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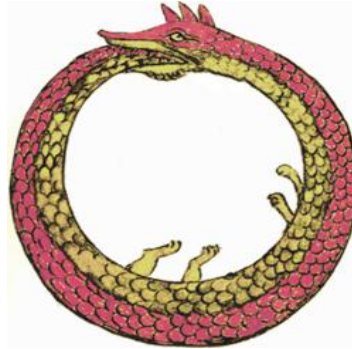
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Narcissistic Vulnerabilities Experienced within the Processes of Change and Development.

OUROBOROS



Author: Elizabeth Meg Camm

Thesis submitted in partial fulfilment of the requirements for the
award of

Doctorate in Counselling Psychology

At

City University

Department of Psychology (School of Social Sciences)

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DECLARATION

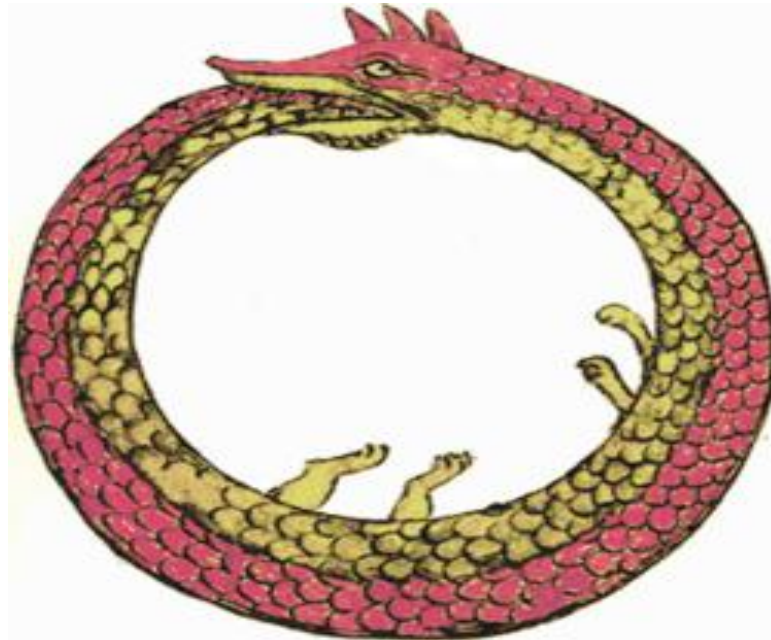
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FOREWORD:

Narcissistic Vulnerabilities Experienced within the Processes of Change and Development.

OUROBOROS



Drawing by Theodoros Pelecanos, in alchemical tract titled Synosius (1478).

The Ouroboros expressed the paradoxical nature of the individuation process through the symbol of the Ouroboros, the snake that eats its own tail (Jung, 1968).

Ouroboros is a symbolic metaphor depicting the process of individuation as a circular self-contained process (Schwartz-Salant, 1986). The Ouroboros often represents self-reflexivity, or cyclicity, especially when referring to something constantly re-creating itself. The way individuals reflect on themselves and re-create, whether from within or without, have within themselves a partially conscious image of how they want to be seen. Jacoby (1994) refers to this as an 'ego-ideal'. Depending on the needs of the 'ego-ideal', we respond to them in narcissistic self-absorbing or narcissistic self-actualizing ways.

My motivation to use this metaphor of Ouroboros was because it reflects all the struggles and triumphs experienced by the individuals in the client study, critical literature review and research study, illustrating how the different spectrums of narcissism can be understood and utilized.

This thesis comprises of sections: **A:** Preface; **B:** Client Study; **C:** Critical Literature Review; **D:** Research Study. They are set out in the temporal order of completion. I wrote the client study at the beginning of my 3rd year as a trainee counseling psychologist; and the critical literature review was the last piece of work in my 3rd year. The research study followed seven years later. Although the client study and review have been updated, I still feel that these pieces of work reflect my growing understanding of narcissism and its presentation - not only in the client and participant's but also in me. Underpinning all three pieces of work are the subtle interactions of the different spectrums of narcissism unraveling and evolving within the intersubjective space between us.

A: The preface provides an overview of each component of the thesis as well as how the various components of the Portfolio are inter-related with the concept of narcissism.

B: The case study illustrates the slow development of trust within the therapeutic relationship when working with a client with dual diagnoses of Generalized Anxiety Disorder and Narcissistic Personality Disorder. Therapy with this client took place within the context of his high managerial position in a very competitive organization within the international environment where displaying 'narcissistic behavior' is rewarded. As his therapist, challenges to my way of working was firstly, in identifying the tensions between self-absorbing and self-actualizing narcissism that were maintaining Phil's unmanageable levels of anxiety. Secondly, to find ways of working with both concepts and feelings that were in tension with one another that were also in the client's best interests.

C: The critical literature review examines the nature of counter-transference experienced by myself as a 3rd year trainee as a result of a critical incident in the workplace. Available literature on counter-transference is reviewed; the unconscious processes involved, as well as available empirical studies on countertransference as experienced by qualified therapists and trainee therapists.

D: The research study explored how women in midlife experienced facial ageing and facial rejuvenation within a 'culture of narcissism'. The study aimed to explore in-depth phenomenological experiences of a 'non-clinical' sample of women who chose to undergo facial rejuvenation cosmetic surgery and/or procedures and were satisfied with the results. Interpretative Phenomenological Analysis was chosen as this approach enabled participants to express the meaning this experience held for them. As the researcher I engaged with these reflections with the intention of hermeneutically understanding the meanings this act held for them. The findings revealed interplay between external facial appearance and internal intra-psychic phenomenon maintaining a repetitive cycle of self-conscious emotions such as shame and pride. The thesis concludes with the argument that the concepts of shame, pride/vanity and shame are circular in nature and integral aspects of facial ageing and rejuvenation for most of these women. It concludes with a chapter on Validity, Limitations, Building-on the Research, and Relevance to Counselling Psychology.

Section A: Preface

This section outlines the development of this portfolio from its beginning to its end. It reflects the interface between counselling psychology, midlife and the different spectrums of narcissism. Justification for each piece of work is also discussed.

Jung (1968) arguing from a psychoanalytic perspective, maintained that the central task in the process of individuation is to recognize and integrate a personal re-evaluation of opposites. In order to do this, he believed in the value of recognizing and accepting the parts we don't like about ourselves i.e. negative or shadow, as well as positive parts of our personality.

Narcissism was chosen as the main theme because in relation to 'being' it can be used in positive or negative ways (Jung, 1968., Benjamin, 1996). There has also been a recent surge of interest in narcissism among psychologists, both researcher and clinicians, in studying different meanings attached to it, e.g. as a personality disorder; an aspect of personality structure, as a psychological defense mechanism; as normal self-interest; as pride; cultures of narcissism with its values of consumerism, and self-gratification (Sokolova, 2009). Hence there is value in studying it further within the context of cosmetic surgery to understand these women's choices to change their aging appearance.

Jung also argued that midlife is the prime time for conscious integration of opposites in personality to occur, hence midlife can be period of individual transformation. The individuals involved in Sections B, C, & D were in the different stages of midlife and dealing with challenges facing them during this age-related transition period within their own different contexts. All manifested different aspects of narcissism during this period of adjustment and change, as will be identified and discussed within each section.

Case Study

Jung (1968) believed we are so busy doing and achieving that we have lost touch with our inner life. Phil¹, (the client of this study) presented in such a manner as described by Jung. His sense of self, or identity, appeared to be

¹ Name has been changed to protect identification

largely determined through his ability to be busy and successful at work, solving difficult problems and coping with heavy workloads. He came for therapy because he was between different positions at work and had little work to do. This reality left him in a constant state of high levels of anxiety accompanied by panic attacks that seemed to him to come out of the blue. He was confused and felt he had lost touch with his inner life. This client study drew my attention to the inter relationship between loss of identity attached to status, anxiety and narcissistic types of behaviour that were maintaining his anxiety. It also highlighted challenges facing therapists (myself in this instance) when working with clients who have narcissistic vulnerabilities originating in childhood (Kohut, 1971). Phil defended against his childhood vulnerabilities attached to his fears of not being perfect by identification with his identity of being the 'whizz kid.' The dominant role of his envy, which is a defensive structure of narcissism (Lowen, 1997) was illustrated when giving generous gifts to his subordinates who had done well – while at the same time his inner 'envious' self of their success remained a secret to others. This envy revealed hidden aspects of himself that was attached to his fears that no one could ever care enough for him (Schwartz-Salant, 1986). In Phil's case, the Ouroboros self-absorbing narcissistic aspect was resisting transformation and eating itself (metaphorically a circular self-absorbing state).

When one side of the self structure (the self-absorbing in this case) dominates, fusion of opposites cannot take place (Jung, 1968). In understanding what was underpinning Phil's anxiety and self-absorbing state, psychoanalytic theory integrated with cognitive behavioural therapy and cognitive analytic theory was used with this client. The integrative approach was informative as it shed light on understanding narcissistic behaviour as a defense against a poor sense of self identity.

This case make it possible for me to gain new knowledge and insight about clients who are enormously successful in their working lives while at the same time feel quite empty inside. I was also attracted to writing about this client because when self-absorbing narcissism causes distress therapy can offer the opportunity for this suffering to become the route towards new self-awareness. This does not mean that the shadow or negative aspects of self disappear but rather learning develops to accept the shadow side to ourselves.

In summary, the client study describes working with a client with a narcissistic personality disorder who works and lives within the Western 'narcissistic culture' that rewards narcissistic behaviour. As a trainee, I narcissistically invested in my ego to learn to develop particular integrative knowledge and skills needed when working with someone like Phil to empower him to carry both these positive and negative aspects of himself while responding to life in a positive way (Schwartz-Salant, 1986).

Critical Literature Review:

Countertransference: Narcissistic Vulnerabilities within the Therapeutic Milieu.

There remains long-standing disagreement over the actual clarity about the meaning of the term countertransference ever since Freud's initial mention of it in 1910. Back then it was treated like a 'poor cousin' in the sense that very little attention was given to it in comparison to attention given to transference. However since the late 1970s researches have begun to re-look at the meaning of this phenomenon clinically as well as empirically (Rosenberger & Hayes, 2002).

Understanding of the concept of countertransference is essential as failures in the countertransference and transference relationship can lead to destructive working alliances and can be chronically eroding - especially when the transference and countertransference reactions are so strong that it overwhelms the participants present. So, according to Joseph (1985) the therapist 'acts out' the client's transference fantasies. Here the concept of projective identification and the strength of feelings that accompany it, lead to a growing understanding of how countertransference is elicited by the client in the therapist (Feldman, 1997).

In America, countertransference has become largely subsumed in the 'relational turn' where the therapeutic relationship is understood as being co-constructed by the client and the therapist. However, if the therapist lacks experience and skills in the management of these intense feelings, the situation cannot be appropriately controlled (Clarkson, 2003).

Therefore, it is important to be able to distinguish between what is the patient's transference and what is your countertransference as the therapist, as these two dynamics clearly impact on the therapeutic relationship and are fundamental to therapeutic practice outcomes (Clarkson, 2003). This developing awareness is a challenge to trainee therapists as countertransference is largely an unconscious experience (Singer & Luborsky, 1977). Therefore, as a trainee therapist, it is essential to be able and willing to learn; refine and develop skills; increase depths of self-awareness and consciousness of the processes of development within these relationships, and, to utilize reactive countertransference for the benefit of the client within the therapeutic relationship (Clarkson, 2003).

Motivation for this critical literature review on countertransference was for several important reasons. In the first instance, it is very difficult to define and operationalize as it is largely unconscious (Singer & Luborsky, 1977). Thus the review identifies any progress that has been achieved in uncovering the elusive nature of the concept of countertransference. Secondly, it remains an empirically elusive phenomenon because of this lack of clarity (Rosenberger & Hayes, 2002). Hence the review identifies available research studies identifying different concepts of countertransference specifically in relation to trainees' abilities in recognizing it. Thirdly, as it is deemed to be of central importance to client outcomes (Hofsess & Tracey, 2010), I have included as a learning device a personal experience of countertransference as it occurred within a therapeutic milieu to identify and understand therapists' (both qualified and trainee status) experience of countertransference.

In summary, this critical literature review identifies available literature on countertransference reactions and psychological defenses, such as narcissism, used to manage these reactions. The literature review also looks at the wider context of countertransference and transference originating within a group session and continuing outside of the session within the therapeutic milieu.

Research Study

The research study takes an in-depth look at a sample of women in midlife and their lived experiences' of shame that underlie vanity and/or pride related feelings and activities within a 'narcissistic culture'. Appropriate to the research study is Carl Jung's notions of the archetype Ouroboros, as a dramatic circulatory process and symbol for the integration and assimilation of the opposite, i.e. of the shadow. The outer informs the inner and the inner informs the outer (Eskenazi & Streep, 2007). So everything depends upon the consciousness of the individual for growth and re-creating ones self to occur.

Accusations of vanity and narcissism are perhaps true when associated with cosmetic surgery and are useful constructs to refer to when clarifying the degree to which they are experienced. This is pertinent in the light of the sample of women being identified as 'non-clinical.' The narcissism continuum stretches between normal self-interest such as feeling good about oneself (non-clinical), even when other people are being critical; and to self-defeating narcissism as in needing constant support from other people in order to maintain one's feelings of well-being (Nevid, Rathus, & Greene, 2008). According to literature, vanity as a behavior can be placed anywhere along this continuum.

While the concept of Ouroboros is relevant to the research study, I could not resist including the fairy tale of Snow White as this too has relevance. As a young child I remember feeling sorry for Snow White, as she seemed defenseless against the horrible wicked queen. Now that I am in 'midlife' I see the 'Queen's' struggles in a new light and identify with her sadness (not her murderous anger) associated with losing one's physical appearance of youth. Fairy tales mirror real life and the psychosocial developmental task facing the Queen is that of 'middle age'. It is a timeless story of intergenerational socialization where the extreme stereotypical views of young and old portray the tensions of opposites. The opposite positions are: the desirability of youth on the one end; and the undesirability of ageing on the other (Bettelheim, 1976). Snow White, as the main protagonist reflects the psychology of the unselfconsciousness of youth. The "Queen" reflects self-conscious narcissistic struggles and vain

attempts to maintain her youthful status, as her external appearance matters.

The essence of struggling to face the limited realities in midlife, while at the same time living longer and healthier lives, is complicated by an individual's lack of awareness of what these realities means for themselves. According to Jung (1968), this is conscious neglect to avoid confronting difficult or shameful elements of the inner self that developed earlier. Jung referred to these shameful elements as 'shadow' aspects of the self. In this thesis, symbols, ancient fairy tales and contemporary psychology join together in portraying the developmental tasks confronting women in midlife (Chinen, 1987).

While young women have cosmetic surgery to improve to maintain their looks, older women reject their ageing face in favour of a younger one. There is an important role for Counselling Psychology to play here as older women who want their faces rejuvenated can, through engagement with pre-operative counseling, discover the reasons for their own rejection that underpins their conscious choice of wanting to look younger or better. Counseling psychologists can offer women pre and post-operative counseling so that their transformational change and adjustment is both externally and internally experienced.

I have embarked on this portfolio of study to add to psychological understandings of the various ways in which we appear to ourselves and to others in the world; how this is coped with, and whether it leads to change or not. Its intention is to contribute to the practice of counselling psychology in an ever changing, diverse and competitive western world. There is also an important role in the dissemination of knowledge gained from the findings to allied professionals and to mass media popular psychologies to help prepare those who are contemplating such changes to the self.

I would like to end this preface with the thought that 'the narcissist', is identified in the Diagnostic and Statistical Manual No 4 Text Revision (DSM-1V-TR) (2000) as displaying certain personality characteristics. However, '*who is the narcissist*' is always a moving target. To illustrate: Pitts-Taylor (2007) posits that in Hollywood, women who do not have facial

cosmetic surgery are accused of narcissism for wanting to draw attention to themselves. While those who have facial cosmetic surgery fit into the 'normal' category. On the other hand, in the UK there is the general assumption that those who have facial cosmetic surgery are the narcissists. The one thing we can be sure of is that we live in a changing world and it behoves us as psychologists to remain informed of these psycho-social and cultural changes that affect so many lives.

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Section B: Case Study

Title: Narcissistic Defenses within the Therapeutic Relationship

List of Abbreviations used

CAT = Cognitive Analytic Therapy

CB = Cognitive Behaviour/al

CBT = Cognitive Behavioural Therapy

CFO = Chief Financial Officer

DSM = Diagnostic & Statistical Manual

GAF = Global Assessment of Functioning

NPD = Narcissistic Personality Disorder

SSSD = Self States Sequential Diagram

Narcissistic Defenses within the Therapeutic Relationship

1 INTRODUCTION

There were several reasons why I chose to present this particular client study. All of these reasons relate to the challenges Phil's presentation posed to me as a trainee psychologist. The context I am referring to was my trainee status and Phil's complex presentation of having a dual diagnosis of generalized anxiety disorder and narcissistic personality disorder. His dual diagnosis challenged my abilities to make connections with the interaction of symptoms between these two disorders. It also presented particular challenges of working with transference and counter-transference reactions that were related to narcissistic defenses of both the client and myself as the therapist.

Given Phil's complex and unique presentation the working alliance needed to be flexible and tailored to his particular needs. What I have learned in my training is that there is no theoretical approach that can be used in the same way for all clients. Whereas an integrative style is more flexible and accessible for clients where the strengths of different systems are assimilated and accommodated into applicable principles and practices for that client. (Palmer, Dainow & Milner, 1996) For instance, the 'there and then' of transference and counter-transference can be dealt with alongside the 'here and now' of cognitive behavioural therapy (Clarkson, 2003-2007). This gives the client the benefit of the integration of different models strengths while at the same time issues from the past can be identified.

In writing down my experiences with this particular client I hope other counseling psychology trainees in this type of situation will embrace experiences of working with narcissistic defenses as opportunities for personal and professional growth during their training period. This is because as trainees we have to learn how to hold the tension between narcissistic vulnerabilities attached to our professional insecurities while at the same time being able to challenge clients in a confident and constructive manner as part of our preparation as qualified Counselling Psychologists.

1.1 Theoretical orientation

My integrative theoretical framework and interventions were predominantly Psychodynamic integrated with Cognitive Behavioural Therapy (CBT) techniques for the management of specific symptoms of anxiety; and a

Cognitive Analytic Therapy (CAT) model used in the termination stage as a visual means for increasing the client's insight and identifying ways in which he could utilize adaptive behavioural changes. The intention of integration was to take advantage of the strengths of each orientation to meet the client's needs at that particular stage of therapy (Hollanders, 2003., Clarkson, 2003).

The first mode of assessment and intervention was Cognitive Behavioural (CB), as the client's presenting problems (**Appendix B1**) required immediate management of incapacitating symptomatic anxiety (Roth & Fonagy, 1996; Hawton, Salkovskis, Kirk, and Clark, 1989). CB interventions were used in a coherent way best suited for the process of Phil's growth in giving him practical tools in changing his anxiety driven responses and panic attacks (Hollanders, 2003). Symptom reduction and behaviour changes as reported by the client, and observed by myself, were clearly evident by the 8th session. During the 9th session the client requested more sessions as he wanted to explore some of his childhood experiences that continued to 'bother' him.

The 10th session became a turning point in therapy in terms of sharing painful childhood memories associated with his experiences of his mother's needs for a perfect son and linking the consequences of narcissistic vulnerabilities (early narcissistic wounding when failing to reach high standards of performance) with his current functioning in the workplace and at home. At this stage in therapy the integration of psychodynamic understandings became crucial in linking his past experiences with his responses and interactions to current situations.

The psychodynamic approach recognizes that many problems in social relationships stem from one's early childhood experiences (Benjamin, 1996). This approach enables clients to understand and explore how these experiences, originating in childhood, are carried forward to their current situations, and to recognize the nature of anxiety linked to psychological defenses. These defenses developed as coping strategies in childhood against threat/s to their sense of self identity. For instance, a psychological defense in narcissistic disturbance, such as 'perfectionism', is said to develop in childhood as a protective response against anxiety associated with fear of not being 'good enough' (Benjamin, 1996). This is attached to the fear of failing to meet parental expectations of high standards. These defenses become maladaptive when taken forward into adulthood and re-enacted in relation to others e.g. authority figures. Consequently from a psychoanalytic understanding, as a defense

against possible failure, there is a tendency to be egocentric with singular emotional concentration on the self and self-gratification for e.g. by taking advantage of materials and goods offered by institutions (Sokolova, 2009).

As a way to understanding the links between the past (there and then) in childhood experiences with the present (here and now), Malan (1979) visually formulated these concepts as triangles. The benefit of these two concepts meant that they could be used in short term psychodynamic clinical treatment (20 sessions). The first triangle, 'Triangle of Persons' demonstrates how the relationships of the past, current relationships and the therapeutic relationship, parallel one another in terms of core relational themes. The second 'Triangle of Conflict' depicts the intra-psychic interplay between underlying emotions, anxiety and defensive operations that serve to contain affects and modulate the derivative anxiety.

As an example of the triangle of conflict in Phil's case: At one corner of the triangle there is the *hidden impulse* of underlying anxiety (for fear of failing, or not being the best) for which Phil may be conscious or unconscious of; another corner represents the *here and now* as in being insensitive (defense) to what others may need by focusing on his needs only e.g. in the workplace the expectation of admiration and constant care-giving from all those at work in order to boost his self-esteem; and in the opposite corner there is the *there and then* when these fears (emotions) and expectations arose in childhood for having to be the perfect child (Benjamin, 1996). These diagrammatic triangles are used in therapy as tools for increasing understanding and insight that are needed to accompany new ways of thinking about themselves and in relation to others (Malan, 1979., Molnos, 1995).

The CAT model used in Phil's case is a tried and tested modified version of the "Self States Sequential Diagram" (SSSD), a tool developed by Ryle (Ryle, 1995, Beard, Marlowe & Ryle, 1990) that is implemented as part of the reformulation. The application of CAT was in the termination stages of therapy when we were looking at constructive outcomes, strategies and skills required to maintain change and relapse prevention (Culley & Bond, 2007). CAT strategies were closely supervised by my supervisor who is a Chartered Counselling Psychologist, a qualified CAT analyst and a registered psychotherapist. Additional summarized information on CAT is provided on **Appendix B2**.

Drawing on an integrative approach to therapy allowed more flexibility with treatment interventions for this particular client and his circumstances. For example, CBT like psychodynamic theory contend that origins of faulty evaluations and behaviour or psychological defenses arise from early childhood experiences, however the nature of interventions each approach uses may differ (Beck, 1976; Benjamin, 1996). For example, psychodynamic work explores the meaning of early experiences in order to gain insight into them (Benjamin, 1997). Psychoanalytic theory proposes that psychological damage occurring in early in childhood results in disordered personality structure formation and therefore these problems can remain deeply rooted within the psyche (Molnos, 1995). The difference in psychodynamic intervention strategies to CBT is that the former aims to increase insight by identifying earliest emotional experiences focusing on what was lacking, or overdone, or what came at the wrong time leading to particular types of psychological defenses (Benjamin, 1996). Therefore new insights facilitate a deeper understanding of how problems that arose in childhood are being re-enacted in adulthood. This insight facilitates the propensity for adaptive change to some personality structures (Kernberg, 1984).

Whereas, CB contends that behaviours are learned. Thus CB treatment focuses on ways to challenge these faulty evaluating thought patterns and behaviours and to modify or adopt new adaptive behaviours (Hawton, Salkovskis, Kirk, & Clarke, 1989., Trower, Casey & Dryden, 1988).

CAT actually combines these two theoretical approaches by using a visual diagram of origins in childhood, consequences in adulthood and exit points to change old patterns of responding to more adaptive ways in the present (Ryle, 1995). Homework provides a bridge between sessions and is used to enhance and reinforce motivation to change. It is used in both CBT & CAT to put into practice the new skills learned (Trower, Casey & Dryden 1988, Ryle, 1995).

These integrative psychological interventions are not hierarchical but were combined according to guiding principles so that the associated counselling skills were purposefully and consistently used. Choice of techniques varied with each problem *content* brought to the sessions and the *process* or dynamics of the counselling relationship in terms of working together and what was happening between client and therapist (Culley & Bond, 2007).

1.2 Context for the work

Phil was allocated to me during my final year as a counseling psychologist trainee in the private clinic where I work. The procedure at this clinic is for intake officers to do the initial assessment and then refer the client on to the appropriate therapist.

1.3 Referral

Over the past 18 months Phil had become increasingly anxious about almost everything. His worry occupied so much of his time that he could not remember tasks he had to do and had become indecisive. Phil said these worrying thoughts occurred at the strangest times and when least expected e.g. at the gym. Also when asleep he would wake up worrying. He noticed his mood had been labile and found himself “filling up with tears”. Even though he was very successful at work, his worries centered on not achieving further. He felt he was ‘running on empty’. In addition, he believed his wife did not love him enough despite their stable marriage. There were no incidents or trauma in his recent or distant past that he perceived could have caused such worry in the present. He requested CBT treatment for his anxiety.

1.4 Convening the first session

Appearance, behavior and speech:

Phil, 39 year old business man, married with three children. He entered the room in a confident manner and with an engaging smile offered his hand to shake mine and spoke in a loud voice. He was of average height and weight, dressed for his first session in a silver suit, black shoes, and a lime green shirt with red braces. After the initial greeting, without invitation he sat down in the chair furthest away from where I was standing. My immediate emotional response was of pleasant surprise and then my professional side took over and I made a mental note of his entrance and appearance and what meaning it may have once I had more information about this client.

Precipitants: Brief description of anxiety and related problems and mood:

Phil spoke eloquently maintaining good eye contact and expanded on his presenting problems regarding his work situation. He described himself as being trapped in a prison of worry and indecisiveness. He felt life was passing him by

and he had nothing to look forward to anymore. He felt despondent and dejected because he could not understand nor control his anxiety which he felt had been escalating over the past year since the boss told him he would be promoted to Chief Financial Officer (C.F.O)². Symptoms of anxiety included: For the past six months he worried 24 hours around the clock with thoughts centering on work performance, on being a failure; of believing others thought he was a failure; very restless at night with early morning wakening with the same thoughts in his head; irritable most of the time at home; poor concentration; headaches; easily fatigued; and some weight loss. He said that not being able to overcome his anxiety left him feeling low in mood i.e. feeling sad and at times tearful. I did not detect any outward evidence of overt anxiety except perhaps for his rather fast paced speech and earnest tone.

Previous psychological counselling:

At this point he also volunteered to tell me that he had been in therapy a couple of times before but could not remember the duration or the therapist's names. I did not have any strong feelings about that at the time.

History:

In the process of discussing his presenting problem, Phil spoke about other areas in his life such as: childhood, school, family life, work and work relationships plus his relationship with his wife. I found this information very useful in building up a picture of Phil's unique understanding of his world and problems.

Family History and its interpersonal relationships: (genogram, **Appendix B3**)

Phil's maternal grandmother is 82. Originally from Zimbabwe married at 16 years of age and at 18 years of age gave birth to his mother, with a brother following 2 years later. She left her husband shortly after her son was born. She never had time for Phil's mother and sent her off to a convent at 4 years of age only bringing her back home after her second marriage. All her affections went to her son whom she thought the world of, and still does. Mother and grandmother still have a conflictual relationship and Phil says his mother lives

² Status changed for anonymity reasons

for the day when her mother will say “she loves her”. He says he cannot understand this “obsession” she has about her mother and why she just cannot forget about it. Phil’s father, 65, is a retired Director of a large company. Phil described him as a saint never showing anger and always being in control of his emotions. Mother is 64, a natural worrier, the perfect mother and wife. Phil was her favourite wonderful child and she would do, and still does, everything for him. During childhood and adolescence he excelled academically. His mother would be ecstatically happy and proud of him when he came home with excellent results and he would feel wonderful. But if he was naughty or did not do well at something she would punish him by hitting him, crying and then hugging him saying she loved him. He recalled an incident when his mother came to fetch him from school when he was 9 years old and drove the car over his foot. He screamed in pain and she got out the car and screamed accusations at him for making her drive over his foot, slapped him across the face and then hugged him. Phil used to feel awful when she punished him and experienced a crushing feeling of having let her down. Even to this day he fears upsetting her and dreads her visits to his home with her domineering manner and criticism. At the same time he says she is not very bright and he has to be careful not to discuss anything that may be beyond her grasp as it will threaten her.

Developmental Milestones:

All Phil could remember of his early development was that he sucked his thumb until he was 5 years of age. A broken thumb terminated that habit. Otherwise his developmental milestones were described as normal. He described his childhood and adolescence as extremely happy.

Education:

Phil was sent to boarding school from the age of 12 years. On arriving there he remembers hearing the other boys talking about their families and divorce. He immediately wrote to his parents asking them not to get divorced. They telexed back saying that they would never do this and would always be there for him. Phil could not remember any feelings attached to this event and he settled down to do well academically at boarding school. Phil discovered that through achievements at school he gained popularity with his peer group and the teachers and so tried harder and improved with each year. However, he never

made any real friends at school staying on the periphery of groups. During the holidays at home would prefer to spend his time with his mother. This pattern continued until he went to university.

Academic background and Occupation:

Phil was awarded with an under-graduate degree from university. He then started out in the competitive field of banking³ with lots of enthusiasm and was so good at solving problems and finding solutions that he was known as the “whizz kid”. He loved the admiration and approval he received. A few days earlier to his therapy appointment he had presented two young employees with a new car each for their hard work and he had to fight back his tears. He recognized that he longed for this type of attention that he had given them as no one called him a “whizz kid” anymore. From the commencement of his career, his goal was to become the Chief Financial Officer (C.F.O.). At the time of this assessment he was due promotion to this post. His relationship with the current C.F.O., who was also his friend, was strained because he felt the promotion was slow in taking place and he could not broach the subject for fear of causing a strain in their relationship. As C.F.O. he would be expected to maintain the company’s progress and he constantly ruminated about failing in this, even though he knew no one could do it as well as him. He feared failing because “one is rejected when you do”. Phil avoided conflict situations in the workplace and rather than delegating work did the job himself - but only providing he was sure he could do it successfully. In his managerial role he handled sub-ordinates mistakes by re-doing the work in front of them as he could not tolerate fools.

Psychosexual background:

Psychosexually Phil had his first experience at the age of 16 years with his mother’s best friend. He smiled when he recalled the incident and said he enjoyed it. Phil started dating females when he went to university and on a couple of occasions got trapped into relationships he did not want. He just wanted to have sex with them but they wanted engagement. In his marriage he has committed adultery on a few occasions and described these affairs as intense but brief. None of them mattered to him except for one ideal “love” relationship with a younger woman. There was never a sexual side to their

³The nature of business has been changed to ‘banking’ to conceal the real nature of his work.

relationship but after a year she wanted him to leave his wife for her and so he just walked away from the relationship without any explanations. He said he felt quite guilty about that.

Financial Status:

Socio-economically he is extremely well off with 3 houses and 3 cars. His favourite car is his Ferrari.

Marriage:

Phil is married and they have three young children of whom he is very proud. He met his wife when he was 25 years of age and introduced her to his mother. Mother immediately liked her and said he should marry her. So he did. Although Phil wanted to marry her he still feels resentful about his mother interference. He did not give a spontaneous empathic account of his wife and their present relationship. Their conflict is handled by saying awful things to each other then sulking and not talking to each other for the rest of the day. The following day they behave as if there had been no conflict. He thinks she does not love him because when he is successful at something at work she does not appear impressed.

1.5 Assessment & Formulation

As mentioned earlier, the initial CBT work focused on the management and reduction of anxiety and a CBT formulation is included on **appendix B1**.

However, the section of work covered in this study focuses on the work done after the 9th session which was mainly psychodynamic and exploratory. A provisional psychodynamic formulation was completed after the 10th session which is on **appendix B4**. I have provided a fairly detailed provisional psychodynamic assessment and formulation according to the criteria as identified in the DSM-1V-R for two reasons.

Integrative therapists Rowen (1983) and Clarkson (1987) both caution against using a diagnosis as a primary form of assessment in psychotherapy in case it gets in the way of relating to people. I concur with this attitude and believe that great caution and consideration to the client's history should be given before a diagnosis of personality disorder is made. Consequently the DSM psychiatric diagnostic criteria are not referred to during the development of a therapeutic

relationship with the client and their problem. The relationship focuses more on being with client in an empathic way (Basch, 1983). This is how I approached this client in the first 9 sessions however by then I had become aware of Phil's fixed patterns of thinking, feeling and behaving that were not in his best interests.

These enduring patterns of relating to himself and others pointed to early childhood damage which is typical of personality disorders. In the light of the above cautions about using a personality disorder, making of an Axis 11 diagnosis was not taken lightly and is explained in more detail as follows:

By the 8th session enduring particular ways of relating, especially in terms of splitting phenomenon into either or categories, were noted in Phil's interpersonal style. Also evident was his vulnerability and proneness to withdraw (by not attending the next session) after seemingly gentle confrontation (discussion on the commitment to attend all sessions). There was also Phil's account of his mother's mothering where his mother was determined that Phil, unlike her, would have all things better than she did. He said he was the centre of her life and it was as though his mother was resolving her own disappointments in her life with her mother by centering on Phil to "have it all". I turned to consult the DSM diagnostic criteria in order to make sense of Phil's apparently long standing patterns of behavior and relating. It was important and necessary to turn to the DSM-1V-R classification criteria to make sure that the pathology I experienced in Phil was not a result of vulnerabilities and imperfections, strong points and weak points that we all possess. I needed to assess whether his thoughts and feelings connected to emptiness, and his behaviours towards others that were insensitive, were in fact driven by false pride arising from early narcissistic wounds. These findings are also importance as they inform the choice of treatment interventions. Appendices **B4 & B5** provide evidence for an Axis 11 diagnosis of Narcissistic Personality Disorder.

Another motivation related to the characteristic of Narcissus, the mythological figure, who was preoccupied with efforts to retain his inflated self-esteem by honing in on acts of self-perfection (Steiner, 2006). These characteristics symbolically appeared to fit the interpersonal style of Phil's. Criteria for qualification as an Axis 11 personality is dependent upon being able to demonstrate the linking of interpersonal history to interpersonal patterns characteristic of the disorder (Benjamin, 1996). Evidence in Phil's presentation

was the intergenerational pattern of passing on narcissistic behaviours through the generations from maternal grandmother's to Phil's mother. It can only be hypothesized that Phil's mother may have internalized that maternal love is not unconditional and in response to that Phil's mother became insecure, insensitive and domineering. It can be further hypothesized that passing these insecurities onto Phil, he too internalized these verbal and nonverbal messages from his mother and developed narcissistic vulnerabilities in the process. This in turn translated into strong desires to overachieve, tendency to perfectionism in order to overcome insecurities (fear of failure or not being the best) and emotional emptiness (McBride, 2008).

1.6 In summary: Motivation for referring to the DSM-1V-RT

"The essential feature of narcissistic personality disorder is a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins by early adulthood and is present in a variety of contexts." (DSM-1V-RT, p 714)

Within the therapy room Phil demonstrated by words, thoughts and actions a constant need for admiration and a lack of empathy towards others. According to psychodynamic theories of narcissism, this personality type typically develops during early childhood when a parent/s over-idealize their young children and place unrealistic demands upon them (Otway & Vignoles, 2006) It is a system that is fueled by feelings of shame and hubristic pride (Tracy et al., 2009). Based on Phil's accounts of childhood experiences of his mother's expectations he always had to be the best in whatever he did. This pattern continued into adulthood predisposing him to high levels of performance related anxiety and panic attacks, hence his request for therapy. In childhood Phil's mother (Phil alleged) was always contradictory in her responses to his efforts of trying to be successful. It wasn't his efforts she rewarded. She did this by saying he was wonderful, that she loved him and then he got a cuddle. When he did not coming first, then he was awful, she became angry with him and then followed this with a kiss and cuddle. These contradictory responses to Phil's accomplishments seem to have contributed to the development of a narcissistic personality that is characterized by a fragile and defensive self-esteem (extremely sensitive to injury from criticism or defeat) and dissociated internal and external self-representations as illustrated above (Kernberg, 1975., Kohut, 1971).

An integrative framework is built from the many different views of the 'self' as evident in the different genres in psychological literature. For instance, Kohut, a self psychologist, argued that narcissism is a normal adult attribute and is manifested in the mature person as humor, wisdom and empathy. Pathological narcissism in the adult is the result of pre-Oedipal structural deficits in the self that came from deficiencies (lack of empathic mothering) in the developmental experience (1971). Kernberg on the other hand believed that pathological narcissism represents a defense against paranoid projection of rage. According to Kernberg, narcissistic grandiosity and lack of empathy for others are consequences of the pathological projective process in infancy and childhood (1984). Thus, it was necessary to take all these aspects of narcissism within the integrative framework used with this client study.

Taking into account all the information collated during history taking, and from sessions content and process, connections were made between Phil's interpersonal history and his symptoms as listed in the DSM-1V-RT. There are 9 listed criteria for qualifying for this disorder and Phil met 7 of these. A minimum requirement for this disorder is to meet any 5 of the criteria listed (717).

And finally to complete this additional section on motivation for Axis 11 disorders is Benjamin's (1996) summary of a narcissistic personality disorder which has a strong resemblance to Phil's ways of relating:

"There is extreme vulnerability to criticism or being ignored, together with a strong wish for love, support, and admiring deference from others. The baseline position involves non-contingent love of self and presumptive control of others. If the support is withdrawn, or if there is any evidence of lack of perfection, the self-concept degrades to severe self-criticism. Totally lacking in empathy, these persons treat others with contempt, and hold the self above and beyond the fray."
(Benjamin, 1996. P 148)

Multiaxial Assessment DSM-1V-TR (2000)

Phil's provisional diagnosis was as follows:

Axis 1	Generalized Anxiety Disorder	Code: 300.02
Axis 11	Narcissistic Personality Disorder	Code: 301.81
Axis 111	N/A	
Axis 1V	Psychosocial and Environmental problems: Occupational Problems - delayed promotion; reactions to psychosocial stressors e.g. difficulty in concentrating after arguments with his wife	
Axis V	On admission GAF = 51 moderate difficulties in home, social and work functioning 27th session GAF = 80 symptoms transient and expectable	

(Diagnostic criteria for 301.81 NPD – appendix B5)

1.7 Contract and Treatment issues:

Phil came for therapy to address physical and psychological problems associated with his anxiety. We contracted for 12 sessions using CBT to address anxiety related to these specific problems. These sessions included reviews of progress every fourth session. How the terms of the contract changed will be described under the development of sessions.

2. DEVELOPMENT OF SESSIONS

At the time of writing this report Phil had attended 27 sessions. This case study will cover significant content and process issues presented during the pre-engagement, engagement, and working towards termination phases. I shall also focus on narcissistic vulnerabilities of the client and myself as trainee counselling psychologist. These issues in no way negate the importance of other issues presented and dealt with during the totality of therapy processes.

The pre-engagement phase commenced at the first session and continued through to the 9th session. The content of these beginning stages encompassed identifying the specific events and problems relating to Phil's generalized anxiety with its cognitive, physical, affective, occupational and social dimensions. The use of CBT principles and strategies as outlined in

Hawton, Salkovskis, Kirk & Clarke (1989) were extremely effective as aids to understanding Phil's problems and techniques for interventions.

The detailed assessment of each problem also enabled Phil's self-awareness and self-understanding of his presenting problems to be developed. For example while assessing his anxieties about not achieving at work other issues such as his avoidance behaviours; beliefs about the causes of his problems; and, understanding of the attitudes and behaviours of others were also identified. Information identified that while waiting for the promised promotion his work flow had almost ceased. At the same time the young and upwardly mobile employees under his management were achieving and receiving praise and recognition for their work. He felt "trapped in a prison" with feelings of envy towards the youngsters "I miss not being the king pin"; frustration towards his boss for not dealing with the issue of his overdue promotion; and fear of rejection if he spoke to his boss regarding this while at the same time fear of failure if he got the promotion.

This information supported the central notion in the CB model that it was not the events *per se* but rather Phil's expectations and interpretations of these events which were responsible for the production of negative emotions such as his anxiety, frustration, envy and anger (Hawton, et al. 1989). In terms of personality structure and psychodynamic understandings, his narcissistic vulnerabilities also informed me of Phil's high levels of anxiety elicited when not receiving admiration and praise for achievements. As with Narcissus, Phil came across as preoccupied with efforts to retain his self-estimate and to hone his 'self-perfection' in any environment that rewarded such behaviour.

In this first session of CBT the delayed promotion was the first issue to be addressed. We identified and reality tested unhelpful cognitions which were underlying his repeated negative patterns of emotions and avoidance behavior that maintained high levels of anxiety (Greenberger & Padesky, 1995). In developing and testing more adaptive cognitions we role played assertive behaviours that would give rise to a more positive experience of himself and the boss when he went to speak to him regarding his delayed promotion. Whilst his anxiety would be high on approaching his boss, once he started the conversation he believed his anxieties would be reduced to more manageable levels. This in turn would improve his confidence.

By the second session Phil had already spoken to his manager and arrangements had been made for the promotion to take place. Phil was so impressed with his success in dealing with this issue that he launched into identifying the ways in which he was inclined to catastrophize issues when in conflict with his wife. In sessions 3 - 5 anxieties, unassertive behaviour and causes for these were identified. Such as the need to be perfect, the fear of failure, and avoidance of conflict. All these were in relation to his mother and wife because of not wanting to upset them. Phil addressed some of these current events by acting in assertive ways. Progress in therapy appeared to be wonderful and Phil went bouncing off on a two week holiday. However salutations to me at the 6th session on his return caused me to reflect more cautiously on his progress and my professional development in this therapeutic relationship. He greeted me with "Well, did you miss me?" and taking me by surprise I answered "yes" before thinking about a more appropriate response.

After the session as I reflected on the process I recognized that in empathizing with my client I had over-identified with his need to be admired and validated. I could have rather said that I was pleased to see him because that was the truth. There is general agreement that identification is involved in empathy (Beres, Jacob & Arlow, 1974). They argue that there are two distinguishing features to empathy. Applying this argument to the therapist it is firstly transient identification which leads to awareness e.g. "This is what Phil may be feeling". And secondly, the empathizer preserves his separateness from the object in order to respond in a manner that is appropriate to the transference observation. If the therapist (myself in this instance) does not recognize what the client is trying to provoke in the therapist (admiration for perfection), then empathy has failed and counter-transference takes over (Beres, et al. 1974).

Then (with valid reasons of being very busy at work) he missed the next two sessions. The 8th session's content focused on his need to be less fearful and more assertive with his mother as well as being shocked to receive feedback from his wife saying he was not very understanding of other people's problems. We addressed both these issues using ABC forms which identify activating events, beliefs and thoughts, plus emotional and behavioural consequences of the beliefs and thoughts (Trower, et al. 1988).

Then he cancelled the next session. I was irritated by his missed appointments and felt powerless to deal with them because of his 'valid' excuses. This made

me anxious and insecure about my capabilities of being a “good enough” therapist. But I knew that unless I raised the issue, the therapy would be in danger of terminating prematurely (Welt, 1990). During the 9th session I hesitantly (I was still nursing my narcissistic vulnerability as a trainee needing to be the perfect therapist) raised the issue of missed appointments. He looked down on me and said “In reality I won’t always be able to keep all appointments” Verbally his tone was dismissive and contemptuous. His non-verbal communication displayed power i.e. sitting on the chair facing me he crossed his leg over so as to put a barrier up between us while he stretched one of his arms up and by opening his fingers pressed against the wall. Deutsch (1952) reported similar observations in his studies of the posture patients assume on the analytic couch. In fact after the session I positioned myself in the same posture to try and experience the affective state Phil’s action had captured. I felt the power of having the wall as support but at the same time realized that anyone could easily destabilize me by knocking my hand. This was the beginning of my empathic understanding, as my experience of needing the wall for support, symbolically mirrored Phil’s need for objects (human or otherwise) to constantly support him.

The importance of empathic understanding when working with narcissistically vulnerable clients has been underscored by Basch (1983). Basch maintains that empathic understanding lays the groundwork for trust and a less defensive stance in the client. London (1985) supports this notion and describes narcissistic personality disorders as being vulnerable patients who are exquisitely sensitive to misunderstanding, slights or disappointments and may respond to the therapist’s apparent misunderstandings by withdrawing with subsequent loss of meaningful contact with them. He goes on to argue that analytic processes can unfold only if a stable treatment relationship is established.

Towards the end of this 9th session, Phil requested more session as he wanted to get “to the bottom” of his anxieties. We contracted for a further 20 sessions which could be open to review, plus review of progress every 4 weeks. We also contracted around the issues of new goals as identified by himself. These were: his dependency on admiration; and, his difficulty in receiving criticism in the work place and at home. This contract also included shifting from “pure” CBT to

incorporate more psychodynamic work. This type of therapy was explained to my client and he agreed to proceed.

2.1 Engagement

I have chosen this point of the 10th session as the engagement phase because it appeared to herald in the beginning of Phil getting in touch with his 'imperfect' side. It also indicated that he had shifted from blaming external factors to focusing on internal issues. Similarly it heralded a period of self-reflection for myself as student, as I started to feel I was not good enough for this client and his problems.

The 11th session dealt with the re-emergence of Phil's worry, inability to concentrate, indecisiveness and interrupted sleep patterns. He felt he was running on empty. He explored his fear of failure and his need for approval from others. There was also the realization that this fear was preventing him from being all that he could be. I was puzzled at this re-emergence of almost the same types of anxieties that Phil presented at the beginning of therapy and it really shook my confidence.

With the reappearance of Phil's anxieties, I realized that a parallel process could occur within me by not being aware of my own narcissistic vulnerabilities as a trainee. I felt that this fear of not being a competent or perfect therapist for Phil could hamper my effectiveness within the therapeutic relationship (Welt, 1990). I decided to take these issues to supervision as I was also puzzled by the re-emergence of Phil's anxieties again and my own feelings of having 'failed' him as his anxieties had returned.

2.2. Making use of supervision

Supervision has been incredibly important for me with this case and I have learnt two important lessons. Firstly, my supervisor's ability to display empathic understanding towards me enabled me to experience empathic validation of my narcissistically based concerns. Secondly, this modeling enabled me to look at my defenses around my ego development as a therapist (Hawkins & Shohet, 2005). It demonstrated to me that this process of transient empathy and mobilization to act on the client's behalf is possible. I continued with my own education and found that, because personality disorders involve 'faulty' personality structures with damage occurring in childhood, realistically improved

self-esteem takes a long time to achieve in therapy. Behaviour is easier to change in a short period of time compared to personality structure changes that take years to change (Benjamin, 1996). I found comfort in Derksen (1995) who posits that a therapist must often be content with providing a limited contribution to improving the problems and assume that in time the patient will ask for help once again. He also notes that with narcissistic disorders, therapists very quickly end up in a role in which he/she is expected to help regulate the patient's self-esteem i.e. I was expected to valid his competencies and 'make' him feel good about himself.

The narcissistic vulnerabilities of the therapist immediately play a role here as it did with Phil's transference onto me of not feeling good enough, as he went back to his memories of childhood traumas. Derksen (1995) notes that feelings of anxiety evoked in a therapist by a personality disordered patient can be so strong that she/he can start to react defensively i.e. I became hesitant to challenge him when it was indicated, as I was afraid of making a mistake and he would get angry with me. Urdang (2009) writes that students need guidance in becoming aware of how their own feelings, attitudes, and relationships with clients are major factors in the helping process. In fact, helping others is in itself a process. She argues that students are generally idealistic, and wish to ease suffering without understanding the obstacles to be overcome, nor how they themselves would be involved in the process. By sharing these experiences with my supervisor I have identified that my feelings of anxiety, irritation and defensiveness are also elicitors for becoming aware of patient dynamics that evoke relational aspects of my need to be a good therapist (Welt, 1990). Guy (1987) noted that this is also a common experience of trainees, as realistically they are not competent in all areas of work. He also comments on therapists as 'being wounded' previously and that is why this work is attractive to those who want to 'rescue' others as it is a means (unconscious at first) to rescue the self (Guy). These were the issues I could take to supervision but deeper issues relating to my personality and personal life were kept for personal therapy.

My supervisor also gave me positive feedback at this point in understanding Phil's return to therapy was because he felt safe enough with me to work on a deeper level. She felt it could also be attributed to the fact that I had not responded to his verbal attack about attendance in a defensive manner. So by

not rejecting for his contemptuous behaviour this seemed to have increased his trust in our relationship.

It was at this point in supervision that my supervisor suggested that we draw on the CAT reformulation sequential diagram to categorize Phil's dilemmas (Ryle, 1995). She felt that this diagram could provide Phil with a sense of increasing control and integration and as such would help to lessen his defensiveness. I agreed with this intervention as it would present Phil with various options to exit out of his difficulties. So from this point I used information from the sessions to reformulate a sequential diagram of Phil's problem procedures. Raising Phil's awareness and insight would continue to be within the psychodynamic theoretical framework; using CB techniques when indicated to address practical issues; and towards the end of therapy, the incorporation of the CAT diagram as part of relapse prevention and termination.

2.3 Integrative Work

In the 11th session Phil spoke about his terror of losing or failing in everything he set out to do. After exploring this, empathically (person-centered), it seemed an appropriate time to introduce the CAT diagram as a way of re-formulating his problems. Although he looked slightly amused, he was in agreement with it so I explained its principles and said that we could use specific examples he had brought to counselling sessions for this diagram. He then went on holiday for 3 weeks and then missed the next session on his return.

Treatment strategies, for psychodynamic work with people who have personality disorders are to enhance collaboration (Benjamin, 1996). With this in mind I was able to deal with the issue of missed appointments in the 12th session in a warm and supportive manner. At the same time I was able to be assertive saying it would be to his advantage psychologically to take responsibility and be committed to the process for therapy so increasing its effectiveness. He responded by saying "No one has spoken to me like that before - They would be afraid they would upset me if they did." As he was 'trashing' me and had become contemptuous, I recognized he erroneously believed he was being criticized for failing to keep all his appointments and his contemptuous behaviour was in defense of his narcissistic wounding.

From the 13th to the 20th session we worked well together with Phil sharing feelings, ambitions and fears – psychodynamic understandings of the ‘there and then’ and manifesting in the ‘here and now’. Two examples really stood out in my mind revealing the extent to which Phil needed to split off and deny his ‘bad/imperfect’ self. The first example occurred during the 17th session when I was trying to understand what Phil meant when he reacts in an obsessive way to maintain his standards of perfection. He talked about bullying his family to be neat and tidy in the house at all times. From this information we re-formulated the first example of the sequential CAT diagram where he resorts to behaving in a contemptible manner by bullying (**Appendix B6**). He said he used to be shouted at by his mother when as a boy he was untidy. Since then he worries that people will reject him if they find fault with him – even if sofa pillows are not neatly arranged. Interestingly he said in the next goal review session that he no longer tidied the lounge and that his anxiety around that was not as bad as he thought it would be. This is an example of successfully meeting a treatment strategy to facilitate learning about patterns and their childhood roots and changing them (Benjamin, 1996).

The second example occurred in the 20th session when he returned from competing in the New York marathon. He proudly told me he had limped the last 16 miles to finish the marathon coming in last when all the lights were off and everyone had gone home. I knew he wanted an admiring response from me for finishing the race despite his injuries that would satisfy his need for admiration (Ryle, 1995). His efforts did warrant admiration so I supported his courage to endure pain to such an extent. He continued to recall the intense anger he felt towards “Matilda, an old woman” who insisted on walking beside him for about 5 miles of the way. He hated the blind and crippled competitors who ran passed him. He recalled the fury he felt when he arrived at the finishing post and everyone had left. No one waited for him - not even his team. He said that during the race he defended against the fear of being seen as a failure by concentrating on the millions of people watching whom he said did not have the courage to complete.

This particular experience offers a clear view of narcissistic self-esteem regulation by the emotional splitting processes of the ‘good’ (genuine self-esteem) versus the ‘bad’ (narcissistic self-aggrandizement) aspects of the self. Seeing and being seen are important aspects of narcissism where self-

consciousness is always a feature (Steiner, 2006). These self-conscious emotions of shame and the two forms of pride i.e. “authentic” and “hubristic” are in relation to being watched by thousands not doing well. Authentic pride is the more socially desirable facet associated with accomplishment and confidence and does not have the features of rage towards others who are more accomplished in a particular area than you. Being angry with participants could also be understood as a defense in order to hide his internal and external shame evident as a social manifestation (Morrison, 1989., Gilbert, 2003). Thus Phil’s pride appears to be attached to the concept of hubristic pride that is associated with the more narcissistic facet associated with arrogance (I’m better than you for I competed) and conceit (Tracy, Cheng, Robins & Trzesniewski, 2009). The purpose it served was to ward off depressive feelings due to his anxiety of coming in last.

Perhaps my admiration was less than Phil wanted because as he was leaving the room he said he would not be able to come in for the next session. My understanding of his insistence to finish the race and anger towards well-wishers was that this incident was a painful and shameful experience. The anxiety he must have felt seeing competitors pass him generated his need to conceal the shame defect (his failure to complete the race running) and his distress which was so openly visible to the public and to his self. Morrison (1989) contends that shame is embedded in narcissistic vulnerability.

An example of Phil’s process of movement and development occurred on a feeling level and with that came some new insights during sessions 21 to 27. He was now C.F.O. but said his self-esteem was still low and he felt empty and “down.” He painfully realized how much he relied on outside admiration and approval to make him feel worthwhile. He spoke contemptuously about his C.F.O. post that was now not good enough for him. He was looking for something more difficult to aim for. Phil could see how this behaviour and way of thinking maintained his vulnerable core state and although he felt positive about this insight (the second trap of the CAT diagram) he did not know how to could change.

The challenging reality for myself as therapist, and Phil as the client, was the work environment context that rewards competitiveness and perfection at work. So the focus of intervention became how to elicit the motivation to change so that Phil experienced less anxiety in times of stress within the context of a

narcissistic consumer based society? Benjamin (1996) maintains that it is necessary to revert back to the processes of relying on external factors to boost his self esteem and replace them with internal reliance factors.

We are now working on exit issues to effectively encourage new patterns of behaviour with the long term goal of appreciating rewards and not relying on praise as this maintains his vulnerable core state – in effect blocking maladaptive patterns and effectively encouraging new ones (Benjamin, 1996).

3. CONCLUSIONS

Evaluations of the work:

Phil's GAF score was 80 at the 27th session showing a marked reduction in anxiety when compared with the 51 score on admission. He used me as a sounding board in terms of assertive behaviours so within the confines of the therapy room he was able to talk about and acknowledge his narcissistic vulnerabilities. Management of anxiety symptoms improved and Phil's motivation for change increased. This is contrary to Derksen (1995) who posits that with narcissistic person's motivation decreases as complaints diminish. However, as in Phil's case, while there was evidence for the effectiveness of psychotherapy in the treatment of psychological problems, other problems relating to interpersonal relationship presented on-going issues for him. Bateman & Fonagy (2000) argue this point maintaining that there exist problems *"in conceptualizing and defining personality disorder, in separating it from other mental disorders and in designing treatment trials with adequate internal and external validity"*, (p 142).

In view of my experience with this client and the above argument of Bateman and Fonagy (2000), the question that arises from this case study in terms of future research and clinical practice is - how to provide evidence that personality change is measurable and clinically meaningful?

3.1 Learning about myself in therapy with Phil

At times during Phil's therapy I have felt irritated, anxious, inadequate and bullied. To shift from this position I had to understand the real meaning of transference and counter-transference. Once I was able to identify my narcissistic vulnerabilities e.g. fear of not being good enough, I was able to deal

with them in supervision to get them into perspective. This enabled me to feel and demonstrate empathic understanding towards Phil because I was less focused on my own performance and more focused on how Phil was experiencing his world. Kohut (1971) argues that empathic understanding is an essential requirement in the treatment of narcissistic personality disorders. Being empathic I realized just how much my client needed to split off his bad side as his perceived imperfection was intolerable. I was also scared to admit to myself that I may not be good enough as a trainee counselling psychologist for him. Once I recognized this counter-transference, I was also able to realize the possible impact of his arrogant behaviour had on others, e.g. why they may feel 'put down' by him (Casement, 2002). I gained more understanding of the process when he attempted to trash me and how I was able to make sense of this with supervision.

It has been a valuable experience working with this client who had a dual diagnosis and recognizing the impact this particular axis 11 disorder can have on motivation for treatment and change. Particularly when: narcissistic type behaviours, such as arrogance and grandiosity, are rewarded within a 'narcissistic culture' of competitiveness; shame-anxiety that is experienced when rewards are not forthcoming; and, the challenges these predicaments present for the trainee when having to address both the client's 'unhelpful narcissism' while promoting 'healthy narcissism' at the same time.

I was fortunate to have had this experience. Especially helpful to understanding the shameful and vulnerable side to Phil and seeing past his arrogance/narcissistic behaviours was the empathic experience of his non-verbal behavioural posture (Deutsch, 1952) which spoke volumes in terms of his inner anxieties and the little boy within. This enabled me to facilitate a more consciously 'holding' environment.

In sharing this work, I hope it may offer suggestions to other counseling psychology trainees for understanding and accepting that personal growth in this field is a challenging process. This is because as trainees we need to be able to hold the tension between our professional insecurities while at the same time be able to challenge clients in a confident and constructive manner. We are in such a privileged position having the client's trust us to help them.

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5. APPENDICES

B1

CBT assessment taken during the first interview (Hawton, Salkovskis, Kirk, and Clark, 1995)

Development:

Precipitating factors - Boss promises CEO position to client

Time course - Approximately a year ago

Predisposing factors - Need to achieve and be the best
Need for others to see him achieving and being the best
Mother would show her love for him when he achieved well

Description of problem behavior:

Behavioural - Working overtime – correcting subordinates mistakes

Cognitive - Worry to almost ruminating; “I must be seen to be the Whiz
Kid all the time”; nobody must know how I am thinking

Affective - Anxious, envious, resentful

Physiological - Disturbed sleep pattern

Contexts and modulating variables:

Situational - Very competitive environment but little work coming in for the past 3 months

Behavioural - Walking around like a spare part

Cognitive - I’ve got nothing to work on to show how good I am

Affective - Anxious, irritable

Interpersonal - Sulking with superior; being financially generous and complimentary with subordinates

Physiological - Restless, agitated

Maintaining factors:

Situational – Boss in control of situation and promotions

Behavioural – Avoids boss

Cognitive	–	I want this position because no one else can do it but I'm scared I shall fail and be rejected and laughed at if I go to the boss to ask about the promotion
Affective	–	Anxious, despondent
Interpersonal	–	Self-conscious
Physiological	–	Disturbed sleep so never feels rested

Homework:

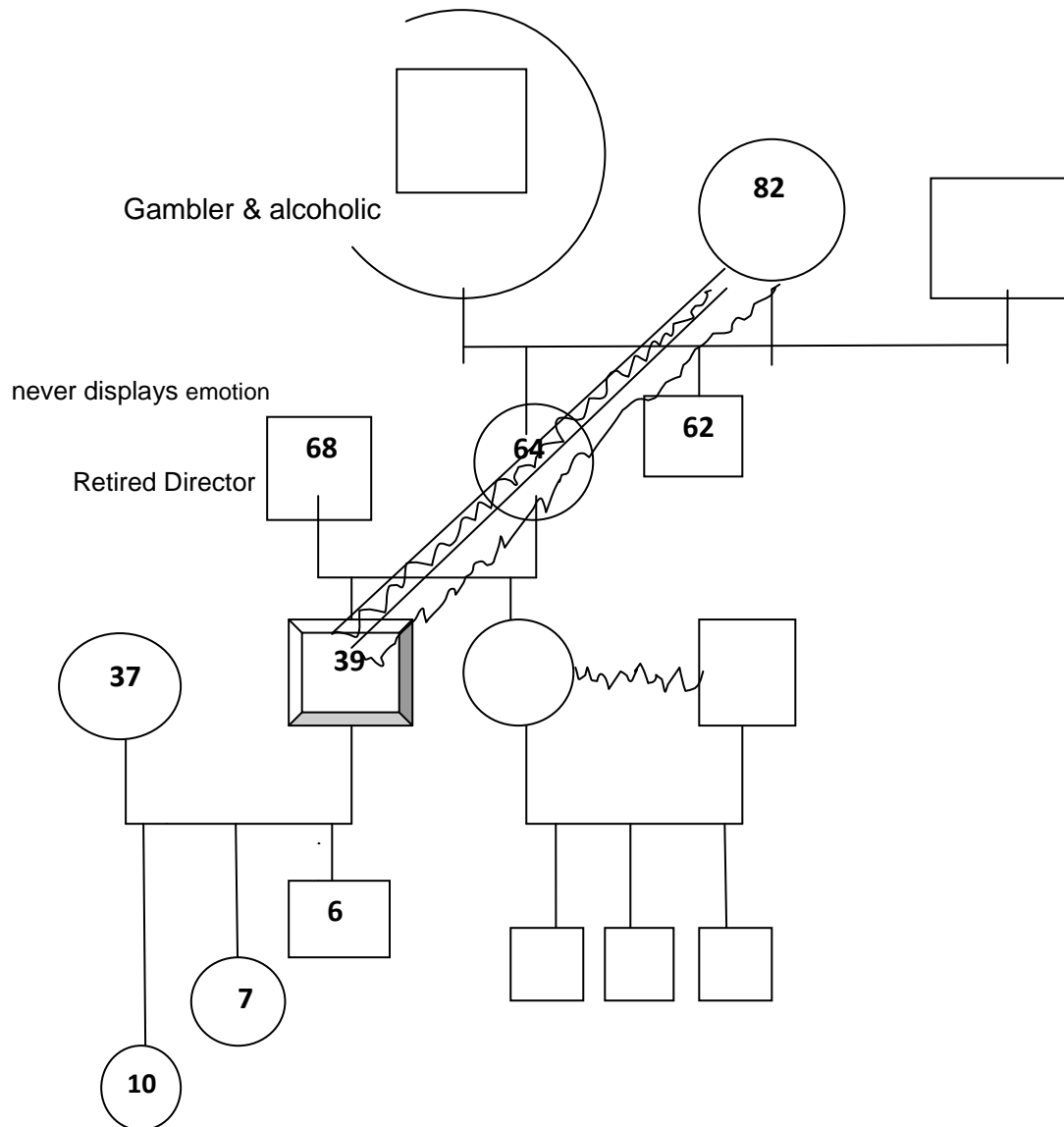
1. We discussed the pros and cons of speaking to the boss to find out about the promotion.
2. The effect of not talking to the boss was having on his anxiety and low mood
3. Discussed and practiced ways of approaching boss about the promotion
4. To arrange any interview with the boss during the week
5. Importance of relaxation; and how to relax

Cognitive Analytical Therapy (CAT)

CAT is an integrated, time-limited therapy suitable for use in the management and treatment of personality disordered patients (Beard, Marlowe & Ryle, 1990). It incorporates a range of psychotherapeutic theories and methods especially CBT approaches and the object relations school of psychoanalysis. Pivotal to therapy is emphasis on the re-formulation of the patient's problems involving accurate descriptions of what the patient does wrong to maintain his difficulties. To limit regression the interpretation of unconscious processes are not involved. The reformulation is aimed to actively enlarge and enhance the patient's capacity for self-observation, control of actions, and responses that maintain difficulties. This is normally carried out over the first few sessions in collaboration with the patient. In my client's case, re-formulation in the drawing of the diagram (**appendix B6**) was during the termination stage. To do a full CAT treatment program a written description of the patient's history is linked with brief descriptions of current maladaptive strategies called 'target problem procedures' (TPP). TPP descriptions identify central core issues based on Object Relations Theory that are derived from early experience. These issues represent long-term unresolved psychic pain. From the core state, various procedures generate a sequence of intentional acts involving perception, appraisal, action and prediction of consequences. These actions are linked in a circular fashion and maintain the intentional acts. From the sequential diagram Phil's two dominant 'coping modes' were i.e. the striving for perfection in order to gain admiration; and, task focused in order to be in control. In general each procedure is addressed as an individual problem. The persistence of Phil's difficulties was explicable with the arrows inevitably returning to the centre showing how the core state was maintained. His target problem procedure formed the basis of therapy once engagement had taken place. His homework tasks included monitoring and recording current uses of 'coping modes' in order to help him recognize, and in due course, modify them. My key role in CAT was to help Phil identify his TPPS and to teach him to monitor and consider alternative ways of responding. My prime concern was with accurate descriptions and non-collusion rather than interpretation, in order to mobilize his capacity for self-reflection (Ryle, 1990).

B3 Phil's

Family Genogram



KEY to Genogram

avoidant

conflictual

MGM remarried 1952 both reclusive: **Mother:** Anxious, heart problems

Mo & Fa: the perfect marriage

Sister. & husband – getting a divorce (shameful for the family)

Index patient 39 Phil who married in 1985

Children: 10 year old high achiever; 7 year old has O.C.D; 6 year old quiet

The origins and meaning of Phil's difficulties can be hypothesized from his history. As the first born he had to actualize his mother's narcissistic expectations of being the perfect son. Phil's mother was rejected by her mother and as a consequence she was unable to take over the empathic narcissistic functions for Phil, as she was in need of narcissistic supplies herself. It can be hypothesized that mother found in Phil what she was unable to find in her own mother i.e. someone who was centered on her giving full attention and admiration. He strove to fulfill these expectations by being the perfect son at home and by excelling academically at school and being popular. However, his success in this regard could not obliterate the unconscious yet pervading sense of emptiness, vulnerability, fear of abandonment and sense of worthlessness derived from his mother's failure to acknowledge and love those parts of him which did not accord with her impossible ideals when he wasn't achieving. His anxiety and low mood associated with performance represented his childhood responses to a mother who projected her own unconscious weakness into her son, and then punished the vulnerability and imperfection she saw reflected there. As a defense against depression he displayed grandiosity but his internal state held a fragile and worthless self which he defended against with the use of primitive defenses of repression and splitting. These were in addition to the more developed defenses such as projection, denial and suppression. His internalized mother condemned him to a lifetime search for unconditional admiration and love, to counteract his underlying sense of worthlessness. Intense focus on his own ego resulted in a lack of empathy for the needs and aspirations of his family. For example, he considered his wife to be subordinate to him and from whom he demanded respect and recognition for his achievements. Her refusal to admire his achievements was experienced as a symbolic re-enactment of his mother's punitive behaviour and his own childhood narcissistic injury. It can be hypothesized that Phil's current state of anxiety and low mood were occurring because of the break-down of his grandiose defense mechanisms as there was little to sustain them. This probably was a result of lack of opportunities in the workplace for special achievements and accompanying admiration i.e. no source of external narcissistic supplies which normally enabled him to avoid the emptiness and neediness in his core state.

Phil presented himself for treatment of his symptomatic complaints related to generalized anxiety, the levels of which had been increasing over the past 18 months. He showed little insight into his psychological and interpersonal problems and his non-verbal behaviours communicated a vulnerable and emotionally threatened person. These behaviours were indicated in the therapy room by his need to keep a physical and emotional distance from me. The information provided by him was descriptive in character yet showed no apparent understanding of his own emotional life.

B5

Diagnostic criteria for 301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior) need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(Key * = client qualifies)

1. Has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. * Believes that he or she is 'special' and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. * Requires excessive admiration
5. * Has a sense of entitlement, i.e. unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations.
6. * Is interpersonally exploitative, i.e. takes advantage of others to achieve his or her own ends.
7. * Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. * Is often envious of others or believes that others are envious of him or her.*
9. * Shows arrogant, haughty behaviours or attitudes.

C.A.T. Diagram

B6

On hard copy only

SECTION C: CRITICAL LITERATURE REVIEW

**TITLE: Countertransference: Narcissistic Vulnerabilities
within the Therapeutic Milieu**

List of Abbreviations

CT	=	Counter-transference
HT	=	Hostile transference
PI	=	Projective identification
BPS	=	British Psychological Society
T	=	Transference

Countertransference: Narcissistic Vulnerabilities Within the Therapeutic Milieu

1. INTRODUCTION

The very nature of therapists' work is concerned with working with client feelings that are chaotic, complicated and diverse (Ryle, 1998., Casement, 1999.; Najavits, 2000., Halton, 2009; Moylan, 2009). Najavits (2000) maintains that it is this intensity of emotions that actually draws many therapists to this type of work. However, therapists themselves are not 'immune' to being affected by client's feelings. Client evoked emotions in therapists' presents a double edged sword, as these emotions can be harmful or beneficial to treatment. Harmful or beneficial, therapists' emotions can be defined as counter-transference (CT) reactions or used as a tool to understanding CT emotions (Hayes & Gelso, 1991., Hayes, McCracken, McClanahan, Hill, Harp & Carozzoni, 1998., Rosenberger & Hayes, 2002., Fauth, 2006., Hofsess & Tracey, 2010).

1.1 Trainee and Therapist's Emotions

Therefore, recognition and understanding of therapists' CT is central to clinical work (Najavits, 2000., Rosenberger & Hayes, 2002., Gelso & Hayes, 2007). This applies to psychoanalytic and psychodynamic models of therapy (Freud, 1910/1957., Kernberg, 1965., Casement, 1999., Najavits, 2000); systemic (open) models for organizations (Menzies, 1983., Obholzer & Roberts, 2009); family therapy (Holmes, 2005., Grant & Crawley, 2002); group therapy (Bion, 1961., Biggs, 1998); person centered and existential (Rogers, 1951., Rowan & Jacobs, 2002., Walters, 2009) cognitive analytic therapy (Ryle, 1998); in supervision (Hughes & Pengelly, 1997., Hawkins & Shohet, 2005) and cognitive-behavioural therapy (Beck, 1979). In the language of Wheeler (2007), CT responses are generic and ubiquitous.

Singer & Luborsky's (1977) earlier review on CT research identified that it is extremely difficult to define and operationalize on account of CT being largely unconscious in nature. Singer & Luborsky maintained that the more one tried to operationalize CT the more complex nuances of the phenomenon were lost.

Twenty five years on, Rosenberger & Hayes (2002) argue that CT still remains an empirically elusive phenomenon owing to this lack of clarity of the concept. Thus while CT is deemed to be of central importance to client outcomes (Rosenberger & Hayes, 2002., Hofsess & Tracey, 2010) there remain relatively few specific empirical studies undertaken on therapists' CT emotions (Najavits, 2000).

So where does this leave counselling psychology students in training in relation to CT reactions that are largely unconscious? British Psychological Society (BPS) standards for Counselling Psychology Doctorate programme curriculum September, 2010, recognize the pivotal role of intersubjective experience and collaborative formulation between those participating in deriving understanding and the approaches to client's distress. Emphasis in training is placed on maintaining external consultation with experienced members such as placement supervisors when working with clients. This stance is embodied in the notion of personal and professional development and the *reflective practitioner*, emphasizing as it does, the joint creation of meaning within the *therapeutic alliance* (BPS, 2010)⁴. While the BPS has guidelines for trainee learning, there is no specific statement therein that universities must include learning about 'unconscious emotions at work' i.e. CT. This can leave the responsibility for clinical competency in this specific area almost entirely with the trainee and their placement supervisors. At the same time the onus is on the university to pass or fail the candidate according to information from supervisors' clinical placement progress reports. Based on the author's own experience as a trainee, and later supervision of many trainees, this raises trainees' anxiety levels regarding supervisors' judgments of their clinical competence. (See University programme standards and student competencies applicable to this critical literature review: **Appendix C1**)

1.2 Aims of the Critical Literature Review

While the field of interest into CT has widened, in general terms I chose this subject of CT because despite its ubiquitous presence in psychological literature there remains little consensus as to the exact definition and

⁴ Personal and Professional Development includes personal therapy and clinical supervision: Counselling Psychologists bring aspects of themselves to this shared enterprise, derived both from their training and their wider knowledge. This personal history is combined with an explicit use of psychological theories to analyze the process of a particular therapy, or counselling situation (BPS September 2010).

therapists' experience of it. My intention is to critically review CT literature in order to identify and clarify in practical terms what CT actually is and how it manifests itself within the therapeutic milieu. As a trainee, the review will also discuss the few research studies that involved trainee participants in order to identify their levels of understanding of CT. As a practical learning device this review will relate some aspects of a personal experience of CT as it is related to this concept in practical terms. This is meant to be a back-drop of learning only. My CT reactions involved interactions with a patient group, a group therapist and the multidisciplinary team after a group session demonstrating that CT reactions can occur anywhere within therapeutic settings.

In particular this discussion will briefly review literature on CT within open organizational systems; the role of hostile transference (HT) between individuals; CT and narcissistic vulnerability as a trainee; and, CT empathic strain of over-identification. The review will conclude with theoretical and practical research difficulties, counselling training and suggestions for future research.

The choice of topic is also related to the over-arching purpose of this portfolio that focuses on the various concepts of narcissism. Referring to this 'real-life' experience of CT, narcissistic vulnerability in this critical literature review relates to trainee status and the concept of the 'wounded healer' (Sedgwick, 1994).

2 CRITIQUE OF LITERATURE

Ever since Freud's initial mention of CT a hundred years ago (1910) there has been, and still is, on-going definitional, theoretical, practical, empirical and technical controversies regarding this rather abstract concept (Freud, 1910/1957; Kernberg, 1965; Gelso & Hayes, 1998; Rosenberger & Hayes, 2002; Fauth, 2006., Gelso & Hayes, 2007; Hofsess & Tracey, 2010). In view of the important role CT plays in psychological treatment in counselling this review now turns to discuss some of the different ways this concept has been understood.

2.1 *Historical developments and problems in defining CT*

Starting with important historical definitions of CT is Freud's (1910/1959) 'classical' definition of CT that focused on therapists' unconscious reactions to the patient's transference (T). T is defined here as unconscious redirection of feelings from the patients' past interactions on to the therapist (Etchegoyen, 2005., Fauth, 2006). 'Classical' CT was considered counter-productive and to be avoided at all costs (Rosenberger & Hayes (2002). The 'totalistic' view followed between 1950s-1980's and included all therapists' reactions, conscious and unconscious emotions; whether CT was in response to the client's T or feelings therapist's experienced towards their clients. CT was not necessarily negative and could be worked through for the client's benefit (Heimann, 1950., Fauth, 2006). Thirdly, the 'moderate' view expands and improves on the 'classical' and 'totalistic' beliefs positing that CT reactions originate in unresolved conflicts in the counsellor and do not solely occur in reaction to the client's T (Heimann, 1950., Gelso & Hayes, 1998). This view does not see CT as necessarily negative for when recognized and worked with can lead to insights into the therapeutic relationship. Thus, while the 'moderate' view is not as inclusive as the 'totalistic' neither is it as narrow as Freud's 'classic' definition (Fauth, 2006). Rosenberger & Hayes (2002), note that during the past 20 years that most of empirical research has been motivated by the 'moderate' definition.

While remaining within the psychodynamic paradigm, the 'moderate' view describes CT reactions as originating in a therapist's unresolved conflicts. Thus it has the potential of rendering a trainee with little experience of working with their CT, unconscious of or unaware of, the meanings these feelings hold for them. They are then vulnerable to empathic strain that can result in either over-identifying or distancing themselves from the client and their distress that has been projected by the client into them (Saakvitne & Pearlman, 1996). Projective identification (PI) refers to this unconscious inter-personal interaction in which the receiver (trainee or therapist) of the projected T and reacts unconsciously to it as if it is their own (Foster & Roberts, 1998; Moylan, 2009). Therefore, Wilson & Lindy (1994) argue that a trainee is more vulnerable, to identifying with issues projected/transferred onto her/him when it relates to their own unresolved issues – especially with more difficult types of T

such as hostile transference (HT). This then compromises their capacity to empathize with the client.

According to the Kleinian object relations/conflict model and cognitive therapists, T is characterized by processes of projective identification and misperception therefore distorting reality. The task of the therapist is to contain these projections and to return them back to the patient in a more palatable form when the patient is more able to accept them (Bion, 1961). A trainee will struggle to do this effectively if they are unaware of the processes of CT and are instead caught up with the intensity of these feelings. On the other hand, the interpersonal-object relations/deficit model focuses on the 'here and now T' with treatment offering change with the experience of empathy and attention from the therapist and from which the patient can build a secure sense of self in relation to another (Bateman & Holmes, 1995/2005). This approach again will be difficult for the novice trainee to execute.

Nevertheless, there is the understanding that T and CT are jointly created between the patient and the therapist. And, because T and CT are largely unconscious, it is not always clear where it starts. To some extent the whole project is recursive and while participants remain unaware or unconscious of these dynamics it is ideally a matter of a benign circle (Gabbard, 1999). Again this knowledge raises the issue of the centrality of therapist's emotions and the need to be aware of them within the therapeutic relationship (Najavits, 2000).

As well as becoming aware of the presence of CT, which may largely be unconscious, there is also the thorny issue of what is it exactly that one observes when observing CT in clinical practice? This is true not only for counselling psychology trainees, but to researchers and qualified psychologists as well (Singer, Sincoff & Kolligian, 1989; Najavits, 2000; Hofsess & Tracey, 2010).

2.2 Integrative Model of CT

To give more conceptual clarity to this complex phenomenon, Hayes (1995) and Hayes et al. (1998) described a CT model that is integrated into five components. These are: origins, triggers, manifestations, management and effects and will briefly be described as follows:

- Origins, are issues within the therapist that are related to unresolved personal conflicts e.g. as in the distant past in not being good enough for parents; or current, as in not doing well enough to pass a specific test and being found wanting.
- Triggers, relate to specific events during therapy that elicit a therapist's unresolved conflicts e.g. client accusing the therapist of not being good enough. When these origins of unresolved personal conflicts are triggered by client material, therapists' may experience CT.....
- Manifestations are affective, cognitive and/or behavioural in nature e.g. cognitions of "it's my fault"; angry feelings; avoidance or over-identification behaviours.
- CT management refers to therapists' coping strategies either within the session or during discussion in supervision.
- The effects are associated with the influences of CT on the process and outcomes of therapy. This model is a useful process model as it enables therapists to gain access to unconscious material of their own by identifying some of these components and reflect on them e.g. as in over-involvement or over-identification , "why am I feeling anxious and taking sole responsibility for this issue when in reality it is not my responsibility?".

This integrative model has potential to be very useful in adding to the clarification of what this concept is when these features of CT are used as an adjunct to the 'moderate' definition of CT. This is because the moderate view of CT identifies therapists' idiosyncratic reactions (conscious or unconscious) to clients' T as being based primarily in therapists' own personal conflicts (conscious or unconscious) and/or difficulties that include cognitive biases, personal experiences or maladaptive interpersonal patterns (Gelso & Hayes, 1998., Fauth, 2006). These can be triggered within sessions or outside sessions within the therapeutic situation (Gelso & Hayes, 1998). Thus understanding CT as an integrative way is trans-theoretical and is believed to occur across all types of therapists, regardless of their theoretical approach or whether they label it as such (Manning, 2005., Hofsess & Tracey, 2010).

Furthermore, Hofsess & Tracey argue that therapists who lack knowledge and experience of the concept of CT may unintentionally spoil the possibility of successful treatment. As they believe CT is important to the therapy process and to clarify what therapists see or hear of CT, they developed a prototype measure for assessing experienced and trainee therapists levels of understanding of this concept. This is prototype is discussed further in the following section.

2.3 CT as a Prototype

The prototype of CT developed by Hofsess & Tracey, (2010) is a new method for assessing experienced therapists and trainee's understanding and use of CT. According to Rosch, (1978), a prototype is a cognitive concept that provides a way of organizing material from people's thoughts, behaviour, feelings, and speech into the clearest way of describing a particular concept. From this prototype examples of CT can be examined for how well they match the CT prototype. An example of each of these categories are: thoughts: thinks about the client throughout the day; behaviour: rushes in to solve a client's problem; feelings: feels like either a great or bad therapist with a client, speech: expresses hostility toward or about a client.

Hofsess & Tracey's assessment study of 34 trainees' understanding and experience of CT against a CT prototype was conducted separately to a sample of experienced therapists (2010). They did them separately because they felt that trainees' personal templates of CT may be less comprehensive than experienced therapist. The task was to read transcripts from different case studies of therapist and client interactions that contained different examples of positive and negative CT. The researchers would then identify differences and similarities between the experienced and the novice therapist's levels of understanding of CT.

While the 2 studies conducted by Hofsess & Tracey (2010) are too extensive to go into here, there are some interesting findings related to the sample of 34 trainees. Firstly, they had a tendency to espouse a more 'classical' type of definition of CT as being a 'bad' thing rather than seeing its potential for having a positive impact. The second observation was that when the trainees thought the therapist had not managed their CT in a constructive manner they substantiated their answer by identifying the lack of empathy and anxiety

management skills of the therapist within the session as contributing towards it. A limitation to Hofsess & Tracey's study was in not knowing how many of the features of the prototype referred to 'unresolved issues' of the therapists with this 'prototype' concept of CT. Given that CT reactions, positive or negative, are associated with 'unresolved issues' this is a particular weakness of this study. However, usefully they identified that features of the prototype exist on a continuum depending on the intensity of the HT and the therapist's response to the T. In terms of trainees' ability to assess CT when they 'saw' it, Hofsess & Tracey identified that trainees' had a lower level of ability to apply the knowledge of CT to individual case material in comparison to a higher level of ability of experienced therapists (2010).

Thus, CT and T are reciprocal in their interaction and are both sides of the same coin. Clarifying integrative elements within CT prototypes are useful concepts in helping trainee counselling psychologists' make sense of how they, and other therapists, are perceived and treated by clients and their responses to this - especially when their CT feelings are felt more intensely than usual (Obholzer & Roberts, 2009).

As afore mentioned CT and T can happen in any social situation such as during individual sessions with clients (Ryle, 1998., Maroda, 2004); during a therapeutic group session (Stokes, 2009); supervision (Hughes & Pengelly, 1997., Hawkins & Shohet, 2005) or within the therapeutic milieu (Chessick, 1986., Stokes, 2009., Roberts, 2009) underlining the importance of being able to identify and manage CT. So it is to the context of CT occurring within a group session and within the open system of a therapeutic milieu this review turns.

2.4 Organizational Anxieties

A stressful aspect for staff working with patients with mental problems is their close proximity to these patients' anxieties associated with their great emotional pain. In turn conscious anxieties are also experienced by the staff members in response to this (Roberts, 1998). For example, when working with borderline personality disorders who are at special risk to themselves when they are self-harming on the ward and the negative impact this can have of the other patients. There are also other anxieties that either staff or/and patients

are unconscious of. These anxieties are evoked by the nature of the illness or the work itself but may be defended against because they may be too difficult to deal with. One of the ways patients rid themselves of these unconscious yet painful and unacceptable feelings is to project them into the staff (Moylan, 2009). This in turn causes distress amongst the staff. If staff remain unaware of these anxiety based projections flying around they may also start projecting their anxieties into other staff or patients. So when working in an acute psychiatric setting one can actually expect a lot of free floating anxiety projections. If this blurring of boundaries is unattended to, the organization runs the risk of this hindering development amongst staff at individual and organizational levels as well as the different patient groups (Obholzer & Roberts, 2009).

In an effort to understand these processes, psychoanalysis expanded their use of individual therapy from the couch into organizations to examine the functioning and dysfunctions of organizational life with the use of psychoanalytic concepts. Through this lens a picture of organizations shaped by unconscious desires, thoughts, expectations and hopes of its employees are examined. These unconscious expectations and fears can have the effect of distorting reality and undermining the effective functioning of the organization with the blurring boundaries of roles and responsibilities. Karpman (1968) famously described this processes of the blurring of boundaries and roles as the 'Drama Triangle' whereby there is the 'passing the painful parcel' of responsibility onto others in a blaming fashion. However, when unconscious fears, defenses and expectations are identified they can be managed more effectively (Menzies, 1983., Fineman, 2003., Obholzer & Miller, 2007). Thus, it is important to recognize the effects of T and CT and its attendant anxiety on patients and staff for when neglected these phenomena have the power to adversely affect the entire therapeutic environment if not managed properly (Imura, 1991).

Criticism has been laid at the foot of psychoanalysis that tends to focus on the emotional areas of anxiety while downplaying the influence of organizational structures of power and its domination on feelings (Fineman, 2003). It is the author's belief that this is a limitation in its applicability, as organizational structures are an integral part of staff and patients emotions. Nevertheless, psychoanalytic theory and concepts are valuable for understanding and

making sense of primitive anxieties in the workplace - even if these anxieties are said to originate from our early-learning experiences. For instance, working in the mental health hospital services – especially acute admissions - personal and professional boundaries are difficult to maintain because of the strength of patients' anxieties and the resultant projections that draw people (other patients or staff) into their oedipal nightmares. These hostile projections inevitably arouse anxiety, pain and confusion in the others (Obholzer, 2009).

Obholzer identifies three different levels of these anxieties namely: primitive e.g. anxieties about survival that are physical or psychological; those arising out of the nature of the work e.g. unclear role boundaries; and personal anxieties e.g. regarding competency to carry out a new task (2009). As a result of painful feelings evoked, working practices and staff relationships establish different ways to defend or protect themselves (consciously or unconsciously) against these anxieties in the workplace. This can happen within the group context when a group leader fails to contain anxiety within the group members and they respond in a defensive manner.

When this type of primitive anxiety is not contained within the group by the group leader then this anxiety is communicated or transferred onto the leader by using projective identification (Bion, 1961). The therapist has to be able to tolerate and contain these hostile projections (HP) from the group member/s for the conflict to be managed or resolved (Saakvitne & Pearlman, 1996). If the leader is overwhelmed with her/his own concerns i.e. narcissistic vulnerabilities about their abilities then their containing function is compromised and the hostility is carried out of the group into the therapeutic milieu ("e.g. acclamations from the facilitator outside of the group after a session to the co-ordinator of the therapy group programme such as *"it's a disaster you fix it"*; the anger from the group within-session is then transferred via PI into the therapy co-ordinator).

When the treatment setting becomes a melting pot into which aspects of the conflict becomes transferred, managers are less able to provide containment because they too are caught up in similar anxieties that are being projected into them for failing to provide a safe environment (Saakvitne & Pearlman, 1996., Roberts, 2009). This is in effect the psychological defense of 'splitting' off the vulnerable part and putting the blame (bad) onto an individual. Attached

to the 'splitting' is the 'blaming' defense where Halton (2009) argues that it is often easier to attribute a staff member's behaviour to personal problems than it is to identify the link with hospital dynamics. With this breakdown of containment within a unit, consultants are brought in to provide the lost function of containment (Roberts, 1998).

2.5 Group Work and facilitator narcissism

Horwitz (2000) normalizes the experience of narcissistic vulnerabilities amongst therapists in general by pointing to its universality among those in the profession. At the same time he argues specifically that group leaders who have such vulnerabilities and do not manage them are capable of impeding progress of group members - at worst, group leaders' narcissistic defences can produce an exacerbation of symptoms, both within themselves and group members when they remain unaware of these dynamics as originating within themselves (2000). For instance, narcissistic vulnerabilities of the group leader may be attached to being or feeling incompetent as a facilitator when having to receive the more difficult feelings of hate and anger that are being transferred into them by a group member/s. The HT comes across as antagonistic or expressing angry, bitter, or contemptuous feelings towards a particular group leader or staff. The patient may be uncomfortable in expressing these feelings in such a negative manner and the staff member/s will usually experience anxieties in response to the 'attack' and dislike being the object of such expression (Imura, 1991). If the staff/group leader is unaware of the origins for feeling this way then their CT is likely to be negative towards that group member/s. Thus, discomfort arises in both parties.

The 'modern' view of HT and CT would understand this as the emergence of latent meanings (present day wishes that are influenced by the past), organised around and evoked by the intensity of the therapeutic relationship in the group (Bateman & Holmes, 1995/2005). Therefore, another important reason for understanding CT is to identify narcissistic T and CT as they may be attached to aspects of unconscious communications that are shame based and manifest themselves in psychological defences such as narcissistic defences, projective identification or splitting by the therapist. According to Foster & Roberts (1998) these particular psychological defence mechanisms are in widespread use within mental health institutions by staff and patients to ward off shame.

As narcissism and shame are two sides of the same coin, Weber & Gans (2003) examined group leaders' shame dynamics within a group setting. They were motivated to focus on shameful elements because they believed that these elements were either ignored, or were discussed in other terms that were more acceptable, such as narcissism. Their hypothesis support Imura (1991) concerns that hidden or unconscious shame of the group leader could negatively affect the efficacy of group processes as the therapist has remained 'wounded'.

2.6 Trainee Status and the Wounded Healer

Wilson & Lindy (1994) expand on anxiety and CT positing that a therapist's own traumatic past resonating with the current 'other's' (patient, or colleague in this instance) then this traumatic situation is likely to activate CT manifestations such as disequilibrium and narcissistic vulnerability in the receiver of the HT.

Guy (1987) wrote on the personal life of psychotherapist's using the metaphor of the 'wounded healer' to explain that healers want to heal because they have personal experience of early narcissistic wounding in childhood. Once they have accepted and resolved it, they know what the process feels like. They enter into a profession where they can help others resolve their difficulties and because of their experience of 'healed wounds' they can heal empathically. Sedgwick (1994) points out that the metaphor of the therapist as the 'wounded healer' is not new. He expands on this metaphor by explaining that these wounds originate from one's family of origin where the therapist (as a child) adopts the rescuer role. When motivation to become a therapist is partly influenced by the need to continue in a rescuing role and being of value to others it leaves trainee therapists' self-esteem vulnerable to others judgments regarding their competency as therapists, as this may threaten their rescuing role (Saakvitne & Pearlman, 1996). Guy (1987) argues that this is not necessarily dysfunctional and to expect all therapists never to have suffered emotionally is naïve. Nevertheless a genuine interest in people and possessing the capacity for empathy and understanding is an absolute requirement. Relieving human suffering makes a therapist feel worthwhile and having accomplished something meaningful. However, motivation must move

beyond “I want to help (rescue) people” to include gaining deeper self-understanding (Guy).

This begs the question “how does a trainee know which aspects of self are vulnerable to CT reactions?” Mearns (1994) is concerned that personal therapy just deals with what you know. Blind areas cannot receive attention unless they manifest themselves in the transference process in therapy with the therapist. Leaving new discoveries of the self to just occurring in therapy is quite a narrow view. I agree with Chessick (1986) and Wilson and Lindy’s (1994) point that a client/trainee can also experience T and CT elsewhere and then bring it back into the therapy room to deal with it.

According to Wilson & Lindy (1994) as a trainee therapist, I had to be aware of my over-identification with my colleague’s emotional perspective in order to understand my processes of CT. The newer object relations approaches to CT give more insight into this phenomenon as being ‘the organizing principles of the therapist’s own psyche’ (Grant & Crawley, 2002). This theory also takes the therapist’s behaviour into account as being part of the T. Partial or over-identification is one of the factors that cause empathic strain within the therapist-patient dyad (Gelso & Hayes, 2007).

The difficulties in identifying and acknowledging CT have also been highlighted in Davis’s study on trainee therapists (2002). His study focused on trainee concepts of CT and the use of self-disclosure to supervisors. Davis’s central research assumption was that trainees, or inexperienced therapists, have less experience working with T and CT issues than experienced therapists and are therefore less able to identify it when it occurs. I would add that this is because they are not able to identify it when it occurs. Furthermore, because they are less able to identify it they are more vulnerable to anxiety related to unconscious narcissistic wounds e.g. fear of being found incompetent (Najavits, 2000).

As already mentioned, suppression of narcissistic vulnerabilities can increase the likelihood of compromising therapeutic outcomes. For example, Hayes & Gelso (1991) noted that the more anxious therapist-trainees tended to choose more low-involvement responses to HT, than less anxious therapists. Examples of those using low-involvement tended to say to the client “You are angry” instead of “You are angry with me”. This in turn impacted upon the

degree of empathy they were able to demonstrate towards these clients. Again the recursive cycle is demonstrated here as this has the potential to impact negatively on effective treatment outcomes. What appeared hardest for trainee and therapists to manage was identified in a study conducted by Pearlman & Mac Ian's (1995). They found that trainees and inexperienced therapists, experienced the most psychological difficulties when dealing with intense feelings associated with their CT which may go some way towards explaining the low-involvement with clients.

2.7 Supervision and personal therapy

As psychologists we chose to work in a field where clients' feelings are intense, chaotic and complex. In fact, Hahn (1995), Hawkins & Shohet (2005), and Roberts (2009) all maintain that we also chose to work with this type of client group because we are aware of our need to deal with unresolved issues from our past. Within this context, Farrants (2003) stresses the importance of being a 'reflective practitioner' arguing that reflexivity is central to the work of a counselling psychologist in gaining self-awareness in the use of the self within the therapeutic relationship. Therefore, working with CT is much the same as T with the additional responsibility that the therapist has to deal with her/his own issues and endeavour to minimize (it's never eliminated) CT in therapy or the therapeutic milieu (Rothschild, 1993). This does not just apply to trainees for Theriault & Gazzola (2005) also found that qualified therapists acknowledge having feelings of inadequacy, personal distress and doubts about their competency which negatively impacts on their ability to sustain empathy towards clients.

To assist the counselling psychology trainee to achieve a required level of PD the purposeful activities of personal therapy and supervision aim to build up this professional and personal competency. The goals of this type of PD training are for trainees to become *aware* of inner fears that may be evoked in a stressful situation; secondly, to *understand* the fears; and thirdly, to be willing and able to *experiment* with increasingly fearless relating (Dryden, Horton & Mearns, 1995., Irving & Williams, 1999). While at the same time this development helps to protect trainees against powerful CT feelings evoked when working with hostile and traumatized patients (Hawkins & Shohet, 2005).

Thus a high value is placed on therapists' understanding and the use of self in clinical practice (Rizq & Target, 2008).

Of relevance to this review is the importance attached to therapists being able and available for T and projections from the patient. The containing function of the therapist is to be able to take in these projections, reframe them and return them to the patient in a less anxiety provoking form. The patient's hostile T must not overwhelm the therapist nor must the therapist be too preoccupied with their own concerns otherwise they cannot be psychologically available to contain the patient's anxieties and fears (Foster & Roberts, 1998). In terms of organizational conflict within a team, sharing their different responses to particular conflictual incidents in staff support groups or case study presentations, allows for the pulling together of these experiences. This is not only supportive of the members but also helps them make sense of the work in a new way (Moylan, 2009).

3. SUMMARY

CT has been the subject of endless theoretical and clinical debates with broad and narrow range of meanings – particularly in the field of psychoanalysis. Seeking to understand and interpret it is at the heart of individual and group psychotherapy and within organizational/open systems.

It is clear from the literature review that the concepts of T, HT and CT are complex phenomenon. The personal practical experience of experiencing negative CT manifested itself conceptually as: cognitions: reactive defensive mental activity and uncertainty; affects: shock, anger, anxiety, over-identification; and immediate action: emotional withdrawal to guard against unconscious feelings of shame (narcissistic wounds of inadequacy). All these reactions were identified within the integrative model of Hayes et al (1998) that included 5 elements namely origins, triggers, manifestation, management and effects. Hofsess & Tracey (2010) CT prototype measurement identified in therapist/client transcripts of therapy that included particular thoughts, feelings, behaviours and speech enabled them to distinguish the different levels of competency in recognizing CT amongst trainees and qualified therapists also shows promise to be a useful tool for training novice therapists.

As CT reactions have been inextricably linked with individual, professional and group functioning they need to be recognized and understood before they can be addressed and changed (Huffington, Armstrong, Halton, Hoyle & Pooley, 2004). When we recognize that these painful feelings and responses come from PI we (as trainees or staff members) can avoid being a player in the dynamic drama triangle of blurred responsibilities and role boundaries by blaming others within the ward itself or across different disciplines within the hospital and deal with it constructively instead (Karpman, 1968).

As therapists we are expected to provide a safe containing environment where patient/s can share and explore conscious and unconscious connections and meanings that have given rise to CT symptoms. To help therapists manage anxiety driven symptoms PD activities such as personal therapy and supervision of client work increases self-awareness and understanding of these processes within ourselves as therapists - and subsequently the clients we serve. Self-reflection enables us to tolerate this discomfort and contain these projected feelings and provides the potential to bring about constructive change (Halton, 2009). Specific strategies named in the prototype for managing CT included anxiety management and the ability to display empathy.

This can be done using psychoanalytic tools and theories (Obholzer, 2009), organizational open/systems theory – social systems as a defense (Menzies, 1983., Roberts, 2009)., group relations - the relationship between the individual and the group (Bion, 1961), and the multidisciplinary team (Stokes, 2009); supervision (Hawkins & Shohet, 2005) and personal therapy (Rizq & Target, 2008).

4. CONCLUSION

CT has developed from being considered within a psychoanalytic framework as destructive to a psychoanalytic concept that is a far more encompassing referring to all a therapists' responses to patient T. This 'modern' view of CT posits that these processes can be used constructively for the benefit of therapy outcomes. Particularly helpful to understanding the CT psychological processes that are largely unconscious is Hoyle's (2007) argument that the application of the Kleinian concept of PI from 1946 remains fundamental to

understanding the unconscious communication taking place between individuals and group members within organizations and therapeutic milieus in particular. However, as the concepts of T, PI and CT are often unconscious, bringing them into the trainee and therapists' awareness will always pose challenges.

So while this psychoanalytic approach is very useful there remains an elusive nature to this phenomenon. Springman (2002) aptly describes CT as referring to a broad spectrum of processes, i.e., all analyst's feelings towards the patient – unconscious or conscious, some of which are problematic, some useful, and some both. It is almost needless to say that all these different variables mainly account for the continuing confusion about this phenomenon.

Clearly, the concepts of T and CT can be understood in their theoretical and meta-theoretical context. Using these concepts implies that we believe that we are able to be both subject and object, and have sufficient ego-freedom to reflect on our experiences, identities and wishes. According to Ryle (1998) this means we can learn to distinguish what we have been through, what we are from and what we wish to be (Ryle).

4.1 Recommendations

Using earlier research findings and improving on them with future field research, therapists' emotions are a fruitful and valuable area of research, not only for qualified and trainee psychologists' personal and professional development, but also to increase the beneficial outcomes in therapy for the clients (Najavits, 2000). It is clear that CT is not just about emotional reactions. I found that an integrative approach to understanding CT reactions that includes the different elements of cognitive, affective, biological, behavioural and social dimensions very helpful. But even with this expansion of the processes involved researchers may still struggle to adequately capture CT manifestations because they are displayed in such a myriad of different ways.

The choice of a wider focus of CT in this critical literature review was to demonstrate how CT that originates 'within-group sessions' can flood out into the therapeutic environment. I wished to draw attention to this and the associated consequences for staff and patients should HT and CT is not recognized and dealt with. Furthermore, with specific training in recognizing

and learning ways of dealing with these processes therapists learn to recognize when CT occurs within group work and the therapeutic milieu. The point of the personal incident was to highlight a trainee's CT emotions within the context of 'real-life' clinical situation on the ward and the learning that occurred in response to it.

The universality of narcissistic vulnerability among trainees has been acknowledged (Horwitz, 2000). As a protective measure, BPS standards for the doctoral counselling psychology programme explicitly states that trainees understand how their training equips them with transferrable skills that are of value to employers⁵. Possible remediation is proposed in recognizing and responding to T, PI and CT through training, supervision and personal therapy for students. In this way, trainees will be provided with opportunities to learn how to facilitate within the therapeutic milieu and in-sessions, of group or individual, management of CT so that over-identification and/or avoidance/withdrawal behaviour becomes less likely. To remove any possible stigma, Najavits (2000) suggests, there must be no prior assumption of CT emotions as being either positive or negative when initially raising awareness in order to increase self understanding and acceptance of them. Rosenberger & Hayes (2002) believe that origins of unresolved conflict require therapists to examine their own issues through PD such as personal therapy, instead of assuming the conflict to be a result of a skill deficit and receiving training for it. PD is based on the belief that it provides the trainee opportunities to explore and strengthen personal vulnerabilities that may resurface with clients if they have gone unrecognized previously. This engagement with PD aims to build "resilience to survive being exposed to considerable emotional distress, and an attitude of tolerance towards people who are angry, critical or dismissive" (p 642).

Finally, acceptance and awareness are the key tools to working with T and CT. Including the learning and experiencing of T and CT as part of the

⁵ "Opportunities for interdisciplinary working can enrich the learning experience, however, and where these exist education providers should clearly outline their availability for the benefit of students. The Society does not advocate a particular approach to programme delivery, and interdisciplinary or inter-professional learning may be more or less appropriate depending upon the organizational context within which the programme is operating" (BPS., 2010)

programme curriculum will normalize trainee therapists' potential shame when experiencing intensely felt CT in response to HT. This inclusion will emphasize the challenges and complexity of being a therapist or group leader and so enhance developing therapists' self-esteem rather than diminish it.

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Our standards for Doctoral programmes in Counselling Psychology



Programme standard 1: Learning, research and practice

A Required competencies for Doctoral programmes in Counselling Psychology

6.....Personal Development

Trainees will be actively and systematically engaged in personal development work so that greater understanding of personal issues is developed through:

- 5.6 an understanding of therapy from the perspective of the client;
- 5.7 an understanding through therapy of their own life experience;
- 5.8 an ability for critical self-reflection on the use of self in therapeutic process;
- 5.9 a personal philosophy to include responsibility and accountability in relation to their counselling psychology practice;
- 6.5 an understanding of the dynamics present in therapeutic and other relationships; *and*
- 6.6 creativity and artistry in the use of language and metaphor, in the service of empathic understanding.

7.....Professional Issues

Trainees will seek high standards of professional conduct as counselling psychologists in the interests of all those with whom they come into contact and will:

7.1

understand the purpose and practice of receiving supervision;

7.2

accept responsibility for their continuing professional development by developing greater powers of awareness, and the courage to pursue deeper personal knowledge and understanding relevant to working well;

7.3

develop an ability to present and communicate professional knowledge and information;

7.4

have an understanding of the management of professional relationships, including appropriate liaison;

7.5

have a commitment to abide by the Society's ethical framework and professional codes of conduct (including the Division of Counselling Psychology's *Professional Practice Guidelines*); and

7.6

have knowledge of organisational policies and contextual and legal frameworks within which they practice.

Client Work

Trainees will endeavour to provide services of counselling, psychotherapy and psychological consultancy appropriate to the level and breadth of their experience and will:

8.1

develop the ability to initiate, develop, maintain and end a purposeful therapeutic alliance;

8.2

develop an understanding of explicit and implicit communications in a therapeutic relationship;

8.3

develop the ability to conduct psychological assessments and make formulations of a range of presentations;

8.4

develop a personal, coherent, and ethical way of working with clients;

8.5

operate safely and professionally in a range of modalities, contexts and time-frames of therapeutic practice;

8.6

develop the ability to reflect critically on their practice and consider alternative ways of working; and

8.7

develop the ability to respond appropriately to the complex demands of clients.

Note:

Modalities are defined as: work with individuals, couples, groups, families, organisations.

C Supervised practice

This part of our standards relates to Section 5 of the HPC's Standards of Education and Training, which focuses on programme practice placements. For Society-accredited Doctoral programmes in Counselling Psychology, supervision is defined as a personal interaction between the counselling psychologist in training and their supervisor for the purpose of addressing the trainee's needs and performance in relation to the requirements of the accredited programme. In addition to HPC's requirements, accredited programmes must meet the standards outlined below:

1. Accredited programmes are required to provide practice placement experience that offers equivalence to the provisions outlined in the regulations for the Society's Qualification in Counselling Psychology.

Programme standard 5: Personal and professional development

The programme must be able to articulate a strategy for supporting students' development as psychologists, in a way that is appropriate to the level of study.

- The programme must have in place mechanisms for the support of student personal and/or professional development, as appropriate.
- This standard is included because close attention to students' personal and professional development is key to their employability. Education providers may liaise with local and/or national employers in a variety of ways, and the Society is keen to develop its understanding of these approaches through partnership visits.
- Psychology graduates should explicitly understand how their training equips them with transferrable skills that are of value to employers.
- In particular, providers of postgraduate professional training programmes should consider the ways in which their students are supported in developing their identity as practitioner psychologists of the future, and be able to outline the resources that are allocated to leading and co-ordinating this aspect of the provision.
- Postgraduate programmes should also pay particular attention to professional development where students on accredited programmes are taught alongside other student groups (for example, those that do not hold eligibility for the GBC, or other professional groups).
- Opportunities for interdisciplinary working can enrich the learning experience, however, and where these exist education providers should clearly outline their availability for the benefit of students. The Society does not advocate a particular approach to programme delivery, and interdisciplinary or inter-professional learning may be more or less appropriate depending upon the organizational context within which the programme is operating. However, the Society is keen to collate clear information on the range of approaches that are taken to learning and teaching through exploration and enquiry with education providers at partnership visits.

SECTION D: RESEARCH STUDY

Title:

**Behind The Mask: Women's Mid-life Experiences of
Facial Ageing Followed by Facial Rejuvenation
Cosmetic Surgery:
An Interpretative Phenomenological Analysis**

Research Study

List of Abbreviations

BAAPS	=	British Association of Aesthetic and Plastic Surgeons
BDD	=	Body Dysmorphic Disorder
DA	=	Discourse Analysis
DP	=	Discursive Psychology
FRCS	=	Facial Rejuvenation Cosmetic Surgery
GT	=	Grounded Theory
IPA	=	Interpretative Phenomenological Analysis
MMPI	=	Minesota Multiphasic Personality Inventory

Behind The Mask: Women's Mid-life Experiences Of Facial Ageing Followed by Facial Rejuvenation Cosmetic Surgery: An Interpretative Phenomenological Analysis

ABSTRACT

Anti-ageing facial cosmetic surgery and non-invasive cosmetic procedures are becoming more accessible and a dramatic increase in numbers of women are taking advantage of these interventions to reverse the effects of facial ageing (Crerand, Cash & Whitaker, 2006).

Available statistics In the United Kingdom, state that "Facelifts had the largest increase among all cosmetic surgery procedures in the UK in 2007 rising by 36% from 2006." Women had 91% of all cosmetic procedures in 2007. Face-lifts came in the top five requested operations with a rise of 2.8%. Most patients were in their 40's to 60's, but facelifts are also popular with people in their 70's or 80's (BAAPS). *(Unfortunately South Africa (SA) APRSSA (The Association of Plastic and Reconstructive Surgeons of SA) www.plasticsurgeons.co.za have no statistics available to contribute towards current trends in SA.)*

Of particular interest is the increasing surge in number of 'Grandparents' wishing to turn back this ageing clock (British Association of Aesthetic Plastic Surgeons (BAAPS), 2005). This thesis investigates the phenomenon further. Its focus is on women in mid-life who chose to rejuvenate their facial appearance by having a face-lift and were satisfied with the results.

Therefore, this study aims to explore and describe women's experiences of facial ageing in mid-life; having Facial Rejuvenation Cosmetic Surgery (FRCS) and non-invasive (injectables) facial rejuvenation cosmetic procedures, and their perceptions of their facial appearance and themselves after healing. A purposive sample of six women participated in qualitative semi-structured interviews.

Interpretative Phenomenological Analysis (IPA) was chosen as the appropriate qualitative approach for this research. It allowed for these women's cultural and biopsychosocial perspectives to be identified within their changing facial appearance experiences across their life course. All their narratives were transcribed from individual interviews and analyzed identifying the following three superordinate themes: Temporal experiences of facial ageing, (FRCS) and/or non-invasive procedures; Mother, self and facial appearance; and, The cyclical nature of shame, pride and shame.

Embedded within these three superordinate themes are the concepts of vanity; pride, narcissism, and shame. These concepts are defined here to clarify how they are understood in this thesis.

- **Vanity:** The Concise Oxford Dictionary (2008) locates vanity in the social arena and defines it in pejorative terms. It refers to futility and desire for admiration based on physical attractiveness. Vanity can also be referred to as 'empty' pride, is generally regarded as 'bad' and that answering to the whims of vanity is a silly pursuit. Basically it refers to someone who is obsessively over-concerned with looks (Skarderud, 2007). It was the term mostly used by the participants.
- **Pride:** Is classified as a positive self-conscious emotion (Fischer & Tangney, 1995, M. Lewis, 2000, Tangney & Dearing, 2002) and can serve intra-psychic functions e.g. feeling 'proud' of ourselves when we do well and achieving social status as a consequence (Tracy & Robins, 2004) .
- **Narcissism:** Is discussed as a personality trait that functions either positively or negatively. Positive narcissism functions to *adaptively or as self-individualization* to promote normal self-interest e.g. caring for one's appearance and appreciating acclaim, but not requiring it in order to maintain self-esteem. Negative narcissism is *self-defeating or self-absorbing* e.g. is caring for one's appearance but craving adoration insatiably and requiring acclaim in order to feel momentarily good about oneself (Nevid, Rathus & Greene, 2008). Where these concepts differ, or add to this way of understanding narcissism, an explanation will be given.

- **Shame:** Is classified as either specific positive or negative self-conscious emotions (Fisher & Tangney, 1995, M. Lewis, 2000, Tangney & Dearing, 2002, Tracy & Robins, 2004). Shame constitutes a significant portion of our total experience that ranges on a continuum from a mild affect such as mild embarrassment to, to guilt, to extreme mortification. It may also be an unconscious phenomenon, (Nathanson, 1987., Tangney & Dearing, 2002). Shame is the contrasting emotion to pride. The assessment of shame in this study is an intense negative feeling and a perception of having attributes which others would find unattractive and be a cause for rejection (Gilbert, 2002).

Findings are discussed in relation to existing and available literature on facial rejuvenation cosmetic surgery (FRCS); female ageing and midlife (+45 years); daughter and mother relationship; self and mirror reflections; and specific self-conscious emotions. Of particular relevance to findings is the interplay between external facial appearance and intra-psychic phenomenon, each informing and influencing the other thus maintaining a repetitive cycle of shame, pride and shame. The thesis concludes with the argument that the underlying assumptions of the respondents' narratives of this phenomenological study illustrate the concepts of pride and shame as specific self-conscious emotions, and are integral parts of facial ageing and facial rejuvenation for these participants.

The study identifies the important role of counselling psychology in providing pre and post-operative psychological counselling with the following aims: to raise patient's consciousness to all their motivations for wanting to rejuvenate their ageing faces; to enhance realistic expectations for surgical outcomes; preparation for pain management and personal adjustment pre and post- surgery; and so facilitate real transformation of both the inner and outer self.

Furthermore, as clients do not function in isolation from social reality, as professional psychologists we also have a duty to include in the sessions discussions on the relevance of anti-ageing procedures within the wider cultural and moral values present in the individual's environment (Richardson & Manaster, 1992). Justification for this inclusion is acknowledgment of the influences of technological advancements and

modern commercial pressures that, according to Lasch (1979), promote consumption as a way of life that results in a “culture of narcissism⁶.” Similarly Cushman (1990) agrees that the self is a social construction shaped by culture, history and economics. Thus, the inclusion of this aspect within counseling is to enable clients to make rationally informed choices that include not only the desires of the self, but also how these personal choices may be influenced by the wider cultural, social and economic environments, and the consequences thereof.

Additional aims of this study is the dissemination of knowledge derived from findings to other disciplines in related fields and to all women who are contemplating facial cosmetic surgery and/or procedures.

⁶ Narcissism referred to in this sense is a primarily a psychoanalytic concept in the field of psychology (Masterson, 1988). Hence the ‘stigma of narcissism’ above that Lasch’s makes reference to refers to personality traits that are self-centred to the point of obsessive self-gratification (1979).

REFLEXIVITY

In keeping with the philosophy of Counselling Psychology, the purpose of reflexivity is to acknowledge the impact of my role as researcher throughout the development of the research process. The reflexivity framework shall loosely follow the format of answering a set of questions, as suggested by Langdridge (2007). Reflexivity texts will denoted in italics.

Who I am

I am a white, English speaking female in mid-life living in London. I was brought up in South Africa under the blazing sun enjoying all my spare time playing on the beaches and swimming in the sea. Because of my life experiences in South Africa and the importance attached to the colour of one's skin, and re-occurring cancers on my face due to sun damage, I have always been sensitive to, and fascinated by, the effects of external appearance on internal psychological process and identity formation.

Chapter 1

1.1 BACKGROUND

A cosmetic surgical face-lift, i.e. Rhytidectomy, performed in midlife as an anti-ageing procedure is aimed to rejuvenate an ageing facial appearance. It is not intended to change facial structure (Widgerow, 2004).

“It diminishes facial wrinkles and lines, tightens loose skin and muscle, and freshens up facial features”

(Widgerow, 2004, p 69).

Face-lift results may be interpreted as younger looking. Other benefits are associated with psychological aspects such as improved self esteem, improved physical and psychosocial functioning that leads to improved quality of life (Crerand, et al., 2006). In this study there is also reference to undergoing non-invasive facial rejuvenation cosmetic procedures. These refer to Botox and Restylane Injections (**appendix D3** descriptions of cosmetic face-lift/rhytidectomy and non-invasive procedures).

Ways in which individuals' experience, and are treated for, facial ageing, facial disfigurement or facial trauma are different and unique. Therefore, cosmetic surgery in this thesis is not about surgery to treat physically sick patients or patients' disfigurements⁷. Neither is it about women who need to have pathology addressed such as Body Dysmorphic Disorder (BDD), Social Anxiety Disorders or those with Eating Disorders (Veale, 2003). It is about the experiences of women in midlife (between the ages of 45 years to 70 years) who made the decision to have physical signs of facial ageing removed or minimized for appearance's sake.

Despite all these exclusion criteria there are abundant western literature resources on cosmetic surgery and general gender appearance concerns

⁷ While this thesis is not about facial disfigurement⁷, I would like to point out that the feelings experienced by women in mid-life towards their faces in this thesis are not being compared with, nor does it seek to deny or minimize the emotional distress experienced by people with facial disfigurements (Partridge, 2003; Rumsey, Clarke, White, Wyn-Williams & Garlick, 2004; Ong, Clarke, White, Johnson, Withey & Butler, 2007).

falling under the category of 'body image'⁸. And, while not specifically on the face, it is inclusive of it. This literature is contained in all forms of mediums and media ranging from TV, internet, academic research publications through to popular magazines. Perspectives vary widely from psychological, psychiatric, medical, health, reconstructive surgical, social, cultural, consumer culture, feminist, historical, evolutionary, anthropological, autobiographical, and BAAPS press statistical releases – in fact the list is almost endless providing evidence for the popularity of body image and appearance concerns in our contemporary western society (BAAPS, 2006., Clarke, Repta & Griffin, 2007., Moss & Harris, 2009., Zeedyk, 2010).

Connor (2004) a cultural theorist, maintains that we are controlled and manipulated by the mass media that saturates us with visual images and obsessive displays of skin surfaces – the appearances of which have been controlled and manipulated by computer air-brushing techniques, photo-shop manipulations of images, cosmetic and plastic surgery - to name a few - that are displayed in cinemas, advertisements, TV screens, and photography. At the same time there are opposing views that express anxiety about the abject frailty and vulnerability of the skin that is being subject to destructive rages and representation of all kinds. Connor declares that one thing is certain i.e. the significance of the skin is anything than just skin deep. In his book '*The Book of Skin*' he maintains that the skin must be understood as a powerful and ubiquitous arena in which all our complex relations with self and the others take shape (2004).

Notwithstanding the burgeoning of media messages about the body beautiful and the rapid expansion of these anti-ageing technologies, women's desires to enhance their facial appearance have existed since time began (Haiken, 1997). Aesthetic⁹ facial surgery is not a new development and its history can be traced back to the earliest records of 600BC in India of a nose reconstruction. In fact, Haiken proposes that with

⁸ 'Body Image' is a multidimensional construct concerning the shape, size and appearance of ones body that consists of two overarching components: perceptions and attitudes. It refers to the total body i.e. body and face (Cash, 2006).

⁹ Aesthetic and cosmetic may be used interchangeably as they both refer to procedures intended to improve somebody's physical appearance.

beauty concerns and self-consciousness associated with these have been with us since Adam and Eve. However, owing to brevities sake, the pursuit of anti-ageing beauty practices to rejuvenate facial appearance in women's lives in our contemporary society is this thesis's focus.

Therefore, motivation for this phenomenological research includes the following: first, there is little scientific research evidence on specific qualitative and phenomenological experiences of individual women in midlife, their facial ageing, and their experiences once they have undergone facial surgical or non-surgical rejuvenation procedures; second, the rapidness of technological advancements in surgical cosmetic surgery that has not been equaled by psychosocial long term after-effect studies; third, its increasing availability that has resulted in more and more individuals taking advantage of it; fourth, from its inception and despite its popularity, modern cosmetic surgery has been treated with skepticism by the medical profession and allied professions, and the general public. Thus in the face of strongly voiced opposing views with charges of vanity and narcissism being attributed to the individuals who partake of these practices, the practice of cosmetic surgery is surging ahead (Dunofsky, 1997., Widgerow, 2004., Davies & Sadgrove, 2002., K. Davis, 2003., Eskenazi & Streep, 2007, Gimlin, 2007). Indeed, the act of participation appears to resemble something akin to being 'between a rock and a hard place.'

Therefore, this research was undertaken in order to explore these phenomenon further. While this phenomenological qualitative research embraces the above inherent tensions between pathology and wellness for individual's motivations for cosmetic surgery, it seeks to understand these woman's experiences of having facial rejuvenation surgery, within such an environment that holds deeply held conflicting opinions and attitudes towards this practice (Haiken, 1997, Blum, 2003, Gimlin, 2007).

1.1.1 Development of Consecutive Generation Studies

In the light of the above, the following section aims to track and identify relevant developments in trends of thought, associated psychosocial issues and developmental paths taken by researchers and practitioners into this field of female facial ageing and rejuvenation cosmetic surgery, taking the discussion into current issues of today. The format used by Crerand, et al. (2006) of placing these developmental trends into *consecutive generation studies will be adopted*.

1.1.2 First generation – 1950's -1960's

In the 1950's the public were aware of the potential of cosmetic surgery. However, opinions from public and medical arenas were divided into for or against with questions of moral and ethical justifications underpinning this diversion of thought (Reich, 1978). The first line of empirical enquiry therefore came from studies seeking to understand motivations for wanting cosmetic surgery.

Motivational research studies undertaken in the 1950's and 60's were underpinned by psychodynamically oriented interviews that focused on individual pathology as a reason for wanting facial cosmetic surgery. Psychiatrists undertook these research studies using personality profiling as their methodology. Patients having rhinoplasty (nose restructuring) and facelifts were the foci of study. It was hypothesized that these patients were psychologically disturbed and because of this surgery could have the potential of exacerbating pathology, such as excessive self-consciousness (Linn & Goldman, 1949). Hill and Silver's (1950) study on 48 consecutive plastic and cosmetic surgery patients drew the following negatively skewed conclusions that are briefly summarized as follows: first, motivation was always over-determined owing to problems in significant interpersonal relationships; second, decisions were made after some acute event had left them feeling defenseless; and third, seldom was the person requesting facial surgery 'ugly' therefore the patient could be considered neurotic. Despite these negative conclusions they also believed that the prognosis for surgery could be favourable.

At the same time, there were also increasing numbers of outcome evaluation reports by psychiatrists and surgeons documenting that surgical interventions such as rejuvenating facelifts were indeed psychologically beneficial (Edgerton, Webb, Slaughter & Meyer, 1964). Edgerton, et al. conducted a clinical study and follow-up of psychosocial adjustment in 30 patients requesting rejuvenating face-lifts. Ages were between 50 and 60 years. 90% were experiencing a grief reaction to loss of a significant other and personalities were assessed as dependent and depressed. Post-surgery revealed favourable subjective responses to results, despite being previous depressed. Edgerton and co-workers (1964) also found the face-lift seemed to produce a high level of objective improvements in life situations.

In 1978, Reich prescribed a more holistic approach to understanding patient motivations by moving away from moralistic values to acceptance of patients who were unwilling or unable to endure what they considered unacceptable facial appearance. While arguing in favour of these patients having cosmetic surgery he stipulated that they should meet two criteria: one, that their outcome expectations were realistic; and two, they had the ability to withstand an imperfect result.

In summary, cosmetic surgery as a physical intervention offered a way of relieving emotionally painful preoccupations. Medical attitudes towards the patients ranged from seeing them as neurotic; having the potential for exacerbation of pathology such as excessive self-consciousness; psychologically disturbed, and having dependent and depressive personalities. Despite these negative psychological assessments pre-surgery, after surgery these patients experienced significant improvements in their quality of life.

1.1.3 Second generation – 1970's -1990's

Motivational research studies while still focusing on pathology, also turned towards including sociological aspects and justification factors for requesting cosmetic surgery. Edgerton (1975) argued that it was crucial to understand the influence of the different contexts of the lives of these patients and to identify justification factors. To help uncover these motivations, questions that focused on the 'why' the patient wished to

undergo cosmetic surgery at that time, and what changes were expected in their lives as a result of surgery were included.

A study conducted by two psychiatrists and plastic surgeons, Gion, Burgoyne and Goin (1976) on 20 female face-lift patients' justification factors and reactions to informed consent for facial cosmetic surgery. The design was a mixed qualitative (pre and post operative interviews) and quantitative (pre operative Minnesota Multiphasic Personality Inventory (MMPI) completion and post-operative questionnaire on their opinions about the surgical results) methods. Ages ranged between 40 -70 years. Question revolved around patient hidden agendas and whether these could lead to dissatisfaction with results should complications occur. The MMPI identified only 20% with mild emotional disorders while 50% indicated perfectionism. In terms of pre-surgery motivations, 12 of the 20 patients gave additional motivations for having the surgery once the surgery was completed. For instance pre-operative expectations were to 'look better', and post-operatively it changed to 'look younger'. None of the 20 patients confirmed Edgerton's (1975) justification theory on external motivating factors e.g. so not getting a husband after surgery did not deter the patients from experiencing results as excellent. Apropos 'informed consent', despite the surgeon having discussed the four major complications that are associated with this type of major surgery with the patients pre-operatively, out of 21 patients, only 1 patient remembered 2 complications, 18 patients remembered 1 of the complications, and 1 could not recall any. Gion, et al. (1976) concluded that if potential face-lift patients truly believed that they may develop any of these major risks e.g. facial paralysis, they would not indulge themselves in having aesthetic surgery. Finally, there appeared to be only one patient who had a secret motivation. Prior to surgery she had said she had a responsibility to look nice for others. Post-operatively she believed she had really done it for herself. She said she had done it out of vanity and felt ashamed of these needs. These changed or additional motivation talked about post-surgery may suggest some presence of embarrassment or shame about requesting the surgery pre-operatively.

Responding to the charges of alleged vanity, Dunofsky (1997) investigated narcissism, body image concerns, self-esteem and anxiety among women

who had FRCS. Results indicated that these women had significantly higher levels of narcissism and less body image dissatisfaction compared to a control group. However, pre-operative assessments were not obtained in this study so the actual significance of this finding is unclear.

This 2nd generation of studies identified the importance of individuals' subjective feelings regarding their looks, different levels of confidence, or anxiety about it in relation to observing others. Relevant connections were being made about the relationship between the mind and the body and considering that requests for cosmetic surgery did not rest on objective judgments alone. Thus, there was an attempt in research to consider that an individual's experience of their body is seen through the mind's eye – it is the body-mind relationship. Therefore, a surgeon or observing others, could not know what another individual felt about their looks based on their clinical and objective evaluation (Rankin & Borah, 1997).

Other important psychological indicators were identified such as: perfectionism; narcissism and vanity, and higher levels of self-consciousness in comparison to those not wanting cosmetic surgery. The role of the defense mechanism of denial was also identified. Body image studies seemed to indicate that patients seeking facial anti-ageing procedures placed greater importance on their facial appearance than their overall body image compared with those who requested other cosmetic procedures.

1.1.4 *Where we are now: 2000 and onwards*

It is well known that facial attractiveness is a psycho-social asset that results in greater acceptance by others, including peers, teachers, and employers (Kiyak & Reichmuth, 2002). Clinical data derived from social and psychological studies of internal and external attributions and appraisal theories also strongly indicate that attractive individuals receive better judgments from observing others (Jackson, 2002., Tracy & Robins, 2004). Conversely, the opposite may be true that unattractive facial features can be a social liability resulting in peer rejection, employment problems and discrimination (Gilleard & Higgs, 2000).

Taking one's own, and other's perceptions into account, Sommer, Zschocke & Bergfeld (2003) conducted an empirical study to determine whether favourable judgments would also be given to people who had improved their facial appearance with non-invasive anti-ageing procedures. Their study design involved 30 young female adults who had Botox injections for the smoothing out of facial lines. Nearly 50% of subjects reported greater confidence and pride in their appearance and over half reported others commenting on their attractiveness. Sommer et al. concluded that attractiveness improves on first impression judgments and also identified additional psychosocial benefits for the attractive person.

Jackson (2002) expands on these assumptions of attractiveness posing that within our western culture physical attractiveness is highly valued, and that these values influence how people think about and behave toward people who vary in attractiveness (Jackson). Internalized cultural messages about physical attractiveness may serve as personal ideals to aspire to. These internalized messages may also predispose women to connect achievement of these ideals with their sense of self-worth. An identified component of objectified body consciousness is 'appearance control belief' and underlying this belief is the assurance that with enough effort, these cultural standards are achievable. However, this also means that the more discrepancy there is with one's self-evaluation with these cultural ideals, the greater the dissatisfaction can be experienced with appearance (Jackson).

Building on the above research, Dayan, Clark & Ho (2004) also investigated 'first impressions' within the context of surgically altered facial appearance. Their empirical research study was to determine whether cosmetic alteration of facial features projects a better first impression to others in social situations. Randomly chosen participants were asked independently to grade standardized pre-operative and post-operative photographs of patients who underwent facial cosmetic surgery. The viewers were not told which photographs were pre- or post-surgery. While the photographs were of a younger age group than women in midlife, the results may also be relevant for women in midlife. For instance, findings indicated that post-operative cosmetic surgery patients were judged as

31% more attractive, 27% better in social skills, 15% better in relationship skills and 13% more financially successful than those with faces photographed pre-operatively. Findings and conclusions drawn from this study was that facial cosmetic surgery can socially improve on first impressions individuals create and has additional psychosocial benefits for them. These findings support the findings of the previous research of Sommer et al (2002).

Continuing with motivational research, Thorpe, Ahmed and Steer (2004) study on older women motivations included both internal and external factors. Findings identified the anti-ageing procedures were engaged in, in order to reduce discrepancies between a younger internally felt self (ideal self) and the older external looking self (real self). As such Thorpe et al. believed that older individuals were attempting to reclaim or restore a lost identity of a younger self.

The importance of including all psychosocial aspects in research has also been confirmed in research conducted by Clarke, Repta & Griffin, 2007. They conducted in-depth interviews with 21 women in midlife aged 50-70 years, regarding their perceptions of and experiences with non-surgical cosmetic procedures such as Botox, microdermabrasion and injectable fillers. Findings revealed that most of these women used the procedures to increase their physical attractiveness and self-esteem, confirming earlier reviews on the benefits of cosmetic enhancements and improvements in their quality of life (Sarwer, Wadden, Pertschuk & Whitaker, 1998).

Further research was conducted by Clarke & Griffin's (2007b) on women's attitudes towards facial ageing. They examined how older women in midlife experienced and defined natural and unnatural ageing specifically in relation to their own beauty routines. Beauty work was defined as the full range of anti-wrinkle creams, invasive and non-invasive cosmetic procedures. Natural ageing was defined as no beauty work interventions. The 44 agreed that 'natural' was a commendable goal, but on the other hand the majority of them engaged in natural looking 'beauty work'. Contradictions were also evident in the belief of acceptance in the ageing process, while at the same time it must be fought against using whatever technology is available. Findings revealed contradictions, acts of secrecy

and ambivalence towards issues of facial and bodily rejuvenation, ageism and technology.

Brooks (2010) stated that empirical studies on how 'real live' woman's use of aesthetic anti-ageing surgeries and technologies interacts with their understandings and experiences of their ageing processes, is near to none (Brooks). This lack of empirical studies motivated her to investigate American women in midlife attitudes about, and experiences of, aesthetic anti-ageing surgeries and technologies against the backdrop of increasing commercialization of the anti-ageing industry, and the increasingly normalized culture of aesthetic anti-ageing surgery. Some of her findings illuminated a paradigm on 'successful ageing' where these women felt pressurized, by the growing availability, marketing of anti-ageing surgeries and technologies, to be responsible for maintaining a healthy, active body through diet and exercise, and to look younger in body and face through surgery and injectables. In fact, aesthetic anti-ageing surgeries and technologies offered women the opportunity to assert some control over the biological process of natural ageing. This enabled them to conform to the feminine norm of youthfulness despite growing older.

1.1.5 Summary

In summary, studies into anti-ageing procedures during the past twenty years (3rd generation studies) indicate that patients wishing to restore and maintain a youthful appearance, are not as pathologically motivated as earlier studies suggested. Conversely some studies negatively affirm narcissistically driven motivations with body consciousness and pre-operative feelings of shame being identified. The internalization of negative attitudes towards ageing appears to undermine the confidence of some older adults in their dealings with the physical and social world leading to beliefs of lost identity, for instance "I feel young but look old". At the same time FRCS promises a way out to restore a lost identity and a release from unbearable and unwanted feelings of anxiety and shame in many people (BAAPS, 2006), despite growing older.

Participants in this FRCS study had their procedures done during 2005-6. According to the statistics compiled by the British Association Aesthetic Plastic Surgeons (BAAPS) March 2005, there was a greater rise in the

number of older patients i.e. Grandparents, rather than younger people, requesting cosmetic surgery. Martin Kelly, consultant plastic surgeon and BAAPS member 2005 said *“Older patients usually ask to ‘turn back the clock’ when requesting rejuvenation facial surgery. Douglas McGeorge, consultant plastic surgeon and BAAPS President-Elect 2005, commented “We live in well-off society where people now retire to start a new life. Social stigmas about cosmetic surgery are less common and as they feel young, people want to look younger.”*

So it is to the subject of women and ageing within their social and cultural contexts this review turns.

1.2 WOMEN AND FACIAL AGEING

Darwin (in Izard, 1991) stated that the visible face, more than any other body part, is subject to self-attention by virtue of its being the “seat of beauty and ugliness”. Therefore, we cannot look at the meaning of the ageing face and facial rejuvenation cosmetic surgery before the significance of the face is considered.

The simplest way to do this is to start describing the face. Physically it is made up of skin, muscle, soft tissue, blood and underlying skeletal support that provide basic shapes of the face (Friedman, 2005). We all love to look at ourselves in the mirror and we all have some pathology related to these ‘mirror reflections’, as there are times when we like what we see or dislike what we see. Our facial reflections are fascinating and can be something to marvel at or abhor. It is also the most potent social instrument available to us and cannot be understood on a physical level alone. Without saying a word to others, the subtlety of its movements is how we communicate and in this process we instantly attune to respond to faces with a kind of visual acuity that we do not devote to any other areas of the body (Kuczynski, 2006).

1.2.1 The Ageing Face

Of relevance to this study, is that once we pass the 40’s mark ageing is apparent on all our faces. Basically every feature on the face starts to gravitate downwards. Neck skin starts to crepe; jowls start to sag; there are deepening grooves between the nose and mouth; lines appear across the

forehead; upper eyelids start to hood and hang over the eyelashes; lower eyelid skin becomes lax; wrinkles appear around the eyes, corners of the mouth and cheeks, and with time the loose hanging skin exaggerates all of the above ageing features (Widgerow, 2004). Thus, ageing facial features such as wrinkles and sagging jowls is a natural process and happens to everyone. Physiologically and developmentally this process is out of our control and it is there for all to see as our face is always on display more than any other part of our body. Hence, the daily experience of women patients requesting facial cosmetic and plastic surgery to remove age-related characteristics from their faces can be one of great emotional distress (Gimlin, 2007).

1.2.2 Socio-cultural aspects

Such feelings of distress do not come as a surprise against the back-drop of a British culture of self-transformation where social value lies in being 'still young' (Gilleard & Higgs, 2000). It seems that particular forms of media exploit body image concerns in our society by focusing on the negative aspects of ageing and positive aspects of youth. Lijtmaer (2010) argues the same point that American society's feminine ideal constantly emphasize youth as beauty and getting old as ugly. Youthful body image related advertising can promote emotional insecurities associated with physical signs of ageing in an older person as its effects stigmatize this normal bodily process of ageing. However, these trends and conflicting debates about these trends in beauty fashions are not new. Reich (1978) commented that since the earliest recorded evidence of women seeking to alter their faces for self-beautification purposes, there have been strongly voiced differences of opinion as to whether it 'shouldn't' or 'should' be done'.

The influence of the counterculture's emphasis on 'looking and being natural with no interference' was supported by the first wave of feminists in the 1960's whose criticisms were against the practice of wearing make-up and submitting to male-dominated visions of female beauty (Eskenazi & Streep, 2007). Their arguments against cosmetic surgery were based on assumptions that all cosmetic alterations mutilate the body; victimize women patients who have it, and can also be a sign of internal pathology (Pitts-Taylor, 2007). But these attitudes may deny the experience of some

women's realities. For example, focus on the ageing face as an undesirable quality can also leave women in mid life vulnerable to negative comments from observers about their ageing facial appearance (Ring, 2002). Reports of subjectively high levels of fear of negative judgments regarding appearance, self-consciousness, shame and anxiety are reported by these patients (Gimlin, 2007,. Moss & Harris, 2009). Anti-ageing products and procedures, as a quick way to remaining youthful looking, is a very powerful marketing device used by the beauty industry that promotes all forms of cosmetic rejuvenation. While 'successful ageing' stimulates resistance towards the stigmatization of ageing, it may also contribute towards it, for successful ageing is increasingly being equated with anti-ageing (Bayer, 2005, Brooks, 2010) or at the very least, not looking old.

1.2.3 Ambiguities towards facial ageing and rejuvenation

While there are people who accept the inevitable and do not change their appearance of ageing, there are also women who determine for themselves to have facial rejuvenation cosmetic surgery in order to look younger, or better. Feminists' Bordo (1993) and Davis (1995) argument against rejuvenating techniques is that by engaging in practices of self-beautification via anti-ageing products, women are effectively submitting to objectification in a social realm where the overt message is about personal feminine failure to achieve and maintain a youthful body. This determinist perspective sees submissive actions of engaging in self-beautification practices as maintaining cultural notions of feminine inferiority (Bartky, 1990; Bordo, 1993; Davis, 1995).

Looking at the ambiguity of female ageing, Susan Sontag's (1972) 'double standards of ageing' proposed that because women's beauty is aligned with youthfulness, ageing has more serious consequences for women than it has for men. Throughout women's lifespan they are judged more on their physical appearance than men are. For women, looking good means being seen. Therefore the diminishing of physical beauty and sexuality with ageing is more painful for women. It is a painful emotional experience of loss. This loss is more keenly felt by women because women's self esteem in is more closely linked to their physical appearance than it is for men (Stimson, Wase and Stimson (1981).

Deutsch, Zalsenski and Clark (1986), research findings also support this evidence for double standards of ageing. They identified the decline in attractiveness for both genders with ageing, however this decline in attractiveness was perceived to be greater for women than for men. Older women in our society tend to become desexualized, an experience described by older women as a “fearful and rather sudden disconnection from public reflections of themselves as vital women” (Strayer, 1996, p 159). Gilleard and Higgs (2000) maintain that women disguise their age as they feel uncomfortable with the designated identity status of being desexualized. They name this process ‘internalized ageism’. They contend that when our disgust and fear for old age is hidden or denied, we displace these feelings of disgust and fear onto those who undergo cosmetic rejuvenation strategies. Gullette (1997), expanding on perceptions of ageing as a social construction argues that as we are aged by culture. And, despite physical decline being a natural process, we are vulnerable to the loss of our own sexual and youthful images.

Opposing the false consciousness perspective (determinist) is the argument that women are empowered and judicious decision makers who opt to undergo extreme beauty-related practices (e.g., invasive cosmetic surgery) through free choice (Gagne & McGaughey, 2002). In this view, women are not just submitting passively to the decrees of ageist and patriarchal power structures but are actively engaging with it while being aware of its drawbacks as well as its benefits. Similarly, Davis’s earlier thoughts now include ‘normality’ as a motivation for cosmetic surgery (2003). Her change in attitude arose as a result of her interviews with women who chose facial cosmetic and plastic surgery as a way of overcoming their psychological suffering. Her thinking includes the possibility of self agency (free will) in choosing to surgically alter one’s body. Perceived in this light, Davis maintains that facial cosmetic surgery can provide an avenue towards becoming an embodied subject (personal choice for oneself) rather than remaining an objectified body (choice based on public pressure to remain desirable).

Feminists’ debates in the 1990’s involve political, cultural and social aspects of the rights and wrongs of having facial cosmetic surgery over which they were divided in opinion continue today (Davis 1995, Blum

2003). This highlights the fact that cultural attitudes towards beautification and facial cosmetic surgery remain deeply ambivalent – those who are on the one side and those against on the other (Eskenazi & Streep, 2007).

As afore mentioned, Brooks (2010) argued that empirical studies on how 'real live' woman's use of aesthetic anti-ageing surgeries and technologies interacts with their understandings and experiences of their ageing processes, is near to none. Being in the USA she might have missed the following episode which gives a tiny snapshot of how real live women interact with anti-ageing products in the UK. There was an evening TV documentary on 'truth' in advertising in the UK, March 2007 relating to a miracle beauty facial cream product from Boots No 7 range called Protect and Perfect. This particular beauty serum for ageing faces was scientifically proven as doing what it says on the label. By 12:00 the following day, after a frenzy of women buying up all stocks of over 50,000 tubes of Boot's anti-ageing serum, there were exactly 3 tubes of Protect and Perfect left in the whole of the UK (Boots press release web site March 2007). This narcissistic type of behaviour of satisfying desire describes in part women's submission to cultural norms of feminine beauty that necessitates an ongoing struggle against the physical realities of growing older and the suppression of the natural body. Rumsey & Harcourt (2005) stress the importance of gaining more psychological knowledge on older women's adaptation in a culture of narcissism as little empirical research has been undertaken in this field of adjustment to these physical changes.

In summary, this section of the literature review identified different biopsychosocial, feminist, psychosocial and cultural perceptions impacting on women's attitudes and behaviours towards their ageing faces, and the anti-ageing products and practices available to manage this eventuality. The role of physical appearance is one of the core aspects of femininity and this feminine identity begins early in the life of young girls who are exposed to parental and societal expectations to pursue physical attractiveness across the life span (Tiggemann & Lynch, 2001).

Therefore, the literature review turns to discuss some aspects of the mother-daughter relationship during the development of self-esteem in infancy, childhood, adolescence and as adult daughters with regards to

grooming, self and identity as women. It seeks to explore and add further insights into some of the origins of this phenomenology of emotional responses to ageing and rejuvenation in midlife.

1.3 MOTHERS AND DAUGHTERS

The family is traditionally regarded as the primary site of socialization for coming to know who we are as we age. It is also the site for identifying generational changes in the psychological aspects of gender in women. That is to say one's social and gender identities develop through processes of social interaction between family members and across time (Arcana, 1981; Hockey & James, 2003). Even though there are other sites for processes of identification such as school, friends and media, the role of mother in the family regarding gendered practices, makes itself felt in different ways at different transitional points throughout the life course of their daughters (Bee & Boyd, 2002).

Therefore it will be helpful to place in historical and cultural contexts the kind of environment these participants' mothers lived in with regards to gender and grooming, as these have some influence the kind of messages passed down through the generations of women in families.

1.3.1 1950's Mother

After WW II and before the dawn of feminism, make-up had become an intrinsic part of a woman's face. It was developed and marketed by cosmetic industries e.g. departmental stores beauty counters, Elizabeth Arden products in the late 1940s and onwards as essential elements of a woman's identity. Beauty and grooming in the post-war years in America was clearly equated with youthfulness (Haiken, 1997). Wearing lipstick, rouge and eye makeup was relatively free from criticism and was considered a symbolic act associated with a new and bold view of womanhood. Women freely engaged in age-resisting practices such as 'having their hair done' to cover over the soon to be irrelevant graying tell-tale signs of ageing. Women of the 1950's and 60's became accustomed to cosmetics as forming part of their 'woman's identity'. The era heralded a general culture of self-transformation (Gilleard & Higgs, 2000). They

planted the seed of individualization and 'being' the kind of women they wanted to be (Nielsen & Rudberg, 1993).

1.3.2 Growing up with mother

Arcana (1981), writing within feminist and psychoanalytic frameworks proposed that when very young, the daughter role is the framework within which all of our gendered woman behaviour is learned. Arcana's writings and most available literature on the mother and daughter relationship is derived from feminist, developmental and psychoanalytic writings. While not making assumptions about existing theoretical positions, this literature review briefly identifies some important developmental age-related transitions and generational transformations within the context of the mother and daughter dyad, as they may relate to the development of appearance concerns in daughters as adult women.

The capacity for self-awareness and a formation of stable self-representations (Lewis, 1995, Tangney & Dearing, 2002) seem to develop around 18 to 24 months which is approximately the same age that the first self-conscious emotions make their appearance (Lewis, Alessandri & Sullivan, 1992). To become aware of SC emotions, children must first understand the particular rules and standards that determine what appropriate social behavior entails, and that their own behaviour will be evaluated by others according to these standards (Lewis, 2000).

Theory of Mind capacities enable young children to learn that significant others, i.e. parents, with regards to social conduct, evaluate what they do in terms of right or wrong. So mother's approval or disapproval towards certain acts of the child becomes internalized. Thereafter the child develops the capacity for self-awareness as well as self-evaluation which lays the foundations for SC emotions (Retzinger, 1987).

Between the ages of 2 to 6 there is a developing sense of autonomy and interdependence as little girls play at being 'little mother'. McBride (2008) notes that children learn more through what they see their mother doing, than through what their mothers tell them. "Like mother, like daughter" is a phrase with deeper meanings than we often appreciate (Tallmadge, 2004).

Girls learn by observing, assimilating and adopting the mother role through the process of identification with her (Bee & Boyd, 2002).

In this process, daughters internalize both roles and values of daughter and mother at the same time. It is posited that positive empathic 'mirroring' by mother facilitates the growth of a positive healthy self-feeling in the developing child and hence 'healthy/normal self interest' narcissism (Miller, 1987). On the other hand, a misused mirror' as depicted in psychoanalytic literature is when a mother projects her own introjects of expectations, fears and plans for the child onto the child e.g. to be beautiful (Wurmser, 1981). In this case a child would not find herself in her mother's face (figuratively) but rather in the mother's own predicaments (Kohut, 1977a). If the child cannot be this, she would then feel guilty because she, like her mother, can never be 'good enough'. So while shame reflects a failure of the self, guilt is felt as a transgression towards another (Morrison, 1989).

In older childhood they become less dependent on external standards and more on their own internalized norms for judging their own behaviour. For instance, they know that some people may not like them anymore when they do something wrong. By adolescence they can use their own standards to judge themselves e.g. I failed or I was successful.

The tasks at hand in adolescence during the ages of 13 to 21 years is to integrate new found self-awareness, and develop a stable identity as an independent female within society. The moratorium becomes the site of change (Nielsen & Rudberg, 1993). Chenin (1987) agrees with this transformation process during adolescence. She suggests that on entering adolescence we become self-consciousness of our appearance and identity of *being-in-the-world*¹⁰, and if our self-concepts are not robust enough to accept valid criticism then transformation becomes a challenge. Jacoby (1994) expands on this phenomenon arguing that experiences of negative criticism associated with a physical facial feature can leave an adolescent daughter with a predisposition to shame or embarrassment in adulthood when in the presence of observing others. Failure to negotiate Erikson's (1968a) second stage of development, 'autonomy versus shame

¹⁰ *Being in the world* in this sense also refers to 'gendered subjectivity' of 'gendered being-in-the-world' i.e. those gender-specific and often unconscious ways of relating to the world and oneself (Nielsen & Rudberg, 1993). It is something you are, whereas 'gender identity' is something you have (p48).

and doubt', would also have meaning here as it leaves the daughter in late childhood, and on entering adolescence, vulnerable to shame-anxiety experiences.

1.3.3 Adult mothers and daughters

It is not surprising, given the above, that daughters fear any signal from their mothers that 'unconditional love' which includes acceptance, admiration and approval, does not exist or is incomplete (Arcana, 1981). As one her interviewee's commented:

"I always wanted to please my mother and many of the things I did, did not please her." (p8).

Arcana, maintains that these fears contribute towards an ambivalent mother-daughter relationships in adult life – if not earlier. Phillips (1996) illustrates some aspects of this ambivalence by arguing that within this close relationship with mothers there is a great sense of continuity with her i.e. they are a lot alike and see themselves in each other; while at the same time the relationship is often fraught with conflict and unfinished business e.g. such as never satisfying mother's projected needs. Arcana (1981), also argued that as a result of unfinished business, women consciously try not to model themselves as women after their mothers. They do this by rebelling against them or ignoring them *"I never wanted to be like her..."* (p10). However, their attempts to be as different as possible from their mothers in behaviour and appearance are futile – *"She would put her red hair over my forehead to cover my black hair and claim I looked her and that bothered me for some reason."* (p107). Underlying this participant's ambivalence appears to be associated with looking like her mother. Ambivalence was evident in another way with 63% of the women Arcana interviewed. They admitted they consciously tried not to model themselves as women after their mothers but became aware in midlife that on an unconscious level they had followed her - *"I rejected her as a model consciously, and followed her unconsciously."* (p10). The embodiment of the one woman who is most like us personifies aspects of our future. For 63% of these women, anxiety and ambivalence were evoked when externally they looked similar to their mother after they had psychologically separated themselves from her in adulthood (Arcana, 1981).

1.4 SELF, IDENTITY AND THE REFLECTING MIRROR OF SOCIETY

The fairy tale of 'Snow White' reminds us of the deep insights about human nature and ageing (Bettelheim, 1976). Its metaphors illustrate important developmental tasks during our life cycle. As such, Snow White reflects the psychology of youth and conversely the "Queen" reflects women's struggles associated with ageing. In fact, this fairy tale mirrors real life today and the reality facing the Queen is that of 'middle age' (Strayer, 1996). Contemporary psychology and the symbolism in this ancient fairy tale first published between, 1812-1815, can be brought together in portraying the developmental tasks confronting women in midlife. The unconsciousness of one's mortality in youth becomes conscious in midlife (Chinen, 1987). This brings the review onto the subject of identity i.e. a sense of who we are constantly becoming and its relationship to self esteem as markers in the nature of our adjustment to physical decline.

Identity process theory hypothesizes that as individuals we are more vulnerable to changing physical appearances during periods of age related transitions across the life course (Whitbourne & Skultety, 2002). Particular to this context is the 'appeared' self i.e. our perceptions of what we see when we look in the mirror as opposed to what we want to see. Harter's (1992) empirical research findings on self-development found high correlations between perceived appearance and self-esteem. They were typically between .70 and .80, thus marking out appearance as being the number one predictor of self-esteem (p17). So while external factors such as physical, cultural and social interactions influence identity and self-esteem development, 'intra-psychic' mechanisms of perception may maintain it.

Thus an individual's sense of identity operates on, and needs to adapt to, many different changing levels of cultural, biological and social structures continuously throughout life (Whitbourne & Skultety, 2002). Developmental theory posits that three mechanisms are involved in this adaptation e.g. to the ageing process (Hockey & James, 2003):

- Firstly, Assimilation occurs when an individual is aware of ageing e.g. wrinkles, and minimizes or ignores the importance of it in order to maintain a consistent view of self. There is no negative shift in identity. Research conducted by Whitbourne and Collins (1998) on older adulthood (60+) found that identity assimilation relates positively to self-esteem with regard to women and their appearance. Applying the theory to this study, identity assimilation can incorporate FRCS as a strategy to minimize the look of ageing while at the same time using preventive and compensatory activities such as preventive sunscreens for the face to slow down the re-appearance of wrinkles.
- Secondly, Accommodation is when the individual is aware of ageing e.g. wrinkles on her face, is overwhelmed by this and prematurely define themselves as old. This is accompanied with re-examination or redefinition of self identity. An ideal state is when the sense of self remains constant even when incorporating information of ageing.
- Third is Identity Balance, when the individual maintains a positive view of self while incorporating new information but changing when necessary (Whitbourne & Skultety, 2002).

Erikson's (1959) 'mid-life crisis' stage describes an anticipated psychological state associated with being conscious of the physical effects of the ageing process. Therefore, a desire to live longer without the signs of ageing will inevitably create conflict. Being conscious of the physical effects facial ageing coupled with a low self-esteem may render the individual sensitive to the slightest experience of rejection for looking older. This is very challenging within the context of a youth-orientated culture that holds negative ageist stereotypes (Sneed & Whitbourne, 2003). Thus, a woman in midlife within this kind of culture that promotes youthfulness can experience feelings of dissonance when their appearance is contrary to their own internalized image of a younger self. As psychological adjustment to facial changes takes time to assimilate into our self-perception and self-esteem, this process creates internal tension (Rumsey & Harcourt, 2005) between adjusting to ageing process and desires to stay young.

Merleau-Ponty stressed this ambiguity within our life-world ([1945]1962) such as the personal experience of one's ageing face as not being representative of the true inner younger self. According to Sadala & Adorno (2002), our phenomenological perception of the world is that our understandings are always positioned in a particular experience of embodiment e.g. my body and I are one.

1.4.1 *Metaphors of the Mirror*

Therefore, facial ageing for some women can be experienced as a rupture in their taken for granted ability (unconscious self awareness¹¹) to negotiate the world as an embodied self. At this point they became self-conscious of these physical changes that are out of their control (Nettleton & Watson, 1998). Meyers (2002), captures this disembodied experience in the metaphor of the mirror. She argues that women's reflected mirror image causes a double effect (Meyers). Their inner younger felt self 'me' (body-subject/Merleau-Ponty) remains the same but the outer 'me' a face that does not feel as if it is mine as it is old and does not look like me (body as object/Merleau-Ponty). We speak and think from the body. Our self-doubt in this context is related to how we perceive our faces to look and includes our perceptions of others perceptions of our facial appearance – do they see who we really are?

So the face and the body are central in the tension between physical ageing and the possibility of a continuous self identity. As such embodiment¹² and continuous self identity are matted together. Turner (1995) contends that our internal subjective feelings are of ourselves as forever young. So while our phenomenological experience mirrors continuity of the self identity, the mirror reflecting the external ageing processes on our face challenges this sense of continuity of the youthful self identity. Our identity is often primarily determined by the face, its structure, overall appearance, and expressions. Our faces also reveal our chronological age first before other parts of our body (Sarwer, 2006). So

¹¹ As defined in this thesis, 'unselfconsciousness', are those parts of herself she is not aware of and those parts she does not want to be aware of (Symington, 2006). 'Self-Consciousness' is what an individual is aware of and capable of being aware of in herself.

¹² Embodiment: the body and mind connection – woman is the person whose body it is. Female body and mind (self) as subject and female body as object (society) (Davis, 2003)

these facial ageing signs provide influential cues for our own self identity as well for others to recognize (Rumsey & Harcourt, 2005).

Cooley (1864-1929) an American sociologist argued that society and individuals are not separate phenomenon (in Scheff, 2003). His social psychology theory proposed the concept of the 'looking glass self' (LGS) that drew attention to the ways in which individuals' sense of self (reflexive self consciousness) is derived from the perceptions of others. LGS links two concepts of shared awareness and the social emotions of self-consciousness (SC) e.g. emotions of pride, shame and embarrassment.

Furthermore, the looking-glass self involves three steps marking the beginning of psychological and social processes of self-monitoring and self-conscious emotional reactions to it. Firstly, we have a picture of our own appearance; secondly, we use the reactions of others to imagine and interpret how others judge us; and thirdly, in response to this we move towards self-feelings such as pride or shame (Scheff, 2003). Cooley theorized that through this reflection process, we actually become the kind of person we believe others see us to be. This is where self-feelings such as genuine pride or mortification as shame variants arise (Goffman, 1956). Therefore, just like our perceptions of our reflected mirror images, the self depends on the perceived responses of others – as Cooley said “each to each a looking glass, reflects the other that doth pass” (Scheff, 2003).

Again, the timeless fairy tale of the 'Wicked Queen' in 'Snow White' and her constant referral to the mirror for feedback on her facial appearance can also be understood as her deference to the reflecting mirror of society (Strayer, 1996). The unselfconscious youthful Snow White and self-conscious ageing Queen provides us with wonderful psychosocial metaphors of the mirror, as the reflections of society's value on beauty and youthfulness, and the attitude towards women who deviate from this norm. For instance, the mirror reflects the social values of competitiveness and judgments of society receives the same one question over and over again “*Who is the fairest of them all?*” and always gives back just the one answer, “Snow White (i.e. youth) *is the fairest*”.

So women who place a high value on their appearance and strive for perfection and approval from others must frequently check their faces in the mirror for reassurance. Stayer (1996), comments that in this way she becomes an object looking for her 'self'. In the context of middle age, the 'Mirror Reflected Self' can exact a self-consciousness of an imperfect Self. Harris's (1989) investigation into self-conscious emotions and cosmetic surgery is relevant at this point. He identified significantly higher levels of self-consciousness in patients who underwent cosmetic surgery compared to patients without any type of cosmetic surgery in mind. The conclusion was that these patients place greater emphasis on their appearance than those who did not want cosmetic surgery. Furthermore, as self-conscious emotions play a role in motivating and regulating people's thoughts, feelings and behaviours, having cosmetic self-enhancement procedures may be driven by the desire to promote feelings of pride and/or to avoid feelings of shame (Fischer & Tangney, 1995).

Thus, of relevance to this study is the argument that if an individual feels specific SC emotions of shame, guilt, embarrassment or pride then that in itself is an important psychological event with implications for future behaviour, decision making, mental, and physical health (Tangney & Dearing, 2002). It is to this concept of self-conscious emotions this discussion now turns for further investigation.

1.5. SELF-CONSCIOUS EMOTIONS

According to emotion researchers, specific SC emotions such as embarrassment, shame, pride and guilt have received little empirical attention in comparison to theoretical and empirical attention given to our 'basic' emotions of anxiety, anger, fear, disgust, sadness, happiness and surprise (Tracy & Robins, 2004., Leary, 2004). This is in spite of the fact that SC emotions are central to a wide range of psycho-social processes that occur when people become self-aware that they have either succeeded, or failed to succeed, in some actual, ideal or stable self-representation (Tangney, 1996).

In fact, SC emotions originate from, or alongside, 'basic' emotions and defenses through their reciprocal interactions with our cognitive abilities e.g. theory of mind and symbolic self-awareness (Gilbert, 2004). However

as SC emotions are part of and/or subsumed by basic emotions e.g. sadness subsumes shame; joy subsumes pride. As such, SC emotions that consist of positive (pride) and negative (shame) experiences are often lost in interpretation (Shaver, Schwartz, Kirson & O'Connor, 1987).

Therefore, SC emotions require personal self-evaluative processes in order to become self-aware and maintain self-representations (Lewis, Sullivan, Stanger & Weiss, 1989., Tangney & Dearing, 2002). The 'self' identity includes the capacity for an on-going sense of self-awareness "I" and the capacity for complex self-representations "me". As an example, the women in this study were aware of the tell-tale signs of physical facial ageing in spite of the fact that they had always taken care of their health and body. Self-representations of 'being' and 'being seen' as always taking care of one's appearance may shatter with the advent of facial ageing. Thus, SC emotions can also play a central role with self-reflections and self-presentations that are linked with narcissistic self-esteem regulation (Tracy & Robins, 2004).

1.5.1. Different attributions of narcissism

The recent surge of interest in narcissism was initially instigated with the emergence of the 'culture of narcissism' and the 'Me Generation' factor (Lasch, 1979). Lasch specifically argued that narcissism as a psycho-social concept defined the 1970's culture and that contemporary culture had become excessively narcissistic, self absorbed and competitively individualistic. In such a 'culture of narcissism', he believed that ageing came to mean losing in the competition.

Twenty years later, Haiken (1999) believed that the stigma of narcissism¹³ once associated with individuals who under-took to have cosmetic surgery had largely vanished in America, being replaced by concepts such as 'self-improvement' and 'fitting in' with the modern world and its requirements. This deflection away from pathology was later echoed by Cash (2002) who

¹³ The 'stigma of narcissism' relates to Lasch's concept of the American "culture of narcissism" and refers to behaviour that is self-centred to the point of obsessive self-gratification (1979).

reframed narcissistic motivation for altering ones' appearance as lying within the realms of pride and interest in one's appearance as a way of taking care of it. Conversely, a broader perspective sees individuals embedded within such a socio-cultural, historical, political and economic society and looks upon narcissism as a "disease" that is based upon over-consumption (Gruba-McCallister, 2007).

There are parallels with individual psychology here, as the understanding of narcissism as a disorder is embedded within the person and is caused by intra-psychic dynamics. Richardson & Manaster (1992) have made the point that individuals are fundamentally social beings and psychologists need to situate their clients within the broader social contexts and wider cultural values in which they are embedded, in order to understand them. Thus, narcissism, the issues of self-conscious emotions such as pride and shame, individualism and consumerism are all inextricably interwoven and can be analyzed or researched at any of these levels.

1.5.2. Research into the area of SC emotions

Despite their centrality to psychological, social and cultural functioning, Tangney, Miller, Flicker & Barlow (1996) highlight the fact that there is little empirical research on antecedent cognitive processes that generate SC emotions. However, studying the interface between self and SC emotions present a number of difficulties. Firstly, SC emotions show weaker universality than basic emotions, as phenomenological experience and consequences differ across cultures (Eid & Diener, 2001). Second, while 'basic' emotions have recognizable facial expressions, there is no evidence of this with SC emotions (Shaver, et al, 1987). Therefore it has to be studied with reliance on verbal reports on individuals' internal experiences.

Nevertheless, since 1996, some researchers have linked SC emotions to a wide variety of outcomes, such as specific SC emotions of guilt and shame (Tangney & Dearing, 2002). For instance, guilt has been identified as being centrally involved in reparative and pro-social behaviour such as empathy, and shame has been identified in mediating the negative emotional and physical health consequences of social stigma.

Following these empirical outcomes research studies, Tracy & Robins (2004) refer to the lack of knowledge on the actual processes that are involved in 'how' SC emotions become linked with certain behaviours. Since then, Gimlin (2007) conducted a phenomenological qualitative study on women narratives regarding cosmetic surgery that identified SC emotions within their narratives.

Gimlin's (2007) phenomenological and cross-cultural investigation of women's narratives of their cosmetic facial and bodily enhancing surgery involved women from the USA and Britain. Some British women's narratives challenged the negatively held cultural meanings of cosmetic surgery as being narcissistic, vain, self-centered and selfishly motivated. These women were very thoughtful in the way they managed their money making sure 'the family' would not go short of anything as a result of the money spent on the operation – even when this meant waiting a few years before they went ahead. Nevertheless, despite these considerations, some of these women felt guilty about the amount of money spent on themselves. Other British women who denied that having cosmetic surgery was being 'vain' presented with emotional pain associated with SC shameful feelings attached to their appearance flaws. The shame they felt led to self imposed exclusion from social activities. Alongside this denial of vanity and contrary to it, these British women admitted to being ashamed of their actions preferring to keep it secret from others. Unlike their American counter-parts who were open to others about their cosmetic surgery and acknowledged that engaging in these enhancing practices was coming from a place of 'vanity'. However, despite being proud of what they done, their statements also displayed ambiguity for the American women normalized these charges of vanity by pointing out that it was 'culturally' expected to invest one's available resources in cosmetic improvements (Gimlin, 2007., Fraser, 2003).

Mesquita & Karasawa (2004) proposed that pride and shame attributes are partly influenced by cultural values. These values are important as they may be predictive of many psychological processes that emerge as part of SC emotions. They maintain that identity goal congruence, and the internal locus of attribution, are two significant parameters for the independent self that is associated with Western cultures where successes and failures are

often attributed to individual ability or lack of it. Like Sarwer, Whitaker, Wadden & Pertschuk (1997), they distinguish between appraisal configurations of SC emotions that are negative (experienced as failure) and positive (linked to success).

The positive SC emotion of pride is defined as good feelings about identity-congruent outcomes for which one is responsible (Tracy & Robins, 2004). Pride is associated with the self as being competent, valuable, and capable of producing socially worthy outcomes. On the other hand, negative SC emotions such as embarrassment or shame, are experienced upon personal failure when the situation has been appraised as incongruent with identity goals Mesquita & Karasawa (2004).

The questions that follow on from these positive and negative aspects of SC emotions, is at what point in life do they develop and when are they elicited?

1.5.3. Origins of appearance related shame-anxiety

The capacity to experience shame first appears with the realization that the self (face in mirror) can also be seen from the outside (Jacoby, 1994). Thus self-image plays a role in the experience of shame. Lewis, et al. (1989) observed children's behavioural responses to their facial image in a mirror (rouge had been put on their noses), to identify when self-recognition occurred. By touching their own rouged noses they observed that self-recognition behaviour in front of the mirror starts from approximately 15 months of age. Thus the 'objective self' is born out of this awareness of being able to recognize oneself in the mirror. So a 'subjective self' in infancy starts to develop a rudimentary attitude towards their face in childhood when there is realization that the self can be seen from the outside. This increased self awareness and self-consciousness is part of the experience of either pride and/or shame that is triggered by anxiety in response to the self feeling threatened (Morrison, 1989).

1.5.4 Anxiety as a basic emotion and interaction with specific SC emotions

Thus, anxiety is the precedent to guilt or shame and acts as a warning to the individual to protect oneself (Jacoby, 1994). Clarifying the difference between SC emotions of guilt and shame can be difficult especially when

shame can be experienced unconsciously. Tangney (1996) posits that individuals cannot be expected to know the abstract difference between shame and guilt, and definitions of shame and guilt are best left to the researcher. For this thesis, guilt refers to the act e.g. "I did a bad thing" whereas shame refers to the whole person/ whole self e.g. "I feel completely worthless". Both concepts may relate to shame-anxiety for Izard (1991) proposes that shame-anxiety is embedded in questions such as 'will I be able to meet the expectations of others or myself?' Tangney & Dearing (2002) are clear in making the case that shame is not a moral emotion but guilt is. So depending on how an individual may respond to these expectations determines whether guilt or shame is experienced or parallel to each other.

Jacoby (1994) maintains that it is a normal human need to be seen, admired and loved and the role of 'basic' and SC emotions such as anxiety, fear and shame (shame-anxiety) in their broadest sense serve as reminders of the importance of these social bonds. Jacoby argues that shame-anxiety therefore plays an important role in underlying all feelings in relation to shame when one invests a high level of pride in appearance. It can then be hypothesized that if such women feel they have failed to maintain personal appearance values and goals once their faces start to age they will experience shame-anxiety.

Morrison (1989) and Scheff (2001) both stress the important role of anxiety that underlies feelings of shame when one has failed to achieve, or maintain, appearance related values and goals. They suggest that shame anxieties are inextricably linked to disturbances in self esteem, lack of self-confidence and emotional reactions to threats of rejection and disconnected social bonds. The anxiety about losing social status in the eyes of others means that our social acts are influenced by the slightest chance of being exposed to public shame or loss of face (Tangney & Dearing, 2002). Hence, within an individualistic and competitive society, most people invest a great deal of time and effort to avoid social disapproval which is a strong elicitor of specific SC emotions of embarrassment or shame (Tangney & Dearing).

1.6 SHAME

Helen Lewis (1971) pioneered the importance of shame as representing an entire family of emotions. To name a few here, she identified humiliation, embarrassment, feelings of low self-esteem, exposed, flawed, hurt and feelings of being stigmatized. Wurmser (1981) made the distinction between positive and negative shame. While Kaufman (1989) added to this list of affective shame states such as: shyness, humiliation, discomfort, mortification, degradation and guilt. Therefore it is not surprising that Nathanson (1987) identified shame as often being a central ingredient in ones' experiences of being in the world, and is often unbearable. In fact, Cook (1994) argued that the experience of shame is ubiquitous, as shame follows any positive or negative affect experiences.

Thus shame variants constitute a significant portion of our total experiences ranging from a mild affect such as mild embarrassment to extreme mortification. So it is not surprising that shame is avoided in the "real" world – in fact as an unconscious phenomenon, most of us feel shame about feeling shame. Consequently shame is rarely acknowledged to others, or even to oneself. And, as with any feeling that is denied (knowingly or unknowingly) it remains and resurfaces in other disguises that are just as emotional painful, confusing and is often unbearable.

Gilbert (2004) posits that there at least two processing and monitoring systems for identifying social threats to the self and the generation of SC emotions such as shame. One is related to what is in the mind of others. This may have its origins in infancy when infants first begin to experience, through a process of intersubjectivity, rejection and non-engagement communication signals from others in their social context (Trevarthen & Aitken, 2001). The other is related to one's own self-evaluation and attributions that require more mature meta-cognitive abilities that develop later in childhood. As these attributions mature over the life span the experience of, and triggers for shame may also change.

Gilbert (2002, 2004) also made the distinction between external and internal shame. External shame is the experience of 'being' shamed by others and can be experienced as self-consciousness, humiliation and

embarrassment. Internalized shame is the experience of 'feeling' ashamed and evokes feelings of inadequacy, self-hate or narcissistic vulnerabilities associated with the ideal self.

Similar to Wurmser (1981), Skarderud (2007) writes that "shame is something we want and something we do not want" (p 82). She argues that while the response to it may be a withdrawal from the public arena, this withdrawal acts as a protection against being hurt or rejected within relationships.

Thus, it is easy to deduce from the aforementioned that shame, both positive and negative, are multifaceted experiences (Tangney, 1996). Therefore, it is helpful to clarify the various concepts of these particular shame experiences. Gilbert (2002) building on the work of Tangney (1996) conceptualized shame as having the following components¹⁴:

Emotions: a primary feeling of its own or in combination with basic feelings such as anger, anxiety or self-disgust;

Cognitions: beliefs about oneself e.g. inferior, especially when making social comparisons with others;

Physical: blushing;

Behavioural: concealing e.g. withdrawing, wearing a scarf around ones wrinkled neck, make-up, Botox injectables, anti-ageing cosmetic surgery;

Interpersonal relationships: relationship between the shamer and the shamed

Gilbert (2002) also made the distinction between internal and external shame. He proposed that shame can be experienced internally as a felt sense of self with cognitions about the self; or externally focused in terms of cognitions about what others are thinking about the self; it can be both positive and negative; it is multifaceted, and shame requires the more mature meta-cognitive abilities to be able to make self-evaluations and attributions. He maintains that people with external shame are more

¹⁴ Examples given with the conceptualizations are from the women's narratives in this thesis, and are not from Gilbert, (2002).

focused on self-presentations and can be reassured if they feel you like and accept them.

If shame involves the experience of being unattractive, people with the internal experience of shame tend to be highly self-critical and condemning, and less open to reassurance. However, self-criticism can motivate to self-improve, correct or get rid of or destroy the parts of the self associated with self-hatred or disgust (Gilbert, 2002., Gilbert, Clarke, Kempel, Miles, & Irons, 2004).

1.6.1. *Shame, pride and shame cycle*

Positive shame is about respect for oneself and others and while it protects social bonds it also defines boundaries for privacy. For example, feelings of pride about one's surgically rejuvenated face can be tempered so that becoming grandiose i.e. 'full of oneself', is prevented (Skarderud, 2007). As such it may function as justification for not to telling others why they are looking younger and be an adaptive response. On the other hand, it may function as negative shame that is internal i.e. they may feel ashamed that they have resorted to 'unnatural' means to restore a youthful appearance and keep the operation a secret from others. Whereas narcissistic pride is more applicable to those who unconsciously feel shameful and need to hold on to their grandiosity and boast so as not to feel their shame – thus shame and feelings of grandiosity are different sides of the same coin.

Several studies on shame have investigated its presence in eating disordered patients. In this regard Troop, Allan, Serpell & Treasure (2008) identify shame as essentially an emotion of social comparison and associate it with a fear or anticipated fear of eliciting disgust in others. So shame in an eating disorder is a self perception that the self is of low social status. It also includes another self perception that other people see the self as being of low social standing (Troop et al.). While their work on shame in women with a history of eating disorders is not the shame processes that involve women in midlife facial ageing, it offers parallels in the way that shame can be experienced i.e. shame attached to experiences of perceiving oneself to have fallen short of particular internalized standards, and that the self therefore is bad or found wanting.

Pride and shame evoked by anxiety, while multifaceted are also abstract concepts, and as mentioned afore, can only be inferred indirectly. Psychoanalytically, Freud believed that acts of guilt, narcissism or shame were psychological defense mechanisms. They were employed to protect the ego (the self) from the conflicts (anxiety) created by and between the id (instinct) and superego (conscience) and the demands of reality (to maintain a youthful appearance), in order to provide some respite from a difficult situation (Fonagy, & Target, 2003). This latter process suggests that these psychological defenses, particularly shame and narcissism can be 'adaptive' or 'maladaptive' (Rhodewalt, Madrian & Cheney, 1998; Morrison, 1989). Therefore, there is always a relationship between anxiety, narcissism/vanity and shame and they can be employed as either psychological defenses or experienced as feelings (Lewis 1971, Wurmser, 1981, Morrison, 1989, Izard, 1991).

Mascolo & Fischer (1995) and Tangney (1996) refer to the dynamics between shame – pride; and, shame – shame as repeating cycles in patients with eating disorders. These cycles indicate attributions of what comes first and what comes afterwards. Shame as coming first, has emotional and cognitive aspects associated with self dislike or disgust. Thus, following are positive functions of shame or pride (for being able to restrict food intake) that seek ways to compensate for such feelings. With regards to feeling ashamed of ones ageing facial features it may prompt such women to seek facial rejuvenation and enhancement procedures and feel proud about the results.

Skarderud's (2007) qualitative study on shame and pride in Anorexia Nervosa offers very interesting and applicable parallel models of shame-shame or shame-pride cycles. She comments on the fact that shame based syndromes are associated with addictions, self-harming and eating disorders. Again these repeating cycles are not related to midlife and facial ageing – however highlighted is the feeling of shame that is often both origin and consequence of these conditions. Given the relevance of the concepts and functions of the development of shame and pride throughout the life course, and in particular during midlife, this study seeks to identify whether shame as origin attached to facial ageing - followed by pride of rejuvenation - that is followed by shame (positive or negative) as a

consequence, plays a mediating role in managing unbearable feelings and harnessing desire to restore a more youthful identity.

The purpose of this section on specific self-conscious emotions was to identify and explore shame and pride variations and their hypothesized interactions with symptoms of ageing facial features. As Baldwin and Bacchus (2004) argue SC emotions such as shame and pride only occur when an interpersonal aspect of one's identity is threatened or elevated i.e. excluded or rejected, versus included and accepted by others. Thus this section on SC emotions identified and described the role of pride, vanity or narcissism, as contrasting emotional and cognitive experiences that can occur in tandem with, or separately to negative or positive SC emotions of shame and its variants.

1.7. SUMMARY

The importance of investigation patients' motivations for all types of cosmetic surgery (but not specifically related to faces) has been highlighted by many research studies done in this area in the past few decades (Webb, Slaughter, Meyer and Edgerton, 1965; Goin, et al., 1976; Sarwer, et al. 1997). While cosmetic procedures are considered "psychological interventions," gradually thoughts on pathological motivations for facial cosmetic surgery, while still relevant, now include questions that seek to identify and include factors that are not inherently problematic. They also include aspects of the individuals' developmental, social and cultural environments as well. However, the debate on the rights and wrongs of cosmetic surgery, controversies and all the inherent ambiguities remain.

Theory of Mind capacities enable children to learn that significant others, such as mother, evaluate what they do in terms of right or wrong. So mother's approval or disapproval towards certain acts or external appearance of the child becomes internalized. Thereafter the child develops the capacity for self-awareness as well as self-evaluation which lays the foundations for SC emotions (Retzinger, 1987).

A central part of a person's social identity is the social self, reputation, feelings of social acceptance, and status. As noted the self has long been a

fundamental social construct and self-representations reflect the perceptions of significant others, generalized others and imagined others. A large part of who we are, is based on the values of our cultural society (Tracy & Robins, 2004., Skurderud, 2007). In our current socio-cultural environment that values youth and youthful appearance, women in midlife who choose to have rejuvenation cosmetic surgery have to manage theirs, as well as society's continued ambivalence towards it. The importance of positive and negative SC emotions involved in the overall sanctioning and maintenance of social relationships has been identified (Parrott, 2004).

SC emotions of pride and shame appear to be central to many important self-evaluative processes. The different variants of shame and pride can be textured with 'basic' emotions of anger, anxiety or disgust and may be difficult to recognize. Issues of individual narcissism, vanity and pride are best understood from a holistic perspective that includes broader psychological and socio-cultural perspectives. This is because these concepts are embedded intra-psychically within individuals while at the sometime individuals are embedded within their socio-cultural environments (Mesquita & Karasawa, 2004., Gimlin, 2007).

A tentative suggestion is made from data analysis and above information that shame may be a response to facial ageing and a consequence of rejuvenation. Pride may also present as a link between shame of ageing as origin, and shame of rejuvenation as consequence.

The literature review has identified a paucity of specific detailed experiential work into the area of FRCS and in-depth qualitative research on women in midlife phenomenological experiences' of facial ageing. Owing to this paucity, this research seeks to contribute to, and enlighten our understanding on facial appearance concerns by exploring phenomenological experiences of women in midlife who decide to rejuvenate their facial appearance, either surgically or non-surgically. This is inclusive of their experiences and perceptions of themselves after rejuvenation has taken place. IPA, a qualitative research approach, was selected as an appropriate method concerning itself with each individual lived experience (Smith, 1999). As an approach it concerns itself with the many aspects of individual women's temporal experiences of facial

ageing, facial cosmetic rejuvenation surgery and/or procedures, and so affording a more holistic understanding of their experiences.

After the section on reflexivity, the next chapter is on this methodological approach.

1.8. Reflexivity: Where it all started

Five years ago I had some facial rejuvenation procedures. Making the decision to go ahead and rejuvenate was not difficult. My desire was strong and my motivation was internal (the type you are supposed to have if you don't have pathology). On TV, it looked pretty straight forward, easy, and painless, as one woman on a make-over programme said of her experience "it was just like having a tooth out". Well No! It wasn't for me. It was an experience that totally took me by surprise because nothing that happened to me was 'flagged up' on TV. It was not 'cosmetic surgery from hell' but it was painful, the plastic surgeon laughed and said "Oh you're just having a panic attack" when my head was about to explode with brains everywhere; one of my sons said "you didn't think about how we would feel about this!"; friends I knew well were peeping at me through net curtains trying to get a good look at my face while they thought I wasn't looking. I had told most people I was in contact with that I was going to do it. It did not occur to me to keep it a secret. All in all it was an enlightening experience coming from being an insider of the world of people in midlife ageing naturally, to becoming an outside member of that group, then becoming an insider of the world of people who take 'unnatural' measures to look younger. It all came as quite a shock to me.

I had so many unanswered questions but I did not know of anyone else who had done this with whom to share experiences. It occurred to me that if I had unanswered questions then so did others. In 2006, there was little research or attention given to older women having facial rejuvenation cosmetic surgery and/or procedures. Hence my decision to conduct my doctoral research into the field of facial cosmetic surgery. Ultimately I hoped that the findings could help prepare women for this journey, so that their transformation would not only be an external one but could also be internal. I also hoped that I could apply these findings to counselling

psychology and potential clients. So I decided to carry out this study on women in mid-life and their facial ageing.

CHAPTER 2: METHODOLOGY

The sample of participants who were satisfied with the results of their surgery were specifically chosen with the purpose of shifting away from a pathological focus on problems generally associated by the various disciplines with cosmetic surgery, to the more every day experiences of 'ordinary' women choosing to have facial rejuvenation.

2.1 Research Purpose and Design

Using the Interpretative Phenomenological Analytic (IPA) approach, the overall aim of this thesis is to identify and explore personal meanings of lived experiences of facial ageing in mid-life, having FRCS and, how they perceive themselves after healing had taken place.

2.1.1 Research objectives

The research objectives are as follows:

1. To explore and describe these participants' lived experiences of facial appearance and facial ageing in mid-life leading them to choose to have facial rejuvenation.
2. To explore and describe their experiences during the 'peri-operative' period.
3. To explore and describe their experiences of themselves during the 4 week post-operative period.
4. To explore and identify their facial appearance perceptions after healing had taken place.
5. From the findings identify potential psychological support and counselling needs before, during and/or after the period of facial rejuvenation.

2.2 Reflexivity on the Research questions

Being an insider to this phenomenon of rejuvenation, I realized I would have to be aware of unhelpful over-identifications with participants and their experiences. So I spent considerable time thrashing out research questions that would enable participants to talk about their stories and experiences of rejuvenation and not lead them to areas that were specific to my experience, such as with pain. That is one of the reasons why I choose Interpretative Phenomenological Analysis as

the approach to this research. It allows individuals to tell their stories while at the same time allows for some broad framework of questions relating to the experience being investigated.

Being able to choose a research subject on mid-life facial ageing and cosmetic surgery with a group of women who were satisfied with their rejuvenation results was an exciting challenge for me as a counselling psychologist. I aimed to reflect the philosophy underlying counselling psychology by identifying personal strengths and vulnerabilities in its endeavour to maximize psychological well being. I found Duffy's comments on this question pertinent and motivating. Duffy (1990) stresses the importance of understanding that difficulties and challenges occur in everyone's daily life. The ways one uses to manage this adversity is not to be judged as pathological but rather to be seen as coping strategies that have the view to creative change and enhanced well-being. This of course does not deny women's reality and experiences of psychological distress.

I couldn't wait to get started.

2.3 Rationale for a qualitative study

As identified in the literature review, there are gaps in available knowledge of individual experiential and in-depth personal experiences of wanting and having cosmetic surgery. There are a number of autobiographical accounts: Blum (rhinoplasty, 2003); Kron, (2 face-lifts, 1998); Pitts-Taylor, (rhinoplasty, 2007; Eskenazi (brow-lift, 20078); Toyah Willcox, (face-lift, 2005). Qualitative research, on the other hand, is concerned with meanings and interpretations from comprehensive records of a participant's words and actions (Willig, 2008a). As a way of starting to address this gap, the use of qualitative research that focuses on describing the nature of an individual's experience within their personal 'life-worlds' was chosen for this particular research (Ashworth, 2008).

2.4 Epistemological considerations underpinning qualitative research

My choice and approach to investigating the meanings of women's lived experiences of facial ageing and rejuvenation was influenced by my philosophical

belief in humanistic psychology. The humanistic therapeutic value base gave credence to this idiographic approach where the individuals took a significant role in determining what they said about their phenomenological, and therefore unique, experiences (Ashworth, 2008). This is in keeping with humanistic epistemological considerations. Interpretation is necessary when one recognizes that an individual can never know everything about the particular phenomenon under investigation as experienced and recalled by that individual (Gergen, 1994). Epistemologically the above embraces two ways of knowing i.e. phenomenological, that is, the given totality of individual's consciousness and lived experiences, (as originating in the Husserlian tradition), and hermeneutic or interpretive understandings that derives its focus primarily from Heidegger (1927/1961) in Langridge, 2007. This also includes illuminating the meaning of external objective and subjective factors such as contextual, social, cultural, geographical and historical aspects of the phenomenon under investigation, with the same desired outcome of understanding meanings and perspectives as experienced by these participants (Lewis, 2003).

These epistemological underpinnings outlined above are compatible with the theory, practice and research of Counselling Psychology. It is for these reasons that Counselling Psychology has drawn up and developed phenomenological models of practice that seek to:

- “1. To engage with subjectivity and inter-subjectivity, values and beliefs.
2. To know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feelings, valuing and knowing”

(British Psychological Society, Division of Counselling Psychology, 2007).

As reflexive practitioners we aim to be reflective about the impact of our own background as Counselling Psychologists and personal preconceptions when seeking to gain knowledge, understanding and ability to interpret the embodied experiences of our research participants (Brenner, 1994). In this qualitative research, priority was given to my role as researcher in the creation of meaning i.e. 'heuristic' in nature (filtering possible meanings through myself). Being in a reflexive relationship with the women I interviewed, I invited them to talk about potentially deep personal experiences that may have been unarticulated to

anyone before. Humanistic values and psychology has been linked with phenomenology and existentialism (Misiak & Sexton, 1973) and therefore has great relevance to the meanings these women give to their experiences of looking 'older' and then turning back the time clock to look younger again. In order to obtain this privileged insider knowledge, I was able to do this sensitively as a Chartered Counselling Psychologist using my therapeutic skills of empathic engagement, unconditional positive regard and genuineness in the role of qualitative researcher.

2.5 Comparison between methodological approaches

In choosing which specific qualitative approach to use, IPA, Grounded Theory (GT) and Discourse Analysis (DA), were considered. While GT and IPA are similar in their data collection and analysis of themes, they differ in other respects. IPA's approach to research is phenomenological understanding of individual's lived experiences and makes interpretations from this data. In this process theory may be verified (Willig, 2008a). In contrast, GT's main focus is sociological. Its focus is on an explanatory framework and contextualized social processes, to ultimately develop theory that is created from the researcher's perspectives (Glaser & Strauss, 1967, Willig, 2008a). With its sociological focus, GT is interested in individual's experiences. However, experience is just one of the many factors considered and as a result loses the individual's unique experience along the way. IPA on the other hand focuses on the individual and is explicitly psychological. Given these comparisons IPA was better suited for this study than GT. The other qualitative design considered was DA which has two approaches. I shall briefly mention one of them, i.e. Discursive Psychology (DP). Its focus is on the role of language in the construction of psychological and social reality and is mainly influenced by conversation analytic principles. (Willig, 2008b; Coyle, 2007). It provides information about cognitions and perceptions in the construction of personal meanings (Phillips & Jorgensen, 2002). IPA also explores cognitive processes. However as its focus is on the meaning of 'lived experience' it includes psychological, cognitive, social, historical, cultural and developmental processes. IPA acknowledges that in understanding individuals' experiences they are already embedded in language and in fact our interpretations are always gained from language. That is, IPA does not take the position that language constructs all reality. DP differs in this respect as it gives more weight to discursive representations as the units of analysis (Smith,

Flowers & Larkin, 2009). IPA primary purpose is to understanding experience that is already embedded in the narratives. Therefore, IPA as a qualitative approach to research was best suited for this study.

2.6 Overview of IPA

IPA was developed by Jonathan Smith (1996) and drawing upon the tradition of phenomenology was specifically developed as an approach to gaining insight into the individual's psychological world. The philosophy underlying IPA is to investigate the phenomenon in its own terms i.e. 'return to the things themselves' experienced in a system of interrelated meanings in the individuals' 'life-world' (Husserl, 1964). Phenomenology is concerned with consciousness, experience complexity and processes in peoples' psychological and social worlds. IPA for this study offers a methodological approach to meet the complexity of enquiry into personal experiences towards the visible changing features of one's face through the passage of time, and the process of those experiences (Smith & Osborn, 2008).

It is an idiographic mode of inquiry and therefore it is possible to make specific statements about the participants. Smith and Osborn (2008) maintain that links between IPA findings; the reader's own personal and professional experiences, and claims in extant literature, can make it possible to think in theoretical generalizability terms rather than statistical (p 56).

The important assumption is that what is being explored is the participants' perceived reality. However, trying to empathically 'put yourself in the participants' shoes' as it were, in order to understand their experiences and then interpret them is flavoured by the researcher's own view of the world. These personal dynamics are unavoidable and are in indeed necessary for an interpretative activity to take place (Smith & Eatough, 2006). This process of interpretation is depicted as a 'double hermeneutic'. First, 'the participants are trying to make sense of their world'. Secondly, 'the researcher is trying to make sense of the participants trying to make sense of their world'. While acknowledging, that as human beings we can never fully express ourselves, these interpretations are approximations (Smith & Osborn, 2008). In effect this double hermeneutic process combines empathic and critical questioning hermeneutics (Ricoeur, 1970). Smith and Eatough (2006) posit that as an IPA researcher you can be empathic while at the same time maintain an objective stance while sense-

making. This is achieved by being curious and asking oneself objectively focused questions about the participants lived experiences. To help with this process of 'being with' the participant subjectively and then objectively reflecting on and interpreting their experience, Husserl's (1964) phenomenology starts with the methodological strategy of "bracketing off" my reality, so that my questions, understanding and interpretations are guided by the participants' experiences and not my own. In fact '*a return to the things themselves*' as previously mentioned. So while I may empathize with some of the participants' emotional experiences, at the same time I shall be able to keep a sufficient empathic distance from their emotive stories. This is by being reflexive and asking myself questions such as "what are these participant's emotions underlying this response?" and "how did this process of guilt in her life develop?" As these stories are to be examined in detail, generic convergent statements about their shared ways of thinking, feeling and behaving as well as dissimilar statements may be made about each participant's experience.

2.7 Participants

A homogeneous sample of participants were selected all sharing the experience of facial ageing and facial rejuvenation. The sampling was also purposive in terms of inclusive criteria, for example age, ethnic group and so on (Smith & Osborn, 2008).

Inclusion criteria

- Women, Caucasian, between the ages of 40 - 60 (there was one exception of a 32 year old)
- Women who have had successful (by their own subjective judgment) facial cosmetic rejuvenation surgical and non-surgical procedures
- Any socio-economic background
- Any occupation, housewife or not working
- English speaking: South Africans and/or British citizens

Exclusion criteria

- Women who have had reconstructive surgery as a result of trauma, illness, or a congenital birth defect
- Any corrective (structure altering) procedure such as a rhinoplasty
- Actively psychotic or receiving in-patient care for mental health problems e.g. Body Dysmorphic Disorder or Major Depression (DSM-1V-TR, 2000).
- Celebrity status

At a post-graduate doctoral level, qualitative sample sizes generally tend to be small (Smith & Eatough, 2006). In keeping with this number, the aim for this study was to recruit 7-8 women as this was considered a sufficient number for examples of convergence and divergence experiences to be identified. The choice of mid-life (40-60) was two-fold. From the ages of 40 – 45 (taking into account the varying effects of genetics) our facial skin starts to become thinner and less elastic, ligaments and connective tissue weaken, and eventually the most noticeable effect is of sagging jowls, double chin, wrinkling neck, drooping eyebrows – basically skin and the underlying muscle fibers gravitate downwards (Davies & Sadgrove, 2002). Anti-ageing and anti-wrinkling creams are no longer effective. Despite this natural ageing process, between the ages of 50 to 60, facial skin is usually still elastic enough with bone structure strong and well defined. Therefore, this age group are good candidates for rejuvenation cosmetic surgery. Seven participants were identified through colleagues and a professional contact. Two participants withdrew after the initial contact. The reasons for withdrawal were unfortunate. In the first instance, the participant's mother died suddenly, and in the second instance, the participant had a brief psychotic episode following her surgical face-lift under local anesthetic. This meant I was left with 5 participants. Fortunately a colleague of a colleague volunteered. This woman was 32 years of age and had undergone non-surgical facial rejuvenation interventions. So given time constraints and practical reasons, I included this woman in the study. I also thought it would be interesting to have one participant outside of the age limit, as any age divergent experiences of this woman's in relation to the others would be important from a developmental point of view. So in the end I had six participants in this study. Smith and Osborn

(2008) make a realistic comment about samples in that “one’s sample will in part be defined by who is prepared to be included in it.” (p56)

2.7.1 Recruitment

Statistics claim that thousands of women have cosmetic facial rejuvenation every year. Everyone I spoke to knew someone who had had a facelift, so I thought recruiting participants would not be a problem. This assumption proved incorrect. Starting with ‘word of mouth’ nobody was prepared to approach their friend about the research because it meant they had told someone else about it. So it was not easy to obtain participants this way. It seemed that in the UK and SA cosmetic surgery has a ‘secret status’ with most women preferring to keep the rejuvenation to themselves (see Literature review and Discussion). Snowballing supported this practice of secrecy but finally, after months of trying, I managed to get one participant from SA. Then through networking with professional colleagues, I was put in touch with Prof. Alan D. Widgerow, a worldwide respected academic and plastic surgeon who lives in Johannesburg, South Africa who very generously contacted some of his patients who consented to be interviewed. Recruitment through contacting U.K. Plastic Surgeons electronically, telephonically and face to face failed completely as they either ignored the correspondence or as in a couple of cases, the secretary said they were too busy. Fortunately I was able to obtain 2 participants from the UK through the efforts of professional colleagues. Once initial contact had been made all participants (plus Prof. Widgerow) were given an information sheet (**Appendix D1**) and consent form (**Appendix D2**). Once they had read the information sheet and given time for any possible queries they signed the consent form.

2.7.2

Table: Demographics of participants – Descriptions of surgery and procedures

Participant Pseudonym	Age	Date of Surgery	Type of surgery &/or procedure	Nationality	Occupation	Intimate Relation-ship	Grand-mother	Mother
Rina	59	Dec 2005	Face-lift plus jowls; and Eye lid surgery, upper & lower eyelids	South African	Joint Managing Director	Married	Yes	Deceased 2004
Angela	59	Sept 2002	Face-lift plus neck- lift	South African	Partner: private company	In partnership	Yes	Deceased 2004
Sally	59	June 1999	Face-lift plus jowls; Eye lids surgery (upper & lower eyelids). Restylane fillers around mouth and nose area	South African	Housewife	Married	Yes	Deceased 2002
Molly	57	April 2006	Eye lid surgery for upper eye lids; Restylane fillers around mouth and nose area; laser resurfacing to re-move scar on chin	British	Housewife and co-partner with husband's business	Married	No	Deceased 2006
Cathy	55	March 2006	Face-lift and neck lift; Eye lid surgery for upper and lower lids	British living in South African	Joint Managing Director	Married	Yes	Deceased 2004
Pat	32	Aug 2005	Botox: forehead; Restylane: nasolabial	British	Dr. in Social Sciences; own business	Married	No	Alive

2.8 Ethical considerations

Approval

Ethical approval for this study was granted by the Ethics Committee, School of Social and Human Sciences, Department of Psychology, City University. Completed Ethics Release Form (**Appendix D4**).

Informed Consent

As part of increasing participants' awareness of types of questions they would be asked and therefore increasing the value of 'informed' consent, prior to signing consent a few of the research interview questions were given to the participants to read. Once they showed interest, the rest of the questions were given to them (**Appendix D6....**).and they signed consent. This strategy is also related to contextual sensibility and as such, an important ethical consideration (Kvale, 1996). For the SA participants, Prof A. Widgerow, selected from his patient group those he thought would be willing and able to participate. He made the initial contact and using my information sheet, introduced them to the interview questions, and then obtained their informed consent for their voluntary participation. I received the signed consent through the post as well as confirmation of consent via their emails.

Vulnerable participants

Although conducting interviews with participants who had successful rejuvenation are not classed as 'vulnerable participants', the subject matter had the potential of being sensitive. Reflective judgment and application of my professional skills related to contextual sensibility in this regard. However, no participants became distressed; requested follow-up interviews or asked for any details about therapists after the interviews (**Appendix D5** South Africa (SA) and United Kingdom (UK) web address). In fact some of them said it had been a great relief to talk about such a major life event in their lives with a psychologist doing this research and it gave them new understandings as well.

Confidentiality and anonymity

Procedures for ensuring participant confidentiality and anonymity were explained to participants. Anonymity was ensured by applying fictitious names on all the

transcripts and the nature of specific incidences supplied were generalized to protect participants from being recognized in any published articles. Generally, I sought to ensure sufficient anonymity for the level participants' required (Wengraf, 2001). Participants' material, written or audio taped were kept locked in a filing cabinet at work when not in use. All audio recordings were erased once transcription was completed.

Data Protection Act

The Data Protection Act, 1998 was adhered to at all times, as well as the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines, (2007). The data on hard discs will be kept in a secure place for five years after the doctorate has been successfully completed.

2.9 Procedures

In view of the fact that my participants were in (SA) and the UK (United Kingdom) interviewing strategies had to be flexible enough to accommodate different locations.

2.9.1 Interviewing strategies and techniques

Smith and Eatough (2006) encourage IPA researchers to adopt a flexible method of data collection. Semi-structured interviewing strategies were considered the most appropriate fit for the exploratory nature of the phenomenon under investigation (McLeod, 2001). My semi-structured interviewing techniques used 3 different methods; electronic (E-interviewing) followed by telephonic interviews for South Africans, and face-to-face interviews in the UK. With each new topic of investigation the set of suggestive and open interview questions were the same with both methods of interviewing with general type questions asked first followed by more specific ones. I first contacted the SA participants via their email addresses given to me by Prof. Widgerow, in order to confirm a time I could telephone them. The initial call was to establish rapport and explain how they would be interviewed. Once this was established I sent the interview schedule to them electronically (the same one shown to them by Prof. Widgerow. "E-interviewing" refers to e-mail exchanges between the researcher and participants (Bampton & Cowton, 2002). E-interviewing has certain advantages and limitations. A disadvantage is transcribing all interviews as it can take days. So an enormous advantage was the saving of time in transcribing and of course

travelling (Wood, Griffiths & Eatough, 2004). Bampton & Cowton, argue that sending the e-questionnaire gives time for a busy participant and researcher to reply and relieve them of the task of having to identify a particular block of time in their busy schedules to complete an interview. The time between sending the semi-structured e-questionnaire and the participants returning the complete schedule back to me was within a week. This relatively short delay in replying was not a problem for me as I was busy with other doctoral related activities. It can be a disadvantage however if the delay on reply is too long, as the interactions become too asynchronous and with the relationship taking place at a distance it can lose its impetus. Replies may also not be spontaneous which can be the basis for the richness of data collected in verbal exchanges (Bampton & Cowton). This is in fact why I chose another collection technique to explore issues further because their e-mailed answers tended to be confined to answering questions as concisely as possible. This does not mean that their replies were not valid.

The advantage for myself, as researcher, was it gave me time to plan my response to the developing dialogue. So on return of the completed semi-structured e-interviewing schedule, I telephoned them to explore interesting areas they had identified. In terms of validity, any type of self-report is reliant on participants answering truthfully and it is a general issue (Wood, et al., 2004). So while exploring replies in more depth over the phone, at the same time I was able to verify e-mailed responses for genuineness. I did not suspect that the e-mailed responses were from someone else and therefore not genuine as these emails addresses had been given to me by Prof Widgerow. Rather I am referring to the concise answers that needed more 'fleshing out' to gather in their richness. These calls were all audio taped so as not to lose any information and to keep the transcriptions accurate.

Using open and broad based questions over the telephone allowed for the development of spontaneous exploration of thoughts, feelings, behaviour and beliefs introduced by the participants that I, as the researcher, had not previously thought of (Smith & Osborn, 2008). For example, with the first interview the participant gave 'thick' descriptions of her relationship with her mother and thereafter all interviews with new participants whether electronic or face-to-face incorporated questions around this new area of mother. As no new material developed in subsequent interviews the schedule remained the same for the

other participants. While the number of participants was small, the in-depth interview data obtained was more than one hour worth of data per participant regardless of whether the data was obtained via the email, telephone or face-to-face.

My particular challenge was in maintaining the balance between not being neutral (otherwise I would never know how the participant felt and thought) nor as personal and emotional as a therapeutic session would be (otherwise my role would become one of therapist). My task with each interview was to set up in a relatively short space of time the right facilitative conditions to encourage the participants to get beyond merely polite conversation or exchange of ideas in order to cover both factual and meaning levels (Kvale, 1996). My style of conversation in the emails, over the phone and face to face, although having the same purpose, had to be adjusted accordingly. For instance, I used email mainly for demographic and factual information gathering from the participants in South Africa. According to their answers I would send a second email asking them to think about more specific situations or actions linked to their email answers, in order to build on personal meanings to their answers. In this second email I also arranged a time when it would be convenient for me to phone them so that we could discuss these answers in more detail. The phone calls were a very valuable adjunct to the emails as it enabled me to focus on certain themes; to obtain open nuanced descriptions of different aspects of their life world relating to the research central question; to remain curious and open to new and unexpected phenomena; and, to reflect on any ambiguous statements of the interviewee. My questions related to the purposes of seeking understanding of meaning of what the interviewees were saying (Kvale). Of course the non-verbal body and face positions I could not see but I made good use of my telephone counselling skills to listen not just to the content but the use of voice. The call never lasted longer than 40 minutes and with their permission I followed it up with another call the next day to say thank you and to ascertain whether there were any feelings or questions they wanted to discuss about the research.

Face to face interviews are ideal for interviewing participants as it enables observation and cognizance of facial and bodily movements to take place providing a more complete understanding of what is being communicated. This can be pertinent when sensitive issues may cause some embarrassment for the participant and they may find difficult to share. I remained sensitive to the subject

and empathic towards the participants throughout the time of the face-to-face interviews. I did not want my participants to feel any discomfort or shame and being mindful of their non-verbal behaviour was an advantage. The interviews lasted between 60 minutes to 90 minutes and from the information I obtained, either over the phone or face to face, there seemed to be no obvious limitations when compared with the e-interviewing schedule replies.

Debriefing was straight forward. To enable some emotional processing could take place for both the participants and myself, I arranged to contact them the day after the interview had taken place (either telephonic or face-to-face). If they felt they needed counselling then we would take steps to ensure that occurred. However it was not necessary. A letter thanking them for participation, plus a small beauty product gift, was given to them once their contribution was completed.

2.9.2 Transcriptions and analysis

All verbal interviews, including my own questions to them, telephonic or face-to-face were audio-taped and then transcribed verbatim. For the **first stage** of the analysis I read an individual transcript several times until I was as familiar as possible with that particular story. With each reading I became more immersed in the data (Smith & Eatough, 2007) which is a necessary part of the process of understanding their realities. On each page of the transcript in a left-hand margin I noted impressions of relevant and interesting details of what was being said, with second and third readings offering up new insights. My comments were either paraphrased or were documented as tentative interpretations.

The **second stage** involved returning again to the beginning of the transcript and in the right hand margin I documented comments, derived from my initial notes that were of a higher level of abstraction, such as, tentative formulations of psychological concepts and themes.

The **third stage** involved looking for connections between the themes throughout the transcript and organizing these themes into clusters – at all times preserving the integrity of what the participant actually said. I did this by making sure I stayed within the words and meanings of their texts. This empathic approach also prevented me straying into my experiences (which were bracketed off) to short circuit understanding theirs. Some themes were dropped at this point

because their evidential base was not strong enough. From **fourth stage** of the analysis superordinate themes were identified along with their sub sets of subordinate themes (Smith & Eatough, 2007). (Paper trail for these stages of analysis see **appendix D9**). It involved re-ordering the list of themes into a coherently structured table. Themes that were rich in detail were kept and those that did not have strong evidence were dropped. Making sure each superordinate theme and their subordinate themes were firmly grounded in the text, the table includes the cluster labels together with subordinate themes labels, brief quotations and references to where the relevant extracts are located in the interview transcripts.

Each case was fully analyzed this way before moving onto the next case. In this process I was also identifying where participants' stories differed and where they were similar (Smith & Osborn, 2008). Documenting in such a manner allowed for theoretical connections within and across cases to be made with such connections always remaining located within their texts thus providing for methodological features of transparency of the results and reflexivity in my interpretations.

The rest of the transcripts were also analyzed inductively going through the same stages. Analyzing each participant separately encouraged me to keep an open mind in obtaining idiographic views of the phenomenon under investigation. IPA is complete when that which is shared between participants has been identified and placed under the appropriate superordinate themes (Smith & Osborn, 2008). For the **fifth stage (table 2.10.1)** I integrated all participants' superordinate and subordinate themes into an inclusive master list identifying convergence and divergence of experiences that reflected experiences of the group as a whole thus capturing the essence of the phenomenon itself (Willig, 2008a). Again, identifying labels of participant's pseudonyms and line references from the texts which supported each one are indicated.

2.9.3 Summary Table of Integrated Themes (5th stage)

Superordinate and Subordinate Themes	Examples	Pat	Cathy	Molly	Sally	Angela	Rina
1. Temporal experiences of facial ageing followed by FRCS <ul style="list-style-type: none"> Contemplation: Peri-operative period Euphoria Repeats 	<p><i>"I just couldn't look at it as I felt too old."</i></p> <p><i>"I panicked suddenly, I thought, God, what the hell am I doing here?"</i></p> <p><i>"I've never been happier with myself."</i></p> <p><i>"Everything is starting to go a little again. It's the one bloody little line that is bugging me."</i></p>	<p>1/10, 1/8 1/19</p> <p>5/21, 5/27, 5/29</p> <p>5/ 23,</p> <p>5/3, 5/5, 5/18-19</p>	<p>1/1-3,</p> <p>5/18-27</p> <p>5/14</p> <p>5/2,5/5,</p>	<p>1/4,5,6,</p> <p>1/60-83</p> <p>3/1</p> <p>25/1,</p>	<p>2/1-2,</p> <p>3/4</p> <p>24/2-5,</p> <p>17/5, ,</p>	<p>1/6-7,</p> <p>3/31</p> <p>4/1</p> <p>3/10,</p>	<p>1/10-12,</p> <p>1/77</p> <p>4/14</p> <p>4/5,</p>

Superordinate and Subordinate Themes	Examples	Pat	Cathy	Molly	Sally	Angela	Rina
2. Mother, self and facial appearance <ul style="list-style-type: none"> • 1950's mother & her facial grooming • Intergenerational appearance concern messages • Developmental influences & appearance concerns • Ambivalence within their relationship with mother with regards to their perceptions of their own facial appearance 	<p><i>"I have vivid recollections of grooming at night"</i></p> <p><i>"I'm a bit worried now she said I am going to have liposuction on my legs."</i></p> <p><i>"She would watch women coming out of church and rip them to shreds."</i></p> <p><i>"I didn't need her to tell me I looked beautiful. I wanted her to but....."</i></p>	<p>3/9-10, 3/17</p> <p>3/11, 3/15, 3/30,</p> <p>4/14</p> <p>3/6</p>	<p>4/2</p> <p>2/3,</p> <p>3/4-</p> <p>10,</p> <p>4/9</p>	<p>2/5-11</p> <p>2/10</p> <p>2/2-3</p> <p>14/4</p> <p>2/16</p>	<p>13/7-9</p> <p>13/9-10</p> <p>2/2-10</p> <p>14/1</p> <p>13/10</p>	<p>2/10-14</p> <p>2/5</p> <p>2/9</p> <p>2/2-3</p> <p>2/15-17</p>	<p>3/16-17</p> <p>3/2</p> <p>3/1</p> <p>3/13</p> <p>2/12</p>

Superordinate and Subordinate Themes	Examples	Pat	Cathy	Molly	Sally	Angela	Rina
3. The Cyclical nature of vanity and shame <ul style="list-style-type: none"> The double-edged sword of vanity & shame Hiding shame for vanity's sake Roots of shame Self-absorbing and/or self-individualizing shame 	<p><i>"People can see you have had RFCS and judge harshly. I would hate to be thought of as vain and self-obsessed."</i></p> <p><i>"Gee that hair style makes you look 20 years younger", then I didn't say - well I had a face-lift."</i></p> <p><i>"There is something very deep there for me. I was embarrassed for myself."</i></p> <p><i>"I'm not obsessed with myself but I would not, not do my grooming."</i></p> <p><i>There is some acceptance of the ageing process. On occasions I see the humour in it."</i></p>	<p>1/51, 1/54,</p> <p>1/24, 1/56</p> <p>1/50-1, 2/15-16</p> <p>3/22</p>	<p>1/18</p> <p>2/2-5</p> <p>2/6-7,</p> <p>2/1</p>	<p>1/32</p> <p>1/7</p> <p>1/91</p> <p>1/95</p>	<p>19/2-4,</p> <p>18/2</p> <p>8/4</p> <p>18/3</p>	<p>1/21,</p> <p>1/28</p> <p>1/12-14,</p> <p>1/12</p>	<p>2/1</p> <p>1/31-34,</p> <p>3/1</p> <p>4/12</p>

2.10 Reflexivity

As a Chartered Counselling Psychologist with 10 years, I wasn't too anxious about my ability to set the participants at ease and to establish a trusting relationship – I was excited about the prospect. My preferred research approach is qualitative because I can relate to the intimacy of it. I believe I possessed the required empathy to facilitate the emotional depth of such interviews. Well, my personal and professional experience did help in many ways and enabled me to manage the 'unexpected' with my first participant. This relates particularly to the first face to face interview when the participant started to talk about her traumatic relationship with her mother. So while I left the questions open to allow for personal expressions and emotions, at the same time I had to avoid allowing the interview to turn into a therapeutic situation. As noted, the double hermeneutic of the qualitative interview using the IPA approach, is to obtain qualitative descriptions of these women's life world with respect to: facilitating her understanding of her experiences of facial ageing and rejuvenation; and secondly, myself as the researcher try to make sense of her trying to make sense of her ageing and rejuvenation experiences in her world (Smith & Osborn, 2008). This is impossible to achieve without empathy. So this particular challenge was in maintaining the balance between not being too neutral (otherwise I would never know how the participant felt and thought) but having the right' kind of researcher empathy so my role would not become blurred with that of therapist. My task with each interview was to set up in a relatively short space of time the right facilitative conditions to encourage the participants to get beyond merely polite conversation or exchange of ideas in order to cover both factual and meaning levels (Kvale, 1996).

CHAPTER 3: ANALYSIS

3. INTRODUCTION

Temporal experiences of facial ageing and cosmetic rejuvenation is the first super-ordinate theme. It is the over-arching one and interlinks with the other two super-ordinate themes. They have been separated in order to highlight the importance of underlying biopsychosocial lifespan developmental aspects in each superordinate theme that appear to have enduring influences on these women's temporal experiences of their changing facial appearances. The analysis is an iterative inductive process moving between the different levels of interpretation, noting points of interest and significance that best describe the participant's lived experiences (Smith, 2004).

The three super-ordinate themes are:

- *Temporal experiences of facial ageing followed by FRCS and/or non-invasive procedures*
- *Mother, self and facial appearance.*
- *The cyclical nature of vanity and shame*

3.1. Temporal experiences of facial ageing followed by FRCS and/or non-invasive procedures

This super-ordinate theme describes phenomenological perceptions and experiences of these women in midlife from the time they saw their faces age; taking the decision to have cosmetic rejuvenation, and after healing had taken place. It has four sub-ordinate themes as follows:

1. Contemplation
2. Peri-operative period¹⁵
3. Euphoria
4. Repeats & reflections

¹⁵ A non-medical term but used by Plastic Surgeons to describe the period surrounding treatment i.e. before, during and immediately after (approx 48 hours) the day of treatment (Rankin & Borah, 1997).

3.1.1 Contemplation

Contemplation refers to the period of time when these women became aware of the impact stressful events were having on their faces causing premature ageing. The sub-ordinate theme starts with these women's descriptions of the types of stressful events; how this made them feel about themselves when they looked in the mirror; coming to a decision to rejuvenate their faces; expectations of results. This period of time marks out the different stages and their emotional responses to their ageing faces. It takes them up to taking the decision to go ahead with the rejuvenation. It is the last time they shall see this particular ageing face of theirs.

Angela names stress as the cause of her facial ageing:

"Over a period of one year, I started a new relationship after ending a marriage of 37 years, moved to a different city and started a new job and a new life. Shortly thereafter I noticed signs of facial ageing [...] due to the stress of all the changes."
(Angela 1/6-.7)

As does Molly

"The ageing on my face really became obvious following a very long stressful period preceding my mother's death three months ago. I was with her in the hospital every day for many weeks. It was very stressful."
(Molly 2/22)

And Pat

"I was stressed and worn out after 6 years of studying. Just the face that showed the stress, not my body as I never stopped training. So I don't know what happened to the face."
(Pat 1/8)

Pat explains her facial ageing differently to the others and is seemingly more surprised by it. She always took care of her body by remaining fit throughout her six year period of study. The way she seemingly tagged on the last sentence is almost symbolic of 'the face' as being separate to the rest of her body as it did 'its' own thing not responding to the control that training gives. There seems to be a splitting between the 'normal' self and the less controllable body and ageing happens to the face and not the self – it is the 'body as object'. But she like the others only noticed this facial ageing once their period of transition was over. They all made causal attributions between stressful periods of transition and adjustment with their facial ageing.

Sally differs to them as she had noticed signs of ageing 'early on in her life' (1.1 and 1.2.).

"I have one of these 3 piece mirrors. I was lucky to have such a mirror ... I saw identifiable physical signs of facial ageing. My front and side views showed a sagging neck, hardly any chin, a lot more wrinkles around mouth (..) I hated the side profile especially the neck area. I thought who on earth is that! How awful I look. I just couldn't bear to look at it as I felt too old."
(Sally 2/1-.2, 10/2-.5)

She seems to come across as almost disgusted with her own appearance. So I wondered whether in the light of Sally saying she was 'lucky' that being self-conscious she thought others would also see her side view as a "*hateful, awful old face*". So with this awareness she was 'lucky' to be able to take steps to change this appearance. She also refers to facial features as 'the' and 'that' describing these bodily facial features as objects.

Angela describes them similarly as objects:

"The neck was crepey, aged, wrinkled and droopy (gooseneck) as in the skin hanging down loosely. The skin of face had a crumpled look."
(Angela 1/12-14)

While Pat also describes the 'flaw' as an object, at the same time there is an additional frightening sense of what was happening to her face was out of her control.

"All I could see was my forehead crease. I focused on that flaw. I saw these different contortions of my face and I thought Oh my God. I saw me becoming her (sister.)"
(Pat 1/10, .39 and 2/12, 2/1).

Shocked and transfixed, all Pat could see was the flaw. All her thoughts and anxieties became imbued in this flaw. Her experience captures the essence of a scene from a horror movie where she, as the victim, looks helplessly on as her face is being transformed into something terrifying i.e. her sister.

Rina also talks about a transformation process out of her control with a great deal of emotional distress.

"I looked like my Mom unfortunately, sagging eyes and jowls. I looked haggard and I looked old. The mirror was saying POOR ME [.] This is not what I wanted to see. I wanted to see me. This was not

me. I was embarrassed, uncomfortable and had a feeling of inadequateness”

(Rina 1/10, .3, .12, .13, .17 and 3/1) (Rina’s own capital letters)

I felt a strong sense of regret and self-pity as Rina recalled looking like her Mom – a Mom that was haggard and old. Like the others, Rina had no sense of control over the mirror image. She also mentions internalized feelings belonging to the shame family e.g. embarrassed, inadequate accompanied with a deep sense of despair.

Their own mirror reflections, reflected back to them an unrecognizable old woman; parts of an animal; and their mom were given as motivations for wanting to rejuvenate their faces. Other contemplations of themselves reflected in the eyes of others also provided another aspect to this subordinate theme.

“This difference (of looking older) never really bothered me, except when youngsters look at you as if you’ve just crawled out of the ark when you try and join in with them.”

(Angela 3/2/.8)

Angela describes the fluidity of her ageing experience when she tries to step out of her own age group and join in with a younger group. She shares her experience of being socially marginalized. Within the South African context, South Africans spend a lot of time engaging in outdoor activities. It is a ‘body beautiful’ culture that privileges youth and youthful bodies. Therefore, Angela’s use of the metaphor ‘ark’ seems to exaggerate her ‘oldness’ contrasting starkly with their youth.

Rina describes a similar rejecting experience with her grandchild drawing attention to a facial feature that seemed out of place to her.

“Before my operation my lovely 4.5 year old grandchild really confirmed my perception of my face “why is your skin falling by your mouth?” and with her little finger pulling on my jowls”.

(Rina 2/1)

Young children cannot hide their curiosity. What they are thinking finds expression in what they say and do. Rina, as a mother and a grand-mother would know this because of her experience with children. Her grand-daughter at the tender age of four and a half, confirmed the meaning of the visibility of her sagging jowls i.e. she was looking old.

The impact of stressful events causing premature facial ageing; unacceptable unfamiliar mirror images of themselves evoking untenably painful feelings; experiences of discrepancies between their external and internal ages, and perceptions of rejection by others for looking old contributed to an unshakeable determination for all these participants to do something about their faces. They were self determined.

"It was what I had decided I wanted to do"
(Angela 1/23)

"I said I need it. It's got nothing to do with anyone else. It's just got to do with me."
(Rina 1/19)

While only two examples are given above, all these women were unshakeable in their determination to do it for themselves.

In the quotes from these women's stories that follow, these women describe expectations they had for the physical outcomes from the operation and/or procedures.

"There were no great expectations as I just wanted to alleviate or improve problems of very noticeable areas of ageing. It all happened very quickly within a week."
(Angela 1/30-32)

Words such as, 'just' alongside 'very noticeable and 'happened within a week' captures the ambiguity of her existence. Contrary to this seeming casualness regarding expectations, there is an underlying sense of urgency in Angela's story for once she made up her mind to have surgery it all happened very quickly.

Sally on the other hand is very specific about what she wanted as she had been thinking about having the face-lift for over a year (1.9):

"I wanted to look more relaxed, 10 years younger, to stay as young looking as possible and to stay as good looking as possible, just had a holiday look is what I wanted, not the pulling up thing. I was excited about the coming improvement."
(Sally3/4, 1.8, 23/1-4)

Sally and Angela had contrasting surgical rejuvenating expectations. Angela speaks in more generalized terms of alleviating the look of her ageing face while Sally was very specific about the changes she wanted in order to look 10 years

younger. What they had in common was their determination to get rid of the ageing features in order to look younger again.

The promise of rejuvenation cosmetic surgery is to transcend age by turning the ageing clock back. Their decision to have cosmetic surgery comes across as quite a pragmatic one in the light of their distress at their ageing features. However, at the same time this is a decision involving 'major' surgery and what struck me was the absence of anxiety regarding the risks associated with such surgery. Is it possible that once they made the decision, their distress either dissipated or disappeared as they focused on their expectations?

Although not specifically asked for during the interviews, five of the six women specified not wanting to change any of their structural features as part of their expectations from rejuvenation. For instance,

"I was never unhappy with my looks". (Angela 1/12)

"I felt I needed to look like I had before." (Rina 1/77)

All these women wanted to look younger and healthy again – they did not want to look different. Although only two quotes have been given, the meaning attached to wanting their faces to be the same – yet younger - could suggest that their identities were still attached to the 'younger self' – the internally felt younger self. What was not said was possibly that they wanted to reclaim that younger self.

Common to all were their beliefs that their facial ageing was due to stressful circumstances – not the natural processes of ageing. A common theme to five of the six participants was the feelings of dissonance experienced between their inner and outer selves.

3.1.2. Peri-operative period

On the day of the surgery and procedures, these women describe a roller coaster of emotions all underpinned by a high state of arousal. It is also interesting to identify the different coping strategies they used to manage this anxiety.

Below Cathy, Molly, Sally and Pat recall their experiences and feelings.

Cathy uses a wonderfully descriptive metaphor of surfing on a wave.

"So I kind of took it like a surfing wave. I had 100% faith in him. TV programmes on cosmetic surgery can be quite a daunting thing that they are going to do with you. So I tried not to think about it in too much detail. When he came to draw on me I didn't give too much thought to it. He marked here and marked down the side. I never had this feeling that he mustn't mess this up."

(Cathy 5/18 -27 and 2/4)

Cathy's metaphor beautifully portrays the thrill and excitement she felt as if she was on an adventure. Cathy said she trusted her surgeon as he had successfully operated on her before. 'Daunting' is an anxiety laden word but as a positive coping strategy Cathy stayed focused on her complete faith in the surgeon's ability and seemingly this appeared to minimize any negative effects of anxiety associated with 'daunting'. This had a calming effect on her state of mind so that when the surgeon came to draw on her she had already laid her anxiety to rest.

Like, Cathy, Molly's anxiety management pre-operatively worked well. However, the strategies she used differed to Cathy's.

"There was no fear or any anxiety at all. This is what's so weird. As a dress maker I could see what my eyes needed. he said I want to draw on you. If that was me I would do it carefully. He was just drawing away and I said is that alright? And he said ye ye. I thought it was a bit quick. I said what are you using, it's not just ink is it? I looked at myself in the mirror and I was horrified."

Molly 1/60-83)

Three years prior to deciding on having surgery, Molly found out as much as she could about facial rejuvenation (Molly 1/19-24) thus doing "homework" before taking this decision. Secondly, Molly transferred her own skills of dress making to visually work out what the surgeon would need to do to her eye lids. Thirdly, she voiced her concerns to the surgeon while he was drawing on her. The strategies enabled Molly to be an active participant in this adventure. But in spite of all her pre-worry work, seeing all the markings on her face in the mirror shocked her into the reality of where the surgeon would be cutting into her face. This possibly suggests there was an element of denial pre-surgery.

Sally, on the other hand, experienced high levels of anxiety while waiting to be taken into theatre. She recalls:

"I panicked suddenly, I thought, God, what the hell am I doing here? I thought, I'm young but it is still a bit of a risk. I am totally in the surgeon's hands but he is not God you know. No operation can be 100% perfect. This is the whole thing."

(Sally 6/3-15)

Sally's appeal to the Higher Power followed by panic set up a downward spiral of thinking beginning with a negative thought followed by a positive thought only to be followed by a more convincing negative thought. This negative spiral was repeated twice. This pattern of flipping from one position to another suggests high levels of anxiety associated with dominantly competing, yet conflicting feelings. The feelings of desire to rejuvenate, while at the same time feeling fearful she would come out looking worse than she did prior to the operation struggle to co-exist (Sally 5/2-3). However, desire supersedes fear. But, even when she chose to follow her heart's desire, she knew realistically that results of the operation could never be perfect. This thought pattern thus maintained a negative level of anxiety associated with uncertainty.

Pat also experienced anxiety prior to having the rejuvenation (1.45), and below she names other thoughts that occurred to her during the procedures:

"It was a very painful very unpleasant procedure. You feel this piping stuff in your face and I was injected 17 times. It was intrusive and invasive. Their hands are in your mouth, pushing it and molding it. It was quite aversive to me when I first did it. I thought am I doing this for pleasure or vanity?"
(Pat 5/21- 29)

Unexpected intensity of pain, intrusiveness and invasiveness of procedures prompted an inner questioning of what her true motives really were.

Waiting for surgery appears to have been experienced as a stressful transitional period causing disturbances in these women's psychological and physiological homeostasis. Information gathering in the form of 'homework' before taking the decision to have cosmetic surgery appeared to be an effective cognitive strategy for alleviating anxiety.

During the first 48 hours following surgery the face is in pain, it is bruised and swollen. It is not recognizable as your own. Pain, swelling and discomfort from face-lifts take months to heal. Just like Pat in the above narrative, these women's experiences of pain appeared to facilitate the break-down of denial uncovering of previously suppressed anxieties, thoughts and feelings regarding the risks they took in order to rejuvenate.

Sally's realization of what she had committed herself to came with the pain immediately after surgery.

"I had a funny sensation and felt like shit I wondered what I had done. I didn't analyze it really. Some kind of denial. You are totally in your surgeon's hands. Yes, he can make a slip. Only afterwards I thought gee, I took a bit of a chance then. Not so aware of taking a chance before the op."
(Sally 17/1-15)

Prior to the operation, it appears that Sally defended against the real meaning of major surgery in order to have her face-lift. After the operation when her psychological defense of denial lifted, she realized that had not really considered what she had let herself in for.

Angela had only given herself a week to prepare for the operation and was clearly shocked by severity of the pain she experienced post operatively.

"I was unprepared for how sore it would be. I felt I would choke to death. I felt cross towards the surgeon who did not tell me to expect pain".
(Angela 1/46-48)

Angela told no one about the operation (*super-ordinate them 4 line 1/32* so she was alone at home during her recovery. Being alone during her recovery must have been a frightening experience as the swelling around her neck left her feeling she was going to die. Again the issue of confidence in the surgeon, and therefore trust in their ethical behaviour, is a serious one. Had the surgeon neglected to tell Angela about the degree of pain to expect or was it a case of desire being greater than fear and hearing only what she wanted to hear? If it was the former it suggests the surgeon's abdication of responsibility. If it was the latter, then it suggests that Angela, similar to Sally, some elements of denial were present pre-operatively enabling her to go ahead and have the operation.

Cathy's approach to pain management and the sight of her surgically traumatized face was described and experienced differently to Sally and Angela:

"No doubt the operation is a painful one. My ears were the worst. But I have an extremely high pain threshold and I bit the bullet and got through it. The surgeon warned about the bruising and swelling. I would look like someone gone through a car's windscreen. He cut this side deeper, took a lot into my hairline., he worked on my brow a bit more. This eye was definitely cut out more because he said I had more loose skin. My bottom eyelids were pulling down slightly. My neck felt as if I had a tight polo neck jersey on."
(Cathy 1/32- 36, .41-44).

Cathy's surgeon prepared her for what her face would look like after the surgery. But no amount of verbal and medicinal treatment takes away pain and discomfort after having so much of the loose skin removed, tucked, tightened and lifted. The face and therefore the body are physically distressed. This is major surgery and Cathy 'bit the bullet' (another wonderfully descriptive metaphor suggesting she was prepared for a hard ride) to get through the pain and discomfort.

From these post-surgery experiences, it appeared that those who were less anxious about the surgery suffered less emotional distress and showed less defensive behaviour such as denial prior to surgery.

3.1.3 Euphoric and proud

I interviewed these women after the swelling and bruising of surgery had disappeared so the benefits of the surgery and/or procedures would be obvious to themselves. The period of time since rejuvenation and healing varied but they all shared common feelings about the results.

*“I look younger ... It's more than I expected”.
(Angela 1/52)*

*“I have never been happier with myself. I ...cannot believe it's me!! It's..a better me. .
(Cathy 1/48-49, 5/1)*

*“The effect was profound. Subtle but incredibly powerful. ..Oh my God that was a very powerful treatment. It felt it was like going into a cocoon and coming out a butterfly. I've got my wings and I can fly”.
(Pat 5/19, 5/29, 7/1, .7)*

There were feelings amounting to euphoria for everyone with results surpassing expectations. Cathy almost sounds as if she had witnessed a miracle. Pat's imagery of her experience is, as she said 'profound', for it is as if this was the moment she became alive – reborn – beautiful, liberated and free.

Cathy saying she is proud to be 54 suggests it was the physicality of facial ageing that was the problem for Cathy and not her chronological age. Again this reference to age was echoed by Sally:

*“ Now I'm proud to say I'm 54 years old”.
(Cathy 5/11)*

"I had a lot of compliments from a lot of people that I looked good for my age. Everyone now says I look 10 -12 years younger than my age. I have no regrets".
(Sally 16/2)

Sally and Cathy illustrate proudly the importance of having a younger appearance than their real age when in the company of others.

Rina's perceptions of the meaning of a younger and healthier face were different to the women.

"I look exactly like I should do. Before what I was looking like wasn't what I thought I should look like. I was looking at my Mum. The surgeon gave Me back. Well, he lifted my face back to what I was before. He gave it all back to me."
(Rina 1/84, 4/1-2)

Rina's experience of facial rejuvenation is complex in that face had been ravaged by a life threatening illness prior to surgery. Now she describes her "whole self" as having been restored. Her painful associations with her own mortality and her mother's ageing features were removed from her face. She feels in control of her life again.

Seven years after her rejuvenation, Sally describes her experience of the outcome.

".. taking the decision to have the rejuvenation is "EASY AS PIE". That was how sure I was that I wanted this rejuvenation and this was confirmed everyday when I looked in the mirror prior to the operation!!!
(Sally 25/1-2)

Sally's narrative read in isolation to the rest of her experiences gives an impression of trivializing cosmetic surgery. With "EASY AS PIE" Sally seems to be saying 'Why put up with a face you can no longer recognize as your own when you can just as easily have a face-lift that recaptures a 10 years younger looking you? Growing old gracefully is not an option when you can have surgery'. But reading carefully, Sally is referring to taking the decision and how she looks after her face-lift, and not her total experience. She talks painfully about her ambivalence of repeating rejuvenation procedures in the next sub-ordinate theme (20/1-10) and reading this metaphor in context with her whole experience it can be hypothesized that "EASY AS PIE" is quite beguiling as it can just as easily become a problem in itself.

For all participants, external rejuvenation improved their internal processes linked with self-esteem and identity. Their responses to the outcome appeared to confirm the importance of looking younger than their chronological age. All were very happy, proud and positively euphoric but all had uniquely different reasons for feeling so.

3.1.4 Repeats and reflections

As some time had passed since the rejuvenation, I wondered whether any of the women had repeated or were thinking of repeating procedures/surgery. Rina was not going to repeat; Angela would repeat but had to think about her pension bundle, Cathy and Molly were definitely going to repeat; and Sally and Pat had repeated.

This section focuses on the experiences and reflections of Sally and Pat who had repeated their rejuvenation procedures, illuminating the different nature of their second experiences when compared with the first.

Sally recalls:

“Yes, I did have the Restylane before my son's wedding. Quite honestly I do not think it made much difference at all. Botox is a better option as far as instant results would be concerned.”
(Sally 24/2-5)

Disappointed with the results, Sally appears to be looking for something better – perhaps it's Botox next time for better results. Sally's continued thinking about self-improvements suggests she is not ready to 'get out' of the anti-ageing market just yet.

Pat goes on to talk about the difference in her emotions after repeating the same procedures she had the first time.

“The first time that's when it hit - the effect was profound. The 2nd time I had the same repeat of Botox and Restylane injections 3 months later and it wasn't with that hit. It wasn't so powerful. The feeling in intensity was different. It was about OK the second time (dull tone of voice).”
(Pat 5/19)

Pat, like Sally, experienced feelings of disappointment the second time. She seems to be referring to the absence of the emotional thrill and excitement she experienced the first time - but not with the results per se.

Wanting to repeat is not without ambivalent thoughts and feelings. Sally struggles against her desires to rejuvenate, as her thoughts are influenced by socially constructed norms of how one is supposed to behave as one grows older.

"Everything is starting to go a little again. I'm thinking hum I think something like Restylane so easy to have them dealt with. Yes, but I'm thinking no no I can't do that. I can't get paranoid because one is going to start ageing. It's the one bloody little line that is bugging me. You must accept that you are getting old. You must do it gracefully. It's hard to eventually accept"
(Sally 21/4, 20/1-10, 23/7)

Sally is vigilant for new signs of ageing. Unwanted signs of facial ageing leave her feeling ambivalent and uncomfortable. Her reactions suggest that she is torn between desires to arrest the physical evidence of facial ageing which is so easy to do. On the other hand, feels she has to accept the social norm of the 'natural' ageing process and leave rejuvenation alone. Her use of the word paranoid suggests she is left feeling very anxious about having to make a choice between the two options.

It is now 18 months since Pat had Botox injected into her forehead and Restylane into the nasolabial folds. She has had time to reflect on her experience.

"Having the work done came out of obviously some kind of insecurity. Yet once I had eradicated it, it was like Oh God it's like a line on my skin, is it a big deal – no – did I feel better when I had got rid of it. Momentarily, but actually no one reacted any differently to me. Do I feel better about myself. Mildly - and I felt free from the whole family thing. Very powerful."
(Pat 1/74, 5/16-17)

Pat makes the link between her external physical appearance and her inner emotional state. She realizes that the removal of the line did not significantly change who she was as an individual. This insight seems to have been confirmed by others who did not react any differently to her before or after the rejuvenation. This suggests that removing the line enabled her to experience that she is not like her sister, brother or father (*superordinate 2: 2/15-16*), for with or without the line she remains the same person internally. This realization set her free. She illustrates this with a return to her metaphor of herself as the butterfly having come out of the cocoon. (7/1)

“Those butterflies, come the end of the summer don’t look quite the same. Their wings get tattered looking. I didn’t keep my wings after but it didn’t feel like a loss for me when the work wore off. I was in a different place. Maybe I didn’t feel the need to be that butterfly anymore because I had something else. I felt more stable”.

(Pat 7/1-10)

After the rejuvenation, Pat married and was awarded the PhD (2/26). Internalizing these achievements and incorporating them into her identity empowered her and increased self esteem.

The four sub-ordinate themes sign-post the different stages of what appears to be an anxiety laden journey underlying these women’s experiences of facial ageing and rejuvenation with different conflicting and ambivalent feelings pre-, peri-, and post-operatively. Facial ageing ruptured their embodied sense of self. Rejuvenation reclaimed it and returned a more continuous sense of self back. The rejuvenation was a transforming experience for all. Further signs of ageing appears to remain underpinned by appearance anxiety except for Pat (who was 32 years old) whose outlook appears to differ to the others – a possible explanation is that she is still in mid-adulthood and her facial concerns are not so ‘time-bound’ as in midlife.

3.2 Mother, Self and facial appearance.

While describing their experiences of having facial rejuvenation procedures, these women frequently talked about memories of their mothers in association with appearance concerns. While I had expected them to talk about their mothers, I had not expected such richness of material, depth of feeling and meanings that helped shape and influence their sense of self and their appearance concerns as women. Therefore, the aim of this super-ordinate theme is to demonstrate how this process of influence develops and becomes an integral part of these women’s daily appearance concerns. To meet this aim, the first sub-ordinate theme begins with descriptions of themselves as young children observing their mother’s daily routine of facial grooming. This is followed by a subordinate theme of intergenerational continuity or change patterns associated with appearance concerns. This sub-theme then progresses onto developmental experiences of being taught how to groom by mother and becoming participants

themselves in the exciting art of grooming practices. Practices that also became associated with personal vulnerability about their own appearance concerns. Their experiences then proceed into their own adulthood and how their mothers' facial ageing influenced their perceptions of their own facial ageing when it bore similarities to her ageing facial features. The sub-ordinate themes are identified as:

- *1950's Mother and her facial grooming*
- *Intergenerational appearance concern messages*
- *Developmental influences and appearance concerns*
- *Ambivalent relationship with mother regarding perceptions of their own facial appearance.*

3.2.1 1950's Mother and her facial grooming

These narratives recall childhood memories of Mother's facial grooming practices. The physical caring for her face refers to the cleaning, massaging, moisturizing and creaming, and for its adornment it is the putting on of make-up. Five of the six participants mother's grooming took place in the 1950's and needs be understood within the socio-cultural context of the 1950's make-up fashion practices of women, as described in the literature review.

In telling this part of her story, Sally as a young girl, would gaze in wonder at her mother as she groomed herself.

"I used to sit on the bed and watch her getting changed and thought how beautiful she was. It was not so much the make-up. It was the end product. She looked so pretty."
(Sally 13/7-9)

These types of memories could not fail to take on crucial importance in Sally's life as a young girl for the message imbued in these actions was that this is what a woman should do and look, if she wants to be admired.

Molly very clearly remembers her mother's daily grooming rituals and her appearance as preceding the needs of immediate family members and, indeed more important than anyone else.

"She would sit at the dressing table for about 2 hours before we went out. She never ever receive anyone even if it was my sister, me, you would have to book an appointment. If she wasn't ready to receive you dressed and made up, she would never open the door."

(Molly 2/5-11)

Molly does not say how she felt being shut out of this exclusive activity and domain of her mother's boudoir. Mother's constant grooming could not have failed to make an impression on Molly as she was a young girl then. The message Molly may have internalized was a 'gendered message' that was imbued in these grooming behaviours e.g. this is the only way you appear before others.

Angela vividly remembers her mother's grooming practices also taking hours in front of the mirror.

"I have vivid recollections of mother's facial grooming at night using umpteen tissues and a jar of Ponds Cold Cream cleaning, massaging, and caring for her skin. I could never understand the hours she used to spend in front of her mirror. It was a ritual come hell or high water."

(Angela 2/8-17)

As a child Angela interpreted her mother's preoccupation and attention to her facial grooming as a ritual that took precedence over everything, and, everybody else. There is also a covert suggestion that Angela did not agree with, or disapproved of, the amount of time spent over it e.g. *"I could never understand the hours..."*

Cathy's memories of her mother grooming have a different focus of meaning for her.

"Mother was a very proud person and took great care in her appearance. I used to watch her getting herself 'tidied up' for my Dad coming home from work."

(Cathy 4/2)

In the 1950's, just before the dawn of feminism, women's femininity was linked to her role as a woman. It comes across in Cathy's narratives that her mother subscribed to this, was proud of her appearance, and enjoyed grooming – a ritual performed at the end of each working day – a ritual in order to please her husband.

As I was transcribing these stories of mother's grooming, I could picture these children standing in the 'wings' watching grooming performances of their 1950's mothers absorbed with her daily grooming routines. As children they observed these practices and assimilated this new information into their developing cognitive schemas. While at the same time being psycho-socially influenced, either to adopt or reject their mother's beauty values and practices for themselves as women.

Pat's experiences as a child watching her mother's grooming, took place in the mid and late 1970's. There are echoes of the 1950's in her practices while at the same time also additional motivations for such grooming practices.

"Mom would not go out without her face on. She would always be clean and shaved when going to M&S. She always put her lipstick on before Dad came home from work. But I realized that putting on lipstick for Dad wasn't for him – it was for her. He would be getting drunk and coming home drunk – so it wasn't for him, it was for her."
(Pat 3/9-22)

Despite understanding mother's grooming practices being embedded in 1950's (line.....) cultural practices, Pat's narrative identifies differences in the transitions of socially constructed definitions of what femininity and self representations are over time. Pre-dating the arrival of feminism, the 1950's women appeared to groom for husbands and appearances sake. Whereas in 1985, 10 year old Pat understood that mother's attitudes and values towards her own grooming was for her own benefit as a woman and not for others. This realization was also confirmed for Pat when mother said *"it is very much for yourself. She said we do it for ourselves, to feel nice and feel good (3.20)"*.

3.2.2 Intergenerational appearance concern messages

In addition to their relationships with mother and their mothers being agents of gendered socialization, many of these women's narratives included socially contextual interactions with their daughters and their daughter's children (grand-children). These interactions impressed upon me how messages related to appearance are intergenerational. They are passed on by assimilation and adoption through the generations according to contemporary socio-cultural fashions or technology available at the time.

After talking about the different issues her mother had on her (Molly's) development of perceptions towards appearance, Molly shifts this attention to the link between herself and her daughter.

"Yes, my daughter is the same, she wears nice make up. But I'm a bit worried now she said I am going to have liposuction on my legs."

(Molly 1/99 and 2/16)

Although this comment is to be understood within the context of Molly's concerns about her daughter's health (1/100), it also highlights the way particular culturally learned behaviour may be transmitted through the generations. In this instance, as a cultural phenomenon in compensating for perceived faults in visible appearance, a surgical procedure is a way of managing and improving bodily appearance. One does not have to live with it as it is – "just do it narcissism." Has Molly become a role model for her daughter's attitude towards appearance concerns, just as her mother was a model for her.

Anxiety is also present in the warnings Sally passes on to her daughter to prevent the same mistakes she made in the past.

"If I hadn't been in the sun I wouldn't look like this (freckles and wrinkles). Lucky we can advise our daughters about sun damage. She's also got a very fair skin and doesn't like to get a tan. I say 'Klara', don't ruin your skin please. Very, very aware of sun damage to the skin Yes, Ooh yes. And she says Yes Mom"

(Sally 14/4-16)

In all probably this warning is about two issues. First, there is the warning about SA sun damage, wrinkles, lines and skin cancer. Secondly, speaking from Sally's own experience, there is also the covert warning about the sun making you wrinkle and look aged before your time.

The comments and observations of 4 year olds on facial appearance in this study has reaffirmed and alerted me to their capacity to assimilate knowledge and form perceptions regarding facial appearance – as Cathy's grandson illustrates.

"After the operation my 4 year old grandson asked me what happened to my face and I told him that I had an operation; he happily accepted this, gave me a kiss 'to make it better'

(Cathy 1/36)

I was intrigued by the grandson's response to Cathy's explanation and wondered what meaning he really attached to her 'battered and bruised face' and her seemingly low key response – especially as he felt it appropriate to 'kiss her better' and then ran out to play.

Rina passes on a different type of socialization message to her 4 year old grand-daughter. But like Cathy, these narratives also have 'two sides' to their stories.

“.. my little young granddaughter, again, said to me “you have big ears” and I turned around and said ‘and guess what, I’m not having an operation’ (laughs)”.
(Rina 2/16)

Rina's message to her grand-daughter is saying there were some facial features I was prepared to change. But there are also other facial features I shall keep - despite what others may want me to do – she seems to be saying I'll decide what I want for myself – I'm self determined.

3.2.3 Developmental influences and appearance concerns

During the periods of early childhood and adolescence, these women moved from being observers to active participants in learning the rules for appearance in relation to one's self and observing others, as well as the 'how to' of taking care of their own grooming and make-up practices.

From 4 years of age Pat witnessed her mother and sister negatively criticizing other women's appearances.

“From 4 years old, I can't remember her not doing this. She'd call it 'bullet watching'. She'd stand at the window to see who was coming out of the mass. She'd say “Oh look, she isn't looking very good today.” And they (sisters and mom) would rip people to shreds. I was quite fascinated about that.”
(Pat 4/11-14)

Pat has intense recollections of 'bullet watching' unsuspecting women for the way they appeared before others. These criticisms left strong impressions on her. Firstly, as a young girl she was included in this female family bonding activity. Being fascinated suggests she was spellbound in a positive sense. On the other hand, these criticisms of others appearances left a negative mark in Pat's memory (as will be seen later) and probably contributed towards Pat's anxiety about appearance concerns. This is in relation to observing others as she grew up into adolescence and early adulthood. For instance, already as a child she

learned that women could be denied or given approval for her appearance by other women. Facial appearance comes with thrills and spills.

Moving onto early adolescence, some of these women spoke about their experiences of being taught the art of grooming by their mothers. These memories are poignant given that the beginning of early adolescence for girls heralds in the time for a 'rites of passage' that begins their journey into womanhood.

As Molly grew older her mother must have felt it was time for her to learn how to use make-up for she allowed Molly into the private sanctity of her boudoir.

"She taught me to make-up my face and paint my nails. It was me copying her. I used to experiment with her make-up and she used to say try this lipstick and try that. Probably I was about 10 years of age. My mother was encouraging about this. I went to school with makeup on all the time .Frequently I was asked to go and wash my face or I was sent home until it was changed".
(Molly 2/10, .11/.12)

Being invited to join in with her mother, Molly willingly adopted the same practices of putting on make-up. I got the impression that she loved it and the positive feelings associated with putting on make-up out-weighed the punishment metered out at school. For being sent home frequently to wash the make up off was not a sufficient deterrent to stop her from doing it again and again until, because of her make-up practices, she was asked to leave the school at the age of 15 (2/14-15). And since then.....

"I've worn make-up since I was 13 and there has never been a day that I have gone without it."
(Molly1/15)

So already from the age of 10 years Molly had assimilated and adopted her mother's attitudes (thoughts, feelings and behaviours) and values regarding a woman's facial appearance (2/5 as in 2.1 above). By 15 years of age, facial grooming and make-up had become part of her gendered identity – it is the way you appear before others.

Pat also describes moving from observer to participant.

"I remember Mum buying me my first make-up. I was 13. She taught me how to do it. Going to makeup counters with her was so exciting. This is what women did. You buy night cream and eye cream. I was buying night cream from the age of 15. I have very fond memories of [...] and the grooming."
(Pat 3/13-18, 3/11)

These were the exciting days of the booming rise of consumer culture. The arrival of large departmental stores beauty counters with women assistants who looked like angels serving and demonstrating how make-up should be applied in order to look beautiful. Well, that is how I remember it, and it seems that is how Pat remembers it too. She remembers the excitement of 'becoming a woman'.

Unlike Pat and Molly's adoption of the same values and behaviour towards facial grooming and appearance like their mothers, Angela has a different reaction.

"When I was aged 11 she bought me facial products and perfume. She taught me skin care routine. She was very kind about it but I did not have too much enthusiasm keeping care for my skin. I thought it was tedious and a nuisance."
(Angela 2/19-21)

Pat, Molly and Angela were entering adolescence and as a 'rites of passage' were allowed to practice with skin care products. They responded to this 'rites of passage' in their own unique ways. Pat and Molly immediately adopted them with enthusiasm but Angela did not. Angela's mother had spent time with her teaching her the art of grooming. So the question is why should Angela not be interested whereas all the other participants, and in particular Molly and Pat, loved the opportunity?

Following Angela provides some other information which sheds light on this choice of hers.

"I thought she was vain. She had the painted look"
(Angela 2/12)

I could not help wondering whether Angela's behaviour of not grooming or wearing make-up (1/39) was in opposition to her mother's painted look. In 2.1 Angela recalls her mother spending hours in front of the mirror (2/9) and possibly Angela was left with the impression that hours in front of a mirror for a painted look meant her mother was vain. Possibly by association she would also be vain if she adopted the same grooming and make-up practices.

Vanity is generally considered a bad thing but what specifically did it mean for Angela? One possibility was that Angela felt excluded during these periods and she may have felt hurt, irritated or resentful about this. If she did feel any of these painful feelings then it is likely that she learned to associate grooming practices with the negative connotation of vanity and pointless. Another possibility was that self appearance was very important to Angela's mother (2/3), yet despite her careful grooming, she was teased at work about her facial appearance and she was called 'Mrs. Pointy Nose' (2/4). While Angela did not allude to this, it is possible that she learned to associate a made-up face with embarrassment and shame and became self conscious of her own facial appearance. So I wonder, tentatively of course, to avoid getting the negative attention her mother received, she may well have opted for the natural look, i.e. no make-up. I have given more tentative explanations to Angela's experiences and subsequent attitude towards her own facial grooming because it was different to the other participants. Angela appeared to be in opposition to her mother's influence. Yet at the same time Angela had a face-lift.

During mid adolescence, some of the participants began to experience different reactions from their mother's towards their appearance.

"Every time I walked in at home she would say oh that mark on your face it's terrible. I also remember her shouting at me when I was about 15 year old. She screamed 'oh my god you look 9 months pregnant'. And that really hurt me as it is the way I am built."

(Molly 2/19/.21)

"Why are you wearing that? It doesn't do much for you. So it left you vulnerable. So your bubble could be pricked at any time. And that scares me and that relates to me being judged by my Mom, harshly criticized and never feeling good enough."

(Pat 4/16-17, 1/59)

I do not know what their mothers were seeing, feeling or thinking during their interactions with their daughters but psychologically their mother's critical comments appear to have profound negative effects on their daughter's developing self-concepts as adolescents. Molly comes across as helpless and shameful and Pat was left feeling not good enough. So it is possible, given Pat and Molly's stages of identity development, that these comments left them both feeling insecure and anxious about their self-concepts as daughters and therefore as women. Immersing myself in this text I felt that as daughters they seemed to understand the criticisms as the whole truth about themselves and

their appearance. So, while they experienced the excitement and thrill of positive learning experiences of grooming from their mothers, at the same time they were left vulnerable to her criticisms. There will be more about this need for approval in super-ordinate theme 3, when these women defend and protect themselves against possible criticisms of their appearance.

Development of anxieties during childhood and adolescence about not feeling good enough can also arise within families as a result of patterns of relationships and coalitions that are formed between the members. Pat goes on to describe such coalitions in her family of origin.

“Mother was lovely looking. My middle sister is different to us. She doesn’t have the line neither does my Mother. My brother and older sister were the beautiful children in the family. Myself and my middle sister weren’t the golden children. Mother would say you (Pat) are stunning but not like X (my elder sister) who is beautiful.”
(Pat 2/2-18; 3/10-38)

The underlying commonalities between the coalitions relate to inclusion and exclusion criteria, of who is ‘in’ and who is ‘out’. Although Pat does not verbalize it, there is a sense of helplessness and frustration within her. She inherited the line (flaw) and so was ‘in’ the flawed group of father, brother and older sister. But she was ‘out’ of the ‘golden children’ group (of the same brother and older sister who had the line), because she was not beautiful. These unfavourable comparisons resulting in exclusions and inclusions described by Pat are based on physical appearance alone. Exclusion or inclusion is about potential separation and adds to Pat’s anxiety as this type of separation would probably be associated with not being good enough again.

3.2.4 Ambivalent relationship with mother regarding perceptions of their own facial appearance.

Following are snapshots focusing on the ambivalent nature of these women’s relationships with their mothers. This is in relation to psychological attachment to her, and perceptions of their own facial ageing when the physical features looked like their mother’s ageing facial features.

Molly clearly articulates the ambivalence she feels about looking like her mother and why she feels this way.

"She was beautiful looking and [...] very glamorous. She looked like Marilyn Munroe. But I had a dreadful childhood. My sister and I called her the wicked witch of the north. I don't know whether I want to look like them really. Perhaps I'm paranoid about looks."
(Molly 2/2-10)

There is a strong sense that 'if I look like her then I become her'. And, in Molly's case she would become or be associated with a wicked witch. Because of unhappy experiences with her mother it seems Molly learned that beauty and glamour do not equate with goodness. This creates ambivalence and anxiety within Molly should she look like her beautiful mother.

Just as Molly was unsure about her feelings looking like her mother, she is also unsure as to why she went out of her way to help her mother during the long period leading up to her death.

"I don't know why I always did so much for her because she never did anything for me. She only just died on February 2nd aged 89. In the end I was doing and looking after her, for God knows how many years."
(Molly, 2/22)

Even at the age of 60, Molly was the dutiful daughter doing everything possible to help her mother. At the same time saying "*because she never did anything for me,*" seems to imply she feels hurt and resentment at having to fulfill the dutiful daughter role. These ambivalent feelings and actions puzzle her. This suggests that even in middle age Molly yearned or hoped for approval from her mother. That is why she went out of her way to help her. If so, not knowing why she went out of her way to help could suggest that she is in denial. For while she remains puzzled about her behaviour, she protects herself from the emotional pain of rejection for not being mothered and accepted in the way she longed to be.

Now in her 30's Pat spoke sadly, but also with ambivalence, about her mother's response towards her on her wedding day.

"On my wedding day she just says 'nice. Mum finds it so hard to praise you in any shape or form. The next day she (mum) was raving 'Oh I was so proud of you. Everyone was saying how stunning you looked'. It's easier for Mom to say to me that other people said I was stunning. I didn't need Mom to tell me I looked beautiful. I wanted her to but..."
(Pat 3/2-8, 3/51)

Wanting but not needing mother's approval for her appearance as a bride captures an aspect of Pat's ambivalent feelings towards her mother. Pat's needs for approval were not fulfilled and she was left unsure about how she actually looked as a bride. Conscious of wanting mother's approval but not getting it maintains Pat's anxiety associated with appearance concerns.

Sally had her face lift in her 50's and what she said about her mother just seemed so sad to me.

"My mother never even knew that I had had facial rejuvenation. She didn't even notice. It was never ever a case of competing with her as it is in some cases. You know, my mother was beautiful until she was 80 and then when she died in December, she was 86. Wonderful beautiful, magnificent –"
(Sally 13/2-5, 22/4)

Did Sally's mother really not notice she had a rejuvenating face-lift or did she notice but chose not to comment on it? The answer is not available to us. What we do know is that Sally follows on from this with denying being in competition with her mother. There is also an underlying suggestion that mother being *wonderful, beautiful and magnificent* until she was 80 that Sally saw her mother's beauty in an idealized way. Idealization can be used a psychological defense mechanism as a way of coping with unconscious feelings of inferiority about her own facial appearance when compared with her mother's beauty. If you feel inferior towards your mother's beauty then idealizing her beauty makes it difficult to be in touch with feelings of competitiveness or envy towards her appearance.

Rina describes negative feelings associated with her mother's ageing facial appearance that she saw on her own ageing face.

"I loved my mom. She had a hard life and looking at her made me feel guilty. Looking like one's mother can trigger strong emotions. We did pity her. That's where the very real guilt comes from. And I didn't want to be like that. I didn't want my children to look at me and think that they must pity me. They must definitely be free of guilt."
(Rina 3/13; 3/18-24)

Rina's strong emotions of pity and guilt towards her mother, became contained within, and took on a life of their own in her own jowls. This suggests that Rina saw herself as a 'victim' to the life events that overtook her as she had no control over them - just as they had overtaken her mother. As the connotation of sagging jowls was so strongly connected to pity and guilt, Rina appears to have

introjected a belief that her children would feel the same towards her (as she did towards her mother) when they looked at her jowls. Evidence in her narrative suggests strong identification with mother while at the same time wanting to distance herself physically and psychologically from her. Hence, ambivalent feelings towards her mother remain as she appears torn between the emotions of love, guilt and resentment towards her mother. I felt there was underlying resentment because Rina did not like or want to look like her mother and yet she did and this was very painful for her.

Like Pat, Sally and Rina, Cathy also talks about her mother with ambivalence, and as with Rina, these inner feelings have strong associations with her outer facial features.

"I had a very close relationship with my Mother but there was a family 'disagreement' and things went sour. As my signs of ageing progressed so did the bitterness between us. Subsequently, seeing her likeness in the mirror I had mixed reactions of anger with sadness. These emotions made it very difficult to look in the mirror. My Parents both died in 2001. The matter was never resolved and I am still bitter about the whole fiasco."
(Cathy 3/4-10)

This must have been an extremely painful experience as Cathy struggled to look at her own mirror image after her mother died. Her lost self was replaced by a mirror reflection of an older woman looking like her mother who looked angry and sad back at her.

Linking ageing and mother together, Cathy goes on to talk about the meaning of ageing and looking like mother.

"I do not believe that many ladies enjoy looking like Mom. A 'Mom' is always an older person that we believe grew up in the 'olden days'. When we start 'looking like her' we are ageing and leaving our 'youth' and 'youthful' appearance behind."
(Cathy 4/3-10)

Expanding on what Cathy has said I shall stretch the boundaries of interpretation by looking at what is not being said. (This is not to undermine or detract from Cathy's account, it is more about moving a little beyond the descriptive and towards explanation). Is Cathy also afraid of facing her own ageing face that looks like her mother's because of having to face her own mortality? So is the facelift a 'rites of passage' for Cathy? If so, is it also a 'rites of passage' for the

other women who's mother's had died before they had their facelifts? I am saddened by Cathy's thoughts that it is a universal experience that most women do not want to look like their mothers when they age. This aspect I shall discuss in the reflexivity section.

Pat describes just how potent her mother's message was on her self presentation as a woman.

"Mom would not go out without her face on. I wouldn't go out without make- up. At home on my own I even put on some mascara and some lipstick. I know no one will see me. I remember that grooming was done for yourself first and looking good for others comes second. I fell into the trap of what Mum prized highly, I went the beauty route."
(Pat 3/22-25, 3/40, 4/15)

So what is Pat referring to when she talks about "....the trap..."? It is a very interesting ambiguous comment and I shall attempt, with the evidence provided in Pat's narratives, to understand and interpret this. Placing the origins of Pat's facial appearance concerns in the "bullet watching" incidents (4/12) and personal vulnerability that proceeded from those experiences, Pat remarks....

"If people are going to look at me then at least I must make sure I'm OK, healthy and well and also that fear of being judged harshly) but yes negatively."
(Pat 1/63)

Pat does not want to be judged negative by others for her appearance. During our interview Pat said if she lived in the bush she wouldn't bother about make-up as that is not the norm there (line 6/8). So while regular grooming is a part of her identity it also seems to serve as a protective measure against being judged by others for 'not being good enough' - just as her mother and sisters did behind curtains. Taking care of herself in private is just as essential for her well being as it is in appearing before others. She must always be prepared.

Ambiguous meanings and ambivalent feelings as described in this section partially explain and contributes to underlying anxiety associated with inter- and intra-personal concerns about their outer facial appearance when their ageing facial features looked like their ageing mothers had looked.

Important aspects of these women in midlife that have been influenced by and through their relationship with mother over their life span are discussed here. During the informative years of childhood and adolescence positive or negative self concepts develop. Their developing self concept regarding pride in their appearance seems to have been influenced by mother's approval and/or criticism of their appearance. The unpredictable nature of mother's feedback may have contributed to their present vulnerability to appearance concerns now in midlife. There also seem to be other painful memories associated within their mother-daughter relationship. These painful emotions appear to be given expression through these participants' ageing facial features when these features resembled their mothers. It is not solely down to mother as these idiographic narratives also describe processes of social interactions within the family based on inclusions and exclusions. All these different types of intergenerational interactions around appearance concerns that also interact within the wider contextual environment, are important sites (although not the only sites), for developing a sense of whom they were 'becoming' as gendered women in relation to appearance.

3.3. The cyclical nature of shame, pride (vanity) and shame

This super-ordinate theme sets out to illustrate where and how the experiences of pride (vanity is referred to when the participants use the term) and shame are intertwined with each other and their presentation within the two other super-ordinate themes. It highlights descriptions pertinent to thoughts, feelings and acts associated with pride and shame that interact with other thoughts, feelings and behaviour perpetuating, in most cases, their role in maintaining appearance related shame-anxiety. A lot more weight is given to this superordinate theme because it is at the heart of their experiences.

To illustrate the inter-connections of pride and shame in this super-ordinate theme with the previous 2 superordinate themes, their links are indicated by referring to the other specific themes and lines of dialogue. The four subordinate themes identified within this super-ordinate theme are delineated in the following way in order to demonstrate consequences and psychosocial developmental processes of interactions between of pride and shame. These are:

- *The Double-edged sword of Pride (vanity) and Shame*
- *Hiding Shame for Pride's (vanity) Sake*
- *Roots of Shame*
- *Narcissism: Self-absorbing or Self-individualizing*

3.3.1. The double-edged sword of pride (vanity) and shame

Most of us want to look good to others but within following narratives the double-edged sword of vanity (participants term) and guilt (guilt related to shame) is present in Molly's experiences of looking good.

*"It's a lot of money for a bit of vanity. How can I justify that sort of money. I've always tried to look like I wanted to look. With everything ageing I still wanted to look good. So I call that vanity."
(Molly 1/32, 1/35-37)*

By having rejuvenation, the role of vanity appears to protect Molly's public self from the external shame of her visibly ageing face. But, in responding to the needs of vanity with expensive surgery, inner feelings of doubt are evoked. It is as if she is thinking 'Am I worth it?'

Molly's narratives of self-doubt post-operatively appear to be internally perpetuated by negative self-evaluations for spending a lot of money on her younger appearance. On the other hand post-operatively Pat's fears are directed towards others negative vanity-laden judgments for having had rejuvenation.

*"Fear of being found out I would have hated. I can tell when someone has had Botox. But with Restylane you would never know. It's a nice feeling. I told no one except my husband. I had a fear that everyone would notice and this would mortify me. They judge you as needy and superficial to have it done."
(Pat 5/30, 1/24, 1/45-46 and 1/54)*

Their ambivalent feelings towards having had rejuvenation are clearly illustrated.

So in spite of the 'nice feeling' of Restylane (*theme 1, line 3/1*) Pat experiences fear and mortification at the thought of being observed by others and judged as needy and superficial. As nobody has commented, these emotions suggest Pat's critical self-reflections are to do with her own self-evaluations and judgments about herself in relation to social norms. This suggests high levels of self-consciousness in the social presence of others. Feeling mortified is a strong feeling associated with the shame group. So on the one hand the invisibility of

Restylane to others is reassuring and removes Pat's appearance related anxiety to being observed by others. But now it appears that Pat is experiencing, along with her good feeling, anxiety about being judged negatively – this time for having rejuvenation. Like Molly, internal shame is present after the rejuvenation and limits sustained happiness with the rejuvenation – thus has the potential to perpetuate the negative cycle of shame, pride and shame.

Like Molly and Pat above, and despite having no regrets after having her facelift (*theme 1, line 9/4*), Sally continues to experience a heightened sense of self-consciousness when in the presence of others.

*"We are so aware of everyone looking at us. You might as well say
"hello everybody I've had a face lift". The one thing I felt afterwards
was that it's so obvious. Oooh and ooh."
(Sally19/2-4)*

The desirous act of rejuvenation and the good feeling of being seen by others as younger than her age (*Theme 1, lines 20/1 and 12/1*), is experienced in tandem with psychological feelings of external shame on being observed with the knowledge that she had undergone a face-lift. These particular conflicting thoughts and feelings illustrate the 'double edged sword' of vanity and shame clearly.

The presence of the double-edged sword of vanity and shame laden is illustrated above. These women felt ashamed (internal shame) of their ageing facial features (superordinate theme 1). Shame triggered appearance related anxiety and to protect them from these painful feelings, the role of vanity in having rejuvenation protected them from this shame. They were very happy with the results (Theme 1 section 1.4) However, it appears from these narratives that while they experienced joy and pride with their rejuvenated faces, at the same time they felt anxious and ashamed in relation to others in case they found out why they looked younger – hence the double-edged sword. With some of these women rejuvenation as a consequence, evoked internal shame again.

3.3.2 Hiding shame for pride's (vanity) sake

Shame is such a powerful and painful feeling that the natural tendency when feeling its effect is to hide or conceal the source of the shame from self and others. In the first instance of hiding or concealing, they surgically and/or non-surgically had removed the physical features of facial ageing (*theme 1*). Then, in

the second instance of post rejuvenation interventions, shame-anxiety is present again and this time it is in response to feared negative judgements from others for having rejuvenation.

So how do they hide this shame given the ageing features are gone? There are also questions of where this powerful need to hide their shame came from, and how they cope with this?

Below, Rina identifies the prevailing socio-cultural norms in South Africa towards surgical or non-surgical facial rejuvenation and how she coped with this.

"I did not discuss it with anyone except my family. Here it's not totally acceptable to have a face-lift really. People have them quietly in SA"
(Rina 1/31-34)

Rina demonstrates the power of transgressing this sociocultural norm to not surgically alter your face, by her outward compliance to it i.e. keeping it a secret from others. Although resenting the need for secrecy, Rina realizes it is necessary to conform in order to 'fit in' and be accepted within that society (Theme 1 line 1/30).

Sally gives an account of how she copes with the shame attached to the physical evidence of her rejuvenation when in the presence of others.

"I have a scar line that runs from behind the ear to the front into the hair line and near my ear in the front. So I always hide my scar line with my hair. But too bad, that's what it was all about".
(Sally, 18/2, 19/5-6)

As with Rina, Sally appears to be referring to the need to be seen as not contravening prevailing social norms. As mentioned before, she has no regrets about her cosmetic surgery but on the other hand she feels compelled to hide the evidence of why she looks so good for her age. These conflicting thoughts, feelings and behaviour and always having to hide the scars from others suggests that internal shame, and a potential of external shame (being shamed) connected with rejuvenation is attached to anxiety about others knowing how she is able to look so young. She lives in an ambiguous and therefore anxiety provoking situation i.e. 'between a rock and a hard place'.

Similarly to the other women, Cathy also experiences the ambiguity of her predicament influenced by her own unique circumstances.

“Somebody said to me – My but you’ve lost a lot of weight. I didn’t mind saying I’ve had a tummy tuck as I was proud and happy about it. Then people said ‘Gee that hair style makes you look 20 years younger’ then I didn’t say well I had a face-lift. I don’t know why”.

(Cathy 2/2-5)

Cathy attaches different meanings to ‘losing her figure’ and ‘losing her youthful looks’. But why does she hide the truth about her facelift? This shame-anxiety may be associated with the fear of losing approval from others if she answered “Well, I had a facelift”.

It is possible that Cathy is also feeling a heightened sense of self-consciousness in case others found out she had her face surgically altered. It wasn’t a natural process. Again there is a possibility that her anxiety is about creating an unfavourable impression and therefore loss of self-esteem in social situations - hence her need to remain silent about her face-lift in order to retain approval from others. She could be hiding her transgression of an unspoken social moral law which she believes says that you can alter the shape and contours of your body but that there is something untouchable about the face – she does elaborate on this later.

These narratives suggest that these women are hiding and living with a secret which maintains their feelings of external and internal shame associated with their appearance concerns. The question now is whether the vulnerability and shame about appearance has always been with these women or is it just because of the facelift?

3.3.3. Roots of shame

These women’s descriptions of hiding their shame are within the context of observing others, prevailing socio-cultural norms, and how they judge themselves. This subordinate theme goes on to identify some deeper and intra-psychic origins of their shame that may underlie the tendency to hide their shame. For instance, how Cathy is perceived and accepted by others has particular relevance to her.

“Who am I, who comes from a working class background. I didn’t want people to think that I thought I was better than them.”

(Cathy 2/6-7)

Cathy spent her childhood within a working class background in the North of England during the mid 1940's and 1950' (*Theme 2, line 4/1*). Although Cathy is in midlife, and living in SA, she seems to think South African's will judge her as being 'above her class'. Cathy went to live in South Africa with her parents when she finished schooling in the UK (1965). Culturally there are not the same types of class divisions in SA as there were in the UK. Therefore, she is speaking about childhood experiences in the UK and her own internalized value systems from UK childhood experiences that appear to have given rise to her shameful feelings (*theme 2, lines 4/26-29*). Could Cathy be afraid of others envy towards her for having a youthful and pretty face and therefore reject her from their social group? Cathy experienced this type of rejection when she entered grammar school in England. She was never accepted into any of the groups of girl friends there. As the girls there were from middle class backgrounds, she believed this rejection of her was because of her working class background and being inferior to them. She said she never had a 'friend' like other pupils did (*theme 2, lines 4/26-28*).

This does not mean Cathy is responding to her current anxieties of inclusion or exclusion solely because of her experience at grammar school. But because of her past experience of exclusion and rejection, it does render her vulnerable to future shaming experiences of inclusion or exclusion when she believes others will think she is trying to be better than them (*theme 2, 3/11*). This suggests her shame is internal, deeply felt and experienced.

Similar to Cathy, the personal meaning Rina associated with her own ageing face and sagging jowls has its roots in the past, but with idiographic meanings specific to Rina.

*"After my mother having a terrible night my mother's jowls were hanging more. That is where my guilt comes from. It's looking like her and knowing. I mean we were powerless we could actually do nothing."
(Rina R3/4)*

The feelings of powerlessness and guilt were traumatizing and internalized at an intra-psychic level. Rina not only shared her mother's pain but also strongly identified with it. Such emotional trauma is very difficult to bear consciously and in defence against the anxiety this knowledge would cause her, the meaning of the traumatizing experiences became represented by, and contained within....

“What my father had done was now on my face. My face had become because of what had happened to me. That is what I didn’t like on my face. The bad me, because I was portraying the same look”
(Rina 3/6 and 3/10)

Rina’s sense of who she was became blurred and she took on herself her mother’s shame – this shameful and destructive intra-psychic meaning became located within specific features on her face. So it seems that Rina, prior to rejuvenation, felt she was looking at her bad self as the ‘old vulnerable mother’. Thus, retrieving her own face, by removing her mother’s facial features was imperative in order to regain her own identity and getting a sense of being in control of her life again (*theme 1, line 1/72*).

Regarding roots of her shame, Pat makes links with her family’s inter-generational patterns.

“Dad, brother and older sister all have the same line and they are alcoholics and a drug addict. There is something very deep there for me. I was embarrassed for myself.”
(Pat 2/15-16)

Like Rina, Pat also experienced the family shame within her psyche. The physical evidence of this shame was located in the line on her face. She too, like Rina, has internalized the meaning of the physical facial flaw as being her own mark of shame. Pat never said others would see her line and think of her as an addict. She saw the line and identified with its negative connotation as marking her out as an alcoholic and a drug addict to herself. While Pat is not an addict, “*something very deep there*” and “*embarrassed*” shows how her feelings of internal shame involved her whole self and is rooted in childhood and early adulthood familial patterns of inclusion and exclusion within this group (*theme 2, lines 2/1-5, 16-18*).

3.3.4. Narcissism: Self-absorbing or self-individualizing

Narcissism, although often used synonymously with vanity, has deeper intra-psychic meanings and is associated with defending against general issues of loss of identity, loss of a sense of self, or self-esteem. Therefore narcissism and shame are inextricably linked. Experiencing a personal threat, real or imagined to one’s identity and self-esteem results in thoughts, feelings and behaviours belonging to the shame group. To defend against the anxiety of shame this type

of threat causes, we use narcissistic defences that can be healthy, as in self-individualizing or alternatively narcissistic defences that are unhealthy, passive or self-absorbing. That is why the concept of narcissism has been used in this subordinate theme as opposed to vanity.

Molly describes how she manages her appearance

"It's always with appearance I tend to be a bit of a perfectionist and I can't bear things if they are not perfect. I've always worn makeup since I was 13 and there has never been a day that I have gone without it."
(Molly 1/7, 1/15)

Molly admits being 'a bit of a perfectionist'. She always covers her face with make-up to hide the imperfections she perceives are there - that is the imperfections her mother said were there.

Molly had recalled the shaming effect her mother's criticism had on her self-esteem in childhood and adolescence when she criticized her face and body. As a young girl she defended against this shame by hiding behind the door in the house and not going out (*theme 2, 2/19-20*). When she had to go out back then, and as now in the present, she copes with her anxiety related to appearance concerns by wearing make-up and taking great care of her whole outward appearance. Her make-up probably serves to protect her from the outside world. These narratives suggest that perfecting her appearance is a way to protect her inner self against the anxiety of rejection of not being perfect to others and her 'self' – and the social marginalization she experienced prior to having her eyes rejuvenated. As long as Molly feels the need to hide behind make-up and rejuvenation as a narcissistic defense against shame, her psychological defenses are self-absorbing and therefore self-perpetuating.

Below Pat names her coping strategies she uses to defend against her anxiety of being (anticipated) negatively judged.

"If people are going to look at me then at least I must make sure I'm OK, healthy and well and also that fear of being judged harshly. So it's not because I think I'm great and I want people to look at me and I want attention. If anything it's the opposite. I kind of do it for them to leave me alone."
(Pat, 1/61-63)

She goes on to explain in more depth.

“There is something of being a perfectionist there. I’ve always tried to look my best. I’m not obsessed with myself. But I would not, not do my grooming. Part of my fear I think of looking less than kind of OK is about people behind nets poking fun at you - you don’t even know that.”

(Pat 1/38, 1/51, 3/39, 4/15)

As an adult, Pat remains vulnerable to other people’s negative comments regarding her appearance. She learned in childhood how unsuspecting women can be criticized for their appearance (2.1). During adolescence Pat experienced harsh criticism from her mother for the way she put on her make-up, and being unfavourably compared with her sister’s beauty. Pat never felt good enough (*theme 2, line 1/61*). So defending against anxiety that is associated with ‘not being good enough’ and exclusion from the beautiful children of the family (*theme 2, line 2/18*), it can be hypothesized she defends against possible hurt by being prepared and groomed all the time. Pat’s fears and experiences of negative criticisms that have their roots in the past continue to manifest themselves in the present. Like Molly, in order to cope with her fears of negative judgments, perfectionism appears to have become a protective strategy to ward off possible negative judgments (*theme 2, 3/23*) “even if I am sitting most of the day at home on my own I even put on some mascara and some lipstick. I know no one will see me”). Perfectionism, as a coping strategy to avoid criticism and anxiety associated with that, may maintain Pat’s dependence on others’ approval for her appearance. It is possible Pat has internalized self-doubts about her appearance. Not ever letting anyone see her without make-up appears to have become a circular and self-absorbing process.

Cathy also refers to the importance of how her facial appearance appears to others.

“I wanted to ‘keep it quiet’. I really can’t tell you why I felt this way. Maybe it’s because you can see it (the face). Maybe it’s because it’s your whole image. I wondered why this happens to some people and not to others, I would ask myself if it was something that I did?”

(Cathy 2/1 and 3/5)

Your face is generally what people see first, form an impression from, and relate to. Cathy says it is the ‘self’ (your whole image) you present to others. The above suggests that Cathy has an implicit belief that if you change your face by

rejuvenation you are presenting yourself falsely to others - perhaps you will be judged as false. Could this be what she is ashamed of as she also made reference to this avoidance in the previous section? There could be the presence of some denial here about the meaning shame has on the integrity of the self. Maybe it is important to be accepted as 'one of them' and not someone trying to be better than them. On the other hand there is also a sense of "why me? I base this on a comment Cathy made (*theme 2, line 3/5 "Was it something I did? Why doesn't it happen to some people? It (ageing face) sort of crept up on me", line 3/12*).

Linking this with unresolved conflict with her parents before they died, does Cathy think she has been punished with premature facial ageing for the conflict between herself and her mother just before she died (*theme 2, line 4/3*).

Like Pat and Molly, for as long as Cathy defends against potential loss of self-esteem with denial and secrecy in social situations, Cathy's shame is also a circular and self-absorbing process.

However, other kinds of coping strategies in protecting the self and identity were employed. Following Rina's successful treatment of her illness and successful rejuvenation cosmetic surgery she reflects.

*"I actually think it's your inner feeling about yourself that will actually give you a whole different outlook on life. You've sort of got a lot more energy because you are happier in yourself".
(Rina 4/12)*

During the previous year Rina overcame the damaging effects of physical illness on her body and face. She regained her life after successful medical treatment and she experienced getting back 'her self' through successful rejuvenation facial cosmetic surgery. Therefore, it seems Rina is suggesting that belief in her to overcome adversity enabled her to have a whole different outlook on life. This is a self-individualizing process and for as long as her face looks the age she is (and she is happy with this (*theme 1 line 1.20 - I have never thought age mattered – I feel young say 35 yrs but being 59 yrs and looking good is fine with me.*), she will continue to self-individualize. However

"For me, the cosmetic surgery was the right thing to do. I didn't want to be old and haggard and that. If it happens in the next couple of years – I don't think the jowls will come back, I mean after taking all that skin away – Will they come back again? (Voice up an octave). I just don't know (sort of laughter). I don't mind ageing but I don't want the jowls she (mother) had."
(Rina 4/6-7, 4/14)

It is not possible to ascertain whether the re-appearance of sagging jowls will become untenable for Rina. But the above narrative does suggest that the return of the hanging jowls is something she dreads and is accompanied by quite a lot of anxiety. This can suggest two things. First, if the nature of her awareness is associated with the natural process of continuing to age (and is accompanied with hanging jowls) then her anxiety could be understood as part of normal psychological adjustment to physical ageing. Then, healthy narcissistic defences against this anxiety will be in terms of normal adjustment and therefore self-individualizing. Alternatively, if anxiety over the reappearance of the jowls is solely associated with unresolved guilt and shame related to her mother, then there is a possibility that her narcissistic defences and therefore her internal shame will become self-absorbing.

Angela's response to my question about her perception of continuing to age and how she will deal with it, Angela admitted that she

"I would not be able to afford to have it done again."
(Angela 4/3)

Angela does not the option of repeating rejuvenation – she does not have a choice and so she must live with and accept the ageing process continues. Is this the reason why there is no explicit evidence of vanity and shame? No again.....

"I am grateful for what I have. There is some acceptance of the ageing process to a reasonable degree and on occasions I see the humour in it. An attitude of acceptance is very important. I refuse to be unhappy about it."
(Angela 5/3)

As a coping strategy against the unhappiness that comes with physical ageing, Angela is focusing on self acceptance and her sense of humour. She is looking at what she has as opposed to what she has not. She is choosing self acceptance in the process of change that ageing brings. To this end she is already replying

on her internal resources to cope with changes that ageing brings. This appears to be a self-individualizing process.

3.4 SUMMARY

The ageing, lined, wrinkled face was the antecedent of shame for all the participants. All the rejuvenation procedures were successful and participants were very satisfied with the results. However fear of being thought of as vain or being noticed for having cosmetic procedures evoked shame again. External reliance on appearance for approval from others, that often had roots in the past, appeared to contribute to and maintain anxiety associated with these appearance concerns and a need to repeat rejuvenation procedures. A more balanced approach of engaging both external and internal resources to cope with the changes of ageing did not appear to give rise to further shame.

3.5 Reflexivity

I found it almost impossible to bracket off my own experiences of the phenomenon under investigation. They were there in the back of my mind. So I wrote them down and put them on the other end of my desk to remind me that their presence was 'over there' as it were - so that there could be minimal influence of them on my thinking on the instance being investigated (Giorgi and Giorgi, 2003). In this way I could interpret my own interpretations of their stories by testing current thinking against my earlier bracketed thinking and so enhance the trustworthiness of the findings (Etherington, 2004). My battle to keep "bracketed off my experiences" was evident when analyzing the narratives about 'bad' or 'inadequate' mother.

Thinking about this phenomenon was different to feelings about it, for while I could write about their relationship with their mothers, I also felt guilty about identifying this. I think I also tried to avoid these findings because I kept on putting off writing about it. When my supervisor confronted me about putting off writing about this finding, I realized it really was about my own relationship with my mother – a mother I always felt I needed to protect. I then revisited that area of my life making distinctions between what agenda belonged to me and what belonged to the research participants. With more clarity of my issue, I was able to continue and allow their meanings to emerge from the study towards their appearance and relationships with their 'mothers' that had not been anticipated in advance (Yardley, 2008).

As an individual, this experience was rather awe inspiring as I realized how powerfully moving our relationships with our deceased mothers can be – theirs as well as mine. The imagery that came to mind was of an invisible thread that remained attached to our mother forever. As a researcher, I felt ethically bound (more so as the analysis continued to evolve) to honour their experiences and to produce work that was of a standard worthy of their stories and the profession of counselling psychology doctoral programme.

Chapter 4: Discussion

4. INTRODUCTION

This study aimed to explore the lived experiences of women's facial ageing in mid-life; having facial cosmetic rejuvenation surgery and/or procedures; and, the time period after healing had taken place until the interviews. A detailed analysis of their interview narratives identified three key themes. This chapter summarizes the most interesting aspects of these results linked with research questions and the aforementioned literature. It identifies how this research is rooted in, and contributes to, the ongoing development of knowledge in this field of midlife facial ageing in women and cosmetic rejuvenation (Smith, 2004). Following this, will be an evaluation of the study's validity, strengths and limitations. I shall identify areas for future research to build on results of this study. Finally, I shall discuss relevance of this research's findings for Counselling Psychology as a discipline. Relevant aspects of my own reflexivity as it occurred throughout the study are also discussed.

4.1. Brief overview

In spite of personal and professional gains women have made in recent years, appearance remains a key to women's perceptions of her own self-worth (Haiken, 1997). To maintain a youthful and healthy appearance, women in this study engaged in surgical and non-surgical facial age-resisting practices to be able to meet personal goals of maintaining a youthful appearance. Self-conscious emotions such as embarrassment, shame, pride and guilt all played a central role in these women's experiences both prior to rejuvenation and afterwards. These self-conscious emotions appeared to originate from, and were experienced alongside basic emotions such as anxiety, sadness, disgust, happiness and surprise.

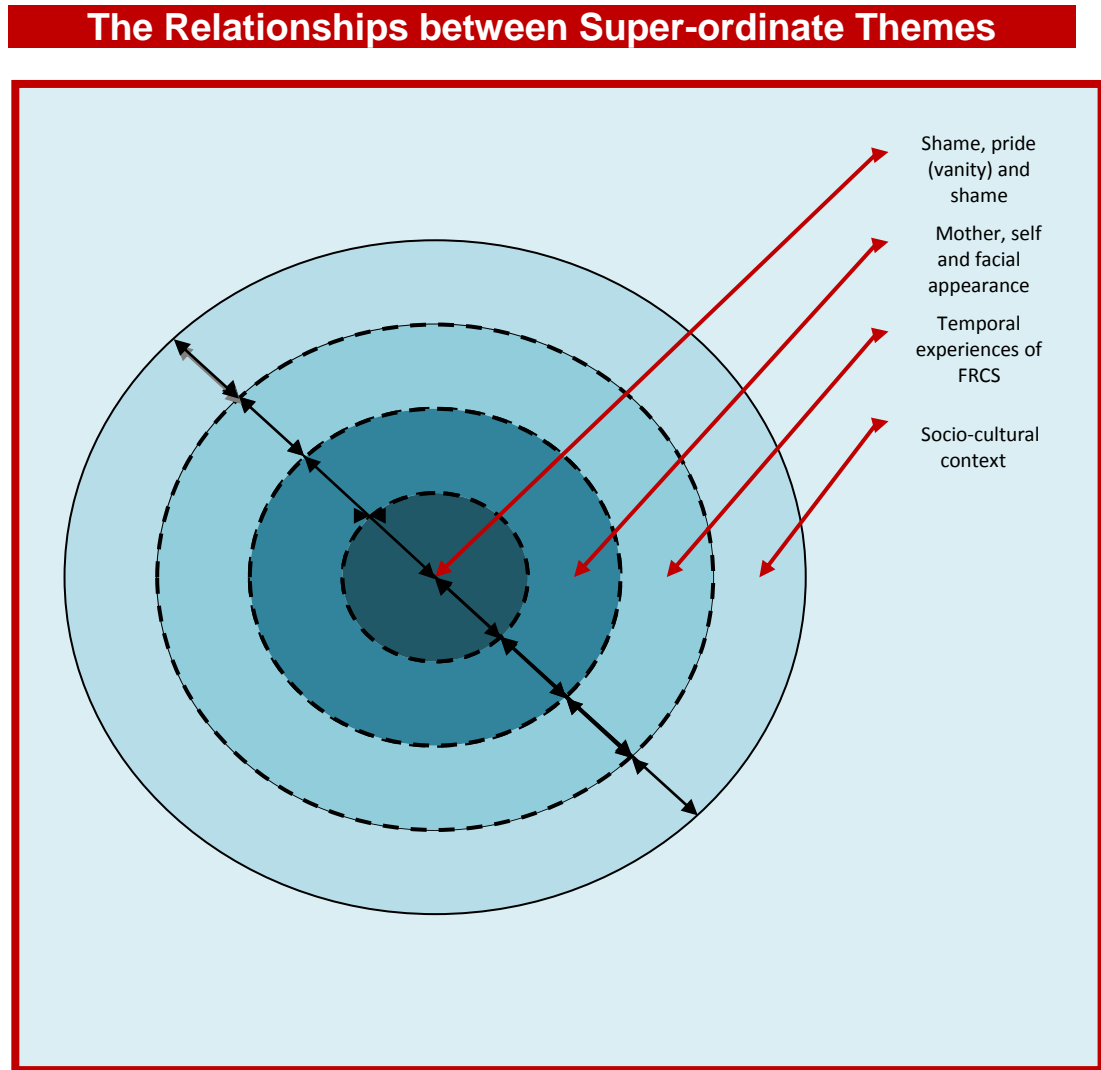
Findings of this doctoral research adds interesting insights, fills gaps and tentatively makes links between different areas of knowledge within this field of cosmetic surgery. These women's narratives illustrate how their anxieties towards

unwanted ageing facial appearance make links with past experiences of their mother, and her facial appearance concerns. In the context of their socio-cultural environments these experiences are pertinent given they seemingly contribute to, and maintain, external and internal shame variants leaving them vulnerable to feared critical judgments and rejection from others. This in part, demonstrates Damasio's (2000) hypotheses about how past experiences, mental images and body feelings influence us in thinking and decision making.

The interesting discussion areas I have chosen to summarize relate to ambiguities and ambivalent feelings associated with maintaining a youthful facial appearance with the use of rejuvenating cosmetic surgery and non-invasive rejuvenating injectables. These discussion points are significant especially in view of the fact that five out of the six participants, despite being completely satisfied and happy with the results, appear to have the presence of internal subversive processes limiting their sustained happiness with the outcomes.

Although the three superordinate themes have been discussed separately in the analysis, as a backdrop to this discussion the schematic diagram below illustrates the context within which these three themes interact with and influence one another. This diagram is illustrative of the ongoing interaction but is not comprehensive. Drawing on and using Bronfenbrenner's (1989) ecological theory, the diagram examines development in terms of the relationships between people and their environmental contexts. The contexts of development are like circles within circles all interacting with one another. I have added an inner circle of intra-psychic processes that appear to be at the heart of facial appearance anxieties to themselves and to observing others. These intra-psychic processes of pride, vanity/narcissism and shame constantly move outward and inward through the circles touching on and influencing all of these women's experiences throughout their life course.

4.1.1. Diagram:



In order to orientate the reader to the main focus of this study, a brief re-visiting of each superordinate theme and their subordinate themes will be described first, as these all contain the linking threads between shame, pride (vanity/narcissism) and shame.

4.1.2 Temporal experiences of facial ageing; FRCS; and, non-invasive facial rejuvenation procedures

Five subordinate themes identify the different temporal stages of these women's anxiety laden journey. Within these five themes are subjective and objective descriptions of their ageing and rejuvenated faces within their socio-cultural contexts. The different presentations of anxiety peri-, and post-operatively are discussed. Anxiety is also present after rejuvenation and is managed with vigilance for further signs of ageing. The further away in time from the rejuvenation, the most pronounced vigilance became. There was also the presence of ambivalence towards these signs. Despite feeling very happy with the results, explicit references to 'feared' charges of vanity and implicit references to self-consciousness are evident throughout their narrated experiences. This is indicative of problems that are more than skin deep.

4.1.3 Self, Mother and facial appearance:

This super-ordinate theme identifies ways in which these women as young daughters learned by watching their mother's grooming practices in the 1950's, how 'to do gender'. During adolescence, criticisms and compliments from mother regarding facial appearance became associated with personal vulnerability to negative stereotypes and subsequent need for approval. For some participants, 'good' was never good enough in accordance with mother's beauty standards that appear to have contributed towards an ambivalent relationship towards her. In midlife, shame and guilt are experienced in relation to their ageing facial features that resembled their mother's. The need to rid themselves of the 'bad' and old mother takes centre stage in this theme. These narratives offer further explanations as to how older women's facial concerns are shaped over their life course.

4.1.4 The cyclical nature of shame, pride (vanity) and shame.

A closer look at intra-psychic levels of pride, vanity and shame vicissitudes (internal and external shame) are presented, identifying pervasive influences of their emotional states on facial appearance concerns across their life span. Coping strategies such as self-absorption or perfectionism appear to maintain

shame-anxiety associated with facial appearance. In this regard vain or narcissistic behaviours are psychological defenses employed to ward off feelings of shame and are not related to narcissistic personality disorder criteria. Self-actualizing or adaptive strategies involving the 'whole self' appear to result in less appearance related anxieties and a gradual acceptance of facial ageing.

This discussion will now compare these main themes associated with FRCS against aforementioned literature.

4.2. Temporal Experiences of Facial Ageing followed by FRCS and Non-invasive Procedures.

Specific aspects of these women's anxiety laden journey leaving them locked in a battle with time will be summarized in the following section.

Waking up one day to discover their faces had suddenly become old looking, is an experience that has been identified and discussed in extant literature. Specific to these woman's narratives was a process of feelings of initial shock to strongly felt feelings of self-disgust and then outright rejection of their ageing faces. They could not relate to, what seemed to them, someone else who was looking back at them in the mirror. Kron (1998) confirms these participants experiences of similar thoughts and feelings when looking upon her own face in the *mirror* "*Who's that woman in the mirror? I don't recognize her.*" (p24).

4.2.1 Coping with age related transitions

Eskenazi (2007) comments on her older women patients motivations for face-lifts as usually being connected to a life transition. It is never random. The symbolism and personal meaning of the body part they want to change is 'usually highly charged with personal meaning' (p 48). Eskenazi also identified other reasons that were highlighted by these women, particularly, 'wanting myself back'. These motivations strengthen Kron's (1998) argument that RFCS is a solution to renegotiating identity. These woman's narratives captured the sense of having experienced a sudden loss of a significant part of their identity. The face of an

ageing woman had replaced the younger face they were attached to and identified with.

Age transition identities and having to adjust to these changes were shared experiences to all these participants. Pat had just entered into the end stages of young adulthood at 32 years of age and the other five women were just at the end stages of middle age with an age mean of 58.5 years (Hockey & James, 2003). Their disgust towards their ageing faces and subsequent decision to have facial cosmetic surgery, seemed for most participants to be symbolically connected to their 'past' aged-identities as younger women – they wanted to retrieve an identity that what was lost. So specific to this study and ageing is that the act of rejuvenation may symbolize a putting off of mourning the necessary losses that accompanies ageing (Viorst, 1986).

One woman in this research, who had overcome a serious life-threatening illness, mentioned that when she looked in the mirror she was confronted with her *"mortality that was looking me in the face"*. Heidegger (in Langdridge, 2007) stated that time and temporality is at the heart of what it means to exist – our present, past and our projected future are all interlinked. Heidegger articulated this as 'being-towards-death' as a temporal existence. Mostly, we do not think about our death until there is a rupture in our unselfconsciousness that renders us conscious of the meaning of our advancing years (Jones, 2004). In the case of these woman's experiences they became aware of the passage of time as moving on to older age which seemed to have caught them unprepared. Thus they become conscious of this when they saw their physically ageing faces. The participant mentioned at the beginning of this paragraph was the exception in that when she saw her ill and gaunt face she became aware of the time left in her life and hence 'being-towards-death' became more real to her.

Therefore, it is also possible to understand the act of rejuvenation from these women's narrative data in many ways. It could be a symbolic act of denial of actual ageing; it may be a strategy to resist the physicality of facial ageing; it may be aimed at reclaiming a lost youthful or younger appearance; a conscious act of defiance, and as an act geared towards 'successful ageing' which is increasingly equated with anti-ageing (Bayer, 2005) or at the very least, not to look old

(Calasanti, Slevin & King, 2006). All strategies appear to function as a way to reclaim or restore a lost self. Davis (1995) also suggests that it represents an act of actively renegotiating identity rather than passively accepting fate (Davis).

While these women rejected their own signs of facial ageing and perceived facial flaws, four of them experienced marginalization by others. The context in which this marginalization occurred left them believing that it was because of their ageing face. So they rejected their own ageing face as they also felt others rejected it. It is useful here to refer to Sprayer's (1996) paper on Snow White at this point in terms of being observed by others. The mirror plays a central role in this fairy tale as depicting the queen's continuing need for reassurance from the 'evaluating mirror of society'. The queen is responding to culturally received images of middle aged women's loss of beauty and status that is given to the young. The Queen knew, with her increased self-consciousness (and because the mirror told her who had replaced her) that mid-life is not valued as beautiful. Morrison (1989) refers to this type of rejection by others as 'social marginalization' because the ageing self is unacceptable.

These participant's experiences of ageing revealed high levels of anxiety and self-consciousness - particularly those who were at the receiving end of 'social marginalization'. These incidences were painful and shocking to them. Harris's (1989) psychological analysis of patients planning to have cosmetic surgery identified heightened levels of self-consciousness compared with a control group who were not planning to undergo cosmetic surgery.

According to McGregor (2006), 'real life' unwanted changes in facial appearance, and hence our identity, may leave us uncertain about whom we are and can lead to anxiety and defensive psychological coping strategies (McGregor). Cooley's 'looking glass self' and the intricacies of internal and external evaluations of shame are particularly relevant to this study's findings. Particularly when being attractive and needing to be approved of is already within us as an evolutionary innate need (Etcoff, 1999).

In view of self-conscious emotions evoked as a result of anxiety, concerns about an ageing face may seem rather vain and self-indulgent. However, as identified discussed in the review, perceptions of one's facial appearance and wanting aesthetic improvements, is entirely subjective. Secondly, our theory of mind enables us to make assumptions about other's thoughts and beliefs (Bee & Boyd, 2002). We assume we know what they are thinking about us. These perceptions and feelings, are in part, influenced by past experiences of appearance matters that can have origins in childhood and within the social and cultural environment of those times and places.

4.2.2 Role of anxiety and denial: pre- and post- operatively and/or procedures.

The presence of anxiety in patients surfaces prior to any operation. It is a natural response when you are placing your trust in the surgeons' abilities to do it right. However, Rankin & Borah (1997) maintain that there is almost no research in the area of anxiety occurring peri- and post-operatively with cosmetic surgical patients and argue that this is an important area to be developed. So it is to this area of anxiety the discussion now turns to identify the nature of the anxiety experienced at the time of the operation and immediately afterwards.

There were clear indications of pre- and post-operative anxiety recalled by participants in this study. For example, some of these participants talked about concealing their fear from their surgeons of something going wrong. Rankin & Borah (1997) have also identified this type of secret fear in their research. Sally spoke about her secret fear while waiting for surgery. She recalled feelings of panic associated with fears of a 'botched' operation and imagined returning again and again for corrections with the corrections becoming worse every time. Another participant had a different focus for her fear-anxiety prior to her cosmetic procedures that was related to self-consciousness in front of others. She feared others would be able to see the effects of the botox and restylane injections on her face. This anxiety stayed with her all the way home after the injections. She recalled horrifying visual images of her forehead being hugely swollen and being visible to everyone whilst walking home. These two accounts of anxiety, both

before and after cosmetic procedures, provide examples of catastrophic thinking patterns and visual images underlying and fuelling these high levels of anxiety.

All of the participants managed their pre and post operative anxiety in different ways in attempts to ameliorate it. For example, Molly thought the surgeon's markings around her eyes reminded her of how she would mark a hem for a dress or tucks for the bodice. So she used her knowledge of dress-making skills of cutting and tucking to 'objectify' the techniques he would use on her face to smooth it all out and this was reassuring for her. Both Sally and Angela admitted to being in denial pre-operatively – Sally's denial broke down just as she was wheeled into the theatre realizing what she had let herself in for (as above). Angela's denial which served to keep anxiety at bay pre-operatively was in not realizing that the face and neck lift would be painful. Cathy trusted her surgeon 100% never thinking for a second that he would botch it up. It was after the operation was over and they saw and experienced their swollen faces that these women realized with hind-sight just how anxious they had been prior to the operation.

A few studies have confirmed the presence of pre-operative denial with patients having cosmetic surgery (Edgerton, 1975; Gion et al, 1976; Crerand, et al., 2006). These patients, like the ones in this study, only admitted to it post-operatively when they realized they had been in denial before the operation. Becoming aware of their pre-operative anxiety post-operatively may be because once the danger period following the operation is no longer a threat psychological defenses of denial can fall away. Then they were able to talk with relief about their fears once they knew the operation was a success. These experiences support findings in previous research and literature reviews regarding the phenomenon of pre-operative denial (Rankin & Borah, 1997).

Not taking the time to consider what major surgery entails (because of denial) raises a few questions. Firstly, is denial a 'flight' reaction in response to fear based anxiety. Secondly, does denial protect the self from internal and/or external shame ramifications (Gilbert, 2002) about having rejuvenation? Third, did these women not want to consider anything that would interfere and cause them to reconsider their decision to rejuvenate? Fourth, as their primary focus was on

outcome expectations to look younger, did they consider this treatment as 'beauty therapy' thus trivializing major surgery as proposed by Bradbury (1994)? Sally's metaphor of FRCS as being "easy as pie" seemed an overly simplified way of viewing major surgery. But this way of thinking does provide support for Bradbury's concerns about major cosmetic surgery operations being 'trivialized.

Meyers (2002) and the BAAPS, (2005) have expressed concerns regarding patients' shortcomings in decision making when they regard major cosmetic surgery as 'beauty treatment'. They argue that this type of perception by-passes the psyche in order to be able to go ahead and have surgery. As we have seen, there was a certain degree of defensive denial attached to all their decisions to have surgery, for, as Sally put it "*I never analyzed every detail of my decision and why I did it.*" And Angela "*It all happened very quickly within a week.*"

These researchers (psychiatrists and plastic surgeons) did not comment on the potential consequences of keeping fears unconscious or secret, pre or peri-operatively, would have on their physical (elevate blood pressure) or psychological (distorted images) states. Concern usually focused on the inattention to, or denial of, possible post-operative complications and how the patient may react should some of these complications occur (Ward, 2005). I propose that fear based anxiety that is denied pre-operatively and therefore not addressed, can add to and intensify feelings of devastation if their face-lift did 'wrong'.

On the other hand, some denial of the pain and long recovery period does have a protective function and so healthy denial needs to be acknowledged as having some place in preparation for surgery. Jones' (2004) argument sums up these participants' predicament...

"fear and desire are at the heart of cosmetic surgery particularly anti- ageing cosmetic surgery." (p 531).

Cathy's metaphor aptly captures the strength of anxiety behind the pushing out of adrenaline associated with fear and desire - "*So I took it like a surfing wave.*"

Those who had done their ‘homework’ on what to expect following a face-lift, appeared to tolerate the physical pain with fewer catastrophic cognitions that can accompany feelings associated with swelling, bruising and looking like someone who had just come crashing through the windscreen of car.

4.2.3 Results, repeats and ambiguity

All participants were satisfied and very happy with the outcomes. Satisfaction has been identified in previous research studies when evaluating facelift outcomes (Alsarraf, Larrabee, Anderson, Murakami & Johnson, 2001).

Other post-operative psychosocial benefits included: improved mood; improved self-esteem, confidence; and, importantly they felt they had been given their control back. Most of the participants affirmed that to look good is to feel good as it is this that gives them confidence in social spheres. By having FRCS these women reconnected with their sense of embodiment and this process appeared to allow their taken-for-granted, unselfconscious being the world to be re-established. As Rina described: *“He gave it all back to me – he gave me back myself.”* The external facial appearance informed and influenced the internal perceptions of the self identity – a transformation had taken place. Pat’s metaphor beautifully describes a transformation of re-birth:

“The effect was profound. Subtle, but incredibly powerful .Oh my God. Like going into a cocoon coming out a butterfly. I’ve got my wings and I can fly.”

These women’s high satisfaction rates suggest they had reasonable expectations pre-operatively (Blum, 2003).

There were other unexpected benefits, for instance, Cathy’s euphoric evaluation of the results paradoxically included acceptance about growing older. As long as she *looked* younger than her age, she felt she did not have to hide the fact that she was 54. This partly agrees with Gilleard and Higgs (2000) findings that it is the look of the ageing face that women are reluctant to accept, not ageing per se. Post-operatively, five of the participants said that their inner feelings of being about 35 years of age was more in alignment with their rejuvenated face. Thus their original feelings of dissonance towards their internal and external

experiences of age were replaced with acceptance of chronological ageing because of their younger looking faces.

Cathy's euphoria may in fact mask the ambiguous nature of RFCS as experienced. For instance, while these women were proud to admit their age, at the same time they kept secret from others how their faces became younger. It can be hypothesized that part of one's motivation for having rejuvenation is about reliance on one's appearance for receiving others approval and acceptance. Therefore this need may entail hiding whatever appearances one finds unacceptable to avoid feared rejection. This 'hiding' reaction is associated with painful feelings of shame (Kilborne, 2002). From these women's narratives it appeared that shame was a motivator for rejuvenating their facial appearance. Then the results that were so satisfactory, made them feel proud of how young they could look again "*it was like a miracle*". But this satisfaction and happiness became a double-edged sword because after rejuvenation Pat said she would be mortified if anyone knew about her rejuvenation. This was not isolated to Pat alone for all the participants kept the rejuvenation a secret from others (apart from their immediate family unit). Merleau-Ponty's ([1945]1962) ambiguity of the life-world that gives rise to anxiety is confirmed here with their experiences of disconnection (as opposed to feelings of embodiment). For before the rejuvenation there was incongruence between the feelings associated with ageing face and the younger inner self which appeared to result in shame-anxiety – post rejuvenation, for all except one, there appeared to be incongruence again between the happy feelings associated with the outcome with internal conflict about needing to keep the reason for the rejuvenation a secret – hence shame-anxiety related to appearance appeared to be present again.

Jones (2004) argues that researchers cannot attempt a cultural analysis of cosmetic surgery and ageing without close attention to the role of the media and its influence on us. The media is a double edged sword of perpetuating our fear of ageing. These women did comment on media 'make-over' programmes and advertisements for anti-ageing products but refuted the idea that the media influenced them to have rejuvenation surgery. Pat, who was of a later cohort, said she was brought up surrounded by different media promoting the benefits of youthfulness, health and beauty so it wasn't something new to her. Is this 'self-

sustaining narcissism' referred to by Meyers (2002) where choices for beautification are not motivated by insecurities but rather self-determination for one's own aesthetic pleasures? Narcissism or vanity can be de-pathologized by understanding pride in one's appearance as being a way of positively identifying with one's body as one's identity. Cosmetic rejuvenation may be affirmation of Davis' (1995) hypothesis in that it is a way to renegotiate one's identity through one's body.

There is evidence of individuals in midlife having more anxieties about ageing than those who are already in 'old age' (Whitbourne & Skultety, 2002) as they have passed through the 'rites of passage' to the other side (Hockey & James, 2003). These women's narratives suggest that they would want to stall ageing for as long as possible. So the 'battle' against ageing was ever present in their minds. Anxieties about physical ageing reoccurring were noted by increased vigilance for the re-appearance of unwanted signs of ageing *"Everything is starting to go a little again. It's that one bloody line that is bugging me."* And *"I'm quite prepared to have it done again if the effects of rejuvenation have gone."* While these strategies of repeats may be expressing the desire to hold onto their reclaimed youthful appearance and maintaining 'integrity of the self', it leaves them vulnerable and anxious to new signs of physical ageing. Over-reliance on identity accommodation leaves them more likely to suffer negative consequences of the ageing process (Whitbourne & Skultety, 2002).

Sally's determination appeared to leave her vulnerable to assumed consequences of observing others and their negative judgements towards her for transgressing these norms of 'natural beauty' (theory of mind, Bee & Boyd, 2002). So she remained self-conscious in the presence of others fearing they would know that she had undergone a face-lift – her heightened sense of self-consciousness is illustrated in her thinking she might as well just say e.g. *"Hello everybody I've had a face-lift."*

Despite the continued anxiety, or as a result of the continued anxiety, two participants had repeated non-invasive procedures to their faces at the time of this research. One of these participants graphically illustrated the inner struggle

for dominance between prohibitions of NO to repeats causing anxiety versus competing demands of YES desires causing anxiety. The needs for desire dominated. While the repeated physical results were successful, both expressed emotional disappointment as they did not experience the same “high” feelings as the first time.

In summary, deeper meaning of the face can be inferred from the symbolism of “the mask” (drawn from Featherstone & Hepworth, 1991). Here the rejuvenation “mask” can hide deeper levels of conflicting motivations that maintain anxiety about appearance. Rina for instance, was determined not to repeat rejuvenation yet her fear of reappearing sagging jowls was almost palpable. This suggests some unresolved deep psychological pain imbued in sagging jowls.

On a superficial level, anti-ageing surgical and non-surgical practices represent an aesthetic preference not to look like an old person (Gilleard & Higgs, 2000). Cunningham-Burley and Backett-Milburn (1998) support the notion that middle year ageing processes challenge the lived experiences of the body and self that is tied together with self identity. Cosmetic surgery offers a time-limited escape from unbearable realities of ageing. Hockey & James (2003) hypothesize that,

“ageing is always in tension with the possibility of continuous self- identity” (p 19).

Therefore, cosmetic surgery (rejuvenation in this study) has the potential to lock us into a constant battle of time (Jones, 2004).

This discussion now moves on to identify deeper issues of the past that still exist in the present. These issues have some origins in childhood and their relationships with their mothers, and are associated with these women’s experiences of facial ageing and the need to rejuvenate.

4.3. Self, Mother and Facial Appearance

Rumsey and Harcourt (2005) argue that lifespan processes are clearly influential in the development and perpetuation of appearance-related self-perceptions and behaviour patterns (p 66). They also comment on the large gaps in current research in the area of developmental aspects of appearance for those without visible differences (Rumsey & Harcourt).

To address this gap, this section identifies narratives containing some developmental aspects of appearance related self-perceptions; values and behaviour patterns. They have origins in childhood and continue across the life course into midlife. Tentative links can be made between the influence of mother/daughter relationship early interactions on the development of self-esteem and subsequent experience of self and the world in midlife. These recollections are important because they are memories the participants wanted to recall. So it is from these narratives it is possible to identify some predisposing factors to their vulnerability on encountering their ageing faces in the mirror in midlife.

While the media, education and peer influences are important, the primary agents of socialization of cultural norms and values as we develop and age are family members, especially the parents (Hockey & James, 2003). It is to these aspects of the mother/daughter dyad the discussion now turns.

4.3.1 *Growing up with mother*

As noted in the literature review, from around 15 months of age children demonstrate self recognition in front of the mirror. This also means they realize that their face (self) can also been seen by others (Jacoby, 1994). This is where Erikson (1964a) hypothesized that shame and doubt appear. It is also the beginning stages of Theory of Mind when you can think about others' thoughts or judgments about yourself (Gilbert, 2002). Emotions such as fear/anxiety, sadness/despair, joy/happiness, and rage/anger are considered to be primary emotions. Self-consciousness competencies begin to unfold at the same time as shame - providing the child has the ability for Theory of Mind and is able to learn about consequences of approval and disapproval. These self-conscious

competencies merge with the primary emotions that give rise to emotions from the shame group, e.g. self-conscious emotions. I am noting this here as a backdrop to understanding the theorized origins of shame, as none of us as young as 15 months can remember what it was like to become conscious of our self in relation to others and feeling shameful when we lost control of our newly found autonomy (Erikson, 1950; Lewis, 1992). As Gilbert (2002) points out, there are a number of different hypothesized on what constitutes a shame experience and the development of self-consciousness.

Vivid memories of themselves as young children observing their mother's daily routine of facial grooming began the processes of internalizing messages for self-beautification. Mother's grooming elicits different types of messages which may be internalized as routines of self-beautification such as "*this is what women do*", thus, as young children observe and learn these messages, foundations are laid for their own developing identities as women. Chodorow's (1978) argument that girls are particularly influenced by their mothers gives support to these women's experiences. Thus through the mother-daughter relationship women start to internalize what it means to be a woman.

Early memories between the ages of 4 – 7 years are dominated by concrete thinking rather than abstract psychological thought so they are impressionable to what they see mommy doing. They have the ability to make cause and effect between feelings and events. Their memories of mother and her facial grooming would be viewed in fairly concrete and absolute terms e.g. Beautiful = good (Bee & Boyd, 2002). This is the time when little girls dress up in mother clothes and jewelry. They want to be like mommy. In terms of egocentric bias this does not necessarily mean 'be' mommy (Arcana, 1981). These firmly imprinted memories identify some possible influences on how, through observation of mother's grooming, part of their feminine identities were being formed, constrained and defined within the context of facial grooming and appearance for themselves (McBride, 2008).

Firm evidence of early memories imprinted in a child's mind is shown in 4 year old Pat's experiences of mother and sisters 'bullet watching'. Pat makes the links between cause (mom judging these women as not looking good today) and effect

(she and my sisters rip them to shreds and being fascinated by this). There was a sense in Pat's telling of this story that was so meaningful to her that she internalized the power of the message i.e. that she had to be properly groomed at all times if she did not want to be ridiculed.

New information is assimilated into developing cognitive schemas (Bee & Boyd, 2002). And, depending on the nature of the experience they internalized, they could either adopt or reject mother's beauty values and practices for themselves. Angela was the only one who described her mother in negative terms for spending hours on just cleaning her face. In spite of memories of mother telling her to take care of her face and buying her expensive grooming products, Angela, (apart from having a face and neck lift), never did and still does not spend time on grooming her face. She does not wear make-up preferring to have the 'natural' look. So Angela's behaviour appears to be ambiguous as she is in opposition to her mother's practices yet has rejuvenation. All the other participants appear to have been enthralled watching mother grooming and internalized this as a positive activity for themselves.

4.3.2 Developmental influences and appearance

In childhood, these women focused on what they saw mother doing. During adolescence their recollections were on the inter-subjective space between mother and themselves as daughters. Literature and research on child and adolescent development support the phenomenon of vulnerability during this critical period of identity formation (Erikson, 1950; Bee & Boyd, 2002).

During this ongoing process of identity formation there is an intermeshing with one another regarding learning and doing gender (Bee & Boyd, 2002). The period of adolescence seems to be a time where self-consciousness about appearance is heightened. To protect her predisposition to vulnerability, it is important for adolescent's growing sense of identity to have mother's approval for her appearance. Molly's and Pat's experiences of their mother's criticism about the way they looked contrasted with her earlier encouragements of their grooming practices. Such contradictions seemed to put them on guard against further hurts.

This experience is supported in autobiographical descriptions such as Blum's (2003).

Blum recalls her own experiences of her mother's criticisms of her nose.

"Having a parent criticize a physical facial feature is a complicated emotional experience that induces both anger and guilt. You feel as if you have let the parent down" (Blum, 2003, p1).

These participants recalled some stories of how their some of their childhood experiences shaped later understandings of their facial body image and self-esteem. These discussion points are tentatively posed in the light of extant literature. For instance, Jacoby (1994) also contends that negative criticism associated with a physical feature can leave an adolescent daughter with a predisposition to shame or embarrassment in adulthood when in the presence of others. Chenin's (1987) concepts on valid criticism, is that an adolescent's self-concept must be robust enough to accept and learn from it – despite this being a challenge. This means allowing for positive and negative feedback so that the daughter can learn to distinguish, trust her own opinions and make independent judgments as to who are trustworthy and who is not (McBride, 2008).

Pat and Molly's recollections of mother's alternating criticisms and compliments left them feeling 'not good enough' - a point which McBride (2008) expounds on in her book on the mother/daughter relationship when daughters never feel 'good enough' for mother (her accounts give credence to intergenerational patterns being passed on through time). Hence grooming practices may have the predisposition to become associated with personal vulnerability about appearance concerns and need for approval. However, even if the child (or the mother) were to be beautiful, intelligent and successful, nobody can be perfect. In reality, feeling one has to be perfect (as a defense against criticism for not being good enough) may predispose a daughter to depend on being perfectly groomed at all times to ward off shame related anxieties (Lewis, H.B. 1971). This is often counterproductive both for mother and daughter as it may lead to guilt or shame in both of them (Jacoby, 1994).

During the process of a developing sense of self, traumatic experiences of shame that occur in childhood and adolescence often leave a sense of emotional defeat that may persist for the rest of one's life (Jacoby, 1994). In this instance, shame is a reaction to the absence of approving reciprocity hence it is a defensive event. Pride in one's physical appearance whether through acts of vanity or self-regard can be used to defend against possible criticism (Ikonen & Rechardt, 1993). Our bodily perceptions formed in this process of vulnerability and uncertainty means that we can have many different established 'body images'. Kilborne (2002) argues that because of our own and others fluctuating judgments, we use our body images to control the way we feel about ourselves – and to control the way we perceive others judgments about us.

This type of conflict can also be constructive and help daughters to psychologically separate from mother by being less dependent on her for approval. Thus, such experiences of shame can be seen, not only as negative but also positive, signalling to the individual to try and deal with the bond threat. The experience of shame-anxiety sensitizes an individual to the opinions and feelings of others and can act as a force for social cohesion and motivation to find within oneself the strength to continue to develop (Morrison, 1989, Izard, 1991).

4.3.3 *Ambivalent relationship with mother*

The previous section identified biopsychosocial influences from mother's alternating criticisms and compliments during late childhood and adolescence that had the potential to leave them predisposed to appearance concerns. This section identifies early experiences and perceptions within their relationship with mother that may have left them predisposed to ambivalent feelings towards her in their lives now as adult daughters. There is a proviso here as it is not about putting blame on mother, for mothers just like daughters, are constrained in a social context that emphasize females' outer appearance and their ability to maintain a normative female beauty ideal. It is about trying to understanding their phenomenal experiences.

Arcana's (1981) hypothesized that when a mother has failed in something, such as in the marital relationship, or is an alcoholic there is a tendency for daughters

to struggle to rise above that failure. This was noted in Pat's struggles to disown the line on her forehead that was associated with the alcoholism in her family. Arcana stated that daughters do this as a measure against being compared with mother or other members of the family. Her interviews with women on their relationships with their mothers confirmed the experiences of five of these six participants' fears and anxieties of looking like mother. Interestingly, Arcana (1981) referred to these unwanted facial appearance concerns as being motivated by competition with mother. She argues that daughters compete to surpass their mothers, perhaps out of the fear of "being" their mothers over again. On a concrete level Sally was the only woman who denied being in competition with her mother while none of the others mentioned 'competition' at all. Sally idealized her mother's looks "*she was beautiful marvelous magnificent until she was 80*". Psychoanalytic understanding is that the daughter believes she can't possibly be in competition with mother's beauty so she idealizes her in order to stay inferior to her. Alternatively, she can abhor her mother's looks. An example of abhorring mother's beautiful features is Molly's experience of ambivalence about looking like her beautiful mother because of the memories of abuse mother metered out to her in childhood, adolescence and young adulthood. When you call your mother the 'wicked witch of the north', it stands to reason that you may not want to be identified with the 'bad' (wicked) mother (Ford, 2006).

So what is the connection between competition, ambivalence and not wanting ageing facial features that look like mother? Daughters may suppress or repress such consciousness about competition when it is associated with their fear of the similarity between themselves and their mothers. We do not want to *be* her, particularly when her life was not what we want for ourselves (Arcana, 1981). Jones (2004) postulates that mother's features that were either to be admired or abhorred have intra-psychic meanings. Experiences of being dependent upon mother's approval for your appearance in adulthood, such as Pat on her wedding day which was denied her, left her vulnerable, confused and anxious "*I didn't need her to tell me I wanted her to but.....*" I suggest that this response is not necessarily pathological – it is a normal response. But here is ambivalence – 'I need to trust my own judgment but I also want Mother's approval'. Pat and Molly's example of always doing so much for their mother, regardless of being in

adulthood and leading independent lives, give a sense of an underlying yearning for their mother's approval. So too is Rina's strong identification (projective identification) with her mother, leaving her feeling shame, inadequacy and guilt when her ageing features bore similarities to mothers. The personal meaning imbued in her own sagging jowls was that Rina saw herself through her mother's features and it stirred up painful past memories. These memories were intensified by their shared experiences of a life threatening illness. Rina needed her sagging jowls cut out and got rid of. So while Rina acknowledged that she loved her mother, she did not want to be reminded of unhappy times "*I was looking at the 'bad' me*" – this is splitting off the 'bad' mother in psychoanalytic terms.

Notman (2006) on mothers and daughters as adults, assert that for most women, their relationship with their mothers, both external and internal, remains important throughout life, although it may be intensely ambivalent. The tension between the ongoing process of differentiation and developing a sense of self, and also maintaining the attachments that have been present during development into adulthood, continue to be present fluctuating with life events and changes for both daughters and mothers. Viorst (1986) argues that in order to proceed forward we constantly have to let go of painful memories. If we cannot let go or accommodate them, we may always fear its return if psychological connection is not made and mourned.

Friday (1977), writing from a psychoanalytic perspective, urges women to use their new found liberation in midlife by accepting physical ageing as a natural process. She argues that fear of ageing and loss of one's femininity is located intra-psychically. This fear arises from the nature of the interactions and socialization processes generated by and through the daughter and mother relationship. She contends that becoming a fully sensual woman is not about resisting ageing but resisting the stereotype that ageing mothers imposed upon their children daughters. Arcana (1981), opposes Friday's view point and criticizes her for reinforcing resentment and anger many women feel for their mothers. She argues that Freudian-based psychology made us aware of the 'bad' mother who repressed their daughters and never gave them the unconditional love and support that should exist between mother and daughter. With the

blooming development of the feminist movement of consciousness raising, instead of perceiving mother as the oppressor, Arcana (1981) invites women readers to get to know their mothers through the feminist lens as a 'sister woman' – no matter how hard this may be. This leads to an understanding of her position in her 'day' and forgiveness for the way she socialized her daughter/s.

According to the aforementioned literature, childhood and adolescence is a vulnerable time during which positive or negative self concepts develop. These women's experiences seem to confirm these notions, as their developing self concept appears to have been, in part, influenced by mother's approval and criticism of their appearance. In analyzing psycho-social developmental influences, these women's idiographic narratives describe processes of social interactions within the family, and their interaction with the wider contextual environment as important sites (although it is not the only site) for developing a sense of who they were 'becoming' as women in relation to appearance. Their narratives identify the ambivalent nature of their relationship with their mothers in terms of facial appearance, and the consequences of this. Phenomenological experience of aversion to their ageing faces appeared influenced by retrievable memories and existing associations with mother and features of mothers' face. The decision to have facial cosmetic surgery, whether on conscious or subconscious levels, seemed to be for most participants symbolically connected to their own identity as a woman, as well as to the stories of their daughterhood and of their own mothers. There are additional experiences of their facial appearance also being shaped by and through the nature of their ambivalent relationship with their mother's over time. This suggests that ambivalence is at the heart of facial appearance concerns as is their relationship with mother.

The above perspectives confirm the important meaning of faces being powerful and important symbols of psychological and social identity within the mother/daughter dyads, ones' family and culture. It is also apparent that women may consciously or unconsciously connect her facial features symbolically or literally to her mother's facial features. Unresolved issues or ambivalence in their relationship has the potential for conflict being played out on the landscape of the face.

4.4. THE CYCLICAL NATURE OF SHAME, PRIDE (VANITY) AND SHAME

Responding to their fears of looking old and desires to stay young looking, the solution to rejuvenate came at an unexpected cost to these women's physical, social and emotional experiences of self. These unexpected costs appeared to be underpinned by self-conscious emotions that were driven by self-evaluative processes for the failure to maintain a naturally young looking face. This section of the discussion sets out to illustrate where and how some of these women's experiences of rejuvenation appear to perpetuate a cycle of specific self-conscious emotions of shame, pride and shame.

4.4.1 The Double edged sword of pride (vanity) and shame

All of the participants were euphoric about the results and loved looking at their younger face in the mirror – but when it came to meeting others in public, five of the women re-experienced fears, anxieties and shame in case they were negatively judged as vain for having rejuvenation. We all have an evolved need to belong and accepted in intimate relationships, as well as in wider social circles (Swami and Furnham, 2008). Thus we seek to be attractive, physically and socially, to them – this is common human psychology. However, when appearance is shown to be vain, the wish to recapture a youthful appearance can easily backfire (Kilborne (2002). It then becomes another shameful and humiliating defeat – only this time it is attributed to a transgression of some sort of social unwritten rule, as one of the women recalled *“I would hate to be thought of as vain and self obsessed.”* and *“It’s so obvious afterwards Oooh and ooh.”*

To discuss the double edged sword further in context of negative stereotypes attached to people who have plastic surgery (Davies & Sadgrove, 2002) these women feared being thought of as vain despite undergoing rejuvenation for self-improvement reasons. This bears testimony to our western culture notion that persists in understanding the mind and body as separate entities by; placing a high value on youth and youthfulness; describing patients who have cosmetic surgery in medical literature as narcissistic and psychologically unstable (Davis, 2003), and feminists such as Blum (2003) who equates cosmetic surgery patients with suffering from ‘delicate self-harm syndrome’. So even though cosmetic surgery is similar to other forms of body management, the way it is interpreted is

symbolized as a fault of women's internalized oppression and vanity (Gimlin, 2007). These and other equally derogatory opinions may well influence women who rejuvenate to narrate their motivations for surgery in a way that normalizes them but also seem to contribute to subverting sustained enjoyment of it (Meyers, 2002; Eskenazi & Streep, 2007). The problem with such prevailing attitudes and fears regarding 'charges of vanity' and so on, is that these charges have the potential to perpetuate a lack of dialogue about how changing the body can have potential benefits of changing the 'self' (Gimlin, 2007). These negative judgments are in spite of previous research pointing to the psychosocial advantages for having cosmetic surgery (Goin & Goin, 1981., Gilleard & Higgs, 2000., Sarwer, Magee & Crerand, 2004., Thorpe, et al., 2004., Pitts-Taylor, 2007).

There is also another 'double edged sword' for women who have cosmetic surgery and remain dependent upon others for approval, as the act of rejuvenation comes with the price tag of heightened self-consciousness. In the first place, when nearing the end of midlife and these women felt they no longer met the cultural norms of youthfulness. And, in the second place, after having FRCS, they did not meet the norms of socially controlled competitiveness that set standards of youthfulness as a 'natural' state. This external shame easily becomes internalized because it is, in a sense, validated by internal shame that has been there from the beginning of self conscious competencies that start to develop in children from 15 months old onwards (Gilbert, 2002).

These women's experiences of external shame as a consequence of rejuvenation – real or imagined - really came as a surprise to me as the researcher. I also had the impression when they recalled their rejuvenation that they too were surprised by their continued embarrassment in relation to others. It was as if it was the 'battle' they didn't anticipate or see – that is the battle of shame that is in relation to others. It can be said that self-identity, shame and pride, seem as foggy as your face you see reflected back to you in the steamed up bathroom mirror.

On the other hand, one of the participants admitted openly that she had her "eyes done" for vanities sake. She even felt quite proud when her husband boasted to others about her new face saying "look at my wife's eyes." In this instance, there

could be a link between being open about rejuvenation eye surgery and no apparent shame – she was however the only one who mentioned feeling guilty about spending so much money on herself. This is the only example of openness to others amongst these participants.

Living in a culture of narcissism we have social rules endorsed by society and we may feel shamed if we do not conform to these standards. Gilbert (2002) argues convincingly that self-conscious competencies based on social comparisons is the bedrock for shame e.g. others' negative feelings towards us that leave us feeling inferior, In these circumstances, one's identity can even feel unattractive. Subsequently, shame is publicly and privately experienced. Their experiences validate Bartky's (1990) argument that guilt, shame and obsessional states of self-consciousness are the price many women pay for trying to satisfy their narcissistic needs. This is the double edged sword. While these women were all very happy with their results, at the same time they assumed they would be "*harshly*" and negatively judged for their actions by others.

In summarizing the central issue of the double edged sword, I am drawing on Derrida's (1967) metaphor of shadow and light – of revealing and hiding. Its meaning concisely portrays the dilemma faced by five of these women in wanting people to **look** at them as being young for their age, but not to **see** how they are younger, and the ambivalent intra-psychic tensions that are inherent in that type of situation.

4.4.2 *Hiding pride and shame*

Jacoby (1994) maintains that shame makes us fearful of entering into potentially shameful situations – particularly when people see us for whom we really are. When one's secret is revealed in public, this can be likened to shame as an archetypal phenomenon. To illustrate the origins of shame, Jacoby refers to Adam and Eve's expulsion from the Garden of Eden and the consequential development of their 'soul mask' persona. Adam and Eve dealt with their shame of sin by covering up their nakedness with loincloths – symbolically this is a defensive strategy against their anxiety for being publically found guilty (by God) for having sinned, for which they also feel ashamed. By analogy, loincloths

become 'secrecy or a means to conceal' in this section of the discussion. This emotional process suggests one feels guilty when you have been accused of transgressing a moral law. This process of thinking suggests that guilt is a consequence of sin which is then followed by the experience of external shame (Gilbert, 2002). If some of these women believed in the state of 'natural' given beauty then making surgically enhanced beauty treatment may not sit well with their conscience. Furthermore, continually hiding their shame also suggests these feeling continue. So, different self-conscious emotions can be felt in quick succession which adds to the confusion referred to by Tangney et al (1996) in the difficulty of identifying guilt from shame.

Another interesting point is the way some of these women described 'the face' as being separate from their body when maintaining secrecy about their rejuvenation. Cathy was proud to admit to someone in the street that she had a tummy tuck, but then people said, *'Gee that hair style makes you look 20 years younger', then I didn't say well I had a face-lift*". Another example is of Pat who always kept fit by eating healthily, going regularly to the gym and riding her bicycle. While her body was in top shape, her face aged from the toll taken by stressful study for 6 years. She could not bear to see her face etched with lines and felt ashamed that others could see them too. These are two different experiences but both illustrate the different feelings attached to these different body parts.

So what is the difference between the body and the face when the subject chooses to reveal the body work but not a face-lift? Sarwer, et al. (1997) investigating 'Body image dissatisfaction in women seeking rhytidectomy, blepharoplasty and rhinoplasty,' found rhytidectomy and blepharoplasty patients had greater investment in facial appearance as well as greater satisfaction with overall body image compared to the women who had a rhinoplasty. In terms Hypotheses can only be made about Pat's, Angela, Sally's, Molly's and Cathy's separation of the face and body when taking into account the totality of their stories and making links between the different episodes. So other than Sarwer, et al. research (which for our purposes only illustrates the way body is divided into sections), identifies the need for more research into these areas of different perceptions of our body parts and our actions towards them.

Strongman (2003) argues that shame is the most important of the social emotions because it provides disincentives for individuals to violate social consensus. If you violate social consensus, you are shamed because you may create unfavourable impressions and lose self-esteem in others' eyes. Violating social consensus, perhaps in terms of the fairly small knit community and culture of the South African community Cathy described living in (and based on my personal experience of these small communities in SA), she feared they would think she had transgressed an unspoken social, religious or moral law which implicitly states you can alter the shape and contours of your body but the face is untouchable. So the intention of secrecy, or concealment, serves to function as psychological and social protection.

Having to conceal shame is not so easy to do as it involves the whole person (Lizard, 1991). It is sometimes confused with guilt but it is not like guilt. Guilt involves an act or omission. A person can generally do something about this guilt. While shame refers to the whole person there are also many different evaluations involved in shame (Deonna & Teroni, 2009). One can be ashamed of one's ageing face which is evaluated as shame about permanent traits. One feels ashamed of one's dishonest behaviour which is moral shame. You can feel social shame when seen by others doing something you would rather they did not see. The problem highlighted for the researcher in this study involved the 'unity' problem of shame. Keeping the surgery a secret by hiding operation scars with your hair as Sally did, only seemed to protect her from social shame. This hiding seems to be an attempt to locate the whole 'self of shame' within the scars. But it also appears that the 'self of shame' cannot just be confined to the scars as in this instance, externally felt shame was still present. Deonna & Teroni claim that shame consists in an awareness of a distinctive inability to discharge a commitment attached to self-relevant values. So even when social shame is avoided the self of shame can still be experienced. Lazarus (1999) and Gilbert (2002) similarly argue that shame is essentially an emotion of social comparison while true the data from these narratives suggest that it is much more than that.

Notwithstanding, shame in this instance of secrecy or concealing also has positive attributes as it stops one from boasting. It is there to remind you of the importance of 'fitting in' with society. Whether it has positive or negative

attributions, Nathanson (1987) cautions concealing as this act can bring with it the possibility of more anxiety and shame.

The possibility of more anxiety and shame refers to more recent comments by Scheff, (2001) and Strongman (2003) who refer to 'more' anxiety and shame as a circular phenomenon. Their concept of circularity is also applicable to these women's experiences. For instance, part of the initial response to feeling disgusted and ashamed of their ageing faces was to choose rejuvenation as a strategy for reversing this ageing process. The outcome made them tremendously happy and proud when they looked at their reflections in the mirror. But when in public there was a need to keep the rejuvenation, as the source of their younger appearance, a secret. This suggests they felt ashamed of what they have done (by breaking a moral code of 'natural' beauty) or for being judged as psychologically unstable (Davis 2003) and so feared negative reprisals and rejection from others. This process of alternating feelings of self-consciousness seems to point to the presence of a repeating cycle of shame, pride and shame.

Thus, this process sheds some light on the nature of the anxiety laden journey most of these women went through, in order to maintain a standard of youthfulness and a wrinkle free face.

4.4.3 *Roots of Shame*

Identity has often been presented as a key developmental task of adolescence with its continuing presence being felt throughout adulthood (Erikson, 1968a). This section discusses normative identity issues presented in the narratives by some of these participants during various times in their life as young children, adolescents and adults. The central focus of understanding is in identifying the links between their internal shame with past conflicting and enduring patterns from childhood.

Cathy spoke about being rejected by the girls at grammar school because of her working class accent. Did she at that point internalize values of superiority and inferiority (hers) to different class groups? Cathy recalled not wanting to go to grammar school but her father had insisted upon it. He aspired to, or had ideals, for his "*princess*" as he called her, to belong to that higher class of people at the

grammar school. Unfortunately, what the 'upper class' pupils saw before them was a "*pretty*" young girl with a northern accent trying to fit in. They did not see the girl behind the pretty face. She was bullied and hated it, and at some level she may have internalized this experience as her shame of exclusion. Morrison (1989) refers to this as feeling 'shame' for not being good enough. This may to some degree explain why she couldn't tell other women about her face-lift for as she said "*I didn't want them to think I was better than them*". This also makes links with the positive aspects of shame when Cathy did not want to tell others why her face looked so much younger

As a young child and adolescent, Pat also experienced these inclusions and exclusions within her family that was based on appearance and was always left feeling she was 'never good enough'. These roots to Pat's shame seemed to be located in unfavourable comparisons her mother constantly made with her beautiful sister and handsome brother – she was excluded from the category of "*golden children*". The line on her forehead marked her out as an addict to others and included her within the category of family addicts i.e. the sister, brother and father. This made she feel "*embarrassed*" for herself as the roots of shame were "*very deep there*". Some feelings of envy towards the 'golden children' may have related to not being included or being 'good enough'. This makes tentative links with Blum's (2003) comments noted in the literature review that that patients' underlying motivation is wanting the essentially flawed features to vanish along with the feeling of distress and disbelief associated with it.

There are other aspects associated with roots of shame with all these participants, such as Rina's childhood and adolescent experiences of seeing her helpless mother's face etched with pain and sagging jowls leaving her feeling "*guilty and powerless*". These memories remained attached to her identity. When in adulthood Rina saw her ageing face resembling her mother's face she seems to have strongly identified on an intra-psychic level with the powerlessness and lack of control over her situation. She only saw the "*bad me*" part of her identity which could not do anything. So she needed to remove all traces of it by cutting it out (Blum, 2003; Eskenazi & Streep, 2007). Kilborne (2002) warned that the despair of oneself becomes shame in itself.

This section on shame identified some powerful contexts of facial appearance being saturated with ambiguity along with the mask of shame hiding feelings of being flawed. Some origins of shame appear to have their roots in childhood, and family patterns of inclusion and exclusion. Strong identification with mother and unresolved issues relating to these experiences seemed to have been played out in the area of the face leading to shame being attached to those facial features. Other examples of repeating cycles of shame, pride and shame were illustrated.

4.4.4 Narcissism: Self-absorbing or self-individualizing

There were difficulties in using the concept of narcissism and to elucidate its use in this thesis because it is frequently used derogatively in everyday speech, and in psychological and cultural terms (Lowen, 1997). Nevertheless, this portion of the discussion uses psychoanalytic understandings of narcissism on intra-psychic levels of meaning. At this level findings identified the use of narcissistic ego defenses against shame-anxiety that arose from a personal sense of lack of identity and self-esteem (Rhodewalt, et al., 1998., Morrison, 1989). These narcissistic defenses were either positive or negative.

The positive side of narcissism was used for 'adaptation or normal self interest' purposes and in self-individualizing. Positive narcissism in this sense was based on a sense of self having a healthy concern for, and pride in one's appearance. The other aspect identified was negative narcissism which appeared to be unhealthy, passive or self-absorbing when, for instance there was an attempt in the act of improving their looks, it came at the expense of displacing identity from the self to the perfect cultural and psychological 'image' of body beautiful (Lowen, 1997).

Morrison (1989) and Jacoby (1994) both maintain that if narcissistic needs cannot be met, shame is experienced. Therefore, narcissism and shame are inextricably linked. Shame in this context of narcissism, can also be evaluated as having positive or negative aspects to it. In negative terms, shame refers to having failed in some aspects according to certain attributes one believes one should have. It's about something being wrong with our character i.e. 'feelings of not being good

enough' (Lewis, et al, 1989). Viewed positively, feelings of shame alert one to conform, rather than deviate from, particular norms of appearance. Thus feelings of shame can be perceived as positive when by conforming to the prevailing norms prevents a threat to the social bond (H. B. Lewis, 1971; Morrison, 1989; Scheff, 2001) i.e. *"I never not put on my make-up"*.

Morrison (1989) explored the relationship between shame and narcissism positing that shame is a protection against narcissistic wounding when you feel you have failed in something. For instance, one can feel ashamed if you believe you are responsible for your ageing face (Brooks, 2010). In this study most of the women referred to subjecting themselves to prolonged periods of stress which they believed aged their faces. Defending against this shame, narcissistic self-regulation as adjustment, they engaged in self-enhancement strategies by choosing to rejuvenate in order to restore equilibrium. But the rejuvenation was more than just looking younger or better as it incorporated perfectionism. In this instance, three of the participants mentioned that they were perfectionists when it came to grooming and facial appearance.

Perfectionism, as a narcissistic defense, is often driven by both a need to protect one's identity, to keep oneself from being seen as anything less than the best, and/or the need to maintain a sense of control in order to stave off potential criticism and rejection (Morrison, 1989). Morrison refers to efforts in being perfect as being the 'mask' that is used to hide the shame of rejection for not being good enough *"...Fear of looking less than OK is about people behind nets poking fun at you and you don't even know that."* Pat realized the link between childhood experiences of women being ridiculed for not looking good. She acknowledged she has the same fears of ridicule. Possibly this is why her rejuvenated look did not remove her fear of rejection i.e. internal shame of mortification for being found out and ridiculed. Molly also realized that if she is not perfectly turned out it would make her anxious in social situations as she would leave herself open to ridicule. Pat, Molly and Cathy made the choice to always be perfectly turned out and to always wear make-up. All of the participants, except Angela, loved grooming their faces as time they wanted to spend on themselves – time mother said you should have. This is not to say Angela did not want to look good – she just did not want to be seen as making any effort to do so. This attitude and belief

possibly relates to her experiences of watching her *'vain' mother* and people at work calling her mother *"Mrs. Pointy Nose"*.

The origins of narcissistic disturbance can be found during children's early emotional adaptation and development of self-conscious competencies (Miller, 1987; Erikson, 1968a; Gilbert, 2002). Molly, Cathy and Pat believed that the roots to their self-conscious emotions regarding appearance lay in their childhood experiences e.g. Molly described this experience as constant, yet unpredictable, ridicule from her mother for her appearance. These early experiences during identity formation can be inferred from later experiences of shame in adulthood. Important knowledge for this third theme were narcissistic defenses that ran 'deep' and permeated some of these women's understandings of their phenomenological existence. Thus, for most of these women, internal feelings of shame and external appearance concerns that depended upon others' approval appeared to be a circular and self-absorbing process. Here is the paradox, that one strives to be perfect – yet no one can ever be perfect - especially in the sense of never having wrinkles (McBride, 2008). These goals in midlife are impossible to achieve and it is normal to feel a wrench of despair when facing this loss. It requires a period of soul searching to find ways to replace what has been lost that will lead to ultimate adaptation and growth (Viorst, 1986, Chinen, 1987).

In terms of 'normal self interest, some of the participants found ways to celebrate other achievements and integrate them into their identity. For example, four of the six participants were already enjoying being grandparents in their 40's. The stereotype of grandmother sitting and knitting next to the fire with grandchildren climbing over her no longer fits this generation of women. Five of the six participants remain successful in business and are very active in management positions. This deconstruction process of middle-age is supported by Featherstone and Hepworth (1991) who posit that 'middle-age' is now 'mid-life' and refers to a stretched middle period of 35 to 60 years of age. As Angela said when reflecting on her experiences *"On occasions I see the humour in it. Acceptance is very important..."* Pat realized that whether she had the 'line' or not, she was responded to in the same way by people she knew before and after the rejuvenation. This was such a liberating experience for her. She admitted she felt like a butterfly coming out of a cocoon and added that when her wings

became tattered it would no longer matter because she was '*in a different place*' (5/16-17).

You can rectify the act that gave rise to feelings of guilt but with shame the whole self must be changed (Ikonen & Rechardt, 1993). I do believe that as these women felt shame again after the rejuvenation but the nature of it is different. That is why you have to look shame in the face because if you cannot look within yourself, you lose yourself.

4.5 CONCLUSION

For these participants, the ageing, lined, wrinkled face was the antecedent of (the 'before') shame when in the presence of others and when alone gazing upon their reflection in the mirror. Ageing facial features are out of our control because it is the skin that is becoming old. Their vivid accounts justified why their faces had aged prematurely and they looked forward to enhancing facial cosmetic surgery as the answer to overcome this problem (McKinley, 2002). Subjectively, all the rejuvenation procedures were judged as satisfactory by themselves and they were euphorically happy and proud. However, fear of being thought of as vain or being noticed for under-going cosmetic procedures by others evoked shame 'after' the rejuvenation.

External reliance on approval from others for appearance, that often had its roots in the past associated with mother and other life span identity formation issues, appeared to maintain anxiety associated with facial appearance concerns and the desire to repeat rejuvenation procedures to ward off shame. These participants provided evidence of striving to attain 'identity balance' employing healthy and unhealthy coping strategies for pride and shame's sake before and after rejuvenation. All participants' anxieties were more than just skin deep.

Some of these intense and painfully felt memories became located within particular ageing features on their faces. While all of these women said they were very happy with the results of rejuvenation and they did not regret having done it, shame seemed to remain within them in relation to observing others.

This 'after' shame appears to be external but more research is needed in this area before it can be said that with these women there was internal shame afterwards as well. Nevertheless, their narrative data identified the 'before' rejuvenation shame that was external and internal elicited, followed by pride 'after' rejuvenation and then externally motivated shame again – thus a cycle of shame, pride and shame was identified.

From this study the analyzed data suggest that elective surgery can re-create the physical and psychological conditions necessary for inner growth. However, when the implicit reason for rejuvenation is to resolve inner conflict, this unresolved conflict has the potential of leaving the candidate 'between a rock and a hard place'. However, Eskenazi and Streep (2007) maintain that tending to self-improvement of the inner and outer self in our post-modern society can promote a healthy inner self, a state they call "cosmetic wellness". This type of well being was identified in the data of those who had their rejuvenation done within the past year. The longer the time period after the rejuvenation, the less euphoric about their rejuvenation the participants appeared to be, as they started to become focused on new signs of ageing.

As a foot note:

The participants were from South Africa and United Kingdom. Both countries are regarded as being part of the 'western' culture and this thesis was not intended to be a cross-cultural study. The choice of participants happened because of who was available. However, I did not note any particular cultural differences in attitudes towards grooming and care for facial appearance. The only differences were geographic in that emphasis was placed on the damaging effects of the sun by the South Africans. Two of the South African women spoke about wrinkles as being caused by excessive sun-tanning. By way of comparison, an English participant spoke about false tanning creams for special occasions. Therefore, such similarities in these practices that were geographically different suggest that preoccupation with beauty and grooming is, in part, a basic human instinct and innate preference. This phenomena places innate grooming practices into the

realms of evolutionary psychology and biology (Swami and Furnham 2008). No cross cultural differences in wanting to keep it secret except were evident except for one from the UK who only had her eyes surgically rejuvenated who was open to others about it.

4.6 Reflexivity

In the process of doing this doctorate, I have learned so many things on both personal and professional levels. Indeed at times it was quite difficult to identify these distinctions. The importance of personal and professional experiences and how we use this foreknowledge in our work does have impact on our efficacy as qualitative researchers. Having necessary levels of self-awareness and being able to recognize what I was thinking and feeling was crucial to developing my understanding of the participants, and my own vanity and shame, in terms of facial appearance – Cooley's 'looking glass self' is so appropriate in the context of the intersubjective space between us when researching appearance. When I saw the photographs of their faces after the telephonic-interviews it hit me as to just how much I interpret and evaluate a person based on their appearance. It is similar to us, the public, reaching saturation point with media programme advertising anti-ageing products – we think they don't influence us anymore – but they do – it's subliminal. These women were incredibly good looking and I was so glad that I had not seen their photos prior to the interviews. I may have prematurely foreclosed possible meanings by assuming they did not need to rejuvenate. This may have lead to minimizing the importance and origins of their distress linked to their ageing face had I looked at their photos before interviewing them. From a professional point of view, the role of my supervisor reading and re-reading my analysis of their narratives was invaluable in making sure that I remained within their texts of meanings in order to understand their lived experiences.

Chapter 5:

VALIDITY, LIMITATIONS, BUILDING-ON THIS RESEARCH AND, RELEVANCE TO COUNSELLING PSYCHOLOGY

5.1 VALIDITY

The criteria claiming qualitative research is valid and of good practice is constantly evolving. Of special interest is the on-going debate on possible influences on the study due to researchers' subjectivity. As Yardley (2008) comments

"Most qualitative researchers believe that the researcher inevitably influences the production of knowledge by formulating a research question, choosing particular measures and analyses, and interpreting findings"
(Yardley, 2008 p 237)

Yardley substantiates her argument saying that if influences of the researcher would be eliminated from the research, subjectivity and new insights identified from the analyses would be lost. On the other hand, the participants knew I am a psychologist and this knowledge may have influenced what aspects of their stories they chose to tell me or leave out. To minimize the possibility of their bias, open-ended questions were formulated with the main aim of capturing the essence of their experiences. In this case it is advantageous to research outcomes for qualitative researchers to maximize engagement with participants, and the semi-structured interviewing schedule helped to ensure the participants had the opportunity to describe their experience in detail (Willig, 2008a).

Working with small samples, I focused on unique and in-depth phenomenological experiences occurring in particular contexts of these women, their facial ageing and cosmetic surgery. By analyzing interactive processes and identifying individual similarities and differences 'theoretical' or 'logical' generalizations were made, as opposed to generalizing findings to the general population (Smith & Osborn, 2008).

In order to address issues on the validity (trustworthy and usefulness) of this research the following core principles according to Yardley, (2008) are used:

Sensitivity to context; Commitment and Rigour; Coherence and transparency; Impact and Importance.

5.1.1 *Sensitivity to context*

Features of validity in this research are demonstrated by drawing on existing literature and research in the field of 'body image' and 'disfigurement'. These sources come from a range of disciplines within the social sciences and medical fields. Drawing on these parallel fields was beneficial to outcomes, as little information was available on specific experiences of women in midlife facial ageing and facial rejuvenation. For example, Ong et al. (2007), quantitative research investigating levels of psychological distress experienced by people with facial disfigurements was extremely valuable to this research in terms of emotional distress experienced in relation to the extent of facial disfigurement. They found there was no relationship between the subjective nature of emotional responses and the severity of facial disfigurement. Their findings drew parallels with some aspects of this research's findings in terms of subjective responses to facial ageing. In terms of universality, this study's particular qualitative research findings on levels of emotional distress and facial ageing appearance confirms and adds support to some of Ong et al. quantitative research results i.e. that reaction to one's own facial appearance is a subjective experience and is not related to objective measures of appearance.

Other studies relating to cosmetic surgery, women in midlife and facial ageing were explored. Feminists of the first (1950's – 1970's), second (1980-1990) and the current waves have all given abundant attention to women and body image. However feminists have not given attention to the ageing women's experiences of cosmetic surgery. So while their valuable work laid foundations of thought about women and social constructions of femininity and self-beautifying practices, this research explored phenomenological and unique experiences of women in midlife and FRCS adding to existing knowledge by filling in some of the gaps.

5.1.2 Commitment and Rigour

A purposive sample of 6 women meeting the qualifying inclusion criteria for a purposive sample were selected so that thorough descriptions of their phenomenological experiences could be analyzed and offer new insights. One participant deviated from these criteria in terms of age only. At 32 she was nearing the end of young adulthood years as opposed to the others who were near the end of mid-life at 58.5 years. She was chosen for practical reasons (as outlined earlier in the methodology) which proved to be informative as her narratives highlighted differences between her attitudes towards 'waiting to see if she would' repeat rejuvenation later in life, as opposed to the older women who were definite in their 'would repeat' or 'cannot afford to', shedding light on possible developmental processes, time and age-related transition rites of passage differences.

Commitment and rigour was achieved through empathic understanding of participants' perspectives, based in part on professional/functional skills as a psychologist and in part on personal experience of my own facial rejuvenation procedure.

5.1.3 Coherence and transparency

All transcriptions and analysis of data was checked and supervised with my IPA supervisor until agreement between us was reached. Additionally a paper trail of all data involved in the transcription and analysis has been kept electronically. One particular participant trail is supplied (**Appendix D9**) to provide evidence of a carefully and professionally documented study. Interviews and transcriptions can be supplied should examiners wish to confirm.

In order to monitor my own role and influence on the research, engaging in the act of reflexivity throughout the study formed an important part of promoting transparency in validity. I have included reflexive analyses at the end of each section of the study. I agree with Finlay (2003) who believes that in her research she is also a participant trying to understand participant's meanings as well as her own. My reflexivity was a way to monitor my own subjective reactions during the research process.

5.1.4 *Impact and Importance*

Findings identified the complex biopsychosocial, multi-layered contextual levels of understandings associated with women in midlife adjusting to facial ageing. They highlight convergent and divergent experiences with positive and negative influences associated with their choices to rejuvenate. An important finding identified the hidden and cyclical nature of vanity and shame. This suggests that further research in this field is indicated. Findings of this research and future research in the areas of vanity and shame would be of benefit to plastic surgeons should they choose to pay additional attention to this phenomenon. These findings can also be of benefit to psychologists involved in assessment and preparation of patients who wish to undergo cosmetic surgery.

5.2 LIMITATIONS OF RESEARCH

Willig (2008a) identifies three concerns associated with IPA. They are the role of language, suitability of account, and explanation versus description. These are taken into account below.

5.2.1 *Role of language*

In terms of language, all participants were English speaking. Willig (2008a) argues that 'language constructs, rather than describes, reality. (p66). Participants use words (of their choice) to describe their experiences but at the same time language can never completely express the essence of the experience. I concur with this short-coming. An advantage I had was having lived in SA and the UK, and being familiar with colloquialisms used in both countries. So in terms of barriers to understanding the meanings of the language they used, they would have been minimal. However, because of the geographical distance with the SA participants, language was expressed through different mediums to give accounts of their experiences. Online interviews were initially conducted via the email. This was followed by telephone conversations to elaborate and clarify the e-interviewing information. Not having visual contact with three of the SA participants may have increased my ability to listen, and not limited it, for while

they spoke there were no additional non-verbal aspects to incorporate into the meaning. However, their faces were central to this phenomenological study and it stands to reason that just having the written text and voice may have compromised this form of research with three of the participants. Langdridge (2007) posits that online interviewing causes a rupture between the researcher and the participants with regards to the body. But, he does not see this as necessarily limiting the research. He bases his argument of Heidegger's notion of '*the bodily*' aspect to embodiment where our senses do not stop, say for instance, at the tip of a pointing finger – it stretches out beyond to the object pointed at (p 71). This certainly applied to my 'bodily empathy' (Finlay, 2006) in response to Sally verbal descriptions of self-consciousness when in view of others as I blushed.

Two of these participants offered to send me photos of them-selves 'post surgery' and I accepted. They must have felt an aspect of their experience was missing from the e-interviews and they wanted to share it with me i.e. the picture of their reclaimed younger self. That was when I realized the actual impact visual representations had on my perceptions about them (and people in general) because prior to the photos I remained solely focused on the verbal and written communications and had no way of judging their facial features. So from my researcher point of view some aspects of non-verbal behaviour were missed with the e-interviewing and telephone calls but whether this was a limiting factor - I'm inclined to say "not" (and in fact perhaps the opposite for I realized how powerful visual appearance is on one's perceptions of others - well mine that is). On the other hand there were many other aspects to these interviews that could have been picked up on and integrated into the research had it been possible to do so e.g. the meaning of the post-surgery photos - the meaning it has for participants when not been seen by the researcher when interviewing them on their experiences of their face-lifts.

Nevertheless, it is important to note a limitation in not being able to make full use of the communicated meanings (verbal and non-verbal) conveyed through language via the different mediums. All their experiences of facial procedures contained similarities and differences to each other with different aspects having different focuses – including emotions. What is certain is that all their stories

were rich in detail and were all transcribed. The texts were read and re-read until the researcher was completely familiar with them – only then did the analysis commence.

5.2.2 Suitability of accounts

The aim of phenomenological analysis is to explore and try to understanding 'what it is like' to go through that particular experience (Willig, 2008a, p67) The first woman I called mentioned that she was afraid I would think she was narcissistic - and she did seem a little hesitant to speak. This hesitancy may have been due to her assumption that as a psychologist I would judge her negatively as a 'narcissist'. I did not want to turn the interview into a therapy session yet at the same time I needed to address this possible limitation of her holding back on her accounts.

So I made the decision to share with her that I had some rejuvenation and that this experience motivated me to do research into the important area of cosmetic surgery (after this incident I told all the participants). I hoped this would lessen any defensiveness she may have been feeling and enable her to communicate more freely. My revelation seemed to have a good effect as she spoke very freely after that. Pitts-Taylor (2007) who also had her own cosmetic surgery during her research into 'Surgery Junkies' wrote about specific changes in her perceptions towards the patients and surgeons she interviewed once she became a 'patient'. She became more aware of her own face and nose (she had a rhinoplasty) and other peoples'. She also noted that when she revealed her cosmetic status, all patients became more 'chatty' (p 164). They became less defensive, more open about the pitfalls and thrills. As she became more immersed in their experiences, as well as her own, she realized how they seemed surrounded on all sides by conflict and ambivalence. She also did not find them to be the 'self-hating' victims as depicted by feminists who are against the willing mutilation of women to their bodies with cosmetic surgery. In order words, she was able to become more empathic with them. This concurs with my experiences of Finlay's (2006) '*embodied self-awareness*' of my own facial changes and '*embodied intersubjectivity*' of the meaning of shared experience as it took place between researcher and researched.

5.2.3 Explanation versus description

This phenomenological research focused on these midlife women's perceptions and experiences of '*being in the world*' (Willig, 2008a). It briefly touched on why some of these experiences and perceptions occur. This 'some' is a limitation to our understanding of ageing and rejuvenation. I have made very tentative links between experiences during periods of age-related transitions during childhood and adolescence as this is when identity formation and self-esteem development is most vulnerable. These links are 'snapshots' giving us miniscule glances at biopsychosocial developmental perspectives – much more interpretation and explanation is needed.

In terms of psychometric findings, a limitation to the study was that they were not given any form of self-assessment questionnaires prior to the interviews, post surgery and at 6 months follow-up. One particularly useful psychosocial assessment of self-esteem is Rosenberg's Self-Esteem Scale (1989) which is a widely used scale to measure global self-esteem and overall evaluation of worthiness. Importantly it measures self-regard as opposed to egotism/narcissism so is inclusive of a non-clinical population. So while this study has rich accounts of their phenomenological experiences, it does not have psychometric findings of determining whether cosmetic surgery enhanced the participants self-esteem or not.

Consideration was given to the possibility of using the DAS-24 (Carr, Moss & Harris, 2005), the shortened form of the Derriford Appearance Scale DAS59. The shortened form, like the Derriford Appearance Scale, also assesses the distress and difficulties experienced in living with problems of appearance. However, it was not quite honed in on distress experienced by women with an ageing facial appearance even though the questions are suitable for a non-clinical population.

5.3 BUILDING-ON THIS RESEARCH

There is so much research potential in this area that would be of benefit to all disciplines in the social sciences, medicine and the public. In response to this fruitful area of research following are three examples of different areas for potential investigation. The aim of identifying these three areas is to highlight the all-pervasive nature of appearance related concerns and the potential it offers for further exploration.

- **Longitudinal or systemic research:** Over a period of 10 years a longitudinal study could follow women who have had face-lifts and the impact this has on their quality of life and self-esteem. This would include both pre and post-operative psychometric assessments of their: self-esteem (inner world); the psycho-social effects on their perceptions of their changing facial appearance (external world); and the assessment of the process of facial ageing over time on body image self concept. In addition to the quantitative aspects of this research, the data obtained can be enriched with the addition of qualitative interviewing at different points during this 10 year period tracking how individual perceptions of facial ageing and rejuvenation are affected. This longitudinal research would be able to track developmental correlations occurring between these three concepts and the meaning these have to the individuals involved.
- **Media impact:** Marketing analysis can be conducted with a content analysis of television commercials looking at what types of non-verbal behaviours are used by the 'protagonists' i.e. the 'seller' when promoting the sale of their beauty product and are used to influence the potential buyer to buy their product. This could usefully be done with teenagers to increase their awareness of the subtle persuasive techniques used by the media when marketing their product in order to influence teenagers to go ahead and buy.
- **Research into maternal influences on daughters' perceptions of their own appearance:** This could be a very fruitful area of research

identifying specific types of positive and negative feedback from mother (or female primary care givers) to daughter. As this is a reciprocal relationship, daughters' experiences of this feedback can also be obtained. The central research questions would focus on identifying: positive and negative internalizations of mothers' feedback on their appearance that impact on daughter's body image; what aspects of mothers' feedback are influenced by mother's concepts of her own body; what impact does this type of feedback on appearance have on the mother-daughter relationship?. Transitional age periods between early childhood and late adolescence would be an important time for this research as the development of the child's identity formation is taking place. A further aim of the research would be to identify psychological buffers or resilience factors against developing body dissatisfaction, appearance concerns or eating disorders.

5.4 RELEVANCE FOR COUNSELLING PSYCHOLOGY

FRCS shows no signs of abating as statistical press releases from the BAAPS indicate. Therefore, I am advocating that women who want a face lift engage in counselling prior to the operation so that any deeper and more difficult psychological issues pertaining to their storied bodies can be identified and dealt with. During this time many other issues that will contribute towards better results can also be addressed. In this way any negative tensions and anxieties can have the chance of reversal leading to personal development.

None of these participants admitted to previous, existing psychiatric or psychotic disorders and indeed none were evident. Findings in this research; literature, and previous research supports the phenomenon of unconscious and secret motivations (Edgerton, 1975; Gion et al, 1976; Crerand, et al., 2006) with high levels of anxiety that may occur during peri- and postoperative with any plastic surgical patients for many different reasons (Rankin & Borah, 1997). Therefore, careful questioning and psychosocial assessment by a psychologist can be of great benefit when there is doubt in the surgeon's mind as to the patient's suitability for the operation. This can also benefit patients psychologically, as the

assessment can prepare them for management of anxiety should they choose to go ahead. While the surgical and medical teams in operating theatres and on the ward can manage normal anxiety in patients, higher levels of anxiety such as panic may be more difficult (Rankin & Borah). Therefore, it is also beneficial for medical staff caring for them that the patient has some practice in anxiety management, so that they can give more time to their specific duties. It will also be less anxiety provoking for immediate family members who will be seeing to their after care.

Pre-operative counselling interventions can provide the patients with a sense of control against 'abnormal' levels of anxiety and can help prepare patients for major surgery such as for altering body image as in facial rejuvenation (Bradbury, 1994). Coping strategies such as different forms of relaxation, music therapy, cognitive therapy for challenging unrealistic thoughts and journal writing have been shown to be effective against 'abnormal' anxiety (Rankin & Borah, 1997).

Drawing on some of Woodman's (1982) psychological Jungian work on perfectionism, I have drawn the following understandings of some of these women and their unconscious motivations for FRCS. Accusations of vanity and answering to the demands of Western 'culture of narcissism' perhaps are true, but seen in the context of their experiences, I suggest tentatively that other possible underlying factors need to be taken into account. For instance, where unconscious motivations that involve the woman's ambivalent relationship with her mother are not understood, these motivations may be acted out destructively i.e. vigilance for the slightest signs of inevitable re-occurring facial ageing followed by repeated rejuvenation procedures which fail to satisfy. What consciousness demands is recognition of the difference between their own facial features resembling mother's appearance and reality which defines some of their ambivalent feelings toward their mothers.

The implication for counselling is to make conscious enough reasons for the ambivalent feelings by clarifying the distinction between appearance and reality i.e. I may look like my mother but I am not my mother, I am separate from her. All of these women were (in my opinion) physically very attractive, were accomplished professionally, were wives, mothers and a daughter – but they still

could benefit from some understanding of the matriarchal dynamics behind their resistance to looking like mother. While young women may have cosmetic surgery to improve or maintain their looks, more mature women recognize that they can benefit from seeking out underlying causes for their rejection of the ageing face that resembles their mothers (Woodman, 1982). Counselling can provide opportunities to differentiate themselves out from the 'bad/negative' mother so that they can discover fully who they are as mature women. Through counselling prior to surgery, they can discover these causes and adjust their conscious values, attitudes and expectations towards facial ageing accordingly. The stronger the ego, the more flexible it becomes (Woodman).

It is important to note that this type of counselling concerns adjustment to change and not pathology. It is recognizing what was not good and dealing with it. Then we can acknowledge and tolerate both positive and negative feelings towards our mothers. We can learn to see her as a woman of her time i.e. 1950's and that she too had unconscious material that was visited on our generation. Women in mid-life today have the opportunities to unravel this unconscious material and emotionally heal themselves while their mothers generally did not have this opportunity. Healing can incorporate the ability to tolerate ambivalent feelings. This type of healing can also break an inter-generational cycle of passing on appearance concerns to the next generation of daughters. Thus by increased self-awareness of the possible origins of vulnerability to external appearance, and acceptance of these, women with these issues can let go of them as well as the anxiety that accompanies such beliefs and memories.

5.5 Final Reflexivity

This research process was a fascinating and valuable experience for me as a trainee counseling psychologist. Professionally it signifies the scope of different and new areas of knowledge available to explore and report on in counselling psychology research. I trust that colleagues and related disciplines will respond well to this type of research that identifies the phenomenology of subjective truths, and the temporal and developmental changes that are occurring within our biopsychosocial and cultural domains as women adjust and adapt to changing facial appearance fashions. There is also place for this information to be published e.g. in women's magazines, as it can be of value to women in midlife who are contemplating FRCS. Women can avail themselves of the opportunity to transform themselves inside and out - not by being guided by narcissistic cultural pressures - but by making connections with the storied part of their body that they have chosen to alter. As Eskenazi & Streep (2007) propose, the more conscious a person is about the decisions to undergo a procedure, the better the results.

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5.7 APPENDICES

City University letter headed

D1

Research Study Information Sheet

School of Social Sciences

Psychology Department

Northampton Square

London EC1V 0HB

24.11.05

Researcher: Meg Camm: Chartered Counselling Psychologist

Dear Participants,

I plan to conduct a research project that focuses on the personal experiences of women, over the age of 40 years, who have had facial rejuvenation cosmetic surgery and/or facial rejuvenation non-invasive procedure/s. Currently, I am seeking to recruit participants who would be willing to share their experiences.

In order to do this, there will be one or two individual semi-structured interviews with each volunteer. These interviews will be semi-structured. What I mean by this is that I shall have some specific questions to ask while at the same time also leave space for you to decide what you would like to share of these experiences. The interviews will take between one to two hours. However, the length of time it may take will really depend upon you and the amount you will wish to share. The second interview (which may not be necessary), is a follow-up session in order to discuss anything that you may not have thought of in the first interview. It will also give us time to clarify any issues.

The kinds of questions we will cover in the interview are ones like:-

“How did you come to reach the decision to have the procedure?”

“Let me about your experiences of having the rejuvenation.”

“How did you experience the rejuvenated look of your face once the healing had taken place i.e. when all the bruising and swelling had gone down?”

The interview sessions will be tape recorded, for ease and accuracy in transcribing and doing analyses of your information. Only I and my doctoral supervisors will hear the tape and read any transcription made of the interactions. The tape recording and transcripts will not have any participant's name on it. Any other names or events mentioned in the interview will be changed so that they will not be recognized. Who your consultants were or where you had the procedures will not be identified at any time. Audio recordings will be kept in a lockable cupboard and destroyed upon completion of the study. This all means that your details will remain anonymous. You can also chose to stop the interview at any time and have the tape recording destroyed should you wish it to be so.

This study is being conducted as part of my Doctoral Degree in Counselling Psychology at the City University, Psychology Department, London. The results of the research will be written up as part of my doctoral portfolio for submission to the Psychology Department at City University, London. Sharing information on your experiences will be helpful to other women thinking about having rejuvenation. Psychologists who are involved with preparatory and post-operative cosmetic counselling will benefit greatly from these findings as will the clients. It will also be of value to the medical profession who are committed to work with those undergoing cosmetic work.

The study has received ethical approval from the university and will be supervised by two supervisors. Both these supervisors have Doctoral Degrees in Psychology. They are:

1. Dr. J. Farrants, City University, Social Sciences, Psychology Department, Northampton Square, London, EC1V 0HB

2. Dr. V. Eatough, University of London, Birkbeck College, School of Psychology, Malet Street, London WC1E 7HX.

Both may be contacted at these addresses if you are interested to know more about their role in supervising my work.

If you are willing to take part please contact me at:

Phone: [REDACTED] Alternatively, you may write to me at the following address:

Meg Camm, Doctoral Student,
City University,
Social Sciences, Department of Psychology,
Northampton Square,
London, EC1V 0HB

Thank you.

Meg Camm – Researcher:

.....Date.....

Professional Doctorate in Counselling Psychology: 2006 – 2007

Consent Form

*I confirm that I have read the information sheet regarding this research project.
I have had the opportunity to ask any questions regarding what is required from
the participants and understand what is required of me.*

*I understand that this research project will abide by the Code of Conduct,
Ethical Principles and Guidelines of the British Psychological Society as well as
the policy and procedures of the Research Ethics Committee of the City
University, Psychology Department, London.*

It has been made clear to me:

- *I have the right to withdraw from the interview at any time.*
- *I have the right to request that my recording be destroyed and not used should I
Withdraw from the interview/s.*
- *The tape recordings will be destroyed after the research project is complete.*
- *I understand that all names and other identifying information will be changed.*
- *I understand that your supervisors will look at the transcripts and that extracts
from the transcripts of the interviews might be used in scientific publications.
Under these instances names will not be identified.*

*I understand that my personal details will remain anonymous at all times as in
the case of supervision, writing up of the project and any publications.*

Signatures:

Participant:Date.....

Researcher:Date.....

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Ethics

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On hard copy

SA & UK web site directories for psychologists

South Africa

<http://www.psyssa.com/regions/directory>

<http://www.psychotherapy.co.za>

United Kingdom

<http://www.bps.org.uk/> find a psychologist

<http://www.ukcp.org.uk/> find a therapist

<http://www.babcp.com/> find a therapist

Semi-structured interview questions and prompts: email and face-to-face format

Preceding email question format

Here are some points before you read and answer the questions that are to guide you.

- You can come back to a question anytime if you think of something you may have left out. Just refer to the question number if you come back to it.
- There is no right, or wrong answers.
- You can send me the answers to one question at a time or do them all at once – it is up to you.
- I shall not be changing any wording from your answers, as I am seeking to understand your world as you experience it.
- In trying to understand your experiences, I shall be identifying themes from your experiences once I have your story – I shall check with you if my understanding is how you meant it to be once we have finished the interviewing.
- If at any time you feel you want to add something that I have not thought of please do – remember it is your experience I am interested in.
- Questions aim to capture your personal experiences over a period of time from starting to think about having cosmetic surgery and/or non-invasive procedures to the present day.
- Please don't feel you have to rush over these – my cut-off date for receiving your information is the 17th July so you have a few weeks.
-

Email and Face-to-face Interview Questions

1. Demographic:

- 1.1 Age
- 1.2 Type of facial cosmetic surgery
- 1.3 Date of surgery
- 1.4 Nationality
- 1.5 Occupation

2 **Before you had the operation:**

2.1 *“Tell me how you came to take the decision to have facial rejuvenation procedure/s?”*

Prompts to aid answering the questions but please add other factors of your own:

- Your motivations from different aspects of your life e.g. personal, intimate, social, occupational, physical, sexual, role of the media
- Your mood (emotions or feelings) you had about your facial appearance and how you thought it may change once you decided to have the procedure/s,
- Perceptions of others (how you thought others thought about your facial appearance - link with your age). Others being: family members, friends, people in the work environment; social arena; public/strangers.

2.2 *“Did you have any concerns or worries about the surgery before it took place?”*

- You may relate this to any subject matter
- Did you speak to anyone about your decision and expectations, or worries, prior to the surgery
- Dreams – before during or after related to your face
- Femininity - sexuality

2.3 *“In what way was your face a part of your identity before the rejuvenation surgery?”*

- Degree of importance i.e. the meaning it had for you and how this may have changed over time up to the point of having rejuvenation surgery

2.4 *“When did you begin to notice signs of ageing?”*

- Tell me anything about this:
- When – any specific occasion or slowly over time
- What did you notice e.g. physical signs

2.5 *“Facial Ageing”*

- What did you see when you looked in the mirror
- Who did you see when you looked in the mirror
- How did people (anyone) look at your face
- Tell me about your experiences of looking at the reflection of your face in the mirror
- Soul – ancients believed when looking at the mirror either your soul was reflected back at you or was behind the mirror. Tell me about soul and what it means to you?

- 2.6 *“What did facial ageing mean to you before your facial rejuvenation procedure/s?”*
- What impact did it have on your life in areas such as: Work; social; health; financial ; psychological; intimate, spiritual
 - How old did you feel inside of yourself – was it the same as the outside appearance – discuss this a little if you can please
- 2.7 *“In the course of interviewing other ladies who have undergone facial rejuvenation procedure/s they have mentioned their relationship with their mothers as having had an impact on their own facial appearance – could the same be said for you?”*
- Make-up activities – impression on you
- 2.1 *“Again in the course of interviewing other ladies, they have mentioned being treated as if they are invisible. Do you have any perceptions or experiences of this?”*
- 2.9 *Childhood memories*
- How she dressed you 7 – 12
 - Sayings your Mother had about women, girls
 - Comparisons with other girls?
 - Dolls - books
- 2.10 *“Any metaphors come to mind – for this process of rejuvenation Before, during or after”*
- 2.11 *“Please add anything else you wish to share that I have not asked.”*

Meg Camm 09.02.2007
Face-to-face interview questions

Professional Doctorate in Counselling Psychology:

City University: 2005 – 2007

Date

Dear Participant,

I would like to take this opportunity to thank you for the time you spent with me during our interviews for my research project. Your willingness to share your personal experiences has provided valuable information on this subject. As the expert in this area you have illustrated so clearly the decision making processes you experienced prior to undergoing the procedure/s. You have also provided valuable information on your experiences during and after the procedure/s.

This information can now help and guide others who may be considering having facial rejuvenation procedure/s. It will also be of interest to any consultants who are committed to doing this type of cosmetic work.

If you would like to explore your experience further in personal therapy, please do not hesitate to request contact details of Psychologists and Psychotherapists in your areas.

Once again, thank you for your participation, it has been greatly appreciated.

Kind regards,

Meg Camm:

Chartered Counselling Psychologist

Table of sample of unsorted themes from the 6 participants

Decision making

First reason
Senses: visual
Strong emotions social influences
Cognitions
Self motivated own satisfaction
Work life
Time taken to make the decision
Feelings linked with outcome expectations
Weighing up pros and cons
Surgeon's abilities
Unflinching decision
Social ageing clock

Mirror reflections

Distressing
Rejection
Denial
Unrecognizable
Too old
Not me
My Mom unfortunately

Risks and defenses

Anxieties
Shock of recall
Only have one chance
Surgeon is not God
Fears
Breakdown of defenses on morning of op
Management of pre-op anxiety

Secret

Not telling others
Only family
Husband
Not friends or acquaintances
Family members in opposition

Making sense of identity

Facelift to maintain a confident self
Intersection of psychological influences on identity
Intersection of work influences on identity

Experiences of ageing

Growing old gracefully
Passage of time

Younger inner outer too old
Comparison with younger others
Emotions associated with mirror image of being too old
Descriptions of skin as objects or animals
When she feels old
Ignored by others
Mocked

Internal and external age

Resignation of ageing before surgery
Motivations for surgery to align differences between internal and external felt ages
Can't hide ageing process can with facelift
Analogy of body with face – taking care of both
Self acceptance

Perceptions post-op and readjustments

Surgical dividends
Own observations of swelling, bruising and blood
Once healing over
Euphoria
Can't believe it
Over the moon
Satisfied and happiness
Secrecy

Relationship between mother and daughter (participant)

I didn't tell her
Description of mothers looks
Mothers grooming
Criticism and compliments
Mother teaching grooming
Negative comparisons
Ambivalent relationship want and need are different
Vain
Intergenerational passing on from mother to daughter
Doing it for her

Vanity and shame

Hiding scars
Vigilance for further signs of ageing
I'm invisible
Self consciousness
Narcissist: Done it for vanity's sake
Embarrassment
Can't see restylane
Can see had botox
Some age naturally (with beauty) others who are not pretty don't
Pretty women are luckier
Indecision

Metaphors

Easy as pie
Butterfly coming out of cocoon
Took it like a surfing wave
Looked at me as if I had just come out of the arc
Tidied up the house (face) outside and inside for counseling

Pat: Cluster of Themes

1. The experience of having facial rejuvenation interventions

- **Period of contemplation**
 - Role of stress
 - Mirror reflections
 - Motivation
- **Pre intervention**
 - Consultation
 - Expectations
- **Day of the rejuvenation procedures**
 - Experience of having Botox and Restylane injections
- **Post interventions**
 - Results of Botox: immediate
 - Results of Restylane 1 week later
 - 10 days later
- **Post rejuvenation injections: 1 year 2 months**
 - Assessment of facial appearance

2. Influence of relationships with significant others on perceptions of self

- Mother's grooming
- Developmental influences: Mother's Bullet Watching
- Early teenage years (10-12y)
- Girls World - magazines
- Eldest sister's grooming
- Family Coalitions
- Reinforcement of appearance anxiety
- Mother's responses to Pat's appearance as a bride
- Generational life course and facial appearance

3. Reflections: Intersections between time, ageing and rejuvenation

- Reflections on motives to have RFI (rejuvenation facial interventions)
- Perceptions of a physical self

- 2nd time around for repeated Botox and Restylane
- Continuing to Age

4. The double edged sword of shame and vanity

- Mark of shame
- Reinforcement of shame
- Disclosure: Who told
- Secrecy and vanity
- Theory of Mind - vanity
- Meaning of eradication of the mark of shame

Features of Normal self-interest compared with Self-defeating narcissism

Normal Self-interest	Self-defeating narcissism
Appreciating acclaim, but not requiring it in order to maintain self-esteem	Craving adoration insatiably; requiring acclaim in order to feel momentarily good about oneself
Being temporarily wounded by criticism	Being inflamed or crushed by criticism and brooding about it extensively
Feeling unhappy but not worthless following failure	Having enduring feelings of mortification and worthlessness triggered by failure
Feeling 'special' or uncommonly talented in some way	Feeling incomparably better than other people, and insisting upon acknowledgement of that pre-eminence
Feeling good about oneself, even when other people are being critical	Needing constant support from other people in order to maintain one's feelings of well-being
Being reasonably accepting of life's setbacks, even though they can be painful and temporarily destabilizing	Responding to life's wounds with depression or fury
Maintaining self-esteem in the face of disapproval or denigration	Responding to disapproval or denigration with loss of self-esteem
Maintaining emotional equilibrium despite lack of special treatment	Feeling entitled to special treatment and becoming terribly upset when one is treated in an ordinary manner
Being empathic and caring about the feelings of others	Being insensitive to other people's needs and feelings; exploiting others until they become fed up

Nevid, J.S., Rathus, S.A. & Greene, B. (2008). *Abnormal Psychology in a Changing World* (7th ed). New Jersey: Pearson