertive). When I reflected this to her she stated that she felt like she had 'woken up'.

6.2.4. Difficulties in the work and use of supervision

Cognitive Behavioural therapists are increasingly recognising the dearth of adequate language in the existing theory to explain the dynamics of the therapeutic relationships (e.g., Miranda and Andersen, 2007; Milton 2008) and so are borrowing terms such as 'transference' from psychodynamic literature. I will use these terms in the following section, as I did in supervision, to explore some of the relational dynamics at play in my work with Lilly.

I fitted Lilly's descriptions of both the bullies at school and her sisters; slim, similar age and 'mainstream' (i.e., not dressing alternatively) and (in the case of her sisters) occupationally successful. I was therefore mindful of the potential for Lilly to experience transferential feelings towards me in relation to these groups of people, both of which could impact the already rife power dynamics in any therapeutic interaction (as discussed by Grant, Townsend, Mills and Cockx, 2008) and trigger feelings of shame and inferiority. I hoped that the genuine compassion that I felt for Lilly alongside my mindfulness of these issues would enable our relationship to develop, and I believe this was the case.

As discussed, at times I also felt a counter-transferential pull towards taking a more authoritative, protective and maternal role with Lilly. I believe that my awareness of this, ability to reflect on it in supervision and continued emphasis of the development of a *collaborative* and not didactic relationship, helped for this dynamic not to be re-enacted. In addition my validation and acceptance that aspects of Lilly's problems were not 'intra-psychic' but interpersonal and societal was different to previous unhelpful dynamics between her and her mother and her previous therapists.

6.2.5. Changes in the formulation and the therapeutic plan

The identification and development of Lilly's feminist beliefs was not planned however the moment that this was illuminated I felt it was an important protective and empowering tool that could be used to move Lilly towards her goals. This was discussed and agreed with my supervisor and added to the therapeutic plan (Appendix O).

6.4. The conclusion and review of therapy (Sessions 16-20)

6.3.1. The therapeutic ending

We constructed a therapeutic document as form of relapse prevention (Westbrook et al., 2007), aiming to remind Lilly of her newly developed skills including mindfulness practice and her compassionate approach to herself. We focussed on structured problem solving for situations in the future (e.g., not getting a job she wanted) with the hope of arming Lilly with skills to face difficult

situations by becoming her own CBT therapist (Beck, Rush, Shaw & Emery, 1979).

We explored the experience of sadness and loss at the end of therapy and discussed the potential for Lilly to continue our therapeutic work once our sessions had ended. We also reminded ourselves of the changes Lilly had made- particularly encapsulated by comparing her first activity schedule to one I asked her to do in the penultimate week of therapy, which was considerably fuller.

6.3.2. Evaluation of the work

I think that my work with Lilly was an effective piece of therapy that illustrated my competence in working within CBT but also my ability to be a reflective and creative practitioner. This alongside a strong therapeutic bond and Lilly's motivation and hard work enabled her to meet her therapeutic goals.

Postle (2003) highlights the importance of support and education, as well as resourcefulness, of the client in relation to their outcome. Lilly arrived at therapy with a University education, the support of her partner and family, and the ability to be financially *recued* by her parents. In agreement with Postle, I believe that these aspects of Lilly's life considerably influenced her processes and the outcomes of our work.

6.3.3. Arrangement for follow-up

It was agreed that whilst Lilly was discharged from the psychology service she remained under the care of her Psychiatrist within the Assessment and Treatment team, whom she was going to continue to meet every 8 weeks to review her medication. Lilly's medication was reduced to 20mg of Citalopram by the end of our work due to her decreased symptoms of low mood. Lilly signed up to a 'mindfulness skills' group being held by another trainee Psychologist within the CMHT starting two months after our ending. Lilly had stated that her previous disengagement in the depression group was due to her interpersonal anxiety. We noted that her engagement in the mindfulness group could illustrate the considerable shift in her interpersonal experiences.

6.3.4. Liaison with other professionals

I wrote an assessment and discharge letter to Lilly's GP[20] and was in regular contact with Lilly's Psychiatrist. I arranged for Lilly to meet with the finance and benefits advisor within the CMHT to discuss her financial issues. I appreciated the range of expertise available to both Lilly and me within the CMHT.

6.3.5. Learning about psychotherapeutic practice and theory.

My work with Lilly re-affirmed to me the potential power of a strong therapeutic alliance. I believe that Lilly's internalisation and modelling of our relationship considerably influenced her therapeutic movement.

I was reminded, once again, when working with Lilly, of the invaluable role of a collaborative case formulation to enable a sense of hope and control (the importance of which are discussed by Snyder et al., (1999) and Frank, (1971) respectively) early on in therapy for both the therapist and the client. I believe my engagement in third wave ideas has significantly enhanced my CBT practice, and continues to inform my challenge, alongside Isabel Clarke (2009), to claims that CBT is a 'monolithic' approach.

Another common criticism of CBT describes it as being purely intra-psychic (e.g., Strong, Lysack and Sutherland, 2008) and thus unfairly placing all the responsibility for change on the client and not society. Lilly's supporting systems (e.g., mother) had promoted an intra-psychic approach to Lilly's experience of bullying. Her internalisation of blame for these experiences illustrates, regardless of intention, how damaging this approach can be. My development of an increasing ecological and community consideration of psychology, advocated by Kagan, (2007) during my training, has led me to be wary of this tendency.

Our compassionate consideration of her experiences of bullying helped Lilly to locate less blame for her experiences within herself and to develop an *acceptance* of a complicated world with inevitable pain. I believe that Lilly's

[20] All communication between me and the GP was copied to Lilly.

position as already *alternative* to society enabled her to feel freer to reject some of its more 'toxic' aspects (e.g., importance placed on beauty) and I was astounded at the empowerment I witnessed in her continued development these feminist ideas. I believe that this provides an example of the richness of creative therapeutic work within CBT.

6.3.6. Learning about myself as a therapist.

Informed by Gilbert's (2010) 'Compassionate Mind' work, my experiences with Lilly have enabled me to articulate my most important therapeutic skill; *my compassion*. I am developing my compassion towards others and myself in personal therapy and in the practice of Mindfulness Meditation. I believe this poignant recognition offers me boundless reflection and development both professionally and personally.

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2.12 Appendices

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Appendix A
Letter of invitation (Version 3)
06.04.2009

Royal Free Hampstead NHS
NHS Trust

Dr Alex Clarke
Research Project
Department of Plastic and Reconstructive Surgery
Royal Free Hampstead NHS Trust
Lawn Road Division
Royal Free Hospital
Pond Street
London NW3 2QG

Date

Dear (Participant)

Re: Research exploring the experience of people adjusting to their appearance following significant weight loss and subsequent removal of excess skin.

The Department of Plastic and Reconstructive Surgery at the Royal Free Hospital is dedicated to carrying out research that will improve the service and treatment of service users.

Fran Smith, a trainee psychologist, who worked in this department from 2006 to 2008, is currently carrying out research, which aims to explore the experiences of people who have lost a significant amount of weight resulting in excess skin and who have undergone plastic surgery to remove this skin.

She is hoping to interview people who have undergone plastic surgery to remove their resulting excess skin following significant weight loss. She is hoping to learn from the experiences of people like you, who have experienced this process, with a view to enhancing our understanding of the experience and informing future care for patients. She has enclosed an information sheet for further details on this research, which includes my contact details if you require any further information.

She is happy to meet with people for the interview either at the Royal Free hospital or at your home (travel expenses to the hospital will be reimbursed). The interview would last no longer than 80 minutes.

If you wish to participate in the interview study, you can register your interest by returning the consent form that is enclosed in this pack. Fran Smith will contact you by telephone within the next month to provide you with more information regarding selection and participation in the interview study.

Please note that if you give *permission to be contacted* on your Form of Interest, then Fran Smith may telephone you within the following month to you to provide you with further information and opportunities for participating in this research project.

You can also contact Fran Smith by telephone or email, to ask any further questions.

Fran Smith email address: **frances.smith.1@city.ac.uk**
Fran Smith telephone number:

I would like to reassure you that your decision not to take part in the study **will not** in any way affect the care you receive from the Department of Plastic and Reconstructive Surgery at the Royal Free Hospital.

Yours sincerely,

Alex Clarke
Consultant Clinical Psychologist
Plastic and Reconstructive Department
Royal Free Hospital

Appendix B (Version 2)
26.08.2009
Information Sheet

Royal Free Hampstead NHS
NHS Trust

Research Project
Department of Plastic and Reconstructive Surgery
Royal Free Hampstead NHS Trust
Lawn Road Division
Royal Free Hospital
Pond Street
London NW3 2QG

Research

Experiencing change in appearance following significant weight loss and removal of excess skin

You are being invited to take part in a research study. Before you decide 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. If there is anything that is not clear or if you would like more information, please contact Fran Smith, the researcher (details provided at the end of this information sheet). Please take time to decide whether or not you wish to take part. Please keep this copy of the information sheet.

Thank you for reading this.

PART 1

Why is this research happening?

Research has shown that significant weight loss can result in excess skin. Some people have this excess skin removed with by a plastic surgery operation called an 'abdominoplasty' or 'tummy tuck'.

To date, no research has explored what it is like to adjust to your change in appearance when you have lost a lot of weight, had excess skin and then had this excess skin removed.

Why have I been invited to take part?

Patients who underwent abdominoplasty surgery at least one year ago are being invited to participate in this research.

Do I have to take part?

Taking part in this research is entirely voluntary. If you want to take part in the research you will be asked to sign two consent forms. One is for you and one for the researcher. The signed consent form will also be photocopied for the Department of Plastic and Reconstructive Surgery at the Royal Free Hospital and kept with your clinical notes, along with a

copy of this information sheet. If you start to take part in the research but then change your mind, you are free to withdraw at any time without giving a reason. A decision not to take part or withdraw at any time will not affect the standard of care you receive from the Department of Plastic and Reconstructive Surgery at the Royal Free Hospital.

What will happen to me if I take part?
If you decide to take part you will have a telephone conversation with the researcher to discuss the research further and have the opportunity to ask any questions you may have and, if you still want to participate, arrange a convenient time and place for the interview to take place. You would meet with the researcher for one in-depth interview about your experiences regarding weight loss, excess skin, abdominoplasty and adjustment to a change in appearance. The questions are not designed to be difficult and there are no right or wrong answers. The researcher is interested in your experiences from your point of view. The interviews will take place in a quiet and private room at the Department of Plastic and Reconstructive Surgery at The Royal Free Hospital at a time convenient to you and your travel expenses will be reimbursed. If you are unable to travel to the hospital alternative arrangements can be made with the researcher. The interview will usually take between 50 and 80 minutes. You are entitled to withdraw from the interview at any point. At the end of the interview you will have an opportunity to ask any questions about the research or anything discussed during the interview.

The interview will be audio-recorded and then written up. When it has been written up the audio recording will be destroyed by the researcher.

When the researcher has analysed the written up transcript of your interview, you will have access to the results of the analysis and the opportunity to provide feedback on this to the researcher. It is your decision whether you choose to read the results or to provide feedback to the researcher. If you did decide to provide feedback the results would be sent to you by email or by post or the results can be discussed over the telephone.

Will participation affect my normal treatment?
Your participation in the research will not be a substitute to your normal treatment or contact with the Department of Plastic and Reconstructive Surgery. If you decide to participate in the research, you are not required to make any changes to your lifestyle or impose particular restrictions on your life. You should continue to follow the medical advice / treatment you have been given by your Plastic Surgeon or GP.

What are the possible disadvantages of taking part?
The disadvantages and risks of taking part in this research are considered to be minimal.
In the unlikely case where you feel distressed (e.g. more tearful than usual, nervous etc) during or following your participation in this research, it is important that you contact Fran Smith (the researcher) with your

concerns. If further support is required then this will be referred by the researcher to Dr Alex Clarke (a Clinical Psychologist at the Department of Plastic and Reconstructive Surgery at the Royal Free Hospital). If you remain concerned or unable to contact the researcher, please contact your GP. Fran Smith's contact details are provided at the end of this information sheet.

What are the possible benefits of taking part?
As already described, no research has explored the experiences of people who had excess skin as a result of weight loss and have had this skin removed. Therefore, taking part in this research will help improve how plastic and reconstructive surgery services and weight loss services understand and support patients' experiences of treatment. In addition, the interview may provide you with a space to reflect on your experiences, which some people find beneficial.

What if there is a problem?
Any concerns, queries or complaints you have about the research will be addressed. The detailed information on this is given in PART 2 of this information sheet.

Confidentiality
All information collected about you during the course of the research will be kept confidential in accordance with the 1998 Data Protection Act and the researcher will abide by the code of ethics outlined by the British Psychological Society. The details are included in PART 2 of this information sheet.

This completes PART 1. If the information in PART 1 has interested you and you are considering giving consent to participate in this research, please read the additional information in PART 2 before making any decisions.

PART 2

What will happen if I don't want to carry on with the research?
If you start to take part in the research but then change you mind, you are free to withdraw at any time without giving a reason. A decision not to take part or withdraw at any time will not affect the standard of care you receive from the Department of Plastic and Reconstructive Surgery at the Royal Free Hospital.

What if there is a problem?
If you have any queries or complaints about any aspects of this research, please contact Fran Smith (the researcher), who will do her best to answer any of your questions in consultation with Dr Jacqui Farrants (Counselling Psychologist and the research supervisor for this project, at City University) and Dr Alex Clarke (Clinical Psychologist at the Department of Plastic and Reconstructive Surgery at the Royal Free

Hospital). Fran Smith's contact details are provided at the end of this information sheet.
If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints procedure. Details can be obtained from the hospital.
City University provides insurance and indemnity to meet the potential legal liability for harm to participants arising from the management and design of this research.

Confidentiality
All information collected about you during the course of the research will be kept strictly confidential in accordance with the 1998 Data Protection Act. Any information about you that leaves the hospital will have your name and any personal information removed so that you cannot be recognised from it. By requirement, the researcher will keep all information related to this research for a maximum of five years. During this time, information will be kept safely, securely and in a format that will not allow for you to be identified. After five years, information will be destroyed by the researcher. In addition the researcher will abide by the code of ethics outlined by the British Psychological Society.

What will happen to me when the research has finished?
The results from the interviews will be analysed, written up as part of a thesis project undertaken by the researcher and possibly published in a peer-reviewed journal. All information and any quotes taken from interviews will be strictly anonymous and will not allow for you to be identified.

You will not be contacted again after participating in this research and your treatment with the Department of Plastic and Reconstructive Surgery will continue as usual.

Can I get feedback about the study?
If you wish to see the results of your analysed interview please contact the researcher, who would welcome any feedback you have on this.
If you wish to gain information about the findings of this research as a whole, please contact Fran Smith (the researcher), who can send you written information once the research is complete.

Who is organising and funding the research?
This research is part of a doctoral research project being carried out independently by Fran Smith, the researcher. The project is part of the researcher's qualification and is not funded or sponsored by the Royal Free Hospital.

Who has reviewed the study?
Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. Your project has been checked by City University's Ethics Committee and a London NHS Trust Research Ethics Committee.

The researcher's contact details

Fran Smith
Trainee Counselling Psychologist
City University
Social Sciences Building
Northampton Square
London
EC1V 0HB
Email: frances.smith.1@city.ac.uk
Tel: xxx xxx xxx xxx

The research supervisor's contact details

Dr Jacqui Farrants
Counselling Psychologist
City University
Social Sciences Building
Northampton Square
London
EC1V 0HB

Email: j.farrants@city.ac.uk

Tel: xxxxxxxxxxx

Thank you for taking the time to read this information sheet.
This is your copy to keep.

Appendix C (Version 2)
06.04.2009
Form of interest

Royal Free Hampstead NHS
NHS Trust

Form of Interest

Research

Experiencing change in appearance following significant weight loss and removal of excess skin

Please read the information leaflet before completing this form of interest

Please tick the box

I am interested in participating in Fran Smith's research about experiences of significant weight loss, including excess skin and abdominoplasty. ☐

I give permission for Fran Smith to contact me by telephone within next month to provide me with further information regarding my participation in this research. ☐

Name: ……

Contact telephone number: ……

Address ……..

……..

Thanks for your interest and participation

Fran Smith (Researcher and Trainee Counselling Psychologist)

Appendix D (Version 2)
06.04.09
Consent Form

Royal Free Hampstead NHS
NHS Trust

Research Project
Department of Plastic and Reconstructive Surgery
Royal Free Hampstead NHS Trust
Lawn Road Division
Royal Free Hospital
Pond Street
London NW3 2QG

Research
Experiences in change in appearance following significant weight loss and removal of excess skin

Please read the information sheet before completing this consent form

	Please initial box
1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above research. I have had the opportunity to consider the information and been given the opportunity to ask questions. I am aware that I may contact the researcher for any further information.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that this interview will be audio-recorded and following the interview it will be written up.	☐
4. I understand that this interview is part of a doctorate research project and that anonymous quotes from my interview may be published in a thesis or article.	☐
5. I understand that any information I provide will be confidential and that all material relating to the research will be stored securely, anonymously computerised and will be destroyed after 5years.	☐
6. I understand that a copy of this consent form and a copy of the Information sheet will be kept with my hospital notes at the Department of Plastic and Reconstructive Surgery at the Royal Free Hospital and will be sent to my GP.	☐
7. I agree to participate in this research	☐

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of researcher	Date	Signature

1 copy for participant; 1 for researcher; 1 photocopy to be kept with the hospital notes

Appendix E (Version 2)
26.08.2009
Demographics Sheet

Royal Free Hampstead NHS
NHS Trust

Fran Smith

Research Project
Department of Plastic and Reconstructive Surgery
Royal Free Hampstead NHS Trust
Lawn Road Division
Royal Free Hospital
Pond Street
London NW3 2QG

About you

Name ……
……

First Part of your postcode: …….. Date of birth: ……

Gender …… Age: …….

Occupation: ……
…….

Family status (please circle):

Married / living with partner
Living alone
Living with relatives / friends

Ethnic background (please circle):

White

British
Irish
Any other white background

Mixed

White & Black Carribean
White & Black African
White & Asian
Any other mixed background

Black or Black British
Caribbean
African
Any other Black
background

Asian or British Asian
Indian
Pakistani
Bangladeshi
Any other Asian
background

Chinese
Any other ethnic group (please
state_

……

I do not wish to answer this
question

Appendix F
Interview Schedule (Version 2)
01.05.2009

Warm-up question

1. How have you been finding recovery from abdominoplasty surgery?

Experiences of abdominoplasty

2. Can you please tell me your experiences of having abdominoplasty surgery?

Example prompts:
What led to you deciding to have this surgery?
What has been the impact of the surgery on how you feel/ think about yourself?
Could you tell me of any impact of the surgery on your relationships?
Could you tell me of any impact of the surgery on your social/ working life?
How do you feel about the outcome of surgery?
How has the surgery affected how you feel about your appearance?
Has anything else changed?
Can you tell me more about that?

Experiences of change in appearance

3. How are you finding adjusting to your changes in appearance since surgery to remove the skin?

Example prompts: How does it feel to have had the excess skin removed?
Are there any parts of looking different that have been difficult?
Are there parts that have been enjoyable?
Is anything different?
How do you feel in your body at the moment?
Can you describe the changes you have seen in the mirror?
What has this experience been like for you?
How have you experienced reactions from others?
What has this felt like for you?

4. What has it been like to adjust to your changes in appearance since you lost the weight?

Example prompts: Are there any parts of looking different that have been difficult?
Are there parts that have been enjoyable?
Can you describe the changes you have seen in the mirror?
How does it feel to look in the mirror now?
Is anything else different?
What does it mean to you to be the weight you are now?
What does it mean to you to look the way you look now?
Could you tell me of any impact this has had on your relationships/ social/ work life?
Has this impacted the way you think/ feel about yourself? – How?
How have you experienced reactions from others?
What has this felt like for you?

Excess skin

5. What was it like to live with excess skin?

Example prompts:

Can you describe to me what it was live in your body with the excess skin.
How did you feel when you were first aware of the skin?
What did your excess skin get you thinking about yourself?
Did your excess skin have an impact on aspects of your life? (e.g., relationships, social life, education, career)
What did it feel like to have excess skin?
What did it mean to you to have excess skin when you lost the weight?

General feelings about appearance

6. How do you feel about your appearance now?

Example Prompts: *Can you describe to me what if is like to live in your body right now?*
What does your current appearance get you thinking about yourself?
Does the way you feel about your appearance now affect your relationships/ social/ other areas of your life?
How do you experience your body now?
How do you feel when you see your body? (in mirror/ bath/ shower)
How do you feel when you picture your body in your mind's eye?
How does that feel in your body?

The entire process

7. Looking back, how do you feel about the whole experience of loosing weight, having excess and having it removed?

8. Where do you see yourself in this process?

Example Prompts: If you could go back what would you say to yourself at the start of this process?
Would anything else have to happen for you to feel that this process is over?
How would you know that you were at the end of this process?

9. Is there anything that we have not talked about that you think is important, or you would like to talk about before we finish?

Appendix G (Version 1)
06.04.2009
Debrief sheet

Royal Free Hampstead NHS
NHS Trust

Fran Smith
Research Project
Department of Plastic and Reconstructive Surgery
Royal Free Hampstead NHS Trust
Lawn Road Division
Royal Free Hospital
Pond Street
London NW3 2QG

Sometimes, after talking about our experiences with somebody, we can find ourselves being more upset than usual and thinking more about the concerns we talked about. Should this happen, please do not hesitate to contact someone for some support.

- You can contact your GP. It is best to discuss your concerns with your GP and they will be able to take further action.

- You can contact the researcher (Fran Smith) who will think, together with you and her supervisor, of the most appropriate local services available to you. If you leave a message on this number, the researcher will call you back: xxxxxxxxxxx

- You can contact Dr Alex Clarke (Consultant Clinical Psychologist and the Plastic Surgery Department of the Royal Free Hospital) to discuss re-referral to the psychology team at the Plastic Surgery Department. xxxx xxx xxxx

- You can contact The Samaritans offer a 24 hour, 7 days a week service for people experiencing distress and despair. Their telephone number is - xxxxxxxxxx

If you ever feel so distressed that you consider causing harm to yourself or to others, go immediately to your GP practice and request an emergency appointment. If you feel this way when the GP practice is not open, go to A and E of your nearest hospital and they will arrange for you to meet with someone.

If you have any further queries please do not hesitate to contact the researcher on the above number.

Yours Sincerely,

Fran Smith

Researcher and Trainee Counselling Psychologist.

Appendix H (Version 1)
06.04.2009
Letter to GP

Royal Free Hampstead NHS
NHS Trust

Fran Smith

Research Project
Department of Plastic and Reconstructive Surgery
Royal Free Hampstead NHS Trust
Lawn Road Division
Royal Free Hospital
Pond Street
London NW3 2QG

Dear Dr XXXXX,

Re: Xxxxx Xxxxx (D.O.B. xx.xx.xxxx)
I am writing to inform you of your patient's involvement in a qualitative research project investigating the experiences of people who have lost significant amounts of weight had have subsequently had their resultant excess skin removed by cosmetic surgery. As part of the research, the above patient will be interviewed by myself. Attached is the 'Information Sheet', providing more detail on the study and a signed consent form from your patient consenting to participate in the research.

If you would like to discuss your patient's participation please contact me on xxxxxxxxxxx.

Yours sincerely

Fran Smith
Researcher and Trainee Counselling Psychologist.

Appendix I.

Points discussed at Riverside Research Ethics Committee Meeting held at Chelsea and Westminster Hospital on 3rd August, 2009.

Four main points were discussed at this meeting:

1. The committee queried how potential participants would be identified, given that observing their rights to confidentiality would mean that no one outside of their care team should access their records. I stated that a psychologist within the department would access their information on my behalf and write to potential participants inviting them to participate in the study.

2. The committee requested clarification on how recently potential participants will have had plastic surgery, given that the minimum time lapse was one year. I stated that I would not invite participants who had undergone the procedure more than two years ago due to the importance of the recency of the experience.

3. The committee queried the number of potential participants that might be eligible to take part. I estimated that there might be 30 – 50 potential eligible participants.

4. The committee queried why I had requested the nationality and ethnicity in the demographics questionnaire. I responded that ethnicity would be useful information with which to describe the population I have interviewed and acknowledged that nationality was not necessary information to include.

Amendments requested following the interview.

1. The committee wrote to me asking me to re-submit the demographics questionnaire using standard NHS format.

2. The committee asked that the question relating to nationality on the demographics questionnaire be removed, due to lack of necessity of information.

3. They also asked me to proof read the participant information sheet and to remove a sentence stating that there would be no use of drugs or divides in the study, as it was not necessary.

I made the above changes and ethical approval was granted. On being granted ethical approval, my Research and Development application at the Royal Free Hospital was then approved and I was permitted to start recruiting participants and collecting data.

Appendix J
Exemplar of stages two and three of analysis process: Table illustrating initial noting and emergent themes on a section of Daisy's interview transcript.

Emergent Themes	Interview Transcript	Initial Noting Normal text – descriptive notes/ *italic text – conceptual notes*/ underlined text – linguistic notes
	What was that like when you first saw it?	
Body as a patchwork doll **De-humanisation of the body** **Anger at post op appearance?** **Anger at not being listened to**	It was like, oh my god patchwork doll. Cos you look like a patchwork, your stitches are all there and it's all bruised. And because I had complications I was swollen on my left side, so it was sort of uneven, so at that point I couldn't really see it, but my belly button I immediately noticed and I was very upset and I was like I can't believe you did this, cos we marked it the second time, and I made sure. Even before with the anaesthetist I said, make sure it is this one, you know.	Shock at seeing her own body after surgery. Use of 'you' not 'i'. *Is this functional - distances self from experience?* Body as patchwork doll. *Body as inanimate object, not human, not living, not her?* Complications in surgery. Worse than expected? Brutality of plastic surgery Asymmetrical appearance attributed to swelling at first Distress at appearance of belly button Disbelief at outcome *Anger at not being listened to?* *Anger about appearance?* Her determination to be clear about it She had certain ideas about where her new belly button would be, felt that she had been clear about it.
	What does it mean to you that it is not even?	
Interpretation of surgical outcome **Only half done** **Questioning importance of self** **Real vs. Imagined perception of self by others** **Assumptions self seen as non sexual by surgeons**	They did it, it's like I am only half done. Was I not worth doing properly? Did I not deserve that? Why didn't they take into consideration... did they not think, did they think 'oh it doesn't matter what she is going t to look like because nobody is going to look at her? I felt a bit like that, oh now, she is not thin, I still wasn't think when I did it, but for me I was really a lot thinner.	Only half done. *She is still applying for more surgery, is this to finish the other half?* Questioning self importance, considering self as viewed as not important by the surgeons. *Viewed not important by the self?* Concept of deservedness. *Shame of obesity, and sense of not deserving surgery?* Assuming that surgeons view her as not sexual/ womanly, that she will not be looked at by others. *Suggestion that our bodies are only there to be seen by others?* Self as not thin. Setting parameters for self and weight 'for me I was...' *How does she think the outcome would have been if she was thin?* Real vs. Imagined thoughts of surgeons? She has obviously

Imagined thoughts of others about self, reflection of own thoughts? Assumed disregards from surgeons **Anger but gratefulness and no regrets**	But it was like oh well its not important, you know she is flabby all over the place anyway, having a flat tummy is like, yeah whatever, it doesn't really matter what she looks like as she is not going to be exposing her body anyway. So i felt a bit like that, so it was a bit like, hang on a minute, you have like marked me more now. I would never regret having the operation though. Never ever regret having it. I am thankful for it everyday.	thought about this a lot. What is the impact of these thoughts on how she feels about herself. Is this what she things about herself? Self seen as flabby all over the place Implication is that Body only important if it will be exposed to others. Self as being 'marked' by surgeons. *Power dynamic Anger?* No regrets about having the surgery. Grateful for the surgery every day – *implies great improvement from how things were.* Ends on a positive note about not regretting and being grateful. Start contrast at the end. *Functional to reassure self that made the right decision?*
	What did it feel like when you, you said when you first saw it you thought patchwork, uneven, what did it feel like for your body , your body to feel like a patchwork, or to look like one?	
Pleased with absence of tummy when removed **Overhang as cloud/ memory/sack** **Acceptance of being viewed as non sexual Acceptance of self as not sexual** **Marked for life** **Anger at appearance of body post**	I was glad that that big huge tummy was gone and I just thought, what's better? To have a huge hanging thing that was like a huge cloud and a memory, a sack of what I had to carry around with you for what? And no I am not going to be exposing my body to the world. So I would rather be a patchwork quilt than having that big tummy. I did look at and think oh patchwork, oh I am marked for life, but I was just really angry that they didn't get it right but my anger was with that. So , yeah,	Pleased that absence of tummy – *relief?* Rationalising what is most important. *Is she convincing herself/me that she does not have regrets?* Skin as 'cloud'. Skin as sack *Skin is dehumanised, externalised* *Skin as memory of obesity?* Accepting that she will not expose body Agreement with imagined thoughts of surgeons. Prefers to be patchwork than sack. *Stuck between two unwanted options?* Dehumanising of body, using inanimate language to describe parts of body and body Marked for life. Is *this just feeling physically marked by surgery, or emotionally?* *Eternal memory of previous body?* Anger *Is her anger also directed in other directions?*

operation		
	Just thinking, how you feel about your body now, do you think how you feel about your body now has an effect on how you are?	
	Yes absolutely, absolutely	Agrees that how she feels about her body has an effect on her in the present
	Does it effect your relationships?	
Concerns about body as isolating Imagined perceptions of self by others Link between psychological wellbeing and appearance Strut or hide - Hidden body or sexual body as two options	Oh my god yeah, I don't think anyone is interested in me whatsoever and I don't, and people say oh did you see him look at you, but no one approaches me so i have to assume that nobody fancies me. Um, you know, I don't know. Umm, no it just a huge effect from the way you get out of bed in the morning, from the way you face your day. You know whether you leave the house that day or not, how you leave the house that day. How you walk up the road, are you going to strut or are you going to hide, are you going to be one of these people who wears all these sacky things. I try not to, I try to , but because I have put on weight, I can't get into lots of things	How she feels on her body has an impact on her relationships in the present. Assumes no one would be interested in her sexually Uses others behaviour to judge what they think of her. Assumes that she is not fancied. Tells me that other people notice men looking at her. *Implies that she does not notice attention she gets* Concerns about body having a huge effect Link between psychological processes and behaviour and emotions. Body effecting how 'you' face the day, your behaviour. Importance of body language. Link between psychological processes and how you hold your body. Link between psychological processes and how people dress *Strut- sexual connotations?* Presenting extremes here – strutting confidently or hiding in shame. Sacky clothes. Role of clothes to hide the body. Tries not to hide body? Does not finish this sentence – why? Put weight on so cannot fit old clothes
	How do you feel when you look in the mirror now	
Self as bad when gained weight Avoidance of considering body in	I think you are bad, because you really need to get that weight off and I think unless you get that weight off they are not going to do that	Self as bad because of weight gain. *Weight being linked to being good or bad person. Shame of obesity?* Sees body and things about what she needs to change about her body when she looks in the mirror *Does not consider the present*

present state **No acceptance of present reflection** **Body as 'not right'**	surgery. Umm, you need to get the weight off. And I think its still not right. I need to exercise so I can get my body shape in a better shape really. If I exercise more, and with weight off you can exercise more.	*body, is this functional?* Orientated towards her body in the future – *not accepting of reflection in the present.* 'need' to get weight off. Not want to but need to. Body as 'still not right'. *What is right?* 'Needs' to exercise. Improvement of body shape desired. She is locating responsibility for her weight within herself and her own behaviour. Exercise positioned as key to weight loss

Appendix K
Exemplar of stage four of analysis: Table illustrating cluster themes from Daisy's interview, with associated emergent themes and quote references.

Cluster themes	Emergent themes	Page/line number
Fear of splitting open following surgery	Fear of 'falling apart' after surgery	26/12
	Negative expectations and fears of scar	26/13
Age and the urgency to 'live' in improved body	Urgency to live now	14/17
	Age as 'another battle'	14/15
	Anxiety regarding ageing process	14/9
	Urgency in improvement of body so can 'live'	14/26
	Disgust at old age	14/12
	Urgency of living life as thin person	30/19
Experience of a chaotic and disconnected system	Disconnected system not supporting holistic needs of service users	36/18
	Confusion with the system	3/13
	Chaos of system	2/19
	Needing to make a fuss to be heard in the system	4/12
Assumptions viewed as not important and not sexual by surgeons	Assumed disregard from surgeons	27/20
	Assumption of negative views of surgeons about self -seen as 'blob'	27/16
	Interpretation of surgical outcome and questioning importance of self	27/7
	Assumptions seen as non-sexual person by surgeons	27/12
	Perceived flippancy of surgeons to self	2/1
	Perceived categorisation by surgeons	24/3
	Perceived treatment as an idiot	3/23
	Assumed views of others about self	12/18
Future focus on continued 'correction' of body	Continued need for surgery	2/4

	Focus on body in future following more changes	23/13
	Extra things that need to go	17/4
	Hope for future surgery	2/17
	Body needing correction	1/17
Disempowered passive position of the NHS plastic surgery patient	Disempowered and disrespected position of plastic surgery patient	24/10 25/22
	Passive position in body change	1/25
	Metaphorically and literally 'left hanging'	3/1
	Frustration of passivity of position	2/28
	Disempowered position	1/25
	Difficulty of uncertainty	3/11
	Male nurse taking control of her experience of post surgical body	26/1 26/18
	Waiting game- passivity of process	2/24 2/8
	Not-knowing-others withholding information about her body	24/10
Disgust and difficulty of living with the 'tyre'	Being dragged down by the tyre	9/5
	Un-cleanliness of overhang and associated shame	21/1
	Obsessional concern of cleanliness of overhang	11/9
	Hyper vigilance of others seeing tyre	9/20
	Disgust at overhang	17/16
	Overhang as sack/cloud/memory	28/6
	Feeling amazing...but-disappointment of tyre	9/2
	Impossibility of hiding tyre and public shame of body	9/6 9/22
	Tyre holding back experience of increased energy post weight loss	9/2
	Please with absence of tummy when removed	28/4
	Shame of associations between obesity/overhang and poor hygiene	11/16
Need for psychological insight and support throughout process	Need for psychological understanding and support in weight loss	3/21
	Wants more emphasis on psychological processes	3/29
	Recognition of cognition as a problem	14/4

	Medicalised and pathologised view of psychological problem	3/30 32/10
	Advice for improvement of service	34/16 32/14
	Eating as emotional problem	33/10
	Need for counselling	32/14
	Search for understanding of food issue	32/26
	Link between psychological wellbeing and attractiveness acknowledged	29/2
Brutality and butchery of plastic surgery	Brutality of plastic surgery	24/5 25/25
	Self as meat that is butchered in plastic surgery	24/5 23/29
Practical and celebrated improvements from removal of tyre	Relief and Physical sense of 'lightening' when thinks of removal	16/25
	Enormity of positive impact of removal	16/26
	Continued celebration of new size post removal	18/6
	Feeling more normal after removal	18/20
	Acknowledgement of feeling somewhat improved	29/22
	Unexpected positives celebrated	10/10
	Removal of tyre-removed some of public shame	10/15
Continued battle for control with weight and food	Permanent and cyclical relationship of weight and difficulties in life	13/14
	Food as emotional problem	13/22
	Continued struggle with weight	2/11
	Continued wish to be smaller	7/6
	Centrality of weight issue	23/15
	Negative cycle of overeating	
	Ongoing 'fight with food	19/20
	Self as 'bad' when overweight	29/15
	Current weight gain's negative impact on sense of self	30/3
	Fear of returning to old body	30/9
Conflict of motivations for surgery- comfort vs. vanity	Conflict with motivations for removal	15/1 10/7
	Shame around vanity and plastic surgery	14/27
	Secrecy (and shame?) around plastic surgery	13/3
	Importance of comfort and 'looking alright'	36/14

Continued adjustment and distortion of body size and shape	Distorted sense of new body size	18/10 17/22
	Continued surprise at new body size	18/3
	Continued attempts to hide tyre although removed	16/14
Embodied change	Change in body size and change in how body is held	19/4
	Change in body- change in 'persona'	19/3
Splitting of asymmetrical body	Split view of scar- love and hate	1/22 13/7
	Asymmetrical new body	1/18
	Elation and disappointment with scar	15/17
	Physical relationships with loved part of scar	15/19
Frustration with society's lack of understanding of the seriousness of this experience	Frustrating with society's perceived belittling of experience	3/4
	Desperation for systems to understand seriousness of experience	16/27
	Global lack of understanding	33/4
	Highlighting importance of experience	33/26 34/20 34/18
	Frustration of process not being taken seriously	33/29
	Frustration of other service users not taking it seriously	34/1 34/10
	Sense of being only one taking it seriously	34/5 34/13
	Despair at lack of understanding of systemic nature of problem	34/6 34/4
Conflict and variation in caring about how others think about self	When thinner do not care as much about what others think	17/16 20/21
	Conflict- caring vs. Not caring what others think	20/22
	How appears to others- fore fronted	22/30
Imagined experience of others assumed as real	Assumed others staring at her 'tyre'	9/20
	Character split between focussing on self and on how others focus on self	12/13

	Assumed interest in what she eats	20/1
	Imagined vs. Real thoughts of others	20/6 27/13 32/4
Focus on external and avoidance of internal processes	Focus on external and avoidance of internal processes	22/16
De-humanising the body- self and others	Depersonalisation of 'hanging flesh'	11/24 8/11
	Objectified body as 'it'	1/20
	Body as piece of flesh	23/30
	Perceived dehumanisation by surgeon	24/4
	Surgeons as brains	24/30
	Dehumanised Body as patchwork doll	26/21 28/12
Patchwork body as non-sexual and unfeminine	Body as unfeminine	9/14
	Body as patchwork doll	26/21
	Absence of sexuality in new asymmetrical body	9/14
	'only half done'	27/7
	Marked for life	28/14
	Acceptance as non sexual body	28/9
	Self as unattractive	22/30
Isolating process	Others not understanding	31/4
	Weight loss in the way of friendships and shared experience	20/14
	Concerns about appearance as isolating	28/23
Hope to end 'life long nightmare' of body	Body as lifelong nightmare	6/21
	Desire to stop hiding and accept body	15/5-8
Link between size and ability to accept self	Obesity as barrier life achievements	31/20
	Shame and rejection in obesity	31/1 31/30 32/3
	When thinner-more able to accept body	29/26
A hidden body	Shame of revealed hidden body	16/2
	Hidden body as blob	16/4
	44 Ability to hide arms and breasts- private shame	
Mistrust of others	Immediate suspicious of motives of others	21/10

	Difficulty believing compliments	21/1 22/4 23/2
	Shock and mistrust of others finding her sexually attractive	21/17
	Mistrust of motivations of surgeons	25/4
Perceived increased notice-ability as a woman since weight loss	Weight loss and perceived increase in notice-ability of self	20/28
	Previous avoidance of peoples eyes	21/12
	Panic and being found sexually attractive	21/12
	Now interpreting being noticed as positive	21/21
Non acceptance of current body	Non acceptance of surgical outcome and current reflection	15/23
	Avoidance of considering body in its present state	29/14
	Daily disappointment of surgical result	13/9
Disconnection from body in surgery experience	Split from body's surgical experience	26/3
	Others attempts to reconnect her to her body after surgery	26/3
	Avoidance of scar	26/6
	Disconnection with body	13/14
Anger at not being listened to and taken seriously	Anger at not being listened to and taken seriously by surgeons	27/3 30/27
	Anger at appearance post op	28/15
	Anger at system and self	30/23
	Anger at peoples blindness to this issue	35/6
Sensations as triggers for self disgust	Physical awareness of lump triggering self disgust	11/6
	Skin touching skin	11/29
Being sexual or invisible as options for woman	Strut or hide – hidden or sexual body as options	29/5
Compassion for obese people	Compassion for obese people	6/19
Functional narrative	Discusses anger but grateful and no regrets	27/21

Appendix L.
Exemplar of stage six of analysis: Table illustrating super ordinate themes, cluster themes for individual participants and relevant quotes and line and page references for these quotes.

Super-ordinate themes	**Cluster themes**	**Participant**	**Quote (page/line number)**
Continued shame of hidden body; assumed lack of acceptance from others	Sadness that still misses out through hiding body	Edana	Because of my thighs, I can't go in a swimming pool. I put shorts you know but it still doesn't feel comfortable do you understand. So it's upsetting you know some things. But they are not going to go back. It's sad, nobody can see me. I used to enjoy swimming very much. 19/16
	Anxiety about others seeing present body	Babette	R: What do you think they might think if they did see [your body]? B: What on earth has she got there? Oh so I thought I will just say I am pregnant. That will be easy, I will be accepted then. So I hadn't started to wear really small clothes, I still had me big clothes cause I thought if I still have me big clothes people wouldn't see the skin flapping around. 19/16
	Happy in body when in clothes- not when naked	Abi	I would say I am a hundred percent happy with how I look when I am clothed. I am not as happy when I am undressed and um, although I can get passed that because there is no one that really sees me undressed anyway. 5/6
	A hidden body	Daisy	Everything I put on there was this hanging tyre, you know boobs you can put into a bra and pull up, saggy arms, no way am I exposing them, which I haven't done ever, you know, your legs are all saggy and I was like, oh my god, reality. I am doing all this and I feel bloody awful. I look awful. I don't feel sexy, I don't feel like a woman, like I should feel. 9/ 5
	Public shame of	Callie	I bent down to get the milk out of the fridge and two of the

	exposed hidden body		technicians were standing at the door and its wasn't until I went to pick the milk up and I noticed something here and I thought it was my hair and as I have looked down I have noticed that it wasn't, it was my wrinkly boobs and they were standing there looking and never said a word. I have got to face them every day now and the minute I look at them I see my boobs, that will never go...and I was adamant that is not funny, that is humiliating. Do it at home and there is no one to see that hasn't seen it before but at work, that is, you know, you think, oh they've gone away and I bet they are talking to everyone else now, 33/15
	Hidden clothed body and private shame	Callie	But it was afterwards when you stand up and you put certain clothes on. One side will stick out and one side doesn't. So again you have to hide with what you are wearing. 6/4 C: Callie, Even now, if he [husband] was to open the door to the bathroom, he'd think nothing of the way I look now but I would break his nose with the door with the way I slam it. You know it does cause problems. R: So after the apronectomy it means a lot for... C: Yeah because its exposed other areas... yeah, yeah, that I couldn't see because it was under my stomach. 16/7
	Imagined vs. Real experien ce of others	Daisy Callie	Yeah, well I am sure that there is this part of us that turns into this kind of dual character, split personality thing, where you are almost talking to yourself. You are almost thinking for other people 'well that's what they think'. Well [inaudible] you could think nothing of them but the presumption is 'oh yeah they're

			judging me, they are thinking this and they are thinking that'...12/13 C: It may be that people don't notice. It maybe that I assume, because I have to look at it [excess skin] every day, that they can see it but worse, because its new to them. It's not to me but it's still a shock R: What do you think they might think if they saw it? C: Gross R: Gross? C: Yeah, yeah, gross. It's not smooth hanging skin, its horrible hanging skin. Callie 12/25
	Fear of non acceptance and disgust from others at body	Gabby	R: What are you thinking other people might think? G: Just looking at how disgusting I am. How disgusting. But when people know me like my partner now, he knows what kind of, I know it sounds like a bit of a cliché but what's inside. 38/15
	Resolution of eternally hidden body and associated grief	Gabby	I accept it. I have seen it lot worse. You know that's me. But I am not confident enough for other people to accept it. You know, umm, yeah. But we wear clothes every day, when would you not? I am not going to be running along a beach in a bikini. You know I wouldn't. I wouldn't have done that when I was big, I won't do it now, even after my surgery. I think even if I looked perfect I wouldn't do it now. Because I have lost that kind of umm, I have still got inhibitions. I have lost that kind of freedom if you see what I mean. But I have put that on myself. 37/2
	Conflict of caring vs. not caring what others think	Callie Daisy	I don't, I don't take any notice at all. I find it funny. When they say 'oh you haven't lost any weight, you are still overweight' I find it funny. I don't get depressed. Cos I think if you were as big as I was, mmm. I am happy even

			though I am over [pause]. I don't do slim slim slim. I never have done. 22/26 Once I had lost some weight, when I was feeling good, I didn't give a damn. People that knew me, I didn't really give a damn. People that didn't know me didn't know so there was no difference any way. It was just the fact that I noticed people looking at me a lot more but I don't know why. 20/22
	Avoidance of intimate relationships for fear of non acceptance of body	Edana	R: What do you imagine somebody might think? E: I don't, I am a monster and I am cut into pieces. Maybe they make funny comments. I don't think I could accept, do you understand. 24/15
	Deep concern of impact that her disgusting body might have on those who see it	Edana	E: I don't think I would allow anyone to see it (current body). To tell you the truth, it's not fair for the other people because other people on the beach will be sick. R: You think other people might have been sick if they saw it? E: Yeah, I think so, or it would put them off you know, something. So I had to avoid you know any public, going to the swimming pool. You know, London, you go to swimming. I don't go. People say maybe you wear some shorts or something you will be ok. No, because I don't want to upset the other people. Not because I would be upset if somebody see me but I think they would be upset. It's much work for people. If they see me it might put them off, do you see? I don't think it's very fair....some people I don't know, it's like they can't take it [seeing

			her body]. I can't take it. For example, if I saw somebody like that coming and I was normal, I don't think I could take it. I would be the same you see. 16/27
	Assumptions and meaning making that viewed as not important or sexual by surgeons	Daisy	What does it mean to you that it is not even? They did it, it's like I am only half done. Was I not worth doing properly? Did I not deserve that? Why didn't they take into consideration....did they not think, did they think 'oh it doesn't matter what she is going to look like because nobody is going to look at her? I felt a bit like that, oh now she is not thin, I still wasn't thin when I did it but for me I really was a lot thinner. But it was like, 'oh well it's not important', you know, 'she is flabby all over the place anyway, having a flat tummy is like, yea whatever, it doesn't really matter what she looks like as she is not going to be exposing her body anyway' 27/5

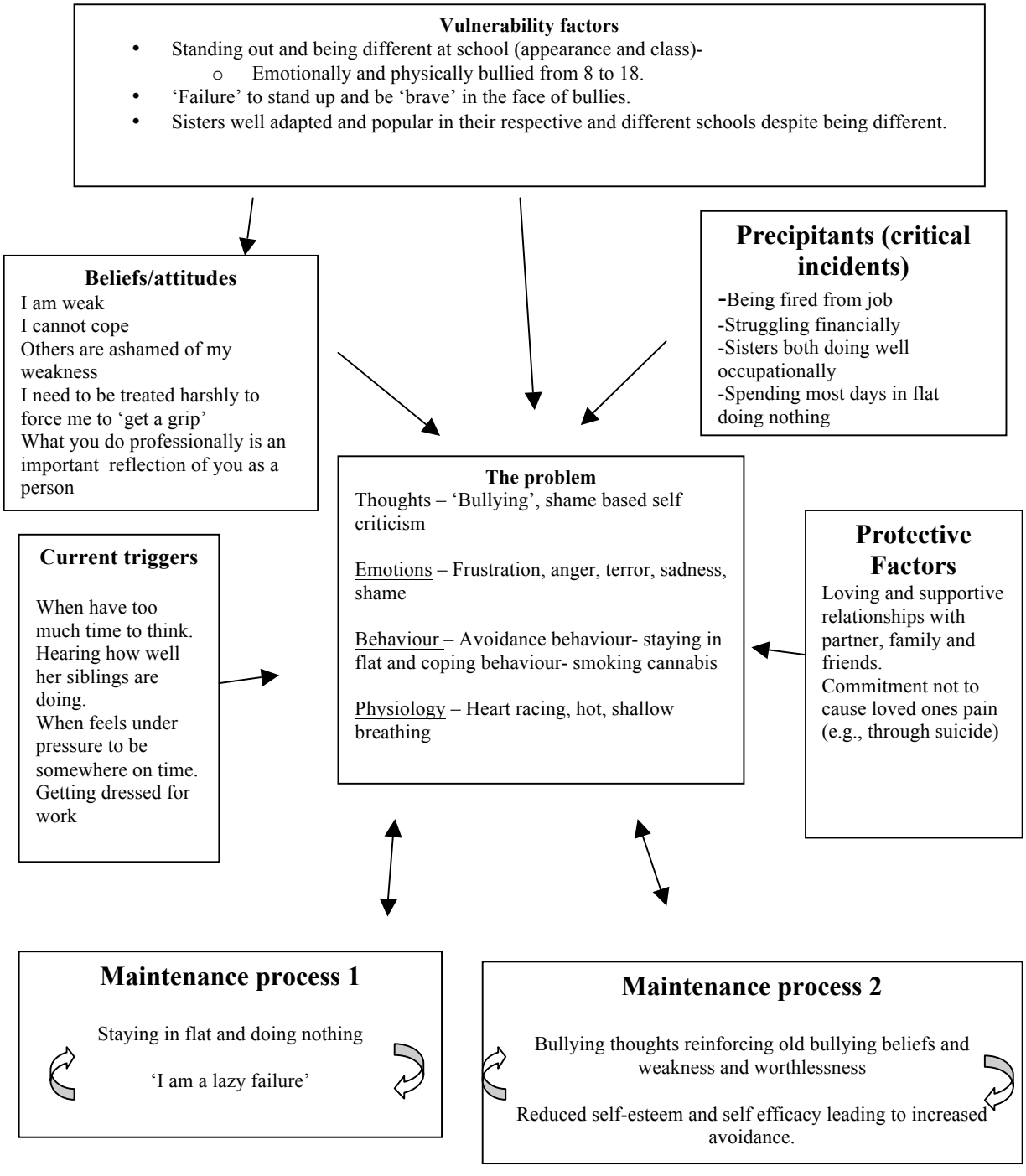
Appendix M

Appearance of themes for each participant

Themes	Participants who display this theme
DESTABILISED EMBODIMENT	All participants
1. Self acceptance in continued flux	All participants
Lack of self acceptance; the future focussed body	All participants
Continued shame of hidden body; assumed lack of acceptance from others	6/8 (all but Habiba and Fae)
Continued 'battle' with weight	7/8 (all but Edana)
Continued shock at different body	3/8 (Gabby, Daisy, Babette)
Body as butchered but functional	All participants
Continuation vs. Transformed of self	All participants
Hope and disappointment	All participants
Connection and disconnection	All participants
2. Past turbulent experiences of embodied existence	All participants
Shame and denial of body in obesity	All participants
Increased awareness of body by self and others in weight loss	All participants
Removed overhang as disgusting barrier to living new life	All participants
Motivational conflict and disempowered position of the plastic surgery patient	All participants

Appendix N

Collaborative Formulation (based on version by Westbrook, Kennerly and Kirk, 2007).



Therapeutic Goals and Aims

- Increase repertoire of coping mechanism for her anxiety and low mood
- Decrease engagement in coping mechanisms which fuel the 'bullying thoughts' (e.g., cannabis smoking)
- Move from 'self-critical' thinking towards a more compassionate approach to the self (increasing self-esteem).
- Increase Lilly's (perceived) ability to meet the requirements of full time employment

Appendix O

Lilly's Therapeutic Plan

Beginning stages of therapy (1-5)

- Formulation of the development and maintenance of Lilly's problem (Curwen, Palmer and Ruddle; Westbrook, Kennerly and Kirk, 2007; Persons and Davidson, 2002)

- Develop strong, trusting and collaborative therapeutic alliance (Gilbert and Leahy, 2007).

- Psycho-Educate regarding depression (Beck, 1979) and generalised anxiety (Wells,1997)

- Socialise Lilly to the cognitive behaviour therapy model (Addis and Carpenter, 2000)

- Introduce concept of compassion (Gilbert, 2009)

- Increase Lilly's daily activity (Leahy and Holland, 2000)

- Identifying and naming self-critical thoughts (Gilbert, 2009)

Middle stages of therapy (6-15)

- Psycho educate, model and develop Mindfulness skills (Kabat-Zinn, 2003)

- Continue to monitor and increase daily activity

- Explore and elucidate metacognitive beliefs (Gilbert, 2009; Harvey, Watkins, Mansell, & Shafran, 2004).

- Differentiating between compassionate and self critical thinking and development of alternative 'compassionate' thinking and behaviour towards the self (Gilbert, 2009)

- *(Added following conversation about feminism with Lilly-session 6) Development of Lilly's feminist identity- both cognitively (articulating her values (Hayes, 2004) and beliefs and examining how these could provide*

alternative helpful thoughts) and behaviourally (joining feminist activist group with friend)

- *Reduction of cannabis use with development of emotional regulation using daily Mindfulness Meditation and Mindful walking (Kabat-Zinn, 2003))*

End stage of therapy (16-20)

- Relapse prevention (Westbrook et al., 2007)

- Formation of therapy document as 'blueprint' to refer to in future (Beck, 1995).

- Consolidation of all the techniques developed and maintenance of new changes she has made.

Appendix C. Situation level 'Hot Cross Bun' formulation from 5th session (constructed prior to presented segment).

