

**CUTS BOTH WAYS: WOMEN'S EXPERIENCES
OF COSMETIC BREAST SURGERY**

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A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfillment of the Requirements
for the Degree

MASTER OF ARTS

Sociology Department
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

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Dedication

To my amazing parents, Dave and Sherry Boulton, for their unfaltering love and support.

Abstract

This research project examines the experiences of women who have undergone elective cosmetic breast surgery. Drawing from qualitative in-depth interviews with twenty four women, this study examines why these women were willing to undergo dangerous and invasive cosmetic surgery procedures to change the appearance of their breasts. It is argued that although the women exercised agency in their decision-making, their choices were severely constrained by a culture that rewards women for conforming to feminine beauty norms, and sanctions those who do not. The women's experiences further reveal that their decisions often "cut both ways." These women's decisions "cut both ways," because while the women acquired personal benefits, these came with significant physical and emotional costs. Finally, it "cuts both ways," because while these women personally benefited, their decisions result in the reproduction of the current beauty system and uphold the unjust feminine beauty norms on which it is based.

Acknowledgments

This research project would not have been finished without the generous assistance of many people. First, I must acknowledge the women who openly and candidly shared their stories with me. My most heart-felt thanks are offered to all of the women who spoke with me about their intimate experiences of cosmetic breast surgery. I am very privileged to have been trusted with their stories.

I am also indebted to my thesis supervisor, Dr. Claudia Malacrida, for her mentorship. She inspired me to undertake this project in the first place, and her knowledge and insight during the course of this project have improved my ability to think creatively and critically. I owe her a debt of gratitude for her careful reading and constructive critique of numerous drafts. I feel honored to have been given the opportunity to have Dr. Malacrida as my mentor.

I would also like to thank Dr. Muriel Mellow and Dr. Michelle Helstein for their work on this project, and for providing valuable critique and comments on early drafts.

I would like to extend a special thank-you to Keith and Hope Ferguson for their generous scholarship. This scholarship and the research grant from the Social Science and Humanities Research Council provided useful financial assistance throughout this project.

Finally, I must thank all of my family and close friends for their much needed support. I am especially grateful to my good friend and confidante, Sarah Fitton, for believing in me and constantly reminding me of the value of this project. Throughout the last two years we had countless discussions regarding this project and Sarah's insight proved to be of immeasurable value.

Table of Contents

Title Page	i
Approval/Signature Page	ii
Dedication	iii
Abstract	iv
Acknowledgments	v
Table of Contents	vi
Chapter 1: Theoretical Framework	1
Research Question	2
Embodied Social Research	3
The Normalization of Cosmetic Surgery	4
Foucauldian Analyses of the Body	7
Bourdieu and Physical Capital	13
Medicalization and Medical Discourse	15
Risk and Uncertainty	17
Feminist Perspectives on Cosmetic Surgery and the Question of Choice	18
Chapter 2: Methodology	25
The Method: Semi-Structured In-depth Interviews	25
Interview Guide	31
Deductive vs. Inductive Approaches to Research	31
Ethical Considerations	33
Recruitment of Participants	35
Description of Participants	39
Collecting Data: The Interviews	42
Data Analysis	49
The Women’s Experiences as Data	52
Chapter 3: An Empowering Decision or Simply a way to “Get By?”	54
Choosing Cosmetic Surgery: A Contradiction in Terms?	54
What Size and Shape of Breast is Best?	59
Growing Pains	62
Undisciplined Flesh	64
Becoming a “Whole Woman”	66
Breasts as Sexual Objects	68
Sexually Desirable Breasts	71
“Using Your Assets”: The Marketability of Physical Capital	74
“I Did it For Myself”: Justifying Cosmetic Breast Surgery	78
“Fun Bags”: Men’s Ownership of Women’s Breasts	80
Doing it for Him	81
Conclusion	84
Chapter 4: “Booborexia”: Medicalizing the Healthy Breast	86
Booborexia	87
What is Medicalization?	88
Medicalization and the Politics of Appearance	91
Medicalization at the Institutional Level: The Impact of Mainstream Media Images	93
“Big Fake Boobs” as the New Normal	95
Resisting Mainstream Media Images?	100
Medicalization at the Interactional Level: Doctor-Patient Interactions	102

The Pre-Operative Consultation as a Site of Medicalization.....	103
Creating “Correct” Female Body Proportions	105
Women’s Breasts as Objects of Medical Scrutiny.....	109
Visual Persuasion.....	110
The Different Degrees of Medicalization	114
Booborexia (Revisited)	119
Chapter 5: Assessing, Managing, and Experiencing Risk	121
What is Risk?	122
Ideal Consumer vs. Passive Patient	125
Strategies for Understanding and Assessing Medical Risks.....	127
Seeking out Risk Information from Non-Medical Experts.....	129
“Reskilling”: Becoming an Expert.....	132
Strategies for Managing Risk and Uncertainty	136
Timing is Everything	136
Finding the “Best” Cosmetic Surgeon	139
Focus on the Benefits.....	142
Minimize or Disregard Risks	145
Barriers to Making Wise Consumer/Patient Decisions.....	147
Contradictory Risk Information	147
Misleading Risk Information	149
Lack of Information	151
Risk as Indefinable.....	153
Experiences of Risk: “At What Cost Do We Have To Pay?”.....	154
Losing Nipple and/or Breast Sensation.....	155
Breast-Feeding Post-Surgery	156
Paying the Cost: Robin’s Story	159
Risk and Personal Responsibility: Leanne’s Story	162
Conclusion	163
Chapter 6: Post-Surgery Experiences	165
Positive Experiences	165
A New Body Image	167
Feeling Youthful, Feminine, and Sexually Desirable.....	169
Becoming “Normal”	173
“Cashing In” on Physical Capital	176
Negative Experiences.....	178
The “Never-Ending Battle”.....	179
Unexpected, Negative Reactions Post-Surgery	184
Conclusion	189
Chapter 7: Cuts Both Ways: Personal Gains and Political Losses	191
Personal Suffering.....	191
Medical Issues.....	193
Consumer/Patient Decisions	194
Resistance in the “Culture of Cosmetic Surgery”	195
Is Meaningful Resistance Possible?.....	199
Individual Acts of Resistance	202
“Beauty Secrets”: The Personal is Political	204
References.....	207

Appendix I: Biographical Information.....	217
Appendix II: Interview Guide.....	221
Appendix III: Face Sheet	228

Chapter 1: Theoretical Framework

I was a late developer. And I was very small. I was always the smallest. I was really wiry and straight and flat. And my friends in school when they started to develop I was still straight and flat. I had my best friend in grade eight her name was “bud” and I was “board.” We were known as “bud” and “board.” And, I only ever got to be an A cup, and it was not even big enough to fit clothes, really. And my husband is a boob guy, he likes boobs, and so we talked about it together. So part of the reason I had a breast augmentation was the self-esteem thing, and part of it was practical because of how clothes fit, and part of it was for him so that we could have a good relationship.

(Lindsey, breast augmentation surgery)

I was the first girl I think in grade 6 to wear a bra. And since I was the first girl to have a bra I was the first one that the guys are trying to pull the bra strap on and stuff. So you are always getting that kind of attention from guys. So I didn't feel good about it [...] And my back was always hunched over, because you are always trying to cover up. And clothing wise, you could never find any clothing where the buttons actually closed. Trying to find a bra that fit was just about impossible. And like when you have boobs that big, they encompass your whole chest, so it doesn't look like boobs anymore it just looks like you're fat there too. You couldn't even see my waist or anything. And, my back hurt constantly because they were so big. So yeah all of that stuff contributed to my decision to have surgery.

(Larissa, breast reduction surgery).

According to Susan Brownmiller (1984), the “emblematic prominence” of breasts makes them the “chief badge of gender” (p. 40). Within our culture breasts are “seen simultaneously as a marker of womanhood, as a visual signifier of female sexualization, as synonymous with femininity, and as essential for the nurturance of infants” (Millstead & Frith, 2003, p. 455). As the excerpts above reflect, from the moment that girls begin to develop breasts they become aware of the various cultural meanings attached to breasts. In part, this means that beginning at puberty we experience our breasts as sexualized objects that are judged under the scrutinizing male gaze. For Lindsey her A cup breasts were a source of dissatisfaction and embarrassment during her youth as her peers judged

her breasts to be “lacking” and taunted her for having a “flat” chest. In contrast, Larissa explained that because she developed breasts before other girls her age she felt uncomfortable in her body, as young boys often paid unwelcome attention to her highly visible chest. Through interactions like these, we begin to learn that this part of our bodies is constantly “on display” and that at times we have little control over what signals our breasts send to others. Over time, we come to realize that a certain size and shape of breast is valued above others, and that our breasts are judged against this ideal. This sexual objectification is clearly reflected by Lindsey’s description of her husband as a “boob guy” and his desire for her to have larger breasts.

While we experience our breasts as sexualized objects that are looked at and judged by others, we simultaneously experience our breasts in intimate and embodied ways. This part of our body changes a great deal throughout our lives due to natural bodily processes such as weight gain, pregnancy, breast-feeding, and aging. From puberty onward, our breasts are the sources of pleasurable sensations while they are also the sources of physical pain or discomfort. In short: we experience our breasts in various, and often conflicting, ways throughout the course of our lives. As the above excerpts suggest, and as we will see in this thesis, the women’s reasons for undergoing cosmetic breast surgery were intimately shaped by the multiple, complex, and contradictory cultural meanings that are attached to women’s breasts.

Research Question

Before I enter into any further discussion on the experiences of the women in this research project, I feel it is necessary to explain why I chose to interview women who have undergone cosmetic breast surgeries. In doing this, I will engage in what Finlay

(2002) describes as “explicit self-aware meta-analysis” (p. 209). In concrete terms, this means that through a reflexive self-analysis I will describe how it was that I came to study this topic and how my own feelings, experiences, beliefs, and values intimately affected this decision. I think that it is crucial to be reflexive, because as Guillemin and Gillam (2004) argue, social researchers need to understand that “[o]ur research interests and the research questions we pose, as well as the questions we discard, reveal something about who we are” (p. 274). Further, as this is a feminist research project, I understand that the “personal is political” and that I must acknowledge how my personal biography as well as my political interests have impacted this research project from start to finish (Reinharz, 1979; Cook & Fonow, 1990; Westkott, 1990; Maynard, 1994; Letherby, 2003).

Embodied Social Research

I experience myself as embodied, incorporated, incarnated in my body. To be present in the flesh is to evidence this implication of my self in my body (Young, 1997, p. 32).

In part, my decision to research this topic stems from my own feelings and experiences regarding my breasts. I can recall numerous occasions in my teenage years when I stood naked in front of the mirror silently wishing that my breasts would one day look like the full, firm, perky breasts that I saw in the media. I would stand there and using my hands, would push my breasts up and squish them together in an attempt to make them look like the perfect breasts showcased on television, in movies, and magazines. As I grew up and went off to university I began to come to terms with the fact that my wish for the perfect breasts would never (naturally) come true. However, it was not until I completed several senior-level undergraduate courses on gender, feminist

theory, and the body that I began to connect my own subjective experiences regarding my body with Western cultural standards of hegemonic femininity and idealized beauty.

It was in one of these undergraduate classes that I first encountered Iris Marion Young's (2003) article entitled "Breasted Experience: The Look and the Feeling." In this important feminist work on the body, Young aptly states that "[i]n the total scheme of the objectification of women, breasts are primary things" (p. 152). Further, she explains that in our culture where breasts are objectified and fetishized, there is one ideal size and shape for breasts, and this is an ideal that few women, if any, naturally possess. Young states:

Like most norms of femininity, the normalized breast hardly describes the "average" around which real women's breasts cluster. It is an ideal that only a few women's bodies even approximate; given the power of the dominant media, however, the norm is ubiquitous, and most of us internalize it to some degree, making our self-abnegation almost inevitable (p. 154).

After reading Young's article, I began to understand that within our culture where there is one ideal feminine size and shape of breasts it is to be expected that many women, including myself, would feel that their breasts are inadequate and problematic because they do not resemble this cultural ideal. Following the revelation that my individual feelings and experiences regarding my breasts were intimately linked to larger social and cultural structures, I began to consider interviewing women about their experiences of undergoing cosmetic breast surgeries.

The Normalization of Cosmetic Surgery

At this point in my decision-making process I turned my attention to literature on cosmetic surgery, and I became convinced that this project could not have been

undertaken at a more opportune time. Recent statistics on cosmetic surgery demonstrate how increasingly popular these procedures have become. According to the American Society for Aesthetic Plastic Surgery (2006) there were 11.5 million cosmetic procedures performed in the United States in 2005 and 91% of those procedures were done on women. This is a 444% increase in cosmetic procedures since 1997. Statistics on cosmetic procedures done in Canada, report that there were 302,000 surgical and non-surgical cosmetic procedures performed in 2003, and this is an increase of nearly 60,000 procedures or 24.6% from 2002 (Plastic Surgery Statistics, 2003). Next to liposuction, the most popular cosmetic surgery procedure in the United States and Canada is breast augmentation surgery (ibid).

These statistics are startling because unlike other “beauty treatments,” cosmetic surgery procedures are dangerous and invasive. However unlikely, it remains a fact that undergoing cosmetic surgery could result in serious complications and possibly death. For example, potential complications following cosmetic breast surgeries include: excessive bleeding, infection, complications from the anesthesia, change in nipple and/or breast sensation, the inability to breast-feed or difficulty breast-feeding, breast asymmetry, disfigurement, and excessive scarring (Canadian Society of Plastic Surgeons, 2006; American Society of Plastic Surgeons, 2007). In addition to those already listed, potential complications specific to breast implants may also occur, such as: rupture or deflation of the implant(s), wrinkling or rippling of the implant(s), chest wall deformity, tightening of the scar tissue surrounding the implant(s), and difficulty detecting cancer through mammograms due to the placement of the implants (U.S. Food and Drug Administration, 2004; Health Canada, 2005). It should also be noted that silicone breast implants have been linked to autoimmune symptoms and diseases, such as rheumatoid

arthritis, Lupus, Raynaud's phenomenon, and Sjogren's syndrome (Mellican, 1995, p. 11).

The current social context has led writers such as Blum (2003) to argue that we are living in a *culture of cosmetic surgery*. Within this culture the decision to undergo cosmetic surgery procedures is constructed as a completely natural and normal solution for women who wish to fix their "abnormal" or "problematic" bodies. Further, Bordo (1997) argues that because cosmetic surgery has become an ever more acceptable way for women to alter their physical appearances, our culture is increasingly made up of "plastic" and "malleable" bodies. In fact, Morgan (2003), claims that not only is "elective cosmetic surgery moving out of the domain of the sleazy, the suspicious, the secretively deviant, or the pathologically, narcissistic, it is *becoming the norm*" (italics in original, p. 165). The mainstream media greatly facilitates the normalization of cosmetic surgery by constructing cosmetic surgery procedures as the only means through which women can achieve a physical appearance that meets, or at least approaches, the ideal feminine body shape. Several feminist writers have critiqued these mainstream media forms for constructing the decision to undergo cosmetic surgery as a potentially empowering and liberating choice for women who wish to change their appearances (c.f. Woodstock, 2001; Brooks, 2004; Weber, 2005).

The increasing normalization of cosmetic surgery procedures, combined with my own embodied experiences, convinced me that it was important to undertake a research project that looked at the experiences and meanings of women who have undergone cosmetic breast surgeries. More specifically, I wanted to examine the experiences of women who voluntarily undergo cosmetic breast surgeries, with the goal of understanding what our Western cultural feminine ideals and hegemonic beauty standards mean in the

lives of some women. In so doing, I hoped to address why some women are willing to risk undergoing dangerous and sometimes life-threatening operations in order to modify their bodies. However, before I could begin speaking to women about their embodied experiences, I felt it was critical to undertake an extensive review of literature relating to women's bodies, cosmetic surgery, idealized beauty, and hegemonic femininity.

Foucauldian Analyses of the Body

In my review of the literature, I found Foucauldian analyses of the body to be particularly enlightening. According to Sandra Lee Bartky (2003), Foucault provides useful tools for understanding why women spend a large amount of time, energy and money engaging in beauty practices. In her article, "Foucault, Femininity, and the Modernization of Patriarchal Power", she employs Foucault's conception of the *panopticon* and the *gaze* to understand women's strict adherence to norms of femininity. The Panopticon was an architectural design for a prison put forward by Jeremy Bentham in the eighteenth century. This design would allow an observer to see all of the inmates of the prison without the inmates being able to see their observer or to see one another. At the same time, inmates would not know exactly when they were being observed so they would begin to self-police in order to ensure that they would always be seen favorably. In his book *Discipline and Punish* (1977), Foucault uses the idea of the Panopticon as a metaphor for understanding modern methods of social control. Bartky employs Foucault's metaphor to demonstrate that women in our current society are like the prisoners of the Panopticon, in that they are self-policing. According to Bartky, women are constantly objects of the scrutinizing male gaze, and as such, women feel extreme pressure to look like the socially constructed feminine ideal. This extreme pressure leads

women to internalize society's norms and values of femininity, which in turn compels women to engage in self-policing so as to discipline and manipulate their bodies to represent the idealized feminine body. In addition to self-policing, Bartky states that women actively police one another to look and act "properly" feminine. Thus, the internalization of the norms of femininity comprises an insidious form of social control that results in many women spending a large amount of time, money, and energy on their appearances.

Bartky also appropriates Foucault's ideas of the *docile body* and *technologies of the self* to argue that gendered bodies are produced through disciplinary techniques. In Foucault's work entitled *Technologies of the Self*, he provides a very useful theory for understanding how bodies become imprinted with the norms and values of the society in which they live. According to Foucault (1994), technologies of the self can be understood as techniques that "permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (p. 146). Bartky incorporates gender into Foucault's definition of technologies of the self to demonstrate how, through technologies of femininity, women are able to produce "proper" feminine bodies. Specifically, through the use of disciplinary techniques such as exercise and diet, Bartky argues that women discipline their bodies to reflect the ideal feminine body. In addition, women ornament their bodies, according to Bartky, through technologies of femininity such as the use of make-up and clothing. However, this ornamentation requires discipline as women face social sanctions for not employing these techniques of femininity correctly. Thus, although make-up and clothing are often constructed as ways for a

woman to be creative and embody her identity, Bartky states that this is a very limited form of creativity.

Bartky's analysis demonstrates the usefulness of Foucault's theoretical framework for understanding how culture is imprinted on individual bodies. According to McLaren (2002), Foucault's work is important because he "politicizes the body, and his notions of disciplinary practices and micro-power are useful tools for feminist analyses of the body, especially to illuminate the patriarchal power of feminine cultural norms" (p. 81). Indeed, Foucault (1977) argues that in modernity the body is "directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs" (p. 25). Similarly, through the use of cosmetic surgery procedures women invest time and money into their bodies, and literally carve into and mark their bodies, to ultimately emit signs of ideal femininity. In her Foucauldian analysis of cosmetic surgery, Brush (1998) states that, "[t]he metaphor of inscription becomes alarmingly literal as the surgeon's knife carves socially endorsed, nevertheless essentially arbitrary, ideals of beauty on to the plastic bodies of women who 'choose' to conform more closely to the norms or ideals society constructs" (p. 24). The invasiveness and permanence of cosmetic surgery as a technology of femininity takes Bartky's analysis to a frightening new level.

Currently, the media puts extreme pressure on women to look like the cultural ideal. In contemporary Western society we are inundated with images of women in magazines, advertisements, television programs and movies who have the ideal feminine body shape. The media's representations of the perfect feminine body are increasingly understood to be reflections of what "normal" women's bodies should look like. Although they are taken to be the norm, the ideal feminine body shape showcased in the

media is not easily achieved by the majority of women in society. According to Saul (2003) what is considered the ideal feminine body shape has changed throughout history, but what has remained the same is that the ideals are always “unnatural for many women” because “women naturally come in a variety of sizes” (p.145). This means that no matter what is considered ideal there will be a large number of women who will not embody this ideal.

Although we may realize that the ideal feminine body shape portrayed in the media has been “corrected” and “enhanced” surgically and through computer programs, we often cannot help but engage in self-policing and self-critique by comparing our bodies to these idealized images. However, when we discover through our own critical gaze that we do not measure up to this ideal, we can begin to view our bodies, or certain parts of our bodies, as problematic. The significant gap that exists between most women’s physical appearances and the ideal feminine appearance requires women to spend a great deal of time and energy disciplining their bodies to conform to the norms of femininity. Further, this narrow ideal of feminine beauty means that we become alienated from our own bodies, which become fetishized to us as “things” to be improved in order to conform to these impossible ideals. Currently, the ideal feminine body shape is “curvaceously thin” (Harrison, 2003). This ideal is embodied by women who are thin but have large breasts. Obviously the majority of women in society cannot fit this current ideal because women who are thin have less body fat and thus typically have smaller breasts. In order to fully embody this ideal the majority of women would need to engage in cosmetic surgery procedures such as liposuction and/or breast augmentation.

As the above discussion demonstrates, Foucauldian analyses of the body reveal how through social practices such as cosmetic surgery, bodies are marked with cultural

norms. In the following section, I will discuss how Foucault's conception of power provides a useful framework for understanding women's decisions to undergo cosmetic surgery procedures. McLaren (2002) summarizes Foucault's understanding of power in these words:

Foucault's analytics of power is clearly superior to traditional modes of power...the idea that power operates through cultural and social norms, through discourses, and from below as well as from above allows for the recognition of the normalizing power of the media and visual images, as well as the discourses of science and medicine (p. 96).

As McLaren points out, power operates on bodies through multiple channels. And in the case of cosmetic surgery power is literally engraved into the bodies of women by the surgeon's scalpel.

According to Foucault's model, power is both repressive and productive. Power can be understood as repressive in the sense that disciplinary methods such as constant supervision, categorization, and intense training, are oppressive ways of controlling bodies. Indeed, in *Discipline and Punish* Foucault (1977) argues that modern forms of disciplinary techniques are a much more invasive use of power than traditional modes of control and discipline. The invasive nature of these disciplinary techniques can be witnessed as power is transmitted and acts upon individual bodies. However, Foucault points out that these same repressive techniques are also productive. For Foucault disciplinary techniques are productive in the sense that they produce useful and efficient citizens, and these citizens experience "gains" through their compliance.¹ Therefore, Foucault suggests that docile bodies are the result of power relations that are simultaneously repressive and constructive. Foucault terms this relation of power

¹ The idea that individuals benefit through their complicity is something that I will discuss more fully later in this chapter.

“docility-utility” (p. 137), because bodies become docile through oppressive disciplinary techniques, but bodies are also made useful. This complex relationship is further highlighted by Foucault (1977) when he states that “[t]he body becomes a useful force only if it is both a productive body and a subjected body” (p. 26).

By applying a Foucauldian understanding of power to cosmetic surgery it is possible to understand why women would choose to engage in oppressive technologies of femininity such as cosmetic surgery. McLaren (2002) argues that in Foucault’s model, “[w]omen are not simply passive objects adhering to patriarchal demands, nor are they duped by culture”, but rather “[t]here is an entire system of social rewards (and punishments) that reinforces appropriate gender behaviour” (p. 97). As McLaren points out, Foucault’s model of power allows one to see how cosmetic surgery is both an oppressive and a productive act of power. On the one hand, the act of cosmetic surgery results in the inscription of oppressive feminine beauty norms onto a woman’s body. On the other hand, undergoing cosmetic surgery can be productive for women, because in a beauty obsessed culture embodying ideal femininity results in real rewards for women who comply with these norms. Conversely, those who do not embody “correct” feminine body norms may face painful social sanctions. Bartky (1988) states:

The lack of formal public sanctions does not mean that a woman who is unable or unwilling to submit herself to the appropriate body discipline will face no sanctions at all. On the contrary, she faces severe sanction indeed in a world dominated by men: the refusal of male patronage. For the heterosexual woman, this may mean the loss of badly needed intimacy; for both heterosexual women and lesbians, it may well mean the refusal of a decent livelihood (p. 38).

Given the above possible social sanctions for women who do not discipline their bodies to look “properly” feminine, it becomes clear why some women might choose to undergo painful cosmetic surgeries.

Bourdieu and Physical Capital

Pierre Bourdieu's conceptualization of capital provides a different, but complementary, theoretical perspective that allows for an understanding of women's strict adherence to feminine beauty norms, and their complicity in the practice of cosmetic surgery. Bourdieu builds on Marx's idea of economic capital to provide a more nuanced understanding of how the volume and structure of the different forms of capital, such as economic, cultural, physical, social, and symbolic, directly effect the positioning of individuals within social space. In his work, "Social Space and Symbolic Space" Bourdieu (1998) demonstrates that the different types of capital are powerful "weapons." This is because an individual's social position is directly related to the volume and structure of capital that they possess. This idea can be usefully applied to the topic of cosmetic surgery. For women in Western society embodying the feminine ideal body shape is a powerful type of physical capital. Chris Shilling (2004) states the Bourdieu's conception of physical capital "illuminates the value placed upon the size, shape and appearance of the flesh" (p. 474). In a culture that is obsessed with beauty and the female body, to possess physical capital is to increase one's social value.

As was noted above, there are real rewards for women who embody dominant norms and values of femininity in Western culture, just as there are severe social sanctions for women who do not measure up to the hegemonic feminine ideal body shape. Using Bourdieu's theoretical framework one can see how cosmetic surgery might be used as a tool for women to increase their physical capital. In this sense women are not cultural dupes, but rather they are culturally aware agents who are investing in their bodies in order to better their positions within social space. Debra Gimlin (2000) draws on this

idea in her article “Cosmetic Surgery: Beauty as Commodity.” Although Gimlin does not explicitly acknowledge Bourdieu’s theory of physical capital, one can see the link as she argues that “beauty is a commodity,” and that women who choose to undergo cosmetic surgery should be viewed as “savvy cultural negotiators” who understand that a woman’s worth is largely measured by her physical appearance (p. 96).

As “savvy cultural negotiators” women are likely to realize that increasing their physical capital may have real “pay-offs” in the dating market and the job market, which may in turn lead to increased economic capital. Shilling (2004) states:

While our physicality has become a possessor of symbolically valued appearances, it is additionally implicated in the prosaic buying and selling of labour power and the accumulation of other forms of capital. These facets of the body’s importance can be acknowledged conceptually if we refer to the *production* of physical capital as involving the development of bodies in ways recognized as possessing value in social fields, and the *conversion* of physical capital...into economic capital (money, goods and services), cultural capital (e.g. educational qualifications), and social capital (interpersonal networks that allow individuals to draw on the help/resources of others), and is key to the reproduction of social inequalities (italics in original, p. 474).

Thus, as Shilling points out, physical capital finds its way to other forms of capital. And as I will discuss in the third chapter, some of the women in my study described how changing their appearances (increasing their physical capital) allowed them to accumulate other forms of capital through relationships and employment opportunities, for example.

It is important to acknowledge, however, that not all individuals have equal access to all forms of capital. According to Bourdieu the reproduction of class differences does not occur in a “social void,” but rather, the reproduction of class takes place within social space where certain classes of individuals have greater access to the different types of capital (Bourdieu, 1998, p. 12). White middle and upper class women are more likely to have access to economic capital which they can then exchange for physical capital by

purchasing cosmetic surgery procedures. Thus, in the pursuit of physical capital, middle and upper class women “win out,” as lower class women are judged by the same beauty standards, but are constrained by their lack of economic capital. Bourdieu further argues that the class differences which exist in social space are not “given”, but are “something to be done.” Thus, the reproduction of differences among women in terms of physical capital is something women “do” through practices such as cosmetic surgery.

Medicalization and Medical Discourse

Having adequately addressed the impact of cultural norms on women’s decisions to undergo cosmetic surgery, I will now turn to a brief discussion of the medicalization of healthy feminine features and attributes. According to Riessman (2003):

The term *medicalization* refers to two interrelated processes. First, certain behaviors or conditions are given medical meaning – that is defined in terms of health and illness. Second, medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms (p. 47-48).

Today, one can see how through medicalization completely normal and healthy body parts and facial features are constructed as abnormal and problematic, and in need of a surgical solution. In her discussion of medicalization Riessman also points out that through the process of medicalization the social causes of a disease, illness, condition, or disorder are obscured. In other words, medicalization masks the social reasons that cause women and men to undergo dangerous cosmetic surgery procedures in the first place, and hinders the potential for social change. Thus, instead of seeing how the practice of cosmetic surgery is socially and culturally rooted, we understand cosmetic surgery as rooted in medical realities. In chapter four, I will discuss the cultural reasons underlying the women’s experiences of medicalization, and how the women’s decisions to undergo

cosmetic surgery are reflective of a culture that constructs one size and shape of female breasts as “normal” and “healthy.”

Medical discourse, which is dispensed through medical institutions, practices, and expert knowledge, plays a significant role in medicalization as it constructs diagnoses and treatments for healthy and normal features or attributes. According to Pippa Brush (1998) the medical and popular discourses relating to cosmetic surgery imply that:

If there is a “problem,” a “symptom” which needs to be “cured,” then to refuse to elect that “cure” is only perverse; who after all, would not want to be cured of deformity? Cosmetic surgery is characterized as “corrective,” then as preventative, and ultimately as necessary (p. 31).

Women who do not want to “fix” their bodies are constructed, at best, as complacent or lazy, and at worst, as mentally ill or perverse. Thus, women may appear to be free to choose whether or not they should undergo cosmetic surgery procedures, but in reality their decisions are largely shaped by discourses that tell women they will be rewarded if they embody “correct” femininity, and punished if they do not.

A clear example of the process of medicalization and the power of medical discourse is found in Eugenia Kaw’s (1993) research on Asian-American women who underwent cosmetic surgery procedures to alter the shape of their eyes and noses. According to Kaw, medical discourse constructs Asian-American women’s features as pathological and this heavily influences Asian-American women’s decisions to undergo cosmetic surgery procedures. Kaw’s research highlights the political element of medicalization as it is subordinate groups within society that are the most likely to have their physical features and attributes defined and treated as medical problems. The use of medical language to define normal physical features as problematic was frequently reflected in the interviews in my research. In chapter four, we will see how this medical

language, used on behalf of the cosmetic surgeons, served to deepen the women's feelings of defect and convince them that cosmetic breast surgery was a necessary medical treatment.

Risk and Uncertainty

While medical and popular discourses serve to medicalize healthy feminine appearances, these discourses also help to create the understanding that women are responsible for understanding the medical risks associated with undergoing cosmetic surgery and for adequately assessing and managing these risk possibilities. Drawing on Foucault, Robert Castel (1991) argues that over the last hundred years the “notion of *dangerousness*, formerly used to designate the privileged target of preventative medical strategies”, has been replaced by the “notion of *risk*” (italics in original, p. 282). According to Castel, risk “is the effect of a combination of abstract *factors* which render more or less probable the occurrence of undesirable modes of behaviour” (italics in original, p. 287). Deborah Lupton (1999) argues that the notion of risk is intimately tied to “individualization” which “emphasizes personal responsibility for life outcomes” (p.107). More specifically, she states that within this social context individuals are expected to be aware of risks and to make decisions in order to avoid these risks.

According to Suzanne Fraser (2003), the idea that individuals are responsible for their life outcomes occurs frequently in medical discourse relating to cosmetic surgery. In an analysis of medical texts Fraser found that an emphasis was put on the “individual to become informed about the risks and benefits of surgery, and to weigh them up independently and dispassionately” (p. 36). Concretely, this means that although cosmetic surgeons are required to be open and honest regarding risks, it is ultimately up to the

individual to understand the risks and decide for herself if the benefits outweigh the risks involved. Fraser states that while on the one hand women are constructed as responsible decision-makers, on the other hand, women are often treated as being unable to fully comprehend and cope with the medical information given to them. She argues that ultimately this contradiction results in cosmetic surgeons being excused for providing insufficient advice and inadequate results. Thus, when women have complications following cosmetic surgery they are often understood to be responsible for their own suffering, because it is assumed that they knew the risks involved and chose to have the surgery despite these possibilities. In chapter five, we will see that the women's actions reflected that they understood it was their responsibility to make "wise" consumer/patient decisions, and thus they employed various strategies for assessing and managing risk and uncertainty.

Feminist Perspectives on Cosmetic Surgery and the Question of Choice

As the above analysis demonstrates, women's decisions to undergo cosmetic surgery can be impacted by a variety of social factors, and within this social context the issue of choice in relation to cosmetic surgery becomes increasingly contentious. Currently there are important debates with feminist literature relating to cosmetic surgery and the issues of agency, choice, social control, and hegemonic femininity. On one side of the debate, theorists have drawn from Foucault's theories, outlined above, to argue that women police one another and engage in self-policing in order to discipline their bodies to look and act like the hegemonic feminine ideal (Bartky, 1988). Thus, some academics have concluded that women do not freely choose cosmetic surgery, but are systemically coerced by oppressive patriarchal beauty norms (c.f. Spitzack, 1988; Morgan, 1991;

Brush, 1998). On the other hand, some researchers have argued that women are free agents who make a culturally conscious choice to undergo cosmetic surgery, and this choice may actually be empowering for women. Academics within this vein of thought argue that women are conscious of the fact that having an ideal feminine body shape is a form of cultural capital, and thus women choose to modify their bodies in order to gain power through their bodies (Davis, 1995; Gimlin, 2000; Davis, 2003). A third argument is that cosmetic surgery can be an empowering individual choice, but is oppressive for women as a group (Gagne & McGaughey, 2002).

Space will not permit me to give a detailed account of this debate, but instead I will outline the radical feminist framework set forth by Sheila Jeffreys, and then explain why I chose to take a different approach in this research project. Jeffreys (2005) argues that Western beauty practices ranging from make-up to cosmetic surgery should be understood and *legislated* by the UN in the same way as female genital mutilation. The main argument of her book *Beauty and Misogyny* is that Western beauty practices, such as cosmetic surgery procedures, should be understood as “harmful cultural practices” that represent women’s subordination. Indeed, Jeffreys argues that “a continuum of western beauty practices from lipstick at one end to invasive cosmetic surgery at the other, fit the criteria set for harmful cultural practices in United Nations understandings, although they may differ in the extremity of their effects” (p. 28). Jeffreys states that oppressive Western beauty practices have arisen out of a society in which women are afforded a subordinate status relative to men, and that women are required to embody feminine beauty ideals because this demonstrates their “difference/deference” relative to men (p. 24).

Although Jeffreys analyzes several different Western beauty practices, most interesting for this research topic is Jeffreys's discussion of cosmetic surgery as a harmful cultural practice. In an article published prior to *Beauty and Misogyny* Jeffreys (2000) argues that cosmetic surgery should be understood as "self-mutilation by proxy." She states that cosmetic surgery, or "self-mutilation by proxy" is similar to "self-mutilation in private by the fact it is practiced overwhelmingly by groups in society with unequal access to power or influence" (p. 414). Jeffreys states that cosmetic surgeons should be understood as proxies who assist women in acts of self-mutilation and self-hatred. She further discusses how the "proxy [cosmetic surgeon] gains financial benefit, sexual excitement, or both, from carrying out the mutilation" (Jeffreys, 2005, p. 150).

Jeffreys' work is perhaps the paradigmatic example of feminist literature that constructs women who undergo cosmetic surgery as oppressed victims of a patriarchal society. Jeffreys is highly critical of liberal feminists who, beginning in the 1990's, argue that cosmetic surgery might be an empowering choice for women. Specifically, Jeffreys argues that, "beauty practices are not about women's individual choice or a 'discursive space' for women's creative expression", but rather they are "a most important aspect of women's oppression" (p. 2). In addition, she states that "liberal feminists do not acknowledge the forces that restrict and can even eliminate women's ability to choose" and thus "they can be seen to protect the status quo of the cultural sexual objectification of women" (p. 13). According to Jeffreys, her work is an attempt to dismantle the status quo, upheld by liberal feminists, through a radical feminist analysis of Western beauty techniques. She concludes her book by arguing that in order for women to increase their status within Western society we must eliminate harmful beauty practices that construct

women as “different/deferent” and this means that the “bastion of male dominance will have to be breached” (p. 179).

I think feminist literature such as Jeffreys’ is useful as it provides a strong critique against oppressive beauty techniques such as cosmetic surgery, and in so doing, encourages the need for social change. In addition, this literature demonstrates how social structures constrain and shape women’s decisions to undergo cosmetic surgery procedures. However, the main problem that I see with this type of theorizing is that it leaves little room (or in Jeffreys’ case no room) to consider women’s agency. The underlying assumption is that women are passive victims of a patriarchal beauty system, and I would argue that this construction of women as passive victims is largely false and offensive. I agree with Alkeline Van Lenning (2002) who argues that women are not “just passive victims; they are capable of taking responsibility for their actions, and responding to reason as they see it” (p. 548). Further, it is important to note that Jeffreys never actually talked to women about their decisions to engage in these beauty practices. Perhaps if she had, it might have been necessary to take the agency of women into account. In addition, I agree with Lenning who states that as feminists we should be critical of practices such as cosmetic surgery “without undermining the people who choose [cosmetic surgery] as a solution for their problems” (ibid). Thus, I needed to find a theoretical framework in which I could take women’s agency into account while simultaneously remaining critical of the social structures that impinge on women’s decision-making.

Patricia Gagne and Deanna McGaughey (2002) provide a good example of a feminist approach that treats women who undergo cosmetic surgery as both agents and objects. The authors argue that on the one hand, a feminist approach that sees women as

culturally coerced into undergoing cosmetic surgery is problematic because it overlooks individual agency. On the other hand, the authors argue that a feminist perspective that constructs women as rational decision makers is problematic because it tends to lose sight of how social structures impact women's decisions to undergo cosmetic surgery procedures. These authors state that there is a need for a "synthesized theoretical perspective that simultaneously accounts for women's agency and subordination within the practice of cosmetic surgery" (p. 817). Through an analysis of qualitative interviews with women who underwent elective cosmetic breast surgeries, the authors argue that "women electing cosmetic mammoplasty exercise agency, but they do so within the confines of hegemonic gender norms" (p. 835). Furthermore, Gagne and McGaughey argue that the practice of cosmetic surgery "can be empowering for individual women while reinforcing the hegemonic ideals that oppress women as a group" (p. 814). In addition, the authors state that there is a need for a new language in order to transcend the current dualism present in feminist writing. They conclude by stating that a new language combined with a synthesized approach to understanding why women choose to undergo cosmetic surgery is necessary in order to provide a more complete picture.

I find the approach put forth by Gagne and McGaughey to be very useful for understanding women's decisions to undergo cosmetic surgery. This framework is similar to the one employed by Kathy Davis (1995) in her book *Reshaping the Female Body*.

Davis states:

My analysis is situated on the razor's edge between a feminist critique of the cosmetic surgery craze (along with the ideologies of feminine inferiority which sustain it) and an equally feminist desire to treat women as agents who negotiate their bodies and their lives within the cultural and structural constraints of a gendered social order. (p. 5)

Feminist researchers such as Davis and Gagne and McGaughey offer approaches that I think are superior to Jeffrey's framework, because they appreciate the agency women employ, but at the same time, do not lose sight of the social context within which women make choices regarding their bodies. In this research project I have attempted to respect and understand the women's experiences and choices while simultaneously remaining critical of the practice of cosmetic surgery and the oppressive feminine beauty norms which uphold it.

There are noteworthy issues with this theoretical framework, however, that must be addressed. According to Llewellyn Negrin (2002), stating that cosmetic surgery may be an empowering choice for women who wish to change their appearances overlooks the "causes for women's dissatisfaction with their bodies in the first place" (p. 24). Negrin (2002) argues that although it is important to acknowledge that women are not completely passive objects, writers, such as Davis, tend to "overstate the degree to which individuals are able to actively intervene in the system and construct meanings that run counter to those of the dominant ideology" (p. 26). In fact, Davis (1995) emphasizes individual agency to the point that she states that women who undergo cosmetic surgery are "heroes," who actively pursue their goals and overcome various obstacles in the process (p. 132-134). I do not agree with Davis' construction of women who undergo cosmetic surgery as "heroes," because it implies that women who choose to change their physical appearances are somehow more "heroic" than women who choose to suffer with their self-perceived flaws. Furthermore, I find it unsettling to think that these women who Davis understands to be heroes are, through their actions, perpetuating oppressive dominant feminine beauty norms. Although I do not believe that constructing women

who undergo cosmetic surgery as victims is the answer, I also do not believe that understanding women as heroes or empowered individuals is the answer either.

Therefore, in this study I employed a theoretical framework that allowed me to understand the women as agents who often decide to undergo cosmetic breast surgery, not as a way to gain a sense of empowerment, but as a means through which they can “get by” within a cultural context that offers them few other viable alternatives. While I do not condemn the women in this study for their decisions, I am extremely critical of the practice of cosmetic surgery as it only affords women power through their complicity in an oppressive beauty system. Further, the power gained through this complicity is extremely limited, and as many of the women in this study will attest it often comes at a high price.

Chapter 2: Methodology

After reviewing some of the literature outlined in the first chapter, and carefully reflecting on my own embodied experiences, I decided to undertake a research project that examines the experiences of women who voluntarily undergo cosmetic breast surgeries. I felt that this topic was very important given both the symbolic importance of women's breasts in our culture, and the recent normalization of cosmetic breast surgeries. In addition, given my own experiences and feelings regarding my breasts I knew that I would be able to bring compassion, empathy, and understanding to the research project. Finally, I decided that an analysis of different cosmetic breast surgeries (breast augmentation surgery, breast reduction surgery, and reconstructive surgery) would permit me to understand issues of choice, idealized beauty, identity, and the social control of women's bodies in more subtle ways than studying one form of cosmetic breast surgery alone.

The Method: Semi-Structured In-depth Interviews

Furthermore, I decided it was important to undertake a qualitative interview-based study after considering the value that I place on women's embodied experiences as sources of knowledge. One main reason I chose this method is because I believe that women who have undergone cosmetic surgery on their breasts are authorities or experts on the topics of their breasts and their cosmetic surgery experiences. Recognizing my own complex, and often contradictory, feelings and experiences regarding my breasts, it seemed obvious to me that the best way to fully understand other women's experiences and meanings of their breasts would be to talk to women themselves. My belief that women are authorities on their own experiences is rooted in feminist scholarship that has

critiqued the male-centered tradition in the social sciences and its ignorance towards women's experiences (c.f. Smith, 1974; Fox Keller, 1983; Westkott, 1990; Hartsock, 1998). Reinharz (1992) argues that interviewing women is a way to begin to hear and value women's historically silenced voices. Reinharz states:

Interviewing offers researchers access to people's ideas, thoughts and memories in their own words, rather than the words of the researcher. This asset is particularly important for the study of women because this way of learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women (p. 19).

Thus, part of the reason I decided on a qualitative interview-based approach is because it would allow the women in the project the rare opportunity to talk about their largely ignored experiences with a researcher who could relate to their embodied experiences. And, through in-depth semi-structured interviews the women's embodied experiences and their voices would be given important value, as they would form the basis of the research project.

This method was chosen because I wanted to understand the meanings and experiences of women who have undergone cosmetic breast surgeries. Seidman (1991) states that “[a]t the root of in-depth interviewing is an interest in understanding the experiences of other people and the meaning they make of that experience” (p. 3). McCracken (1988) argues that this method allows a researcher to “step into the mind of another person” and to “see and experience the world as they do themselves” (p. 9). Thus, I felt this method would provide me with the opportunity to understand the intimate experiences of women who have undergone cosmetic breast surgeries and the meanings that they attached to these experiences. As Johnson (2002), argues, this method allows researchers to gain a deep understanding of their research topic, as it allows the researcher the ability to gain a thorough understanding of a complex, multi-dimensional

phenomenon. According to Johnson, through in-depth qualitative interviewing researchers may be able to gain the same “deep level of knowledge and understanding” as the participants (p.106).

This research also draws from literature on feminist standpoint epistemology. Letherby (2003) states that at the heart of feminist standpoint epistemology is the belief that “experience should be the starting point for any knowledge production” and the insistence on the “need to investigate and theorize the social world from the perspective of women” (p. 44). The importance of starting from women’s perspectives can be traced back to Smith’s (1974) article, “Women’s Perspective as a Radical Critique of Sociology” which critiques the traditional masculinist discipline of sociology and argues for a “new” sociology that starts from the standpoint of women. Following in line with Smith’s argument, Hartsock (1998) states that “women’s lives differ structurally from men’s” and thus she argues that studying women’s lives provides a way to connect personal experiences with structures that disadvantage women as a group (p. 107). In addition, by acknowledging as Hartsock does, that there are plural standpoints rather than a single “standpoint” it is possible to incorporate women’s experiences without engaging in essentialism (Fawcett & Hearn, 2004, p. 210). The literature on feminist standpoint theory convinced me that interviewing women would allow me to hear the women’s intimate and complex stories from their own unique standpoints, and to connect their personal stories with cultural and social structures that oppress women as a group. In addition, due to my own embodied experiences I felt that I would be able to relate to the standpoints of the women I interviewed, and by recognizing our common embodied experiences I would be able to “bring the women’s realities into sharper focus” (Cook & Fonow, 1990, p. 73).

Because of the intersubjective nature of this method, the participants in my study were not objects of study, but rather were active subjects in the interview process. Several writers have put forth the argument that one of the crucial tenets of feminist qualitative research is the intersubjectivity between the researcher and the participants and the mutual construction of knowledge (c.f. Cook & Fonow, 1990; Westkott, 1990; Maynard, 1994; Olesen, 1994; Letherby, 2003; Oakley, 2003). This non-hierarchical, non-exploitive, approach to interviewing fit with my goals of understanding the women's experiences from their standpoints and allowing the women an opportunity to discuss their largely ignored experiences with an understanding researcher. In addition, as I will discuss later in this chapter, I found that this approach allowed the women I interviewed to talk to me candidly about their intimate experiences as if I was their friend or peer. Although a completely egalitarian relationship between the researcher and the participants is advocated, it is also important, as Letherby (2003) points out, to recognize that as researchers we are often in a "privileged position" because we are tied to the privileged and respected academic world (p. 125). Thus, although I intended my relationships with my participants to be egalitarian, I also cannot deny that some of the women saw me as an expert, or as someone to be respected, given my ties to the academic community.

The idea that the interview is an intersubjective experience necessitates a discussion of reflexivity in the interview process. As noted earlier, I have chosen to take what Reinharz (1979) describes as a "reflexive stance", and I hope to use my "self-awareness as a source of insight and discovery" (p. 241). Furthermore, as Guillemin and Gillam (2004) argue, "[re]flexivity in research is not a single or universal entity but a process – an active, ongoing process that saturates every stage of the research" (p. 274). Part of the process of reflexivity involves understanding how through in-depth

interviewing I necessarily impact the knowledge that is generated in the interviews.

Rhodes (2000) describes the interaction of the face-to-face interview in these words:

The interview is the result of an interaction between the researcher and the participant. It is not characterized by the passive interviewer recording the interview participant describing chunks of his or her word; it is an interactive process in which information and interpretation flow between both parties (p. 521).

Therefore, due to the very nature of in-depth qualitative research I must acknowledge that I am implicated in the stories that are ultimately told by the participants, and in the end, I am the one who will analyze and write about the stories that are fabricated in the interviews.

In taking a reflexive stance I also need to be critical of my position in relation to the research participants and how my emotional responses to the participants affect the research process (Reinharz, 1979; Rhodes, 2000; Mauthner & Doucet, 2003; Guillemin & Gillam, 2004). As I discuss in greater detail later, throughout the interviewing process I was emotionally affected by the participants in my study. On the one hand, the emotions I felt while interviewing women positively affected the research process, because it kept me attached to the research project. Reinharz (1979) argues that social research should be “unalienated labour” (p. 10). Or in other words, to ensure that we are not alienated from our work we should choose to engage in research projects that stem from personal concerns (ibid). Through interviewing and listening to women’s embodied experiences I became emotionally attached to the research and the research participants, and this in turn validated my belief that this was a socially important research project. On the other hand, my emotional reactions to the respondents clouded my analysis at times. Specifically, at one point during the research process, I realized that my strong emotional affiliation with the women was making it difficult for me to “step back” and analyze their experiences

from a critical feminist stance. I was struggling because I did not want the women I interviewed to feel like I had betrayed them by being critical of their choices. However, as this was a feminist research project, I knew I had to be critical of the normative aspects of cosmetic surgery and the women's decisions to engage in this beauty practice.

There are two final notes on reflexivity that I would like to briefly discuss before moving on to other topics. First, while it is crucial for me to be reflexive, it is also important that I not place too much emphasis on myself and my position in the research and lose sight of other important methodological issues (Rhodes, 2000; Finlay 2002). According to Finlay (2002), when researchers engage in reflexivity the “[d]angers of *infinite regress*, with researchers getting lost in endless narcissistic personal emoting or interminable deconstructions of deconstructions where all meaning is lost, remains an ever-present threat” (p. 226). Second, it is also important to acknowledge that although I have attempted to be reflexive throughout the research process, as Mauthner and Doucet (2003) argue, “[i]t may be more useful to think in terms of ‘degrees of reflexivity’, with some influences being easier to identify and articulate at the time of our work while others may take time, distance and detachment from the research” (p. 425). Thus, while I have attempted to demonstrate reflexivity in this research project, it might be that I realize certain important issues that should have been considered and brought to light only after this project is finished and I have distanced myself from it.

Interview Guide

The interview guide for the research project followed a semi-structured design² that provided the interview process with both focus and flexibility. The interview guide was deliberately structured so as to focus in on my research interests and objectives. In addition, questions in the interview guide were designed to be flexible and open-ended in order to encourage the participants to describe their experiences in their own words. All of the main questions I decided to include in the interview guide related to a particular theme that I was interested in studying. Following each of the main questions was a set of possible probes that could be used in order to gain further information or to clarify something that the participant said. Specifically, the interview guide was designed to explore the following themes: Issues of choice and agency relating to undergoing elective cosmetic surgery, the women's self-perceptions of their bodies before and after surgery, support or censure for undergoing cosmetic surgery from the women's social networks, issues arising from interactions with medical professionals before, during, and after the surgery, knowledge of risks relating to elective cosmetic breast surgeries, and the women's experiences of pain and medical complications following surgery.

Deductive vs. Inductive Approaches to Research

The research questions that I included in my interview guide related to themes that I wanted to explore during the data analysis section of the research project. In this sense, the project was deductive because I drew on feminist theory and literature to decide what questions I wanted to ask and what issues I wanted to analyze and eventually write about. In addition, as this is a feminist research project it is necessarily "theoretically grounded."

² A complete interview guide is appended.

According to Maynard (1994), feminists who argue that “to do anything other than simply let women ‘speak for themselves’ constitutes a violation,” neglect to see that “*all* feminist work is theoretically grounded” (italics in original, p. 23). She goes on to explain that:

[W]hatever perspective is adopted, feminism provides a theoretical framework concerned with gender divisions, women’s oppression or patriarchal control which informs our understanding of the social world. It is disingenuous to imply otherwise. No feminist study can be politically neutral, completely inductive or solely based in grounded theory. This is a contradiction in terms (ibid).

As highlighted above, one of my main research objectives was to analyze the women’s stories and make connections between their subjective positions and social and cultural structures. This goal is distinctly feminist and it requires that I do more than simply let the women “speak for themselves” as grounded theory implies.

This is not to say, however, that my approach was completely deductive as I did draw on some components of grounded theory (Corbin, 1990; Strauss & Corbin, 1998). Strauss and Corbin (1998) argue that grounded theory provides researchers with a “set of tools” for conducting research (p. 14). I chose to use certain tools from grounded theory while discarding others that I did not think would be useful given my research objectives. According to Corbin (1990) one of the main tenets of grounded theory is that data collection and analysis are interrelated. Corbin states “analysis begins as soon as the first bit of data is collected” (p. 419). To some degree I incorporated this goal into my research project. From the first interview forward I began analyzing the data by making notes and connecting and contrasting themes that emerged out of the data. This process allowed me to add questions to my interview guide that related to themes introduced in the research process, and eliminate questions that did not pertain to the experiences of the interviewees. For example, I added further questions relating to the women’s pre-surgical

appearances, such as the size of their breasts before surgery, and additional questions on decision-making in terms of risks and rewards. I also removed a question regarding the impact of nurses on the women's experiences as this did not seem to "fit" with their narratives. Further, during certain points in the research process I was simultaneously involved in note-taking, data collection, and transcription, and this allowed me to incorporate and analyze emerging themes.

Ethical Considerations

Before I recruited participants for the research project I submitted an ethics proposal to, and received approval from, the ethics committee at the University of Lethbridge. The ethics proposal included important sections on anonymity, confidentiality, informed consent, and potential risks to the participants. In addition, the ethics committee reviewed, and approved, the consent form and interview guide to be used in the interviews, and the poster that would be used for recruiting participants.

In order to ensure that the women's identities remained anonymous I have disguised any identifying information and details such as the women's names, specific locations, and any distinguishable features. Furthermore, the interview data has been, for the most part, reported in aggregate, and illustrative examples were presented in such a way that no identifying feature of the individuals was included. Moreover, during the consent process of the interview I explained to the participants' that the information that they provided me with would remain completely confidential. The interview tapes and tape containers did not carry any identifying information on them, so that confidentiality would be maintained. In addition, the interview tapes and transcripts were kept in a locked filing cabinet in my office. The transcripts, tapes, and disk data did not include the

names and addresses of the participants, and the master list for participant pseudonyms, and the actual participants' contact details, were kept in a separate location in my office.

The participants were given informed consent, and I took special care during the research process in order to achieve this goal. The participants were briefly informed of the research requirements at the time of first contact, and at this time, voluntarism was discussed, and potential interviewees were invited to commit to participate if they so wished. At the time of the interviews, the consent form was provided to the participants to read. The consent form was made available in a plain language print version. I also provided each potential interviewee with a brief verbal overview of the consent form contents. At this time in the interviews, the participants were told that they were not obliged to continue if they felt any uncertainty. If the participants chose to sign the consent form, as all of them did, then they were provided a copy for their records along with a statement inviting them to contact me at any time with their questions or concerns. This copy included a statement that informed participants that they may withdraw their participation at anytime without penalty. To date, no one has done so.

In addition, participants were reminded during the interviews that they were not required to answer any question(s) that they are uncomfortable with, and that they may withdraw their consent for sections of the interview at any time. In line with this, the participants were told that, following the interview, and any time prior to the conclusion of the project, they may withdraw their consent for any portion of the interview, or their participation in entirety, without penalty. Although none of the participants chose to withdraw from the project, I was prepared to destroy all of the information that they contributed to the research project if they did choose to withdraw consent.

A final element of informed consent relates to the issue of potential harm to participants. As Guillemin & Gillam (2004) point out, it is often difficult, if not impossible, for researchers to gauge how research participants might be negatively affected by the research project and what strategies should be employed in order to minimize these risks (p. 272). Despite this difficulty, however, I did anticipate some of the experiences I would ask the women to talk about might be potentially difficult and that talking about these experiences could be very trying. I devised a section in the consent form where I notified participants that I could provide them with information on local counseling services if they required additional support following the interview. However, as I will discuss in more detail later, none of the women requested information on local counseling services, and in fact all of the women seemed to be positively affected by the opportunity to discuss their experiences with a non-judgmental researcher.

Recruitment of Participants

Upon receipt of ethics approval from the University of Lethbridge internal review board, I began recruiting women from Southern Alberta who had undergone either breast augmentation or breast reduction surgeries.³ In order to reach women who might fall into this category I placed advertisements on public notice boards in grocery stores, coffee shops, medical clinics, hair and beauty salons/spas, fitness centers, tanning studios, bars, restaurants, shopping malls, universities and colleges. Further, the Lethbridge Herald newspaper aided in my recruitment of participants by publishing an article based on my research project. This article proved to be very useful as many women in Lethbridge and the surrounding area read this newspaper. In addition, I employed snowball sampling as a

³ The geographical area included Calgary, Lethbridge and surrounding rural communities.

method to reach potential interviewees (Seidman, 1991; Warren, 2002). Through snowball sampling I was able to reach women who agreed to participate because they heard about the project through a trusted person within their social network. Given my methods for recruiting participants, I realized that there would be a risk that some of the participants would know each other either as friends, acquaintances, or through a shared cosmetic surgeon. However, as discussed above, I have protected the women's identities within their communities by disguising details such as names, locations, and identifying features. I also ensured that the individuals who referred participants to me through snowball sampling would not receive any information from me as to the outcome of those referrals.

Initially I only recruited women who had undergone these surgeries within the last ten years. The main reason I decided on this time period is because, as mentioned above, cosmetic surgery procedures have become more normative over the last twenty years (c.f. Morgan, 1991; Bordo, 1997; Blum, 2003; Brooks, 2004). Thus, I felt that by recruiting women who have undergone cosmetic surgery on their breasts during a time when cosmetic surgery is becoming normative, I would capture a set of comparable experiences. The second reason for recruiting this group of women was simply based on my assumption that because the women would have only undergone the surgeries within the last ten years, recalling their experiences clearly would be fairly straightforward and would yield a richer vein of information than less recent experiences would.

However, my initial sample group proved to be too narrow, and a brief example will illustrate this point. During the course of my research I was contacted by a woman who had undergone breast augmentation surgery over thirty years ago. I decided to interview this woman, despite the fact that she did not fit my sample criteria, in order to

see how her experience compared to the other women's experiences. This interview was extremely interesting because, unlike the women I had previously interviewed, this woman described her horrible suffering as the result of various complications long after her breast augmentation surgery. This woman's experience led me to believe that by only interviewing women who had undergone recent cosmetic surgery on their breasts, I would be unable to gain a thorough understanding of the possible complications that may affect women fifteen to thirty years after their surgeries. This woman also stated, unlike the other women I had interviewed up to that point, that if she could go back she would have never chosen to have a breast augmentation. After hearing this, I decided that interviewing women who have undergone cosmetic breast surgery over ten years ago might allow me to gain a better understanding of how women feel about their body modification choices later in life. Further, as I will discuss in later chapters, I felt that by interviewing women who underwent cosmetic breast surgeries over ten years ago, I would be able to hear women's experiences relating to aging and motherhood that I might have missed out on otherwise. Therefore, following this woman's story I chose to expand my sample population to include women who had undergone cosmetic breast surgery at any point in their lives.

At another point in the research process I was forced to decide whether to expand my sample population to include women who had undergone cosmetic breast surgery following mastectomies. During the recruitment phase of the research, I was contacted by a woman who had one of her breasts augmented with a saline implant following a mastectomy, and had her other breast reduced. I decided to conduct an interview with this woman in order to see if her experience might be comparable to the other women I had interviewed up to that point. After the interview, however, I decided against interviewing

any other women who had reconstructive breast surgeries following mastectomies. I decided this mainly because the questions in my interview guide did not seem to be applicable to this woman's story. Specifically, I felt that there was a "disconnect" between what I was interested in hearing (her experiences relating to her breast surgeries), and what she wanted most to tell me about (her experience of surviving breast cancer). During the interview I felt it was difficult for this woman to focus on the questions in the interview guide, because she wanted (quite understandably) to discuss her experiences of breast cancer. Therefore, I decided interviewing other women who had undergone post-cancer cosmetic breast surgery would likely take my research into an unintended direction. However, because certain sections of this woman's interview were applicable to my research objectives, I chose to keep some of her experiences as part of my final data set.

Thus, as the above examples demonstrate, the women who were eventually included in my research project were not necessarily women I had initially intended on interviewing. In addition, the final sample did not include some categories of women that I had initially hoped to include. Specifically, I was unable to interview women of various sexualities, social classes and of various ethnic and racial backgrounds. This is likely due to a number of factors, but I would speculate that one important reason for this is the socioeconomic status of women who undergo cosmetic surgery. Drawing from Bourdieu's theory of *physical capital* (see p. 17), Chris Shilling (2003) explains that, "[d]ifferent classes and class fractions tend to develop distinct orientations to their bodies which result in the creation of various bodily forms" (p. 112). Shilling goes on to explain that unlike the "working classes" the "dominant classes are more willing and most able to produce the bodily forms of highest value as their formation requires investment of spare

time and money” (p. 116). As cosmetic surgery is, in most cases, paid for by the individual it is a beauty practice largely engaged in by those individuals who have the necessary resources to afford it. It is thus perhaps not surprising that my sample only represented white, middle to upper class women, as these are the women who would most likely occupy a social position that allows them the time and money to undergo cosmetic breast surgery. Thus, cosmetic surgery perpetuates both racism and classism because “only a minority – generally white, economically privileged women – have the means to have surgery and because the hegemonic heterosexist ideal of feminine beauty is essentially a white standard” (Gagne & McGaughey, 2002, p. 826). Despite the clear reasons for my biased sample, it unfortunately meant that I was unable to gain an insight into the multiplicative effects of class, ethnicity, and race on women’s body modification experiences. As such, the generalizability of my findings is perhaps even more limited than that of other qualitative research projects.

Description of Participants

Ultimately, I conducted twenty-four interviews with women who had undergone cosmetic breast surgeries.⁴ The sample of participants included ten women who had undergone breast augmentation surgery, thirteen women who underwent breast reduction surgery (including one woman who had only one breast reduced and the other breast lifted in order to “correct” the asymmetry of her breasts), and one woman who had reconstructive surgery following a mastectomy. At the time I conducted the interviews, the women ranged in age from 21 to 71. Half of the women (12) in the sample underwent cosmetic breast surgeries before the age of 25. The youngest woman in this group was 16

⁴ A detailed description of the participants, including their pseudonyms, is appended.

at the time of her surgery. Seven women had their surgeries in between the ages of 25 and 35, four women had their surgeries in between the ages of 36 and 45, and one woman had cosmetic breast surgery after the age of 46. The oldest woman I interviewed was 67 at the time of her surgery. In addition, ten of the women I interviewed had undergone cosmetic breast surgery within the last five years. Included in this group was one woman who underwent her surgery only two weeks before the interview. Further, nine of the women I interviewed had undergone cosmetic surgery within the last 10 years, and lastly, five of the women I interviewed underwent cosmetic breast surgery over 10 years ago. This final group included one woman who had her surgery in 1987 (19 years ago), one woman who had her surgery in 1977 (29 years ago), and one woman who underwent surgery in 1974 (32 years ago).⁵

The women included in the sample all resided in the Southern Alberta area. I interviewed women who were living in the cities of Calgary and Lethbridge as well as women residing in surrounding rural towns, such as Strathmore, Coaldale, and Raymond. Although it is not a large geographical area, it is still plausible that other women in different Canadian cities and towns would have experiences that are reflective of the women's experiences in this study. At the same time, this relatively small geographic area meant that I was unable to examine the ways in which different cultural contexts impact women's decision-making experiences. In a cross-cultural analysis of women's reasons for undergoing cosmetic surgery, Debra Gimlin (2007) found that women in the United States employ different arguments to justify their decisions than women in Great Britain. These differences in the women's narratives, according to Gimlin, are due in part to the

⁵ These are the women's ages at the time of their initial surgeries. As will be discussed in later chapters a few of the women had additional surgeries due to complications. Information regarding these additional surgeries is also available in the appendix.

different healthcare contexts in the two countries. The scope of this research project did not allow for a cross-cultural analysis, however, and thus it is important to acknowledge that the women's experiences in this study are reflective of a particular cultural context at a specific moment in time.

All of the women had at least a High School education, and the majority (21) had attended post-secondary institutions (college or university), including three women who had completed Graduate level degrees, and one woman who had completed a Law degree. The sample included women with a variety of occupational backgrounds. At the time of the interview, their occupations included hair stylist, bartender, retail salesperson, pharmaceutical sales representative, urban planner, florist, administrative assistant, financial consultant, stay-at-home mother, food inspector, day-home provider, college instructor, and lawyer. In addition, a few of the participants were not working because they were students, one woman was not working at the time of the interview because she was on a disability allowance, and two of the women were retired.

The sample included both women who were currently in partnerships and single women. At the time of the interview eight women were single and never married, nine women were married, three women were in common-law relationships, and four women were divorced. Including women who were currently in partnerships, and single and divorced women, was important because, as we will see in later chapters, it allowed for an examination of the women's experiences of social support, and for a consideration of the importance of sexual attractiveness in intimate relationships.

The sample also included both women with and without children. Half (12) of the women I interviewed had children, and the other half (12) of the women did not have children at the time of the interview. Of the women in the sample who had children, seven

had their children prior to undergoing cosmetic breast surgery, three had their children after their surgeries, and two women gave birth to children both before and after having undergone cosmetic breast surgery. Interviewing women with and without children was extremely beneficial as it permitted an understanding of how the women's decisions to undergo elective cosmetic breast surgery effected, and/or were effected by, their decisions relating to mothering (specifically breast feeding).

Collecting Data: The Interviews

I conducted a total of 24 interviews between July 2006 and October 2006. Each of the interviews lasted approximately 1-2 hours. The majority (19) of the interviews were held at the participant's homes, four of the interviews were held at a research office in the University of Lethbridge, and one interview was conducted at a mutually agreed upon public place. All of the interviews were tape-recorded because this allowed me to maintain eye contact during the interviews, and to ensure accuracy of data collection (McCracken, 1988; Seidman, 1991; Silverman, 2003). During the beginning of each interview I completed a short face sheet which compiled the participant's general information⁶. Following in line with grounded theory's goal of beginning one's analysis once data collection begins (Corbin, 1990; Strauss & Corbin, 1998), I made notes following each of the interviews on the participant's appearances, demeanor, and any other characteristics or interesting information that I felt might link to important themes or issues that should be considered during transcription and coding of the interviews.

Before I began interviewing the women, I worried that participants would be unwilling to give up one to two hours of their time to sit and discuss their body

⁶ A copy of the face sheet is appended.

modification experiences with me. However, my worrying proved unfounded. All of the women interviewed were extremely willing to take time away from their busy schedules in order to meet with me. Further, the women seemed genuinely pleased that I was researching their experiences. This is likely because although women are the large majority of recipients of cosmetic surgery, women's experiences of undergoing cosmetic surgery procedures have been largely overlooked. According to Reinharz and Chase (2002) women may have dramatic reactions to being interviewed, as it allows women the opportunity to speak in a culture where women's perspectives and voices are often silenced. These authors state:

Although on the face of it [interviewing] is not a remarkable activity, it may turn out to be an extraordinary experience for women interviewees. This is because some women still feel powerless, without much to say. In many societies girls are still raised to be pretty objects who should be seen and not heard (p. 225).

It is perhaps not surprising then that the majority of the women I interviewed for the research project felt that they were benefiting from the opportunity to speak openly about their largely disregarded experiences of undergoing cosmetic surgery.

In addition, one particular woman was very grateful noting that she viewed my research as a tool for educating people. This woman's experience with breast implants had spanned almost thirty years, and during this time she had suffered many serious medical complications as a result of the implants. She told me that she wanted to participate in my research project because she felt that other women should know about her experiences so that they might be able to make an informed decision regarding cosmetic surgery. She was extremely appreciative that I listened to her story, and she told me that she felt very strongly about her involvement in the research project.

Finally, several women thanked me after the interview for allowing them the opportunity to speak to a non-judgmental person about their very intimate experiences and feelings. The statement “glad to get that off my chest” took on new meaning for me during this project, as many of the women joked following the interview that talking to me was therapeutic because it allowed them to discuss issues or experiences relating to their breasts that had been weighing down on them. In fact, a few women stated that they were very grateful to be able to talk to me, because they had never fully discussed their experiences with any other person.

Although I had anticipated that I would enjoy interviewing women, I had not anticipated the degree to which I would enjoy the actual women themselves. My surprise is likely, in part, because often textbooks and classes on methodology do not contain a discussion on the relationships that can be formed during qualitative social research.

According to Ann Oakley this absence is largely due to the fact that,

[t]he entire paradigmatic representation of ‘proper’ interviews in the methodology textbooks, owe a great deal more to a masculine social and sociological vantage point than to a feminine one. For example, the paradigm of the ‘proper’ interview appeals to such values as objectivity, detachment, hierarchy and ‘science’ as an important cultural activity which takes priority over people’s more individualized concerns (p. 249)

Within this paradigm there is no room for a relationship between the interviewer and the participant, because as Oakley explains, both are to remain “depersonalized participants in the research process” (p. 248). Given the shortcomings of the traditional model for interviewing, Oakley suggests a feminist model for research where both the interviewer and the interviewee are personally invested in the interview process.

Further, as highlighted above, many other feminist writers have argued that qualitative research should be an intersubjective experience where both the researcher and

the respondent are subjects working to mutually create knowledge and understanding (c.f. Cook & Fonow, 1990; Westkott, 1990; Maynard, 1994; Olesen, 1994; Letherby, 2003). This feminist literature helped me both to understand why my interviews often seemed to be a form of one-sided “girl-talk,” and why I was at times uncomfortable with this interaction. During the interviews I conducted I felt like it was a discussion among two girlfriends rather than two complete strangers. However, I also felt that I was the ideal girlfriend because I appeared to be completely non-judgmental, I rarely spoke except to ask questions about their lives, and I did not interrupt them when they were talking. In the interviews I was able to ask the women questions that I would only ask my closest friends, and in turn, the women seemed to be completely comfortable telling me about their most personal and intimate stories relating to their breasts. I believe these interview experiences are likely a result, in part, of my attempt to make the interview process non-exploitive and the research relationship egalitarian. Specifically, I tried to demonstrate to the women I interviewed, through both my words and actions that they could trust me, not as an expert, but as a woman who understands and empathizes with their embodied experiences.

All was not completely one-sided, however. Perhaps largely due to the nature of the interviews, many of the women felt comfortable asking me questions as well. In order to deal with this issue I again turned to Oakley’s article mentioned above. Oakley discusses how it is much more beneficial to the research process, in terms of rapport, if interviewers answer the questions posed by the interviewees, rather than ignore or refuse to answer the questions asked. During the interviews, I was asked personal questions about myself including why I chose to study this topic, if I was considering undergoing cosmetic surgery, and questions relating to the other women I had interviewed. Within the

limits of ethical restraints on disclosing information about other research participants, I chose to respond to the questions that the interviewees asked. I found that my honesty and candor was much appreciated by the women I interviewed. I felt that this approach advocated by Oakley helped me to create a more egalitarian relationship with the participants, because both the participants and I were actively involved in the sharing of information.

It should be noted that although I very much enjoyed my interactions with the women I interviewed, I did not intend to develop a “sisterly bond” as some feminist writers suggest. I based this decision on Reinharz and Chase’s (2002) argument that it is much more important to create rapport in an interview than to create an “intense bond” with the participants. These writers argue that the goal of creating a sisterly bond may be counteractive as some women are able to disclose personal and intimate details about their lives during the interviews simply because they do not have a relationship with the interviewer (p. 229). I definitely found this to be the case in the interviews I conducted as several women made comments such as “I can say this because I know that this is anonymous” or “You don’t know the people I am talking about so I can tell you this story” and “I feel like I can talk to you about things I would never talk to other people about.” Thus, I felt that the fact that I did not have relationships with the women before or after the interviews, and that it is was completely anonymous and confidential, actually allowed the women to tell me things that they would never have told me in any other social interaction.

Another methodological issue I struggled with was the way I should dress to go to the interviews. Deciding what to wear to an interview is an important decision for all interviewers. As Fontana and Frey (2003) argue, “[t]his decision is very important,

because once the interviewer's presentational self is 'cast', it leaves a profound impression on the respondents and had great influence over the success (or lack of it) of the study" (p. 77). However, I felt that I needed to take extra care when presenting myself given the topic I was studying. In the interviews I was asking women intimate questions about one of the most intimate parts of a woman's body. While struggling with this issue I came across an article by Burns (2003) that proposed the need for an "embodied reflexivity in research" (p. 230). In this article she states that as researchers engaged in qualitative interview research,

[W]e must be careful not to imply that the meanings that are fashioned are simply an outcome of disembodied 'intellectual' interactions (as if this detached interaction between 'talking heads were even possible'). Rather, they are the product of 'physical' exchanges that occur in a reciprocal manner between the researcher and the participant and that have implications at the 'physical level'. If we consider that the self is always embodied and we argue that a feminist methodology involves reflexively locating the self in one's research, then there are important consequences for how we theorize that embodiment and understand our embodied selves to be implicated (ibid).

Beginning from a reflexive position I realized that it was likely that the women I interviewed would look at my breasts (as the face-to-face interview is an embodied interaction) and wonder about my feelings and experiences in regard to them. Keeping this in mind, I tried to find a balance between formal and casual wear when I went for the interviews, and I made an explicit point never to wear a shirt that would draw attention to my chest.

In addition, I decided to present myself in this way because I did not want the way that I dressed to contradict the feminist goals of my research project. During her interviews with women suffering from bulimia Burns (2003) states, "I would wear looser clothing as if my body somehow signified and embodied complicity with the slender

imperative I was seeking to undermine” (p. 233). I think to some degree I felt that I should dress in a way that did not show my complicity with hegemonic beauty standards. Even the idea of wearing a push-up bra and a tight shirt to an interview made me feel uncomfortable, and I believe that this was partly because I felt that embodying “appropriate” femininity directly opposed my feminist belief that current hegemonic beauty norms are oppressive.

However, despite my efforts to take attention away from my chest, I must admit that my breasts were always as much a part of the social interaction of the interview as my words and body language. In almost all of the interviews I noticed women would glance at my chest, but most of the women would not make any verbal comments regarding my appearance. In other instances, however, I noticed that women would glance at my chest before asking me both why I chose to undertake this project, and if I was considering undergoing cosmetic breast surgery. As I discussed above, I chose to answer questions such as these openly and honestly. I would often tell the women that I decided to undertake this project because of my own feelings and experiences relating to my breasts. Further, when the women asked me if I was considering undergoing cosmetic surgery on my breasts, I would explain to them that I was not considering undergoing cosmetic surgery on my breasts, but that the thought had entered my mind on more than one occasion given my own feelings of inadequacy regarding my breasts. Reflecting on these embodied interactions, I would say that they were ultimately positive, as they provided an opportunity for me to demonstrate to the women that I could understand and empathize with their experiences.

Overall, the women I interviewed seemed to be pleased with their decision to participate in the research project. None of the women I interviewed said that they

regretted doing the interview, or would like to withdraw from the research project.

Further, none of the women were too uncomfortable or upset to terminate the interview and none of the women seemed to be upset following the interview. As mentioned above, the women were offered a list of local counseling services during the consent portion of the interview, but none of the women asked to receive this information following the interview. In addition, all of the women agreed that I could call them following the interview for any follow-up information, and many of the women requested for me to send them a brief overview of my research findings once the research was completed.

Data Analysis

As was mentioned above, I combined an inductive and a deductive approach when working with the data. Although my research project was grounded in feminist theory, I also employed some grounded theory “tools” that I found to be useful. Drawing from a grounded theory approach, I engaged in interviewing, note-taking, transcription, and data analysis simultaneously, at certain points in the research process, in order to allow for the examination of emergent themes (Strauss & Corbin, 1998; Corbin, 1999). Further, as I discuss below, grounded theory provided very useful tools during the process of coding.

One of the main reasons I chose to tape-record each of the interviews was because I wanted to transcribe the interviews in detail at a later time. According to Lapadat and Lindsay (1999), detailed transcription is important as it “preserves the data in a more permanent, retrievable, examinable, and flexible manner” and “although the cost and time involved in doing transcriptions is a serious disadvantage in most practice settings, more expedient and inexpensive shortcuts to data interpretation have typically proved unsatisfactory” (p. 80). Although I chose to make detailed transcriptions, I did not engage

in “naturalized transcription” where every utterance is transcribed. This type of transcription style is most often used in conversation analysis and this did not fit with my research objectives (Oliver et al., 2005). I decided it was not useful to transcribe every utterance, such as “umm,” “uh huh,” and “mm” because not all of these utterances were crucial for data analysis purposes in my research project. However, I did not exclude sections of the taped interview that might not be useful for coding purposes. I realized that once I omitted part of the tape then it would be very difficult, if not impossible, to recover that piece of data (Seidman, 1991; Lindsay & Lapadat, 1999). In specific terms, I employed a “denaturalized” style for transcription, because this form of transcription focuses on the informational content of the data rather than the technical linguistic nature of the data. Thus, my main focus when transcribing was on the “substance of the interview, that is, the meanings and perceptions created and shared” during the interviews (Oliver et al., 2005, p. 1277)

Rather than hire someone to do the work of transcription for me, I chose to do all of the transcribing myself. Although the work of transcription is very time-consuming I found it to be very beneficial as it reinforced my memory of the social interaction that took place during the interviews. By listening and transcribing the tapes myself, I could recall many important aspects of the interviews I had forgotten, including the context and atmosphere of the interviews and the personalities and appearances of the participants. According to Strauss and Corbin (1998), “theoretical sampling” is the process of altering the research project in order to accommodate emergent themes or concepts. In this research project I employed theoretical sampling by engaging in transcription and interviewing during the same time period and using the information I gained through transcription to scrutinize and critique my interview style and the interview guide, and to

make necessary changes. For example, after transcribing a few tapes I decided to include questions based on experiences brought up by participants, to remove or change questions that did not seem to fit with the experiences of the women, and to alter certain aspects of my speaking style.

In addition, the act of transcription proved to be useful in terms of data analysis. Lapadat and Lindsay (1999) argue that it is not only the transcription product that is crucial to research, but rather, the process of transcription that is important. These authors state: “Analysis takes place and understandings are derived through the process of constructing transcripts by listening and re-listening, viewing and re-viewing” (p. 82). I agree with this statement because as I transcribed the interviews I was able to begin to analyze the transcripts for important and recurring themes. I made notes in a journal and placed footnotes on the transcripts relating to themes or ideas I wanted to explore later when I began to do more focused coding.

Although some conceptual categories were developed during the transcription stage of the research process, the focused coding of the data was done through the use of *Atlas-ti*, a qualitative data analysis software program. In the coding stage of my analysis I again drew from grounded theory (Corbin, 1990; Strauss & Corbin, 1998). According to grounded theory there are three main types of coding: open, axial, and selective coding. In open coding the researcher looks for “concepts,” “categories,” or what Strauss and Corbin (1998) term “labeled phenomenon” which is an “abstract representation of an event, object, or action/interaction that the researcher identifies as being significant in the data” (p. 103). Axial coding, in grounded theory, is the process of “relating categories [concepts] to their subcategories” (p. 123). Finally, selective coding is the “process by which all categories are unified around a central ‘core’ category” (Corbin, 1990, p. 424).

I employed two of the three types of coding proposed by grounded theory when I coded the data for the research project. I initially coded for general concepts in the data (open coding) and then related the general concepts to more specific sub-concepts or sub-categories (axial coding). Using the qualitative data analysis software, *Atlas-ti*, I engaged in what Strauss and Corbin (1998) term a “line-by-line analysis” of the transcripts and coded for important concepts and themes in the data (p. 119). During the process of coding I used both an inductive and a deductive approach. In other words, I had conceptual categories already in mind when I began coding the interviews, and at the same time, I analyzed the interviews looking for important themes and concepts that I had not previously considered. The first few interviews I coded were especially crucial for developing conceptual categories, and these interviews provided me with a basic code list to use when analyzing subsequent interviews. However, following in line with the idea of theoretical sampling (Strauss & Corbin, 1998), I went back and analyzed interviews I had coded in the initial stages of data analysis because important themes and concepts emerged throughout the process of coding. In the final stage of coding I looked at all of the interviews to determine which themes were common among the participants and thus reflected shared experiences.

The Women’s Experiences as Data

This chapter allows one to see this research project as a process from conceptualization to analysis. As this preceding chapter has outlined, I was implicated in every stage of this project, and thus although it is the women’s experiences that are the foundation of this thesis, it was I who ultimately decided what parts of their stories to write about and how to write them. It is important to be mindful of how my role as the

researcher and my personal/political beliefs and values impacted this project when reading the following chapters.

The subsequent chapters are an examination of the women's experiences of undergoing cosmetic breast surgery. When I refer to the "women's experiences" in the following chapters, I am not simply referring to the women's "lived experiences," but also to the "strategic" and "situated representations" that the women provided of themselves during the interviews (Coxhead & Rhodes, 2006, p. 100). Further, when analyzing and writing this thesis I drew from Joan Scott's (1992) idea that "experience is at once always already an interpretation" (p. 37). Thus, by understanding that the women's narratives were strategic and situated representations and interpretations of their experiences, I recognize that "it is not individuals who have experience, but subjects who are constituted through experience" (Scott, 1992, p. 26).

Chapter 3: An Empowering Decision or Simply a way to “Get By?”

When I discussed my research project with people I met over the last two years, one of the first questions always asked was why women would be willing to undergo dangerous and invasive surgical procedures to alter the size and shape of their breasts. For all of the women in this study their decision was rooted in their longing to feel contentment with their bodies, and to be valued, loved, desired, and successful. While undergoing cosmetic surgery may initially appear to be an illogical or extreme route to achieve these goals, one has to remember that within Western culture women continue to be largely judged and valued based on their physical attractiveness. A woman who is considered beautiful by cultural standards is much more likely to be successful in both the job and marriage markets, than a less attractive woman (Sullivan, 1993). Further, women who do not conform to cultural beauty standards are likely to face severe social sanctions. As Victoria Pitts (2003) explains, “appearance-related worries for women include harassment, mistreatment, and discrimination” (p. 51). This chapter will examine how the women’s decisions were shaped and constrained by this cultural context which rewards women for conforming to beauty norms, and sanctions women who resist. As the following analysis shows, the women’s experiences in this study reflect that the decision to undergo cosmetic breast surgery was not an act of empowerment, but rather a means for the women to “get by” within a culture that severely limits their options.

Choosing Cosmetic Surgery: A Contradiction in Terms?

To frame the following analysis I will briefly reiterate some of the discussion in chapter one regarding recent feminist responses to cosmetic surgery. As I explained in chapter one, within current feminist literature on cosmetic surgery there are important and

complex debates surrounding issues such as agency and choice. The main contention within feminist writing on cosmetic surgery is whether or not women are active agents who freely choose to undergo cosmetic surgery. Feminist writers, such as Jeffreys (2005) argue that cosmetic surgery is an oppressive, dangerous, and damaging cultural beauty practice that operates within a patriarchal society. Given the patriarchal context in which we live, women do not freely choose to undergo cosmetic surgery, but are instead victims of an oppressive beauty system. From this perspective, “body modifications represent both patriarchy’s willingness to make literal use of the female body as well as women’s psychic internalization of its aims” (Pitts, 2003, p. 53). According to Amy Winter (2004), when looking at issues such as cosmetic surgery “it is important to understand that women’s choices may appear to be free, but in many cases are actually constrained by the system of patriarchy” (p. 15). In other words, although it is true that women are ultimately making a choice to undergo cosmetic surgery procedures, it is not a *free* choice because it has been made within a patriarchal context. Furthermore, she argues that “the second wave feminist emphasis on a woman’s body autonomy and sexual self-determination has been widely misinterpreted to mean that any choice a woman makes about sexual behavior and appearance is automatically feminist” (p. 14). By utilizing second wave feminist discourse on choice, individual freedom, and empowerment women who undergo dangerous and invasive cosmetic surgery procedures are falsely constructed as free agents.

Building on this idea that women do not freely choose to undergo cosmetic surgery, some writers argue that we should begin to look at, and understand, cosmetic surgery procedures in the same way as other cultural practices such as female genital mutilation. According to Simone Weil Davis (2003), the line differentiating female

genital mutilation and cosmetic surgery procedures is significantly blurred in light of new cosmetic surgery procedures such as “vaginal rejuvenation” and “labiaplasty.”⁷ She argues that the motivating factors behind Western cosmetic surgery procedures, such as “beautification, transcendence of shame, and the desire to conform” are the same as those behind female genital operations performed in other cultures (p. 23). In line with this argument, Clare Chambers (2004) argues that the practices of female genital mutilation and cosmetic surgery are not fundamentally different. She argues that both procedures are extremely dangerous and are only engaged in by women “in response to unjust, unequal norms” (p. 30). Both Chambers (2004) and Jeffrey (2005) go so far as to argue that Western liberal states which choose to prohibit the practice of female genital mutilation should also prohibit the practice of cosmetic surgery procedures. Essentially, all of these writers are fundamentally arguing that cosmetic surgery is similar to self-mutilation or female genital mutilation because all of these practices “violate the body and reproduce oppressive relations of power” (Pitts, 2003, p. 73). The women who undergo cosmetic surgery procedures are thus constructed as victims who are engaging in practices of self-hatred. According to Pitts (2003), from this perspective the “marked body is injured or attacked either literally through pain or symbolically through harming the body’s appearance” (p. 74).

In contrast, feminist writers such as Kathy Davis (1995) argue that women who undergo cosmetic surgery procedures are active social agents, not victims of an oppressive beauty system, and the decision to undergo cosmetic surgery can actually be empowering for the women who choose it. Within this theoretical framework, reshaping

⁷ Vaginal rejuvenation is a procedure in which a woman’s vagina is surgically tightened, and labiaplasty is a procedure that involves “trimming away labia tissue and sometimes injecting fat from another part of the body into labia that have been deemed excessively droopy” (Davis, 2003, p. 7).

the body through cosmetic surgery procedures, and other forms of body modification, is seen as a form of self-expression, a way to change the physical body to fit the self, and as a means to reclaim one's body (Pitts, 2003). In her research, Davis (1995) discovered that undergoing cosmetic surgery is often a very positive and empowering experience for women, because it is a means for women to "alleviate their suffering and take their lives in hand" (p. 158). Davis (2003) further explains that "women often have 'good' - that is, credible and justifiable - reasons for wanting to have cosmetic surgery" (p.14), and she states that undergoing cosmetic surgery is a means to "alleviate unbearable suffering" and "reappropriate formerly hated bodies" (p. 85). Debra Gimlin (2000) is another feminist writer who argues that cosmetic surgery can be an empowering choice for women, stating that feminist critiques of cosmetic surgery do not take into account the fact that women often view cosmetic surgery as a satisfactory means to achieve certain beauty goals. Based on her analysis of 20 qualitative interviews, Gimlin concludes that none of the women she interviewed were "cultural dopes", but rather the women in her study should be viewed as "savvy cultural negotiators"(p. 96).

What I have just outlined above, and in chapter one, is obviously a very simplistic overview of the different sides of this important feminist debate. However, it does allow for one to see where I am situated within this debate. As I stated in chapter one, my theoretical position in this study is one which takes women's agency into account, while simultaneously remaining aware that the women's decision-making operates within a system that provides few other alternatives. As Brush (1998) acknowledges, women can "choose" to undergo cosmetic surgery procedures, but they "can only make the correct choice without being penalized" (p. 37). Similarly, Spitzack (1988) argues, that in Western society, cosmetic surgery is constructed as "the only 'reasonable option', the

choice made by normal and/or healthy women” (p. 11). Indeed, for a few of the women in this study there was really no “choice” in the simplest sense of the word, as the women knew they would suffer severe social sanctions (such as the possibility of their husbands leaving them) if they did not undergo cosmetic breast surgery. In other words, the women’s actions were often simply a way to “get by” within a culture that offers them rewards for conforming to dominant beauty norms and punishes them if they do not.

Despite the fact that many of the women were happy following cosmetic breast surgery does not automatically mean that it was an empowering decision. Instead, the decision simply reified the current oppressive beauty system that only benefits women for their complicity in it. Bordo (1993) suggests that while women may experience power and receive rewards from self-policing and disciplining the body through practices such as dieting or cosmetic surgery, it is “deeply and dangerously illusory” (p. 179). Indeed, the engagement in beauty practices that normalize and discipline the female body are subtle forms of social control which can be seen as a backlash or resistance to the power women have gained in society. She states:

Viewed historically, the discipline and normalization of the female body- perhaps the only gender oppression that exercises itself, although to different degrees and in different forms, across age, race, class, and sexual orientation- has to be acknowledged as an amazingly durable and flexible strategy of social control. In our own era, it is difficult to avoid the recognition that the contemporary preoccupation with appearance, which still affects women far more powerfully than men, even in our narcissistic and visually oriented culture, may function as a backlash phenomenon, reasserting existing gender configurations against any attempts to shift or transform power relations. (p. 166).

In turn, women are “rendered less socially orientated and more centripetally focused on self-modification” (ibid). Thus, by undergoing cosmetic breast surgery, and conforming to feminine beauty norms, the women in this study may reap benefits (for a period of

time), but their decisions ultimately uphold the current oppressive beauty system and the unjust norms which sustain it.

What Size and Shape of Breast is Best?

In order to understand why women would decide to undergo cosmetic breast surgery, one has to first acknowledge the symbolic importance of breasts within our culture. Janice, who underwent breast reduction surgery, explained that she was frustrated that her pre-surgical breasts were often the focal point during her conversations with others, because as she said, “they don’t talk!” Although our breasts obviously do not “talk”, they do however, “say” something about who we are, and beginning at puberty we become acutely aware of this. Female breasts are often “on display,” whether we intend for them to be or not, and they are “read” by others in ways that are informed by cultural meanings and values. As was briefly discussed in the first chapter, within Western culture breasts are symbolic of sexualized femininity and female sexuality, while they are simultaneously markers of maturity and motherhood. The various, and contradictory, meanings associated with breasts in our culture intimately impact our embodied experiences. According to Susan Brownmiller (1984), “breasts are a source of female pride and sexual identification but they are also a source of competition, confusion, insecurity and shame” (p. 40). Further, we experience our breasts both as a source of power in our interactions with others, and as disempowering as they are often objectified and consumed by the male gaze.

Despite the fact that it is normal and natural for breasts to come in a variety of sizes and shapes, we are all acutely aware that some breasts are “better” than others. During the interviews the women described their breasts in the following ways: “saggy”,

“droopy”, “stretched-out”, “too big”, “too small”, “old woman’s boobs”, “ugly”, “scrawny little things,” “wrinkly-things”, “inside-out”, and “unsightly.” These descriptions were often used by the women to describe why it was necessary to undergo cosmetic breast surgery. As Karen explained, “I thank God that cosmetic surgery is an option for some of us [because] no girl should have boobs like I did.” The women’s descriptions of their pre-surgical breasts were in marked contrast to the breasts that they wished to have post-surgery. The women’s narratives seemed to reflect a shared understanding that desirable breasts are simultaneously full, round, and perky.

The idealized breasts the women described are like solid objects; this shape makes breasts appear as tangible “things” and highly visible under the scrutinizing male gaze. According to Iris Marion Young (2003), feminine beauty norms which dictate that breasts should be simultaneously full, round, and perky, “suppress the fleshy materiality of breasts, the least muscular, softest body part” (p. 153). The media bombards us with images of women who possess the ideal breasts, and in turn we scrutinize and judge our own breasts against these perfected images.⁸ Many of us will then discipline our bodies to achieve the current culturally desired breasted appearance. Indeed, the women’s internalization of cultural beauty norms is reflected not only by the women’s decisions to undergo cosmetic breast surgery to change the size and shape of their breasts, but also by their engagement in other less invasive strategies or practices to discipline their breasts to conform to these strict feminine beauty ideals. According to Erika Summers-Effler (2004), women employ “defensive strategies by either downplaying the body or playing

⁸ In the following chapter I will discuss the normalizing effect of the constant representation of artificially enhanced breasts in the mainstream media and pornography, and how these unnatural beauty norms become culturally constructed as “normal,” “natural,” and “healthy.”

up the body so that they [can] maintain a sense of control over the responses they receive” (p. 40-41). Many of the women in this study engaged in defensive strategies prior to undergoing cosmetic breast surgery, however, the strategies the women employed tended to differ depending on the women’s pre-surgical embodiment. Specifically, many of the women who underwent breast reduction surgery discussed that prior to surgery they “downplayed” their breasts by wearing large clothing to cover up their breasts, and/or developing poor posture so as to draw less attention to their chests. In contrast, many of the women who underwent breast augmentation surgery discussed how they engaged in strategies that “played up” their pre-surgical breasts, such as wearing padded push-up bras, wearing two bras at one time, and/or using make-up to create the appearance of cleavage.

All of these disciplinary techniques intimate that our breasts, more than any other part of the female body, are understood to be markers of our value as women. The women in this study internalized the belief that to have breasts that are the ideal size and shape is to be valued, loved, desired, and successful. Ultimately, the women decided to undergo cosmetic breast surgery, at least partly, because they no longer wanted to engage in these “defensive strategies.” Thus, their decision might be viewed as an “offensive strategy” that allowed the women to “get by” when other strategies were no longer sufficient, and without the same degree of conscious effort on a daily basis.⁹ As Kathy Davis (2003) explains, undergoing cosmetic surgery may allow women to “reenter the mundane world of femininity where beauty problems are routine and - at least to some extent - manageable” (p. 85).

⁹ In the following chapter, I will examine how some of the women’s narratives reflected that undergoing cosmetic breast surgery “freed” them from engaging in “artificial” beauty practices (such as wearing push-up bras), and thus allowed them to “naturally” embody feminine beauty norms.

Growing Pains

From the moment that young girls begin to develop breasts they become conscious of the complex, and contradictory meanings, attached to female breasts. According to Janet Lee (1997), “at puberty girls encounter the confusions and contradictions associated with the social construction of feminine identities” and “breasts figure largely in this adolescent drama” (p. 453). Young girls learn early on that their breasts are not their own, as their peers (especially adolescent boys), as well as family members, and even strangers, begin to focus attention on their chests. The scrutinizing gaze from outside may result in self-policing and self-disciplining behaviour on behalf of young girls. Despite attempts to manage their breasted appearances, however, many girls experience their breasts as sources of disempowerment, humiliation and shame during their interactions with others. In their study, Millsted and Frith (2003), discovered that for many girls/women “not having control over whether or not to make their breasts a salient aspect of their embodiment and identity in any given context, and having no choice over visibility, was experienced as disempowering and distressing” (p. 460).

Similarly, in this current study many of the women recounted how they experienced objectification during social interactions that resulted in them feeling disempowered, self-conscious and embarrassed. For a few of the women, this objectification was first experienced at a young age. Karen explained that as a young woman she was taunted by her peers because her breasts were noticeably different in size and shape:

I hated them [her breasts]. And people would laugh. I remember I was in junior high school and all of my friends went out to the lake and we were all wearing bathing suits, and the guys started laughing at me. And *you feel like a freak show* right? Everyone would notice.

As Karen's words reflect, it was extremely difficult for her to manage her breasted appearance so as to keep her breasts from becoming the focus of unwanted attention. Similarly, Lindsey discussed that growing up she began to understand that she could not control how people read her developing breasts. She stated that her peers constantly teased her about her small breasts, calling her demeaning names such as "board" to refer to her "board-like" chest. These women's narratives reflect that they experienced emotional trauma from the reactions that their breasts elicited from others. During these interactions, the women were made to experience their breasts as sources of humiliation and insecurity, and the social sanctions the women endured in younger years often stayed with them, significantly impacting their decision to undergo cosmetic breast surgery. The negative reactions the women received at a young age during interactions with others resulted in them disciplining their bodies to conform so as to not be set apart by their appearances.

This sense of a loss of control over the reactions of others, and the desire to self-discipline and conform, was not only experienced during some of the women's youth, but also into adulthood. While almost all of the women in this study recounted experiencing negative reactions from individuals that made them feel humiliated and self-conscious, the type of reactions they received from others was often dependent upon their pre-surgical embodiment. The following section will contrast the experiences and feelings of the women who underwent breast augmentation surgery against the experiences and feelings of the women who underwent breast reduction surgery. This contrasting analysis is necessary in order to address how the cultural meanings attached to large breasts differ from those attached to small breasts, and to examine how the women internalized these cultural meanings depending on their pre-surgical embodiment. The following analysis

reflects that the cultural meanings attached to women's breasts, combined with cultural beauty norms that dictate breasts should be a certain size and shape, means it is difficult for most women to "get it right." In other words, there is such a narrow range of acceptable breast sizes and shapes that the majority of women will fall somewhere outside of this range, and will consequently experience social sanctions for their inability to discipline their breasts to appear properly feminine.

Undisciplined Flesh

Breasts are culturally constructed as synonymous with femininity, while they are simultaneously markers of a girl's entry into womanhood. Reflected in many of the women's narratives was the internalized belief that their pre-surgical breasts were inadequate because they were not properly feminine or womanly. For some of the women who underwent breast reduction surgery, their large breasts were difficult to manage, and their breasted appearances signaled to others that they themselves were disreputable women. According to Millstead and Frith (2003) within Western culture, large breasts are constructed as "a marker of excessive sexuality and a lack of control," and as such, "large breasts mark women as vulgar, tasteless unruly and undisciplined, in short as not respectable" (p. 460). Some of the women's narratives reflected that they had internalized the belief that the soft flesh of their breasts was "unruly" and "undisciplined," requiring self-policing behaviour. According to Bordo (1993) anorexic women often describe wishing to rid their bodies of feminine curves, specifically their breasts, because these fleshy body parts represent a lack of control and restraint. She further argues that for the anorectic the ideal body is one which is "absolutely tight, contained, 'bolted-down,' firm: in other words, a body that is protected against eruption from within, whose internal

processes are under control” (p. 190). The current ideal breasts, like the ideal body shape, are perfectly firm and properly contained. This understanding was clearly reflected by Kelsey who stated: “Mainly it was *big boobs made me feel fat*. And especially nowadays everyone is skinny, and if you’re not skinny then you’re fat. You know it’s just the way that society is now.” Kelsey hoped that by undergoing breast reduction surgery she could reform not only her soft fleshy breasts, but her overall body, to appear taut and controlled.

Other women in this study who had large pre-surgical breasts similarly expressed that their breasts made the rest of their bodies look “fat” and undisciplined. These women often engaged in self-policing behaviour to try and camouflage these fleshy parts of their bodies. For example, Jamie explained: “Like sometimes you can hide your stomach or your arms, but your breasts are always big. And then when they’re out there *it just makes the rest of your body look bigger*.” According to Jamie she tried to hide her breasts, but they were simply too large to be concealed by clothing. In fact, she explained that wearing larger clothing to cover her breasts had the opposite effect as it only made her feel “bigger.” This problem was discussed by Janice as well:

I remember being in high school, and I was *the fat kid*. I have never worn more than a size 6 pair of jeans in my life, but just having big breasts you are automatically wearing an extra large hoodie, an extra large this, and everything is just big because you have to cover them.

Lisa also shared this understanding when she explained: “I wore sweatshirts that were literally four sizes bigger than I was, thinking I was hiding. Well *you just look like a blimp*, really.” All of these women’s experiences reflect the difficulty of managing the appearance of large breasts. Their ultimate decision to undergo breast reduction surgery is partly rooted in the desire to discipline their breasts to embody proper femininity, thus signaling to others that they themselves are self-disciplined and respectable women.

Becoming a “Whole Woman”

While many of the large-breasted women in this current study underwent breast reduction surgery so as to appear disciplined and respectable, many of the women who were small-breasted expressed that they wanted to surgically augment their breasts in order to signal to others their adult status. As breasts are markers of female maturity, women with large breasts often have the benefit of being fully accepted as adult women. In their study Millsted and Frith (2003) discovered that large-breasted women could gain “unproblematic access to the status of someone who is both a woman and who is feminine” (p. 461). In contrast, women who are small-breasted are culturally constructed as not adequately embodying femininity or as incomplete women. Marilyn explained that she underwent breast augmentation surgery, in part, because she did not feel like a “whole woman.” She stated: “I thought it would be a good thing to have the augmentation. I thought, *I’m going to be a whole woman now*, because I did really feel very inadequate before.” Similarly, Tara explained that she wanted to undergo breast augmentation surgery because she is a “girlie girl” and she wanted to have larger breasts in order to appear “more feminine.” She further discussed how prior to surgery she was self-conscious because her breasts were not large enough to fill out clothing, stating that she felt the need to wear specific clothing and bras in order to compensate for her lack of womanly curves.

Like I filled out nothing before the surgery. It was awful. I always had to wear an under-wire bra. I actually had gel inserts for my bra that I wore, because I couldn’t even fill out a 32 B. And I always, always wore a push-up bra. I would not wear a shirt if I couldn’t wear a push-up bra with it.

Tara's feelings of inadequacy regarding her small breasts reflect how full, round breasts are highly valued because they are symbolic of femininity and womanliness. Thus, undergoing breast augmentation surgery was a way for some of the women to enter into a feminine embodiment that is afforded status within our culture. Further, as we will see in the following chapter, for women such as Tara, breast augmentation surgery was a means to "naturally" embody idealized femininity, without the aid of artifices such as push-up bras.

The cultural construction of small-breasted women as inadequately feminine or womanly means that women with this particular embodiment may have their status as adult women and their roles as mothers contested. Teresa, a 26 year old mother of two, discussed that she was always small-chested, but that following breast-feeding she was "practically inside out." She recounted that her petite frame, and her small breasts, visually separated her from other women, particularly other mothers.

Because I'm not a huge person, it wasn't just a breast issue, it was being small all over and having people say, "Oh, is this your daughter?" or "Are you twelve?" Like I've had a lot of crazy people that have said some silly things that made me think I should do this [undergo breast augmentation surgery].

As Teresa explains her small breasts made it difficult for her to be accepted by others as an adult woman, and as a mother. She discussed that when she was in public settings, people who did not know her would often question her status in these two roles. As the above excerpt reflects, individuals would question her age and her relationship to her daughter, suggesting that her status as a woman and as a mother was contestable. She explained that shopping for a bathing suit every year was a time when she particularly felt set apart from other women, because she was often told to try and find a bathing suit in the children's section of the store. She stated: "It was awful. I don't want to buy a bathing

suit in the same section I just bought my daughter's in." Thus, for Teresa, undergoing breast augmentation surgery was not only a means to appear more womanly, but it was a way to gain status as an adult woman and a mother.

Breasts as Sexual Objects

While breasts are markers of femininity and symbolize a girl's entry into adulthood, they are simultaneously symbolic of sexualized femininity. According to Summers-Effler (2004), female breasts are "fetishized in contemporary Western cultures" as they "constitute the defining feature of sexual attractiveness" (p. 32). Indeed, within our culture, women's breasts, more than any other body part, are culturally constructed as sexualized objects. Large breasts are highly visible, and thus it is unfortunate, but not surprising, that many of the women who underwent breast reduction surgery complained that their pre-surgical breasts were constantly viewed as sexual objects by others. These women described the sexual objectification they received as the "wrong" type of attention. Natalie simply expressed: "I just felt like everyone was staring at me for the *wrong reasons*." Similarly, Janice stated, "Every guy is staring at your boobs, so yes, you get a lot of attention, but it is the *wrong kind of attention*. It is something that other women don't understand unless you have em [large breasts]." These women's experiences reflect that the attention they received from people was interpreted to be the "wrong kind of attention," because the women's breasts were read by others solely as sexual objects to be looked at.

In the following excerpt, Larissa contrasts the "wrong" attention she received pre-surgery against the attention she wished to receive.

A lot of the time *the wrong attention was the only attention I ever got*.

Everyone was always looking at my chest and they weren't looking at me for my brain. Especially because I went to University and I thought I was smart, but *I always got attention because of my chest, and never got attention because of what I was saying, or what I was doing.*

From Larissa's perspective she only received the "wrong" attention because her breasts were what everyone appeared to notice. She was frustrated because she wanted to be respected and admired for her intelligence, but instead her large breasts were interpreted by others to be the sole source of her value as a woman. For all of these women the decision to undergo cosmetic breast surgery was made, in part at least, to limit further unwanted sexual objectification, reflecting that this attention is often experienced as invasive, humiliating, and demeaning.

In addition to being viewed as sexual objects, some of the women's narratives reflected that others judged their large pre-surgical breasts to be symbolic of their sexuality. According to Brownmiller (1984), it is a strongly held cultural assumption that women with large breasts are hypersexual and have a "ready-to-go sexual nature" (p. 41). Many of the women's narratives intimated that their large breasts incorrectly signaled to others that they were sexually deviant women who were "slutty" or "promiscuous." Larissa candidly explained that it was not just men who interpreted her large breasts to be markers of her sexual availability, but that women also read her breasts to be representative of her "inherent hyper-sexuality."

Women would treat you differently because you are big boobed. Women would be more like you are some kind of *slutty girl*, or something like that, because you have these big boobs. Well it's not your fault that you have those big boobs. And, just because you have big boobs doesn't mean you are *promiscuous*, but that's what it came off as all the time.

This excerpt reflects how large breasts, as markers of excessive female sexuality, are interpreted by others to mean that the women who possess them are themselves are

hypersexual. Larissa explained that she felt powerless in these situations because she could not control how others read her large-breasted embodiment, and thus her ultimate decision to undergo breast reduction surgery reflects her desire to manage her breasted appearance and control the attention her breasts elicited from others.

It is important to acknowledge, however, that the current culturally fetishized and sexually desirable breasts are not only large, but they are also firm and perky. Thus, although all of the women who underwent breast reduction surgery had large breasts, their pre-surgical breasts still fell short of this sexual ideal. Specifically, many of the women who underwent breast reduction surgery discussed how they were self-conscious about becoming sexually active with men, because their large breasts were not firm and perky. Brandi simply stated: “I didn’t like to take my shirt off if I was with a guy. I never liked to take my shirt off. I was insecure in that way.” Some of the women explained that they were self-conscious about men seeing their breasts naked, because they felt their breasts were “saggy” or “old” looking. Natalie who was 21 at the time of her breast reduction stated, “I was very self-conscious. I just felt terrible about myself. I like compared myself to a grandmother.” While Natalie is only in her twenties, she felt as though her breasts look like those of a “grandmother,” because they were not round, firm and perky.

Some of the women also explained that because their breasts were large they could not find sexy lingerie to fit and support their chests. For example, Chantelle stated: “I had to get these special order bras because I was so big. So I had to wear granny bras, and that is not what a teenage girl wants to wear.” Similarly, Barbara explained that walking past lingerie stores and seeing all of the “cute bras” that she could not fit into, significantly impacted her decision to undergo breast reduction surgery. Finally, Lisa

described that prior to her breast reduction surgery “dating was an issue” and that there was “no baring that [her breasts] for a long time.” She further explained that part of the reason she did not want to bare her chest in front of men was because of the bras she had to wear in order to support her heavy breasts.

I had to wear grandma looking bras. And that was devastating. Especially when you are getting intimate with somebody and you're young, so you should be wearing something flashy, pink, and satiny from Victoria Secret. But no, you are wearing grandma's bra from Sears, you know? It was horrible. Horrible. But what did you do? I couldn't go to Victoria Secret. I couldn't go to regular stores. I had to go to department stores, or somewhere that carried large enough sizes.

As all of the above excerpts reflect, having breasts that were large, but not simultaneously firm and perky, made some of the women feel self-conscious about becoming intimate with men. The women's feelings of insecurity and inadequacy regarding their breasts were deepened by the fact that elite lingerie stores only manufacture sexually appealing bras in a narrow range of sizes. Thus, these women felt “abnormal,” or set apart from other women as they were forced to buy bras from specialty stores or department stores.

Sexually Desirable Breasts

As the above discussion has shown, large-breasted women experience their embodiment in a culture where their breasts are “on display” and objectified. However, within our culture large breasts (which are simultaneously firm and perky) are also highly valued and they mark the women who possess them as sexually desirable. Within this cultural context, women with large, firm, perky breasts can exercise power through their embodiment as they are able to harness the male gaze.¹⁰ In contrast, Brownmiller (1984)

¹⁰ The women who underwent breast reduction surgery appeared to recognize the power that they could exercise by continuing to have large breasts, because none of the women's breasts were reduced to a size smaller than a B cup, and the majority of their breasts were reduced to either a 34 or a 36 C cup size.

argues that it is a long-held cultural “myth that a flat-chested woman is nonsexual or unglamorous” (p.41). Thus, while women with small breasts may not experience sexual objectification to the same degree as large-breasted women, they are more likely to be seen as less sexually desirable or even nonsexual. Marilyn explained that she thought undergoing breast augmentation surgery would be positive, because her enlarged breasts would be more sexually pleasing for her husband.

I felt that my husband didn't like them, although he denied it when I would say something like, “Oh, but you really don't like them because they're just so little.” And I guess maybe that would have been my insecurities. And he would deny it, but I still felt that he would like me better when they were bigger [...] And, *there are not too many men that would be turning down the opportunity of having a bit more.* I don't know whether it be sexuality or sensuality. I mean that is the normal image that *the female breast is an attractive feature to a man.*

This excerpt reflects that Marilyn has internalized the understanding that large breasts are sensually and sexually pleasing for men. Despite her husband's assurance that there was nothing wrong with her pre-surgical breasts, she assumed that he would find her breasts more sexually pleasing once they were enlarged, stating that few men would “turn down” the possibility of having a wife with larger breasts.

The idea that few men, if any, would prefer smaller breasts to larger breasts was frequently reflected in the interviews. Even the women who staunchly argued that they underwent breast augmentation surgery “for themselves,” explained that their post-surgical appearances would be pleasing for their male partners as well. When asked how her common-law partner reacted to her decision to undergo breast augmentation surgery, Tara stated: “When he learned that I was going to do it, he was excited, of course, he's a guy. So by the time I got did it he was just so excited.” In this same line of thought, Diane commented that her husband reacted, “like most boys would,” stating: “I don't know

many men that wouldn't be excited if their spouses wanted to get something for themselves done that would make them have *eye candy*." According to Diane, any "normal" man would be excited at the possibility of his wife undergoing breast augmentation surgery because it would result in "eye candy" for him. Underlying these women's comments about their male partners is the widely taken-for-granted cultural assumption that men find larger breasts to be more sexually desirable than smaller breasts. Although all of these women explained that their male partners said they should "do it for themselves," and not for them, it was understood that undergoing breast augmentation surgery would be as Marilyn put it, "a win-win situation" for both parties.

While women with small breasts are culturally understood as inadequate sexually, women who have lost a breast, or both breasts, following cancer treatment may risk being viewed as asexual. According to Garland-Thomson (2002), the "amputated" or "disabled breast" is culturally understood as "abnormal" or "deformed," and thus requiring normalizing practices or procedures, such as prosthetics or cosmetic surgery (p.12).

Women who have lost a breast, or both breasts, following cancer are often viewed as disabled or "deformed" and as such, they are subject to the same social sanctions levied against all disabled women. In other words, women with amputated breasts (like all disabled women) are culturally constructed as asexual, unattractive, and "as generally removed from the sphere of true womanhood and feminine beauty" (Garland-Thomson, 2002, p.17). Lenore, who underwent reconstructive surgery following a mastectomy, explained that both her doctor and the cosmetic surgeon strongly encouraged her to undergo reconstructive surgery because she was "too young" to live without a breast. She stated: "They just explained that I was just way too young to be not having anything." This doctor-patient interaction clearly reflects that losing a breast is constructed as a

“deformity,” which requires a surgical solution.¹¹ It is also telling that Lenore’s medical team insisted that she undergo reconstructive surgery because she was “too young” to continue living with only one breast. This statement is possibly a reflection of the cultural understanding that breasts are integral elements of youthful feminine embodiment. As Lenore was only 44 years old at the time of her surgery, she was considered young enough (by cultural standards) to be sexually attractive, and thus cosmetic breast surgery was framed as necessary in order for her transform her disabled, asexual body into a “normal” feminine and sexually desirable body.

“Using Your Assets”: The Marketability of Physical Capital

As the above analysis shows, there is an extremely narrow range of acceptable feminine breasted appearances, and thus it is difficult for women to “get it right,” and appear properly feminine. Nevertheless, the women’s engagement in self-disciplining practices and their ultimate decision to undergo cosmetic breast surgery reflect that the rewards of “getting it right” can be substantial. For some of the women the rewards of conforming to cultural beauty standards included increased opportunities in both the job and dating markets. Indeed, some of the women who explained that they underwent cosmetic breast surgery “for themselves,” were referring to investing in their bodies in order to become successful through increased economic and relationship opportunities. As was outlined in chapter one, Bourdieu’s conceptualization of physical capital refers to an embodied or an incorporated form of capital. In our consumerist society, this type of capital has become increasingly important “given a prevailing aestheticization of

¹¹ The following chapter provides a detailed discussion of the ways in which the pre-surgical consultation is site of medicalization.

everyday life” (Frew & McGillivray, 2005, p. 163). Individuals possessing physical capital can use this to their advantage and acquire other forms of capital including economic, cultural, and social capital. The current ideal feminine body shape is embodied by a woman who is slender with large breasts and small hips (Harrison, 2003). As such, women with this particular body shape possess a great deal of physical capital.

Further, individual body parts contain their own capital apart from the body as a whole. According to Frew and McGillivray (2005) particular body parts are valued in various social contexts, but especially in the job and dating markets (p. 168). Thus, breasts possess their own capital in a heterosexist culture such as ours, but only a certain size and shape of breast is marketable. As Featherstone (1991) explains, within our consumerist culture “the body is proclaimed as a vehicle of pleasure: its desirable and desiring and the closer the actual body approximates to the idealized images of youth, health, fitness and beauty the higher its exchange value” (p. 177).

Two of the women who worked as waitresses explained that during their decision-making they considered how undergoing cosmetic breast surgery would be beneficial in the workplace. Tara explained that she was not averse to the idea of using her breasts to gain better tips as a waitress: “I’m all for being feminine and using your assets and doing what you have to do, within reason of course, to get where you want to be.” She further commented that her work in bikini contests impacted her decision to surgically enlarge her breasts. She stated: “I knew it was going to help, because I do bikini contests and it really helps to fill out a bathing suit.” Similarly, Diane explained that her decision to undergo breast augmentation surgery was impacted by her work as a waitress. She stated that working in a bar is a “different life” because unlike most jobs, “when you go to work everyone is showing cleavage and everything else.” When specifically asked if she

decided to get breast implants to improve her tips as a waitress, Diane answered: “It probably would have influenced it a bit, because I had been more or less a career waitress. You know it probably did. If I had been in an office job maybe I wouldn’t have wanted it so badly.” These excerpts reflect that undergoing cosmetic breast surgery was considered an investment in their bodies, because these women’s increased physical capital could be used to gain economic capital.

In addition to increased economic capital, conforming to feminine beauty norms can have “pay offs” in the dating market as well. As was discussed above, many of the women in this study discussed wanting to undergo cosmetic breast surgery, because it would allow them to appear feminine and sexually desirable. The desire to conform to beauty norms reflects the women’s understanding that within our culture physical attractiveness is an important asset. Indeed, according to Synnott (1993), “attractiveness is the *prime* predictor of romantic attachment for dating” (emphasis in original, p. 74). Further, the current “patterns of marriage, divorce, and remarriage mean that single women who want a mate face an increasingly tight marriage market” and thus increasing one’s physical capital through cosmetic surgery becomes an even greater asset (Sullivan, 1993, p. 103). Karen reflected her cultural awareness of the relationship between increased physical attractiveness and the likelihood of finding a male partner when she stated:

I mean if my breasts are not very attractive then I can’t wear attractive clothing. So I can’t wear bustiers or things like that, you know? And then obviously I am the girl that’s going to get passed over by guys all the time. And so I had the surgery.

This excerpt reflects Karen’s conscious understanding that she could improve her marketability in the context of dating by undergoing cosmetic breast surgery. While not

all of the women were quite as candid as Karen, most of the women's narratives reflected the taken-for-granted assumption that cosmetic breast surgery was a practical means to attract and sexually please men. As we will see in chapter six, a few of the women, including Karen, did experience "pay offs" in both the job and dating markets following cosmetic breast surgery.

However, the benefits of physical capital are limited. According to Summers-Effler (2004):

Meeting feminine attractiveness standards may enhance the power a woman has over her social environment, yet the very fact that she physically matches the cultural stereotype of a feminine woman may also cause her to be taken less seriously by others (p. 41).

Similarly, McCall (1992) argues that physical capital (a gendered form of capital) is not as powerful as other types of capital, because it does not follow Bourdieu's clear-cut formulation: "capital finds its way to capital" (Bourdieu, 1998, p. 19). Specifically, McCall argues that physical capital "in a culture dominated by heterosexuality, cannot escape the consequences of such capital when compared to other types of cultural capital, such as educational qualifications (feminine beauty= no brains)" (p. 845). The limit of physical capital in comparison to other forms of capital was not lost on some of the women in this study. Larissa explained:

I had worked in the bar a lot too, and that was how I made my money was from my looks and stuff. And I made more tips because I looked better, and probably because I have a bigger chest and stuff. And like getting an education, I thought, okay, there is going to be a point when I have to get a job, and I don't want them to be staring at my chest while we are having the interview. I want to be able to buy a suit that I can wear to an interview that is going to cover me all up. I didn't want my breasts to get in the way of my job and being taken seriously.

Larissa insightfully describes the limits of embodying feminine beauty norms. She acknowledges that while having large breasts is useful in certain workplaces it may

actually be disadvantageous in others. Thus, while increasing one's physical capital *can* result in "pay offs," it is a context-specific form of capital. That is to say, conforming to beauty norms will be beneficial in certain contexts, but it may actually be detrimental in other contexts. Relying on physical capital is further problematic, because within our sexist and ageist culture, a woman's physical capital severely depreciates in value as she ages.

"I Did it For Myself": Justifying Cosmetic Breast Surgery

During the interviews many of the women seemed to make a conscious effort to frame their decision to undergo cosmetic breast surgery as something that they "did for themselves." The women's use of justifications such as, "I did it for myself," were so common that it must be addressed. The following will first briefly examine why many of the women likely used this language to justify their actions, and then I will address why this line of thinking is problematic and misleading.

When justifying her decision to undergo cosmetic breast surgery, Teresa stated: "I didn't do it for anybody else. I did it for myself. I did it for me. If I knew someone else that wanted to do it I would say: 'Do it for yourself.' If you are doing it for yourself, it feels great." Other women similarly expressed that they underwent cosmetic surgery as a means to improve themselves and feel better in their skin. Danielle, who underwent breast reduction surgery, stated: "It was just kind of all about making me feel better." Further, it was clearly reflected in many of the women's narratives that undergoing cosmetic breast surgery for "self-improvement" was considered the "right" motivation. For example, Diane, who underwent breast augmentation surgery, stated: "If you are doing it for someone else you are not doing it for the right reasons." Similarly, Tara explained: "It

should be about making yourself feel better. The only person who it should be necessary for is you.” Both of these excerpts reflect the understanding that undergoing cosmetic breast surgery is acceptable if it is a freely made choice done for individual reasons. This idea was also reflected by Marcy, who stated: “If you think that’s best for you, think it over, and then do it.” All of these women’s statements reflect how liberal feminist notions of choice, agency, and individualism can be employed to justify oppressive beauty practices such as cosmetic surgery. The women’s justifications reflect that undergoing cosmetic breast surgery to improve oneself is a “normal” or “legitimate” reason in our consumerist society. Through this language cosmetic breast surgery is likened to other forms of “self-improvement” such as dieting and exercise, and thus the women are essentially arguing that undergoing cosmetic breast surgery was simply another body modification practice to improve their overall well-being. Some of the women even drew from feminist “pro-choice” discourse to argue that women should have the right to make decisions regarding their bodies, including the right to choose cosmetic surgery. Janice clearly reflected this discourse when she stated: “It is my body and this is what I want to do.”

All of these women who argued that they “did it for themselves” were obviously aware that their decision would be individually rewarding, but what the women were not conscious of is how their complicity in the beauty system would uphold oppressive and unjust beauty norms which all women are judged against. Further, by framing their decision to undergo cosmetic breast surgery as a free and liberating choice, these women mask the social reasons that caused them to be unhappy with their appearances in the first place. When discussing their decision to undergo cosmetic breast surgery as a means to improve one’s self or a way to self-fulfillment, the women gloss over their appearance-

related struggles and the painful social sanctions they experienced as a result of their inability to conform to strict beauty norms.

It is also problematic that while many of the women discussed wanting to undergo cosmetic breast surgery for their own pleasure, a “woman-centered meaning” of their breasts, which centers on the sensation that women derive from their breasts rather than their appearance (Young, 2003, p. 154), was noticeably lacking in the women’s narratives.¹² This lack of a “woman-centered meaning” calls into question the assertion made by many of the women in this study, that they underwent cosmetic breast surgery “for themselves.” I would argue that when many of the women were discussing their decision in terms of individual fulfillment, they were referring largely to the pleasure they would receive from entering into a feminine embodiment that is culturally valued and seen as sexually desirable by men. I am not arguing that all of the women in this study were coerced by individual men (although some of the women were) into undergoing cosmetic breast surgery, but I am arguing that the women’s decision-making was framed by the internalized desire to meet a “generalized, perceived male gaze” (Gagne & McGaughey, 2002, p. 834).

“Fun Bags”: Men’s Ownership of Women’s Breasts

As women in a heterosexist culture we are scrutinized, critiqued, and judged by the generalized male gaze. And, perhaps no part of a woman’s body is more subject to this scrutinizing gaze than her breasts. According to Young (2003), a woman’s breasts are constantly under the male gaze that “positions her from outside, evaluating her according

¹² As we will see in later chapters, some of the women felt that their decision to undergo cosmetic breast surgery was “worth it,” despite the fact that they lost nipple and/or breast sensation following surgery.

to standards that she had no part in establishing and that remain outside her control” (p. 153). In this cultural context men symbolically own women’s breasts, and as such, it is difficult to “imagine a woman’s breasts as her own, from her own point of view, to imagine their *value* apart from measurement and exchange” (italics in original, Young, 2003, p. 154). The contested ownership over women’s breasts was clearly reflected by Diane who explained that her husband referred to her breasts as his “fun bags.” After breast-feeding her two children, however, she referred to her own breasts as her children’s “baby-feeders,” she stated: “Since I’ve had kids it’s like I tell my husband to just leave them alone, because they are just baby-feeders.” Diane’s words intimate that her breasts are at times her husband’s “fun bags,” and at other times “baby-feeders,” but that her breasts are never her own. Her desire to undergo a second surgery to have breasts that are once again seen as sexually desirable by her husband further reflects that breasts may be periodically “owned” by babies when nursing, but they are ultimately the sexual possession of men. Thus, her experience reflects why it is problematic in our male-dominated culture to argue that women undergo cosmetic breast surgery for individual fulfillment or improvement. On closer analysis it is clear that the decision to undergo cosmetic surgery is not really an act of empowerment, but instead a means for women to enter into a feminine embodiment that conforms to heteronormative standards.

Doing it for Him

While the decision to undergo cosmetic breast surgery was a way for all of the women to meet the standards of the generalized male gaze, for a few of the women cosmetic breast surgery (specifically breast augmentation surgery) was done to please individual men. In these women’s narratives it is clear that their husbands had staked

claim over the women's breasts, because they strongly encouraged (and in two cases paid for) the women to undergo cosmetic breast surgery.¹³ These women explained that they really had no "choice" but to undergo breast augmentation surgery, because they were young, vulnerable, and financially dependent on their spouses at this time. Thus, undergoing cosmetic surgery was clearly not seen as a liberating decision by these women, but rather as a way to "get by" in their marriages and "get on" with their lives.

Lindsey was a 25 year old mother of two children when she found out that her husband had a sexual affair with another woman. She explained that following this she decided to undergo breast augmentation surgery, because her husband was a "boob guy," and Lindsey hoped that undergoing breast augmentation surgery would improve their relationship. According to Lindsey it was ultimately her choice to undergo cosmetic surgery, but clearly her husband's actions and her resulting insecurities played a major role in her decision-making. In addition, her husband may not have coerced her into having her breasts enlarged, but he also never questioned her decision or told her she did not need the surgery. Instead he "supported" her by paying for the surgery, because she was a stay-at-home mother at the time. Thus, Lindsey may have chosen to undergo breast augmentation surgery, but it was a very constrained choice, as she realized that by not undergoing breast augmentation surgery she could potentially lose a great deal.

The possibility of making a free choice was not offered to Robin, because her husband requested that she undergo breast augmentation surgery. Robin was only 20 years old when she had her first child, and she explained that after breast-feeding she "lost" her breasts which left her feeling self-conscious about her body:

¹³ Robin's husband did not pay for her breast augmentation surgery, because it was paid for by the Alberta Government (see footnote on p. 118).

I was feeling awful about my body because I had gone from a 34B to basically nothing. And I thought well that's awful, you know? And I was having trouble trying to deal with it psychologically. I was trying to deal with how my husband felt because he had me at this [size] and now has me at that. And, I had finally come to terms with it and just thought, "That's it. No big deal. I am going on with life." And then my husband came to me and said, "I would appreciate it if you had breast implants." So then I had to really consider it. And he really hounded me about it for a long time.

Robin did eventually decide to undergo cosmetic breast surgery after the strong urging of her husband, explaining that she had to convince herself to "just let it go." She stated: "I thought just let it go and get it over with. And let's get on with our lives." Similarly, Leanne explained that she underwent breast augmentation surgery as a way to cope in her marriage. Leanne was only 18 years old when she was married, and following the wedding she moved with her husband miles away from her family and friends. She was clearly socially isolated and vulnerable in this situation. Leanne recounted her experience in these words:

We had been married a month and basically he just said, "Hey we're going to do this." And he brought me into a cosmetic surgeon a month after we were married. And so I had the consult, and then shortly after I had the surgery. You know it happened so quickly that I didn't even have time to process it. I was just coping. It was like I was on autopilot.

As the above excerpt reflects, Leanne's compliance was a way to cope or "get by" in a social context where she had little power or control. Her experience thus reflects that in some cases women's choices are constrained to the point that there really is only one option available. As Leanne stated, "I didn't really get to make the choice and it was awful. I felt horrible."

Conclusion

The women's decisions to undergo cosmetic breast surgery were framed within a culture that values and judges women based on their appearances. As the above analysis reflects, many of the women realized this and engaged in less invasive disciplinary practices prior to undergoing cosmetic breast surgery. The women's self-disciplining behaviour reflects the difficulty all women experience in the attempt to manage our breasted appearances and conform to dominant beauty norms. While large-breasted women are seen as womanly and feminine, they must simultaneously self-police their soft fleshy breasts so as not to appear undisciplined or hyper-sexual, and they must negotiate being treated solely as sexual objects. In contrast, small-breasted women are culturally constructed as not adequately embodying femininity or as incomplete women, and while small-breasted women may be able to escape the male gaze to some extent, they are also at risk of being viewed as sexually undesirable or asexual. The narrow range of acceptable feminine breast sizes and shapes meant that it was extremely difficult for the women to manage their breasted appearances through less invasive disciplinary practices. The decision to undergo cosmetic breast surgery reflects the women's internalized belief that by permanently modifying their breasts to conform to these strict beauty norms the women would be loved, valued, desired, and successful. Further, the women recognized that by complying with hegemonic standards of beauty they could escape severe social sanctions, in the same way as "deviants are liberated from the sanctions of deviance when they conform to societal expectations" (Gagne & McGaughey, 2002, p. 835).

While embodying dominant beauty norms does result in real rewards, it does not mean that undergoing cosmetic breast surgery is an empowering decision that is solely rewarding for women. As the above analysis reflects, the women's decisions were made

within a cultural context that severely limits their options. The decision to undergo cosmetic breast surgery was often simply a means for the women to “get by” in a culture where there were few other viable alternatives. For a few of the women, choosing not to undergo cosmetic breast surgery was not really even an option, as refusal would likely have ended in significant losses. Therefore, to argue that the decision to undergo cosmetic breast surgery was an empowering “free choice” would not be reflective of the women’s experiences in this study. Further, as we will see in the following chapter, the idea of “free choice” in relation to cosmetic surgery is made additionally problematic by the medicalization of healthy feminine breasts and the construction of cosmetic surgery as a necessary procedure to “cure” women’s bodily “deformities.”

Chapter 4: “Booborexia”: Medicalizing the Healthy Breast

Within our culture, it is seemingly rare for a woman to be completely satisfied with her natural appearance. In fact, women’s concerns for their appearance are socially constructed as “*essential* to their nature as women” (italics in original, Dull & West, 1991, p.64). As women, we engage in a variety of beauty practices, on a routine and day-to-day basis, that are aimed at altering our faces and bodies. Daily, we use products such as make-up to both enhance and conceal, moisturizers to soften our skin and hair, depilatories and razors to remove unwanted hair, deodorants to hide unwanted smells, and perfumes to create desirable scents. As we saw in the previous chapter, women often also engage in practices to specifically manage their breasted appearances, including wearing push-up and/or padded bras, and wearing specific clothing to augment or hide our breasts. Indeed, our extensive day to day beauty practices demonstrate that within Western culture, “femininity is a state to be constantly sought” (Black & Sharma, 2001, p. 101).

For the majority of the women in this study, however, the decision to undergo cosmetic breast surgery, a far more invasive and permanent “beauty practice” than those described above, resulted from more than these typical feelings of dissatisfaction with their appearances. Reflected in most of the interviews was the understanding that the women’s breasts were no longer simply cosmetic problems, or as one woman stated, “the normal girl freak-out”, but that they had become pathological problems that required medical attention. The women’s feelings regarding their breasts raises the question of why women who have breasts that are healthy and function normally would experience their breasts as abnormal and defective.

Booborexia

For many of the women in this study this sense of abnormality or lack extended so far as to comprise a medicalized concept of their own bodies. Tanya, a 27 year old woman, who underwent a breast augmentation surgery, engaged in self-medicalization, even creating a disorder to explain her thoughts and feelings regarding her breasts:

We call it “booborexia”- like I don’t even feel like I got implants, because I feel like they are still too small. And then people who know me think that I’m crazy. But when I just look at myself on a daily basis I wish that they were bigger. It is the same with how anorexics think they are fat when they aren’t. It is totally like you don’t see it for yourself- that’s booborexia.

According to Tanya, women with booborexia have a distorted body image and consequently wish to change the size and shape of their breasts. Tanya considers herself to be “booborexic,” because she perceives her breasts as being “too small” despite the fact that her breasts have already been surgically enlarged.

Drawing on contemporary sociological theory and the women’s narratives I will discuss how the medicalization of healthy feminine breasts contributes to women’s experiences of “booborexia.” I will examine the process of medicalization by looking at how the women in this study came to understand their breasts as abnormal or problematic and their decisions to undergo “corrective” cosmetic surgery. Specifically, I will examine the ways in which the women experienced medicalization at the *institutional level*, through the normalizing images in the mainstream media, and at the *interactional level*, when the women’s breasts were defined and treated as medical problems by their cosmetic surgeons. Finally, I will discuss how different cosmetic breast surgeries are separated by “degrees of medicalization” (Conrad, 1992). In particular, I will address why

there is reason to believe that whereas breast reduction surgery is almost fully medicalized, breast augmentation surgery remains only partly medicalized.¹⁴

What is Medicalization?

Before entering into a discussion of the women's experiences it is important to outline the general theoretical framework which grounded my analysis. The obvious place to begin is with a definition of the term *medicalization* which I have employed in my analysis. Put simply, *medicalization* refers to a process by which previously non-medical problems are defined and treated as medical problems. According to Peter Conrad (1992) medicalization can occur at the *conceptual*, *institutional*, and *interactional* level: at the *conceptual level*, when medical language is used to define a non-medical problem as a medical problem; at the *institutional level* when medical professionals legitimate a medical treatment or a problem; or on the *interactional level* during doctor-patient interaction when a physician defines and treats non-medical problems as medical issues (emphasis added, p. 211). As we will see, the women's narratives reflected that medicalization occurred on both the *institutional level* through the mainstream media, and at the *interactional level* when the women's breasts were defined and treated as medical problems by their cosmetic surgeons.¹⁵

Regardless of the level on which medicalization occurs, however, the ultimate result is increased power and influence for the medical profession because through the

¹⁴ In the following, I can only make reasonable assumptions regarding the degree to which cosmetic breast surgery following a mastectomy has become medicalized, as I only interviewed one woman with this particular experience.

¹⁵ Medicalization also occurs at the conceptual level, for example, when medical language such as *hypomastia* or *micromastia* is used to define small breasts as a "disease." However, the majority of the women's narratives did not reflect how medicalization at the conceptual level impacted their embodied experiences.

process of medicalization an increasing number of previously non-medical problems come to exist under medical jurisdiction. According to Irving Zola (1981) medicine as an institution of social control exercises power by medicalizing “much of daily living” and “by making medicine and the labels ‘healthy’ and ‘ill’ *relevant* to an ever increasing part of human existence” (italics in original, p. 511). Further, as an increasing part of our lives come to be under medical jurisdiction, the social causes of disease and illness are diminished (see for example, Zola, 1981; Conrad, 1992; Riessman, 2003). According to Peter Conrad (1992):

The criticism of medicalization fundamentally rests on the sociological concern with how the medical model *decontextualizes* social problems, and collaterally, puts them under medical control. This process *individualizes* what might be otherwise seen as collective social problems (emphasis added, p. 223-224).

Similarly, Zola (1981) explains that the “labels health and illness are remarkable ‘depoliticizers’ of an issue” because “[b]y locating the source and the treatment of problems in an individual, other levels of intervention are effectively closed” (Zola, 1981, p. 523).

In my study, one can see how the process of medicalization individualized the women’s experiences and effectively obscured the cultural significance of the women’s feelings regarding their breasts and their decisions to undergo cosmetic surgery. The disorder “booborexia,” created by Tanya to explain her negative body image is an extreme example of the way in which medicalization individualizes and decontextualizes a social problem. For Tanya, the cultural imperative of ideal femininity becomes a personal disorder, and the social context in which she experiences her “disorder” is masked. Thus, in this chapter I hope to lay bare the underlying social reasons that caused

the women to experience their breasts as abnormal and defective and encouraged them to undergo “corrective” surgeries.

At the same time, however, I do not want to construct the women in this study as passive victims in the process of medicalization. Indeed, the women were often complicit in the medicalization of their breasts. According to Catherine Kohler Reissman (2003) women cooperate with the medical profession to benefit their own interests and needs. In fact, she states that, “both historically and currently, there has tended to be a “fit” between medicine’s interest in expanding its jurisdiction and the need of women to have their experience acknowledged” (p. 57). This “fit” is clear in terms of cosmetic surgery because women often seek out cosmetic surgeons and their medical expertise creating a demand for surgical solutions. In turn, cosmetic surgeons advertise and supply cosmetic surgery to patients which legitimates the practice and further creates a demand for these surgeries. This results in “medical markets” wherein “medical products, services, or treatments are promoted to consumers to improve their health, appearance, or well-being” (Conrad & Leiter, 2004, p. 159). Consumers are integral in “medical markets” as they often “pursue the goals of promotion or reception of new medical interventions” (p. 172). Thus, the medicalization of healthy female appearances is not simply the result of the medical profession expanding its jurisdiction, but a complex process operating within a capitalist society wherein women are complicit actors.

The medical markets that have developed demonstrate the “fit” that exists between women’s needs and the medical profession; however Reissman (2003) argues that this “fit” results in both gains and losses for women. On the one hand, women can gain a great deal from having their experiences legitimated through medical intervention. As I will discuss later in this chapter, through their interactions with cosmetic surgeons

the women's feelings of pathology were confirmed, and their decision to undergo cosmetic breast surgeries were given medical legitimacy. The medical credibility afforded to their experiences convinced many of them that they were not acting irrationally. On the other hand, women lose out in this process because as "doctors acknowledge women's experience and treat their problems medically, problems are stripped of their political content" (p. 59). Thus, as was discussed above, the process of medicalization individualizes the problem and obscures the social causes underlying the issue. Further, through their complicity, the women in this study perpetuate the medicalization of normal and healthy functioning breasts and uphold the cultural norms on which this medicalization is based.

Medicalization and the Politics of Appearance

In addition to literature on medicalization, I drew from feminist theory and disability theory to understand the women's experiences. The following analysis draws from the theoretical framework outlined by Rosemarie Garland-Thomson (2002) in her article, "Integrating Disability, Transforming Feminist Theory." According to Garland-Thomson integrating disability theory with feminist theory provides a radical critique as it is rooted in a "broad understanding of disability as a pervasive cultural system that stigmatizes certain kinds of bodily variations" (p. 5).¹⁶ More specifically, she states:

¹⁶ To be clear, I am not referring to the women in this study as disabled, but rather I am suggesting, in the words of Garland-Thomson (2002), that the "concepts of disability discourse" (p. 7) are useful for shedding light onto the medicalization of women's breasts. For example, Garland-Thomson argues that women's bodies are "conceived of as either a lack or an excess" and similarly "the differences of disability are cast as atrophy, meaning degeneration, or hypertrophy, meaning enlargement" (p. 7). As such, it is perhaps not surprising, that one of the medical terms used to define the 'disorder' of small breasts is *hypomastia*, meaning a *lack* or a *deficiency* of breast tissue. And in contrast, *hypermastia* is a common medical term used to refer to the "deformity" of *excessively* large breasts.

Disability is a broad term within which cluster ideological categories as varied as sick, deformed, crazy, ugly, old, maimed, afflicted, abnormal, or debilitated – all of which disadvantage people by devaluing bodies that do not conform to cultural standards. Thus, the *disability system* functions to preserve and validate such privileged designations as beautiful, healthy, normal, fit, competent, intelligent – all of which provide cultural capital to those who claim such statuses, who can reside within these subject positions (emphasis added, p. 5-6).

By adopting a feminist disability theory framework it is possible to see how the women's pre-surgical bodies in this study were deemed "abnormal" or "problematic," and were thus stigmatized and devalued, because they did not conform to strict feminine beauty norms. As the above excerpt suggests, through the normalizing practice of cosmetic breast surgery, the women were able to gain value and cultural capital as their bodies were "corrected" and erased of their "abnormalities," thus conforming to standards of beauty and normalcy.

Finally, I drew from Susan Bordo's (1993) feminist analysis of anorexia nervosa in order to better comprehend the women's experiences of medicalization. At the beginning of the chapter, Tanya explained the "disorder" booborexia, by comparing it to the medically recognized condition anorexia nervosa. Although there are obvious and important differences between anorexia and booborexia, I agree with Tanya that there are significant similarities. In her book *Unbearable Weight* Susan Bordo (1993) argues that anorexia nervosa should be viewed as a normative expression of our culture, or a "crystallization of culture," rather than a cultural anomaly or an aberration. Specifically, she argues that because the socially constructed ideal female body shape in the 1980's and early 1990's became increasingly slender, the "emaciated body of the anorectic" should be viewed as a "caricature of the contemporary ideal of hyperslenderness for

women” (p.170). According to Bordo’s analysis, anorexia is a reasonable response given hegemonic feminine beauty norms.

Drawing from Bordo’s analysis of anorexia, in this chapter I will argue that the women’s decisions to undergo cosmetic breast surgery should be understood as a completely normal response to the current socially constructed ideal for women to have large, round, perky breasts. In other words, cosmetic surgery is an understandable solution given that as women we recognize that if we wish to attain physical capital (see p. 13) and be valued within our society, we must strive through whatever means necessary to embody ideal femininity. In fact, according to Kathryn Pauly Morgan (2003), in our culture, refusing to engage in beauty practices such as cosmetic surgery may be “akin to a kind of death, to a kind of renunciation of the only kind of life-conferring choices and competencies to which a woman may have access” (p. 177). Thus, the women’s decisions in this study should be viewed as symptomatic of a pathological culture which requires women to embody strict hegemonic beauty norms, rather than indicators of the women’s maladjustment or cultural naivety.

Medicalization at the Institutional Level: The Impact of Mainstream Media Images

Today, the mainstream media is one of the central and most highly influential social institutions within Western society (Silverblatt, 2004). As such, the mainstream media is able to exert a great deal of pressure on women to discipline their bodies to embody feminine beauty norms. We are constantly bombarded with images of perfect female body shapes on the covers of magazines, in advertisements and in movies and television programs. These idealized images are not harmless as they impact our lives in powerful ways. The media’s ability to impact how we feel about our bodies is due in

great part to the representation of the ideal feminine body shape as the norm against which all other female bodies are to be judged. As, Eugene Mellican (1995) states, the “current cultural configuration of socio-cultural forces have dramatically increased pressures on women to conform to a singular body ideal” (p. 10). By portraying a “singular body ideal” as the norm, various media forms construct perfectly healthy and normal, but non-conforming, bodies as abnormal and problematic.

The fact that few, if any, women naturally have breasts similar to those in the media does not prevent us from comparing ourselves to the media images. According to Mike Featherstone (1991), pervasive media “images invite comparisons: they are constant reminders of what we are and might with effort yet become” (p. 178). The unfortunate result of this comparison, for many of the women in this study, was that they felt that their breasts were visible markers of difference and abnormality. For example, Karen candidly explained that her decision to undergo cosmetic surgery to “correct” the asymmetry of her breasts, and indeed her overall body image, was significantly impacted by the mainstream media images she viewed on a daily basis.

The media affects my make-up, it affects my breasts, it affects my weight, it affects the clothes I choose. I mean we watch it everyday. It is on everywhere we go. We see it on magazine racks and TV, and even guys with their Sports Illustrated calendars hanging up. It is something that we are aware of 24 hours a day as females. So yeah absolutely that has an impact on my body image.

Karen’s explanation reflects the pervasiveness of mainstream media images and the effect that these normalizing images have on the way she experiences her body. Her words thus reveal the connection between her subjective experiences and cultural standards of beauty and hegemonic femininity.

Other women also discussed how they experienced their breasts as problematic or abnormal in comparison to those portrayed in the mainstream media. When asked if the media impacted her decision to undergo breast reduction surgery Larissa answered:

Oh yeah. Absolutely. Because on T.V. and in commercials and movies, nobody talked about their boobs hanging down low. And you know I didn't even point in the right direction was my problem. They were just so big and they just fell. Like they would sit on my lap. It was horrible.

Similarly, Chantelle discussed how she perceived her breasts as sitting "way too low" on her chest compared to the ideal breasts she saw in mainstream media forms:

Well the ideal body shape involves a larger chest, but it is generally a round, perky chest, not the kind that I had. Mine were way too low already at that age [21]. It was bad. It didn't work.

The women's negative feelings towards their breasts clearly reflected the impact of the media's lack of representation of feminine bodies that resemble their own. The narrow range of "normal" represented in the media means that the majority of women will fall outside of this range and may consequently feel inadequate and abnormal. Robin, who underwent breast augmentation surgery, felt that her body shape did not "fit" when compared to the feminine body shapes portrayed in the media, saying: "You know in every magazine you looked at, everyone of those women [in the magazines] were great looking women. And it was like, well, I just don't fit into that category at all."

"Big Fake Boobs" as the New Normal

In addition to the above examples, some of the interviews reflected the understanding that the pervasive media images did not represent an ideal; rather they represented the "new normal." Drawing from Foucault's conceptualization of the disciplined body, Bordo (1993) asserts that the "homogenized images" in the mainstream

media “*normalize* – that is, they function as models against which the self continually measures, judges, ‘disciplines,’ and ‘corrects’ itself (italics in original, p. 25). For some of the women in this study the ideal, and often artificially enhanced, breasts portrayed in the media were taken to be models of normal and healthy breasts. Thus, some of the women interviewed explicitly explained that they hoped their surgeons would be able to “correct” and reform their breasts so that might look like the round, firm, perky breasts displayed in the mainstream media. For example, Diane described that she wanted her post-surgical breasts to appear naturally “pushed-up.” In her words: “I wanted to look like I was wearing a push-up bra when I was just wearing a regular bra.”

In the same line of thought, but in much more detail, Tanya described her idea of the perfect post-surgical breast shape:

Like for me I wanted that *definite rounded on the top part*. Like Carmen Electra or Pamela Anderson. That's what I really like. It's that *rounded top, firm like up there kinda look*. And I mean most girls can get that shape with a good push up bra. But I kinda wanted [to have that shape] with just a regular bra. Or if I could've I would have wanted that shape with no bra.

According to Tanya, her desire to have these perfectly shaped breasts stems from her association of “big, fake, boobs with good-lookingness.” This understanding was echoed by 26 year old Tara who described women in the media with breast implants as “attractive,” “really feminine,” and having that “wow” factor. These statements appear to reflect how the constant representation of “big, fake, boobs” in the mainstream media translates into these unnatural breasts becoming culturally constructed as “normal” and “naturally feminine.”

These women’s experiences may also be a reflection of the “pornification of culture” and the resulting social construction of even more restrictive beauty norms. In an

article entitled “The Porn Myth” Naomi Wolf (2003) states that the whole world, post-internet has become “pornographized.” Within this cultural context women learn that they cannot compete with the mainstream pornographic images. According to Wolf now that porn has gone mainstream, for most women simply “being naked is not enough; you have to be buff, tan with no tan lines, have the surgically hoisted breasts and the Brazilian wax-just like porn stars” (para.8). Indeed, for a woman to have the sexualized and fetishized breasts that are portrayed in pornography and other pervasive media forms, most women will require some type of body alteration. This “new normal” in the mainstream media, including pornography, then sets an increasingly high standard for women to achieve.

In order for most women to embody this ideal they will at minimum need to wear a push-up bra to create the desired full, round, perky appearance. Tanya described how make-up could also be used to create this effect. She explained that if you take “a dark concealer [you] can make lines here [above your breasts] and it gives you the image of that top kind of bump like that you see in the magazines.” However, for Tanya it was not enough to have this appearance with a push-up bra or make-up because she desired her breasts to be “naturally” firm, round, and perky. She stated that she wanted to undergo breast augmentation surgery because she no longer wanted to engage in these “artificial” beauty practices to create a “normal” appearance. This line of thinking is reflected by Marilyn, who stated: “I was always choosing to buy the bras with padding in them...so this way I was going to have something that was natural, because nobody else would know that they were not natural.” Similarly, Tara stated that she wanted her post-surgical breasts to look as “fakely natural as possible.” In other words, she wanted to look as though she “naturally” had “fake” looking breasts. Thus, the result of non-standard artificial breasts becoming the new standard of normalcy is ultimately a paradox: in order

for these women to have what they considered to be natural and normal looking breasts, they underwent cosmetic surgery and had foreign objects made of unnatural materials placed into their bodies.

Cosmetic surgeons who request patients to choose their desired post-surgical breasts from images in pornographic magazines, also significantly contributes to the creation of a new standard of normal. This practice was discussed by Jamie and it demonstrated how medicalization can occur simultaneously at the institutional level (through normalizing mass media images) and the interactional level (through doctor-patient interaction). Thus, through this interaction women experience medical confirmation that their breasts are sub-normal and require surgical remedy while the breasts in the pornographic magazines are presented as normal and indeed optimal. Ironically, the perfected images of virtually all artificially enhanced breasts are constructed as healthy and normal, while the woman's truly healthy and normal functioning pre-surgical breasts are constructed as defective and abnormal.

Through this doctor-patient interaction, the surgically perfected breasts in the pornographic magazines are fetishized and commodified as "things" or "parts" to be purchased. When asked how she decided what size she wanted her breasts to be following her breast reduction Jamie replied:

I got porn magazines. Well that's what she [the cosmetic surgeon] told me to do actually. She told me to go buy like Playboy and whatever magazines I could find with women's breasts and pick which ones I like. So I basically just flipped through magazines. And then I just marked x's beside the pictures I liked and just gave her my magazines.

From this quote it appears that Jamie's cosmetic surgeon is providing her with a multitude of options similar to any other consumer choice. According to Jamie she can pick and choose her post-surgical breasts from among those she sees in pornographic magazines.

However, pornography, even more than other media forms, depicts sexual fantasies rather than reality. The images in pornography do not portray natural diversity, but instead represent ideal feminine body shapes. Jamie's choices regarding the size and shape of her breasts following surgery are actually extremely limited in the sense that all of her options fall within a narrow range of what is culturally defined as ideally feminine.

The direct opposite of the culturally desirable breasts discussed above, are the "old woman's breasts" which are "[f]lat, wrinkled, greatly sagging" and "signify for the ageist dominant culture a woman no longer useful for sex or reproduction, a woman used-up" (Young, 2003, p. 154). Mainstream media forms greatly facilitate this cultural construction of "old woman's breasts" as "used-up" through its almost exclusive representation of young, firm, perky breasts which are symbolic of idealized femininity, feminine sexuality, and motherhood. According to Meredith Jones (2004):

While youth is granted privileged status and is associated with active sexuality, independence, beauty, and productivity, ageing is often represented as its opposite: frail, useless, unattractive, and dependent (p. 526).

Jones goes on to explain that "there would be no such thing as 'youthful beauty' without its opposite, aged ugliness" (ibid). These cultural representations of ageing fit perfectly with popular and medical discourses that tell us to employ any means necessary to "fight" against ageing. The completely natural process of ageing has been medicalized so that any woman who does not try to resist or "fight" against ageing is constructed as complacent, lazy, or as "letting herself go." The result, is a "difficult double message: resistance through conformity" (Holstein, 2001/2002, p. 40).

Within this context of an ageist culture Tracy, a 21 year old woman who underwent breast augmentation surgery, came to hate her breasts after pregnancy and

breast-feeding. When asked how she felt about her breasts prior to her augmentation surgery, she stated:

I hated them. [...] Just because of having a child at such a young age they started to look not like they should. [...] I felt that they looked like they were *old woman boobs*.

Similarly, Nancy, a 46 year old stay-at-home mother, explained that following pregnancy and breast-feeding she could not even stand to look at her mirrored reflection as her breasts appeared “deflated” and they were “nothing but loose skin.” In order to “fix” her ageing breasts she decided to undergo breast augmentation surgery to fill out and lift her “deflated” breasts. The women’s descriptions of their breast as “old,” “deflated,” and “nothing but loose skin,” are in marked contrast to the fetishized and sexualized breasts, described above, which are young, solid, round, taut and sit high on the chest. Within our culture that denigrates any physical characteristics associated with ageing, it is not surprising that some of the women felt negatively about their ageing breasts. It is also reasonable, given the medicalization of ageing that these same women chose to undergo cosmetic surgery to “correct” and reform their breasts. Thus, the women’s decisions to undergo cosmetic surgery can be viewed as an attempt to increase their cultural value, and reposition their self-perceived “old” and “defective” breasts as young, feminine, and sexually desirable. However, the decision to alter their “old” looking breasts perpetuates the ageist beliefs and values that made them consider cosmetic surgery in the first place.

Resisting Mainstream Media Images?

Despite the above examples, it is important to note that not all of the women interviewed admitted that pervasive cultural images impacted their feelings regarding their breasts and their desire to undergo cosmetic surgery. It was clear in some of the

interviews that the women did not want to appear as though they were “cultural dupes” thoughtlessly responding to hegemonic beauty norms. This is reflected by Lindsey, who underwent breast augmentation surgery:

[Do you think the media impacted your decision to have a breast augmentation?] I don’t think so, because I didn’t look at the magazines and go, “I wish I was the perfect 36 C.” I didn’t really want to have a body like Barbie...So I don’t think that [I was impacted] by advertising.

Similarly, Natalie explained that her decision to undergo breast reduction surgery was not impacted by outside forces, she stated: “I think it all just came from me. I wasn’t really influenced by anything outside of myself, like the media.” Both of these examples reflect how some of the women resisted the idea that they were “cultural dupes” by presenting their decisions to undergo cosmetic breast surgery as a free choice unaffected by mainstream media images.

In an attempt to avoid being seen as “cultural dupes” some of the women who underwent breast reduction surgeries even went so far as to imply that they were acting against the mainstream media and its images of large breasted women. In this sense, some of the women constructed their decision to undergo breast reduction surgery as an act of *resistance* against mainstream media images of the ideal female body. For example, when asked if various media forms impacted her decision to undergo breast reduction surgery Jamie stated: “No, I mean I don’t see how the media impacted my decision. If anything the media promotes larger breasts.”¹⁷ However, the women’s narratives were often contradictory, because even their reduced breasts were typically altered to achieve the ideal, medicalized “normal.” In the final chapter I will discuss how all of the women’s post-surgical appearances reflected that they were accommodating rather than resisting

¹⁷ It should be noted that Jamie’s actions contradict this statement as she was the woman, discussed above, who chose her desired post-surgical breast size and shape from pornographic magazines.

dominant constructions of femininity. Indeed, by undergoing cosmetic breast surgeries all of the women's bodies became expressions of our culture as they were literally inscribed in response to hegemonic feminine beauty norms.

Medicalization at the Interactional Level: Doctor-Patient Interactions

The above discussion has served to show that at the institutional level the mainstream media is an effective agent of medicalization. Many of the women discussed how the pervasive media images created feelings of abnormality and pathology and consequently impacted their decisions to undergo cosmetic breast surgery. Interestingly, some of the women's narratives seemed to reflect that the "big fake boobs" portrayed in the mainstream media and pornography were now considered the new standard of normalcy; meaning that in order to have "natural" and "normal" looking breasts the women required "corrective" cosmetic surgery. Thus, the above analysis demonstrates that the internalization of hegemonic beauty norms and values occurred long before the women entered the cosmetic surgeon's office.

Nevertheless, creating a demand for cosmetic surgery procedures is only one part of the medicalization process. According to Deborah Sullivan (1993):

Obtaining such services requires the active cooperation and direct participation of physicians, an occupation whose medical license gives members both monopolistic control of surgery and all other medical techniques and the authority to define what techniques are medical and what conditions need medical treatment of the medical profession (p. 104).

Indeed, one cannot underestimate the impact of expert knowledge and medical discourse on the women's decisions to undergo cosmetic breast surgeries. Medical professionals are afforded a distinct social status within our society; at the very least they are

understood as individuals who relieve suffering, and at the extreme they are constructed as miracle workers or Gods. As members of the medical community, cosmetic surgeons are afforded a certain degree of respect and prestige. The medical profession's complicity in cosmetic surgery thus lends credibility and legitimacy to the practice and the social norms on which these surgeries are based.

Furthermore, the cosmetic surgery industry operates within a consumer culture that as Bordo (1997) argues, "depends on our perceiving ourselves as defective and that will continually find new ways to do this" (p. 42). According to Rosemary Gillespie (1996), cosmetic surgery is an example of "a 'brand extension' or expansion of the boundaries of medicine into consumer services, whereby physicians have a vested economic interest in the medicalization of appearance and shape" (p. 74). As Gillespie points out, cosmetic surgeons have a great deal to gain by supplying the service of cosmetic surgery and they have a special interest in keeping the demand for cosmetic surgery high. Thus, given the economic benefit associated with cosmetic surgery, and the credibility and legitimacy afforded to the medical profession, it is not surprising that the women's feelings of defect and abnormality were confirmed during their interactions with the cosmetic surgeons.

The Pre-Operative Consultation as a Site of Medicalization

A shared experience among all of the women was the pre-operative consultation. During these interactions the use of medical language on behalf of the cosmetic surgeons was common as it served to define the women's breasts as medical issues requiring surgical intervention, rather than issues of vanity or a by-product of our consumer culture. The surgeons' descriptions of medical diagnoses and treatments are extremely important

to the process of medicalization because, as Margaret Little (1998) explains: “Medicine enjoys an extraordinarily high institutional status in society; its participation in such surgeries can easily be regarded as sanctioning the importance and appropriateness of [the] norms” on which these surgeries are based (p. 171).

The power of the medical profession to confirm feelings of abnormality and defect and to uphold dominant beauty norms is reflected in Marilyn’s description of her pre-operative consultation. During her pre-surgical examination, Marilyn’s cosmetic surgeon explained that in addition to an enlargement “mammoplasty” he would perform a “mastopecty” to “remove a lot of the nipple so that it would be more the norm”, because her “nipples were very, very large” to begin with. The simple fact that medical terms exist to both diagnose and treat Marilyn’s healthy and normal functioning breasts provides medical legitimation for her decision to seek a surgical solution. Thus, even though Marilyn’s decision to undergo cosmetic surgery is rooted in cultural beauty ideals, it is constructed as medically necessary and legitimate through her cosmetic surgeon’s use of medical discourse and expert knowledge.

Although Marilyn was the only woman who discussed the use of technical medical terms, such as “mammoplasty” and “mastopecty,” all of the surgeons nevertheless used language that constructed the women’s breasts as abnormal or defective. Many of the women were told that their breasts and nipples *should* be a certain size or shape, and words such as “correct,” “normal,” “average,” “fix,” “repair,” and “perfect,” were used frequently in the interviews. In the following excerpt, Larissa gives a detailed description of the language her surgeon used when she went in for her medical consultation:

The first appointment you go in and then this guy is drawing on your

boobs saying where your boobs should be. And saying you know *you should be up 2cm* and you are thinking, “Oh my goodness I didn’t think my boobs were that bad.”[...]And he tells you that *this is where your areola should be*, and this is how big they should be. He would actually say that *your nipple is supposed to be this many centimeters wide* and yours is this many wide so it is too big and so we will cut that down. And we’ll move this up, because *this is where this is supposed to be*. And I’m thinking well how do you get that? And I think I even asked him at one point, “*How do you know what the perfect boob is?*” And he said that just from research or whatever that that’s what it came to be and that’s how breasts should be if they are this size and whatever.

Larissa’s description provides another excellent example of how normal and healthy breasts are constructed as abnormal during medical consultations. In this case, the cosmetic surgeon does not use medical terminology, but nonetheless gives a detailed explanation of the various medical problems and the necessary surgical interventions to “correct” these issues. Interestingly, Larissa questions how the surgeon came to these surgical conclusions, and his response is that medical research and scientific testing have discovered the “correct” contours of a woman’s body. This answer serves both to position the surgeon as a medical expert, and to convince Larissa her breasts are indeed a medical problem requiring surgery, because this is supported by a body of scientific research that has allegedly outlined the clinical contours of “how breasts should be.”

Creating “Correct” Female Body Proportions

However, the medical and scientific research on which Larissa’s cosmetic surgeon espouses to draw from are actually rooted in cultural beauty norms. Anthony Synnott (1993) explains that the “idea of beauty as proportion” can be traced back to Aristotle and this resulted in the mathematical calculation of human faces and bodies inspiring not only famous Greek sculptors, but also later Renaissance artists such as Leonardo da Vinci (p. 80). Today, these long held beliefs that beauty is based on symmetry and proportion have

been appropriated by the medical profession and are used as the basis of instruction in some medical textbooks on cosmetic surgery (Balsamo, 1996). In fact, Ann Balsamo (1996) discusses one particular medical textbook that encourages cosmetic surgeons to become familiar with classical art theory as this will allow them to “judge human form in three dimensions, evaluate all aspects of the deformity, visualize the finished product, and plan the approach that will produce an optimal result” (quoted in Balsamo, 1996, p. 58). Thus, historical cultural beauty ideals that value proportion and symmetry have been constructed as contemporary medical and scientific “fact” through medical textbooks and expert knowledge.

Nevertheless, the use of medical language by the cosmetic surgeons created the understanding that their surgical judgments were based not on cultural beauty norms but on scientific and medical research. This language served to show that the surgeons were experts regarding the proportions of the “normal” female body. Many of the women explained that the end goal of their surgeries was not only to reform their breasts, but also to “correct” and “balance” the women’s bodies. Implicit in these interactions was the shared understanding that the women’s pre-surgical bodies were “abnormal” and “out-of-proportion” because their breasts were either too small or too large for their bodies.

For example, when Leanne was unsure regarding the size she wanted her breasts to be following her breast augmentation, her cosmetic surgeon succinctly explained: “Okay well I like to do it so that you look proportional, and so you don’t look ridiculous.” According to Leanne, her cosmetic surgeon explained that he would enlarge her breasts only to the point that it would make her body appear proportionate, and not to the point that she would look “ridiculous.” Conversely, Janice described how her cosmetic surgeon

convinced her that her breasts should be reduced in order to correctly proportion her body.

He does it based on *proportions*, which was really nice, cause realistically I had no idea what size I should go down to [...] So he does full body *proportions* and he measures everything and then he told me my options [...] And he said that I should probably go down to like a big C [because] he said like anything smaller would just not look *proportionate*

As both Leanne and Janice explain, they were unsure regarding the correct breast size for their bodies, and thus they relied on expert knowledge. The women's trust in their surgeons is likely rooted in the assumption that cosmetic surgeons are medical professionals who possess aesthetic judgment that is based on scientific and medical knowledge rather than cultural norms and values. According to Janice, her cosmetic surgeon took measurements and calculated the "correct" proportions for her body. The act of measuring and calculating her body's proportions lends scientific legitimacy to the cosmetic surgeon's claim that Janice's breasts should only be reduced to a "big C" as "anything smaller would just not look proportionate."

The understanding that the women's pre-surgical bodies were abnormal because they were "out-of-proportion" or "unbalanced" was not only expressed by the cosmetic surgeons, but also by the women themselves. When asked what size she wanted her breasts to be following her breast augmentation, Teresa answered:

I just wanted to be *proportionate*. And I let him take care of that. I told him that I didn't want the first thing for people to see is my boobs, or my family to say, "Oh my goodness what did she do to herself?" So I just wanted to be *proportionate*, and so I went up one cup size. The whole reason was just to *proportion* my body.

In a similar line of thought, Lindsey stated:

I never really fantasized about having big boobs. I just wanted my clothes to fit better and I wanted to be a *natural* size rather than being so small. [What do you mean when you say a "natural size"?] I just

wanted to be more *balanced* and *proportionate*.

Interestingly, both women emphasized that they did not want to have large breasts, but instead they were concerned with enlarging their breasts in order to have what they consider to be “normal” or “naturally feminine” body proportions following their surgeries. In fact, Lindsey states that she wanted her breasts to be a “natural size” following her breast augmentation, implying that her pre-surgical breasts were “unnatural” because of their “deficient” size.

In actuality, it is not natural or normal for women’s bodies to be perfectly proportionate and symmetrical. The seemingly normal and proportionate 36”-24”-36” woman is an unrealistic ideal, as it represents a woman who, according to garment industry standards, simultaneously wears a size 10 on her bust, a size 2 on her waist, and size 4 on her hips (Harrison, 2003, p. 255). This body shape is almost as unrealistic as Barbie’s body type, as her chest, waist, and hip measurements would be 32”- 17” - 28” if she were scaled to 5’4” (Urla & Swedlund, 1995, p. 297). Thus, as Harrison (2003) states, a woman with these “perfect” proportions “represents a sexual ideal, a fantasy, a nonrealistic woman who is nonetheless used by real women as a point of comparison in their efforts to ‘improve’ their bodies” (ibid). Unfortunately this comparison results in the medicalization of completely normal and healthy female bodies and constructs them as “disproportionate,” “unnatural” and “abnormal.” And perhaps even more damaging is that these cultural ideals become accepted as medical reality through medical discourse that constructs “perfect” proportions as normal and natural.

Women's Breasts as Objects of Medical Scrutiny

The use of medical discourse during the women's interaction with their surgeons also effectively constructed the women's breasts as "objects" or "things" to be surgically altered and reformed. Drawing on Foucault, Lupton (2003) describes the medical encounter as a "supreme example of surveillance whereby the doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces" (p. 27). When reflecting on what happened during their interactions with their cosmetic surgeons, the women often described their experiences of surveillance and objectification under the surgical gaze. Most of the women described how they stood topless, as the surgeon closely inspected their breasts while their hands manipulated and marked the areas where they would be cutting, shaping, removing and/or enlarging. Janette described her medical consultation in the following words:

It was all very clinical. I mean you are standing naked from the waist up, in front of a guy, and he is using a felt tip marker to draw lines on your boobs. It's not the most easy thing to do. He was very clinical and to the point about it. He was just sort of like, "Well we can take this out, and do this, and move this." It is very clear that he is not paying attention to what is behind those boobs.

According to Janette it was quite obvious that during her examination the cosmetic surgeon was not paying attention to the woman "behind the boobs." Her experience reflects how dehumanizing and disembodied it can be for the women to have their breasts spoken about and handled as objects of medical scrutiny. However, Dull and West (1991) argue that this form of objectification is also important to the practice of cosmetic surgery as it provides legitimacy for undergoing medical treatment by "problematizing the part (or parts) in question and establishing their 'objective' need for repair" (p. 63). By reducing the body into its parts, and treating it as an object or thing, both the surgeons and

the women, were able to focus in on the body part to be medically examined, diagnosed and treated.

Objectifying the women's breasts as medical objects was also crucial because this permitted the women's breasts to be stripped of the cultural meanings normally associated with women's breasts. According to Katharine Young (1997), "[f]or the purposes of the examination, the body is reframed to exclude some of its symbolic properties, especially sexual ones" (p. 11). As all but one of the women in this study had a male surgeon, this reframing of the body in the medical realm allows the surgeons to handle and describe sexualized parts of the body in ways that would otherwise be completely inappropriate. As women's breasts are both sexualized objects and organs of sexual pleasure, it was necessary for the male surgeons to create an atmosphere in which the women would feel comfortable allowing the surgeons to examine and touch their naked breasts. One way this was done was to treat the women's breasts in a clinical and objective manner. When describing their pre-operative examination, the women used the following descriptors: "clinical," "professional," "business-like," "efficient." These descriptions implied that the women's surgeons had managed to make the women feel comfortable by appearing to be objective medical experts. In fact, Lindsey stated: "That's his business so I didn't feel awkward." Similarly, Brandi explained: "They are doctors and they see breasts all the time." Thus, it was clearly reflected in many of the interviews that the women actually preferred this clinical treatment of their breasts, even if it was also dehumanizing.

Visual Persuasion

In addition to the physical examination, the women's narratives reflected other ways that the medical encounter framed their breasts as medical objects to be "fixed" and

“repaired.” One way that this took place was through before and after pictures which show women only from the neck to the waist, focusing all of the viewer’s attention on the women’s breasts. In almost all of the interviews the women discussed that during their personal consultations, their cosmetic surgeon’s showed them pictures of breasts before and after cosmetic surgery. To be clear, all of these images were carefully selected in order to demonstrate the amazing and impressive results following cosmetic breast surgeries.

Larissa illuminates the importance of these carefully chosen before and after pictures:

All the before and after pictures like those were amazing to me and those things were the things that convinced me that this was the right guy [cosmetic surgeon], because after looking at that I was like that’s me in those before pictures and I can be that after, and that was important to me.

As Larissa’s explanation shows, before and after pictures were important for three main reasons. First, the pictures told the women that they have found the “right guy” for the job, as Larissa states, because they demonstrate the surgeon’s surgical abilities and skills. Secondly, and more importantly, the before and after pictures visually persuaded the women that if they chose this particular cosmetic surgeon they could potentially look as good as, or perhaps even better than, the women in the after pictures. Brandi explained: “I looked at a lot of before and after pictures, because then you kind of pick out the ones that you want.” However, while the women admired the “after” pictures, they also recognized their breasts as resembling the abnormal and defective breasts in the “before” pictures. Not surprisingly, once they saw these pictures many of the women wanted to change their breasts in order to be one of the brilliant “after” pictures that would be shown to future patients. Finally, the use of before and after pictures was important in the pre-operative

consultations because they reinforced the predictability and reliability of medicine by showing the women the results of numerous successful surgeries. None of the women discussed being shown pictures that showed botched operations or poor results, and thus these pictures effectively reduced the women's fears regarding possible risks and complications.

Some of the women also discussed the use of computer programs that were designed to take the women's pre-surgical measurements and then calculate the women's "correct" body proportions following surgery. As with the before and after pictures, the computer programs emphasized the predictability of medicine and science while obscuring the possible risks and complications associated with the surgery. According to Balsamo (1996) even more than before and after pictures, these computer programs effectively undermine a "patient's ability to distinguish between the real, the possible, and the likely in terms of surgical outcomes" (p. 78). In other words, because the materiality of the body is concealed through these computer programs, they limit the women from clearly seeing possible complications that might arise following their surgeries.

Barbara gives this detailed description of the computer program used during her medical consultation:

They take your measurements and they show you on a computer screen. Yeah it was all computerized. It was really cool. They give you the *perfect ratio* where it is supposed to be from nipple to neck and across and stuff. And then they can show you what you would look like as a C with your body and as a D and stuff. It was a cool program actually. It's really cool. It's not like your flesh, but it's just like lines and drawing on the screen. It was cool. So yeah you can see what it will look like after.

As this excerpt reflects, these computer programs distinctively objectify the women's bodies by displaying their bodies as visual objects to be technologically and then surgically reformed and manipulated. Like the before and after pictures, the computer

programs permit the woman viewing the image to see her body “as if from the outside, to inspect it, to allude to it, to attend to it, as to a thing” (Young, 1997, p. 51). Ultimately, these computer programs allow the women to internalize the surgical gaze and see their breasts as abnormal or pathological compared to the computer images which represent “normal” or “correct” female body shapes.

From the women’s narratives, it is clear that during their interactions with their surgeons, the women’s pre-surgical breasts were constructed as medical problems which required surgical intervention. A discussion of options outside of surgery was noticeably absent in these interactions. In other words, the women were encouraged to undergo cosmetic surgery because the cosmetic surgeons rarely urged the women to reconsider surgery or to consider other less invasive options. In fact, only one woman discussed having a cosmetic surgeon suggest that she reconsider undergoing cosmetic surgery.¹⁸ The cosmetic surgeon’s support of the women’s decisions to undergo cosmetic surgery is extremely important, because as Allen and Oberle (1995) argue:

In Western society, that which is medically sanctioned is seen as credible and acceptable, which further reinforces women’s belief that they have a “problem” that can and should be fixed (p.88).

Indeed, the women trusted the surgeons as medical experts, with the assumption that a medical professional would not operate on their bodies unless they required surgical treatment. Thus, by not asking the women to reconsider cosmetic surgery the surgeons reaffirmed that their breasts were indeed medical problems that required a surgical solution.

¹⁸ In this one case the woman (Karen) was asked to reconsider only because her surgeon thought that her husband might find the scarring following her breast reduction and lift to be unattractive. This surgeon did not suggest any other options for Karen to consider.

The Different Degrees of Medicalization

The above analysis has served to show how the women experienced medicalization at both the insitutional level (through mainstream media images) and at the interactional level (during doctor-patient interaction). At this point, it is important to discuss the ways in which different cosmetic breast surgeries are separated by “degrees of medicalization” (Conrad, 1992). According to Conrad (1992), “[i]n most cases medicalization is not complete; some instances of a condition may not be medicalized, competing definitions may exist, or remnants of a previous definition cloud the picture” (p. 220). While I would argue that breast augmentation surgery is currently only partially medicalized, there are reasons to believe that breast reduction surgery is almost completely medicalized. To illustrate my argument I will discuss how our healthcare system constructs only certain cosmetic breast surgeries as medically necessary, and how this results in social stigma being applied mainly to those cosmetic breast surgeries that are not covered financially by our healthcare system.

The power of the medical profession to construct healthy appearances as medical problems is documented by the establishment of national healthcare programs that will provide financial assistance to people who wish to undergo cosmetic surgery procedures. Currently, within Canada, healthcare coverage is only available for cosmetic surgery procedures that are deemed medically necessary. According to Conrad and Leiter (2004), healthcare coverage or third party payers are becoming increasingly important agents of medicalization in our consumer driven society, as they are able to define what is “medically necessary” and then pay only for those procedures that they have deemed medically necessary (p. 161).

Within this context, a medical procedure that is fully or partially covered by the healthcare system is viewed as a legitimate procedure, and the reasons for undergoing the procedure are seen to be medically justified. For example, Janice explained:

My close family had been really supportive, because it is a necessary surgery and that's just how they viewed it. It was just something that you do. Like if you had a bad knee you would get a knee surgery, even it is seen as taboo. So it is viewed as this is what I did, period. I mean why would I deal with having large breasts when I can do something proactive in my life and get rid of a problem?

As this quote reflects, Janice's family was supportive of her decision because it was understood that her breast reduction surgery was as medically necessary for her as a knee surgery would be for someone who had a "bad knee." Janice's experience of support from her family was not all that unique. In fact, the women in this study who underwent medical procedures paid for by the healthcare system were far more likely to have support from their social networks, than women who had to pay for the procedures themselves.¹⁹ This is likely because, as was pointed out above, surgeries that are covered by the healthcare system are constructed as medically necessary and undergoing the surgery is seen as a health-seeking behaviour.

The excerpt above reflects that it is expected, or even required, that people who suffer from a medical "disorder" or "deformity" will undergo a medical procedure to treat this problem. According to Janice, it seems ridiculous to suffer with her large breasts when she can undergo breast reduction surgery and "get rid of a problem." Similarly,

¹⁹ The one woman I interviewed who underwent reconstructive surgery following a mastectomy similarly discussed how she received strong support from her social network regarding her decision. Following the mastectomy, her breast was augmented with a saline implant and her other breast was reduced in order to make her breasts symmetrical. Both of these procedures were completely covered by Alberta Healthcare because they were deemed medically necessary.

when asked what advice she would give to other women who are thinking about undergoing breast reduction surgery, Lisa answered:

I think any girl who is self-conscious because of large breasts that are maybe *abnormal* or *too large* or whatever, I think they definitely should think about it and do it. I mean I look at my grandmother who lived her whole life, self-conscious about it, and there was no reason. Not if *you can get it fixed, and get it fixed and paid for.*

As Lisa explains there really is “no reason” to choose not to undergo breast reduction when it will “fix” a problem and it is completely paid for by the healthcare system. In other words, why would a woman suffer with her abnormally large breasts if she can “get it fixed and paid for?”

Two of the women I interviewed even explained that the choice *not* to undergo cosmetic breast surgery was really never even presented as an option. Lenore was the one woman I interviewed who underwent reconstructive surgery following a mastectomy. When asked how she decided to undergo reconstructive surgery, she answered: “I didn’t even really think about it. It was more my doctor...so yeah it was just kind of that’s what we are going to do. And then he shipped me off to the plastic surgeon.” As this excerpt reflects, it was Lenore’s doctor who told her that she should undergo cosmetic breast surgery, implying that his was the best, and perhaps only, medical option available. In fact, it appears that her doctor constructed cosmetic surgery as a necessary part of the healing process following cancer. Similarly, Marcy who was 71 at the time of the interview explained: “I went to my doctor one day for a check-up and I was just sitting there with the sheet, and she came in and she looked at me, and told me that I needed a breast reduction.” As this excerpt reflects, Marcy was “prescribed” a breast reduction by her doctor. Marcy explained that although she had never considered undergoing a breast

reduction surgery prior to this, she decided to go along with her doctors orders, because she had “faith” in her and trusted that this was a medically necessary procedure.

As both reconstructive breast surgery and breast reduction surgery are commonly paid for by the healthcare system, these procedures become socially constructed as essential treatments for medical “problems.” However, one of the reasons that breast reduction surgeries continue to be covered by our healthcare system is because there are in fact medical issues associated with having large breasts. Almost all of the women who underwent breast reduction surgeries had their breast reduction surgeries covered by the healthcare system because they experienced physical symptoms such as neck, back, shoulder pain and headaches, as a result of their large breasts.²⁰

On the surface then, it appears that there is clear medical justification for the healthcare system paying for these surgeries. However, during the interviews the women discussed how their breast reductions were not simply done to relieve physical suffering. Many of the women also complained that their breasts were “too low,” “saggy,” “stretched out,” and/or “old” looking as well. Indeed, as we saw in chapter three the women’s narratives reflected that the physical pain experienced because of their large breasts was not something that factored heavily into their decision-making. And as we will see in chapter six, when discussing their post-surgical experiences most of the women who underwent breast reduction surgery focused on other benefits of undergoing

²⁰Conversely, in all but one case, the women who underwent breast augmentation surgeries were unable to receive financial assistance, because the women’s reasons for undergoing surgery were defined as aesthetic rather than medical. Robin, who underwent breast augmentation surgery in 1974, was the one woman who had her surgery paid for by Alberta Healthcare, because her surgeon decided that she was suffering psychologically from the small size of her breasts.

breast reduction surgery, and only some of the women mentioned how the procedure relieved physical pain.

In many cases the women explained that their cosmetic surgeons did not only reduce the size of their breasts, but also lifted their breasts so that they would appear firm and perky following the surgeries. According to Barbara the breast lift, which was covered by healthcare, was actually what really “enticed” her to have a breast reduction. Indeed, many of the women discussed having their breast lifts covered by the healthcare system, despite the fact that this was done for aesthetic reasons. Therefore, the women’s narratives reflected that undergoing breast reduction surgery had the same normalizing effect as undergoing breast augmentation surgery. Further, the fact that the breast lifts were often covered by our healthcare system provided legitimacy for the procedure, and helped to create the understanding that round, firm, perky breasts are “normal,” “natural,” and “healthy.”

The women who underwent breast reduction surgeries were fortunate in the sense that although their breasts were reformed to embody cultural norms (like the women who underwent breast augmentation surgery) they were often not questioned regarding their motivations for undergoing surgery. In contrast, as breast augmentation surgery is only partially medicalized, the women who underwent breast augmentation surgery were often questioned by others regarding their motivations for undergoing surgery. The women’s reasons for undergoing breast augmentation surgery were more likely to be seen as “vain” or “selfish” because these surgeries were understood to be done for aesthetic rather than medical reasons. As such, many of the women who underwent breast augmentation experienced a lack of support or were criticized by members of their social networks.

Realizing that they would likely receive negative reactions, some of the women even tried to conceal that they had undergone breast augmentation surgery from others.²¹

Given the stigma still attached to these surgeries, the women who underwent breast augmentation surgery often drew from medical discourse to account for their decisions to undergo breast augmentation surgery, as a way to lend legitimacy to their decisions. For example, Tara described how she *required* breast augmentation surgery because the implants would “fill out the loose breast tissue.” She explained: “When I was down to a 32 B, but with a lot of loose skin, I wore two sports bras, cause it just bounced up and down ridiculously if I didn’t. And that really hurts after awhile to be honest.” Similarly, Nancy explained that undergoing breast augmentation surgery was just one of the *necessary* medical treatments she needed to undergo in order to “repair” her “post-pregnancy body.” She explained: “I *needed* to get the damage that had been done *fixed*... and that [the breast augmentation] was just one element of getting my pre-pregnancy body back.” As these two excerpts suggest, the women framed cosmetic breast surgery as a necessary medical treatment that would “correct” and reform their “abnormal” or “deficient” breasts. The fact that these women knew that there was stigma attached to these surgeries, and thus had to justify their reasons by drawing on medical discourse, reflects that breast augmentation surgery still remains only partially medicalized.

Booborexia (Revisited)

At the beginning of this chapter, the “disorder” booborexia was discussed by Tanya to account for her seemingly irrational feelings regarding her breasts. Tanya created a disorder to explain why she felt unhappy with her perfectly normal breasts, and

²¹ In contrast, not one of the women who underwent breast reduction surgery tried to hide the fact that she had undergone cosmetic breast surgery.

believed that they were “too small” even after her breast augmentation. However, rather than understand the women’s experiences as irrational or pathological this chapter has served to show the women’s decisions to undergo cosmetic breast surgery as reasonable and understandable given our cultural context. Indeed, the women’s experiences in this study are symptomatic of a culture that creates defect and pathology by medicalizing healthy feminine appearances.

As the above analysis has shown, at the institutional level, pervasive media images construct an unnatural and unrealistic standard size and shape of breasts as normal and healthy, and thus the women came to understand their own breasts as abnormal in comparison. The women’s feelings of abnormality and defect were later confirmed at the interactional level through their interactions with the cosmetic surgeons who defined and treated the women’s normal and healthy functioning breasts as medical problems. By looking at the process of medicalization through this lens, the women’s decisions to undergo cosmetic breast surgeries come to be viewed as reasonable and understandable, rather than irrational or naive.

Finally, it is important to recognize that in this process of medicalization the women were complicit actors, and this complicity was individually rewarding. Many of the women expressed that they were content with their decision to undergo cosmetic surgery as it allowed them to not only correct their perceived abnormal breasts, but it also permitted them to experience their breasts as feminine, youthful, and sexually desirable which contributed to increased self-esteem and feelings of self-worth. At the same time, however, by undergoing cosmetic breast surgeries, the women’s actions unfortunately reinforce the medicalization of healthy feminine breasts and uphold unnatural beauty ideals as the norm against which other women will be judged and found lacking.

Chapter 5: Assessing, Managing, and Experiencing Risk

As the previous chapter discussed, many of the women in this study constructed cosmetic breast surgery as a necessary and “corrective” surgery, thus separating it from other “beauty treatments.” This chapter will focus on the medical risks associated with cosmetic breast surgery that further delineate it from other far less invasive beauty practices. The significant risks associated with cosmetic surgery procedures have been used to bolster the claim put forth by some feminist writers that cosmetic surgery is an extremely dangerous and oppressive beauty practice (see for example, Wilson, 2002; Morgan, 2003; Chambers, 2004; Jeffreys, 2005). This feminist work provides an excellent critique of the normalizing and harmful effects of cosmetic surgery; however, it also unfairly constructs the women who undergo cosmetic surgery as largely passive victims who are unconsciously and unreasonably risking their lives to embody dominant beauty norms. In this current study it became clear that to understand the women as largely passive victims would be to unfairly represent them, because the majority of the women were well aware of the risks related to undergoing cosmetic breast surgery. As is clearly reflected in the title of this chapter, some of the women were acutely cognizant of the fact that undergoing cosmetic breast surgery was an invasive, and potentially life-threatening, procedure.

The following chapter will examine the strategies employed by the women to assess and manage risk and uncertainty. The women adopted strategies (outlined below) ranging from the *ideal consumer/patient* subject position (actively seeking out risk information from a variety of sources and questioning expert knowledge), to the *passive or dependent* subject position (relying on expert knowledge and formal risk information).

As the following analysis will show, most of the women in this study were aware of the significant risks, and some of the women were highly knowledgeable regarding risks, reflecting that they were willing to take on the responsibility of making a well-informed consumer/patient decision. However, there were social barriers that constrained (and in some cases prevented) the women from being able to freely and rationally calculate the risks and rewards of undergoing cosmetic breast surgery. The second section of this chapter will turn to an examination of the social barriers that hindered the women from making well-informed consumer/patient decisions. In the final section of this chapter I will discuss the women's experiences of risks and complications. This section will reflect the ways in which the women were often held accountable, and took on responsibility, for the negative outcomes of their consumer/patient decisions.

What is Risk?

While it is difficult to imagine living in a world without the concept of risk, our current understanding of risk originated quite recently. The definition of risk has changed drastically over time so that in pre-modern societies it excluded the notions of human error or responsibility (Lupton, 1999; Tulloch & Lupton, 2003). According to Deborah Lupton (1999), in pre-modernity,

[r]isk was perceived to be a natural event such as a storm, flood, or epidemic rather than a human-made one. As such, humans could do little but attempt to estimate roughly the likelihood of such events happening and take steps to reduce their impact (p. 5).

In contrast, our recent conceptualization of risk emerged during the seventeenth and eighteenth centuries and was integrally linked to the underlying assumption in modernity that the social and natural worlds could be studied scientifically. The result, according to

Lupton (1999), was that the concept of risk became “scientized” and based upon mathematical calculations of probability. Thus, she states that in “modernity, risk, in its purely technical meaning, came to rely upon conditions in which the probability estimates of an event are able to be known or knowable” (p. 7).

As such, the definition of risk in modernity was relatively neutral, because it simply related to the probability of some event occurring, but by the twentieth century risk became associated almost completely with negative outcomes (Douglas, 1992; Lupton, 1999). In fact, Mary Douglas (1992) argues that risk in the twentieth century came to be synonymous with “danger.” Similarly, Lupton (1999) states that while today the technical meaning of risk is still neutral, in “everyday lay people’s language, risk tends to be used to refer almost exclusively to a threat, hazard, danger or harm” (p. 8). Further, as risk commonly refers to danger or harm, it is often associated with uncertainty and thus a lack of control. John Parker and Hilary Stanworth (2005) argue that “[s]ome lack of control is intrinsic to risk situations, since risk always involves uncertainty and uncertainty makes complete control impossible” (p. 320).

The interpretation of risk as a potential threat or the possibility of harm is the understanding most often associated with the medical field. *Medical risks*, according to Lupton (1999), are one of the six major categories of risk that dominate the concerns of individuals and institutions within Western society.²² She defines *medical risks* as those associated with experiencing medical care or treatment, such as surgery and drug therapy (p. 13). Although this definition does not explicitly state that medical risks refer to the harmful or damaging outcomes of a medical procedure or treatment, this is in fact almost

²² The other major categories of risk according to Lupton (1999) are environmental risks, interpersonal risks, lifestyle risks (see below), economic risks, and criminal risks.

exclusively the case. When doctors and surgeons explain to patients the potential medical risks related to a particular procedure or treatment, they are often explaining the possible harmful or unfavorable consequences of a medical procedure or treatment. In this study, the majority of the women discussed that their surgeons provided them with verbal and/or written information regarding the potential injurious risks associated with undergoing cosmetic breast surgeries. As I will discuss later, most of the cosmetic surgeons explained a range of risks to their patients including: excessive scarring, change in nipple and/or breast sensation, difficulty breast-feeding or the inability to breast-feed, and infection.

While medical risks are clearly associated with cosmetic surgery, one other category of risk outlined by Lupton (1999) that can be usefully applied to an analysis of cosmetic surgery are *lifestyle risks*. According to Lupton, *lifestyle risks* are those that are associated with the consumption of particular commodities, such as foods and drugs, and the engagement in certain activities and practices, such as sexual activities and driving practices (1999, p. 13). As such, lifestyle risks are understood to be “internally imposed,” meaning that individuals impose these risks on themselves, as they have chosen to consume certain commodities or engage in particular activities and practices (Lupton, 1995, p. 77). In addition, lifestyle risks are closely associated with consumerism and the notion of the *ideal consumer subject* (Lupton, 1997). Within our consumer society, an individual has the freedom to choose to engage in certain activities or consume particular commodities, but with this freedom comes responsibility. Individuals are expected to act as rational consumers and objectively assess risks in order to make wise consumer choices. In turn, individuals are held responsible for the negative consequences of making an unwise consumer choice. For example, as undergoing a cosmetic surgery procedure is understood to be an individual (consumer) choice, those who decide to undergo cosmetic

surgery are viewed as accountable for the potential risks (or negative outcomes) associated with this decision.

Ideal Consumer vs. Passive Patient

According to Lupton (1997) the notion of the ideal consumer subject is congruent with that of the ideal patient as both are represented as rational, objective, and calculating. The notion of the *ideal consumer/patient* is rooted in cultural values such as individual autonomy and freedom of choice, as well as our cultural understanding that health is largely an individual responsibility (Lupton, 1997; Minkler, 2000; Tulloch & Lupton, 2003). This subject position is aligned with cosmetic surgery discourse which emphasizes the “ability of the individual to become informed about the risks and benefits of surgery, and to weigh them up independently and dispassionately” (Fraser, 2003, p. 36). Some of the women in this study appeared to take on this role of the ideal consumer/patient by actively researching the procedure and the possible risks and complications, searching out the “best” cosmetic surgeon, and by asking questions during their pre-operative consultations. The women’s actions reflected what Anthony Giddens (1991) terms “reskilling” or the “reacquisition of knowledge and skills” which is often done when there are “fateful decisions” to be made (p. 7). The women’s narratives suggested that they were aware that they would be held accountable for the possible negative outcomes of their decisions, and thus they “reskilled” in order to make “good” consumer/patient choices. In addition, as risk is associated with uncertainty and a lack of control, “reskilling” was a way for the women to gain a sense of control in the face of significant risk possibilities.

In contrast to the ideal consumer/patient is the *passive* or *dependent patient* (Lupton, 1997). The passive patient is constructed as compliant, uncritical, and dependent upon authoritative and expert knowledge. Lupton (1997) explains that this compliance and dependence is seen as undesirable as it “deviates from current dominant and privileged notions in Western societies about the importance of the autonomous self, the self who governs personal behaviour via reason rather than emotion” (p. 374). While the notion of the passive patient is viewed negatively, all of the women in this study had little choice but to accept this subject position in at least some circumstances. Since the women were dealing with important and “risky” consumer/health decisions it would have been extremely difficult (if not impossible) for the women to remain completely objective and rational throughout their decision-making processes. Indeed, many of the women’s narratives reflected that the context within which they were making decisions was not conducive to allow for an objective, rational calculation of risks and rewards; instead their decision-making processes were highly subjective and emotional.

In addition, it was necessary for all of the women to accept the passive or dependent consumer/patient subject position simply because of the asymmetry of specialized medical knowledge that exists between the women and the cosmetic surgeons. This asymmetry of specialized knowledge meant that all of the women were at least somewhat dependent upon medical experts to understand and assess risks during their decision-making processes. Finally, some of the women’s narratives reflected that they chose to adopt the passive consumer/patient subject position as a way to deal with the responsibility and possible blame of making a “bad” consumer/patient decision. Parker and Stanworth (2005) explain: “To put oneself in the hands of god, fate, or experts can be to free oneself from the worries of responsibility” (p. 321). This approach worked well for

some of the women as it relieved the pressure experienced when trying to make the right decision, and it placed some of this responsibility on the cosmetic surgeons.

Strategies for Understanding and Assessing Medical Risks

The following section examines the strategies employed by the women to comprehend and assess the possible medical risks associated with undergoing cosmetic breast surgeries. As I briefly discussed in the first chapter, there are a number of significant risks and complications that women who undergo cosmetic breast surgery could experience. For example, women who decide to undergo cosmetic breast surgeries risk experiencing the following: excessive bleeding, hematoma, infection, complications from the anesthesia, change in nipple and/or breast sensation, the inability to breast-feed or difficulty breast-feeding, breast asymmetry, disfigurement, and keloid scarring (see for example, Canadian Society of Plastic Surgeons, 2006; American Society of Plastic Surgeons, 2007). Women who undergo breast augmentation surgery could experience additional complications to those already listed, such as: rupture or deflation of the implant(s), wrinkling or rippling of the implant(s), chest wall deformity, tightening of the scar tissue surrounding the implant(s), and difficulty detecting cancer through mammograms due to the placement of the implants (see for example, U.S. Food and Drug Administration, 2004; Health Canada, 2005). Additionally, women who choose silicone breast implants over saline breast implants might encounter future medical problems, as silicone implants have been linked to autoimmune symptoms and diseases, such as rheumatoid arthritis, lupus, Raynaud's phenomenon, and Sjogren's syndrome (Mellican, 1995, p. 11). Finally, as Virginia Blum (2003) caustically remarks, regardless of the actual low fatality rate, individuals who undergo cosmetic surgery procedures "risk death

for beauty” (p. 60). Indeed, it should be acknowledged that although rare, it is possible for a woman to die as a result of undergoing cosmetic breast surgery.

The majority of the women in this study received information on some or all of the risks outlined above from their cosmetic surgeons prior to their cosmetic breast surgeries. Many of the women also discussed attaining relevant risk information from other sources, including nurses, friends, family, internet websites, and mainstream television programs. When confronted with this medical information the women described several strategies they employed in order to understand and assess the risk possibilities.²³ Many of the women took on the ideal consumer/patient role and sought out additional sources of information outside of medical expert knowledge in order to assess the risks and complications. One common strategy employed by the women was to access information from non-medical “experts” within their social networks. These non-medical experts included partners, friends and family members, as well as other women who had previously undergone cosmetic breast surgery. In addition, some of the women’s narratives reflected that their risk assessment strategy was to engage in formal research and become “experts” themselves on the risks and complications of surgery. Conversely, some of the women adopted the passive patient role as a strategy to cope with the possibilities of risks and complications. These women trusted the information provided by their surgeons, and thus they chose not to seek out additional information to assess the risks and benefits associated with the procedures.

²³ Although the strategies the women employed will be discussed separately, it should be noted that some of the women employed multiple strategies for assessing and managing risk and uncertainty.

Seeking out Risk Information from Non-Medical Experts

Many of the women interviewed discussed accessing knowledge and information on risks from members of their social networks. Although all of these women also received information from their surgeons, this strategy allowed the women to learn about the risks and complications from trusted individuals. According to Andy Alaszewski (2005), the extent to which individuals trust the source of risk information strongly impacts how individuals will respond to this information. In this study the risk information provided by individuals in the women's social networks was trusted not only because these individuals were often friends and family members, but because they were "experts" as they either had first-hand experience or they had specialized medical knowledge. This strategy was very useful as it allowed the women to hear complex risk information in simple non-medical language, and it was a way to address the confusing and often contradictory opinions of medical professionals.

This risk assessment strategy was employed by Kelsey who underwent breast reduction surgery when she was only 16 years old. She explained that she relied on her mother's experiential knowledge of the procedure and the possible risks and complications, because she was quite young at the time of her surgery. She stated: "My mom did some [research] just cause she's very much in tune with my health. So she did a bit. I was 16 and pretty naive. But if I was to get it done tomorrow, I would know every single aspect of it for sure." According to Kelsey, if she had been older when she had her breast reduction surgery she would have taken it upon herself to learn about the procedure and the risks, which reflects the understanding that it is an individual's responsibility to learn about risk possibilities. However, because Kelsey was relatively young at the time of her surgery she likely did not have all of the necessary resources or skills to

individually research and comprehend the medical information on risks. Thus, to address this issue she accessed additional information and knowledge from a trusted person in her life. Kelsey felt that she could trust her mother's opinion and assessment of the risks not only because she cared about her health, but because her mother was an expert as she had also undergone breast reduction surgery.

Similarly, Tanya explained that she relied on her partner to help her understand and assess the risks associated with breast augmentation surgery. She discussed that she had her partner go with her to the pre-operative consultations because he "knows the human body really well" as he has an educational background in a medical-related field. She stated: "So I wanted my boyfriend to come to the appointments because if the doctors were talking about something, I'd have no idea what they were talking about like medical-wise. So yeah he went to both appointments." Although Tanya has a Masters degree, she explained that she relied on her partner's specialized knowledge because her educational background is not in a medical-related field. This excerpt thus reflects how the terminology used by medical professionals may make it difficult for the women to fully comprehend medical risks. Tanya's resourceful solution to this problem is to have her partner accompany her to the medical appointments in order to translate the medical language used by the cosmetic surgeon.

Understanding and assessing risk information is additionally problematic as the information provided by medical professionals is often contradictory. Although risk information is produced through scientific and medical research, there is often a lack of expert consensus and this knowledge is often contested (Giddens, 1991; Alaszewski, 2005; Zinn, 2005). As Giddens (1991) states, there is no "overarching authority to whom [we] may turn" for knowledge and advice when making important decisions (p. 141).

Thus, the women in this study faced the difficult challenge of making a competent assessment of risk at a time when there is increasing medical controversy over the actual levels of risk (Rowse et al., 2000). To address this issue, some of the women relied on the expertise of other women who had undergone cosmetic breast surgeries. As the cosmetic surgeons often provided the women simply with a list of possible complications and risk statistics, connecting with other women who have undergone cosmetic surgery provided the women with embodied and experiential information. According to Tom Horlick-Jones (2004) technical risk assessments are often incomplete as they fall short of capturing the “*quality of risk*: in other words the “apples and oranges” problem of comparing the impacts of *experiencing* different possible down-sides” (italics in original, p. 110). Thus, by talking to other women who have undergone cosmetic breast surgery some of the women in this study were able to gain first-hand information that was much more tangible and “real” than that which was offered by the cosmetic surgeons.²⁴

This particular approach was exemplified by Karen who sought out useful risk information from women in her social network who had previously undergone cosmetic breast surgeries. When asked about the research she did prior to her breast reduction and breast lift surgeries Karen replied: “I talked to so many people who had it done. I looked at their scarring. I asked them their stories. But I didn’t look on the internet or anything like that. It was just all word of mouth.” One of the women that Karen talked to was a close friend who underwent cosmetic breast surgery before she did, and thus Karen was able to gain a first-hand account of her friend’s recovery process and the end-results of her surgery. Similarly, Barbara explained that during her decision-making process she

²⁴ The ease with which the women in this study were able to connect with other women who had undergone cosmetic breast surgery reflects the increasing normalization of this cosmetic surgery procedure.

relied on experiential knowledge from friends who had previously undergone breast reduction surgery. She stated that the information she received on the procedure and the possible risks and complications was, “mostly through word of mouth...from women that had already done it and were largely satisfied with it.”

The internet was another avenue that allowed some of the women to connect with other women who had undergone cosmetic breast surgeries. Larissa, who underwent breast reduction surgery, explained that she went to online chat rooms and this allowed her to hear other women’s experiences of risk:

I researched it on the internet, and went into places [chat rooms] where people were talking about having it done. And they talked about preparing for it, them getting it done, and how they felt afterwards. *So I thought I would know kind of how it felt.*

As this excerpt reflects, Larissa sought out information from women who had undergone breast reduction surgery, as she thought this would be a way for her to prepare for her own surgery and the possible risk outcomes. By talking to other women she hoped to know “how it felt” to undergo cosmetic breast surgery, which reflects the usefulness of embodied experiential knowledge. Thus, this strategy provided some of the women, such as Larissa, with first-hand knowledge of risk experiences which allowed them to separate “probable” risks from “improbable” risks. In addition, by accessing information online, Larissa was able to connect with women from a variety of backgrounds with a wide range of experiences.

“Reskilling”: Becoming an Expert

As the above analysis shows, through friends, family, and other women who had undergone cosmetic breast surgery, some of the women in this study were able to assess

and understand complex and often contradictory risk information. Other women in the study employed a slightly different risk assessment strategy: instead of relying on knowledge from others, they became “experts” themselves by searching out information on the risks and complications of surgery. This strategy reflected that some of the women had adopted the ideal consumer/patient subject position by questioning the authority of expert knowledge and referring to other sources for risk information. Alaszewski (2005), points out that although it is the role of experts to provide some knowledge on risks, it is ultimately the responsibility of individuals to take this knowledge and make rational choices (p. 102). Many of the women’s actions reflected that they understood that it was their responsibility to research relevant risk information in order to assess risks and make a wise consumer/patient decision. Thus, these women’s actions suggested that they were engaging in what Giddens (1991) terms “reskilling” by accessing information from various sources, such as medical and scientific journals, internet websites, and television programs. Through reskilling the women were able to gain a sense of control in the face of significant risk possibilities and make well-informed consumer/patient choices.

For some of the women this individual research was extensive and was done over several years. Teresa, a 29 year-old mother of two, explained that she researched breast augmentation surgery over a seven year period. She stated: “It’s surgery and I’ve got family to worry about. So yeah, I researched it a lot.” Teresa’s decision to engage in extensive research is thus a reflection of the understanding that we are individually responsible for making wise consumer/patient choices. Additionally, as a mother, Teresa is largely responsible for her family’s health and thus she is required to take extra steps in order to make a well-informed decision.

This notion that individuals are responsible for the consequences of their consumer/patient decisions was discussed by other women as well. For example, Diane explained: “You have gotta do your research, you gotta do your end, and if you’re not willing to put in the leg work and ask the questions...then don’t do it.” And, later in the interview she reiterated this point: “If you have a good doctor they will tell you the risks, but don’t forget to ask the questions... You need to know everything about everything that you can.” According to Diane, a woman should only undergo cosmetic breast surgery if she has done all of the necessary research in order to make a “responsible” choice. This understanding was echoed by Tara who explained that she did extensive research before going to her pre-operative consultation:

I had done so much research before I even went to the surgeon, and so I kinda had an idea in my mind. *So I asked questions knowing the answers, waiting for his answer.* I ended up knowing quite a bit about it before. Like I had researched Canadian websites, American websites, health associations, all that kinda stuff. So I had a pretty good idea to start.

As this excerpt reflects, Tara “tested” the cosmetic surgeon to confirm that he was well-informed on the procedure and the potential risks and complications. Alaszewski (2005) argues that today individuals who have the necessary skills and resources can access “highly sophisticated risk knowledge” through various media, including the internet (p. 103). The opportunity to access complex and sophisticated risk knowledge through various media meant that some of the women, such as Tara, did not have to solely depend on the information provided by the cosmetic surgeons.

While the majority of the women’s narratives reflected the belief that individuals have a responsibility to seek out information in order to make a well-informed assessment of risk, not all of the women took this particular approach. A few of the women’s

narratives reflected that they had chosen instead to adopt the passive or dependent patient subject position in regards to risk assessment. These women chose to rely solely on the expert knowledge of medical professionals. As such, this strategy freed some of the women from their concerns of responsibility and the potential experiences of blame that would result from making a “bad” consumer/patient decision.

For example, Danielle a 45 year old mother of two, who underwent breast reduction surgery, stated:

I just went into the plastic surgeon and spoke with him and went over whatever he had to show me, and what he knew for knowledge, cause I thought that was my very best bet. [...] So that was my very best bet I thought was just go straight to source, and talk with him. And so that’s what I did.

According to Danielle she did not feel it was necessary to seek out any additional information than that which was given to her by the surgeon, because she trusted him as the authoritative source for medical knowledge. In this same line of thought, Natalie who was 21 when she underwent breast reduction surgery, explained that she did not feel it was crucial to do “in-depth research or anything like that”, as she felt the best source for information was a medical professional. Thus, women such as Danielle and Natalie appeared to adopt the passive patient subject position as they were unquestioning of and completely dependent upon expert knowledge. In turn, by depending solely upon expert knowledge, the women were able to take less responsibility for the outcomes of their surgeries, as it was possible for them to argue that they were not adequately informed regarding certain risks or complications.

Strategies for Managing Risk and Uncertainty

In addition to risk assessment strategies, the women's narratives reflected that they employed specific strategies for managing risk possibilities and dealing with uncertainty. The women chose to cope with risk and uncertainty in the following ways: waiting to undergo cosmetic breast surgery based on risk information, searching out the "best" cosmetic surgeon, focusing on the benefits of cosmetic breast surgery, or choosing to disregard or minimize risk possibilities. All of these approaches, although slightly different, demonstrated that the women's strategies for managing risk and uncertainty were complex and dependent upon a number of contextual factors. A common theme among many of the women's narratives was the notion that the women were individually responsible for finding ways to adequately control or prevent risk possibilities. For the women who were wives and/or mothers, managing risk and uncertainty was especially important, as these women had to consider how the consequences of their decisions would affect others. Thus, as the following analysis shows, the women's risk management strategies reflected the subjective, emotional, and embodied nature of their decision-making processes, and were embedded within discourses of responsibility.

Timing is Everything

One common approach to managing risk and uncertainty was to wait a few years to undergo cosmetic breast surgery so as to lessen or prevent the possibility of experiencing specific risks. Risk-takers are often "represented as irrational, self-deluding and irresponsible if they challenge health risk assessments" (Lupton, 1995, p. 90). The women's decisions to wait several years to undergo cosmetic breast surgery, in order to prevent or lessen the possibility of experiencing certain risks, can be seen as an attempt to

distance themselves from this construction of risk-takers. For example, given that some women experience difficulty breast-feeding or are unable to breast-feed following cosmetic breast surgery (Nommsen-Rivers, 2003), a few of the women discussed waiting to undergo cosmetic surgery until after they had finished having children or until there was an improved likelihood of being able to breast-feed post-surgery.

Nancy, a 46 year old mother of two, explained: “I guess what instigated my decision [to undergo breast augmentation surgery] was that I knew I wasn’t going to have any more children, and so I wasn’t worried about the breast-feeding aspect.” Similarly, Teresa who also has two children stated:

Well I had thought about it before children, and I had checked into it and gone to consultations, and I researched it and everything. And because of the side-effects or complications with surgery you might not be able to breast-feed, so I wanted to wait. I wanted to make sure I could have my kids and breast-feed the way that I wanted to. So I waited till after I had kids.

Both of the above excerpts suggest that the women accepted the cultural understanding that, as wives and mothers, women are “guardians of health,” and thus should be “more risk averse” (Thirlaway & Heggs, 2005, p. 109). The women’s experiences thus reflect the gendered nature of risk and how the women had the difficult task of reconciling the tension between two dominant, but contradictory, cultural meanings associated with femininity and women’s breasts. In other words, the women had to negotiate the tension between embodying idealized femininity and becoming “desirable women,” and being “good mothers” who unselfishly put their needs aside to care for their families. Thus, on the surface the women’s decisions to wait until after they finished having children was a way to guard against encountering any breast-feeding related complications. On closer analysis, however, it becomes clear that that by waiting to undergo cosmetic breast

surgery, the women were able to reconcile the tension described above, and control for any blame or guilt that would likely be associated with “failing” to protect their families from negative risk outcomes.

The majority of the women’s narratives reflected that breast-feeding was one of the risks that they were most concerned about. Interestingly, the women appeared to be more concerned about managing the risk of breast-feeding than they did other risks, such as the possibility of losing nipple and/or breast sensation following cosmetic breast surgery. This is likely partly because it is much more difficult for the women to manage the risk of losing nipple and/or breast sensation, than it is to control for breast-feeding related risks. However, this may also reflect one of the ways in which the women’s experiences were intimately impacted by the cultural meanings attached to women’s breasts. As women’s breasts are often viewed both as decorative (for the pleasure of men) and functional (for the nurturance of babies), it makes sense that the women were most concerned that their breasts would appear sexually desirable post-surgery, and that they would be able to breast-feed. This is not to say that all of the women felt that losing nipple and/or breast sensation post-surgery would be “worth” the benefits, or to say that the women were not concerned about this risk. The point is that the women’s narratives seemed to reflect the common cultural understanding that women’s breasts rarely belong to women themselves. A “woman-centered meaning,” that focuses on the “feeling and sensitivity” of breasts rather than how they look (Young, 2003, p. 154) was noticeably lacking in the women’s narratives. The risks the women were most concerned about managing thus reflect a “cultural priority list” regarding the important functions of women’s breasts. In the final section of this chapter, I will briefly explain why breast-feeding was likely such an important component in the women’s decision-making and the

experiences of women who were not able to breast-feed or had difficulty breast-feeding post-surgery.

A few of the women did in fact discuss how they managed risks, other than breast-feeding, by waiting several years to undergo cosmetic breast surgery. For example, Janette discussed that she considered undergoing breast reduction surgery when she was in her 20's, but at that time the surgery was much more invasive, and so she decided to delay her surgery.

When I first started looking into it, when I was in my early 20's, it was a major operation at that time. It was like ten days in the hospital and it was quite different than it is now. And by the time I had decided in my late 30's to actually get it done, it was a much different procedure, it was then just actually day surgery.

According to Janette, she never wanted to have children and thus breast-feeding was not something that factored into her decision to undergo breast reduction surgery. However, other risks and complications did impact her decision, such as the amount of recovery time and the invasiveness of the surgery. Her decision to wait until breast reduction surgery was “a much different procedure” demonstrated her desire to take control of and manage the risks that she considered to be most serious.

Finding the “Best” Cosmetic Surgeon

A different approach to managing risk and uncertainty was to search out a qualified and respected cosmetic surgeon. Similar to the women who chose to delay undergoing cosmetic surgery, this strategy was used in order to lessen or prevent experiencing risks and complications. How the women decided on the “best” cosmetic surgeon depended on their social context; while some of the women chose their cosmetic surgeon based on personal recommendations, other women investigated and met with

different cosmetic surgeons before deciding on one. Overall, the main goal of this strategy was to find a cosmetic surgeon that was trustworthy and possessed exceptional expert knowledge and skills, as this was believed to be one of the best guarantees against experiencing unfortunate risks and complications. Further, although the women might have taken different approaches when finding the “right” cosmetic surgeon, all of their strategies reflected the understanding that this particular decision was an important component of making a responsible and well-informed consumer/patient choice. As cosmetic surgeons are offering a medical service, the women’s narratives reflected that it was their responsibility to find the “best” service provider.

Some of the women explained that they engaged in formal research in order to decide which cosmetic surgeon they wanted to operate on them. In fact, a few of these women discussed that deciding on a cosmetic surgeon was one of the most important components of their decision-making processes, and thus they put a great deal of time and effort into finding the “right” one. Jamie, who underwent breast reduction surgery, explained: “I did research not as much on the surgery as the doctor that I went to.” In this same line of thought, Janice, who also underwent breast reduction surgery, explained:

More than anything it was [the cosmetic surgeon’s] reputation is what I looked into. And I wanted to know how his clients fared, and what he goes to take for precautions, and what was going into it, and why he chooses to do it at the specific hospital he does. And so I researched more into his practice than anything.

As both of these excerpts reflect, the women’s research pre-surgery focused on finding out the background of the cosmetic surgeon who would be operating on them. According to Janice, she wanted to know the satisfaction level of his previous patients, as well as the necessary “precautions” he employed in order to lessen or prevent medical complications. Similar to the women whose research prior to their surgeries focused on the surgical risks

and complications, this strategy allowed the women to gain a sense of control through knowledge. By researching into different cosmetic surgeons the women were able to control for the possibility of leaving their bodies in the hands of a cosmetic surgeon who has a poor reputation, is unqualified, and/or inexperienced.

Relying on emotions was another way that some of the women were able to find the “best” cosmetic surgeon, and in turn, manage risk possibilities. Specifically, a few of the women relied on “intuition” or a “gut-feeling” in order to assess whether or not they could trust the cosmetic surgeon. Tanya, who underwent breast augmentation surgery, met with two cosmetic surgeons during her decision-making process and she explained: “I knew right away which doctor I was going to go to, just because I felt more comfortable with him.” In a similar vein, Tara explained: “My gut-feeling said, “Yeah this guy is going to do you a world of good”...To be honest if you don’t feel right about a person, chances are there is something wrong.” Like other important consumer choices, some of the women relied, at least partially, on their “gut-feelings” when deciding on a cosmetic surgeon. As such, this strategy allowed the women to find a cosmetic surgeon who appeared trustworthy and dependable.

Finally, a unique approach to finding a qualified and respected cosmetic surgeon was described by Diane:

[Working at the strip club] I could ask all the questions like: “Where did you get yours done?” and “Who was your surgeon?” and all of that information. And I could see like “Oh, I like his work” and “I don’t really like his work” (laughs). You got a good taste of what was good work and what was bad work and all that kind of stuff.

In a sense, Diane was more fortunate than many of the other women in that she was literally able to see which cosmetic surgeon’s “work” she preferred as it was literally “carved” or “written” on the bodies of her colleagues. This strategy was a way to prevent

going to a cosmetic surgeon who produces “bad work,” and it allowed her to have a degree of confidence and a sense of control over the uncertain outcomes of her surgery. Thus, Diane’s experience is perhaps the most reflective of the understanding that deciding on a cosmetic surgeon is an important consumer/patient decision that requires time and effort, including “comparative shopping,” in order to find the cosmetic surgeon with the medical skills and credentials necessary to create “good work.”

It should be noted that while some of the women who underwent breast reduction surgeries discussed using strategies to find the “best” cosmetic surgeon, it was mainly the women who underwent breast augmentation surgery who employed consumerist language and discussed “shopping around” for cosmetic surgeons. This is partly because within our medical system, breast reduction surgery is defined and treated as “medically necessary,” and thus some of these women were not given a choice as they were “referred” by their doctors to specific cosmetic surgeons.

Focus on the Benefits

A third strategy used by almost all of the women to control risk and manage uncertainty was to focus on the benefits of undergoing cosmetic breast surgery. For some of the women in this study, perceiving cosmetic breast surgery as beneficial and rewarding helped to control their feelings of uncertainty and anxiousness regarding the potential risks. Additionally, framing their decisions in positive terms was a way for the women to account for their risk-taking behavior which might be interpreted by others as selfish and/or irrational. This strategy employed by some of the women is reflective of the argument put forth by Parker and Stanworth (2005):

[R]isk-taking in everyday life can have positive meanings and occurs

outside and alongside the risk-*avoiding* regimes typical of many formal organizations. Though risk-taking involves possible loss, this is normally set against possible gains. Voluntary exposure to danger may be done reluctantly but be regarded as “worth it” and necessary if some positive gain is to be made (*italics in original*, p. 319).

As undergoing cosmetic breast surgery is perceived as “risky,” framing their decisions as beneficial and rewarding was a way for some of the women to counter this perception and construct the risks as “worth it.”

Lisa, who underwent breast reduction surgery, explained: “I did look at all the pros and cons and there didn’t seem to be a lot of cons, really. It was all going to be a positive thing if I did it.” This excerpt reflects how Lisa felt that the rewards of undergoing cosmetic breast surgery far outweighed the risks involved. In actuality there are a number of serious “cons” that can result from undergoing cosmetic breast surgery, but Lisa’s words frame her risk-taking decision as highly positive. Similarly, when discussing the possibility of losing nipple sensation following breast reduction surgery, Natalie stated: “I did think about it and it did kinda bother me. But I thought that the greater outcome was worth that for me. For me it was weighing that against what it would be like after.” As Natalie explains, when she weighed the risks against the rewards of undergoing cosmetic breast surgery, she felt that the risks were “worth it.” Specifically, Natalie, who was only 21 at the time of her breast reduction, felt that the benefit of having breasts that no longer appeared “old” and “saggy” was worth losing nipple sensation. Thus, as these excerpts reflect, the desire to undergo cosmetic breast surgery, and the benefits associated with this decision, often seemed to outweigh the possibility of experiencing risks.

Lenore discussed how she thought that undergoing cosmetic breast surgery following her mastectomy would be beneficial for emotional, physical, and aesthetic reasons. She explained:

I mean one of the options is to just take the section taken out where the cancer is, but cosmetically it would have been really ugly. And then there is a chance that within a year I am going to have cancer again [...] So I thought I'd have the mastectomy and get rid of the damn cancer already. And then have the augmentation done. I mean maybe it's not going to be the perfect way to look for the rest of your life, but you're still alive. You've still got your self-confidence, and you've still got your self-esteem. You can still wear a bathing suit. You know? And you're alive. And *you've got a chance to look good and feel better and be cancer free.*

According to Lenore, having her breast augmented following a mastectomy seemed like the best option for numerous reasons: it would be beneficial for her physical health, because the cancer would be fully removed; emotionally it would increase her self-esteem and self-confidence; and having her breast augmented would “look good” aesthetically.

It is interesting to note that during the entire interview Lenore chose to focus completely on the benefits of the surgeries rather than the risks. In other words, she did not seem concerned about risks, such as the invasiveness of the surgeries, the difficulty of detecting future cancer due to the placement of the implant, or the likelihood that she will have to undergo future surgeries as implants are not lifetime devices. Thus, Lenore's approach to managing risk and uncertainty was actually two-fold: focus on the benefits and disregard the risks. This is perhaps not surprising however, because as Rowsell et al. (2000) discovered, the decision to undergo reconstructive surgery following a mastectomy is often framed in very positive terms by both patients and medical experts. In their study it appeared that “living with cancer, an often life-threatening illness,

represented a more salient risk to [the women] than the potential but uncertain risks of implants” (p. 208).

Minimize or Disregard Risks

Similar to Lenore, other women chose to disregard or down-play potential risks and complications as a way to manage risk possibilities and feelings of uncertainty. For example, some of the women compared undergoing cosmetic breast surgery to other medical treatments or interventions that they felt were equally as risky (or more risky) as a way to minimize risk possibilities. Janette, who underwent breast reduction surgery, explained: “Going under general anesthetic is always a risky procedure...but [breast reduction surgery] isn’t that risky of a procedure. It wasn’t like having open heart surgery or something like that.” Similarly, Leanne, who underwent breast augmentation surgery, stated:

I mean he [the cosmetic surgeon] explained the usual risks. You can die from it. But you can die getting your tonsils out. You know anytime you go under [general anesthetic] you could die. So whatever.

As both of these excerpts suggest, the women were able to manage feelings of uncertainty and anxiousness by stating that there are considerable risks involved with many medical interventions. Although cosmetic breast surgery does not seem comparable to open heart surgery, it is important to keep in mind that for many of the women, undergoing cosmetic breast surgery was viewed as completely necessary. Thus, similar to the women who focused on the benefits of undergoing cosmetic breast surgery, this strategy allowed the women to counter the perception that their risk-taking was unnecessary, irrational and/or selfish.

While some of the women minimized risk possibilities, other women chose to largely disregard the risks and complications and take a “fatalistic” approach instead. Giddens (1991) defines “fatalism” as “a repudiation of a controlling orientation to the future in favour of an attitude which lets events come as they will” (p. 110). In their study of women’s responses to risk information, Thirlaway and Heggs (2005) found that some women employ a “fatalistic philosophy,” such as “what will be will be.” This strategy was advantageous as it provided “instant protection against the many anxiety provoking risk scenarios that individuals may face” (p. 120). This strategy was also useful for reducing personal responsibility as it permitted the women to pursue cosmetic breast surgery without having the responsibility of balancing risks against rewards. Thus, when the outcome is left to God or the Surgeon, one is absolved of some of the weight of making the “right” consumer/patient decision. Tara, who underwent breast augmentation surgery, appeared to adopt a “fatalistic” approach to managing risk and uncertainty: “If it [breast augmentation surgery] didn’t work, oh okay well I tried and so much for that.”

In a similar vein of thought, Marcy explained that she deliberately disregarded the possible risks, because “ignorance is bliss.”

I wouldn’t let the doctor show me pictures. I said, “Nope. I want to be ignorant.” And they’ve had it on T.V., cause I remember my daughter saying she watched it. And I said, “Nope I don’t want to see it.” Ignorance is bliss [...] And then the surgeon asked, “Did you want to watch a film?” And I said, “No.” I think he asked me that several times. I said, “No I don’t to watch it.” And I never watched it

By remaining ignorant of risk information Marcy is able to control for any potential feelings of uncertainty or anxiousness. In other words, from Marcy’s perspective being unaware of risk information is “blissful” in that it means she will not have to worry about the possibility of experiencing negative complications. By taking a fatalistic approach,

which allows events to simply happen as they will, she can manage her perception of risk and feelings of fear and uncertainty.

Barriers to Making Wise Consumer/Patient Decisions

As the above analysis shows, the majority of the women in this study were active agents in their assessment and management of risk possibilities, however the social context within which these decisions were made must be acknowledged. There were significant social barriers that hindered the women's ability to adopt the ideal consumer/patient subject position and make rational, objective, well-informed decisions. First, it was clearly reflected in many of the women's narratives that they were given differing and sometimes contradictory information regarding possible risks and complications. In addition, some of the women were not adequately informed about all of the risks and complications. In fact, the women who underwent cosmetic breast surgery over 20 years ago were informed about relatively few risks prior to undergoing surgery. Finally, even the women who were well-informed faced the problem of making a decision based on risk information that is largely imperceptible. In other words, the women were challenged to make rational, calculating decisions about risks that were highly unlikely to occur and/or risks that might not affect them until several years later.

Contradictory Risk Information

Although the majority of the women were told about risks, their narratives reflected that they received differing, sometimes contradictory, risk information. For example, it was clearly reflected in the narratives of women who underwent breast augmentation surgery that they received conflicting information regarding the "shelf-life"

of implants. It is well-documented that breast implants are not life-time devices (see for example, Canadian Society for Aesthetic (Cosmetic) Plastic Surgery, 2006; Canadian Society of Plastic Surgeons, 2006; Moysa et al., 2006). Information for patients on the website for the Canadian Society of Plastic Surgeons states: “Breast implants are not lifetime devices. They cannot be expected to last forever. Surgery may be required at some time in your life to replace your implants, should they rupture or deflate” (para.16). While this information explains that implants are not lifetime devices, it is not clear regarding the amount of time, on average, implants will last before needing to be removed or replaced. In this study the women often turned to their cosmetic surgeons for this information, but it was clearly reflected in the women’s narratives that they were given conflicting information on which to base their decisions. For example, Tanya explained: “The shelf-life, so to speak, of the implants is 19 years...so in 19 years you can go back and get new one’s put in.” Conversely, Tara told me that her surgeon explained that the implants would only last 10 to 15 years before they would have to be replaced. Other women discussed being told that their implants would last 21 years, 25 years, or 15 - 25 years. As I will discuss below, the women who underwent breast augmentation surgery over 20 years ago were not even given this information. In fact, they were told that their breast implants would last a lifetime.

The information that the women received affected their decision-making, and it will likely affect their experiences in the future. For example, it is probable (and understandable) that the women who were told that their implants would last 20 or more years will be unhappy, or perhaps even angry, if they experience complications that result in their implants having to be removed or replaced before this time. More startling, however, is that one woman was not given any information regarding the life expectancy

of implants. Natalie was the only woman, among the women who underwent breast augmentation surgery within the last ten years, who did not receive this important risk information. When asked if her cosmetic surgeon informed her that the implants were not lifetime devices, she stated: “No. No one told me that. Oh well it’s too late now. No he [the cosmetic surgeon] didn’t say that.” Thus, due to the lack of information provided, Natalie was unable to make a well-informed decision. Further, it is possible that she would have reconsidered undergoing cosmetic breast surgery had she been told that it was probable that she would have to undergo future surgeries because the implants are not lifetime devices.

Misleading Risk Information

The risk information the women received regarding breast-feeding post-surgery provides a second example of the limits of medical risk information. Many studies have shown that after undergoing cosmetic breast surgery (breast augmentation surgery or breast reduction surgery), women experience difficulty breast-feeding or are unable to breast-feed (see for example, Nommsen-Rivers, 2003; Souto et al., 2003; Hill et al., 2004; Brown et al., 2006; Gutowski, 2006). Clearly, some of the women were informed about these risks. For example, Karen who underwent breast reduction surgery stated: “He [the cosmetic surgeon] made it very clear that it is very difficult to see the milk ducts and if you accidentally cut it then you accidentally cut it. There is nothing you can do about it.”

However, not all of the women’s narratives reflected that they were adequately informed about breast-feeding related risks. In fact, some of the women were told that the surgery would not affect their ability to breast-feed at all. Kelsey who underwent breast reduction surgery stated: “The cosmetic surgeon told me I could breast-feed, which was

nice. Because technology is different now than it was in the “70’s when my mom had the surgery.” Similarly, Tanya who underwent breast augmentation surgery explained:

Well the one thing that I was concerned about is that you couldn’t breast-feed once you got [implants], but that’s false. Like I mean maybe back in the day when women were getting them. I don’t know the details. But if I couldn’t breast-feed with them then there was no way I was going to get them.

As these excerpts reflect, both Kelsey and Tanya were convinced that they would have no difficulty breast-feeding post-surgery, because their surgeons told them that this was not going to happen because technology had improved.

While it is possible that the women who were told that breast-feeding post-surgery would not be an issue, it is also possible that they will experience complications.²⁵ For example, Hill et al. (2004) found that women who undergo breast augmentation surgery could experience complications related to breast-feeding and thus they concluded:

For the woman in her reproductive years who intends to breastfeed future children, preoperative counseling and written informed consent for breast augmentation is imperative with an understanding that *future lactation may be impossible or impaired* (emphasis added, p. 242).

Similarly, in their study, Souto et al. (2003) found that cosmetic surgeons were overly confident that patients would be able to breast-feed following breast reduction surgery, and thus they argue that women must be better informed about the risks and “be prepared to face some possible difficulties” (p. 48).

It should be noted that it is very possible that the cosmetic surgeons who told some of the women that they would be able to breast-feed post-surgery did not intentionally misinform the women. According to Nommsen-Rivers (2003), “from the perspective of many plastic surgeons, “being able to breast-feed is interpreted as

²⁵ In fact, as I will discuss later, two of the women did experience difficulty breast-feeding post-surgery.

producing some milk, irrespective of whether supplementation is needed” (p. 7). Nevertheless, these medical findings are concerning because as was discussed above, some of the women were convinced that they would not have any difficulty breast-feeding post-surgery. As Tanya stated above, she underwent breast augmentation surgery before having children because she was assured she would be able to breast-feed. It is quite reasonable to assume that women, such as Tanya, took this information from their cosmetic surgeons to mean that they would be able to produce enough milk to breast-feed without any supplements. Thus, the disconnect between some of the women’s narratives and the medical studies described above, reveals that the risk information provided to some of the women by their cosmetic surgeons was at best overly optimistic, and at worst untrue and misleading. As such, the risk information some of the women received barred them from making well-informed consumer/patient decisions.

Lack of Information

In addition to the problem of conflicting or misleading risk information, the time period in which the women underwent cosmetic breast surgery impacted a few of the women’s decision-making processes. It is important to recognize that the description of risks and complications associated with cosmetic breast surgeries outlined at the beginning of the chapter is based on relatively recent medical information. Over time there has been increasing medical and scientific research on the risks associated with cosmetic breast surgeries, and thus some of the women had very different information on which to base their decisions. In particular, three of the women who underwent breast augmentation surgeries over twenty years ago discussed how they were given very limited information regarding potential risks or complications. Important information,

such as the possibility of the implants rupturing, was not provided to these women simply because there were no major long-term studies on the effects of silicone or saline implants until the early to mid 1990's (RowSELL et al., 2000, p. 210).

The women who underwent cosmetic breast surgery over twenty years ago were initially unsure about undergoing cosmetic breast surgery, but their cosmetic surgeons assured them that there were minimal risks involved. For example, Robin, who underwent breast augmentation surgery in 1974 explained:

I hounded the doctor. You know, up one side and down the other. I asked him every kind of question I could think of. At the end of the day he told me, "*You know, Robin, when they dig you up 1,000 years from now, they will find nothing but implants and bones. That's how good they are.*" And I said, "Wow. Really? Okay." So anyway I thought well maybe this is okay. I mean maybe it will work. Maybe it is true. So I went in and decided, yes I would have the surgery.

Marilyn, who underwent breast augmentation surgery in 1977, recounted a similar experience:

In hindsight I don't think that there was a lot of research that had been available as to the long term effects of this type of surgery. So I guess we all put our trust in the physicians that we go to and we leave our bodies in their care. And I was just going in on face value, he said, "*These things will last you a lifetime. No problem. I've done lots of them,*" that kind of thing...And so I was just going on the positive side of it, and assuming that this was all going to be well and good and everybody will live happily ever after.

As both of these excerpts reflect the women decided to undergo cosmetic breast surgery only after they were convinced that the procedure and the implants were safe. Thus, the women made the "best" decision that they could based on the risk information that was available to them at that time. However, as we will see in the final section of this chapter, Robin and Marilyn did experience serious complications, despite their surgeons' assurances to the contrary, following their breast augmentation surgeries.

Risk as Indefinable

Finally, even the women who were provided with all of the information still had to assess and manage risks that they might not ever experience, or may not experience for several years after their surgeries. The decision-making process is made that much more difficult “[w]hen a health effect may not develop for years, or when a very dangerous hazard is unlikely to occur, the risk is likely to remain indefinable” (Rowell, et al., 2000, p. 206). Tracy, who underwent breast augmentation surgery, explained her uncertainty regarding the risk of her implants rupturing or leaking:

I was, and I still am, very nervous about the breaking or rupturing. And they don't know why it happens or anything like that. So there is nothing that they can really do to make sure that it wouldn't happen. It just kind of happens.

As this excerpt reflects, it was (and continues to be) difficult for Tracy to rationally calculate the probability of this risk occurring as there is no medical consensus on when implants are likely to rupture, or why implants rupture in the first place, or what can be done to prevent this from occurring.

It is also difficult to assess and manage risk possibilities when certain risks may appear to have little consequence at the time. For example, Jamie, who underwent breast reduction surgery when she was only 21, stated:

She [the cosmetic surgeon] said that there is a chance that you might not be able to breast-feed. And *I think I was too young and children were too far away at that time to think about that as a big deal*. Maybe I would have thought a little bit differently now about it. But at that time that wasn't the most important thing to me.

As this excerpt reflects, it was difficult for Jamie to assess and manage risks when it is unclear how these risks might affect her later in life. Three years after her breast reduction surgery, Jamie has realized that having the option to breast-feed might be important to

her, however at the time of her surgery children and breast-feeding were far removed from her lived experience.

Similarly, Karen, who was 30 at the time of her breast reduction surgery, highlights the complexity of making decisions without any certainty regarding risks:

I think it is going to be unrealistic for me to breast-feed. I don't think I will be able to. So no at this point *it's not a big deal*. But ask me on one day and I will say *breast-feeding is the most important thing in the world*...I would be disappointed if I couldn't make the choice myself, you know, if the choice was made for me. So yeah, I would be disappointed, but it wouldn't kill me.

Within this excerpt Karen contradicts herself; at one moment she states that being able to breast-feed is “not a big deal,” and then later she explains that potentially “breast-feeding is the most important thing in the world.” This contradiction, however, underscores the difficulty the women faced of fully comprehending, in advance, how certain risks would ultimately affect their lives. As Karen explains, her feelings regarding breast-feeding change depending on the day, and thus it would have been impossible for her to rationally calculate this risk against the expected rewards of undergoing cosmetic breast surgery.

Experiences of Risk: “At What Cost Do We Have To Pay?”

In this final section I will discuss the women's experiences of risks and complications following cosmetic breast surgery. “At what cost do we have to pay?” was a rhetorical question posed by Robin (whose story is told below), in regards to the cost that we as women have to pay in order to be valued within our society. In Robin's mind the cost that she paid in order to embody cultural beauty norms was much too high. While a few other women in this study would agree with Robin, not all of the women thought that the costs that they paid in terms of pain and suffering outweighed the rewards of undergoing cosmetic breast surgery. Instead, these women felt that the benefits of

undergoing cosmetic surgery far outweighed the “costs.” As will be discussed in the following chapter, post-surgery many of the women had very positive experiences, and in part, this resulted in them feeling as though their decision to undergo cosmetic breast surgery was “worth” the pain and suffering they endured. While it is true that many of the women felt that the risks were “worth it,” it is also true that many of the women were simply “accepting their fates.” By “accepting their fates” it appears that the women have internalized the belief that they do not deserve sympathy for their decisions, because they “chose” to undergo cosmetic breast surgery and thus they are to blame for the negative outcomes of this “choice.” However, the women chose to use language such as it was “worth it,” because explaining the benefits as out-weighing the risks is a way for the women to construct their decisions and feelings post-surgery as rational and acceptable.

Losing Nipple and/or Breast Sensation

The majority (14) of the women in this study had a partial or complete loss of nipple and/or breast sensation following their surgeries. As such, within this particular group of women, this was the most common negative side-effect of undergoing cosmetic breast surgery. While some of these women regained full or partial nipple and/or breast sensation within months or years of their surgeries, other women have never regained full sensation. The women’s feelings regarding their experiences of this risk basically fell into two categories: The women either felt that losing sensation was “worth it,” or conversely, they felt that it was much too high a cost to pay compared to the benefits of undergoing cosmetic breast surgery. The following excerpts illustrate these opposing viewpoints:

I did feel a different sensation in the nipples like when they are being touched...And of course my husband is like, “Oooh.” But I didn’t find that touching to be entirely enjoyable after that...But, I guess that was the risk I took by undergoing surgery [...] I guess it was just part of the

package. It definitely wasn't one of the pleasant things. *But overall the benefits for me seemed to weigh higher on the scale than the negatives.* (Lindsey, breast augmentation surgery)

I mean *I can't imagine anything worse than you being with your partner and not responding and not feeling anything.* There is still a couple areas that I can't feel stuff, but just really small little areas. But luckily they are not in the primary touching zone so it is okay. (Karen, breast reduction surgery)

As would be expected, some of the women's sexual relationships with their partners were negatively impacted by the change or loss of nipple and/or breast sensation following cosmetic breast surgery. Nevertheless, some of the women, such as Lindsey, felt that this risk was worth the rewards of undergoing cosmetic breast surgery. Danielle underscored this line of thinking: "In my one breast there is pretty much no feeling. But I'd still do it again in a heartbeat. If I had lost sensation in both breasts, I would still have done it. You know I really think it was that good of a choice I made." Although it may seem incomprehensible to some, many of the women's narratives suggested that having their breasts looked at positively by male partners was often more important and pleasurable than being able to feel sensations in their nipples and/or breasts following cosmetic breast surgery.

Breast-Feeding Post-Surgery

As was briefly discussed above, the possibility of having difficulty breast-feeding or being unable to breast-feed post-surgery was a risk that factored heavily in to many of the women's decision-making processes. Within this study there were only five women who had children following their cosmetic breast surgeries, and two of these women

experienced breast-feeding related complications.²⁶ Robin explained that she was able to breast-feed her first child prior to her breast augmentation, but after undergoing cosmetic breast surgery she experienced difficulty breast-feeding her second child. She was told, by her cosmetic surgeon, that she would be able to breast-feed post-surgery and thus she was (justifiably) angry that she was not given adequate risk information on which to base her decision.

Lisa was also unable to breast-feed following cosmetic breast surgery. Unlike Robin, however, she was informed prior to her breast reduction surgery that there was a chance she would be unable to breast-feed. Lisa explained that she attempted to breast-feed her son, as the “big push in the hospital is to breast-feed,” but after two days she was told by a nursing consultant that her body was not producing enough milk due to her breast reduction surgery. Lisa described how she felt some guilt over the inability to breast-feed, as is reflected by the following excerpt: “So obviously my son was starved on day two. And I felt bad because I couldn’t figure out why he kept crying, and crying, and crying.”

In contrast, Larissa, who also underwent breast reduction surgery, chose not to breast-feed either of her children because she was worried that she would be unable to produce an adequate amount of breast milk. She stated: “I was worried I wouldn’t produce enough milk after that [breast reduction surgery], and I didn’t want my children to be unhappy at all or not getting enough nutrients.” This excerpt suggests that choosing not to breast-feed was an attempt to avoid the guilt that some women, such as Lisa, feel

²⁶ Although it may appear that relatively few women experienced breast-feeding related complications, it should be noted that the sample was relatively young (half were 30 years or younger at the time of the interview), and thus many of the women were still unsure as to whether or not they would be able to breast-feed post-surgery.

when they are unable to provide enough breast milk for their infants. Larissa could not completely escape these feelings of guilt, however, because of the extreme pressure she felt from medical professionals to breast-feed. She stated: “I wasn’t expecting the pressure to breast-feed to be that bad, I don’t think. And I felt a lot of guilt not breast feeding, because I had chosen not to.”

Both Lisa’s and Larissa’s experiences of guilt over not breast-feeding are likely reflective of the current “breast is best” imperative (Blum, 1999). For example, Health Canada (2004) “promotes breast feeding as the best method of feeding infants as it provides optimal nutritional, immunological and emotional benefits for the growth and development of infants” (para. 1). According to Linda Blum (1999) medical discourse that promotes the “breast is best” philosophy is used to “educate and persuade” mothers to breast-feed. A woman’s choice to breast-feed is viewed as a “moral choice” in this cultural context. Thus, women who choose not to breast-feed, or are unable to breast-feed, are often culturally constructed as “bad” mothers. Additionally, mothers who have undergone cosmetic breast surgery who are unable to breast-feed or have difficulty breast-feeding are seen as particularly “bad” mothers as they “chose” to undergo cosmetic breast surgery, despite the possible negative outcomes. These women are then blamed both for the risks they experience, and for being “unfit” mothers. As such, Larissa’s accounting for her decision to not breast-feed can be seen as a strategy to “present a version of reality [that] is viewed least damning to [her]self in order that [her] moral character is preserved” (Coxhead & Rhodes, 2006, p. 111). Despite their negative

experiences and feelings of guilt, however, both Lisa and Larissa explained that they were ultimately happy with their decisions to undergo breast reduction surgery.²⁷

Paying the Cost: Robin's Story

While some of the women experienced immediate complications, other women did not experience any negative consequences until several years after their surgeries. As was discussed above, Robin experienced difficulty breast-feeding following her breast augmentation surgery. However, she did not experience any other medical complications until 18 years after her breast augmentation surgery. In 1991, Robin began experiencing severe chest pain, which eventually became so unbearable that she was bed-ridden for two years. In addition to the chest pain, she explained that from 1991-1992, her breasts hardened to the point that they were like “rocks,” and she developed lupus-like symptoms, Raynaud's phenomenon, fibromyalgia, and connective tissue disorder. She consulted several doctors and specialists, but was unable to receive a definitive answer as to why she was experiencing medical problems. The lack of medical answers, combined with severe pain, led Robin to contemplate suicide:

It was just getting worse. I just kept developing another disease. And I was taking more medication. I was taking morphine and still couldn't get off of the bed. I was having an awful time. Just an awful time. My girlfriend phoned me one day and said to me, “Is there anything I can do for you?” And I said, “*You can bring me a gun, because I am not living and lying here. I don't want this anymore.*”

Finally, during one visit to a doctor Robin was told that the medical problems she was experiencing could be linked to her silicone breast implants. Following this doctor visit,

²⁷ The following chapter will discuss why some of the women felt that the benefits of undergoing cosmetic breast surgery were worth the risks they experienced.

she began hearing more information in the news regarding the possible negative effects of silicone implants.

Robin decided to contact the cosmetic surgeon who had done her initial breast augmentation surgery in order to schedule an appointment to have the implants removed. However, the cosmetic surgeon explained that he thought it was necessary to remove the silicone implants and replace them with saline implants, as simply removing the implants would leave her breasts “deformed” and “misshapen.” As she did not want to have the implants replaced, Robin decided to find a cosmetic surgeon that would simply remove the implants. In 1993 Robin underwent surgery to have the implants removed. In the following excerpt she recounts this experience:

So I went in and I had the surgery and they tried to scrape all the silicone they could find off of every part of my chest, because they had both broke. And my breast tissue had gone into the implant and the implant had come out into my chest wall, where all the pain is. So he [the cosmetic surgeon] said to me, “I took out as much as I possibly could get. The rest is just going to have to go wherever.” He said, “We have women come in and they have it in the bottom of their toes. We’ve found people have got it everywhere.” And as you can see, I have developed these lumps [of silicone], all over my body.

Although the silicone could never be fully removed from Robin’s body, she explained that following this procedure she began to feel some pain relief. However there are still days when she cannot get out of bed. She continues to take pain relief medication, including morphine, and despite the removal of her implants she continues to develop diseases and disorders, including, most recently, epilepsy. Today, Robin describes herself as an “advocate” against breast implants, and she is not hesitant to tell other women about her experience as it may prevent them from undergoing the same pain and suffering she endured.

It is important to note that other women all over Canada suffered similar side-effects to those Robin experienced following breast augmentation surgery with silicone implants. In January 1992, the concern regarding the possible health risks associated with silicone gel-filled implants resulted in a “voluntary moratorium” (Health and Welfare Canada, 1993, p. 1). At this time Canadian distributors of all silicone gel-filled implants were asked to temporarily stop the sale of these products. However, silicone gel-filled implants were made available “if the benefits for the individual outweighed the risks and where other alternatives were not available or suitable to the specific situation” (p. 2). In October 2006, Health Canada, decided to grant conditional licenses to both Inamed Corporation and Mentor Medical Systems in order to market their silicone gel-filled breast implants once again. This decision was made after several major studies “concluded that there was no evidence of a causal relationship between silicone gel-filled implants and a number of auto-immune diseases or other systemic illnesses” (para. 6).

Thus, although Robin’s experience may seem extreme, there are documented cases of other women with similar silicone implant related side-effects. Further, within this study, Marilyn, Leanne, and Lindsey described experiencing major side-effects related to their implants including: rupturing of their implant(s), wrinkling or rippling of their implants, and tightening of the scar tissue surrounding their implants, which resulted in hardening of their breasts. The difference was that not all of the women felt that the negative experiences outweighed the benefits of undergoing cosmetic breast surgery. Marilyn, for example, endured (and continues to endure) negative side-effects related to her implants, but she explained that she was ultimately happy with her decision to

undergo breast augmentation surgery.²⁸ She stated: “I felt better about my body image, even though I went through a lot of uncomfortable situations, and pain, and this type of thing, I was happier with my body. That was the way that it was.” Unlike Robin, Marilyn believes that the significant “costs” she paid were worth the benefits of undergoing cosmetic breast surgery: “It was positive even though I went through a lot of negatives. I still wanted to keep the implants, and like I said, I want to keep them now. Until there is a significant health issue I will be happy to keep them.”

Risk and Personal Responsibility: Leanne’s Story

To conclude this section, I will discuss Leanne’s experience of risk as it clearly reflects the ways in which women can be blamed for the negative outcomes of their body modification “choices.” Leanne woke up one morning in 2002, eight years after her initial breast augmentation surgery, to find that one of her implants had “shrunk considerably.” Her saline implant had ruptured and it was causing her a great deal of pain as it felt like “it was pushing down” on her chest wall. The suffering had only begun however, as she went to the hospital only to find that the doctors and nurses in the emergency room did not deem her ruptured implant to be an “emergency.” Leanne explained:

So my husband took me to the emergency room and they were such jerks. They just treated me like I am like a piece of crap. The hospital people like the nurses and the doctors treated it like it wasn’t a big deal, like it was nothing. And they said, “Well you know you need a referral to go to the plastic surgeon.” And I’m like, “This is an emergency!” And they’re like, “No. Actually it isn’t an emergency.”

²⁸ During Marilyn’s initial surgery in 1977, she was only given local anesthetic, which meant that she was awake during the entire breast augmentation surgery. In 1978 she underwent a “capsulotomy” to “break up” the scar tissue that formed around the implants, and then in 1979 she underwent surgery to have the saline implants removed and replaced with silicone implants. Since this last surgery she has developed some health issues that may be attributable to silicone implants, such as Raynaud’s phenomenon and Sjorgen’s Syndrome.

And then I'm like, "But, I'm in pain!" And it was so horrible. You know they treated me like I wasn't even human. It was just awful.

The inhumane treatment that Leanne received at the hospital is clearly reflective of the social sanctions that may be imposed on women when there are negative outcomes resulting from their consumer/patient decisions. However, as we saw in chapter three, Leanne did not "freely chose" to undergo cosmetic breast surgery, but rather her first husband strongly coerced her into the decision. Her experience thus strongly reflects that within personal responsibility discourse individuals are assumed to be autonomous, rational, free agents who are in control of their own health. The personal responsibility discourse in relation to risk thus masks the underlying social causes of risk-taking and results in victim-blaming. Ultimately, "victim-blaming" culminated in some of women in this study suffering not only from the physical and emotional pain experienced as a result of medical complications, but also from the social sanctions they received from individuals (including doctors and nurses) who felt they deserved the negative outcomes of their "choices."²⁹

Conclusion

Women who choose to undergo cosmetic breast surgery may be seen as acting irrationally because of the significant risks associated with these procedures. At the same time, as was discussed in chapter four, the medicalization of healthy feminine breasts makes it increasingly difficult to argue against cosmetic breast surgery as it becomes understood as a *necessary* treatment for breasts that do not "measure up" to a historically and culturally specific standard of "normal." The women in this study had to negotiate

²⁹ Leanne's story does have a "happy-ending," however, as she was able to find a cosmetic surgeon to remove her implants within a week of the implant rupturing.

this difficult contradiction, and this was done in part, by employing various strategies to assess and manage risk and uncertainty. As the above analysis shows, by using these strategies many of the women were able to position themselves as rational and calculating subjects who made wise consumer/patient decisions. These purposive strategies for assessing and managing risk and uncertainty might be seen as reflective of the women's desire to "take their lives in hand" (Davis, 1995, p. 181).

Despite the women's attempts to take control of their lives, one cannot lose sight of the various social barriers that impinged on the women's decision-making in terms of risks and rewards. While the majority of the women took on the responsibility to assess and manage risk and uncertainty, they did so within a social context that hindered, and in some cases prevented, them from making free and rational decisions. The women's experiences of risk following cosmetic breast surgery reflect that these women's strategies for assessing and managing risk unfortunately often fell short of their intended goal of preventing negative medical complications. Perhaps even worse, the women's experiences of risk reflect that women are often blamed for their body modification choices when there are negative outcomes. The personal responsibility discourse in relation to risk means that women are placed in a precarious position where they are responsible for making wise consumer/patient decisions, while they are simultaneously held to blame for any negative consequences of their decisions. As we saw above, in some cases the women were made to suffer with the negative consequences because they were viewed as deserving their unfortunate fates.

Chapter 6: Post-Surgery Experiences

The previous chapter concluded with a discussion of the women's experiences of risk following cosmetic breast surgery. In this chapter I will continue this discussion of the women's experiences post-surgery. The following chapter is divided into two main sections: The first is a discussion of the women's positive post-surgery experiences and the second section will examine the negative experiences the women had following cosmetic breast surgery. Throughout this chapter I will address important issues such as: whether or not the women were happy with their decision to undergo cosmetic breast surgery, their feelings regarding their post-surgical bodies, the reactions the women received from others following cosmetic breast surgery, and how the women felt about these reactions.

Positive Experiences

Many of the women expressed that they were happy immediately following their cosmetic breast surgeries. Overall, the women who were most happy were those whose expectations regarding their post-surgical appearances had been met or were exceeded by the results of their surgeries. Additionally, the women who generally tended to have few or no regrets were those who claimed to have "done it for themselves," received positive reactions from family and friends, and/or who had not experienced any major risks or complications following cosmetic breast surgery. The following section will examine some of the main reasons that the women felt that undergoing cosmetic breast surgery was largely positive and worth any negative consequences that they experienced following surgery.

Before I enter into the following discussion however, it is necessary to acknowledge that none of the women expressed that their post-surgical experiences were completely positive. Even the women who did not experience any medical complications and were happy with their post-surgical appearances, still had to cope with the pain they felt during the recovery period following surgery. For example, Tracy explained that overall she was extremely happy with her decision to undergo breast augmentation surgery despite the horrific pain she experienced post-surgery. When I asked her to explain what the pain felt like following her breast augmentation surgery, she said:

It felt like all my ribs around that area were broken and I had gotten beaten with a stick. And my chest was like so stretched out and it felt so tight that it felt like my boobs were just going to pop, like just explode. [And how long did that pain last?] Four to five days.

Although breast augmentation surgery and breast reduction surgery are qualitatively different, many of the women who underwent breast reduction surgery similarly recounted experiencing a great deal of pain post-surgery. Lisa, for example, stated:

I didn't move off my couch, I don't even think, for three days. Like it just hurt. It hurt to breathe. It hurt to move my arms. Drinking water was an issue. Like anything I did was painful. Everything is connected to here, you know? So you are moving your chest area no matter what you are doing. So it was horribly painful [...] And then I had an infection after, which threw me for a loop. And the stitches were supposed to be pulled out, but they blew out cause I was so swollen from infection. But after that two week hump I was like, "Okay, this will be okay. This will be worth it someday." And it did become worth it.

As both of these excerpts reflect the pain the women felt following cosmetic breast surgery was often very intense and lasted several days to a couple of weeks. Despite their experiences of pain, however, many of the women still explained that they felt the benefits of undergoing cosmetic breast surgery made it ultimately worth it. These women's feelings thus reflect the common understanding that beauty comes at a price,

and further, that pain is an acceptable cost to pay in order to embody feminine beauty norms.

A New Body Image

Reflected in many of the women's narratives was the understanding that undergoing cosmetic breast surgery was largely positive, because it allowed them to experience their breasts in ways that they were unable to before their surgeries. Specifically, some of the women explained that they felt cosmetic breast surgery had been successful, because their post-surgical breasts were now sources of confidence and pride. For example, Jamie who underwent breast reduction stated: "I look in the mirror and I love how I look now. Like that just made such a big difference in my body image. So it was amazing." As Jamie states, she loves the way that her body looks post-surgery reflecting that changing her breasts impacted her overall body image. Teresa, who underwent breast augmentation surgery, also spoke about how her overall body image improved, adding that post-surgery she interacted differently with others:

I feel a little more secure sometimes talking to people. And I feel like I walk a little straighter. So I think I feel better about my body image now than I did before. I didn't expect it. I didn't think I had any insecurity issues, but I obviously did, a little bit, because I feel really good about my body now.

Interestingly, Teresa comments that she did not think she had any "insecurity issues" prior to undergoing cosmetic breast surgery, and yet she was willing to go under the knife to change her physical appearance. This lack of self-awareness reflects how easily the imperative of beauty can be internalized.

The following excerpt further reflects the ways in which the imperative of beauty was internalized by some of the women. When discussing that she felt completely

different in public settings following cosmetic breast surgery, Karen stated: “It is night and day, honestly. There is nothing about it that is the same. I sit differently. I speak differently. I listen differently. Like everything is different. Cause *I’m not sitting there thinking that I’m ugly.*” This excerpt reflects that Karen has internalized cultural beauty norms which in turn made her feel as though her pre-surgical body was “ugly.” By undergoing cosmetic breast surgery Karen is able to reposition her body as beautiful, as these strongly internalized cultural beauty norms are now literally carved onto her body. Taken together, all of the above excerpts reflect that changing the size and shape of their breasts to embody dominant beauty norms appeared to “free” some of the women from their previous feelings of discontent and inadequacy. In turn, this afforded some of the women more confidence in their interactions with others.

For a few of the other women, however, it was not a matter of their overall body image improving, but rather post-surgery they were finally content with that particular part of their bodies. These women’s experiences are aligned with studies on the changes in body image following cosmetic surgery. As David Sarwer (2002) states, studies on body image following cosmetic surgery procedures “indicate that individuals who undergo cosmetic surgery may experience an improvement in dissatisfaction with the feature altered by surgery, but these improvements may not generalize to overall body image” (p. 425). When asked if her body image improved following her breast augmentation surgery, Tanya replied: “Well I like the looks of my boobs way better. But I’m not satisfied with my body. But I don’t know if that is something that will ever be achieved really. You know? But am I happy with that part of it? Yeah. Yep.” Similarly, Nancy explained that following her breast augmentation surgery she continued to feel self-conscious about her body:

I still wasn't feeling good about my body. You can't feel good about your body after six pregnancies, like you can't feel good about that, no. So no this was just work in progress. I was just working towards a goal and doing what I needed to do. I mean I knew I looked better, but it still took a long time to change and bring my whole attitude around to being happy and stuff like that. So yeah I wasn't looking for it to be the answer to my problems, because that was just one element in getting myself back together.

As both of these excerpts reflect, undergoing cosmetic breast surgery did not always improve how the women felt about their overall body image. Nancy, for example, felt that breast augmentation surgery only improved "one element" of her body, and thus she was not expecting it to be the "answer" to all of her body issues. Cosmetic breast surgery was not always experienced as a liberating or empowering decision, but rather it simply allowed the women to "get by" in a culture that rewards women for embodying dominant beauty norms, and sanctions those who do not. These women's experiences further reflect the internalization of oppressive beauty norms that require women to conform to strict standards of femininity, and thus make problematic the idea that women ever freely choose to undergo cosmetic breast surgery.

Feeling Youthful, Feminine, and Sexually Desirable

Other women discussed that they were pleased with their decisions because it allowed them to dress and display their bodies in different ways. Specifically, these women discussed how they could now wear clothing that presented their bodies as feminine, youthful, and sexually attractive. For example, Kelsey who underwent breast reduction surgery explained:

I totally feel way sexier having smaller breasts. Some people think like big boobs is sexy, but it's just big. It's just really big. And you know this way you can wear a little tighter shirts and your boobs aren't hanging out everywhere. And it's just a lot nicer. It's just a nicer profile.

In this same line of thought, Larissa discussed how she dressed following her breast reduction surgery:

I used to have to wear large clothes just because that's what fit over top of them. And now I could wear stuff that made me feel good about myself that was more feminine more shapely and stuff. So maybe it wasn't drawing attention so much to my boobs anymore, but just that *I was actually a woman*, that I had a shape and some curves here and there.

According to Larissa, following her cosmetic breast surgery she looked like an “actual woman.” This statement reflects that our breasts are often “read” by others, and by ourselves, as representing us as women. As was discussed in chapter three, our breasts “say” something about who we are, and the signals our breasts send about us change depending on the size and shape of our breasts. Further, the above excerpt reflects the increasingly narrow range of “acceptable” feminine body shapes. As Larissa explains, following her cosmetic breast surgery she looked like an “actual woman,” because her breasts were the “correct” size, and she now had the “right” amount of “curves here and there.”

It was not only the women who underwent breast reduction surgery who were pleased to find that their post-surgical bodies allowed them to display their bodies differently through clothing. Following her breast augmentation surgery Tara commented that she noticed even “simple” clothing looked better: “It's awesome because I don't have to buy the \$70 constructed, push-up, pull-in, suck-back, type of shirt. I can wear like a really simple shirt and it looks awesome now.” Thus, many of the women described the pleasure they received from being able to present their bodies in different ways following cosmetic breast surgery. These women expressed that post-surgery they were able to

dress and display their bodies in ways that made them feel good about themselves, and that would allow them to receive positive attention from others.

The women also described how they felt that their decision to undergo cosmetic surgery was positive, because they no longer received the same degree of unwanted attention following cosmetic breast surgery. In chapter three, some of the women who underwent breast reduction surgery discussed how they wanted to change their physical appearances so that their breasts would no longer elicit the “wrong” type of attention from men and women. Specifically, the women discussed how they wanted to alter the size and shape of their large pre-surgical breasts because they were often viewed by others as markers of excessive femininity and hyper-sexuality. Following breast reduction surgery, some of the women were pleased to see a change in the way that other people reacted to them. Natalie explained:

So like prior to the surgery I just felt like everybody just stared at my chest, as opposed to looking at me, and stuff. And then after *it seemed like people were actually paying attention to me*, as opposed to just looking at my body. I think what I noticed is that people were looking at me as whole, instead of just one area, which was my boobs.

Larissa also voiced that she felt people reacted to her differently following her breast reduction surgery:

I think I noticed that people weren't looking at my chest anymore. I noticed that I wasn't getting that negative attention you know when you are walking down the hallway and you can tell that guys are looking at you kind of thing. I'm not getting that kind of negative attention like they are just looking at my boobs kind of thing [...] And so *women would treat you differently too afterwards, because they are not treating you like you are going to go after their boyfriend or something like that*. So yeah I probably had more women friends after that, because they would actually talk to you kind of thing. I think they felt threatened by my boobs before.

Thus, following breast reduction surgery these women no longer felt as though they were receiving the same degree of negative attention from others, and they were relieved to find that the scrutinizing gaze of others was no longer directed only at their chests. The reactions the women received post-surgery reflect how the cultural meanings associated with breasts differ depending on the size and shape of breasts. As Larissa explains, once her breasts were reduced in size she was pleased to find that even other women treated her differently, because her smaller post-surgical breasts no longer signaled to other women (and men) that she was hypersexual, “slutty,” or “promiscuous.”³⁰

The reactions the women received from sexual partners also impacted how they felt about their decision to alter the size and shape of their breasts, and their feelings about their post-surgical breasts. Prior to her breast augmentation surgery Teresa described that she felt “childish” due to her small breasts and her petite frame. She explained that her breast augmentation surgery improved her sexual relationship with her husband as her new figure was sexier and “more adult.”

I think our relationship has changed a little bit because I know *he finds it more sexy, and it's more adult*. I think it was better than he thought it would be [...] So yeah it has definitely helped our relationship. I can wear lingerie that I never had the chance to even wear before. *Training bras aren't that sexy I guess*. So it's been good.

Barbara similarly explained that following her breast reduction she felt more confident being naked in front of sexual partners:

I think it has impacted my sex-life. Just because you do feel more confident. It is okay now when they see me. Because it wasn't so much the size before, but they hung, cause they were so heavy. And I love that they don't now. And I can walk around without a bra on and it's fine. And *it's not just these burdens that are going to knock*

³⁰ Later in this chapter I will examine how the women who underwent breast augmentation surgery conversely experienced increased negative attention from others (especially men), because of the size and shape of their post-surgical breasts.

someone's eye out when you move. It does make you feel more confident. You are not ashamed to have somebody look at them, cause they look a lot better now.

The women's experiences reflect how the sexualization of women's breasts can be experienced positively by women in certain contexts. The women's narratives clearly reflected that by conforming to dominant beauty norms the women were able to experience this sexual objectification as pleasurable. In fact, the women's narratives suggested that having their breasts looked at positively by male partners was experienced as more pleasurable than the sensations they derived from having their breasts touched by their male partners.

Becoming "Normal"

Some of the women's narratives reflected that cosmetic breast surgery was ultimately worth the pain and suffering involved as it permitted them to experience their breasts not only as youthful, feminine, and sexually desirable, but as *normal*. These women felt that cosmetic breast surgery had been worth it, because their breasts were no longer sources of embarrassment and visible markers of "abnormality" or "defect." After their surgeries, some of the women explained the appearance of their post-surgical breasts using language that suggested that their previously pathological breasts had finally been corrected to a normal and healthy size and shape. For example, when asked how she felt about her post-surgical breasts, Karen explained: "I don't feel ashamed or embarrassed or dysfunctional or anything anymore. It is just nice to finally feel sexy and normal and attractive." Natalie also stated that she felt "normal" following her breast reduction surgery: "I just feel normal. Like I feel like I kinda fit in with other girls who are my height or my weight. Or even just the norm of society. Like I don't just feel like I'm just

this outlying person with these big boobs.” Despite the fact that breasts naturally occur in a variety of sizes and shapes, these women’s narratives implied that prior to their surgeries their breasts were outside what they considered “normal.”

Lindsey also seemed to share this understanding that her pre-surgical breasts were abnormal, explaining that she was pleased with her post-surgical results because she finally felt like a “normal woman”:

I was quite happy. I just felt happy that I looked more like a *normal woman* instead of being too small. Like the women who have reductions probably felt good to not feel too big, so I felt good to not be too small, to be more like a *normal woman*. I guess it impacted my self-esteem because I felt that it was the way it should be. Once I got used to how big they were, then I realized that it probably is right for how my body should be, that it is not too big and not too small, it is just right.

As this excerpt reflects, Lindsey is pleased that her previously small breasts have been “corrected” to a normal and healthy size. Interestingly, she explains that post-surgery she is a “normal woman” not simply stating that her breasts are now “normal,” which implies that undergoing cosmetic surgery has changed her entire identity. In other words, through cosmetic surgery Lindsey was transformed from an “abnormal” or “deformed” person to a completely healthy and “normal woman.” However, in her discussion of her transformation to a “normal woman” she appeared not to see the inherent paradox that in order for her to become a “normal woman” she had to undergo the unnatural practice of cosmetic surgery which included having foreign objects, placed into her body.

It is important to acknowledge, however, that although some of the women couched their experiences in this normalcy language, the “normal” that the women now embody is culturally specific. As was discussed in chapter four, the standard of normal against which these women’s breasts have been examined, critiqued, and reconstructed is

based on dominant beauty norms that dictate that women's breasts should be large, round, perky, and firm. It is not surprising then that some of the women described their post-surgical breasts using the following descriptors: "perfect," "feminine," "pretty," "ideal," "firm," "womanly," "perky," "fantastic." Despite the fact that the socially constructed standard of normal is in fact biologically non-standard, the descriptors the women used when discussing the appearance of their post-surgical breasts reflected that their breasts had in fact been "corrected" and reformed to embody feminine beauty norms.

Two of the women who underwent breast reduction surgery were very pleasantly surprised to find that their post-surgical breasts were reconstructed to look comparable to this unnatural standard. In an excerpt above, Natalie described that post-surgery she felt as though her breasts appeared "normal" following her breast reduction surgery, however later in the interview she explained that her post-surgical breasts were comparable to those of women who had breast implants. She explained:

Cause I mean like you have to admit that the girls who have breast implants- as fake as they do look, or don't look sometimes- they look pretty decent, you know? [...] And I almost felt comparable to that.

Similarly, Brandi discussed how her breasts appeared comparable to implant enhanced breasts, and that she was even asked by a few different people if her breasts were "fake" following her breast reduction:

Well I take it as a compliment, because I'm like if they look like fake boobs and that I paid a lot of money for them then I guess that's a good thing. Or if somebody else would want to pay money for them then that's good.

Interestingly, Brandi proudly speaks about her breasts as if they are commodities that other women wish to possess. This wording reflects the intimate connections between the cosmetic surgery industry and our consumerist culture. In addition, both of the above

excerpts reflect how the women have internalized the understanding that “fake” breasts which are large, firm, and perky are culturally desirable. Despite the fact that breast reduction surgeries are culturally constructed as “medically necessary” these women’s narratives suggest that not only were their breasts reduced in size but they were also “corrected” to embody dominant beauty norms. Ultimately, the women’s affirmative experiences following their breast reductions convinced them that they had in fact made the right decision to undergo cosmetic surgery.

“Cashing In” on Physical Capital

Finally, some of the women discussed how undergoing cosmetic breast surgery was positive as it increased their *physical capital*. As was discussed in previous chapters, Bourdieu’s conceptualization of physical capital refers to the “development of bodies in ways which are recognized as possessing value in social fields” (Shilling, 2003, p. 111). Physical capital can then be “converted” into other forms of capital including economic, cultural, and social capital. Although the women would never use the term *physical capital* to explain their gains from pursuing cosmetic breast surgery, they did describe how they were able to leverage their post-surgical appearance to gain other forms of capital in both the job and dating market. Two of the women who worked as waitresses following their breast augmentation surgeries described how their surgically enhanced breasts could be used to gain better tips from male customers. Tara stated:

I’m not so feminist so if I got them, then I’m going to use them. If you’re going to be sucker and give me a twenty buck tip, then I’m going to lean over a little bit more (laughs). [So you use your breasts to your advantage at work?] If I am putting up with garbage people in a garbage environment anyway I use it to my advantage [...] And I do receive probably about 20% more tips now, but that’s just purely a bonus. It wasn’t like I decided to do it because I’ll make more money at

the bar if I get implants.

Tara justifies her actions by stating first that she is “not so feminist,” so that engaging in this behaviour does not contradict her values and notes it is only “garbage people” she is taking advantage of. Finally, she claims to be sure that other women similarly use their appearances to accrue better tips. It is also interesting that she points out that she did not undergo breast augmentation surgery to gain better tips as a waitress; instead she makes it very clear that this was “purely a bonus.” This excerpt intimates that Tara feels uncomfortable admitting that her breasts can be leveraged to her advantage. In part, this is difficult for Tara to admit to because she presumably does not want to construct herself as someone who sells her body for money. In addition, since Tara continually claimed throughout the interview that she “did it for herself,” this discussion of the advantages her new body obtained from others was likely difficult because it challenged that understanding of having surgery purely for her own pleasure.

Conversely, Diane, who also worked as a waitress following her breast augmentation did not seem to feel the need to justify her actions in the same ways that Tara did, saying:

Well you use your assets for whatever you can, right? And guys are very easy to manipulate, especially when they are out of town on business. And when they buy four beers and throw you a \$50 tip in your cleavage, then I’m like, “Thank-you very much. Can I bring you another four?” [And so you would use your breasts to get a bigger tip sometimes?] Well why not? *Let them pay for themselves.* When you have your shirt done up properly and when you’re holding the tray, then they look like “Wow.” You use whatever you can, you know.

In Diane’s description it becomes clear that she does not feel ambivalent about her actions. Instead she is adamant that “you use whatever you can” (including your body) to further your career and gain economic capital. Interestingly, Diane’s words reflect the

understanding that the financial investment in her body was worth it, because it immediately began accruing economic capital, and thus her breasts would eventually “pay for themselves.”

In addition to the economic market, a few of the women discussed that following cosmetic breast surgery they possessed improved assets to leverage in the dating market. Karen who underwent a breast reduction and breast lift explained: “It’s brought me so much joy. It brought me my relationship. I would never have had Mark if I hadn’t had it. No way.” According to Karen she would never have met her common-law partner if she had not undergone cosmetic breast surgery, reflecting that possessing physical capital can have immediate pay offs in the dating market. Similarly, Lisa explained that following her breast reduction surgery, she was able to date a completely different “caliber of men.”

Even the caliber of men I was dating changed. I used to date the “average joe,” quiet, sort of reserved kind of guys. And then I was picking the one in the room that I wanted. And that made a huge difference for me.

From Lisa’s perspective changing her physical appearance allowed her to quite literally move up in the dating market. Following cosmetic breast surgery, Lisa’s increased physical capital allowed her to meet men of a higher “caliber,” including the man she ultimately married.

Negative Experiences

As the above discussion has shown, many of the women were pleased with their decision to undergo cosmetic breast surgery. However, not all of the women had such pleasant post-surgery experiences. As we saw in the previous chapter, some of the women who were most unhappy with their decision to undergo cosmetic breast surgery were

those who had experienced negative risks and complications. In contrast to the women's experiences described above, the women who tended to be somewhat unhappy or disappointed were those whose expectations regarding their post-surgical appearances were not met. Some of the women unfortunately found that following cosmetic breast surgery, the "battle" with their appearances did not end, but rather it continued as they were considering undergoing future cosmetic surgery procedures. Other women expressed that they received (unexpected) negative reactions from people regarding their post-surgical appearances, and this led them to have some feelings of regret regarding their decision. A few of the women's negative experiences post-surgery were further complicated by the fact that they had not "done it for themselves," but rather they had undergone cosmetic surgery for a male partner. While the women's negative experiences post-surgery did not necessarily mean that they regretted their decision outright, it often led the women to question, or feel ambivalent about, their decision to undergo cosmetic breast surgery.

The "Never-Ending Battle"

This first section will discuss the women's own feelings regarding their post-surgical appearances, and in the following section I will discuss the reactions the women received from others and how the women felt about these reactions. Some of the women discussed feeling disappointed with the appearance of their breasts following surgery. For one of the women her post-surgical breasts fell short of her expectations as she had hoped that her breasts would resemble those that she saw in the mainstream media. Specifically, Tanya wanted her post-surgical breasts to look "pushed-up" without a bra, similar to

Pamela Anderson's or Carmen Electra's breasts. When asked how she felt about her breasts following her breast augmentation, she responded:

I would say it is pretty much what I hoped for, although I don't even know if what I wanted was possible. I really wanted the cantaloupe under your skin look, you know? But I don't even know if that is really possible without a bra. So I would have preferred that look. But I don't know if I could have ever got that effect.

Tanya's ultimate disappointment with her post-surgery appearance is to be expected when one considers mainstream media images are often not only surgically enhanced but also computer-altered. The media images are unattainable ideals, and yet as Bordo (1997) explains, these "perfected images have become our dominant reality and have set standards for all of us - standards that are increasingly *unreal* in their demands on us" (italics in original, p.116). The constant representation of these artificially enhanced breasts in the mainstream media constructs an unnatural and unrealistic standard, and although it may seem irrational to hope for perfect post-surgical breasts, it is quite understandable as these perfected images are constructed as "normal," "natural," and "healthy."

While some of the women were not disappointed immediately following their surgeries, they did describe the desire to have future surgeries if their breasts changed following natural processes such as weight-gain, breast-feeding, and aging. In fact, the majority (20) of women in this study explained that they would be willing to undergo future cosmetic breast surgeries if their breasts changed in size or shape following their initial surgery.³¹ And some of the women were already planning to undergo cosmetic procedures to return their breasts to their ideal size and shape. For example, Janice

³¹ The four women who would not consider undergoing cosmetic breast surgery again in the future were: Robin, Leanne, Nancy, and Mary.

discussed feeling upset that her breasts had enlarged slightly since her breast reduction surgery, and that she would undergo a second surgery if her breasts continued to change.

She stated:

Like I put on probably 10 or 15 pounds since then and I'm like, I had these *perfect 36 C's* and now they are a 38 C and I want my money back or I want that gone. It's just like they were *custom-ordered* before and now they are getting bigger. I am done with getting bigger. It is not supposed to go that way. And honestly if they get bigger and they don't go down I would do it again.

In the same line of thought, Diane explained that she was disappointed her breasts had changed following her breast augmentation surgery:

The only thing that I would have changed about getting them done is timing. I would have rather have had my children first and then had them done, simply for the fact that I'm looking at a lot of loose skin, cause of nursing and now I have to go in for another procedure if I want to have what I had when I started. So it is sort of a *never ending battle* [...] It's just like if you were to lose a lot of weight then things stretch out and there is a point where they don't come back. And that's common with being a mom.

These women's feelings reflect both the increasing normalization of cosmetic surgery, and the impossibility of embodying dominant beauty norms. As Diane states, it is "a never-ending battle," because even when a woman's breasts are "custom-ordered" to begin with, the material existence of her body means that it will inevitably change over time, requiring future surgical procedures over the course of their lives in order to embody these ideals.

Other women described a slightly different "battle" that they had to "fight" post-surgery. Some of the women explained that they were finally content with their breasts following cosmetic surgery, but that they were now unhappy with other parts of their bodies. Several of the women expressed that they wanted other parts of their bodies to look as good as, or complement, their post-surgical breasts. Chantelle, who underwent

breast reduction surgery, explained it this way: “Once they were a smaller size, *I thought maybe I should work on the rest of this now*. So I did end up losing about 65 pounds, not including what the surgery took off.” In this same line of thought, Janette explained:

And I work out more now. I was joking with a friend of mine that when I used to be so heavy you could sometimes camouflage how heavy I was elsewhere on my body because I looked a bit more proportionate when you were just dumpy everywhere. *So now that I am smaller through the breasts I have to pay a little bit more attention elsewhere*.

And, Tara, who underwent breast augmentation surgery, stated:

I thought that would be the final improvement. So I wasn't expecting that I would want to improve anything else. *But now when I see one part of my body that I really, really like then I think well I could just fix everything and be the best damn 27 year old out there*. So it kind of almost encouraged me to maybe take a look at other things that I could work on.

As all of the above excerpts reflect, some of the women felt it was necessary to improve other aspects of their bodies, once their breasts were reformed to an ideal size and shape. In fact, it appeared that following cosmetic breast surgery these women became even more conscious of other body parts that they wished to change. Most of these women would not consider their unhappiness with other parts of their bodies a negative consequence of cosmetic breast surgery, however, and many of them commented that it simply made them realize they *needed* to take care of their bodies, and exercise more, and/or eat better. These women further explained that they simply wanted to “fix” or “work on” other parts of their bodies post-surgery, because they now knew the difference that changing one part of their body could make in improving their self-esteem. These women's feelings about their bodies are likely reflective of body image issues that the women were struggling with prior to surgery, but had hoped would subside following cosmetic breast surgery.

While many of the women hoped that once they underwent cosmetic breast surgery they would finally be content with their appearances, the above excerpts reflect that the opposite happened for some of the women. Rather than finally feeling happy with their post-surgical appearances, they felt the need to change other parts of their bodies. Thus, these women's experiences reflect the tyranny of beauty, and how it really does become a "never-ending battle" to embody hegemonic femininity. A few of the women even commented that they would consider undergoing future cosmetic surgery procedures to change other parts of their bodies. Danielle, who underwent breast reduction surgery, explained: "I know I would, in a heartbeat, when I ever had the money go in and now and have a tummy tuck, for sure. Because what I have there I could never lose. And I would do it, because I know that would feel good to not have that too." Karen stated that she would likely undergo more than one cosmetic surgery procedure later in life:

I would definitely get my eyes done. I would definitely get my chin done. I would definitely do the face lift thing. I am not saying that it would make my life miserable to look at wrinkles, or that I am scared of aging, because I'm not at all. That doesn't bother me the least. But if I can do it age a little bit more gracefully, and feel more confident about myself, and I could see such great changes in my life, and I have the money, then sure I would do it. I wouldn't choose anything where you move cartilage or are cutting through muscle. But *if you can do the odd little lift thing, then why not?*

Although only a few women discussed wanting to undergo cosmetic surgery procedures on different parts of their bodies, as was discussed above, the majority of the women in this study explained that they would undergo future cosmetic breast surgeries if their breasts no longer looked as appealing to them. These women's narratives seem to signal how cosmetic surgery is becoming increasingly normalized, and how the cosmetic surgery industry and consumerism have an insidious symbiotic relationship. Karen's statement, "If you can do the odd little lift thing, then why not?" is a clear reflection of

how cosmetic surgery is becoming understood as just another “beauty treatment” that women (who can afford it) can purchase to improve their appearances. However, the women’s experiences of risk outlined in the previous chapter demonstrate that cosmetic surgery is not something to enter into lightly and that it can have devastating consequences.

Unexpected, Negative Reactions Post-Surgery

This final section is a discussion of the negative reactions the women unexpectedly received from others post-surgery. A few of the women who underwent breast augmentation surgery expressed that they were unprepared for the negative male attention their post-surgical breasts elicited. While not all of the women who underwent breast augmentation surgery regretted their decision due to this unwanted attention, it was nonetheless experienced by many as one of the main negative results of their decision. The women commented that while they had expected their new appearances would draw male attention, they were ill prepared for how some of this attention would make them feel about themselves. Robin stated:

First of all it started off that you would walk down the street and men would whistle at you and I was really not that kind of a person. I did not like that. So in some ways it *made me feel cheap*, like it *made me feel not right about my body*. But other people were telling me that I looked great, you know?

Tanya also commented that she felt uncomfortable with this attention:

But even more so now like guys will just blatantly stare. And it’s more so than they did before. And I mean I knew that obviously they would be more noticeable. But I didn’t get it to attract the attention of strangers [...] And it’s one thing if a person is staring at your natural boobs, cause there is nothing you can do about it. But with fake boobs it’s like you got them and you know that they’re big, because you got them that way. And some people have the misconception that girls in general get them to attract

that sort of attention. When really that's not it at all. It's because I feel like they look better for me. And it makes me happier. Not because I can attract sleazes, you know?

Both of these excerpts reflect the tension between wanting to appear sexually attractive and being treated as a sexual object. On the one hand, the women wanted to receive, and did receive, positive attention from others regarding their post-surgical appearances. On the other hand, these women felt powerless, because they could not control the attention their surgically enhanced breasts elicited from men in general. The fact that the women surgically altered their breasts also complicated the women's feelings regarding this unwanted attention. As Tanya explains, the generally held misconception that women who undergo breast augmentation surgery desire attention from men (in any form) resulted in her feeling as though she could not defend herself against this sexual objectification, because it was understood by others that she wanted, and was responsible for, all of the attention (positive or negative) that she received.

This discussion is reminiscent of the victim-blaming of women who experience sexual assault, and the cultural understanding that it is the responsibility of women to prevent sexual violence. According to Carole Sheffield (2004), *sexual terrorism* is a "system by which males frighten and, by frightening, control and dominate females" (p. 410). The system of sexual terrorism operates in such a way that women are required to alter their behaviour and appearance, because women who do not take the "proper precautions" could be blamed for the sexual violence they experienced because they were "in the wrong place at the wrong time," or "wearing provocative clothing." In this study, some of the women's feelings of shame combined with the fear of being held responsible

for negative male attention, made them change the way they dressed.³² Leanne, who also underwent breast augmentation surgery, explained: “I was really embarrassed by the attention I got and I tried to hide my body. But, it’s hard to cover-up [your breasts], because with men that’s basically what they are looking at.” Leanne’s actions reflect that it is the responsibility of the victims of sexual objectification to prevent any further negative attention. If Leanne were to dress in ways that made her post-surgical breasts highly visible then she would likely be held accountable for the attention she received, because it would be assumed that she “asked for it.”

Some of the women also discussed that they received (unexpected) negative attention from sexual partners following cosmetic breast surgery. As was discussed in chapter three, a few of the women who underwent breast augmentation surgery did so following the intense urging of a male partner. Two of these women were extremely unhappy with this decision, and in part this was due to the reactions they received from their husbands following their surgeries. When asked what reaction she received from her husband following her breast augmentation surgery, and how this made her feel, Robin replied:

I didn’t expect quite the reaction that I got from him. I mean I expected him to be happy, but I didn’t expect him to be like jumping up and down happy. I just expected him to be like, “Oh yeah that’s great. You look good.” But, no, he was more like deliriously happy. It started me thinking about my marriage and thinking, “*Do I even know this man?*”

Robin felt slighted by her husband’s “deliriously happy” response to her surgically enhanced breasts. Her marriage ultimately ended in divorce, in part, because she could not reconcile within herself how her husband’s reaction to her post-surgical breasts made

³² The sexual objectification that women with large breasts often experience was one of the reasons many of the women in this study underwent breast reduction surgery. These women also spoke about trying to hide their large breasts by wearing certain clothing (see chapter three).

her feel about him and their relationship. She explained: “The more excited he got about it, the less I became. And that was definitely in my mind, because I was really ticked off that having new boobs is what it took to make him pay attention to me.”

Leanne also voiced that she was unsettled by the reaction she received from her husband following her breast augmentation surgery, but for a completely different reason:

Seriously, probably in the three years we were married I can probably count the amount of times we had sex on my hands. It was really disappointing to not be having a whole lot of sex [...] It was just surprising that he didn't touch me at all. I was really surprised. I was thinking *if you're going to get me to get breast implants, then use them. If you are going to buy a toy then play with it, especially since it is a very expensive one.* So yeah I was very surprised.

In contrast to Robin's experience, Leanne explained how she was unhappy with her husband's “non-response.” She felt hurt that he had requested she undergo breast augmentation surgery, only to discover that he did not find her more sexually attractive following her breast augmentation surgery.³³ Interestingly, Leanne describes her breasts as “toys” that her husband never “used,” reflecting the disembodied relationship Leanne had with her post-surgical breasts. This is perhaps not surprising, however, considering Leanne did not freely choose to undergo breast augmentation surgery, nor did she pay for the surgery, and thus her words might reflect the internalized feeling that her breasts are “owned” by her husband. Taken together, both of the women's experiences reflect a tension within feminine embodiment between embodying sexualized femininity and feeling like a disembodied sexual object.

It was not only women who underwent breast augmentation surgery who received negative attention post-surgery. A few of the women who underwent breast reduction surgery also recounted how their post-surgical breasts elicited negative attention from

³³ Leanne's marriage also ultimately ended in divorce.

sexual partners. Again, this negative attention did not result in the women regretting their decision to undergo breast reduction surgery completely, but it was nevertheless experienced as one of the main negative outcomes of cosmetic breast surgery. The women's experiences reflected that the negative male attention they received during sexual encounters often resulted because of the significant scarring that can follow breast reduction surgery. Janice explained:

Like to me the scars were never a concern, but I remember the first time that my boyfriend and I went to get into bed that he made a face. He made like a disgusted or repulsed kind of face. So basically anyone that I get in a relationship with now knows I have scars. And so going into a relationship with people you let them know you have the scars, and what they look like, and then most people don't care. The scarring is barely there now. But I will forever see him when I am with anybody else, just because of the face that he made.

Similarly, Janette discussed how her ex-husband contributed to her feeling self-conscious about the scarring on her post-surgical breasts. As a result, whenever she begins a relationship with other men she makes sure to tell them about the scarring before they become sexually involved. She explained:

I am a bit embarrassed about the scars and it has made me more reticent to get involved sexually. So that has been a negative thing I guess. But it has nothing to do with breast size, it is the scarring. It hasn't stopped me completely. But it has made me more reticent. I have to be pretty sure about the relationship before I will undress because the scars are there and you can see them. It is usually someone I have been with for awhile and they understand that that's what the package involves.

In contrast to the women described at the beginning of this chapter who felt that they were able to become freer sexually post-surgery, these women explained that post-surgery they were more cautious sexually, stating that they now employ strategies in order to control for unfavourable responses from sexual partners. As Janette explains, she often warns men about the scarring prior to sex in order that they will understand that this is

“what the package involves.” These two women’s experiences reflect that not only is there one size and shape of breasts that is desired above all others, but that the ideal breasts should also be completely free of any marks or scars. In other words, femininity should look effortless and natural. Thus, despite undergoing cosmetic breast surgery some of the women continued to be socially sanctioned for not perfectly embodying hegemonic femininity.

Conclusion

The women’s post-surgical experiences reflect that undergoing cosmetic breast surgery can “cut both ways.” In other words, the women’s decision to undergo cosmetic breast surgery resulted in both positive and negative outcomes. On the one hand, many of the women were able to experience their breasts in ways that they were unable to prior to surgery. These women discussed how post-surgery their body image improved, and how they began to feel more self-confident as they were able to dress and display their bodies in ways that allowed them to appear youthful, feminine, and sexually desirable. Some of the women also described how their new appearances received positive attention from others, and that they were able to reap real social rewards by conforming to idealized beauty norms.

On the other hand, the women also described enduring a great deal of pain and suffering post-surgery. As we saw in the previous chapter, many of the women experienced medical complications following cosmetic breast surgery, and a few of the women endured, and continue to endure, intense physical and emotional suffering as a result of surgery. In this chapter we have seen other negative outcomes that the women encountered following cosmetic breast surgery; some of the women were disappointed

when their post-surgical appearances failed to meet their own expectations, other women described increased feelings of inadequacy regarding other parts of their bodies following cosmetic breast surgery, and some of the women described receiving unwanted attention post-surgery, including negative attention from male partners during intimate relationships. Although these negative experiences did not always out-weigh the positive experiences, they did complicate the women's feelings regarding their decision to undergo cosmetic breast surgery. Finally, as I discussed above, none of the women stated that her post-surgery experience had been completely positive, reflecting that the benefits of embodying feminine beauty norms does not come without a price.

Chapter 7: Cuts Both Ways: Personal Gains and Political Losses

The colloquial saying it “cuts both ways” refers to a decision with both positive and negative outcomes. When trying to find a phrase or a statement to summarize all of the women’s experiences it was this one that seemed to fit the best. What was most clearly reflected by the women’s experiences was that undergoing cosmetic breast surgery is never a straightforward answer to a clear-cut problem. As we saw in the previous chapter the women’s experiences post-surgery reflect that undergoing cosmetic breast surgery “cuts both ways.” In other words, while all of the women experienced social rewards (at least for a period of time), they also suffered significant pain and paid substantial emotional and physical costs. In this final chapter I want to address a second way that the women’s decisions “cut both ways.” By bringing together the main findings from the previous chapters, I will address how the women’s personal gains ultimately came with political losses. In particular I will examine how the women’s individual acts of accommodation, though personally rewarding, had far reaching negative political consequences. I will then turn to a discussion of why there is reason to believe that despite the women’s acts of accommodation, there were also some important examples of resistance in the women’s narratives. I will conclude with a discussion of how this project is also a form of resistance as it is a way to make the women’s personal experiences political.

Personal Suffering

As we saw in chapter three, the women’s struggle with their appearances were framed by the women as personal issues rather than political issues. The women’s experiences reflect that while breasts are valued in our culture, there is one size and shape

of breast that is viewed as the most valuable and that is one which is large, but simultaneously round, firm, and perky. The women's breasts failed to meet this narrow standard, and they interpreted their inability to appear properly feminine as a reflection of their own personal inadequacy. By speaking to women who underwent breast reduction surgery and women who underwent breast augmentation surgery it was possible to examine how difficult it is for women to get femininity right and make it appear "natural." While the women who underwent breast reduction surgery had large breasts, they also sat "too low" on the women's chests, and many of the women complained that their pre-surgical breasts looked "old." Further, these women's breasts though large, were not firm, making them difficult to discipline simply with bras and clothing. In contrast, the women who were small-breasted prior to their breast augmentations complained that their breasts were lacking and thus they too were somehow "inadequate women" or lacking femininity. These women also felt that they were less sexually desirable, because of their small breasts, and despite the use of bras that fill-out, push-together, and push-up breasts these women were still unable to feel fully feminine or sexually desirable. The contrasting analysis in this regard provided a glimpse into the disciplinary practices of both large-breasted and small-breasted women and how our culture's narrow standards of beauty and normalcy intimately impacted the women's subjective experiences of their bodies and their decisions to undergo cosmetic breast surgery. Chapter three clearly showed that while the women's decisions to undergo cosmetic breast surgery were framed as personal solutions to personal problems, they were really acts to "get by" within a breast-obsessed culture where a woman's worth and value is largely measured by her appearance.

Thus, while the women were able to exercise agency in order to reap individual rewards, the women's complicity in the practice of cosmetic surgery ultimately resulted in the perpetuation of unjust beauty norms. In this sense, the women's actions reflect and reproduce a "breast-obsessed" culture, where a woman's breasts are seen to be symbolic of her worth and value, and their decisions contribute to competition among women as they uphold strict standards of beauty and normalcy that all women are judged against.

Medical Issues

In chapter four, it became clear that the women's appearance-related concerns were constructed not only as personal problems, but also as medical issues. The women's narratives reflected that the medicalization of healthy feminine breasts at both the institutional and interactional levels effectively masked the underlying social causes of the women's feelings of defect and abnormality. Indeed, the personal disorder, "booborexia," provided an extreme example of how medicalization individualizes and decontextualizes social problems. The women's experiences reflected that at the institutional level the mainstream media contributed to medicalization as it portrayed one size and shape of breast as normal, natural, and healthy. Rather than view these images as a means to keep women focused on their appearances, and increase consumerism, the women judged their own breasts against these idealized images and felt as though their breasts were abnormal or defective in comparison. The women's individual feelings of defect and abnormality were later confirmed at the interactional level when the cosmetic surgeons defined and treated their breasts as medical problems. The cosmetic surgeon's framed cosmetic breast surgery as a necessary or required procedure to "correct" the women's breasts to a "normal" and "healthy" size and shape.

However, the women were not passive victims of the media or the cosmetic surgery industry, but instead they were complicit actors who made constrained choices. Many of the women in this study exercised agency by seeking out cosmetic surgeons and their expertise, and by paying for the procedures themselves. As such, the women's demands for cosmetic surgery appeared to "fit" with the goals of the cosmetic surgery industry which operates in a consumerist society. Further, having their breasts treated as medical problems was individually rewarding as it granted medical legitimacy to the women's feelings of defect, and their decisions to undergo cosmetic breast surgery. Despite these gains however, the women ultimately perpetuated the medicalization of healthy feminine breasts. These women's actions thus "depoliticized" (Zola, 1981) their embodied experiences by constructing their decision to undergo cosmetic breast surgery as medically necessary.

Consumer/Patient Decisions

Finally, the women's narratives reflected that their decisions to undergo cosmetic breast surgery were understood to be individual consumer/patient choices. Within our increasingly market-based medical system (Conrad & Leiter, 2004) the women were expected to act as rational, competent decision-makers. On the one hand, this was viewed as positive by the women because it was a way for the women to exercise agency as they were able to "shop around" for cosmetic surgeons, gain knowledge about the procedure beforehand, and to some extent, manage risk and uncertainty prior to undergoing cosmetic breast surgery. In particular, the strategies the women employed to manage risk and uncertainty provided them with some degree of control over their bodies.

On the other hand, the women were really not given a choice but to accept their roles as competent decision-makers, because their decisions were framed as individual consumer choices, or “lifestyle” choices (Lupton, 1999). The women were conscious that they would be held accountable for any negative outcomes of their consumer/patient decisions, and thus these women attempted to control for negative risk possibilities in creative and resourceful ways. As we saw in chapter five, the women were unable to prevent negative outcomes, however, and the negative outcomes of their decisions were often blamed on the women. The personal responsibility discourse in relation to cosmetic surgery meant that the women were constructed as responsible for the pain and suffering that resulted from their decisions. Similar to treating the women’s feelings and decisions as personal or medical, by constructing the decision to undergo cosmetic surgery as the same as any other consumer decision, the women’s feelings regarding their breasts and their decisions to undergo cosmetic breast surgery were “stripped of their political content” (Reissman, 2003, p. 59).

Resistance in the “Culture of Cosmetic Surgery”

According to Rose Weitz (2003), “*accommodation* refers to actions that accept subordination, by either adopting or simply not challenging the ideologies that support subordination” (p. 137). The women’s decisions in this study were thus acts of accommodation, because the women chose to undergo cosmetic breast surgery without questioning how their individual acts might reproduce the current beauty system and the unjust standards of beauty and normalcy that uphold it. To be clear, I do not blame the women in this study for their unconscious reproduction of the current beauty system. In fact, I am sympathetic to their decisions and I acknowledge the personal gains the women

received through their complicity were significant. As we have seen in previous chapters, the women's experiences clearly reflect that accommodation is often far less threatening, and more individually rewarding, than resistance. As Weitz (2003) argues, "[c]ompared to resistance, accommodation offers women (and any other subordinate group) a far more reliable and safer route to power, even if that power is limited" (p. 148). In this study, accommodation offered the women a way to "get by" within a heterosexist culture that is based on unjust feminine beauty norms. The benefits the women incurred following cosmetic breast surgery included increased self-confidence and a better body image, being able to finally experience their breasts as "normal," feminine and sexually desirable, and increased success in both the job and dating markets.

The benefits of accommodation discussed above, however, direct us to the important question of whether or not meaningful resistance is possible. Weitz (2003) narrowly defines resistance as "actions that not only reject subordination but do so by *challenging the ideologies that support that subordination*" (emphasis in original, p. 137). In her research, Weitz found that some women engage in acts of resistance by "consciously adopting hairstyles (such as short 'butch' cuts or dreadlocks) in part to challenge the ideology that women's worth depends on their attractiveness to men and that women's attractiveness depends on looking as Euro-American as possible" (ibid). In the following section I will challenge this understanding of resistance, but before I do this, I want to outline two reasons why the women's narratives reflect that resistance may become ever more difficult within our current cultural context.

First, the women's experiences of medicalization point to the possibility that cosmetic surgery may become increasingly hard for women to argue against. The women's narratives suggested that undergoing cosmetic breast surgery is not just about

becoming more beautiful (although for some of the women it was a definite priority), but it is also about finally feeling like a “normal woman. The women’s experiences further pointed to the possibility that artificially enhanced breasts, an unnatural and unhealthy standard, are becoming culturally constructed as the standard of normalcy and health. A possible consequence of this unnatural standard is that women will be increasingly *required* to undergo dangerous and invasive cosmetic surgery procedures in order to conform to these narrow standards of normalcy. And, women who choose not to conform to these standards may be seen as complacent or irrational, and at risk of receiving appearance-related harassment. It becomes even more difficult for women to argue against surgical intervention when the procedure is not only framed by popular and medical discourses as *necessary* or even *required* in order to “correct” breast “abnormalities,” but is also covered by the healthcare system. A few of the women in this study who underwent breast reduction surgery reflected this line of thinking when they explained that it seemed irrational to *not* have breast reduction surgery because it was deemed “medically necessary,” and thus covered by the healthcare system.

Second, resisting cosmetic surgery becomes difficult when the medicalization of healthy feminine appearances is complemented by the normalization of cosmetic surgery procedures. As was discussed in chapter one, we are perhaps now living in a “culture of cosmetic surgery” (Blum, 2003). When I asked the women: “Given your experiences, and the knowledge you have now, would you choose to undergo cosmetic breast surgery again?” only three women stated that they would not choose to undergo cosmetic breast surgery again.³⁴ This means that the rest of the women in this study stated that they were

³⁴ These three women were Lindsey, Leanne, and Robin. These women’s experiences will be discussed in greater detail later in this chapter.

ultimately happy with their decision to undergo cosmetic breast surgery and that given their experiences and the knowledge they now possess, they would still choose to undergo cosmetic surgery. The majority of these women also commented that they would tell other women about their positive experiences, and recommend their cosmetic surgeon to other women who were interested in undergoing cosmetic breast surgery. Further, some of these women were even considering undergoing future surgeries to change the size and shape of their breasts.

That the women who were happy with their decisions were almost always willing to tell other women about their positive experiences and refer them to their cosmetic surgeons reflects how cosmetic surgery might become increasingly normative over the next few years. Unfortunately, the women's narratives point to the possibility that this will likely become just another way that women will police one another regarding their appearances. Further, that these women were willing to tell other women to go to their cosmetic surgeon reflects the importance that women play in the expansion of the cosmetic surgery industry. In a sense, these women's post-surgical breasts through before-and-after pictures, as well as in their day-to-day interactions with others, become "advertisements" for cosmetic surgeons and the cosmetic surgery industry, and the women themselves become living examples of the benefits that can be incurred from embodying feminine beauty norms.

Finally, some of the women explained that because they were happy with their decisions, they would undergo future cosmetic surgery procedures. As I discussed in the previous chapter this reflects how the women's struggle to embody feminine beauty norms becomes a "never-ending battle." This points to how the women may become "trapped" as their initial decision to undergo cosmetic breast surgery results in further

acts of accommodation. The women framed their desire to undergo future surgeries as a “normal” or “regular” form of “maintenance” or required “upkeep,” so as to not be neglected, unloved, and discarded because they had “passed their prime.” Framing cosmetic surgery as ordinary and mundane, and as necessary for medical reasons, or for essential “upkeep,” makes it increasingly difficult for women to resist. A woman who resists in this cultural context risks being constructed as someone who is complacent or acting irrationally, because what type of woman would choose not to “fix” or “maintain” their appearance when cosmetic surgery is presented as an accessible, effective, and necessary solution.

Is Meaningful Resistance Possible?

These women’s experiences and the ultimate result of their decisions affected me in ways that I did not expect when I initially started this project. What I found most frustrating about this project was how it felt as though the reproduction of the current oppressive beauty system and the norms which sustain it was inevitable. I put some of my thoughts and feelings down in a journal and when I reflected back on these journal entries I found that the emotion I most often felt was sadness. In one journal entry I wrote:

I am sad to live in a society that requires women to embody specific measurements. I am sad that it is through our appearances, and not our talents, skills or intelligence that we are able to gain power. I am sad that this power is fleeting as a woman’s physical capital surely will depreciate with age. I am sad that if I do not “buy in” then I will largely be viewed by others as complacent or ugly, rather than resistant.

The last line in the quote above regarding my ability to resist beauty norms was probably what affected me the most. I was sad and frustrated that the women’s narratives seemed to reflect that meaningful resistance was not likely, or even possible. I remember, in part,

that I also felt guilty, because while I questioned the women's decisions and wrote about how their decisions reproduced unjust beauty norms, I too continued to engage in acts of accommodation. In other words, I felt guilty because I was not a "good feminist" who uses her appearance as a means to resist unjust beauty norms.

At this point in time I was thinking about resistance as something that had to take form through "big statements." My ideas regarding resistance were framed by feminist writers such as Weitz (2003) who argue that resistance must be a conscious act, such as shaving your head to look "butch," in order to instigate effective change. This similar idea is put forth by feminist writers who argue that women could use cosmetic surgery as an effective tool of resistance. For example, Kathryn Pauly Morgan argues that feminist appropriation of cosmetic surgery could be used to "revalorize the domain of the 'ugly'" (p. 178). Specifically, she states that in order to produce any real social change it will require women to participate in "fleshy mutations" such as "having one's face and breasts surgically pulled down (rather than lifted), and having wrinkles sewn and carved into ones skin" (p. 179). These practices, she argues, would challenge dominant feminine beauty norms, and would be a means to demonstrate the "cultural commodification" and malleability of women's bodies (p. 180).³⁵

While my ideas regarding resistance were framed by feminist writers such as Weitz and Morgan, I never fully believed that this form of resistance was the answer, and thus I was left once again to wonder how meaningful resistance could take place. My main issues with using the body as a site of radical resistance have been outlined by other feminist writers. The first main problem, according to Llewellyn Negrin (2002), is that this approach "fails to give due weight to the materiality of the body" (p. 34), and thus it

³⁵ This form of resistance has been put into realization by feminist performance artist Orlan.

overlooks the risks and suffering that result from cosmetic surgery. Secondly, this approach conceptualizes the body as “infinitely transformable” (Negrin, 2002, p. 36) through the use of various technologies, and therefore it participates in the further commodification of the body. The idea that women can resist dominant conceptions of femininity through the use of cosmetic surgery is also problematic because it is a “rather ‘aristocratic’ form of revolt, which can only be engaged by those who have the freedom from economic need to be able to contemplate and realize different forms of embodiment” (p. 39). I agree with all of these contentions and I would add, as Kathy Davis (1997) does, that this form of resistance is a “utopian response” and it “ignores women’s suffering with their appearance” (p. 34). Davis further argues, and I agree, that this form of resistance is not compatible with the narratives of women who undergo cosmetic surgery. Davis states:

The visions presented by both Orlan and Morgan involve women who are clearly unaffected with by the crippling constraints of femininity. They are not dissatisfied with their appearance as most women are; nor, indeed, do they seem to care what happens to their bodies at all. For women who have spent years hating their excess flesh or disciplining their bodies with drastic diets, killing fitness programmes or cosmetic surgery, the image of ‘injecting fat cells’ or having the breasts ‘pulled down’ is insulting (p. 34).

In this same line of thought, Virginia Blum (2003) argues that feminists “who urge us to resist are never tantalized by a surgical solution in the first place, so they aren’t really resisting much of anything” (p. 62). Finally, and most importantly, this “utopian” feminist response to cosmetic surgery distances us from “the more mundane forms of protest,” and fails to recognize and appreciate the less radical forms of resistance women engage in on daily basis (Davis, 1997, p. 35).

Individual Acts of Resistance

Through this project, and my reading of feminist work on meaningful resistance, I came to the conclusion that we need to look for resistance on a smaller scale, and recognize the less radical forms of resistance as meaningful and useful forms of protest. In other words, I do not believe that as feminists we should give up our search for meaningful resistance against dominant Western beauty standards. Instead I think we should take hope in McLaren's (2002) statement that resistance could potentially come from "everywhere," it could come from "alternative discourses, from accidents and contingencies, from gaps between various ways of thinking, from gross material inequality, and from recognizable asymmetries of power" (p. 116).

With this conceptualization of resistance in mind I want to acknowledge how on closer analysis it was clear that the women's narratives were not only filled with acts of accommodation, but also of resistance. The three women who stated they would not undergo cosmetic breast surgery again knowing what they know now, provided meaningful counter-examples to the other women's narratives. Robin was the one woman I talked to who explained that she participated in the interview specifically as an act of protest. As was discussed previously, Robin chose to have her implants removed following severe medical complications. She explained to me that she wants to participate in research such as mine, because it allows her to tell her story, and in so doing challenges how people think about cosmetic surgery. She stated: "This will be the third study that I have been involved in so that people know, and so that people can hear what can happen." For Robin, her participation was a political protest, and an attempt to make other women question their reasons for undergoing cosmetic breast surgery in the first place.

Lindsey provides another example of how less radical forms of resistance can be meaningful. When she underwent cosmetic breast surgery she was 25 years old and at this point in her life she believed that changing her physical appearance would improve her marriage. Now reflecting back on her experiences, she explained that she would not undergo cosmetic breast surgery again because it did not actually repair the part of her marriage that she hoped it would. At the end of the interview Lindsey explained: “I wouldn’t do it again, knowing what I know now. Now that I am in mid life, and now I can weigh it in the overall big picture, I’ve realized that it wasn’t such a big deal as it was back then.” According to Lindsey, having the perfect size and shape of breasts is not “such a big deal” anymore, because her appearance is no longer the sole source of her self-confidence and feelings of self-worth. She explained that over the course of her life she has come to realize that her most important accomplishments were not dependant upon her appearance. By sharing her experience, Lindsey provides a glimpse into how women’s ideas regarding appearance may change over the course of their lives, and challenges the idea that a woman’s worth and value is based on her appearance.

Leanne’s story provides a final example of why it is important to acknowledge the less radical forms of resistance that women engage in. As was discussed in chapter five, Leanne chose to have her implants removed after one of her implants ruptured. When I asked her how she felt about the decision to remove the implants she explained:

When I had them removed I felt healthier than I had felt in a long time. Like they were there and they shouldn’t have been there. It was weird cause I don’t know if that’s how I should have felt, but that’s how I felt. Like there is nothing that’s not supposed to be in my body that’s in my body. And so I felt healthier, and it was really neat. I didn’t realize that I would feel that way.

By sharing her experience, Leanne provides an example of the possible benefits that can be gained through acts of resistance. Taken together these three women provide hopeful examples of how women can engage in less radical, but nonetheless, meaningful acts of resistance. Although these women's subtle acts of resistance may seem insignificant, it should be kept in mind that these women provide important and meaningful counter-examples to the women who stated they would continue to undergo future cosmetic surgery procedures and promote the benefits of cosmetic surgery to others.

“Beauty Secrets”: The Personal is Political

Finally, this project itself is a form of resistance and a meaningful political protest against the current beauty system and the unjust feminine beauty norms which uphold it. Just a little over twenty years ago Wendy Chapkis (1986) stated that a woman who fails to conform to standards of beauty in our male-dominated culture is “not only Other she is Error,” because she is “flawed both by her failure to be a normal male and in her inability to appear as a normal female” (p. 5). She went on to explain that women's private suffering with their appearances is political, and thus we need to go beyond “private solutions” (p. 3). In her book *Beauty Secrets: Women and the Politics of Appearance*, she argues that we must “break the silence” and share our “beauty secrets” as a way to deconstruct the current oppressive beauty system. She states: “In sharing our beauty secrets, our fears and fantasies, we act in the best tradition of feminist defiance and ensure that appearance remains a political not merely a personal concern” (p. 177).

This project has provided the women who participated in it with the rare opportunity to openly share their most intimate “beauty secrets.” I say “rare opportunity” because although women often discuss their beauty secrets in relation to the use of make-

up or fashion, there is less discussion surrounding the practice of cosmetic surgery. Many of the women who participated in this study expressed their gratitude for being able to share their experiences in a safe environment free from judgment. As I mentioned in chapter two, for several of the women in this study, the interview provided the first opportunity in the women's lives to discuss their experiences. For these few women their decision to undergo cosmetic breast surgery had remained a secret for far too long, and they were grateful to finally get it "off their chests." I think that all of the women found the opportunity to share their beauty secrets to be a liberating experience. The women also felt comforted and validated by the fact that there were other women who were sharing similar stories regarding their bodies and their decisions to undergo cosmetic breast surgery. Within the interviews I experienced, along with the women involved, rare moments when we could see that we were not alone in our appearance-related struggles.

Before I began interviewing women I was warned by a member of the ethics committee that cosmetic surgeons might take issue with my project as it might portray them individually, and their profession as a whole, in an unfavorable light. While these concerns proved to be unfounded, the fact that I received this mild resistance reflects the power inherent in the telling of these women's stories. I now recognize the power of this project as a way to bring women's "beauty secrets" to the forefront and make the personal political. In this thesis I have attempted to show that framing the decision to undergo cosmetic breast surgery as a personal choice, or a medical solution, or as a mundane consumer decision is to mask the political importance of the women's decisions, and to obscure the social reasons underlying the women's decisions to undergo cosmetic breast surgery. In so doing, I have tried to show the connection between the personal, subjective experiences of individual women with the politics of a beauty system that operates on

unjust feminine beauty norms. Thus, this project is a meaningful form of resistance as it helps to ensure that women's suffering with their appearances, and their engagement in extreme beauty practices, remains a political concern.

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Appendix I: Biographical Information

Barbara underwent breast reduction surgery in 2004 when she was 23 years old. In 2004 she was engaged to be married and a full-time undergraduate student. At the time of the interview Barbara was 25 years old, single, and working as a florist, but trying to find work as a teacher.

Brandi underwent breast reduction surgery in 2004 when she was 19 years old. In 2004 she was single and a full-time undergraduate student. At the time of the interview Brandi was 21 years old, single, and finishing her fourth year of her undergraduate degree.

Chantelle underwent breast reduction surgery in 1999 when she was 21 years old. In 1999 she was single and a full-time undergraduate student. At the time of the interview Chantelle was 28 years old, single, and working as a food inspector.

Danielle underwent breast reduction surgery in 2000 when she was 39 years old. In 2000 she was single following a divorce and worked as a hairstylist. She has a college level education, and she is a single mother of two children, both of which she gave birth to before she underwent breast reduction surgery. At the time of the interview Danielle was 45 years old, and she continues to work as a hairstylist.

Diane underwent breast augmentation surgery (with saline implants) in 1999 when she was 27 years old. In 1999 she worked as a waitress and was dating her current husband. She has a high-school education, and has taken some college level courses over the years. At the time of the interview Diane was 34 years old and a full-time mother of two children, both of which she had after she underwent breast augmentation surgery.

Jamie underwent breast reduction surgery in 2003 when she was 21 years old. In 2003 she was single, and a full-time graduate student. At the time of the interview Jamie was 24 years old, in a relationship, and working towards her PhD.

Janette underwent her initial breast reduction surgery in 1993 when she was 40 years old. In 1999 she underwent a second surgery to reduce the size of her breasts and to treat the keloid scarring that resulted after the first surgery. At the time of Janette's initial surgery (1993) she was married, and at the time of her second surgery (1999) she was separated from her husband. In 2006 she was 53 years old, divorced, and a practicing lawyer with both an undergraduate degree and a law degree.

Janice underwent breast reduction surgery in 2004 when she was 20 years old. In 2004 she was in a relationship, and a full-time undergraduate student. At the time of the interview Janice was 22 years old, single, and was finishing her undergraduate degree.

Karen underwent breast reduction surgery (one breast was reduced and the other breast was lifted) in 2003 when she was 30 years old. In 2003 she was married, and had just completed her undergraduate degree. Between 2003 and 2006, Karen went through a divorce, and then later met her current common-law partner. At the time of the interview she was 33 years old, and working as a pharmaceutical sales representative.

Kelsey underwent breast reduction surgery in 1999 when she was 16 years old. Between 1999 and 2006, Kelsey completed high school and went on to receive a college diploma. At the time of the interview she was 23 years old, single, and working as a retail salesperson.

Larissa underwent breast reduction surgery in 1998 when she was 24 years old. In 1998 she was dating her current husband, and was a full-time undergraduate student. At the time of the interview Larissa was 32 years old, with two children, both of which she gave birth to after her breast reduction surgery. She has an undergraduate degree and works as a college instructor.

Leanne underwent breast augmentation surgery (with saline implants) in 1994 when she was 18 years old. At this time she was married and a full-time college student. Shortly after her breast augmentation surgery Leanne divorced her husband. In 2002 one of the implants ruptured, and she underwent surgery to have the saline implants removed. At the time of the interview she was 30 years old, and married to her second husband. She has a college diploma and is currently a stay-at-home wife.

Lenore underwent reconstructive surgery following a mastectomy (one breast was augmented with a saline implant and the other breast was reduced) in 2000 when she was 44 years old. At the time of the interview she was 50 years old, divorced, with three adult children. Lenore has a college diploma, and was on disability allowance in 2006, but was trying to get back into the workforce.

Lindsey underwent breast augmentation surgery in 1987 when she was 25 years old. She is unsure if her breasts were augmented with saline or silicone implants. In 1987 she was married to her current husband, and was a full-time mother of two children. At the time of the interview Lindsey was 44 years old, and recently gave birth to her third child. She has a college diploma, and is a full-time mother.

Lisa underwent breast reduction surgery in 1997 when she was 23 years old. In 1997 she was single and working as a waitress while finishing her college diploma. At the time of the interview Lisa was 32 years old, married, with one child who she had after her breast augmentation surgery. She has a college diploma and currently works as an administrative assistant.

Marcy underwent breast reduction surgery in 2002 when she was 67 years old. At the time of the interview she was 71 years old, divorced, with two adult children. Marcy has a high-school education, and she worked as a bank teller prior to retiring.

Marilyn underwent her initial breast augmentation (with saline implants) in 1977 when she was 28 years old. In 1977 she was married with two young children. In 1978 she underwent a “capsulotomy” to “break up” the scar tissue that formed around the implants. In 1979 she underwent surgery to have the saline implants removed and replaced with silicone implants. At the time of the interview Marilyn was 57 years old, and she continues to be happily married. She has a college diploma and worked as an x-ray technician prior to retiring.

Nancy underwent breast augmentation surgery (with saline implants) in 2000 when she was 40 years old. At the time of the interview she was 46 years old, married, with two children, who she gave birth to before undergoing breast augmentation surgery. Nancy has a graduate degree, and is currently a full-time mother.

Natalie underwent breast reduction surgery in 2000 when she was 21 years old. In 2000 she was in a long-term relationship, and was a full-time undergraduate student. At the time of the interview Natalie was 27 years old, in a common-law relationship, and was working as an urban planner while finishing a graduate degree.

Robin underwent breast augmentation surgery (with silicone implants) in 1974 when she was 20 years old. In 1974 she was married with one child, and then she gave birth to her second child shortly after her breast augmentation surgery. From 1991-1992 she began experiencing serious complications related to the silicone implants, and in 1993 she underwent surgery to have the implants removed. At the time of the interview Robin was 52 years old, and divorced. She has a college level education and works as a financial consultant.

Tanya underwent breast augmentation surgery (with silicone implants) in 2004 when she was 25 years old. In 2004 she was dating her current husband, and working as a bartender while finishing a graduate degree. At the time of the interview she was 27 years old and recently married. Tanya has a graduate degree and works as a hairstylist and a bartender.

Tara underwent breast augmentation surgery (with saline implants) in 2005 when she was 25 years old. In 2005 she was in a common-law relationship with her current partner, and worked as a secretary and a waitress. At the time of the interview she was 26 years old. Tara has a college diploma and was working as a waitress in 2006, but was planning on going back to school later that same year.

Teresa underwent breast augmentation surgery (with saline implants) in 2005 when she was 28 years old. In 2005 she was married to her current husband and had two children, who she had prior to her breast augmentation surgery. At the time of the interview she was 29 years old. Teresa has a high school diploma, and works as a day-home provider.

Tracy underwent breast augmentation surgery (with saline implants) in the same year as the interview (2006), when she was 21 years old. At the time of the interview she was a single mother of one child who she gave birth to prior to undergoing breast augmentation surgery. Tracy has a college diploma and works as a hairstylist.

Appendix II: Interview Guide

I would like to begin the interview by asking you some general information about yourself. Please be assured that this information is not meant to identify you in any way. I also want to assure you that we can skip any questions which make you feel uncomfortable, and please feel free to add in anything you think is important.

General Information (approximately 5- 10 minutes)

- a) What is your age? What was your age at the time of your breast augmentation/ breast reduction surgery?
- b) What is your relationship status? (single, married, common-law, same-sex relationship, divorced, widowed) What was your relationship status at the time of your surgery?
- c) What is your occupation? Is this the same occupation you had at the time of your surgery? If not, what was your occupation at the time of your surgery?
- d) What is your level of completed education? What was your level of completed education at the time of your breast augmentation/breast reduction surgery?
- e) Do you have any children? If so, did you have your child/children before or after your breast augmentation/breast reduction surgery?

Now we can start dealing with your breast augmentation/breast reduction surgery. I want to break this interview down into a sequence of before, during and after your surgery. Please understand, however, that this is a flexible interview. If you wish to add something to the interview, please do so without hesitation. I am going to start with the period prior to your breast augmentation/breast reduction surgery. Are you okay to begin?

***Note: Follow-up questions will only be asked when further information or clarification is required.**

I. Before the Surgery (approximately 30-40 minutes)

- a) *How did you feel about your body, and more specifically your breasts, prior to your breast augmentation/breast reduction surgery?*

Follow-up questions: When would you say you began to feel dissatisfied with the appearance of your breasts? How did you feel about your breasts during puberty? How did you feel about your breasts in adulthood? Was there any pivotal event that you can recall that might have made you start to think about surgery?

- b) *How long before your actual breast augmentation/breast reduction surgery did you begin to consider undergoing cosmetic surgery?*

- c) *Is there a specific experience that comes to mind that played an important role in your decision to undergo cosmetic surgery?*

Follow-up questions: Was there ever a conversation you had with someone that prompted you to look into undergoing surgery on your breasts? Were

there ever comments made by someone about your body that made you consider having breast augmentation/breast reduction surgery?

d) *Did anyone in particular impact your decision to undergo breast augmentation/breast reduction surgery? (partner, friend, family member, physician, other- specify) How? Please explain*

e) *Could you please describe, if applicable, how the media impacted your decision to undergo cosmetic surgery on your breasts in any way? Could you provide a specific example?*

f) *Can you describe how people in your life (partner, friends, family members) reacted when you told them you were going to have breast augmentation/breast reduction surgery?*

Follow-up questions: What sort of comments (if any) did they make? Can you describe in what ways they supported your decision? If applicable, can you tell me about an experience where someone tried to talk to you out of your decision?

g) *What kind of research, if any, did you do on breast augmentation/breast reduction surgery prior to your operation?*

Follow-up questions: Any research on the Internet? Did you read any publications on breast augmentation/breast reduction surgery? Can you describe, if applicable, a conversation you had with someone who had undergone breast augmentation/breast reduction surgery?

h) *How did you go about finding a cosmetic surgeon to perform your breast augmentation/breast reduction surgery?*

Follow-up questions: Were you referred to this surgeon by a former patient? Did you find this surgeon on your own through a website, or advertisement, or article?

i) *How did you feel about your interactions with your cosmetic surgeon prior to your operation?*

Follow-up questions: Do you feel that you were treated with respect, and if so what sort of experiences made you feel this way? Do you recall feeling comfortable with your cosmetic surgeon, and if so what did he/she do to make you feel comfortable? Did you feel that your comments and concerns were taken seriously? Were you nervous, and if so, why?

j) *How did you feel about your interactions with the nursing staff prior to your operation?*

Follow-up questions: Do you feel that you were treated with respect, and if so what sort of experiences made you feel this way? Do you recall feeling comfortable with the nurse(s), and if so what did they/he/she do to make you feel comfortable? Did you feel that your comments and concerns were taken seriously? Were you nervous, and if so, why?

k) *What information did you receive from medical professionals regarding breast augmentation/breast reduction surgery?*

Follow-up questions: Were you provided with information (verbal and/or written) regarding the pain involved with the surgery? Did you receive information (verbal and/or written) regarding the risks of breast augmentation/breast reduction surgery? Were you provided with information (verbal and/or written) regarding potential loss of sensation? Were you given

any information (verbal and/or written) regarding breast-feeding after your breast augmentation/breast reduction surgery? (The next two follow-up questions only apply to participants who underwent breast augmentation surgeries): Were you provided with any information (verbal and/or written) regarding the potential difficulty of detecting breast cancer after your breast augmentation surgery? Were you provided with any information (verbal and/or written) regarding the inevitability of future cosmetic surgeries on your breasts following breast augmentation surgery? And how did this information make you feel?

l) How did you decide what size and shape you wanted your breasts to be?
Follow-up questions: Could you describe if applicable, in what ways images in the media (magazines, internet, TV) helped you decide on the size and shape you wanted? Could you describe, if applicable, how your cosmetic surgeon impacted your decision-making regarding the size and shape of your breasts? Could you describe, if applicable, the experience of having someone (partner, friend, family member) help you decide on the size and shape you wanted your breasts to be after surgery? And how did this make you feel?

m) What sort of financial arrangements did you have to make in order to afford your breast augmentation/breast reduction surgery?

Follow-up questions: Did you save enough money to pay for your surgery completely? Were you able to receive any coverage to undergo surgery on your breasts? Did you take out a loan to pay for your breast augmentation/breast reduction surgery? Did someone else (partner, friend, family member) pay for your breast augmentation/breast reduction surgery?

n) What arrangements did you have to make in order to take time off from work in order to have your surgery?

Follow-up questions: Did your employer give you the time off? Did you use your vacation time, or sick leave in order to have the surgery?

o) What were your expectations prior to undergoing the surgery?

Follow-up questions: What were your expectations in terms of the look, and the feel of your breasts post-surgery? What were your expectations in terms of pain?

Now I want to go on to the time of the surgery itself. For now, I would like to talk about the immediate experience, but if something is triggered for you, please go ahead with that thought or feeling. Are you ready to proceed?

II. *The Surgery (approximately 15-20 minutes)*

a) What sort of feelings/emotions did you experience immediately before your surgery?

Follow-up questions: Did you feel confident about your decision at this point? Were you feeling: nervous, worried, scared, excited, happy, relieved, sad, ambivalent?

b) What sort of feelings/emotions did you experience immediately following your surgery?

Follow-up questions: How did you feel about your decision immediately after the surgery? Were you feeling: nervous, worried, scared, excited, happy, relieved, sad, ambivalent?

c) *What were your experiences of pain immediately following the surgery?*

Follow-up questions: Was the pain what you expected? Did your Surgeon adequately inform you regarding the pain you would experience following the surgery?

d) *Did you feel the information you were given by the medical staff prior to your release from the hospital/clinic was adequate?*

Follow-up questions: Were you given adequate information regarding pain treatment? Were you given sufficient information regarding recovery time? Were you given enough information regarding possible complications that might arise?

e) *How long was your recovery time after the surgery? When were you able to function as you had prior to your breast augmentation/breast reduction surgery?*

f) *Did you require anyone to assist you during your recovery?*

Now I would like to talk about your experiences following your breast augmentation/breast reduction surgery. Again, please feel free to add anything you think is important, to take your time in going through these questions, or to stop at any time. Are you okay to proceed?

III. After the Surgery (approximately 30-40 minutes)

a) *How did you feel about the appearance of your breasts after the surgery?*

Follow-up questions: What are your feelings surrounding the size and shape of your breasts? Are your breasts what you had hoped for in terms of their appearance? Why/why not? Could you describe, if applicable, your feelings surrounding the scarring after your breast augmentation/breast reduction surgery?

b) *Please describe to me, if applicable, how the sensation of your breasts and nipples has changed since undergoing breast augmentation/breast reduction surgery. What are your feelings about this?*

Follow-up questions: Is the sensation as good/better as before in terms of the feel? Why/why not?

c) *Could you explain to me how you thought your life would be different following the surgery? And could you describe how your life did or did not change how you expected it would after your surgery?*

d) *Please describe for me how you feel your breast augmentation/breast reduction surgery has impacted your overall body image.*

Follow-up questions: Could you describe, if applicable, how you experience your body differently since undergoing breast augmentation/breast reduction surgery? Do you feel more comfortable in your body now than you did before the surgery? Why/why not? Do you feel more confident now than you did before your breast augmentation/breast reduction surgery? Why/why not?

e) *Has your breast augmentation/breast reduction surgery impacted the way you dress? If so, could you provide any specific examples?*

- f) *What is your knowledge regarding potential complications following your breast augmentation/breast reduction surgery? How do you feel about these possibilities?*
- g) *I am going to name some individuals and groups, which might have responded to your breast augmentation/breast reduction surgery. Please tell me what their response was, and what your feelings were about that reaction.*

- *Please describe for me the response you have encountered from your partner (if applicable). What are your feelings about that?*

Follow-up questions: Do you feel that your partner has been supportive? What sort of comments, if any, has your partner made about your decision, and how does that make you feel? What sort of comments, if any, has your partner made about your body and your breasts since the surgery, and how do those comments make you feel? Do you think that your partner finds you more/less attractive since your breast augmentation/breast reduction surgery, and how does that make you feel? Do you feel that your partner acts differently towards you now than he/she did prior to your breast augmentation/breast reduction surgery? And if so, could you describe some specific examples? Was your partner's reaction to your breast augmentation/breast reduction surgery what you had expected? Why/why not? And how do you feel about this?

- *(If currently single) Please describe for me the response you have encountered from people you have dated (or are currently dating) since the surgery. What are your feelings about that?*

Follow-up questions: Could you describe, if applicable, some of your experiences with dating that you feel are related to your breast augmentation/breast reduction surgery? What sort of comments, if any, have people you have dated (or are currently dating) made about your body and your breasts since the surgery? And how did these comments make you feel? Was the reaction you received from people you have dated since the surgery what you expected? Why or why not? Could you describe, if applicable, why you feel more/less comfortable dating now than you did prior to your surgery? Could you describe, if applicable, why you feel dating is more/less enjoyable for you now than it was prior to your breast augmentation/breast reduction surgery?

Did your breast augmentation/breast reduction surgery impact your sex life? And if so, can you please explain how?

Follow-up questions: Is your sex life more/less enjoyable now than prior to your surgery? And if so, why do you think this is? Do you feel more/less sexually attractive now than prior to your surgery? And if so, why? Do you think your partner finds you more/less sexually attractive now than prior to your surgery? And if so, why?

- *Please describe for me the response you have encountered from your friends. What are your feelings about that?*

Follow-up questions: Do you feel that your friends have been supportive? What sort of comments, if any, have your friends made about your decision to undergo cosmetic surgery and how does that make you feel? What sort of comments, if any, have your friends made about your body, and your breasts since the surgery, and how does that make you feel? Do you think that your friends act differently towards you since your breast augmentation/breast reduction surgery? And if so, could you provide any examples? Was the reaction you received from your friends what you had expected? Why/why not? And how did you feel about their reactions?

- *Please describe for me the response you have encountered from your family. What are your feelings about that?*

Follow-up questions: Do you feel that your family has been supportive? What sort of comments, if any, have family members made about your decision to undergo breast augmentation/breast reduction surgery, and how does that make you feel? What sort of comments, if any, have family members made about your body and your breasts since the surgery, and how do those comments make you feel? Do you think that your family acts differently towards you now than they did before your breast augmentation/breast reduction surgery? And if so, could you describe some examples? Was the reaction that you received from family members what you had expected? Why/why not? And could you describe how their reactions made you feel?

- *Please describe for me the response you have encountered at your workplace (if applicable). What are your feelings about that?*

Follow-up questions: Were people at your workplace (employers, employees) supportive? What sort of comments, if any, did people at your workplace make about your decision to undergo breast augmentation/breast reduction surgery, and how did that make you feel? What sort of comments, if any, have people at your workplace made about your body and your breasts since the surgery, and how do those comments make you feel? Do you think that people at your workplace act differently towards you now than they did before you had breast augmentation/breast reduction surgery? If so, could you please describe any specific examples that you can recall? Was the reaction you received at your workplace what you had expected? Why/why not? And could you describe how the reactions you received at the workplace made you feel?

- h) *What were your experiences surrounding breast-feeding after having undergone breast augmentation/breast reduction surgery? (If respondent does not have children, then skip to next question).*

Follow-up questions: Were you able to breast-feed? If so, could you describe some of your experiences with breast-feeding? If you chose not to breast-feed, what were your reasons for this? Were you told by your cosmetic surgeon, or

another medical professional, that you may be unable to breast feed? And if so, how did this make you feel? Could you describe, if applicable, what your concerns were regarding breast-feeding and your breast augmentation/breast reduction surgery? Were you worried that breast-feeding would alter the size and shape of your breasts, and if so what were some of your concerns?

i) *Could you please describe to me, if applicable, any concerns you have regarding breast-feeding after having undergone breast augmentation/breast reduction surgery?*

Follow-up questions: What are some of your feelings surrounding breast-feeding? Did your cosmetic surgeon, or another medical professional, tell you that you may be unable to breast-feed? And how did this make you feel? Are you concerned that breast-feeding will affect the size and shape of your breasts, and if so what are some of your concerns? Do you think that you will breast-feed if you have children?

j) *If applicable, can you describe to me any medical complications, not already mentioned, that resulted from your breast augmentation/breast reduction surgery?*

k) *Could you tell me about some of the unintended consequences that have arisen since your breast augmentation/breast reduction surgery?*

Follow-up questions: Did you have any experiences, feelings, reactions that occurred due to your breast augmentation/breast reduction surgery that you weren't expecting? And if so, could you describe some of these to me?

l) *What would you say to other women (including family and friends) who are considering undergoing cosmetic surgery on their breasts?*

Follow-up questions: Would you encourage other women to undergo breast augmentation/breast reduction surgery? Why or why not? What advice would you give women considering the procedure?

m) *Given your experiences, and the knowledge you have now, would you choose to undergo breast augmentation/breast reduction surgery again? Why or why not?*

I want to sincerely thank-you for taking the time to share your experiences with me. It is possible that I might need to do some follow-up work with you in order to clarify certain points, or to make sure I have properly understood what you have told me.

This follow-up work would simply involve a short (10-20 minute) telephone conversation. Would you be available for a follow-up?

Thank-you again for your time, and your willingness to participate in this research project.

Appendix III: Face Sheet

Date:

Contact Information:

Name: _____

Address: _____

Phone: _____

General Information:

Breast Augmentation Surgery _____

Breast Reduction Surgery _____

Age: _____

Age at time of surgery: _____

Relationship Status: _____

Relationship Status at time of surgery: _____

Occupation: _____

Occupation at time of surgery: _____

Level of Completed Education: _____

Level of Completed Ed at time of surgery: _____

Children? Yes or No

Children before surgery _____

Children after surgery _____