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BELIEFS AND PERCEIVED BARRIERS IN PURCHASING COSMETIC SURGERY SERVICES

**The consumer decision-making process and the reasoned action
approach**

Master's Thesis
in Marketing

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6.12.2016
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1 INTRODUCTION

Cosmetic surgery has seen a significant increase in demand in recent years. The cosmetic surgery industry has grown 39% during the last five years. In the twenty years that the American Society for Aesthetic Plastic Surgery (ASAPS) has collected data of procedures performed in the US, the industry has grown nearly ten times larger. In 2015, nearly 13 million cosmetic surgery procedures were performed in the United States. (Cosmetic surgery – 2015.) Attitudes towards the industry have significantly softened and acceptance of consumers undergoing cosmetic surgery treatments has grown (Sarwer & Crerand 2004; Patil, Kale, Khare, Jaiswal & Ingole 2011), however, even though consumers are more accepting of the industry in general, this does not always translate to willingness to utilize cosmetic surgery (Patil et al. 2011). It is essential for health care marketers to constantly assess the evolving trends of the industry, such as the long-developing trend of well-being and fitness, and understand the motivations behind health care decisions, in order to develop a competitive edge (Kotler, Shalowitz & Stevens 2008, 73, 147).

The health care service industry is dynamic, complex and fiercely competitive, and a unique and extremely vital area for research, vital in impacting the quality of life of all consumers (Berry & Bendapudi 2007; Cooley & Madupu 2009; Zarei et al. 2014, 796; Ghosh 2015). As a concept, health care marketing is still relatively new, missing established marketing standards and guidelines, and the unique aspects and challenges of the industry pose serious questions for researchers, pointing to the crucial need for the continuing research endeavours of services and marketing professionals. (Berry & Bendapudi 2007; Thomas 2008, 1–2, 6–7; Cooley & Madupu 2009; Zarei et al. 2014, 796.)

Health care services, including cosmetic surgery, involve multiple personal, financial and physical risks (Murray 1992; Solomon, Bamossy, Askegaard & Hogg 2010, 166). It is clear, that professional services, such as health care, significantly differ from the purchase of goods in relation to consumer behaviour, especially regarding information search and evaluation (Zeithaml 1981, 34; Ettenson & Turner 1997). Since the consumer is more involved and faces more risk, the decision-making process becomes more complex, with more factors being considered in the minds of consumers. The process involves numerous steps over a considerable length of time, thus also making it susceptible and vulnerable to change.

In order for marketers to serve consumers and develop more effective marketing strategies, a complete understanding of the different beliefs, factors and attributes of the service that influence decisions and purchase behaviour in different consumer segments is required (Zeithaml 1981, 34; Murray 1992; Evans, Moutinho & Van Raaij 1996, 86–87; Arnould, Price & Zinkhan 2004, 660; Baron, Harris & Hilton 2009, 73; Chan, Tsang & Leung 2013; Van Der Linden 2013; Zarei et al. 2014). This holds true in all aspects of

the health care industry as well (Crane & Lynch 1988; Lane & Lindquist 1988; Ghosh 2015).

It is well noted that *beliefs* are the fundamental building blocks of behaviour. Research has shown us that by studying the beliefs of consumers we can gain significant insight into what factors are facilitators of action and what factors act as barriers (Ajzen 1991). It is crucial to note that the same strategies cannot be used for helping consumers form positive intentions toward a behaviour and helping consumers with existing positive intentions to overcome the barriers they perceive are obscuring behaviour (Fishbein & Yzer 2003, 180). The health belief model states that before making a health-related decision, consumers have, among others, perceived and evaluated possible risks and *barriers to taking action*, such as is the action inconvenient, costly, unpleasant, painful or emotionally upsetting (Kotler et al. 2008, 151–152). However, it remains unclear how strongly the presence of these risks influences the consumer's purchase decision (Solomon et al. 2010, 166).

Several studies have attempted to identify consumer *attitudes towards the cosmetic surgery industry* and factors that predict *interest and likelihood of utilizing cosmetic surgery* (e.g. Henderson-King & Henderson-King 2005; Henderson-King & Brooks 2009; Swami 2009; Slevic & Tiggemann 2010; Patil, Kale, Khare, Jaiswal & Ingole 2011; Furnham & Levitas 2012; Markey & Markey 2012). These investigations have provided considerable insight into the motivational and psychological influences at play in the cosmetic surgery consumer's mind. Factors such as body-image dissatisfaction, aging anxiety and appearance investment have, among others, been shown to explain interest and likelihood of pursuing appearance enhancing procedures. Additionally, there is an abundance of research discussing *factors influencing consumers' choice of hospitals* (e.g. Boscarino & Stelber 1982; Crane & Lynch 1988; Lane & Lindquist 1988; Jayanti & Whipple 2008; De Groot, Otten, Dijns-Elsinga, Smeets, Kievit, Marang-van de Mheen 2012; Kobayashi, Mano & Yamauchi 2013; Ghosh 2015). This research has uncovered that factors such hospital reputation, proximity and physician likeability, to name a few, influence consumers' selection of a health care service provider. However, these types of investigations, while closely involved with the phenomenon of interest, do not tell us anything about the reasons why a potential consumer in the target segment would *not* want to purchase cosmetic surgery services in *general*. This is a glaring research-gap.

1.1 Research questions and purpose of thesis

The purpose of this thesis is to uncover how and why consumers make decisions about utilizing cosmetic surgery services. On a managerial level, the research aims to identify reasons why potential target consumers do *not* wish to utilize cosmetic surgery. For this

purpose, it is necessary to identify beliefs consumers associate with utilizing cosmetic surgery and further how these beliefs translate into barriers to a purchase decision. Thus, the following research questions are proposed:

RQ1: What is the nature of the consumer decision-making process when purchasing cosmetic surgery services?

RQ2: What beliefs do consumers associate with utilizing cosmetic surgery services?

RQ3: How do these beliefs translate into possible barriers for purchase?

As stated in the introduction, cosmetic surgery is a unique and highly complex service offering that combines issues from several different fields of study. Figure 1 illustrates how these theoretical fields overlap and how they will be approached in this study.

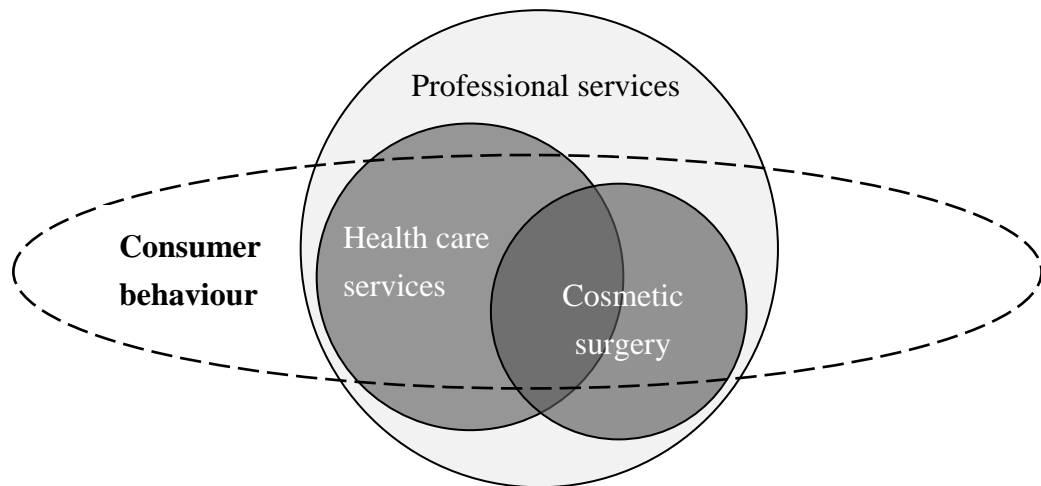


Figure 1 Theoretical positioning

Health care services are an often-used example of professional services. Cosmetic surgery, however, is a unique health service in the sense that while it shares characteristics with health services, such as surgical risks and some degree of an emotional component to purchase decisions, it is not purchased with the same motivations as other health services. Thus, this research will examine the fields of health care, professional services and the cosmetic surgery industry through a consumer behaviour lens. (Fig. 1)

1.2 Structure of thesis

To begin investigating the research phenomenon, the first half of the thesis will focus on assessing relevant literature and the existing research on the subject. The second half of

the thesis consists of the methodology, conduction of the research, and results and discussion. The structure of this paper is illustrated in figure 2 (Fig. 2)

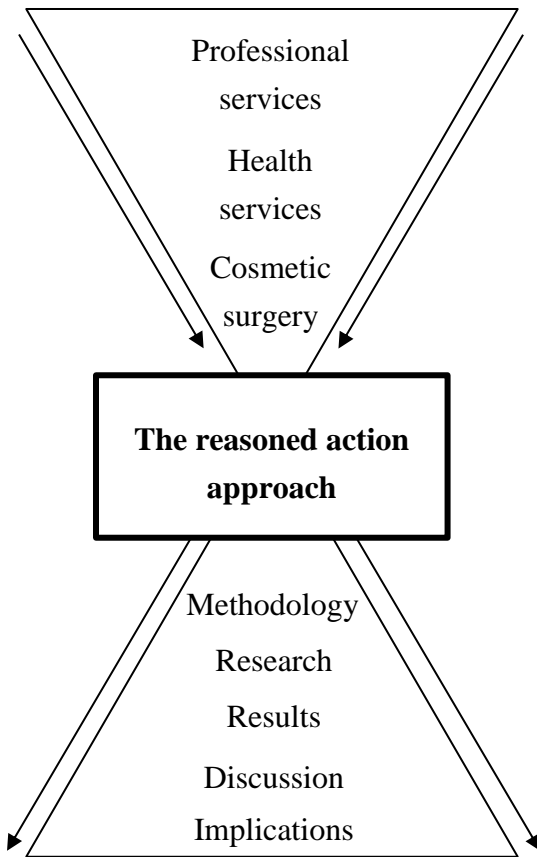


Figure 2 Structure of thesis

To begin with, the literature on purchasing professional services and specifically on the purchase of health care services will be discussed in chapter 1. The unique characteristics of professional services and health care services will be explained relating to consumers' decision-making processes. Furthermore, the process of decision-making when purchasing professional services will be detailed and evaluated. After this, cosmetic surgery will be examined as a research context in chapter 3. Recent development of the industry and some prevailing current trends will be examined in relation to their impact on consumer behaviour and finally the specific characteristics of cosmetic surgery consumers will be discussed. Chapter 4, discussing the reasoned action approach as a tool for studying consumer behaviour, will conclude the theoretical portion of this thesis.

A summary of the theoretical framework will be presented in chapter 5, before detailing and explaining the methodological choices of this research in chapter 6. The methodology section includes a description of the research approach and a detailed description of the research design. It will continue to explain the steps taken in selecting respondents for the study and the methods of conducting the interviews and analysing the acquired data. Finally, the methodological choices will be evaluated. In the final part of this thesis,

the results will first be summarized in chapter 7 before offering discussion and conclusions on the main findings, managerial implications and propositions for future research including limitations of the current study.

2 DECISION-MAKING IN HEALTH SERVICE PURCHASES

There exist clear differences in the decision-making styles between professional and non-professional services (Ettenson & Turner 1997). Furthermore, health services have salient differences that fundamentally set it apart from other professional services (Rathmell 1996, 61–62; Berry & Bendapudi 2007; Baron et al. 2009, 258). For researchers to investigate decision-making in health service purchases and identify possible influencing beliefs and barriers, it is crucial to first assess the unique characteristics of professional services and professional health services, and secondly identify how these characteristics influence the decision-making processes of consumers.

2.1 Unique characteristics of professional health services

Professional services have unique and distinct characteristics that set them apart from other goods and services. Health care services have a high number of all these distinct characteristics (Lian & Laing 2004). For the purposes of this thesis, it is useful to summarize and describe these characteristics through four separate dimensions; *complexity*, *involvement*, *trust* and *perceived risk* (Fig. 3)

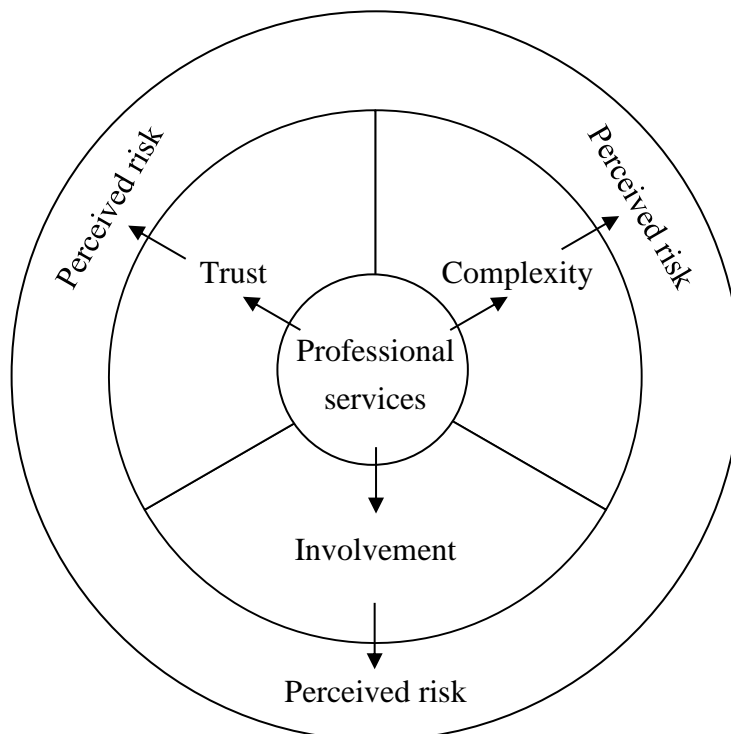


Figure 3 The four dimensions of professional services

The complexity of professional services creates an environment in which it is required for the consumer to be highly involved in process of service delivery, which in turn further complicates the nature of professional services. The complexity and involvement -dimensions further demand for significant trust to take place between consumer and service provider. All three of these separate dimensions substantially contribute to consumers' perceptions of risk.

2.1.1 Complexity

Competition and complexity within the environment for professional services continues to increase (White 2005; Reid 2008). By nature, professional services, such as health care, are highly complex and ambiguous (e.g. Lovelock, Vandermerwe & Lewis 1999, 128–129; Berry & Bendapudi 2007; Jaakkola 2007; Thomas 2008, 4–8, 14–15), often involving numerous steps and different components in the total service delivery process, and as such are excruciatingly difficult to conceptualize. Hospital services especially are quite large, often consisting of numerous smaller services, and the value of the service is difficult to describe and put into words (Thomas 2008, 66).

Since professional services are such large and complicated entities, their delivery, likewise, requires complex and significant knowledge, expertise and skills on behalf of the service provider, often acquired through lengthy higher education (e.g. Lovelock 1983, 26; Thakor & Kumar 2000; Jaakkola & Halinen 2006; Jaakkola 2007; Thomas 2008). Decision-making in professional services usually involves an expert and a novice. (Jaakkola 2007). Due to the high levels of expertise and specialist knowledge required in the delivery of professional services, the average consumer is not able to easily comprehend or evaluate the service or its delivery, since most consumers do not possess the skills, knowledge or extensive training required to understand what goes into producing the service and what constitutes a successful or unsuccessful service delivery (e.g. Zeithaml 1981, 34–36; Lovelock 1983, 27; Evans et al. 1996, 9; Thakor & Kumar 2000; Thomas 2008 4–8, 14–15).

It must be noted that service complexity can stem from several other sources besides solely the service setting. Complexity can occur as two different types; *complicatedness* and *difficulty*. Complicatedness stems from the existence of multiple components in the service and/or high levels of interaction between those components. Complicatedness may further lead to difficulty, which in turn involves the need for significant immaterial or material resources to achieve the objective and/or the element of uncertainty; the inability to be able to confidently predict outcomes or rely on external factors. Additionally, complexity can be either *individual* or *general*. General complexity refers to the nature

of the service in general, whilst individual complexity refers to instances where the complexity stems from the characteristics of an individual service provider. (Benedettini & Neely 2012.)

It seems that with decisions that consumers perceive as complex and high in emotional difficulty, consumers prefer to base their decisions on emotional decision criteria rather than rationality, especially when considering accepting advice from an outside source. The possibility of a stressful decision or decision outcome causes consumers to want to rely on the emotional support of the advisor, in which cases emotional support is valued higher than any perceptions of expertise. This might suggest that complex and emotional decision-making may cause consumers to adopt non-normative strategies in their behaviour, and in efforts to minimize negative emotions, decision accuracy is likely to suffer. (White 2005.)

2.1.2 *Involvement*

Professional services are highly-customized and tailored to the unique requirements of the consumer (Lovelock 1983, 26; Lampel & Mintzberg 1996; Verma 2000; Jaakkola 2007). Health services especially are highly personal by nature, more so than any other professional service. Additionally, there exists a significant emotional component that is absent when purchasing other services. Generally, consumers are thought to be driven by primarily economic motives, but with health services this is most often not the case. The purchasing process of health services often involves a range of emotions, such a fear, pride and vanity. (Thomas 2008, 4, 6.) Thus, the consumer is deeply involved in the service delivery process and the service and its outcome are important and often crucial to them (Thakor & Kumar 2000; Jaakkola 2007).

Professional services are produced with the cooperation of the consumer (Zeithaml 1981, 34–36; Evans et al. 1996, 9; Gabbott & Hogg 1997, x–xi; Grönroos 2007, 53–54; Thomas 2008, 15–16). Participation from the consumer's behalf brings an additional element of uncertainty to the production of professional services. The consumer must be able to specify, communicate and cooperate with the service provider to ensure successful service delivery. Thus, service quality is not only dependant on the performance of the service provider, but additionally on the performance of the consumer (Zeithaml 1981, 36; Lovelock 1983, 26; Gabbott & Hogg 1994, 144; Jaakkola & Halinen 2006, 419).

Involvement may be defined as the psychological outcome of motivation (Arnould et al. 2004, 259, 281–287). It is the perceived relevance consumers give products and services based on their individual needs, values and interests, and may very well change over time (Solomon et al. 2010, 191–192). Involvement is a complicated concept, since it can hold many different meanings in relation to context. Kapferer and Laurent (1985) noted

more than three decades ago that viewing involvement simplistically either as low or high was insufficient at describing this complicated consumer phenomenon. When attempting to measure involvement, it is beneficial to imagine it along a continuum (Arnould et al. 2004, 287).

It is useful to consider the source of involvement as either *cognitive* or *affective*. With cognitive involvement, more systematic information processing and deliberate thinking come into play, whilst with affective involvement the emotional aspect and feelings toward the goal object are highlighted. These two types of involvement do not contradict each other and may in fact appear simultaneously. Additionally, involvement may persist over long periods of time or in contrast relate only to specific or temporary situations. Perceptions of involvement usually increase with perceived importance and amount of social pressure, and the presence of a time constraint. Additionally, the finality or irreversibility of the decision substantially increases involvement whether it involves financial, social or other permanent consequences. (Arnould et al. 2004, 282–283.) Consumers who are highly involved with their purchase or decision willingly spend more time, money and effort in achieving their goals. The consumer's attention and memory are heightened and information is searched for more extensively and actively. (Arnould et al. 2004, 285.)

A total of five antecedents of involvement may be identified. These are 1. Perceived importance of the purchase, and its personal meaning, 2. Perceived importance of possible negative outcomes, 3. Perceived probability of the purchase being a mistake, 4. The symbolic or sign value of the purchase and consumption and 5. Hedonic value and emotional appeal, or the pleasure appeal of the purchase. These antecedents each contribute on their own part to the concept of consumer involvement. (Kapferer & Laurent 1985a; 1985b; 1993; see also Solomon et al. 2010, 196.)

Kapferer and Laurent (1993) noted in their continued research of what they coined the *consumer involvement profile*, that sign value, risk importance and risk probability appeared consistently as separate factors in measuring involvement, but the remaining two factors, personal interest and pleasure value proved more problematic. It seems that these two factors are closely linked and often correlate so strongly that they sometimes merge into one single factor. Kapferer and Laurent, however, argue against combining them into one single antecedent, since whilst they are similar they are not identical. It is true that in the case of some purchases pleasure and interest are closely linked to each other but it is equally likely for them to not correlate. The researchers additionally note the importance of including an analysis of consumers' perceptions of risk probability when studying facets of involvement, since what most textbooks describe as characteristics of high-involvement purchase behaviour, such as information search and prolonged deliberation, are likely to appear as consequences of risk probability.

2.1.3 *Trust*

The quality and performance of a professional service depends largely on the individual characteristics and skills of the human being providing the service in a specific place at a specific time, and as such cannot be controlled and maintained like with goods. As such, services are heterogenous and each service encounter will always be different from the next. (Zeithaml 1981, 34–36; Gabbott & Hogg 1997, x–xi; Thomas 2008, 15–16.) Since services cannot be evaluated prior to consumption, and further, in the case of professional services, evaluation is exceedingly difficult due to the consumer lacking the required knowledge and expertise to be able to tell whether the service has been performed accordingly, the consumer must place an inordinate amount of *trust* in the service provider (Lovelock 1983, 27; Evans et al. 1996, 9).

Trust is confidence that the person one is collaborating with will perform or act in a certain way or per expectations in a specific situation. There exist four subcategories; generalized trust, system trust, personality-based trust and process-based trust. General trust relies on reputation and societal norms whilst system trust stems from trust in laws, contracts and the professionalism of the service provider. Personality- and process-based trust develop through personal experience with the same service provider. (Grönroos 2007, 40.)

The outcome of professional services is often unclear to both the service provider and the consumer. Because of this, the professional providing the service has a crucial role in understanding the needs and unique perceived problems of the consumer and designing a solution that will be the most beneficial for the consumer's situation. This uncertainty may pose a serious challenge for the consumer, and underlines the significance of trust between consumer and service provider. (Lovelock 1983, 27.)

When deciding to purchase a professional service, the consumer must have confidence in the service provider's abilities to cater to the consumer's specific needs and requirements. There exist two levels of uncertainty: the consumer must first assess their perception of the probability the professional will fail in providing an adequate service and secondly consider the possibility the service provider does not truly have the consumer's best interests in mind. (White 2005.) Personal gain may exert at least some amount of influence on the decisions of the professional (Jaakkola & Halinen 2006, 418).

2.1.4 *Perceived risk*

Consumers are increasingly often faced with decisions which involve high stakes, numerous decision alternatives and serious uncertainty (White 2005). With high-involvement, high-risk services, such as professional services, which are high in credence qualities,

perceived risk and the notion of irreversibility play an extremely crucial role during the decision-making process (Zeithaml 1981, 39–40; Murray & Schlacter 1990, 111–112; Lovelock et al. 1999, 131–133; Mitra, Reiss & Capella 1999; Jaakkola 2007).

Professional services are produced with the cooperation of the consumer, or client, and consumption of the service happens immediately (e.g. Zeithaml 1981, 34–36; Evans et al. 1996, 9; Gabbott & Hogg 1997, x–xi; Grönroos 2007, 53–54; Thomas 2008, 15–16). Participation from the consumer's behalf brings an element of uncertainty to the production and delivery of professional services. The consumer must be able to specify, communicate and cooperate with the service provider to ensure successful service delivery. Thus, service quality is not only dependant on the performance of the service provider, but additionally on the performance of the consumer (Zeithaml 1981, 36; Gabbott & Hogg 1994, 144; Jaakkola & Halinen 2006, 419).

Additionally, due to the significant knowledge-gap between consumer and service provider, the average consumer cannot easily evaluate the service, its delivery or the exact nature of the service they are purchasing; service selection must be based on minimal pre-purchase information or any evidence of the quality or outcome (Zeithaml 1981, 39–40; Mitra et al. 1999; Thakor & Kumar 2000.) The outcome and performance of health services are especially difficult to evaluate. Even if most health care services do not involve matters of life or death, each surgical operation has an element of risk and the potential of complications (Thomas 2008, 6). Results will not be immediately visible but will often take weeks if not months to appear. This elapsed time brings yet another element of uncertainty to the outcome of the service delivery process; several factors beyond the service provider's control, outside the service factory, come into play and may influence the outcome. (Lian & Laing 2004, 111.)

Consumers may perceive six types of risk during their decision-making process (e.g. Roselius 1971; Kaplan, Szybillo & Jacoby 1974; Turley & LeBlanc 1993, 15; Hoffman & Bateson 1997, 84; Lovelock et al. 1999, 133; Solomon et al. 2010, 328–331):

- a) *Financial risk*: the purchase may involve significant financial loss. Consumers rarely know the price of the entire health service before it is consumed (Thomas 2008, 4). Elective procedures, such as cosmetic surgery, are not covered by health insurance, which means that the consumer must cover the entire cost of the service themselves.
- b) *Physical risk*: the purchase may cause physical harm, injury or damage health.
- c) *Quality or performance risk*: the service or an aspect of it may not perform as intended.
- d) *Social risk*: The purchase may result in loss of social status.
- e) *Psychological risk*: The purchase may result in psychological damage or harm to one's self esteem.

- f) *Temporal risk*: The purchase may involve significant loss of time or be inconvenient.

A coping mechanism for consumers dealing with risk is to attempt to reduce uncertainty surrounding the purchase. This however does not reduce the risk itself. Consumers may feel that knowledge or awareness of different probabilities, such as risk of infection or possible side-effects, will help reduce uncertainty and thus increase confidence in the decision. (Evans et al. 1996, 89.)

2.2 The decision-making process

The decision-making behaviour of consumers of professional services differs significantly from an organizational or regular consumer context (Jaakkola 2007). Logical flow models (Fig. 4) depict the purchasing process as a series of sequential steps (see e.g. Chisnall 1985, 164; Kotler et al. 2008, 155). The way consumers move through the different steps differs in relation to the product or service in question. For instance, low involvement products and services are less likely to cause as much deliberation as high-involvement products and services, with which alternatives and possible influencing factors are considered more carefully (Chisnall 1985, 164–166; Solomon et al. 2010, 314–315, 317).

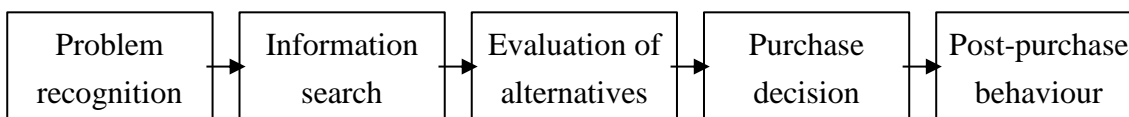


Figure 4 Five-stage model of consumer buying process (Kotler et al. 2008, 155)

The buying process is typically depicted as consisting of five differing steps. At the beginning of each process is a felt need or recognition of a problem, causing tension between the consumer's present state and ideal state. The consumer is thus motivated to find solutions in resolving this caused tension. Following problem recognition, the consumer begins their information search and once enough information has been gathered, consumers form their evoked set of alternatives which they evaluate before making their purchase decision until finally engaging in post-purchase behaviour. (Kotler et al. 2008, 155.)

Thus, the consumer's decision-making process (Fig. 5) consists of the three steps leading up to the purchase decision; *problem recognition*, *information search* and *evaluation of alternatives*.

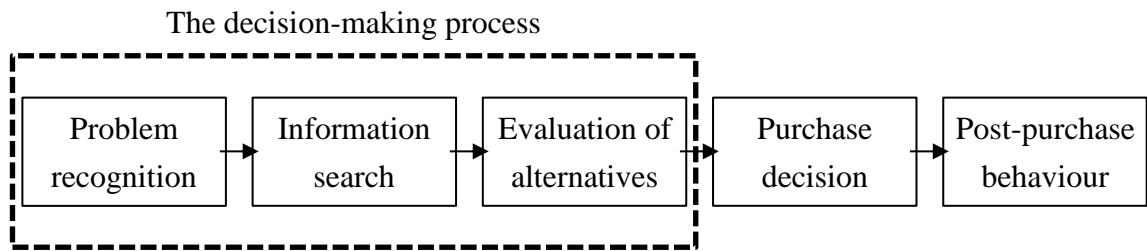


Figure 5 The consumer decision-making process

However, especially in relation to the purchase of health services, decision-making is rarely as straight-forward as this model suggests, but instead involves numerous complex factors and obstacles which consumers must face. With high-risk and complex services, indirect or even seemingly unrelated factors may have a substantial effect on the consumer's decision-making process (Baron et al. 2009, 69–70). Before making a health-related decision, consumers have first perceived and evaluated a) susceptibility; i.e. are they subjected or affected by something that could potentially harm their health, b) seriousness; i.e. would it significantly affect their emotional, psychological, physical or even financial well-being, c) benefits of the action; i.e. what would be the positive outcomes of the decision d) barriers to taking action; i.e. is the action inconvenient, costly, unpleasant, painful or emotionally upsetting, e) cues to taking action; i.e. identifying internal and external reminders or encouragement about the action, and f) efficacy in relation to the action; i.e. are they able to perform the action (Kotler et al. 2008, 151–152).

2.2.1 *Problem recognition*

A purchasing process can be initiated by either need recognition or opportunity recognition. Need recognition occurs when an individual's perception of their present state decreases or moves down. In contrast, with opportunity recognition an individual's ideal state moves higher. In both cases the distance between the consumer's present and ideal state increases, creating tension which consumers are then motivated to resolve. (Solomon et al. 2010, 177, 320–321.)

Motivation is at the core of all consumer behaviour. It is the reason consumers engage in any given action and it explains why that action or behaviour is continued over time (Arnould et al 2004, 258; Chisnall 1985, 36; Evans et al. 1996, 20; Solomon et al. 176–177). Motives are psychological constructs, whose existence can only be hypothesized, since they cannot be directly observed (Arnould et al 2004, 267). Motivation can be either *positive* or *negative*. Positive motivation, or approach behaviour, has to do with instances

where the driving force behind the action is for example pleasure or comfort, such as pleasant or comfortable social situations, approval and acceptance or the enrichment of lives, or the acquisition of attractive goods. In contrast, negative motivation equals avoidance behaviour. Individuals are negatively motivated when they want to escape unpleasant situations or avoid discomfort and negative emotions. Fear of social rejection, shame or low self-esteem are examples of negative motivation. (Chisnall 1985, 36–37; Evans et al. 1996, 20.)

Consumers may often have conflicting motivations or multiple attitudes and feelings towards different products and services that may contradict each other (Chisnall 1985, 45; Arnould et al. 2004, 177). For instance, the object of a consumer's desire may have a negative consequence attached to it, which may cause feelings of guilt or shame (Arnould et al. 2004, 276–277; Solomon et al. 2010, 182–184). The consumer's need and general demand for health services fundamentally differs from other professional services. Whilst with elective procedures such as cosmetic surgery the nature of their demand is like other luxury services, most health services are required unexpectedly and often unwillingly. Marketers face challenges in marketing services with which the need for the service is difficult to anticipate. (Thomas 2008, 6–8.)

2.2.2 *Information search*

The next stage of the decision-making process after problem recognition is searching for information. However, not all information search is conscious and determined, but may be incidental or happen as an on-going process (Chisnall 1985, 32; Solomon et al. 2010, 321–322). Consumers exist within a consumer culture and are constantly exposed to different types of information via numerous sources, such as advertising, word-of-mouth or the media. The internet has significantly eased the information search of consumers. No longer do decision-makers need to rely on solely subjective information, but they can additionally search for objective information to base their decisions on. With the increasing amount of information available for consumers, this trend is only likely to grow, even among consumers with little to no internet skills. (Cooley & Madupu 2009.) The role of information search becomes more important for the consumer with the perceived importance of the purchase, and consumers are more likely to search for advice in complex purchase situations (East, Wright & Vanhuele 2008, 9; Solomon et al. 2010, 323, 327).

Professional services, such as health care, are extremely high in *credence qualities*, i.e. characteristics that are difficult or even impossible for the consumer to evaluate, even after consuming the service (e.g. Zeithaml 1981, 34–36; Murray 1991; Hoffman & Bateson 1997, 85; Mitra et al. 1999; Lian & Laing 2004; Cooley & Madupu 2009). This

poses distinct challenges for consumers in their information search, since objective evidence about the service is difficult to find (e.g. Gabbott & Hogg 1994, 143; Lian & Laing 2004). Thus, consumers perceive higher risk and uncertainty when purchasing services (Murray 1991; Lian & Laing 2004), which results in unique patterns of information search in comparison to goods. When consumers anticipate greater uncertainty, they are likely to engage in a lengthier and more extensive information search to reduce perceptions of risk (Murray 1991; Lovelock, Vandermerwe & Lewis 1999, 131–133; Mitra et al. 1999; White 2005).

Information sources can be divided into *internal* and *external* sources. Internal search refers to consumers using their own memories and acquired knowledge of the product or service. With most purchases consumers still need to search for external information from advertising, friends or other sources in order to make a satisfactory choice. (Solomon et al. 2010, 322.) However, in the case of professional services, traditional advertising falls short. While traditional advertising does well in the communication of search qualities, it fails in adequately describing any experience or credence qualities. In contrast, personal information sources vicariously provide objective and subjective information (Zeithaml 1981, 37; Murray 1991). Thus, when purchasing professional services, consumers strongly rely on personal experiences or the recommendations of important others (Zeithaml 1981; Crane & Lynch 1988; Murray 1991; Gabbott & Hogg 1994, 143; Mitra et al. 1999; Thakor & Kumar 2000; Cooley & Madupu 2009), who are considered more trustworthy and less risky information sources (Zeithaml 1981; Crane & Lynch 1988; Murray 1991; Thakor & Kumar 2000).

However, whilst personal information sources are heavily utilized in the information search -stage of purchasing professional services, it is evident that due to heightened perceptions of risk, consumers also heavily rely on the expertise of service professionals, or in the case of health care; physicians (Babakus, Remington, Lucas & Carnell 1991, 15; Lian & Laing 2004). In the case of cosmetic surgery, results from one study (Babakus et al. 1991) indicated that consumers most frequently searched for information about cosmetic surgery directly from the physician, which was also perceived as the most reliable source of information. This was followed closely by magazines and television as information sources. In contrast, newspapers and radio were used the least frequently and radio was perceived as the least reliable information source. Interestingly, although magazines were heavily utilized as an information source, the perceived reliability of them was quite low.

Whilst with health-related decision-making information from medical professionals and hospital staff is highly valued, the experiences of other patients may in most cases even be preferred. When choosing a hospital, consumers look for information from fellow patients especially about physician expertise and their communication skills, while hospital based information is utilized when researching waiting times. (De Groot et al. 2012.)

The importance of referrals in consumer decision-making is crucial for health care administrators; a positive personal referral may make up for shortcomings of e.g. the physical environment. However, even if the quality of the facilities exceeded expectations, even one negative comment might cause consumers to not want to try the services of said physician. (Crane & Lynch 1988.)

Health care organizations may attempt to take advantage of the heavy trust consumers place in personal information sources and the experiences of others by utilizing testimonials in their advertising. However, in these instances it is of utmost importance to ensure the testimonial is considered as heartfelt and the source perceived relatable and similar with the target consumer (Arnould et al. 2004, 603–607; Dittmar 2008, 20). In a recent study conducted in a Chinese context (Chan et al. 2013), researchers found that advertising messages from medical professionals were seen as being high in information value, however, medical professionals whom advertised caused some suspicions. Respondents strongly believed that the advertising costs of medical services would transfer to the prices of said medical services. Still, it would seem that at least to a certain extent, respondents of the study in question saw advertising by medical professionals in a slightly more favourable light than advertising by professionals in general. Regardless, the majority of the respondents expressed a worry over the possibility of the information from medical advertising being unreliable and that this advertising could benefit certain incompetent medical professionals.

2.2.3 *Evaluation of alternatives*

Consumers are increasingly knowledgeable and aware of their choices in the selection of a professional service provider (Boscarino & Stelber 1982; Reid 2008). However, the high number of credence qualities in professional services poses distinct challenges additionally in the evaluation of available alternatives. By definition, the delivery of professional services requires significant knowledge, expertise and skills on behalf of the service provider (e.g. Thakor & Kumar 2000; Jaakkola & Halinen 2006), and professional service encounters often involve an expert and a novice (Jaakkola 2007). This results in a serious knowledge-gap between consumer and service provider (Jaakkola & Halinen 2006). Not knowing what goes into the process of delivery or what constitutes a successful service delivery, consumers typically lack the required expertise to be able to adequately evaluate a professional service.

Additionally, as stated earlier, the presence of mostly credence qualities makes it excruciatingly hard to find objective evidence of the service to base evaluations on, and furthermore make differentiations between potential service providers (Gabbott & Hogg

1993, 143–144; Thomas 2008, 7). Furthermore, the service scope between different service providers in a specific area is usually quite similar, further complicating evaluation (Thomas 2008, 7). Professional services are often highly customized (Lovelock 1983, 26; Lampel & Mintzberg 1996; Verma 2000; Jaakkola 2007) and personal by nature (Thomas 2008, 15–16; Baron et al. 2009, 197) and as such, are subjectively evaluated by each consumer (Thomas 2008, 15–16).

However, whilst professional services are mostly comprised of credence qualities, before making the final purchase decision, the consumer may need to enter the service factory where they are subjected to several tangible characteristics. These characteristics, such as interior design, food, drink or graphic elements, need to be included in the description of any professional service (Shostack 1977, 7; Zeithaml 1981, 38; Lovelock 1983, 22). A study by Crane and Lynch (1988) identified four kinds of cues which influenced service evaluations in a health care setting; social setting cues (e.g. other patients, the dress and demeanour of staff), physical setting cues (e.g. the location and physical appearance of the office), price cues and information cues (e.g. advertising materials, personal referrals). Cues about the social and physical settings were hard to isolate from each other and the overall impression was the result of a combination of all cues.

When evaluating alternatives, the consumer forms their *evoked set* of choices out of feasible or acceptable alternatives to them. With services, the evoked set is significantly smaller than with goods (Turley & LeBlanc 1993, 15) for several reasons. The service factor only sells one “brand” and often only a small number of service providers for a specific service can be found in a specific geographical area (Zeithaml 1981, 38; Gabbott & Hogg 1994, 143–144; Thomas 2008, 4). In Finland, the health care industry consists of a combination of private health care practitioners and the public health sector. Consumers may choose whether they want to be treated in the public sector, which usually means longer waiting periods, or they may choose to pay more and pick their service provider from within the private sector. However, elective procedures, such as cosmetic surgery, are not provided in the public sector.

Whilst professional services are provenly difficult to evaluate, numerous studies have investigated the factors that influence consumers in their selection of a health care service provider. Physician likeability is an especially crucial factor in the evaluation of health services (Crane & Lynch 1988; Jayanti & Whipple 2008; Zarei et al. 2014; Ghosh 2015). Other, concrete factors that significantly influence the choice between different health care service providers include the physical and technical qualities of the service facilities, cost, reputation, quality and diversity of the provided hospital services, satisfaction with personnel, previous experience with the service provider, word of mouth or recommendations from friends, family or physician, and finally location or proximity of the service provider (Ghosh 2015). In a sample of Japanese consumers, hospital choice was most affected by overall quality of the service provider and least by whether the service facility

was privately or publicly owned (Kobayashi et al. 2013). Overall, consumers seem to be consistent in the choice factors they use when choosing their health care service provider. However, these factors will continue to evolve via better education, increasing proactivity in health care decision-making, rising costs and evolving cultures. (Lane & Lindquist 1988.)

3 COSMETIC SURGERY

Cosmetic surgery is a vital and topical area of consumer research and greater understanding and marketing guidance about the behaviour of cosmetic surgery consumers is needed (Babakus et al. 1991, 16–17). Cosmetic surgery has unique implications as a context for research and consumers of cosmetic surgery have characteristics that set them apart from other industries. It is important to assess these characteristics before embarking on an investigation into the behaviours of cosmetic surgery consumers.

3.1 Cosmetic surgery as a research context

In the case of health care, the distinction between elective and non-elective procedures is imperative. Non-elective procedures are medically necessary to improve the well-being of the patient, or in the most extreme cases save their life. Elective procedures are voluntarily chosen, such as laser surgery of the eyes or appearance enhancing cosmetic surgery (Thomas 2008, 68). As social networks continue to expand through online behaviour, individuals become increasingly subjected to new ideas and possibilities regarding their appearance, including cosmetic surgery (Henderson-King & Henderson-King 2005). Cosmetic surgery procedures have steadily increased in popularity and acceptance of the industry has grown. The significant growth that the cosmetic surgery industry has seen is an interesting phenomenon. In part, the growth and normalization of the industry may be attributed to increasing advertising but mass media trends are additionally a significant contributor. Magazines and television programming discussing cosmetic surgery have surged in popularity and the trend does not seem to be slowing down. (Sarwer et al. 1998, 13; Sarwer & Crerand 2004.)

The cosmetic surgery industry has grown 39% during the last five years. In the twenty years that the American Society for Aesthetic Plastic Surgery (ASAPS) have collected data of procedures performed in the US, the industry has grown nearly ten times larger. The five most popular surgical procedures in the United States in 2015 were liposuction, breast augmentation, tummy tuck, eyelid surgery and breast lift, whilst the most popular non-surgical procedure was botulinum toxin injections. The largest consumer group was between 35 and 50 years of age, accounting for 40.4% of total procedures performed. (Cosmetic surgery – – 2015.)

According to industry professionals, general attitudes toward cosmetic surgery have likewise softened in Finland, and some of the secrecy and stigma surrounding the industry have dissolved (Pystynen 2013; Tarvonen 2014; Aula 2015; Karilahti 2015). Among the most popular procedures are breast implant surgery (Puurunen 2012) and eyelid surgery, with non-invasive procedures continuing to grow in popularity. Most cosmetic surgery

consumers in Finland are between 30 and 65 years of age. (Aula 2015; Karilahti 2015.) The pressure of conforming to perceived standards is increasing to the extent that more and more consumers are resorting to cosmetic surgery. Statistical data of the exact amount of cosmetic procedures performed in Finland is not collected, but some industry professionals estimate the number to be thousands, even ten thousand yearly procedures (Raunio 2011; Pystynen 2013; Laukia 2014; Tarvonen 2014). Some professionals insist that today your looks impact your employment opportunities, salary and career development (Pystynen 2013). In the future, certain professionals predict that fat-grafting techniques and advances in using cell tissues will change the face of cosmetic surgery. The amount of large operations will diminish. An increasing amount of procedures can be performed via injections which is likely to lower the threshold of appearance alteration. (Karilahti 2015.)

The increasing growth of the industry has introduced many risks that consumers must face during their decision-making process. As the number of cosmetic surgery procedures has continued to soar, competition among practitioners has also naturally increased. Some have used questionable advertising strategies to reach and influence potential consumers, which has raised concerns in the U.S. congress (Unqualified doctors – – 1989). Consumers may find it hard to separate serious medical advice from promotional material without regulated information, which may even prove dangerous in the analysis of the potential risks of cosmetic surgery (Gilmartin 2011, 1802). An evaluation of 623 websites containing information about breast augmentation surgery found serious shortcomings in quality of information, especially about risks related to possible complications and mortality rates (Palmaa et al. 2016).

In Finland, non-invasive procedures can be performed without a license. The substances used for the injections can be purchased over the counter, and improper use may result in serious risks, such as infection, allergic reactions, abscess, or even necrosis. (Kautonen 2015.) Additionally, since altering one's appearance through the means of cosmetic surgery is not the most affordable decision, some consumers make the decision of going abroad in search of reduced prices. Language barriers increase the risk of the consumer not fully understanding the situation at hand and any possible outcomes of the operation. (Gilmartin 2011, 1806.)

3.2 The cosmetic surgery consumer

Consumers' motivational factors and predictors of interest in seeking cosmetic surgery have been widely assessed in studies. For example, media influence (Delinsky 2005; Swami 2009; Slevic & Tiggemann 2010; Furnham & Levitas 2012), aging anxiety

(Slevec & Tiggemann 2010), body appreciation and overall satisfaction with one's appearance (Henderson-King & Henderson-King 2005; Swami 2009), general appearance investment (Delinsky 2005; Henderson-King & Henderson-King 2005; Slevec & Tiggemann 2010), weight status (Swami 2009) and vicarious experience of cosmetic surgery (Delinsky 2005; Voelker & Pentina 2011) have been shown to predict interest in pursuing cosmetic surgery.

Broadly speaking, consumers desire cosmetic surgery procedures because they perceive a difference in what they feel they look like and what they ought to look like. Once the perceived difference was reduced or removed, respondents' overall moods were improved. (Thorpe, Ahmed & Steer 2004.) However, Sarwer and Crerand (2004) conclude that despite several studies reporting improvements in postoperative psychological well-being, making any general assumptions of cosmetic surgery leading to psychological benefits remains unwise (see also Sarwer, Wadden, Pertschuk & Whitaker 1998, 9).

In the case of cosmetic surgery, it would seem evident that consumers' primary motivation has to do with measuring up to their own appearance standards, and be less concerned with the feelings and opinions of important others (Didie & Sarwer 2003; Thorpe et al. 2004). Acceptance of cosmetic surgery may in fact be more related to fears of becoming unattractive rather than a desire to become more attractive. Thus, women who are satisfied with their appearances are equally likely to consider cosmetic surgery as are women who are dissatisfied with their appearances. (Henderson-King & Henderson-King 2005.)

Despite the growing acceptance towards the industry in general, it seems that individuals who decide to utilize cosmetic surgery are still subjected to negative comments and stereotyping of their personalities and psychological well-being (Sarwer et al. 1998, 8; Delinsky 2005). Findings from one study indicated slight disapproval of elective procedures, associating characteristics such as materialistic, self-conscious and perfectionistic with consumers of cosmetic surgery (Delinsky 2005). Some consumers have had to endure negative comments about e.g. their post childbirth appearance on the beach and others feel they are judged for wanting to reverse changes brought on by pregnancy, because mothers should "carry their scars with pride" (Aarnio 2015). Indeed, one of the biggest worries of consumers of cosmetic surgery would seem to be someone being able to tell they've had surgery. Procedures are no longer marketed as improvements, but are instead referred to as regaining your "normal" appearance (Puurunen 2012; Pystynen 2013).

In a sample of Indian women from rural areas, the two most important variables affecting the decision were cost and choice of surgeon. Among other additional factors were distance to the hospital and length of recovery. The biggest fears the respondents associated with cosmetic surgery were cost, possible surgical complications and the end-result looking worse than the original situation. A little over 16% of the respondents were not willing to undergo cosmetic surgery, even though they perceived a need for it. Reasons

cited for this were cosmetic surgery being a social taboo, unwillingness to travel far for such an operation, a lengthy recovery which would require admittance to a hospital and once again, cost. (Patil et al. 2011.)

3.2.1 *Body image*

According to social comparison theory, individuals have an innate need for evaluation which often occurs through comparing oneself to others (Dittmar 2008, 20). Concerns related to body-image are at the core of understanding motivations behind desires to undergo cosmetic surgery (Sarwer et al. 1998, 2). Body image is strictly subjective and the unique evaluation of one's own physical appearance, often not in line with other's perceptions of the individual, shaped by one's culture, relationships and values and norms (Arnould et al. 2004, 408; Solomon et al. 2010, 160). Body image satisfaction or dissatisfaction results from how close one's self-perception is to their own idea of beauty standards and ideals (Dittmar 2008, 201; Solomon et al. 2010, 161). Cosmetic surgery consumers may mostly consist of individuals whose self-esteem is dependent on their subjective evaluation of their appearance. However, there may also exist consumers with high body image satisfaction, looking to enhance their already favourable evaluation of themselves by continuing to improve their appearance. (Sarwer et al. 1998, 14–16.)

3.2.2 *Media influence*

In our consumer culture, mass media and advertisements significantly affect our standards and beauty ideals (Solomon et al. 2010, 162). The media has long been criticized of setting unrealistic beauty standards, communicated through the idealization of models and celebrities. Exposure to these messages has been linked with the internalization of appearance-related values, regardless of their basis on reality or health. (Dittmar 2008, 3.) Advertisements portraying overly thin models have been proven to have an immediate negative effect on those exposed to it. Exposure to unrealistic beauty standards causes psychological dissatisfaction with one's own appearance and pressure to adhere to those standards. (Dittmar 2008, 124–125, 143.)

Today, media exposure to cosmetic surgery through advertising, reality television or magazines is exceedingly common (Delinsky 2005). The media in Finland, for example, seems to be portraying cosmetic surgery, non-invasive procedures and dramatic weight-loss in an increasingly more favourable light. Celebrities openly discuss having cosmetic

surgery, and magazines write more openly about the possibility of enhancing one's appearance via cosmetic surgery. (Pystynen 2013; Tarvonen 2014; Aula 2015; Karilahti 2015.)

The more consumers are subjected to these topics, the more it will begin to seem natural. For many, media-exposure will undoubtedly lower the threshold of seeking cosmetic surgery. (Raunio 2011.) Indeed, such media messages seem to have both a direct and indirect influence on motivations and consideration of cosmetic surgery (Swami 2009; Markey & Markey 2010; 2012; Slevic & Tiggemann 2010; Furnham & Levitas 2012). For example, a positive reaction to media messages concerning reality television and makeover-programmes has been shown to result in a greater likelihood of interest in utilizing cosmetic surgery, compared to women who respond more negatively (Markey & Markey 2010; 2012). This may also be partly attributed to the apparent normalization of cosmetic surgery (Slevic & Tiggemann 2010, 70–71.)

However, concerns that reality TV would cause unrealistic expectations of the results of cosmetic surgery or lower perceptions of risk seem to be in vain. Although a slight positive relationship with interest in cosmetic surgery and viewing makeover programmes promoting cosmetic surgery has been proven, one study found little to no relationship between viewing such programming and body dissatisfaction or decreased perceptions of risk. (Nabi 2009.)

4 THE REASONED ACTION APPROACH

The reasoned action approach is a useful framework for evaluating and predicting social behaviour, and it will provide the tools necessary to find the answers to the research questions of the thesis. This chapter will first provide an overview of the theory before detailing and explaining the components of the model and the determinants of intention one by one.

4.1 Overview and development

Whilst some behavioural theorists (e.g. cognitivist) have suggested that feelings and emotional reactions can directly alter behaviour (East et al. 2008, 22–24), through the development of their framework, Ajzen and Fishbein fundamentally reject the notion that behaviour would be significantly controlled by unconscious and overpowering desires or motives. Their argument is that humans rationally evaluate their actions and their possible outcomes before making decisions to engage in any given behaviour. The assumption that human behaviour is generally quite rational and systematically makes use of readily available information has formed the basis for Fishbein and Ajzen's theoretical work. (Ajzen & Fishbein 1980, 5.)

Ajzen and Fishbein (1969) noted at the beginning of their research collaboration in the 1960s that intention to engage in any given behaviour, and thus ultimately behaviour itself, was determined based on *attitudes toward the behaviour* in question but additionally on the presence of *normative beliefs* in relation to the behaviour. The theory of reasoned action was thus developed stating that there exist only two independent determinants of intention; attitude toward the behaviour and subjective norm (Ajzen & Fishbein 1969; Ajzen & Madden 1986). The theory of reasoned action was revised by Ajzen (1991) to include the concept of *perceived behavioural control*. Ajzen named the new revised theory as the theory of planned behaviour. Ajzen and Fishbein (2010) further developed their research resulting in the latest version of theory, which was name **the reasoned action approach** (Fig. 6).

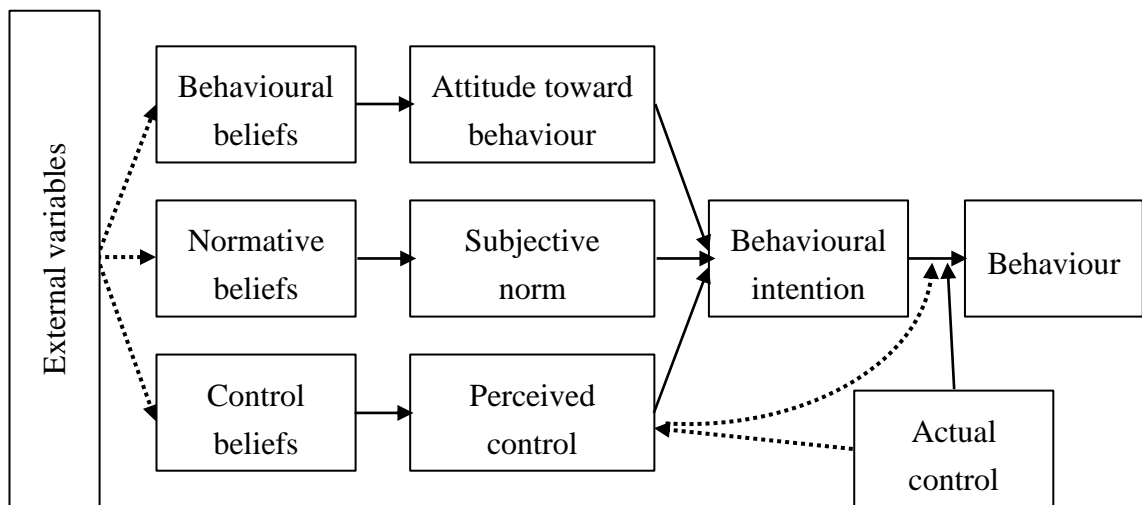


Figure 6 The model of reasoned action, modified (Fishbein & Ajzen 2010, 22)

According to the reasoned action approach, beliefs form the informational basis for all consumer thought and action, influencing the formulation of the three determinants of behaviour through the combination of their respective beliefs; *behavioural beliefs* forming attitudes, *normative beliefs* forming subjective norm and *control beliefs* forming perceptions of control. Thus, beliefs ultimately determine behavioural intentions and finally behaviour itself. The model acknowledges the influence of actual control on behavioural intention and the possibility of perceived control also influencing intentions indirectly. According to the reasoned action approach, external variables such as personality traits, only indirectly influence beliefs. (Fishbein & Ajzen 2010.)

The conceptual framework may be applied to nearly any social behaviour and it has been found to predict intentions with high accuracy (Ajzen 1991). The framework may be used to explain different levels of behaviour, such as evaluate the relative impact of attitudes, social norms or perceived control on a specific behaviour (Ajzen 1991; Arnould et al. 2004, 645–646; East et al. 2008, 131).

4.2 Beliefs

At a basic level, the reasoned action approach argues that all behaviour is a function of the salient beliefs the person has in relation to performing the behaviour in question (Ajzen & Madden 1986). From the start, beliefs have been a fundamental building block in the development of the RAA. They represent the information a person has about any given attitude object. Beliefs are associations or links that consumers form between attitude objects and specific attributes, characteristics or qualities. The attitude object may

be any aspect of the individual's world. (Fishbein & Ajzen 2010, 96–97.) In this manner, consumers form an idea and opinion of themselves and their surrounding world. These beliefs form the informational basis for all consumer thought, ultimately determining their intentions and thus behaviour.

Through the course of their lives, an individual's experiences lead to the formation of several beliefs about objects, actions and events. These beliefs are determinants of the person's attitudes towards said attitude objects. Beliefs may be formed in several different ways. They may be observed directly, indirectly by accepting information from others, such as friends or the media, or be self-generated through reasoning. Beliefs are not static. Some persist change, but over time most beliefs are subjected to some change and some are even forgotten. (Ajzen & Fishbein 1980, 62–64; Fishbein & Ajzen 2010, 96–97.)

Behavioural intentions are a class of beliefs in which the attitude object is the person himself and the attribute is a specific behaviour. (Fishbein & Ajzen 1975, 12–14.) The expectancy-value model of attitudes developed by Fishbein and Ajzen (1975) states that attitudes are based on beliefs. Attitudes are automatically and instantly formed once beliefs form a link between a specific attribute and a behaviour, or a behaviour and a specific outcome. The model, however, does not assume that attitudes are the result of conscious and deliberate construction. (Ajzen 1991; Fishbein & Ajzen 2010, 98–99).

The beliefs of an individual are a representation of the information they have of their surrounding world. *Behavioural beliefs*, or the beliefs the individual has about the possible positive or negative consequences of performing the behaviour, *normative beliefs*, beliefs about the approval or disapproval of their important others, and *control beliefs*, beliefs about the perceived ease or difficulty of the behaviour result in the construction of attitudes, subjective norm and perceived control, which in turn are the determinants of intention. An individual's intention to perform a behaviour determines their actual behaviour. (Ajzen & Fishbein 1980, 79; Ajzen & Madden 1986; Ajzen 1991.) There is an abundance of evidence to support the clear relations between behavioural beliefs and attitudes toward the behaviour, normative beliefs and subjective norm and control beliefs and perceptions of control, but the exact nature of them remains unclear still (Ajzen 1991).

Any changes in one of the determinants, intention or behaviour in general must be the result of the addition of new beliefs or changes in existing ones (East et al. 2008, 137). Since beliefs are formed based on information, differences in beliefs between consumers may at least partly be attributed to differences in available information or knowledge (Chisnall 1985, 69). Through the acquisition of new information, the belief basis changes. When entering a new marketplace, consumers do not have knowledge of all the information available, but through multiple purchases new information and new beliefs are acquired, be they positive or negative. It could be argued, thus, that consumers with more experience additionally have higher intentions. (East et al. 2008, 138.)

Even though we may associate numerous beliefs with an attitude object, all these beliefs are not readily available in the mind at the same time. In general, when thinking about a specific attitude object, primarily only about five to nine *salient beliefs* can be retrieved and act as determinants of attitude and intention. (Ajzen 1991; Fishbein & Ajzen 2010, 98–100.) In most situations, these salient beliefs are the immediate determinants of an attitude, and they can be strengthened, weakened or changed over time (Ajzen & Fishbein 1980, 62–64; Ajzen 1991).

4.3 Determinants of intention

Most of the decisions consumers face are multi-attribute. This means that during the process of decision-making they are faced with multiple issues, influences and environmental barriers, which may each affect the final purchase decision. (East et al. 2008, 120; Solomon et al. 2010, 293.) However, the work of Fishbein and Ajzen (e.g. 1974; 1980; 1991; 2010), offers a far simpler description of the influences on consumer behaviour. The reasoned action approach states that there exist only three independent variables, which determine behavioural intention; *attitude toward the behaviour*, *subjective norm*, and *perceived control*.

4.3.1 Attitude toward behaviour

Consumers are constantly under the influence of numerous global trends and subjected to individual factors that may each result in subtle changes in attitudes (Chisnall 1985, 76). Attitudes are not exact indicators of behaviour, but they are useful in explaining and predicting possible behavioural patterns (Chisnall 1985, 69). Attitudes exist to serve some specific function and are determined by a person's motives. Consumers may have similar attitudes but for completely different reasons. (Solomon et al. 2010, 275–277.) Attitudes are consumers' feelings about any given concept. In explaining behaviour, one class of such concepts is especially significant; *actions*. (East et al. 2008, 119.)

Multi-attribute attitude-models assume that attitudes depend on a combination of several *beliefs* about attributes that are related to the object of the attitude. Basic models usually combine and specify at least three elements, which are attributes, beliefs and importance weights. However, a significant problem with many research instances has been that results have shown relatively little correlation between attitude and behaviour, which has caused many researchers to question whether attitudes have any actual significance in predicting behaviour. (Chisnall 1985, 80; Solomon et al. 2010, 288.) The issue of increasing evidence through empirical findings that have suggested relatively low or even

nonsignificant relations between predictors of attitude and behavioural criteria has been addressed by Fishbein and Ajzen (1977; 1980, 24–25, 27). They conclude that such findings are the result of inconsistencies within target and action elements when measuring attitudes and their corresponding behaviour. It is crucial to measure the correct attitude in relation to the target action; attitude toward the behaviour, not the attitude object itself.

Over the years, numerous definitions for attitude have been offered by researchers. Fishbein and Ajzen view attitude simply as a consistent, general feeling of favourableness or unfavourableness toward a concept or object, that predisposes action (Fishbein & Ajzen 1975, 6; Ajzen & Fishbein 1980, 54; Fishbein & Ajzen 2010, 76, 125). They argue that, whilst other researchers have attempted to define reasons for and consequences of attitudes by assessing complicated concepts of perception, motivation, belief, intention etc., there is no useful outcome of treating these concepts as part of attitude, but rather as separate concepts that may individually relate to the formation of attitudes. Evaluation is seen as being the most important aspect of attitude. Attitudes refer to an individual's subjective evaluation of their own performance in relation to a behaviour, not of the behaviour in general. (Ajzen & Fishbein 1980, 54–56; Fishbein & Ajzen 2010, 76.) Attitudes are determined on the basis of an individual's beliefs that an attitude object has specific attributes and further by how those attributes are evaluated (Fishbein & Ajzen 1975, 14).

Perception is always a subjective phenomenon in the sense that every individual will build their attitudes based on their history and existing beliefs. Furthermore, consumers' perceptions may change over time when they are exposed to new information or their needs develop and change. (Chisnall 1985, 23–24.) The period of time that elapses between attitude and behaviour measurement may additionally explain some discrepancies between measured attitude and actual behaviour. Consumers may be subjected to new information or circumstances that causes a change in attitudes. (East et al. 2008, 129; Solomon et al. 2010, 292.) In decision-making situations, people additionally form attitudes towards several other factors than the object of the purchase itself, which can significantly influence the final outcome (Solomon et al. 2010, 280).

Attitudes consist of three basic components; affect, cognition and conation (Chisnall 1985, 69–70; Arnould et al. 2004, 636, 660). *Affect* refers to an individual's feelings and evaluation of an attitude object, person, issue or event; *cognition* to their knowledge, opinions, beliefs and thoughts of it and *conation* refers to their behavioural intentions and actions in relation to it. Fishbein and Ajzen (1975, 12–13) suggest that since when dealing with attitudes the concern is focused on underlying predispositions to behave rather than with the actual behaviour itself, it is necessary to include behaviour as a fourth category in the classification of attitude. In later research (2010, 82–83) they preferred to use more neutral terms for cognitive and affective; instrumental and experiential.

All consumer behaviour occurs within a cultural and social context. The different behaviours of consumers are the result of unique development through societal and cultural

influences. Consumers' behavioural motivations are developed based on their interpretations of macro-environmental factors such as consumer culture and global influences, local context and social networks such as close family members or important communities in addition to their own personal history, circumstances and life themes. (Arnould et al. 2004, 261-263.)

Attitudes serve a basic function of helping consumers manage in their different environments. Not all attitudes are readily available or accessible and they differ in their relative strengths. (Arnould et al. 2004, 632, 660.) Ultimately, attitudes are determined by readily accessible, salient beliefs about possible positive or negative consequences of a given behaviour. When assessing possible attitudes toward a behaviour it is of crucial importance to additionally investigate attitudes towards *not* performing a behaviour, which may have very different consequences compared to performance of the same behaviour. (Ajzen & Sheikh 2013.) Attitudes follow directly from beliefs about the attitude object. Attitudes are automatically and instantly formed once beliefs form a link between a specific attribute and a behaviour, or a behaviour and a specific outcome (Ajzen 1991; Fishbein & Ajzen 2010, 98–99).

4.3.2 *Subjective norm*

Social comparison theory states that when evaluating one's own attitudes and abilities people have a need to compare their feelings to similar others, guiding and shaping their behaviour. This holds true especially in instances where there is no right or wrong answer. (Arnould et al. 2004, 603–607; Dittmar 2008, 20.) *Subjective norm* refers to the person's conception that most people who are important to them consider the behaviour in question either good or bad, or that important others are themselves performing or not performing the behaviour. The term subjective underlines the fact that these perceptions may or may not be accurate. According to Fishbein and Ajzen, the more a person's important others are in favour of a given behaviour, the more that person will be inclined to behave according to that behaviour. Thus, in most cases people hold favourable attitudes towards behaviours they feel that their important others think they should perform. However, sometimes these two components contradict each other, which is when their relative importance comes into play. This relative importance can also be influenced by external variables, such as age, sex or personality traits. (Ajzen & Fishbein 1980, 57–59; Fishbein & Ajzen 2010, 131)

The influences that an individual's social contexts may have can be identified as either normative (attempting to avoid a sanction or gain a reward), value-expressive (desiring to be socially or psychologically affiliated with others) or informational (using the behav-

behaviour of others as evidence of reality). Often the influences of others cannot easily be separated into these different forms. (Arnould et al. 2004, 594–599, 617.) The anticipation of social rewards or punishment is by no means a prerequisite for social pressure to have an influence on behaviour (Fishbein & Ajzen 2010, 130–131). Subjective norm is an internal influence, thus for a person to perceive social pressure the cause of the pressure does not need to be present or even exist (East et al. 2008, 130).

4.3.3 *Perceived control*

Some theories have failed to consider the fact that consumers are not necessarily completely free in their decisions. For example, they may be pressured by a time constraint, or lack of alternatives, unable to truly reject all unattractive alternatives. (East et al. 2008, 14–15.) Perceived behavioural control was added to the theory of reasoned action and it was renamed the theory of planned behaviour by Ajzen (1991), significantly improving the prediction of intentions and explaining more variation (Ajzen & Madden 1986; Madden, Ellen & Ajzen 1992; Ajzen 2002). It refers to the extent to which people perceive they have the skills and necessary capabilities to engage in a behaviour and can *control its performance*. A person may have formed a positive attitude toward a behaviour and even perceive social pressure to perform it, but if that person does not believe they have sufficient control over the behaviour, their behavioural intention will remain weak at best. (Fishbein & Ajzen 2010, 154–155.)

Any behaviour is, at least to some extent, under the influence of certain factors outside of the person's control. These factors may be internal or external. Internal factors may include skills, abilities or sufficient knowledge and external factors might consist of money, time, resources or even the cooperation of others. (Ajzen 1985; Ajzen & Madden 1986; Fishbein & Ajzen 2010, 154–155, 177.) Perceived control takes these factors into account and additionally considers the possibility of barriers or obstacles impeding behaviour. The amount of control factors varies from behaviour to behaviour.

What is important to note and of greater psychological importance, however, is the difference between actual control and the person's own perception of the amount of control they have over a specific behaviour (Ajzen 1991). Whilst attitudes and subjective norms have an indirect effect on behaviour, mediated through intentions, perceived control can influence behaviour directly as well as indirectly (Fishbein & Ajzen 2010, 217). If a person holds complete control over a specific behaviour, intentions should suffice in behavioural prediction. However, once a person's volitional control over a behaviour decreases, the dimension of perceived control will provide a useful addition. Individuals who believe they possess more resources and skills required for some behaviour and anticipate fewer obstacles in their way, have greater perceptions of control. (Ajzen 1991.)

Perceived control is seen to consist of two subcomponents, *capacity* and *autonomy* (previously termed self-efficacy and controllability). Capacity refers to the actor's beliefs that performing the behaviour will be easy or difficult and that they are capable of it, whilst autonomy refers to the degree to which performance of the behaviour is up to the actor and their perceptions of the amount of control they have over the behaviour. Despite some common assumptions, there exists no empirical support for the idea that autonomy would mainly consist of external factors and capacity of internal factors. On the contrary, it is evident that these components may both reflect internal as well as external factors. Whilst factor analyses reveal a clear distinction between the two, they are not incompatible with or independent of each other. (Ajzen 2002; Fishbein & Ajzen 2010, 177)

4.3.4 *External variables*

The potential importance of general attitudes, individual personality traits, demographic variables etc. is recognized in the reasoned action approach. These variables may possibly influence a person's beliefs; but they do not constitute an integral part of the theory. Instead they are seen as *external variables*. It is important to note that these external variables are seen to have no influence on the relation between a given external variable and behaviour, only possibly indirectly affecting the determinants of that behaviour. One disadvantage of attempting to explain behaviour through such external variables is that different behaviours are affected by different variables. (Ajzen & Fishbein 1980, 9; Ajzen 1991.) Neither demographic characteristics nor general personality traits account for much variance in any particular behaviour. They can explain broad patterns or aggregates of behaviour, but they do a poor job of predicting specific actions. (Fishbein & Ajzen 2010, 17.)

4.4 Behavioural intention

A central factor in the RAA is the individual's intention to perform a specific behaviour. *Behavioural intentions* are a class of beliefs in which the attitude object is the person himself and the attribute is a specific behaviour. Behavioural intention can be defined as the intention a person has to perform those various behaviours. (Fishbein & Ajzen 1975, 12–14.) This intention is a measure of the likelihood that a person will engage in any given action, indicating the strength of the person's general motivations to perform the behaviour in question (Ajzen & Fishbein 1980, 42; Ajzen & Madden 1986; Ajzen 1991;

Fishbein & Ajzen 2010, 39). Intention to perform a behaviour always precedes the behaviour in question. The strength of this intention ultimately determines the likelihood of the person actually performing the behaviour. (Ajzen & Madden 1986.)

The principle of compatibility states that in order to obtain accurate results when measuring the relationship between intention and behaviour, intention and its corresponding behavioural criterion must be compatible in their action, target, context and time elements and each of their various levels of generality and specificity, (Ajzen & Fishbein 1980, 42; Ajzen 1991; Fishbein & Ajzen 2010, 29–32, 44, 75). Although behavioural intentions help predict behaviour, they alone do not explain why a given behaviour is, or more importantly, is **not** performed (East et al. 2008, 127). Additionally, behavioural intention is able to predict behaviour only if the person has *volitional control* over performance of the behaviour. Most behaviours depend at least to some extent on several factors outside general motivational factors, such as time, money and the skillsets of others. These factors represent the amount of *actual control* the person has over performance of the behaviour. (Ajzen 1991)

For a consumer to engage in a specific behaviour, they must a) have formed a strong positive intention to perform the behaviour, b) have no environmental constraints that may restrict performing the behaviour or prevent it entirely and c) have the necessary skills required to perform the behaviour in question. Additionally, strong behavioural intention is the result of the person a) believing that the advantages of performing the behaviour are greater than any possible disadvantages, b) perceiving more social pressure to perform than not perform the behaviour, c) perceiving that performance of the behaviour is consistent with their self-concept, d) having a mostly positive emotional reaction to the idea of performing the behaviour and finally e) perceiving they actually have the capability to perform the behaviour under different circumstances. (Fishbein & Ajzen 2010, 19.)

Problems with control are not apparent with simple behaviours such as grocery shopping or attending lectures, but as the behaviour increases in involvement and complexity, individuals start to face more issues with control. Thus, behaviours might be more easily comprehended as goals and intention as a plan of action in attempting to achieve these goals. (Ajzen 1985.)

4.5 Changes in intention

Once individuals engage in a behaviour, unforeseen positive and negative consequences can occur, such as reactions from important others or unanticipated obstacles or difficulties. These consequences will result in changes in the individual's belief basis and cause

changes in possible future intentions and behaviour. (Fishbein & Ajzen 2010, 217.) Unforeseen, intervening events debilitate the relationship between intention and behaviour. Original intentions may be changed as the result of new information being acquired, which may change behavioural, normative and/or control beliefs. (Fishbein & Ajzen 1974; Ajzen & Madden 1986; Ajzen 1991.) Performance of most behaviours requires a sequence of prior actions. The greater the number of intervening steps, the lower the intention-behaviour correlation is likely to be. At any point of the behavioural sequence new information may become available that might produce a change in the individual's intention. (Fishbein & Ajzen 2010, 57)

For intention to correlate strongly with behaviour, certain requirements must be met. The measure of intention and the behavioural criterion must first match in their level of generality. If the behaviour of interest has to do with e.g. getting breast implant surgery after childbirth, intentions must also be assessed in relation to this specific behaviour. Secondly, it is important to consider that intentions do not necessarily remain stable over time (Ajzen & Madden 1986; Ajzen 1991; Fishbein & Ajzen 2010, 56) and the longer the period of time is between measuring intention and observing behaviour, the more likely it is that intentions will have changed. (Ajzen & Fishbein 1977; Ajzen & Madden 1986.)

The relative importance of the three separate variables will undoubtedly vary between different behaviours and different populations. In any given population, one behaviour may depend predominantly on subjective norm, whilst another may be influenced mostly by attitudes. When creating marketing communication strategies, it is important to first resolve how the different variables influence behaviour in the population under consideration. (Fishbein & Yzer 2003, 167.) The different determinants of intention each explain a separate part of behaviour and can independently serve as different points of attack when attempting to change behaviour (Ajzen 1991). In situations where people are not acting on their intentions, the cause might be insufficient skills or the presence of obstacles or environmental constraints. Any business or marketing strategies attempting to get people to act on their intentions will need to target these issues. The strategies required to help people with existing positive intentions overcome any obstacles they might experience are fundamentally different from strategies attempting to simply generate positive intentions. (Fishbein & Yzer 2003, 167, 180–181)

Any measures of attitudes, subjective norm or perceived control are redundant without a basis on the beliefs of that specific population about performance of the behaviour under investigation. Investigators need to directly ask members of that population about their salient beliefs regarding the three variables in order to gain a full understanding of that behaviour from the perspective of the population. (Fishbein & Yzer 2003, 168.)

5 SUMMARY OF THE THEORETICAL FRAMEWORK

The purpose of this thesis is to uncover how and why consumers make decisions about utilizing cosmetic surgery services. On a managerial level, the research aims to identify reasons why potential target consumers do *not* wish to utilize cosmetic surgery. For this purpose, it is necessary to identify beliefs consumers associate with utilizing cosmetic surgery and further how these beliefs translate into barriers to a purchase decision. Thus, the following research questions were proposed:

RQ1: What is the nature of the consumer decision-making process when purchasing cosmetic surgery services?

RQ2: What beliefs do consumers associate with utilizing cosmetic surgery services?

RQ3: How do these beliefs translate into possible barriers for purchase?

The research began with a literature review. Professional services and health services were assessed in order to identify their salient differences from other service products and uncover unique aspect of consumer behaviour in relation to their purchase. After this, cosmetic surgery was introduced and assessed as research context. The literature uncovered important aspects of consumer behaviour within the cosmetic surgery industry. The third theoretical chapter focused solely on the reasoned action approach and using it as a tool to measure and predict behaviour.

Professional services have unique and distinct characteristics that set them apart from other goods and services. Health care services have a high number of all these distinct characteristics (Lian & Laing 2004). These characteristics were summarized and described through four separate dimensions; *complexity*, *involvement*, *trust* and *perceived risk*. The buying process is typically depicted as consisting of five differing steps, ending in purchase decision and post-purchase behaviour (Kotler et al. 2008, 155). Thus, the consumer's decision-making process consists of the three steps leading up to the purchase decision; *problem recognition*, *information search* and *evaluation of alternatives*. However, especially in relation to the purchase of health services, decision-making is rarely as straight-forward as this, but instead involves numerous complex factors and obstacles which consumers must face. With high-risk and complex services, indirect or even seemingly unrelated factors may have a substantial effect on the consumer's decision-making process (Baron et al. 2009, 69–70). Further, it was shown that cosmetic surgery has some unique implications as a research context and that consumers of cosmetic surgery have specific characteristics that set them apart from other industries.

The reasoned action approach states that the determinants for any behaviour consist of attitudes, subjective norm and perceived control in relation to the behaviour, and ultimately of their corresponding beliefs; behavioural beliefs, normative beliefs and control beliefs. For investigators to begin measuring these determinants for any behaviour, this

behaviour must first be defined in terms of its action, target, context and time elements (Ajzen & Fishbein 1980, 42; Ajzen 1991; Fishbein & Ajzen 2010, 29–32, 44).

Figure seven combines all the elements of theoretical portion of this thesis in a comprehensive framework and illustrates how the framework will provide answers to the research questions.

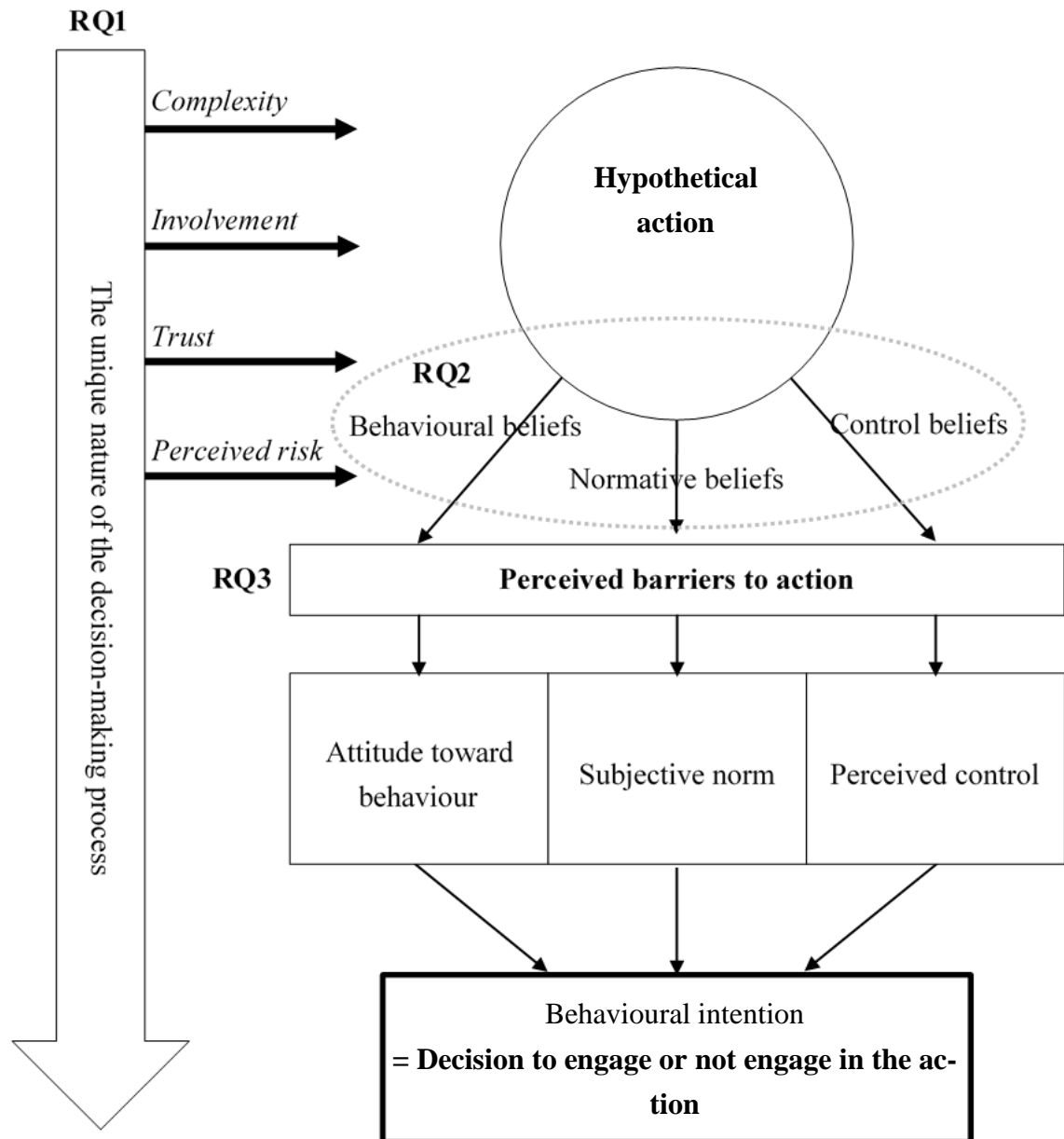


Figure 7 Theoretical framework

The above figure (Fig. 7) illustrates the theoretical framework of this research paper. Any hypothetical action is associated with several behavioural, normative and control beliefs in the consumer's mind. The idea of a hypothetical action also acts as the beginning of the consumer's decision-making process. The complexity, involvement, trust and

perceived risk -dimensions of professional health services all influence the beliefs of consumers. The combination of these beliefs may form perceived barriers to action in the consumer's mind. Through these beliefs and barriers, consumers ultimately form attitude toward behaviour, subjective norm and perceptions of control, which combine to create behavioural intention to engage or not engage in the defined action.

6 METHODOLOGY

In this chapter the methodological choices of the empirical research will be explained and justified. The following subchapters will focus on explaining the necessity of an interpretive and phenomenological approach to the proposed research questions and describe the methods of utilizing the reasoned action approach in research design and data collection and -analysis. Finally, the methods of the empirical study will be evaluated and assessed.

6.1 Research approach

The health care service industry is a unique and extremely important area for research (Berry & Bendapudi 2007; Ghosh 2015), where the nature of the service is highly personal and often involves a significant emotional component (Thomas 2008, 4, 6). This study is an exploratory investigation into consumers' decision-making and purchase behaviour in relation to cosmetic surgery. Exploratory studies aim to uncover new information about a topic area and offer insight into phenomena that is not yet clearly understood. Results are not proposed as definitive conclusions or facts, but as offering tentative ideas and interpretations. Exploratory studies are extremely flexible, often inductive by nature. (Saunders & Lewis 2012, 110–111.) The purpose of this thesis is to uncover how consumers make decisions about utilizing cosmetic surgery services, which involves uncovering descriptions of decision-making processes, identifying beliefs consumers associate with utilizing cosmetic surgery and further how these beliefs translate into barriers to a purchase decision. The subject matter, cosmetic surgery, is an extremely intimate and sensitive topic area. Answering the research questions requires a rich, extensive comprehension of the reasons behind consumers' behaviour and decision processes. For these reasons, a qualitative study is most suitable.

Qualitative studies provide rich insight into individuals' subjective experiences and evaluations of their surrounding world, which are constructed via social interaction and interpretation (Flick 2002, 4–7; Daymon & Holloway 2011, 7–13; Merriam 2014, 23). This interpretivist, sometimes called constructivist, paradigm sees that humans are social actors and individuals' realities, experiences, behaviours and beliefs are all constructed and actively shaped through interpretations of their environments and influenced by social relationships (Daymon & Holloway 2011, 102; Saunder & Lewis 2012, 106). Individuals lives are not independent and isolated from each other, but exist in a shared reality (Daymon & Holloway 2011, 182).

The focus of interpretivism is to *understand* a phenomenon; it accepts the existence of multiple realities and that all individuals have differing perspectives and interpretations of their surrounding world, and that any phenomenon must be considered and understood

via the specific contexts it occurs in. Thus, in contrast to positivists who seek to obtain knowledge which allows for large generalizations or explanations relying on hard facts and evidence, interpretivists focus on gaining a comprehensive understanding of all aspects of a specific phenomenon, through the interpretations of e.g. thoughts, experiences, beliefs and feelings. (Carson, Gilmore, Perry & Gronhaug 2001, 5–7.) The nature of this thesis calls for a phenomenological approach to the research problem; the goal is to uncover the *essence* of a specific behaviour through the lived experiences of individuals, the deep emotions of consumers and interpret meanings behind subjective, individual experiences (Daymon & Holloway 2011, 110, 180–181; Merriam 2014, 23–27).

Interpretivist research often uses existing theory as a guide in formulating a loose basis for their investigation, an initial idea of the phenomenon under study. The goal of the research is not to confirm nor reject this idea, but rather uncover what the *actual reality* of the phenomenon under investigation is (Carson et al. 2001, 63). An inductive approach to research permits flexibility and changes in research emphasis during the investigation. With induction, the research and collected data will ultimately guide the building of theory, moving from smaller observations to larger interpretations and theories. (Carson et al. 2001, 12; Saunders & Lewis 2012, 109–110).

6.2 Research design

In order to comprehensively answer all three research questions, this study will combine semi-structured, in-depth interviews with the process of elicitation, as introduced by behavioural literature. On its own, the elicitation process is a well-established tool in behavioural sciences, and it could well provide satisfying answers for RQ2 and RQ3, but to gain the necessary insight for RQ1, the standard elicitation must be expanded to incorporate some important aspects of semi-structured interviewing. The full structural guide used in the interviews can be found in Appendix 1.

6.2.1 *Semi-structured interviews*

RQ1 aims to identify what the nature of the decision-making process is when purchasing cosmetic surgery services. Whilst the elicitation process will undoubtedly also provide valuable information in understanding the decision-processes related to utilizing cosmetic surgery, it is specifically designed to only uncover salient behavioural, normative and control beliefs in a population. Because of this, it is necessary to expand the standard process of elicitation to include aspects of in-depth, semi-structured interviewing.

By nature, semi-structured interviews would provide a natural extension of the elicitation process, compared to e.g. unstructured interviews. Like semi-structured interviews (Hopf 2004, 204; Daymon & Holloway 2011, 220–225; Berg & Lune 2012, 108–114), the elicitation process follows a specific structure and the questions are designed to be open-ended, and thus permit flexibility. After each question, the researcher asks if the respondent can think of anything else in relation to the question asked. The lack of any predetermined structure in unstructured interviews, and the assumption that the researcher should mainly act as a listener (Hopf 2004, 206) might cause for the interviews to veer seriously off-topic. Furthermore, it would be confusing and inconvenient for the interviewee to mix the relatively structured situation of elicitation with the free-flowing nature of unstructured interviews. Thus, mixing the methods of semi-structured interviews with the elicitation process is natural, convenient and appropriate.

The use of interviews is especially useful in situations where the researcher is unsure of the answers the respondents will give, or the questions may be perceived as complex (Saunders & Lewis 2012, 151). The main asset of semi-structured interviews is first and foremost their flexibility. They allow for the reordering and rewording of questions and other adjustments; the interviewer may answer questions and in turn ask for clarifications, attempting to probe further into a specific topic. Through the course of the interview, surprising topics may come to light which could not be addressed without the flexibility offered by semi-structured interviews. (Hopf 2004, 204; Berg & Lune 2012, 108–114.) The narrative nature of interviews allows for the revelation of thoughts, ideas and memories that might not have been uncovered through direct questioning (Hopf 2004, 207).

A second important aspect justifying the use of in-depth interviews as a research approach, is the extremely sensitive and intimate nature of the phenomenon under investigation. Through interviews, the researcher is able to record and analyse respondents' subjective experiences and perspectives about a phenomenon, and openly enquire about motivations and feelings related to the subject (Hopf 2004, 203). One-on-one interviews, conducted in person, allow for the creation of trust between researcher and respondent. It is crucial for the respondent to feel comfortable and at ease, and equal to the interviewer.

The open-ended research questions will be designed to provide insight into the respondent's relationship with cosmetic surgery and attempt to uncover the steps of a potential decision-making scenario. Examples of these questions will be provided in Appendix 1.

6.2.2 *The elicitation process*

RQ2 and RQ3 focus on uncovering the beliefs consumers associate with utilizing cosmetic surgery and how these beliefs translate into barriers to action. The elicitation process is a widely-used method by behavioural researchers to identify the *salient beliefs* held by a specific population in relation to a specific action or behaviour (e.g. Ajzen & Fishbein 1980; Middlestadt et al. 1996; Francis et al. 2004; East et al. 2008, 122–123; Fishbein & Ajzen 2010). It is fruitless for any investigator to attempt to measure the different variables that affect behaviour in a specific population without first asking members of that population what they believe about the behaviour under investigation (Ajzen 1991; Fishbein & Yzer 2003, 168). Questionnaires based on intuitively or randomly selected beliefs on behalf of the researcher will evidently include beliefs that are not important for decision-making in the population of interest. Attitudes that are measured based on responses to such beliefs will not correlate strongly, and any items that are not salient waste time and space in questionnaires (Ajzen 1991; East et al. 2008, 136).

In an elicitation, respondents are asked about what they believe are the advantages and disadvantages of performing a behaviour, and the beliefs that come first to mind are the salient beliefs that primarily affect that individual's attitudes and behaviour (Ajzen 1991; Fishbein & Ajzen 2010, 100). The process is designed to elicit salient behavioural, normative and control beliefs in a target population. Different individuals will naturally have differing beliefs in relation to a specific behaviour. These differences make it difficult to draw conclusions of the general beliefs of a specific population, and submit results to quantitative analysis. Thus, researchers must elicit beliefs from a representative sample of the population and form *the modal set of salient beliefs* from those that are stated most frequently. (Ajzen & Fishbein 1980, 68; Fishbein & Ajzen 2010, 102.) When eliciting salient beliefs, it is important to not pressure consumers to uncover any subconscious or underlying beliefs, since any belief that needs to be uncovered from the deep psyche is thought to be irrelevant in actual decision-making scenarios (Fishbein & Ajzen 1975).

Next, the process of elicitation, as explained by e.g. Middlestadt et al. (1996), Francis et al. (2004) and East et al. (2008, 122–123), will be described and detailed:

The crucial first step of the elicitation process is to *clearly define the action under investigation*. Behaviour can be measured in relation to action, target, context and time, and varying the level of specificity of any of these elements allows for the definition of any behaviour in terms of its generality and specificity (Fishbein & Ajzen 2010, 71). As stated in chapter 4.3, it is imperative that when identifying beliefs related to a specific behaviour, the levels of generality and specificity of the behaviour are clearly defined (Ajzen & Fishbein 1980, 42; Ajzen 1991; Fishbein & Ajzen 2010, 29–32, 44, 75). For the purposes of this thesis, the action is defined as “*utilizing cosmetic surgery*”. The target

of the behaviour are the respondents themselves, but defining context (where/in what situation) or time was seen as potentially restrictive to the scope of the interviews, and thus deemed unnecessary.

After defining the action under investigation, it is imperative to determine the population of interest. The target group for the research must be clearly defined, and this will be explained and detailed fully in chapter 6.3. Once these definitions have been made and the reasoning behind decisions has been clarified and justified, the actual elicitation of beliefs held in the target population can begin.

The process begins with the elicitation of behavioural beliefs. These beliefs are elicited by asking respondents about the advantages and disadvantages of performing the defined action. Carson et al. (2001) note, that research quality is improved through the inclusion of negative case analysis in the research, which basically attempts to uncover exceptions to perceived rules. This is addressed in the elicitation process next by asking respondents to in turn identify the possible advantages and disadvantages they associate with *not* performing the defined action. The elicitation must be carried out with discretion, after each question inquiring if anything else comes to mind, but careful not to press too hard for a continued response, continuing until the respondent can think of nothing more to state.

The elicitation continues with the identification of normative beliefs and control beliefs. Normative beliefs are uncovered by asking respondents to identify any individuals or groups who might be inclined to encourage or discourage performing the action. Control beliefs, in turn, are uncovered by asking respondents if there exist any conditions or factors that would make the action easier or harder, even impossible, to perform. Middlestadt et al. (1996) additionally include an open-ended question, in which the respondent is asked to describe a stereotypical someone who would be actively inclined to perform the behaviour in question and, in contrast, someone actively disinclined to do so. Thus, the process of elicitation should be able to provide comprehensive insight into the beliefs of the respondents which will allow for the thorough investigation of all research questions.

6.3 Interviewee selection

An important step of the elicitation process is to clearly define the population whose behaviour the research is interested in. This study was conducted with the help of a private sector health care company who had recently opened a clinic for cosmetic surgery procedures. According to the service provider, the two major consumer segments for cosmetic surgery are as follows:

1. Women in their 30s and up, looking to correct changes brought on by pregnancy.

2. Women in their late 50s and up, looking to prevent or diminish signs of aging. This segmentation is supportive of recent statistical data about cosmetic surgery consumers (Cosmetic surgery – – 2015).

The individuals approached about participating in the study were selected to equally represent the characteristics of the two major consumer segments of cosmetic surgery. Thus, the selection of respondents was based on their age and/or life-situation in order to gain equal amounts of interviews from each consumer segment. Furthermore, in order to gain a full understanding of the consumer's decision-making process at different stages of the process, it was decided to include both respondents who had recently purchased cosmetic surgery, referred to as *existing consumers*, and respondents who merely considered to belong to the target segments, referred to as *potential consumers*. This research used a combination of *quota sampling* and *purposive sampling* (Berg & Lune 2012, 52–53; Saunders & Lewis 2012, 137–139). In addition to being a logical and suitable choice for the purposes of this investigation, purposive sampling is additionally a technique that can improve the quality of research results in qualitative studies (Carson et al. 2001, 68). The group of potential consumers were purposively selected by the researcher through their network of acquaintances, whilst the selection of participants for the group of existing consumers was made by clinical staff, whom were given instructions about the required characteristics of the respondents.

One respondent in the group of potential consumers was slightly younger than the indicated target segment, but was chosen due to her life-situation; she had recently given birth to her second child. The second group of respondents, the existing consumers, were all current clients of the healthcare company. To ensure patient confidentiality, the respondents were initially approached by clinical staff on behalf of the service provider, and asked about their willingness to participate in this study. Upon agreement, they obtained permission to deliver necessary contact details to the researcher, whom contacted the respondents in order to set up a time and place for the interviews. With semi-structured interviews, it is useful to avoid determining the number of research participants in advance, but instead continue conducting interviews until *data saturation* is reached (Saunders & Lewis 2012, 159). In the case of this study, data saturation was reached quite early; thus, a total of eight consumers, four potential consumers and four existing consumers, were interviewed.

Triangulation is a research strategy which involves combining data from multiple information sources or different times, places or people (Flick 2004, 178; Berg & Lune 2012, 6), in order to avoid the distortion or one-sidedness of data and ultimately lead to a more comprehensive understanding of the research phenomenon (Steinke 2004, 185). Thus, it was decided to additionally interview two industry professionals: aesthetic nurses from behalf of the service provider. Each nurse had a significant career in the industry and substantial experience with cosmetic surgery consumers. Aesthetic nurses are often

the first contact with the service provider the potential consumer has, and are thus faced with all the worries and inquiries of the consumers before they make a purchase decision. Thus, they are potentially able to provide significant further insight into the behaviour and beliefs of cosmetic surgery consumers. A visualisation of the research interviewees is provided in the following figure (Fig. 8).

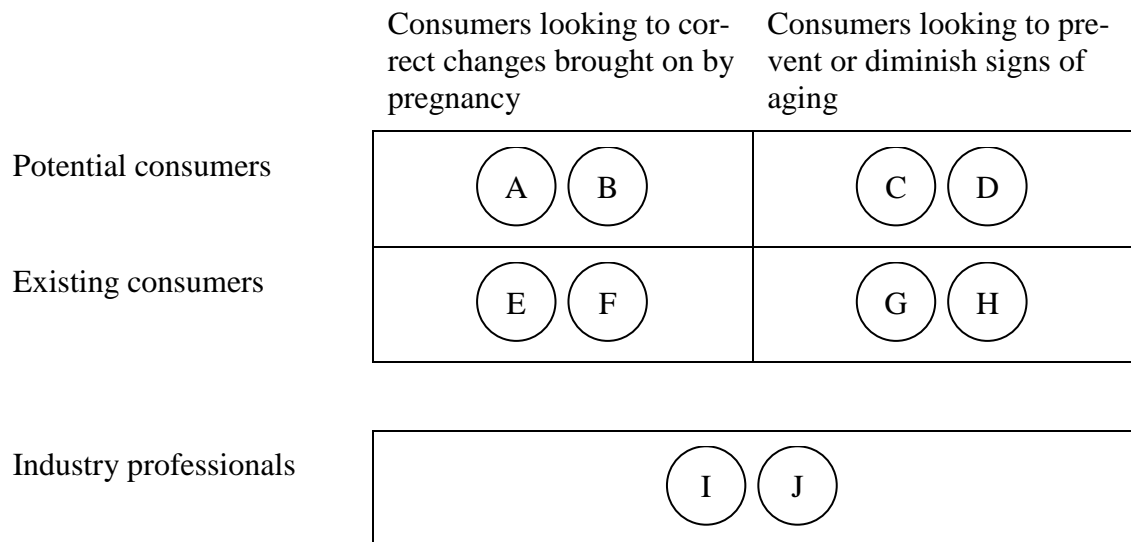


Figure 8 Interviewees

As depicted in the figure, the ultimate group of interviewees consisted of a total of four consumers from the younger target segment and four consumers from the older target segment. Furthermore, it consisted of a total of four potential consumers and four existing consumers, with two representatives from each respective consumer segment. The principle of triangulation was applied to additionally include two industry professionals.

6.4 Conduction of interviews

The interviews were conducted on the terms of the interviewees; some wanted to be interviewed in their home, some in a coffee shop and some suggested the library. This ensured that the surroundings for the interview felt as natural as possible for the interviewees (Carson et al. 2001, 68). Once appropriate respondents have been acquired and researcher and respondent have reached agreement about the time and place for the interview to take place, it is the researcher's responsibility to create a suitable atmosphere in which the respondent feels comfortable and at ease to participate in the study (Hermanns 2004, 209–210; Saunders & Lewis 2012, 153). The researcher must address the goals of the study

and the role and capacity of the interviewee in order to clarify expectations and the interview must be conducted and concluded methodologically (Hermanns 2004, 209).

Respondents were initially briefed of the goal of the study, which was detailed further before the actual interview took place. All but one of the interviews were conducted face-to-face, as one-on-one interviews. A single interview, with the respondent belonging to the group of existing consumers, had to be conducted via telephone due to a significant travel distance. In this instance, the respondent was first approached on behalf of the service provider, whom obtained permission to deliver contact details to the researcher. The researcher spoke on the phone with the respondent twice; first to detail the goal of the research and set up a time for the interview and second for the actual interview to take place. The respondents were all native Finns and thus the interviews were conducted in Finnish. All interviews were recorded with the permission of the respondent. On average, the interviews lasted 45 to 60 minutes.

6.5 Data analysis

In order to use qualitative research data for analysis, it must first be reviewed, processed and organized. Data analysis often involves three components: data reduction, data display and conclusions and verification. Qualitative data must first be *reduced* for it to be manageable and understandable in analysis and *displayed* in a manner which is organized and permits for coherent *conclusions* and analysis to be made. (Berg & Lune 2012, 54–56.)

One of the most common methods of data reduction is to conduct a content analysis (Carson et al. 2001, 83–84), which is also the recommended method of Fishbein and Ajzen (1980, 68; 2010; 102). This is usually conducted in two steps: The first step involves coding each sentence or paragraph in the transcripts. During the second step the researcher evaluates and analyses the coded content and begins grouping subjects and snippets of discussion under various themes, essentially reorganizing the transcripts to reflect the purpose of the research paper.

To begin with, the audio recordings of the interviews were assessed alongside the notes of the researcher and carefully transcribed into text documents using Microsoft Word. After this, the transcriptions were translated from Finnish to English. In this instance, the researcher is bilingual and could thus effortlessly and accurately translate the data themselves. This ensured that the translated data was an accurate representation of the original language and responses of the interviewees. The process was continued by analysing the transcripts and transferring sentences and paragraphs to a spreadsheet in Microsoft Excel, where the data was grouped according to its relation to either a) *the decision-making pro-*

cess, b) *behavioural beliefs*, c) *normative beliefs* and d) *control beliefs*. Behavioural beliefs were further divided and grouped according to either *instrumental* (anticipated positive or negative consequences) or *experiential* (perceived positive or negative experiences) beliefs. In the spreadsheet, the data was additionally presented by grouping them by status: potential consumers, existing consumers and industry professionals. Finally, individual responses were colour-coded to distinguish from each other and identify their respective consumer segment.

This concluded the first half of analysis for the collected data, where data was coded according to its relation to *decision-making* and/or *belief*, providing material for RQ1 and RQ2. For the data to provide insight into RQ3, it would need to be further analysed and coded.

In the second half of data analysis, the meaning and thought behind each individual belief was assessed in order to identify what kind of *barrier* that belief could form in the consumer's mind. The spreadsheet allowed for general notes to be made of each sentence or paragraph which permitted the visualization of some general themes. During analysis, it was noted that the beliefs stated by respondents could be conveniently grouped by using the six types of *perceived risk*: financial risk, physical risk, quality risk, psychological risk, social risk and time risk. The data was thus coded and grouped accordingly.

6.6 Evaluation of the empirical study

The methods of evaluating qualitative studies have caused significant debate (Flick 2007, 5–8, 11). Qualitative studies have faced criticism over e.g. their excessive subjectivity, difficulties in replication and generalization and lack of transparency (Daymon & Holloway 2011, 10–11). Indeed, the criteria for evaluating the quality of qualitative studies differs significantly from quantitative research.

In this chapter the methodological choices of the investigation, including research approach, design, data collection and data analysis, have been presented, explained in detail and justified. Trustworthiness in qualitative research can be assessed through the dimensions of credibility, dependability and conformability, which all stem from the careful use, selection, examination and interpretation of appropriate literature; the careful justification of methodological choices and their appropriateness and value; and the careful construction of a comprehensive data analysis (Carson et al. 2001, 67–69). Justifications for methodological choices have been presented through the research alongside respective decisions. The research methods were found to be appropriate for the phenomenon under investigation (Steinke 2004, 188).

According to Steinke (2004, 187), the ability to produce inter-subjective comprehension is an important criterion for evaluation. This may be done through careful the documentation of the research process, allowing for the reader to clearly see and understand the steps the researcher has taken in their investigation and ultimately form their own judgements about the validity of the research in question, based on the evidence provided by the investigator. *Transparency* is thus crucial in the assessment and evaluation of a qualitative study. Clear and comprehensive descriptions and explanations are required for the data collection method and context, transcription and all the challenges, problems and decisions made through the course of the research process (Carson et al. 2001, 69; Steinke 2004, 187).

This research utilized *triangulation* in the selection of its respondents. The triangulation of data is a strategy of validation and justification through the means of acquiring more data and knowledge about the subject phenomenon. It involves combining data from multiple information sources or different times, places or people (Flick 2004, 178; Berg & Lune 2012, 6). The goal is to avoid the distortion or one-sidedness of data and lead to a more comprehensive understanding of the research phenomenon (Steinke 2004, 185). Triangulation was achieved by using three different groups of respondents: potential consumers, existing consumers and industry professionals.

Special care was taken in the creation of interview-situations, to ensure that data collected was being told truthfully and sincerely. Interview-situations should be assessed and characterized through their openness, trust, willingness to collaborate and little to no perceived power-differences between researcher and interviewee (Steinke 2004, 185). The data obtained from the interviews was appropriate and relevant to the purpose of the thesis. This investigation will contribute to the general understanding of the decision-processes consumers face when purchasing cosmetic surgery, and provide insight into the beliefs consumers associate with the fast-growing cosmetic surgery industry.

7 RESULTS

7.1 The decision-making process

All respondents in the group of potential consumers agreed that the first step in their information search would be the internet. Respondents in both consumer groups indicated that special areas of interest would be pricing, risks, service provider qualifications and searching for similar experiences, either via online chatrooms or through personal contacts. Respondents expressed their doubtfulness over the reliability of information found in chatrooms, but nevertheless stated their willingness to use them for information.

I would probably begin searching online. -- start with the price, and then research risks. -- try to look for similar experiences, -- and I would ask my family and friends for opinions.

(Female A, 27)

I believe that today the first step would be to find things out for yourself, do some research; read magazines, google cosmetic surgery, -- read about other similar cases. Or if you happen to know someone who has undergone something similar -- go and ask (them) about it.

(Female C, 58)

Most respondents indicated their preference for the internet as their initial source of information, but did not hesitate to mention contacting possible service providers about risks, potential benefits and similar experiences. One respondent additionally expressed their doubts over being able to acquire objective information directly from the service provider and stated this as one of the reasons for using the internet for their information search.

Each respondent from the group of existing consumers mentioned a long period of internal contemplation before contacting a service provider. During their contemplation, the women from the younger target group (group 1) had conducted personal information search online and obtained opinions and experiences from important others. Interestingly, the respondents in the older target group (group 2) did not mention conducting any information search e.g. online, but rather contacting the service provider straight away for information, after the initial period of contemplation. At this point, however, both respondents' minds were already nearly made.

I thought about it for a year, struggled with myself and finally counted my pennies and reserved a time -- I called the aesthetic nurses, got a time and met the surgeon. -- The entire process was extremely fast. -- I had thought about it for a long time, it was not spur of the moment.

(Female G, 60, breast-reduction surgery)

Each morning when I woke up and looked at myself I looked so angry, -- I noticed that my eyesight was getting poorer and -- I figured it must have been because of my eyelids. -- My friend had the same operation -- once (she) started talking about it, it made the whole process go faster.

(Female H, 68, eyelid surgery)

Each woman described their need recognition in terms of suffering, distress or anxiety related to their physical or psychological well-being.

After suffering with the problem for a year --

(Female E, 38, corrective breast-implant surgery)

I felt like my femininity had gone away, -- and it bothered me for a really long time.

(Female F, 32, breast-implant surgery)

The first respondent in group 2 did not mention searching for experiences from other consumers, only being encouraged by their husband. The second respondent, however, attributed their decision to their friend who had the same procedure done and thus encouraged the respondent. They additionally detailed that it was due to excellent service on behalf of the service provider that her mind was fully made. Both respondents in group 1 mentioned asking their friends and family about their experiences, and the second respondent had additionally used chatrooms in search of reviews of specific service providers and practitioners, which ultimately guided her choice of service provider.

I thought about it for year and decided to go for it since I had so many acquaintances with positive experiences and these procedures are so common these days. It was an easy decision. -- My friend's positive experience with this surgeon was probably the biggest reason I chose him. -- (she) had to have a larger operation, removal of extra skin etc., and you can't even see that anything has been done.

(Female F, 32, breast-implant surgery)

Reading about the possible risks and searching for information made me feel more confident.

(Female F, 32, breast-implant surgery)

The industry professionals experience first-hand the doubts and questions of potential customers. Naturally they cannot observe the nature of the consumer's decision-making process up until the appointment, but through experience and conversations with the consumers, they have developed a deep understanding of their target consumers.

The professionals stated that based on their experience, need recognition may happen over an extended period of time and usually involves deep internal contemplation. Questions of have I earned or deserved this may easily arise in the consumer's mind. The idea may initially come from an outside source such as the media or an acquaintance, bringing the option of cosmetic surgery to the consumer's attention.

It might have been a few years they have spent thinking about it, discussing it with themselves, have they earned it, am I crazy to want something like this, am I naïve, shouldn't I think of people who are actually sick. -- They see that the surgeons and us nurses are ordinary people and you can talk to us -- Once that obstacle is passed -- they gain the courage (needed).

(Nurse J)

Both representatives of the service provider agreed that today consumers begin their information search online and are usually quite well informed when they come to meet with the service provider. However, information found online may have serious inaccuracies which poses risks for consumers, especially if they end up doing the procedure abroad. The representatives note that consumers are also more well informed due to the industry's increasing media exposure.

After their initial contemplation and information search, the consumer contacts a potential service provider, or someone in the beauty industry with more knowledge, and usually inquires after a price-range, followed with details about the procedure, recovery times and possible risks. Some people care more about the price, while others care more about which doctor would perform the procedure.

The price comes up very quickly. -- Usually they ask what the procedure is like. -- Then about recovery periods, -- Or then they just perceive a problem and ask for our opinion, what can be done about it, what different alternatives there are. -- Some are willing to do the procedure no matter the cost, and for some the problem is only aesthetic in the sense that it won't destroy their self-esteem if it isn't fixed. They are the ones who call first and ask about the price, and maybe make their decision to continue the process based on that.

(Nurse I)

Not all clients who come to discuss their options end up on the surgeon's table. Sometimes clients will say they will think about it, and they never return. The representatives wager they might continue to search for a better price or wait for a more opportune moment.

There's a small percentage of people who have looked at themselves in the mirror that morning, thought they look terrible and just decide to come see us at a moment's notice. -- because they "can't take it anymore". --

with those types of cases the results aren't usually that good. Since these procedures can alter your appearance quite a bit, it's better that there's a longer thought-process involved. That we don't just hand out times at the first opportune moment.

(Nurse J)

The representatives point out the extremely sensitive nature of the industry, and how crucial it is to try figure out how much information the patient wants about the procedures.

If you think of a facelift, there isn't a medical need for it. It's challenging to attempt to discreetly create a need for something like that -- With cosmetic surgery, you deal a lot with people's psyches. Some people struggle with their self-concept. -- You need to be aware, to be able to tell what you can say and when, when trying to sell something like this. It's slightly easier since I'm a woman; I can relate to them.

(Nurse J)

7.2 Beliefs about utilizing cosmetic surgery

7.2.1 Behavioural beliefs

Attitude is simply defined as a consistent, general feeling of favourableness or unfavourableness toward a concept or object, that predisposes action (Fishbein & Ajzen 1975, 6; Ajzen & Fishbein 1980, 54; Fishbein & Ajzen 2010, 76, 125). Attitude toward a behaviour is formulated based on the sum of behavioural beliefs an individual holds about that specific behaviour. Behavioural beliefs may either be *experiential*, positive or negative personal experiences related to the behaviour, or *instrumental*, positive or negative consequences that consumers anticipate will result from the behaviour.

Positive beliefs

All respondents shared similar beliefs about anticipated positive consequences, which were further reinforced by the experiences of the existing consumers and industry professionals. Positive behavioural beliefs were all associated with improved psychological and physical well-being and improved physical appearance.

Words such as self-confidence, self-image and self-concept were used frequently. The anticipation that cosmetic surgery would significantly benefit psychological well-being seemed to be the most prominent positive belief associated with utilizing cosmetic surgery.

In my opinion all the benefits are related to your own sense of self and becoming more self-confident. – – If a person constantly feels that something is an inconvenience or causes distress, it will affect their mood, and it might cause troubles in their relationship, or if their self-confidence is weak it might cause problems that will create an unsurmountable obstacle in their lives

(Female B, 31)

It affects your self-confidence, self-concept, well-being – – The biggest benefits would be related to my self-confidence, quite strongly.

(Female C, 58)

I've already noticed the positive effect it's had on my state of mind.

(Female F, 32, breast-implant surgery)

Respondents additionally believed that in some instances, cosmetic surgery could also improve physical health. In these cases, cosmetic surgery seemed to be considered more justified among the older respondents.

The added health-benefits. – – If I didn't do (the operation), I might end up having more serious negative physical symptoms.

(Female C, 58)

If it's already a health issue, and it can (additionally) improve your appearance, then I accept it – – your mood affects your general health, if you're suffering from something and constantly thinking about it, then I think it's called for. – – this will improve my well-being for years to come.

(Female H, 68, eyelid surgery)

Whilst respondents gave answers relating to improved physical appearances, by far the most significant anticipated positive consequence was the positive impact cosmetic surgery would ultimately have on an individual's psychological well-being. It would seem like respondents consider improvements in one's physical appearance to be a positive catalyst for better quality of life.

My physical appearance – – would improve – – That is definitely the heaviest thing weighing in the procedure's favour.

(Female C, 58)

I didn't want to spend the rest of my life with these eyelids, it had to do with appearances too. – – I've heard that I look happier. I don't look so gloomy anymore.

(Female H, 68, eyelid surgery)

The positive behavioural beliefs (BB) related to cosmetic surgery may thus be summarized as follows:

- BB1: Utilizing cosmetic surgery can improve my physical health and well-being.
- BB2: Utilizing cosmetic surgery can improve my physical appearance and thus improve my body image and self-confidence, and ultimately my psychological well-being.

Negative beliefs

The respondents' answers regarding the anticipated negative consequences were more diverse. All respondents expressed worry over the potential outcome; it not necessarily succeeding or looking different than what you thought it would. One respondent stated they would worry less with a non-invasive procedure, due to the results not being permanent. Surgery in contrast, was seen as permanent and thus riskier.

I would want to be reassured of the benefits - - I'd worry that the result would not look as good as you thought it would.

(Female C, 58)

What if the result isn't what you wanted?

(Female G, 60, breast-reduction surgery)

I was somehow afraid. It was so final.

(Female F, 32, breast-implant surgery)

Sometimes (the customer) might have unrealistic expectations of what can be done -- they want more than what some operation could do for them -- They have an image in their heads of what their bodies will look like after taking a little bit in from here or there. And that might not happen -- What if it won't look like you thought it would. -- what if you won't look like yourself?

(Nurse I)

Respondents expressed worry over possible pain and discomfort, some stating the possibility of scarring. Risks of anaesthesia, infections and other surgical complications were discussed. Out of the four existing consumers, only one respondent mentioned being initially afraid of the procedure. Other than this, the respondents' answers were mostly related to hypothetical scenarios; pondering how without proper information one might fear pain or be weary of the outcome.

If there was a risk of infection -- I would consider it more carefully -- I wouldn't dare to consider it a safe bet, I would have to think about it long

and hard. It might cause pain and discomfort. And you might have permanent scarring.

(Female A, 27)

The procedure itself frightened me, – – That was probably the biggest thing. – – Of course, every surgery is always a risk.

(Female F, 32, breast-implant surgery)

Patients ask about the risks – – pain – – discomfort – – and are there things that can go wrong – – What happens then? What will that cause – – (and) if there are huge ugly scars or something.

(Nurse J)

One respondent had initially had breast implant surgery in Estonia and was now going to have a corrective procedure in Finland in which the initial implants would be removed and new ones would be inserted underneath the muscle. She had not had any physical problems but her sister had an extremely bad experience that she was not aware of at the time of her first procedure.

Had I known that it's possible to have such bad quality implants put in, had I known the risks, big health issues, then I would have never done it, or at least not outside Finland. – – The health factors would have stopped me had I been aware of them. Or at least I would have postponed (the procedure).

(Female E, 38, corrective breast-implant surgery)

Besides this experience, for the most part the physical risks of cosmetic surgery were not seen as any different from surgical risks in general. Each respondent was well-aware of the potential risks of surgery and anaesthesia in general, but they were quite adamant over their trust in the Finnish healthcare system. Respondents did, however, indicate some worry over the products and substances used in the procedures and were anxious about not knowing what was in their bodies and what would happen after the substance dissolved. Nurse J mentioned that consumers often ask whether the outcome will look worse after the effects of procedure wear off. Respondent H specifically stated how she felt more reassured about her procedure since nothing foreign was put into her body.

Have all these silicones and injections been researched enough, are they safe? When something like that is put under your skin, that it won't cause any damage there? I didn't feel that way about this, because something was just removed, not added. I didn't even think it could be dangerous somehow, since nothing extra is put in. That's why I thought it's so safe.

(Female H, 68, eyelid surgery)

Nothing is ever 100% sure. It is still a foreign object in your body. -- I will be so relieved once all this is over. -- I won't have to worry anymore about what is in there -- I just wouldn't be able to take it, not knowing for sure what is in there. -- I had not understood how it would affect me and my body, not being able to trust what has been done to (it).

(Female E, 38, corrective breast-implant surgery)

The implants have improved, they are not such a risk anymore, you don't have to fear silicone leaking into your body or something in the same way. -- I thought of the implants; would I always feel them, that they're inside me, that I have a foreign object inside me. Would I be able to live a normal life, and go jogging and to the gym and so on?

(Female F, 32, breast-implant surgery)

One notable difference between cosmetic surgery and other, more general, surgical procedures was however noted: if any serious complications were to occur, then you would have brought it on yourself, without a medical reason for the operation.

Everything always has its risk, there might be some bad reactions, something might fail -- if something serious happens, then you would you have brought it on yourself for no good reason.

(Female E, 38, corrective breast-implant surgery)

Two respondents additionally brought attention to the possibility of age affecting the outcome of the procedure.

Is my condition something that I could live with, or is it something that will get worse over time -- Should I do it now, as a preventive measure -- when would I get the most out of the procedure -- will it come back in ten years' time?

(Female C, 58)

I thought that (I should do it) now when I've still got my health, otherwise I would have lived with this issue for my whole life, and it would only get worse. -- I feel like maybe I should have done this even sooner. I'm happy that I didn't put it off any longer. With summer coming -- I will be going out, -- I feel completely different.

(Female H, 68, eyelid surgery)

All respondents noted how there have been cases in the media where utilizing cosmetic surgery had gone to the extreme. Respondents expressed their worry over some individuals becoming "addicted" to cosmetic surgery, or making the decision too lightly.

Some might have distorted views of the potential outcome -- then having it not look like what you imagined, and not solve your problems after all.

The problem is between your ears. Then there's the next thing you want to fix, and the next... You notice that were happier all along, before getting started with the whole thing.

(Female C, 58)

You see these horrific images of people trying to transform themselves into human barbies – – Where it's gone overboard. – – (In my work) I constantly run into cases where these things are covered and blown out of proportion.

(Female C, 58)

The respondents' negative behavioural beliefs may thus be summarized as follows:

- BB3: Cosmetic surgery is risky and the outcome may not look it was intended.
- BB4: Cosmetic surgery procedures are risky and painful; it may cause an infection or problems with anaesthesia and result in painful recovery and large scarring.
- BB5: The products and substances used in cosmetic surgery may be unsafe and cause damage to one's body, or feel unpleasant.
- BB6: The success and benefits of cosmetic surgery may depend on what time in life it is performed.
- BB7: Cosmetic surgery may involve psychological problems or cause addiction.

7.2.2 Normative beliefs

Subjective norm refers to the person's perception that most people who are important to him think that the behaviour in question is either good or bad, or that important others are themselves performing or not performing the behaviour. The term subjective underlines the fact that these perceptions may or may not be accurate. (Ajzen & Fishbein 1980, 57–59; Fishbein & Ajzen 2010, 131).

All respondents in the group of potential consumers and both industry professionals discussed the media in their interviews. The respondents believed that the media contributed in creating a more negative image of the cosmetic surgery industry through scandalous stories and examples of individuals who have had excessive surgeries and thus influences the consumer.

First thing that comes to mind is Johanna Tukiainen. And how much she has been criticized for attempting to improve her looks. It's almost like a joke. But with her it goes so overboard. – – the media mostly ridicules people like (her) who try to look good.

(Female A, 27)

The media does have an effect, but I think it's only healthy. In a sense, the media is useful; someone who might have otherwise considered it too lightly just because they have the money might stop and think whether they truly need it.

(Female C, 58)

Both industry professionals mentioned how the image that the media promotes is unrealistic and often false. They felt that the media has a significant role in the creation of normative pressures; consumers do not want to be associated with the image it creates about people who utilize cosmetic surgery. One respondent reckoned that in that sense the media is also useful – causing potential consumers to evaluate their choice harder.

The media sometimes portrays a false image of this industry. – that might also be the reason why people don't want to talk about this openly. They don't want themselves associated with someone who's gone overboard.

(Nurse I)

Still, respondents seemed to be well-aware of the fact that while the media portrays a specific kind of image, it is however only a small part of the industry, and agreed that most consumers of cosmetic surgery are normal, everyday consumers. While saying this, respondents still often referred to how “some people” think that only the rich or vain have cosmetic surgery procedures. It seems that as individuals, consumers realise that only a small minority of cosmetic surgery consumers fit the negative stereotype but they still fear that society in general does not realise this. There was near consensus among the respondent that to some degree there does prevail a negative preconception that cosmetic surgery is frivolous and desiring it makes you vain.

Some people think that all the procedures are for the vain, naïve, or the rich. – so many of these procedures are performed on plain, ordinary farmers, or sales people or us nurses. – In Finland, the attitudes have already softened, but still potential consumers think – that it somehow wouldn't be something your average consumer would do, or that only a specific type of people have (cosmetic surgery).

(Nurse J)

(Cosmetic surgery) has a certain air of secrecy around it here in Finland. – people are still secretive about it, even though normal people do it.

(Female E, 38, corrective breast-implant surgery)

All but one of the existing consumer -respondents stated their reluctance to talk about the procedures, or justify and explain themselves to other people. Likewise, respondents in the group of potential consumers reckoned they would similarly avoid talking about a

potential procedure openly, and had already done so, from fears of being judged or considered vain. The industry professionals both mentioned that consumers are often concerned of whether the procedure will be immediately visible to other people, or if they will be able to tell that they've had something done.

The procedures here aren't the same as in the States. People may not even notice, they might just ask if you've lost weight. -- No one can tell. You can go swimming, take a shower, no one will see. -- people fear that someone will see.

(Nurse J)

Justification in general seems to be an important factor for consumers of cosmetic surgery. In addition to justifying the procedure to other people, respondents also indicated a strong need to justify the decision for themselves. Consumers seem to struggle with their choice and feel more comfortable with their decision if they feel they have earned it and can easily explain themselves to other people if need be. The industry professionals explained how consumers are often seeking for some degree of acceptance, worrying about if they are crazy or foolish for desiring to alter their appearance. The fear of social rejection can play a significant role in consumers' decision-making.

I was talking to my friend and one of the first things I asked her, was that was I being vain. Or is it justified for me to do.

(Female H, 68, eyelid surgery)

Someone might think that who does she think is, what is she trying to achieve, or that I am vain for (wanting cosmetic surgery).

(Female A, 27)

It can be -- justified in some instances. -- (but) in what cases are the benefits justified, is my condition something that I could live with?

(Female C, 58)

In most ways consumers want to keep it a secret, they don't want people to know -- that they've had anything done. -- Some ask if they're vain or frivolous to want something like (cosmetic surgery) in the first place. Maybe they're searching for approval from us, -- (that) you're not crazy or foolish.

(Nurse I)

The importance of consumers' need for justification was most apparent when discussing the respondents' work-environments and colleagues. One's colleagues seemed to be considered a difficult obstacle when it came to admitting to a cosmetic procedure or talk-

ing about it openly among work acquaintances. Your work environment may include individuals with exceedingly differing opinions and views and cosmetic surgery as a topic is something that may very well induce heated opinions. The respondents expressed their disinclination to share such a personal aspect of their lives with others who may not understand the deep, personal reasons and issues that lead to a purchase decision of cosmetic surgery. However, one respondent in the group of potential consumers mentioned that she was almost positive she would receive support for her decision at least after the matter, once her colleagues would see the improvement on her appearance and demeanour.

If I was still working, then I might not have gone so easily. It might have restricted me, -- having to tell your colleagues. Now I didn't have to think about issues like that. I might have felt that someone would think that it wasn't justified, or that it was vain or frivolous. -- I would have had to explain myself. I feel that now that I'm retired I don't have to explain myself to anyone.

(Female H, 68, eyelid surgery)

I think there would be more people who would not approve. That would probably be the reason why I wouldn't talk about it beforehand. I'm sure that in my work-environment there would be people who'd think that it's frivolous. I believe that in Finland people would be more likely to judge you, not support the decision.

(Female C, 58)

However, as respondents in the group of existing consumers indicated, this unwillingness often also extends to closer friends and family members, depending on their opinions. The opinions of important others are naturally important to consumers in their decision-making.

I have hidden this from even some of my closest friends, because I know that they don't think that something like this could be useful, that there would be a good reason for it. -- it might create a negative idea about me, of who I am. -- this might shock my friends, or confuse them. They might think that why would a healthy, beautiful person want to do something like this to themselves.

(Female E, 38, corrective breast-implant surgery)

My husband at least is completely opposed; -- He thinks that natural changes to your body do not need to be corrected. And he doesn't think very highly of people who have had (cosmetic surgery)

(Female B, 31)

I was on a hiking trip with some friends and my eyes looked so heavy that I was embarrassed to show my face in the morning. – – My friends had started to comment on my appearance. – – Initially I felt like I don't want to talk about (the procedure) with my friends – – I don't know how some of my (them) would react if I was open about it.

(Female H, 68, eyelid surgery)

Respondents strongly felt that the experiences of others would significantly ease the decision to utilize cosmetic surgery.

If I knew anyone with good experiences, saw someone's life improve. That would make the decision easier.

(Female A, 27)

Maybe if a friend or acquaintance had something done and would recommend it. – – If a procedure has helped someone else, it always lowers the threshold.

(Female B, 31)

After my friend went and everything went so well I felt reassured that everything would go fine.

(Female H, 68, eyelid surgery)

Interestingly, while most respondents clearly indicated at least some anxiety over the opinions of others, all respondents, both potential and existing consumers, stated that ultimately, if the decision was important enough for the consumer themselves, they would not, and should not matter in the slightest.

I don't feel pressured that much. – – Of course, my friends and family have an effect, since they have their own opinions, but I don't base my decisions on them. I feel that I live my own life and we make our own choices no matter what other people think.

(Female H, 68, eyelid surgery)

I'd imagine younger people are effected by outside pressure. – – It's everyone's own business. I don't think you should care. – – But there does exist pressure to look good today. Once I turned 50 I felt like everyone around me looked so beautiful and young.

(Female G, 60, breast-reduction surgery)

I think that if I felt my decision – – had been made too lightly, or if I couldn't justify (it) to an acquaintance, it would cause me anxiety. I feel that if I can convince myself I need something, or I want to do something,

that it would end up mattering so much that other people's opinions would not matter. You can't please everyone.

(Female C, 58)

When asked directly about possible normative influences, respondents had some difficulties naming or specifying them or directly admitting to being influenced by others. All respondents were positive they would not allow others to influence their decision to undergo cosmetic surgery, entailing they had formed strong enough intentions themselves. However, all respondents indirectly indicated the presence of normative influences; these influences seem to be subtle and effecting the consumer over the course of their entire lives. Thus, consumers may not even fully realise their affect or influence on their decisions.

The respondents' normative beliefs (NB) may thus be summarized as follows:

- NB1: The media contributes to the creation of a negative image about cosmetic surgery.
- NB2: Even though normal, average consumers use cosmetic surgery, many people still associate it with a pervasive negative stereotype.
- NB3: Desiring cosmetic surgery may cause a negative image about oneself, associated with vanity and frivolity.
- NB4: Cosmetic surgery should be justified or earned for it be considered acceptable.
- NB5: It can be hard to try to explain or justify oneself to colleagues, friends or family. Not everyone will understand or be supportive.
- NB6: Knowing someone who has undergone cosmetic surgery would make the decision easier.
- NB7: Ultimately, the opinions of others do not, and should not matter in the decision to utilize cosmetic surgery.

7.2.3 Control beliefs

Perceived control refers to the extent to which people perceive they have the skills and necessary capabilities to engage in a behaviour and can *control its performance*. A person may have formed a positive attitude toward a behaviour and even perceive social pressure to perform it, but if that person does not believe they have sufficient control over the behaviour, their behavioural intention will remain weak at best. (Fishbein & Ajzen 2010, 154–155.)

Based on the interviews, the single biggest factor preventing consumers from utilizing cosmetic surgery is lack of money. Cosmetic surgery procedures range from simple, non-invasive procedures to extensive operations, but even the simplest procedures are costly.

This preconception was extremely strong with all respondents. Three respondents additionally stated that they would not be willing to take out a loan to finance cosmetic surgery for themselves.

I asked about the price -- I myself don't have to count every penny right now, but if my situation had been different I would have had to consider it more carefully -- should I use (the money) elsewhere.

(Female H, 68, eyelid surgery)

Even though I wanted the corrective surgery, money was an obstacle -- the only thing I based my decision on was that it was more affordable (in Estonia). -- If I had to take out a loan or otherwise stress about it, then I don't think I would have done it.

(Female E, 38, corrective breast-implant surgery)

I haven't had many patients who would have the money but are otherwise too scared or something. I can't think of anyone like that. More likely it's so that there would be far more people interested if they only had the money.

(Nurse I)

Respondents additionally indicate that they believed cosmetic surgery was time consuming. Potential consumers stated that they felt they simply did not have the time to even consider cosmetic surgery. From the existing consumers, the two respondents in the older target segment were retired and thus time did not pose an issue for them. Respondent E stated how she had to postpone her surgery due to her new employment.

They ask about recovery periods, what it means, what you're able to do -- when you're able to move again.

(Nurse J)

If we compare invasive and non-invasive procedures, then depending on that there might be a lengthy recovery and such, in the case of a larger procedure. -- Right now, I simply do not have the time. I do not have time to think about such problems.

(Female B, 31)

I had just started in a new job and you need to take some time off work so time passed, constantly thinking about it

(Female E, 38, corrective breast-implant surgery)

In addition to time and money weakening an individual's control over utilizing cosmetic surgery, unforeseen events may prevent a consumer from acting on their intentions.

The group of potential consumers however, did not anticipate unforeseen events preventing them from utilizing cosmetic surgery. As such, such events may postpone behaviour but they do not seem to affect underlying intentions.

*Before I knew it, a year had passed and suddenly I was pregnant again. –
– I had a whole new set of problems, I couldn't go through with the procedure after all.*

(Female E, 38, corrective breast-implant surgery)

All respondents additionally discussed the importance of a trustworthy and expert service provider. Consumers of cosmetic surgery can have no impact on performance of the service themselves, but rather they must trust someone else to perform this invasive, personal procedure on their physical self. Thus, consumers can only control who performs the service and where. The potential consumers explained how they would want to research the service provider's experience and credentials thoroughly but that in general they have trust in the Finnish health care system. Respondents were quite sceptical of the quality of treatment abroad and the integrity of foreign service providers.

Generally speaking, our clients have trust in Finnish health care, but naturally they ask about the surgeon's experience – – they compare it to the possibility of going abroad.

(Nurse I)

I believe that the surgeons would not perform surgeries in vain, or just because of money. Not in Finland. Maybe abroad. In countries where people are greedy.

(Female C, 58)

I would not go abroad; I trust domestic health services more – – I don't believe that in Estonia for example the quality standards are the same as here, or if sterilization is taken as seriously. I don't have any facts; I just have this assumption. That over here they are more careful and the standards are quite strictly followed.

(Female B, 31)

The younger respondents in the group of existing consumers had researched their service provider independently but the older respondents had relied on past experience with the service provider and recommendations from friends. However, after their research and especially after meeting the service provider staff, all respondents in the group of potential consumers expressed how confident they were in the abilities of their surgeon, and how safe they felt.

I was very confident. I thought that the service provider had professional staff, I didn't really think of risks at all, like if something would go wrong or something. I've been very confident in their abilities.

(Female H, 68, eyelid surgery)

Expertise and credentials, however, are not always enough. Nurse J stated from experience, that in some instances surgeons tend to be blunt – which can be off-putting for potential consumers.

Surgeons are surgeons, they don't really talk much. They are straight to the point, "sign here, put a Band-Aid on it, goodbye". Then the patient may be confused and have questions, and us nurses try to clarify and explain what the surgeon meant. But that might have a negative impact on the consumer, if their doctor seems too blunt or otherwise unappealing – Consumers sometimes decide that they do not want the procedure because of a specific surgeon, I have seen that happen.

(Nurse J)

The industry professional further reckoned that consumers form assumptions about the service provider based on their facilities, and it can affect the consumer's opinion about the quality of the service and service provider.

It also matters what the interior of the facilities looks like. Once you see that the facilities are new and clean, and have been designed with the patient's comfort and discretion in mind... That highlights the individuality, quality and uniqueness of the service.

(Nurse J)

The respondents' control beliefs (CB) may thus be summarized as follows:

- CB1: Cosmetic surgery is expensive.
- CB2: Cosmetic surgery is time-consuming.
- CB3: To purchase cosmetic surgery, one must be able to trust the service provider and feel positive about them.

7.3 Perceived barriers to utilizing cosmetic surgery

Respondents stated several behavioural, normative and control beliefs related to the utilization of cosmetic surgery. Some of these beliefs may form barriers to purchase decision for consumers. During analysis of the research data, it was noted that the six types of types of perceived risk; physical, quality, psychological, social, financial and time risk (e.g. Roselius 1971; Kaplan et al. 1974; Turley & LeBlanc 1993, 15; Solomon et al. 2010, 328–331) were useful in summarizing and categorizing these barriers. These risk types could be identified in all the respondents' answers.

7.3.1 *Fear of pain and harm*

Perceived physical risk may be described as potentially causing physical harm or injury to the consumer. This translates to a specific barrier in the consumers' minds: *fear of pain and harm*. Respondents stated numerous concerns and beliefs related to perceptions of physical risk, which were summarized as follows:

- BB4: Cosmetic surgery procedures are risky and painful; it may cause an infection or problems with anaesthesia and result in painful recovery and large scarring.

Consumers believe that cosmetic surgery, like other surgical procedures, is risky and painful. Some consumers may have more realistic views and fear the procedure less, if not at all, but for some this fear may create a clear barrier to purchase.

7.3.2 *Fear of service failure*

Closely related to fear of pain or harm is *fear of failure*. Consumers may perceive performance or quality risk in their purchases, in which there is uncertainty whether the service or an aspect of it will perform as was intended. All respondents elicited beliefs which were clearly related to this risk. The combination of the following summarized beliefs form this barrier:

- BB3: Cosmetic surgery is risky and the outcome may not look it was intended.
- BB5: The products and substances used in cosmetic surgery may be unsafe and cause damage to one's body, or feel unpleasant.
- CB3: To purchase cosmetic surgery, one must be able to trust the service provider and feel positive about them.

Respondents experienced anxiety over whether the result of the procedure would look as they were intended and whether the products and substances used would be suitable for their bodies. Since consumers cannot perform the service on themselves, they must rely on the expertise of others and be able to trust them to perform the service correctly.

7.3.3 *Fear of addiction*

Respondents recalled instances where a consumer had seemed to become addicted to cosmetic surgery procedures and gone "overboard". These beliefs are closely related to perceptions of psychological risk, which in this instance translates to a *fear of addiction*.

- BB7: Cosmetic surgery may involve psychological problems or cause addiction.

Respondents believed that with some individuals the motivations to undergo cosmetic surgery are not legitimate, but stem from a place of a deep psychological instability. While the fear of this may clearly form a barrier to some people, it seemed clear that respondents believed such cases were extremely rare.

7.3.4 *Fear of social rejection*

The *fear of social rejection* formed a prominent barrier for the respondents, especially in the group of potential consumers. The existing consumers had surpassed this barrier, but this does not mean it was not prominent during their decision-making processes. Fear of social rejection is directly derivative from perceptions of social risk. The combination of the following beliefs combine to create this barrier:

- NB1: The media contributes to the creation of a negative image about cosmetic surgery.
- NB2: Even though normal, average consumers use cosmetic surgery, many people still associate it with a pervasive negative stereotype.
- NB3: Desiring cosmetic surgery may cause a negative image about oneself, associated with vanity and frivolity.
- NB4: Cosmetic surgery should be justified or earned for it be considered acceptable.
- NB5: It can be hard to try to explain or justify oneself to colleagues, friends or family. Not everyone will understand or be supportive.

Respondents expressed significant anxiety over being able to justify their decision to acquaintances, friends and family. Respondents believed there persists a negative stereotype about consumers of cosmetic surgery, and utilizing it may also create a negative image of the respondents' selves.

7.3.5 *Financial barrier*

The most straight-forward barrier was formed through perceptions of financial risk. *The financial barrier* is simply dependent on the consumer's financial situation. This barrier stems from the direct control belief that cosmetic surgery is expensive.

- CB1: Cosmetic surgery is expensive.

7.3.6 *Temporal barrier*

The second extremely straight-forward barrier was formed through perceptions of time risk. The *temporal barrier* is another clear obstacle that consumers often face. Cosmetic surgery is believed to be quite time-consuming and mandating long periods of recovery, which would require leave of absence from one's work.

- CB2: Cosmetic surgery is time-consuming.
- BB6: The success and benefits of cosmetic surgery may depend on what time in life it is performed.

Another dimension of this barrier is consumers perceiving that they must choose the exact correct time in their lives to potentially utilize cosmetic surgery.

8 CONCLUSIONS AND IMPLICATIONS

8.1 Discussing the main findings

The purpose of this thesis was to uncover how and why consumers make decisions about utilizing cosmetic surgery services. On a managerial level, this meant the research aimed to identify reasons why potential target consumers do *not* wish to utilize cosmetic surgery. The following research questions were proposed:

RQ1: What is the nature of the consumer decision-making process when purchasing cosmetic surgery services?

RQ2: What beliefs do consumers associate with utilizing cosmetic surgery services?

RQ3: How do these beliefs translate into possible barriers for purchase?

Results from Ettenson and Turner's (1997) study noted clear differences in decision-making styles between professional and non-professional services, but differences were surprisingly additionally found between two non-professional services. Those results proved that simple classifications into professional or non-professional services do not suffice, but that differences may very well exist between services of seemingly similar natures. Indeed, the results of this research tentatively suggest that with complex professional services, at least such as cosmetic surgery, decision-making styles may not be as straight-forward as with other professional services.

All respondents in the potential consumer group stated that they would begin their information search online and quite extensively search for information about the procedure and possible service provider. This was supported by the experiences of the industry professionals and the actions of the two younger respondents in the group of existing consumers. These findings are in line with past research, which has shown that when consumers anticipate greater uncertainty, they are likely to engage in a lengthier and more extensive information search to reduce perceptions of risk (Murray 1991; Lovelock, Vandermerwe & Lewis 1999, 131–133; Mitra et al. 1999; White 2005). However, neither of the existing consumers from the older target segment conducted extensive information search before their purchase decisions, but instead directly contacted the service provider, the other via recommendation, and reserved a time. After only a few days of contemplation, both consumers had already made a purchase decision. Clearly the information search of these two consumers has been mostly indirect and passive, but it presents a clear exception to the prevailing conception of a lengthy and extensive information search being associated with complex professional services.

All existing consumers additionally had at least one direct, personal information source they utilized during their decision-making process, which has been shown to be the norm when purchasing professional services (Zeithaml 1981; Crane & Lynch 1988; Murray 1991; Gabbott & Hogg 1994, 143; Mitra et al. 1999; Thakor & Kumar 2000; Cooley & Madupu 2009). Before making the ultimate purchase decision, three out of four existing consumers additionally consulted with a service professional, which also supports existing research (Babakus et al. 1991, 15; Lian & Laing 2004).

The two industry professionals described the process of the consumers' decision-making based on their personal experiences with cosmetic surgery consumers. The professionals stated that based on their experience, need recognition may happen over an extended period of time and usually involves deep internal contemplation. The idea may initially come from an outside source such as the media or an acquaintance, bringing the option of cosmetic surgery to the consumer's attention. Both professionals agreed that today consumers begin their information search online and are usually quite well informed when they come to meet with the service provider. They noted that consumers are also more well informed due to the industry's increasing media exposure. After their initial contemplation and information search, the consumer contacts a potential service provider, or someone in the beauty industry with more knowledge, and usually inquires after a price-range, followed with details about the procedure, recovery times and possible risks. Some people care more about the price, while others care more about which doctor would perform the procedure.

Based on the respondents' answers, seven behavioural beliefs, seven normative beliefs and three control beliefs were identified.

- BB1: Utilizing cosmetic surgery can improve my physical health and well-being.
- BB2: Utilizing cosmetic surgery can improve my physical appearance and thus improve my body image and self-confidence, and ultimately my psychological well-being.

Respondents clearly believed that the prevailing positive outcome of any cosmetic surgery procedure would be improved physical appearance, resulting in the goal of improved psychological well-being. Not one respondent indicated any desire to undergo cosmetic surgery purely for cosmetic reasons, but they were quite clear they would ultimately feel better about themselves. However, Sarwer and Crerand (2004) conclude that despite several studies reporting improvements in postoperative psychological well-being, making any general assumptions of cosmetic surgery leading to psychological benefits remains unwise (see also Sarwer, Wadden, Pertschuk & Whitaker 1998, 9). This research suggests that while actual psychological benefits may be hard to prove, consumers of cosmetic surgery seem to at least strongly believe in them.

- BB3: Cosmetic surgery is risky and the outcome may not look it was intended.

Respondents indicated that they would be nervous over the outcome of the surgery and what the results would look like. It seems that with cosmetic surgery consumers stress about not knowing for sure what the outcome will be. The two industry professionals described this as the consumer worrying they would not look like themselves. Since with cosmetic surgery, the procedure will directly alter the body of the consumer, consumers seem to fear losing a part of themselves or their identity.

- BB4: Cosmetic surgery procedures are risky and painful; it may cause an infection or problems with anaesthesia and result in painful recovery and large scarring.
- BB5: The products and substances used in cosmetic surgery may be unsafe and cause damage to one's body, or feel unpleasant.

Respondents expressed significant worry over the procedure itself; potential surgical risks, pain and inconvenience and uncertainty over the quality and safety of substances and products used.

- BB6: The success and benefits of cosmetic surgery may depend on what time in life it is performed.

Respondents in the older target segment additionally expressed worry over the procedure being performed at the most opportune moment. Consumers seem to wonder about the long-term implications of different procedures and since the procedures are expensive, they want to ensure that they get the absolute most out of the procedure, which will probably be a once in a lifetime investment.

- BB7: Cosmetic surgery may involve psychological problems or cause addiction.

A few respondents told stories they had heard about cosmetic surgery becoming nearly addictive for the consumer. This was quite clearly related to beliefs about the media and the connection between cosmetic surgery culture and Hollywood.

- NB1: The media contributes to the creation of a negative image about cosmetic surgery.

Interestingly, while it seems that the media in Finland, for example, is portraying cosmetic surgery in an increasingly more favourable light, celebrities openly discuss having cosmetic surgery, and magazines write more openly about the possibility of enhancing one's appearance via cosmetic surgery (Pystynen 2013; Tarvonen 2014; Aula 2015; Karilahti 2015), consumers still strongly believe that the media causes negative stereotypes and preconceptions about cosmetic surgery.

- NB2: Even though normal, average consumers use cosmetic surgery, many people still associate it with a pervasive negative stereotype.
- NB3: Desiring cosmetic surgery may cause a negative image about oneself, associated with vanity and frivolity.

Despite the growing acceptance towards the industry in general, it seems that individuals who decide to utilize cosmetic surgery are still subjected to negative comments and

stereotyping of their personalities and psychological well-being (Sarwer et al. 1998, 8; Delinsky 2005). Findings from one study indicated slight disapproval of elective procedures, associating characteristics such as materialistic, self-conscious and perfectionistic with consumers of cosmetic surgery (Delinsky 2005). The results from this research support these findings. Some consumers have had to endure negative comments about e.g. their post childbirth appearance on the beach and others feel they are judged for wanting to reverse changes brought on by pregnancy, because mothers should “carry their scars with pride” (Aarnio 2015).

- NB4: Cosmetic surgery should be justified or earned for it be considered acceptable.
- NB5: It can be hard to try to explain or justify oneself to colleagues, friends or family. Not everyone will understand or be supportive.

Indeed, one of the biggest worries of consumers of cosmetic surgery would seem to be someone being able to tell they’ve had surgery. Procedures are no longer marketed as improvements, but are instead referred to as regaining your “normal” appearance (Puurunen 2012; Pystynen 2013).

- NB6: Knowing someone who has undergone cosmetic surgery would make the decision easier.

All respondents had either used personal sources with experience about cosmetic surgery or stated that having access to such a person would significantly ease their decision-making. This provides strong support for research which has indicated that consumers prefer personal information sources with decisions perceived as complex and risky ((Zeithaml 1981; Crane & Lynch 1988; Murray 1991; Gabbott & Hogg 1994, 143; Mitra et al. 1999; Thakor & Kumar 2000; Cooley & Madupu 2009).

- NB7: Ultimately, the opinions of others do not, and should not matter in the decision to utilize cosmetic surgery.

Didie and Sarwer (2003) and Thorpe et al. (2004) uncovered in their research, that in the case of cosmetic surgery, it would seem that consumers’ primary motivation has to do with measuring up to their own appearance standards, and be less concerned with the feelings and opinions of important others. Indeed, all respondents in the current study stated that ultimately the only opinion that should matter in the decision-making is your own.

- CB1: Cosmetic surgery is expensive.
- CB2: Cosmetic surgery is time-consuming.

In addition, cosmetic surgery was seen as predominantly expensive and time-consuming. These act as direct obstacles to behaviour, as discussed in the following paragraphs on respondents’ perceptions of barriers.

- CB3: To purchase cosmetic surgery, one must be able to trust the service provider and feel positive about them.

Further, it was uncovered that it is crucial for consumers to be able to trust their physician and according to the industry professionals, disliking the physician's personal demeanour may cause consumers to reconsider their choices. Indeed, physician likeability has been shown to be an especially crucial factor in the evaluation of health services (Crane & Lynch 1988; Jayanti & Whipple 2008; Zarei et al. 2014; Ghosh 2015).

Finally, a total of six barriers to purchasing cosmetic surgery were identified based on the behavioural, normative and control beliefs, modified from the six types of perceived risk. These were: fear of pain and harm, fear of service failure, fear of addiction, fear of social rejection, financial barrier and temporal barrier. These barriers provide a concise overview of all the possible obstacles consumers may experience during their decision-making process, providing considerable insight into cosmetic surgery from the perspective of cosmetic surgery.

8.2 Managerial implications

The results of this study have important and useful implications for health care managers. It is clear, that consumers predominantly value the experiences of others when purchasing complex professional services such as cosmetic surgery. The results of this study regarding the decision-making processes of consumers provide support for this. Managers should direct their advertising efforts to uncovering and fostering truthful and heartfelt testimonials from sources that consumers perceive reliable and relatable (Arnould et al. 2004, 603–607; Dittmar 2008, 20). In a recent Chinese study (Chan et al. 2013), researchers found that advertising messages from medical professionals were seen as being high in information value, however, medical professionals whom advertised caused some suspicions. Respondents strongly believed that the advertising costs of medical services would transfer to the prices of said medical services. Advertisers need to pay attention to the transparency of their advertising efforts and attempt to measure consumers' reactions to their messages, to ensure that the advertising budget does not go to waste.

Further, these results indicate that most consumers spend a considerable amount of time researching potential procedures and service providers. An evaluation of 623 websites containing information about breast augmentation surgery found serious shortcomings in quality of information, especially about risks related to possible complications and mortality rates (Palmaa et al. 2016). Managers should thus focus on the fast availability of quality information but additionally ensure that information directed at consumers is easily comprehensible and answers to the most typical worries of consumers.

Consumers seem to believe that cosmetic surgery is expensive and time-consuming. Further, consumers are concerned of potential surgical risks. Based on this research, man-

agers should provide examples of pricing information, and simple descriptions of procedures that clearly articulate and highlight their benefits through real-life examples and testimonials, honestly and transparently explaining risks and providing easy access to further information.

The results of this study suggest that a significant barrier for purchase is fear of social rejection. The normative beliefs uncovered by this research imply that managers should especially focus their efforts on reassuring consumers of the acceptability and normality of cosmetic surgery. Attempting to strengthen positive beliefs may however be difficult, because with cosmetic surgery the felt need is so subjective. Increasing confidence may result in consumers feeling more confident in their current bodies, and thus not desire to change it. Efforts should also be directed at attempting to reduce the social stigma surrounding the industry. Managers may attempt to influence public opinion through positive consumer experiences and word-of-mouth, with testimonials providing a useful tool for this as well.

Consumers of professional services engage in a lengthy information search (Murray 1991; Lovelock, Vandermerwe & Lewis 1999, 131–133; Mitra et al. 1999; White 2005) and their initial need-recognition happens slowly and over an extended period of time. The results from the interviews with potential consumers of cosmetic surgery highlight this issue; out of the four respondents one had recognized a need for cosmetic surgery, but the three others were mainly discussing hypothetical scenarios. However, their attitudes seemed to be mainly positive in the case an actual need would arise in the future. Managers should perhaps be weary of attempting to coerce potential consumers into coming to appointments too vocally; consumers at the beginning of their need-recognition or information search may find it to be too big of a commitment that early on. Alternatively, managers should ensure that during their information search, consumers are able to easily and effortlessly find all the answers from one place, forming positive and trustworthy associations with the service provider.

Chan et al. (2013) note that health care managers would benefit from supplying their consumers with more information and evidence about the qualifications and expertise of their staff, professionally and non-aggressively. Price appeals do not seem to be a successful tool in advertising, since consumers believe the costs will transfer to the price of the service. Specifically, Thakor and Kumar (2000, 75) found that informational advertising was more effective when selling complex services requiring expertise. They uncovered that such advertising should clarify confusing issues and supply consumers with helpful advice about when and why the service should be used and be encouraging about a potential consultation, but not be aggressive about it. Consumers then become more educated about their options and opportunities and more susceptible to future messages from the service provider.

8.3 Limitations and future research

This research was an initial investigation into the decision-making processes of cosmetic surgery consumers, the beliefs that are associated with its purchase and how they translate into barriers to behaviour. The research was conducted as cross-sectional study due to resource and time-constraints. In the future, it would be interesting and beneficial to study the phenomenon through a longitudinal study (Saunders & Lewis 2012, 124); and investigate the development of beliefs of specific consumers over an extended period of time.

One limitation regarding the methods of the study involved the interview-situations. Fishbein and Ajzen (2010, 72) note that individuals may express different beliefs when confronted with a hypothetical scenario, in contrast to beliefs and behaviour that would occur in a situation faced with actually performing the behaviour in question. However, the beliefs uncovered at the time of the interviews were true to all respondents at that specific time, and acted as determinants to their behaviours. The results were not meant to be generalizable to all consumers or presented as facts, but merely as providing insight into the behaviour of the individuals interviewed. Thus, each response was equally important regardless of the majority of other consumers sharing that belief.

Elicitations are performed to uncover salient beliefs of a target population and those beliefs can be used in the development of further questionnaires (e.g. Ajzen 1991; East et al. 2008, 136). The results of this study can likewise form a basis for the development of questionnaires related to the utilization of cosmetic surgery. However, it should be noted that while data saturation was reached during the interviews, the total number of respondents was relatively small. It would be useful to conduct a similar study replicating the current research, in order to provide more support for the beliefs uncovered through this investigation.

In the past, consumers of cosmetic surgery have predominantly been women, and the current research focused solely on women as consumers. However, as the industry keeps growing, more and more men are becoming interested in the opportunity to enhance their appearance via cosmetic surgery. Out of the total procedures performed in 2015, 10% were performed on men, and the number of male breast-reduction procedures, for instance, increased 26% compared to just the previous year (Cosmetic surgery – 2015). Professionals in the cosmetic surgery industry would benefit greatly from a similar investigation, but focusing solely on the beliefs and decision-making behaviours of men as cosmetic surgery consumers, at a time when the consumer segment has only begun to gain traction, and the majority of men are still likely to consider the industry as mostly taboo.

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APPENDIX 1 INTERVIEW STRUCTURE

- 1) Tell the story of your attitude so far
 - a) Describe your attitude towards cosmetic surgery
 - b) Do you remember any specific incidents related to cosmetic surgery during your life?
 - c) How would you imagine going about purchasing cosmetic surgery? What steps would you take? How would you search for information? How would you evaluate alternatives?
- 2) Elicit salient beliefs:
 - a) What are the advantages or positive things that might result from utilizing cosmetic surgery? Can you think of anything else?
 - b) What are the disadvantages or negative things that might result from utilizing cosmetic surgery? Can you think of anything else?
 - c) What are the advantages or positive things that might result from NOT utilizing cosmetic surgery? Can you think of anything else?
 - d) What are the disadvantages or negative things that might result from NOT utilizing cosmetic surgery? Can you think of anything else?
 - e) Is there anything else you associate with utilizing cosmetic surgery?
- 3) Identify salient referents:
 - a) Are there people, groups or organizations who would approve of, support or encourage your decision to utilize cosmetic surgery? Can you think of anything else?
 - b) Are there people, groups or organizations who would disapprove of, object or discourage your decision to utilize cosmetic surgery? Can you think of anything else?
- 4) Identify control factors:
 - a) Are there any circumstances or factors that might make it easier to utilize cosmetic surgery? Can you think of anything else?
 - b) Are there any circumstances or factors that might make it harder or even impossible to utilize cosmetic surgery services? Can you think of anything else?
 - c) Does anything else come to mind?
- 5) Describe a stereotypical someone who would be actively inclined to utilize cosmetic surgery. What are they like? That is, what do you see as the characteristics or qualities of a person who has decided to utilize cosmetic surgery or has undergone it?
- 6) Now describe a stereotypical someone who would NEVER be actively inclined to utilize cosmetic surgery. What are they like? That is, what do you see as the characteristics or qualities of a person who would NEVER decide to utilize cosmetic surgery or undergo it?