



City Research Online

City St George's, University of London

Citation: Smith, F. & Farrants, J.R. (2013). Shame and self-acceptance in continued flux: qualitative study of the embodied experience of significant weight loss and removal of resultant excess skin by plastic surgery. *British Journal of Health Psychology*, 18(9), pp. 1129-1140. doi: 10.1177/1359105312459095

This is the accepted version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: <https://city-ref-test.eprints-hosting.org/id/eprint/4556/>

Link to published version: <https://doi.org/10.1177/1359105312459095>

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to [City Research Online policy](#).

Shame and Self-acceptance in continued flux: Qualitative study of the embodied experience of significant weight loss and removal of resultant excess skin by plastic surgery.

Abstract

This study explored the embodied experience of body change using a qualitative design. Eight previous plastic surgery patients of a London hospital took part in in-depth, semi structured interviews one-year a post plastic surgery procedure to remove excess skin around their abdomen resulting from weight loss. Participant interviews were analysed using Interpretative Phenomenological Analysis. Two sub themes titled 'Shame of the hidden body' and 'Lack of acceptance; the future focused body' are presented in this article. Findings are considered in relation to theories of 'Body Shame' and in the current cultural context.

Introduction

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

Sawyer et al., (2008) report that many obese individuals seek bariatric surgery for its anticipated psychosocial effects. In their review and meta-analysis Blaine et al., (2007) concluded that psychosocial wellbeing (e.g., self esteem, depression) is generally improved by weight loss treatment. Literature suggests that body image and body dissatisfaction do improve with weight loss (e.g., Guisado et al., 2002) but often remains

significantly higher than that of controls (e.g., Hotter, et al., 2003), particularly in the case of childhood onset obesity (Adami et al., 1998). Quality of life (QOL) measures have been shown to improve following weight loss (e.g., Tolonen and Vicorzon, 2003), and these changes are mainly accounted for by improvements in physical health (Swan-Kremeier, 2005).

In the context of extreme weight loss it is common for patients to experience body dissatisfaction due to the “frequent” resultant excess skin on ones abdomen, arms, face and thighs (Swan-Kremeier, 2005, p. 112). This has been reported to cause discomfort and significant appearance related distress (e.g., Boccheieri et al., 2002). Kinzl et al. (2003) report that 70% of their participants considered that excess skin was a negative consequence of weight loss (Kinzl et al., 2003).

It has been suggested that the “curious omission” of the experience of excess skin in the literature may be due to a bias of obesity research to ignore negative outcomes of weight loss (Boccheieri et al 2002 p. 160). It is predicted that as more obese people lose significant amounts of weight, the demand for cosmetic surgery to remove their resultant excess skin will increase substantially (American Society of Plastic Surgeons, 2003).

Plastic Surgery

A recent audit by the British Association of Aesthetic Plastic Surgeons reports that despite the recent recession, the amount of cosmetic surgery procedures rose by a further 6.7% between 2008 and 2009. Social commentators criticise the normalization and rhetoric of empowerment of plastic surgery in today’s society (e.g., Orbach, 2009) and it is discussed as the most provocative and controversial aspect of the new ‘make over culture’ (Jones, 2008). In a time when so many are encouraged to transform their

bodies, it seems pertinent to consider the psychological experience of body transformation.

Plastic surgery following weight loss

Excess skin is removed from post weight loss patients using a variety of different plastic surgery methods. Excess skin is typically removed from the abdomen (abdominoplasty) thighs, arms, back and breasts. These procedures are grouped together as 'body contouring' procedures (Taylor and Shermak, 2004). Of the 3403 abdominoplasty procedures that were reported in 2009, 3268 were performed on women (BAAPS, 2010).

Mitchell et al., (2008) report that 33 of the 70 participants who had undergone a gastric bypass 6 – 10 years previously, reported undergoing 38 body-contouring procedures. The most common was the abdominoplasty (24.3%) followed by breast lifts (8.6%) and thigh lifts (7.1%). They report that participants were not 'uniformly satisfied' with their body contouring surgery, stating that the affected area was 'unattractive'. They also report that the majority of participants expressed a desire to have body-contouring surgery on several parts of their body. Seemingly a significant subgroup of people who have lost weight wish to and do undergo body-contouring surgery.

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

(Bolton et al., 2002) and anxiety and depression have appeared to remain stable (Bolton et al., 2002; Song et al., 2006; Steurtz et al., 2008).

The literature on this experience paints a complex picture. It appears that functional and psychosocial improvements are likely to be experienced, but that the latter changes are limited and are likely to vary from person to person. The studies into this experience have been of a positivist, quantitative nature with much of it being conducted by bariatric and plastic surgeons considering specific variables. The reliance on constructs such as 'Body Image' and the assumptions which underlie such reliance have been highlighted as problematic by Gleeson and Frith (2006).

As has been mentioned by Boccheiri et al (2002), it could be the case that the pervasive nature of anti-obesity bias has led to particular questions being asked and not asked. For these reasons it is suggested that a qualitative enquiry into this field would be timely and would return the voice to the individuals who live the experience. As a result it would hopefully distance itself from pre-existing theories about benefits of weight loss and from possible anti-fat bias. It could also enable a broader approach, remaining open to novel aspects of experience.

Methodology

Design

The study used a qualitative design with one to one semi structured in depth interviews.

Participants

Eight women who, approximately one year ago, had excess skin removed by plastic surgery following significant weight loss participated. The one-year time frame means that their surgical scars are likely to have 'settled' and stopped changing in feel and appearance. The age range was 29 – 60 years. Whilst males were invited, only females responded to the invitations. Of the sample who were invited only three were men and 26 were women, which reflects the unequal gender distribution in people requesting this particular surgery on the National Health Service.

Procedure

Potential participants were sent an invitation to participate along with an information sheet. They were invited to communicate their interest in participating in the research project by contacting the researcher. They were encouraged to read the information sheet thoroughly before doing this. Interested potential participants were invited to discuss any queries they had with the researcher and/or members of the Plastic Surgery Department. Interviews were predominantly conducted at participant's houses but two were conducted in a hospital clinic room. The researcher reviewed the consent form with the participants before they signed it, ensuring fully informed consent was obtained. Interviews took between 50 and 80 minutes. The interview schedule consisted of open-ended questions regarding the participants' experience of their body change such as 'how do you feel when you think of your body as it is now? And prompt questions such as 'what does that mean to you?'

Participants were provided with various contact details in the event of the interview bringing up issues that they wished to discuss further. Interviews were conducted by the researcher and were digitally recorded and transcribed. Interview transcriptions included all spoken words, pauses, false starts and other aspects worth noting (e.g., laughter).

The researcher engaged in three reflexivity interviews to 'make explicit' some of the features she may have brought into the research. Particular attention was paid to the fact that she is an outsider to the experience of the participants, and the effect this could have on the already rife power differentials in any research interview.

Ethical approval was gained from both the University of the researcher, the research and development department of the hospital and the local centralized NHS Research Ethics Committee

Data analysis

Transcribed interviews were analyzed using Interpretative Phenomenological Analysis (*IPA*) to make sense of the subjective accounts of the participants. As Larkin, Watts and Clifton (2006) state, the phenomenological commitments of IPA 'give voice' to the concerns of the participants, whilst the interpretative aspect allows for the researcher to 'make-sense' of and contextualize these experiences from a psychological perspective.

Broadly speaking IPA is a process that continually moves from detailed description of the text to interpretation, and from looking at the particular lived experience, to the shared. To this end it has been described by Smith (2007) as an iterative and inductive cycle. Six stages of the analysis were engaged in which are most recently outlined by Smith, Flowers and Larkin (2009).

Analysis and Discussion

The analysis yielded two constituent themes consisting of several sub themes each. Please see Table 1 for all theme titles. Due to the breadth of the findings and the depth that is required to consider them appropriately this article will present two interrelated sub themes of the Constituent theme 2 'Self acceptance in Continued Flux'. These themes were selected due to their link to commentary regarding the current cultural context, their related theoretical explanations as well as their potential to shed light on more general experiences of body change.

Include Table 1 here.

Table 1: Table of titles of all themes that emerged from the analysis process.

The two interrelated sub themes presented are; 'Lack of acceptance; the future focused body' and 'Shame of the hidden body'. The analysis presented is intended to be the researchers interpretation of the participants' interpretation of their lived experience.

Lack of self-acceptance; the future focused body

This theme describes the tendency for all participants to talk about their hopes for their bodies in the future, even when asked to reflect on their body in the present. All but two of the participants in this study were still hoping to have further procedures to remove their excess skin on other body areas funded by the NHS. Of the two not applying one had applied but had been told that she would not receive any more funding and the other had already undergone four body-contouring procedures. In addition, most expressed hopes for further weight loss. All participants appeared to prefer to consider their body in the future once it had been 'improved' rather than 'inhabiting' their body in the present.

Below is an example of a typical interaction:

R¹- If you think of your body now, maybe unclothed, what does it get you thinking, what comes up for you?

Daisy- That I want to take those two stone off and get back so I can wear those clothes that made me feel a lot better. But also, I want this corrected. Daisy, 23/10

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

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

Here she repeats the word 'corrected' and describes 'have'[ing] to be corrected. This suggests a refusal to accept her body, and a determination to change it physically. In reality it is not certain that she will have this 'corrected' by the NHS. Her positioning of the 'overhang' as the problem could have implications for her experience of her body in the future.

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

"But yeah I am more confident now. Once I have had this other surgery now hopefully I will be totally totally confident. Cos that is one thing, I have got a nice flat stomach and I can put on a top

¹ R donates words spoken by the researcher.

and that bit looks really nice but I have got these bits that don't look nice so then I have to put a cardigan over the top and things like that. So to me I am near the end of my journey but I am not quite there." Gabby, 34/28

Gabby appears to expect that further physical change will bring about significant psychological shifts. Gabby reports experiencing this to an extent already. She identifies self-acceptance and self-confidence rather than physical change (e.g., body shape) as the end point of her 'journey'.

Babette describes her expectations of her next procedure:

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

She appears to see surgery as being an improvement rather than 'the end', and appears to remain rooted in her body change. Interestingly, Babette talks about her *self* being improved by the surgery, not just her body; 'better than what I am now'. This suggests an inextricable link between the perception of the body and the perception of the self.

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

"I have got no idea about that, that is something that is put on a different shelf. It's not like you can go and buy one get one free [Plastic Surgery procedures]. You can't. That's a different issue. That is something that I am learning to cope with. Not live with but cope with." Callie, 33/2

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

Callie states that she is learning to 'cope' with the uncertainty of whether she will be offered further plastic surgery on the NHS. It appears that she does not feel able to 'live' in her body as it is. Perhaps she feels that life would only be a matter of coping whilst she inhabits the body she has. She seems far from accepting of her body and does not believe that she can be accepting of it without further physical change.

Many aspects the participants reported appear to support previous quantitative research. This includes the lack of regret expressed regarding having lost weight and had plastic surgery (Stuerz et al., 2008; Lazar et al., 2009). Also, all participants reported improved overall quality of life following weight loss (e.g., Tolonen and Vicorzon, 2003) and removal of excess skin (Song et al., 2006; Lazar et al., 2009; Cintra et al., 2008). Despite this change, previous studies found that participants were keen to undergo further body contouring procedures following their first one (Michell et al., 2008) and this was reflected in the present study.

Previous researchers in this field suggest that the tendency to seek further plastic surgery after the initial procedure was due to participants' happiness with the service they received (Cintra et al., 2008), their initial procedure 'intensifying' their desire for plastic surgery (Stuerz, et al., (2008) and their initial procedure triggering dissatisfaction with other areas of their bodies (Song et al., 2006). The findings from this analysis suggest that participants' continual desire for more surgery might be born out of continued disappointment as a result of particular needs not being met by the surgery, and the continued hope that it will be the next procedure that enables the psychosocial shifts they have been hoping for.

Flux and the 'transformation culture'

Commentators on the current 'cultural moment' have discussed the current 'transformation culture' (e.g., Orbach, 2009; Jones, 2008). Jones (2008) refers to the 'make over culture' that positions the body as something to be 'fixed'. This theme seems to corroborate these ideas. It appears that whilst the participants' hold ideas and hopes of the bodies they want in the future, they are unable to 'be' in their bodies in the present. This idea could go some way to explain the findings that whilst all participants discussed improvements in their quality of life since weight loss (e.g., buying 'normal' clothes), their dissatisfaction with their bodies seemed not to have improved as they would have liked.

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

Shame of hidden body

A common theme in participants' accounts related to a long history and a current behaviour of hiding their bodies. It appeared that this was motivated by a sense of shame and an assumed lack of acceptance of their body by others.

C- "See, clothes I can hide everything but unclothed no. I haven't got a full-length mirror in the house. I wouldn't have a full-length mirror.

R- What would that be like for you to have to look at yourself in a full length mirror unclothed?

C- No, no. I wouldn't. No. That's why I don't like my hubby seeing me. I have only got to look down at it and I am looking at a different angle, not full on." Callie, 25/13

It seems as though Callie feels unable to think about looking at her naked self in the mirror. She appears to be fearful and avoidant of what she might see in the reflection and how it might make her feel. She repeats the word 'no' four times in her last two sentences, which emphasises the strength of her resolution to avoid considering her body in this way. This resolution could result in a distanced relationship with her body.

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

C- "Even now, if he was to open the door to the bathroom, he'd think nothing of the way I look now but I would break his nose with the door with the way I slam it. You know it does cause problems.

R- So after the apronectomy it means a lot for...

C- Yeah because it's exposed other areas... yeah, yeah, that I couldn't see because it was under my stomach." Callie, 16/7

There appears to be a conflict here for Callie about whether her husband would be accepting or not of the appearance of her body. She appears to believe that he would 'think nothing of it' and yet she would take extreme measures to hide her body from him. It could be the case that she has an underlying belief that her body could not be

accepted by anyone, and that whilst her husband might have reassured her, she cannot believe that he would not experience the same shame and disgust that she reports.

Callie goes on to describe the fact that since her abdominal overhang was been removed, other areas have become visible to her that she was previously unaware of. This infers that there were parts of her body that she was not aware of, which has interesting implications for the embodied experience and the alienation that she might feel from her body, or parts of it. In addition, the hope for surgery to help her relationship with her body is complicated by its revealing new 'problematic' areas. It seems as though the removal of the overhang has provided an exposed feeling and the arrival of other reasons to feel ashamed of her body. She later describes her body as 'gross' and her remaining excess skin as 'horrible'.

Gabby describes her imagined responses of others to her body:

R- "What are you thinking other people might think [about your body if they saw it]?"

G- Just looking at how disgusting I am. How disgusting.

Gabby states that people would find *her* disgusting.

"You know I wouldn't. I wouldn't have done that [worn a bikini in public] when I was big, I won't do it now, even after my surgery. I think even if I looked perfect I wouldn't do it now. Because I have lost that kind of, umm, I have still got inhibitions. I have lost that kind of freedom if you see what I mean. But I have put that on myself." Gabby, 37/2

Interestingly Gabby is now referring to her body in a more distanced and objectifying manner; as 'it' not 'me'. She describes a strong sense of loss, which she blames on herself. I think that this is a very poignant point, which appears to encapsulate the

experiences articulated by all the participants; that because of their previous size, they have lost the opportunity to live in a body without such restrictive 'inhibitions'.

Edana articulates her concerns about showing her body in public:

E- "I don't think I would allow anyone to see it [current body]. To tell you the truth, it's not fair for the other people because other people on the beach will be sick. 16/27

This is an illuminating description of the beliefs that Edana holds about her body and its impact on others. It appears that Edana anticipates disgust responses to her body, such as nausea. This might reflect her own response to her body.

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

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

Edana seems to believe that people would think of her as un-human; as a monster. Again, this could be representative of her own perception of her body as not human and cut into pieces (This also relates to another theme which emerged relating to the trade off described when undergoing plastic surgery between a more functional body and your body being 'butchered' and becoming unnatural). Edana states that she would struggle to hear comments about her body, implying that she feels sensitive to their comments.

This theme relates to the lack of acceptance of the body by others (imagined or real) which seems connected to the lack of acceptance of the body by the self. When a body is hidden it is less likely that the individual will be able to experience acceptance of the body by another and thus the shame of the hidden body is likely to pervade. It is

important to underscore the point that with western society's negative appraisals of overweight people, there may be some reality in the fear that these individuals bodies would have not be accepted by others. It is proposed that this state of lack of acceptance from the self and other individuals leads to a continued sense of flux where people perceive their body, the very means by which they communicate with the world around them, will be not accepted by that world.

The psychologist reporting in the Lazar et al (2009) study stated that after the long duration of suffering because of their obesity, the new body image can become a source of deep shame and humiliation. Shame has received increasing research and theoretical attention recently (Gilbert, 2002).

It seems that most participants hoped to put an end to their body shame through their body transformation, however most seem to have been disappointed by their reality as it appears that many participants continue to be ashamed of their body. Having already changed considerably in body shape and size, and to still be experiencing shame, it seems unlikely to disappear following further physical change.

The focus and experience of shame described here appear to corroborate Paul Gilbert's bio-psycho-social conceptualisation of 'body shame' (Gilbert, 2002). Gilbert (2002) highlights the fact that as with most emotions, whilst some people are able to tolerate shame without acting out defensive behaviours, others find it intolerable and go to great lengths to avoid it as well avoid situations that might induce it. This avoidance of external shame (being shamed by others) and internal shame (negative, shaming thoughts about the self) is evidenced both in participants' reported behaviour of continuing to hide their bodies out of fear of disgusting and upsetting others, and in their avoidance of acknowledging their body as it is in the present.

Gilbert highlights the vital role of social and cultural contexts that provide the “threads from which shame and stigma are woven” (Gilbert, 2002, pp35). Orbach comments that in today’s cultural moment, failing to get one’s food and size right can signify failure, rejection of societal values and, of course, shame (Orbach, 2009). The role of ‘self control’ in relation to stigma is also discussed by Gilbert (2002), and seems particularly relevant to the present sample. Rozin et al., (1999) investigated a theory regarding the different emotions that are evoked from a variety of different ‘violations’. They state that losing control over one’s body and desires (e.g. food) tends to elicit disgust. Some participants vividly described their sense of disgust at their bodies. This appears to have manifested itself in beliefs that the sight of it would make others physically sick (e.g., Edana) and an avoidance of seeing or even thinking about seeing the body themselves (e.g., Callie). It seems likely that this sense of disgust at one’s own body could be connected to the sense of shame. It could be that participants are assuming that how they feel about their body (disgusted) is how others would also feel.

Shame and self-discrepancy theory:

Self discrepancy theory suggests that those who experience high discrepancy between *actual* self and *ideal* self are likely to experience dejection related emotions such as sadness, where one’s hopes and aspirations are unfulfilled. In an *actual-self* and *other-ought* discrepancy (where the self is perceived as different from what you perceive others think you ought to be) individuals are suggested to experience anxiety resulting from the idea that they have not met standards set by others and so are vulnerable to punishment (Higgins, 1987). There is evidence of dejected disappointment and sadness in not having achieved the aesthetic and psychosocial attributes that they had hoped to achieve through weight loss and plastic surgery. In addition there is evidence of individuals experiencing anxiety stemming from a fear of punishment (e.g., rejection) by others due to their bodies not being how they ‘ought’ to be. It seems plausible that both

of these states could trigger a sense of shame about the self. In the context of this study the 'significant other' who sets standards to be attained could be western contemporary culture. Therefore, when the body of an individual is perceived as different from their *ought self* (thin and young body, stipulated by the media) anxiety is experienced due to fear of lack of acceptance and disgust from others influenced by the same cultural messages.

Shame and lack of acceptance both influence each other in that shame may prevent the body being accepted. In turn, the continued future focus on the body and how it 'should' be places the body in the present as not how it should be, and therefore as shameful.

General Discussion

This study provides an in-depth consideration of this lived experience and provides rich and novel findings regarding experiences of body change and appearance related distress. The sample is self selecting and small and therefore no claims can be made about the representative nature of these findings.

The findings of this study suggest that it would be pertinent to consider a broader range of measures in future large-scale quantitative studies. For example, the inclusion of measures of the experience of shame, disgust, intimacy, and acceptance could provide important findings in large-scale studies of this population.

As previously discussed, Kent and Thompson (2002) suggest that medical treatment for disfigurements only address problems with appearance superficially. It seems this might be the case for participants in this study. In some cases whilst underlying psychological processes and factors in relation to appearance are not addressed it might be difficult to reach psychosocial goals. This is particularly pertinent in the context of findings

suggesting that initial aims of weight loss are often psychosocial (e.g., Tinker and Tucker, 1997).

Conclusions.

Having gone through a tremendous amount of change in body shape and size, participants seemed to be in a continued state of flux in relation to their bodies. How they relate to their bodies appears to be confused and destabilised and they communicated high levels of internal and external body shame. Connected to this was a tendency to only consider the body in the future after further potential transformation and to avoid considering it, let alone accepting it, in the present. It is proposed that these aspects of experience are interconnected and maintain each other in their development. Whilst participants have gone about changing themselves physically it seems that what they have truly been seeking can be summed up in the words of Gabby:

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

Theme titles
1. Past turbulent experiences of embodied existence
<i>Shame and denial of body in obesity</i>
<i>Increased awareness of body by self and others in weight loss</i>
<i>Removed overhang as disgusting barrier to living new life</i>
<i>Motivational conflict and disempowered role of the plastic surgery patient</i>
2. Self acceptance in continued flux
<i>Lack of self acceptance; the future focused body</i>
<i>Continued shame of hidden body</i>
<i>Continued 'battle' with weight</i>
<i>Continued shock at different body</i>
<i>Body as butchered but functional</i>
<i>Continuation vs. Transformed of self</i>
<i>Hope and disappointment</i>
<i>Connection and disconnection</i>

Table 1: Table illustrating titles of all themes that emerged from the analysis process.

Adami, G. F., Gandolfo, P., Campostano, A., Meneghelli, A., Ravera, G., & Scopinaro, N. (1998). Body image and body weight in obese patients. *International Journal of Eating Disorders*, 24(3), 299-306

Blaine, B. E., Rodman, J., & Newman, J. (2007). Weight Loss Treatment and Psychological Well-being: A Review and Meta-analysis. *Journal of Health Psychology*, 12 (1) 66 - 82

Boccheieri, L. E., Meana, M., & Fisher, B. L. (2002). A review of psychosocial outcomes of surgery for morbid obesity. *Journal of Psychosomatic Research* 52 (3) 155 – 165.

Bolton, M., Pruzinsky, T, Cash, T, Persing, J. (2003). Measuring Outcomes in Plastic Surgery: Body Image and Quality of Life in Abdominoplasty Patients. *Plastic and Reconstructive Surgery* 112 (2) 619 - 625.

British Association of Aesthetic Plastic Surgeons. (2010). Audit figures for 2009 from BAAPS. Retrieved on 5th August, 2010 from http://www.consultingroom.com/Statistics/Display.asp?Statistics_ID=39&Title=2009
BAAPS: Over 36,400 Surgical Procedures in The UK in 2009

Cintra, W., Modolin, M. L. A., Gemperli, R., Gobbi, C. I. C., Faintuch, J., & Ferreira, M. C. (2008). Quality of life after abdominoplasty in women after bariatric surgery. *Obesity Surgery* 18 (6) 728 – 732.

‘Gastric Bypass surgery popularity leads to jump in plastic surgery procedures’. Press release: American Society of Plastic Surgeons, March 10, 2003.

Gilbert, P. (2002). Body Shame: A biopsychosocial conceptualisation and overview, with treatment implications. In P. Gilbert and J. Miles (Eds.) *Body Shame: Conceptualisation, Research and Treatment*. London: Routledge

Gleeson, K., & Frith, H. (2006). (De) Constructing Body Image. *Journal of Health Psychology*, 11 (1) 79 – 90.

Guisado, J. A., Vaz, F. J., Alarcon, J., Lopez-Ibor, J. J., Rubio, M. A & Gaite, L. (2002). Psycho-pathological status and interpersonal functioning following weight loss in morbidly obese patients undergoing bariatric surgery. *Obesity Surgery* 12 (6) 835 - 840.

Higgins, E. T. (1987). Self discrepancy: A theory relating self and affect. *Psychological review* 94 (3) 319 – 340.

Hotter, A., Mangweth, B., Kemmler, G., Fialia, M., Kinzle, J. & Biebl, W. (2003). Therapeutic outcome of adjustable gastric banding in morbid obese patients. *Eating and Weigh Disorders*, 8 (3) 218 – 224.

Jones, M. (2008). *Skin Tight: The anatomy of Cosmetic Surgery*. Sydney: MacMillan

Kinzl J. F., Traweger, C., Trefalt, E., & Biebl, W. (2003). Psychosocial consequences of weight loss following gastric banding for morbid obesity. *Obesity Surgery*, 13 (1) 105 – 110

Kent, G., & Thompson, A. R. (2002). The development and maintenance of shame in disfigurement: Implications for treatment. In P. Gilbert & J. Miles (Eds.) *Body Shame: Conceptualisation, Research and Treatment*. East Sussex: Routledge.

Larkin, M., Watts, S., Clifton, E. (2006). Giving voice and making sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology*, 3 (2) 102-120.

Lazar, C. C., Clerc, I., Deneuve, S., Aquit-Auckbur, L., & Milliez, P. Y. (2009). Abdominoplasty after major weight loss: Improvement of Quality of Life and Psychological Status. *Obesity Surgery*, 19 (8) 1170 – 1175.

Mitchell, J. E., Lancaster, K. L., Burgard, M. A., Howell, L. M., Krahn, D. D., Crosby, R., et al. (2001). Long-term follow-up of patients' status after gastric bypass. *Obesity Surgery* 11 (4) 464 – 468.

Mitchell, J. E., Crosby, R. D., Ertelt, T. W., et al. (2008). The desire for Body Contouring Surgery after Bariatric Surgery. *Obesity Surgery* 18 (10) 1308 – 1312.

National Institute of Clinical Excellence (2006). Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.

Pecori, L., Cervetti, G. G. S., Marinari, G. M., Migliori, F., & Adami, G. F. (2007). Attitudes of Morbidly Obese Patients to Weight Loss and Body Image following Bariatric Surgery and Body Contouring. *Obesity Surgery* 17 (1) 68 – 73.

Rozin, P., Lowery, L., Imada, S. & Haidt, J. (1999). The CAD triad hypothesis: A mapping between three moral emotions (contempt, anger, disgust) and three moral codes (community, anatomy, divinity), *Journal of Personality and Social Psychology*, 76 (4) 574 – 586.

Sarwer, D. B., Thompson, J. K., Mitchell J. E., and Rubin, J. P. (2008). Psychological Considerations of the bariatric surgery patient undergoing body contouring surgery. *Plastic and Reconstructive Surgery*, 121 (6) 423 – 434.

Song, , A.Y., Rubin, J. P., Thomas, V., Dudas, J. R., Marra, K. G., & Fernstrom, M. H. (2006). Body Image and Quality of life in post massive weight loss body contouring patients. *Obesity*, 14, 1626 - 1636.

Stuerz, K., Piza, H, NiermanK., & Kinzl, J. F. (2008). Psychosocial Impact of Abdominoplasty. *Obesity Surgery* 18 (1) 34 – 38.

Swan-Kremier, L. A. (2005). Psychosocial outcomes of bariatric surgery. In J. Mitchell and M. de Zwaan (eds). *Bariatric Surgery: A Guide for Mental Health Professionals*. New York: Routledge

Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International journal of Qualitative Studies on Health and Well-Being* 2 (1) 3 – 11.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. London: Sage.

Tinker, J. E., & Tucker, J. A. (1997). Motivations for Weight Loss and Behaviour Change Strategies Associated with natural recovery from obesity. *Psychology of Addictive Behaviours* 1 (2) 98 – 106.

Taylor, J., & Shermak, M. (2004). Body Contouring Following Massive Weight Loss. *Obesity Surgery* 14 (8) 1080 – 1085.

Tolonen, F., & Victorzon, M. (2003). Quality of life following laparoscopic adjustable gastric banding- the Swedish band and the Moorehead-Aredelt questionnaire. *Obesity Surgery* 13 (3) 424 - 426