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Facial Cosmetic Surgery: Women's Voices, Women's Choices

By
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A Thesis
Submitted to the Faculty of Graduate Studies

In Partial Fulfillment of the Requirements of the Degree of
Master of Arts

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FACIAL COSMETIC SURGERY: WOMEN'S VOICES, WOMEN'S CHOICES

BY

DIANE CEPANEC

A Thesis submitted to the Faculty of Graduate Studies of The University

of Manitoba in partial fulfillment of the requirements of the degree

of

MASTER OF ARTS

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ABSTRACT

Population aging has generated an increasing number of potential consumers for cosmetic surgery, the majority of whom are women. To date, little research has examined women's experiences with facial cosmetic surgery. This study draws upon findings from a qualitative study about facial cosmetic surgery among 10 women (ages 23-73) living in Manitoba, Canada. In-depth interviews were conducted to explore the personal, social, cultural and economic influences on women's decision-making processes to have facial cosmetic surgery. Thematically both individual factors and social forces were found to influence women's decisions. At the level of the individual, decision justification, self-identity, agency and choice were identified as key themes. These individual factors, however, were clearly integrated into both society's negative evaluation of age-related changes in women, and cultural images of beauty. As well, social forces such as the role of the medical profession, and the influences of social relationships and cultural images of beauty and aging were strongly implicated in women's decision-making processes. These women's accounts of facial cosmetic surgery allow for issues surrounding women's bodies to be addressed, and they illustrate the interconnections between individual agency and social structure. This study contributes to a greater understanding of women's involvement with facial cosmetic surgery. It also provides insights for the sociology of the body through the use of three dominant perspectives– the naturalistic, social constructionist and phenomenologica, thereby highlighting the significance of embodied social action.

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This long journey would not have been possible without the support and encouragement of many people. I would like to thank each of the ten women who offered their time and their stories. This project would not have been possible without their commitment.

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To my partner Ken, thank-you for the inspiration to persevere and accomplish the goals I have set out. This journey would have been lonely without your support and love.

Finally, I would like to dedicate this thesis to my two nieces, Bryarre and Geneva, who I can only hope will grow up in a society where women are valued and value themselves for more than their physical appearance.

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CHAPTER ONE

Introduction

Cosmetic surgery is the fastest growing medical specialty in North America (Lefebvre, 1995; Sullivan, 1993) and over 80 percent of the current recipients of cosmetic surgery are women (The American Society of Plastic and Reconstructive Surgeons, 1994). The current lucrative market for cosmetic surgeons consists primarily of "baby boomers" (born between 1946 and 1966). "Baby boomers" are the largest cohort in the Canadian population and will continue to be so until the middle of the next century (McKie, 1993). In short, population aging has generated an increasing number of potential consumers for cosmetic surgery, the majority of whom are women.

Even though men are increasingly undergoing this procedure, the overwhelming majority of surgeries are performed on women. In North America, cultural expectations influence and regulate behaviors related to physical appearance resulting in cosmetic surgery being required for women in ways that it is not required for men (Kirkland & Tong, 1996). For example, women have a long tradition of going to extreme lengths to improve and transform their bodies to meet the cultural requirements of femininity, even if in the process they may compromise their health. For women, standards of physical attractiveness are cultural creations that are more stringent and more connected to youth than they are for men (Deutsch, Zalenski & Clarke, 1986). According to Goodman (1994: 377):

> Two factors further guarantee that women will increasingly rely on cosmetic surgery to meet cultural demands for bodily perfection and youthfulness. First, we have disengaged aging from its moorings as a natural, time-ordered, and predictable process. Second, we have shifted our view of the body as personal and immutable to something impersonal and highly alterable.

At the close of the 20th century, North American women are living in a cultural milieu that supports and encourages them to invest heavily in their appearance.

Objectives

This research is centered on women's involvement with facial cosmetic surgery. The main purpose of this thesis is to explain women's involvement with facial cosmetic surgery. The objectives of the study are:

1. to explore how women account for their decision to have facial cosmetic surgery;
2. to understand the social, economic, cultural and individual factors that influence women's decisions to seek facial cosmetic surgery; and
3. to consider what can be learned about the relationship between women and their bodies based on their involvement with cosmetic surgery.

The relevance of this study is related to the increasing number of women who are electing to have cosmetic surgery, and the expected continuance of baby boomer's use of this technology in later life (Goodman, 1994). The information generated in this study contributes a Canadian dimension to work done previously in the United States (Goodman, 1994; 1996) and the Netherlands (Davis, 1995). As no studies of Canadian women's experiences with cosmetic surgery have been reported, this research yields insights into the social, economic, cultural and individual factors that shape a sample of Canadian women's decisions to undergo facial cosmetic surgery. This research also contributes to theoretical developments in the sociology of the body. At a practical level, cosmetic surgery is an important issue for women and this research has the potential to equip women to make more informed choices when making decisions about facial cosmetic surgery.

Overview

To understand women's decisions to have cosmetic surgery, the procedure must be placed within the social, economic and cultural context in which women's decisions are made. As such, the first section of Chapter Two examines social, economic and cultural factors which may influence women's decisions to have cosmetic surgery. The focus shifts in the second section of Chapter Two to the existing literature on cosmetic surgery that seeks to explain women's involvement with cosmetic surgery. In doing so, the discussion outlines the work of several authors who have studied women's experiences with cosmetic surgery. The third section in the chapter turns to insights offered by recent writings on the body in sociology to provide the theoretical foundation for this research project. Chapter Three expands the discussion by outlining the research design and data analysis strategy. Chapter Four presents the findings of this study. The findings are discussed by drawing upon the voices of women who have undergone cosmetic surgery. In this chapter, the aim is to develop an understanding of their decision-making process. Chapter Five expands the discussion by relating the findings to the three research questions that guide this study. It begins with revisiting the findings discussed in Chapter Four followed by a theoretical discussion on women's bodies within the lived experiences of women who participated in this study. The discussion emerges from both from an analysis of women's accounts and existing theory, particularly theoretical insights derived from the sociology of the body. Finally, Chapter Five concludes with the strengths and limitations of this study, practical implications and recommendations for further research.

CHAPTER TWO

Literature Review

Cosmetic Surgery

Cosmetic surgery is not a discipline within itself but a branch of plastic surgery, the aim of which is remodeling "certain body structures in order to improve their function and appearance" (The Canadian Society for Aesthetic (Cosmetic) Plastic Surgery, 1999). The term "plastic" comes from the Greek *plastica* meaning to form or mould (Online Surgery, 1999). The field of plastic surgery encompasses two categories of operations, reconstructive procedures and cosmetic procedures (Dull & West, 1991). Reconstructive procedures "restore or improve physical function and minimize disfigurement from accidents, diseases, or birth defects" (Dull & West, 1991: 51). Cosmetic procedures purport to offer elective aesthetic improvement through surgical alterations of facial and bodily features on otherwise healthy bodies (Dull & West, 1991).

Cosmetic surgery has been defined in many ways. The American Society of Plastic and Reconstructive Surgeons (1999) offer the following definition: "Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem." The Canadian Society for Aesthetic (Cosmetic) Plastic Surgery (1999) suggests cosmetic surgery's "aim is to improve the appearance of certain areas of the body that are unpleasing in size or shape due to genetic or acquired causes." In Canada, cosmetic procedures are typically paid for out of pocket whereas reconstructive procedures are covered through Medicare. However, there is a number of gray areas in coverage for plastic surgery, which may be defined as reconstructive or cosmetic depending on the person's situation. For example, eyelid surgery

(blepharoplasty) is normally performed to achieve a cosmetic improvement but may be covered under Medicare if the eyelids are drooping and obscuring a patient's vision.

The literature distinguishes between two basic types of cosmetic surgery. The first type attempts to improve parts of the face and the body that are perceived to be an undesirable shape or size. These kinds of procedures (for example, breast implants and nose surgery) are type-changing in that they create an appearance the person has not previously had (Pruzinsky & Edgerton, 1990). The second type attempts to rejuvenate and minimize the effects of aging. These types of cosmetic surgery (for example, face-lifts and eyelid surgery) are restorative in the sense that the surgery restores the person to his or her previous physical characteristics (Pruzinsky & Edgerton, 1990).

There is a growing academic and popular interest in cosmetic surgery. Academic research has relied heavily on critiques of the pervasive cultural beauty system (Bordo, 1989; Morgan, 1991; Wolf, 1990) while research based on empirical data derived from women's accounts of cosmetic surgery are sparse. To date, no research on Canadian women's experiences with cosmetic surgery has been reported.

The aim of this chapter is to examine the factors considered in past research to account for the growth of cosmetic surgery and for women's decisions to have cosmetic surgery. This discussion examines a number of external forces which may influence women's decisions. This will help in understanding why an increasing number of women each year go through the pain, anxiety and cost of cosmetic surgery.

The discussion is organized into three sections. The first section examines social economic and cultural factors that may influence women's decisions to have cosmetic surgery. The focus in the second section shifts to a more detailed examination of past

research on women's experiences with cosmetic surgery. This discussion is divided in two parts. The first part examines women's involvement with cosmetic surgery by drawing upon a priori themes identified in past studies. The second part is a critical assessment of this literature. The third section of this chapter examines recent writings on the sociology of the body which theoretically inform this study on women's involvement with cosmetic surgery. This chapter concludes with a commentary on how this work has informed my own research and the research questions that guide this research.

Social, Economic and Cultural Factors

In this first section social, economic and cultural factors which may influence women's decisions to have cosmetic surgery are explored. To begin, a discussion of social factors is presented. This entails an analysis of the emergence and rise of cosmetic surgery, the role of technology, the medicalization of appearance and the manipulation of discourses on health. Next, economic factors are explored in a discussion of the economic feasibility of cosmetic surgery, changes in occupational structure and economic restructuring. Finally, an analysis of cultural factors is provided in a discussion of consumer culture, the media, the construction of femininity, beauty and the double standard of aging.

Social Factors

A discussion of the social factors related to cosmetic surgery is necessary to situate cosmetic surgery in the historical context in which it arose. In addition, social factors aid in understanding the dramatic increase in the number of women seeking cosmetic surgery.

The Emergence and Rise of Cosmetic Surgery. Plastic surgery has a long history. The oldest form of plastic surgery is rhinoplasty, which was first recorded around 1000 B.C. in India where women's noses which had been mutilated by their jealous husbands were reconstructed using flaps of skin from the forehead (Davis, 1995; The Centre for Cosmetic Surgery, 1999). In addition, more than 1500 years ago, the Chinese were surgically repairing noses and harelips (Lefebvre, 1995). Although technology for surgically altering the appearance of the human body has been available for centuries, the development of the field of plastic surgery has been slow and can be linked to the development of medicine (Davis, 1995). Prior to the discovery of ether and chloroform in 1846, surgery had to be done without anesthesia, which was traumatic for the patient (Davis, 1995). Surgery underwent a transformation with the development of medicine as a science (Davis, 1995). According to Davis (1995: 15), "[u]nder the all-encompassing medical gaze, every aspect of the body became a welcome object for scrutiny, including abnormalities of the bodily appearance."

An increased supply of surgeons intensified existing financial and technological pressures on physicians to specialize, which also contributed to the rise of plastic surgery (Sullivan, 1993). However, it was not until the large number of casualties produced by both World Wars that plastic surgery emerged as a full-fledged medical specialty (Davis, 1995).

The emergence of cosmetic procedures in the mid-twentieth century altered the field of plastic surgery. Plastic surgery was once confined to restoring or improving physical function and minimizing disfigurements from accidents, diseases, or congenital deformities, but it has expanded to include the creation of new physical properties, as

well as dealing with phenomena that were formerly associated with the "natural" process of aging such as wrinkles and sagging skin (Zola, 1972).

Sullivan (1993) traces this change to a number of factors. First, the declining demand for non-cosmetic procedures due to the use of safety belts and shatterproof glass in automobiles reduced the need for plastic surgeons to function as trauma specialists. Second, the fall in the birth rate after 1965 reduced the number of congenital deformities requiring plastic surgery. Third, innovations in radiation and chemotherapy also decreased the incidence of large tumors and other disease-related deformities for which plastic surgeons were traditionally consulted. In consequence, the declining demand for non-cosmetic procedures combined with an increasing number of plastic surgeons to create a tight market. In response, plastic surgeons turned to cosmetic surgery as an attractive area of medicine. Based on fee-for-service payment, the specialty was devoid of third-party paperwork, and was associated with great financial rewards. The growth in the number of plastic surgeons specializing in cosmetic surgery has also coincided with changes in technology.

Technology. Numerous technological changes have fuelled the growth of cosmetic surgery (Sullivan, 1993). These technological changes include the introduction of new procedures, the adoption of techniques originally developed for the reconstruction of deformities, and the refinement of existing techniques. Liposuction was only introduced in the United States in 1982, but by 1988 it had become the most frequently performed cosmetic procedure (Sullivan, 1993). In the 1980s, other new techniques were introduced for breast implants, forehead lifts, and for the removal of wrinkles (Sullivan, 1993). Chin and cheek implants, originally developed for reconstruction of deformities

were adapted for cosmetic surgery in the 1980's (Sullivan, 1993). Technological advances in microsurgery and laser surgery have also been widely adopted in cosmetic surgery (The Centre for Cosmetic Surgery, 1999). The refinement of existing techniques has made some cosmetic procedures less invasive than in the past, thereby decreasing the amount of pain and recovery time following surgery. However, other refinements of existing techniques, such as the standard face-lift, are now more invasive than in the past, but are purported to offer longer lasting results (Findlay, 1989). With the emergence of cosmetic surgery, the rationale for surgical intervention in bodily appearance changed, and, along with it, the kinds of technologies being developed (Davis, 1995). This increased attention of medicine to physical appearance is said to represent a new arena of medicalization (Dull & West, 1991).

Medicalization of Appearance. Although there is a vast body of literature on the expansion of medicine into non-medical terrains, this literature has focused primarily on the medicalization of deviance redefining "badness" as "sickness," for example, mental disorders and alcoholism (Conrad & Schneider, 1985; Zola, 1972), and the medicalization of natural processes such as pregnancy and menopause (Riessman, 1983). Dull and West (1991: 67) see cosmetic surgery as fitting into an "aesthetic realm as a third arena of medicalization." The medicalization of appearance sees older people, especially older women as needing a "fix." Riessman's (1983) analysis of women and medicalization examines the medicalization of appearance by focusing on weight. She states (1983: 13) that "[m]edical science in collaboration with a series of industries participate in creating social norms for appearance in the guise of supposedly neutral, objective, scientific standards for 'ideal' body weight." The medicalization of

appearance confirms that medicine is "a powerful form of regulation, restraint and representation of the body as flesh" (Turner, 1987: 19). Themes such as body shape, fitness, beauty, youth, longevity, wellness and sexual appeal are becoming increasingly entangled within both the medicalization of appearance and discourses on health (Crawford, 1984).

Manipulation of Discourses on Health. Wolf (1990: 270) claims the "cosmetic surgery industry is expanding by manipulating ideas of health and sickness." She asserts that "[u]gliness has been created as a disease that only cosmetic surgeons can cure" (Wolf, 1990: 232). Hyman (1990) stresses that although the role of the physician is to serve in the interests of health, aesthetic cosmetic surgery reduces health to mere opinion and medicine to self-indulgence. Cosmetic operations aimed at enhancing a "normal" appearance at the risk of diminished health and physical functioning are in direct contradiction to medicine's social mandate to work to improve the health and the physical functioning of the population (Sullivan, 1993).

The popularity of cosmetic surgery stands in stark contrast to the discomfort and risk that accompany the operations. Cosmetic surgery, like all surgery carries a number of potential health risks and the risks increase with age. Potential risks of cosmetic surgery include infection, hemorrhaging and blood clots in the lung and brain, all of which can cause severe impairment and, in rare cases, even death (Human, 1987). Paralysis after a face-lift and blindness caused by eyelid tucks are among the many documented iatrogenic effects of cosmetic surgery (Walsh et al., 1989). It is estimated that 10 percent of cosmetic surgeries entail some unexpected and negative outcomes (Cobb, 1988). This combination of seriousness and high rates of potential risks would

normally only be used by physicians to recommend surgery for a condition that is more life threatening than the surgery itself. This is not the case with elective cosmetic surgery. The risks of cosmetic surgery are weighed solely against the value of a more attractive appearance. While there may be no physical justification for cosmetic surgery, there is, according to some cosmetic surgeons, a psychological justification. Some physicians argue that cosmetic surgery improves the mental health of their clients and that the benefits are psychotherapeutic (Harris, 1989). However, "in the name of the 'feel good' factor the benefits of beauty procedures are played up, while the dangers are played on a low key" (Tseelon, 1995: 84). Moreover, the voices of women who have had unsuccessful cosmetic surgery, and the effect it has on their mental health, have not received adequate research attention. In short, the psychological consequences of going to surgical lengths for what can appear to be superficial benefits remain unexplored (Goodman, 1994). The psychological justification for cosmetic surgery and other forms of body maintenance are also perpetuated in the media.

Featherstone (1991) explores how body maintenance is manipulated in the media and mass consumption by discourses on health. In turn, health education messages of body maintenance are strongly influenced by the consumer culture idealization of youth and the body beautiful (Featherstone, 1991). The slogan 'looking good and feeling great' is saleable in both the media and health education. Advertisements for cosmetic surgery also capitalize on discourses on health. In the booklet *Everything You Always Wanted to Know about Plastic Surgery*, the discussion on face-lift recipients emphasizes that "[i]nstead of looking like they got 'lifted', today's patients simply look refreshed, rested and healthy" (Schell/Mullaney Inc., 1991).

In summary, this discussion of social factors has weighed heavily on the supply side of cosmetic surgery by focusing on the emergence and rise of cosmetic surgery, the role of technology, the medicalization of appearance and the manipulation of discourses on health. Another factor that needs to be considered is the demand side of cosmetic surgery, which can be seen to be fuelled by economic factors.

Economic Factors

A discussion of economic factors aids in accounting for the increase in the number of people who are electing to have cosmetic surgery. Cosmetic surgery consumers are being increasingly drawn from wider economic groups (Morgan, 1991). These economic factors include economic feasibility, changes in occupational structure and economic restructuring.

Economic Feasibility. Cosmetic surgery is invariably expensive and the costs alone are prohibitive for many individuals. Nonetheless, there are a number of factors in the labor market that have contributed to the rise of cosmetic surgery. With the reduction in prices for cosmetic surgery, it is now more readily available to those in more modest socio-economic classes (Schell/Mullaney, Inc., 1991). Research by Dull and West (1991) on cosmetic surgery recipients indicates that while limited economic resources may hinder the pursuit of cosmetic surgery, they do not necessarily prevent it. No longer the exclusive indulgence of the rich and famous, cosmetic surgery's largest market is now the middle class. Nearly one-third of cosmetic surgery recipients in the United States report household incomes of $25,000 or less (Sullivan, 1993). No comparable Canadian data are available. Moreover, most cosmetic surgeons allow the option of monthly installments and some surgeons even accept credit card as methods of payment.

Changes in the Occupational Structure. Another economic factor is the change in occupational structure from agriculture and factory production jobs to professional, managerial, service and clerical occupations. These are occupations in which appearance is more salient. Moreover, this change in occupational structure coincided with middle and upper class women joining the paid labor force. This change in roles has altered how these women experience discrimination on the basis of gender, age and appearance (Sullivan, 1993). Older workers are viewed as less attractive, productive, creative and trainable than are younger workers. The increased participation of older workers in the paid labor force and ageist attitudes in the workplace compound pressures on individuals to retain a "youthful" appearance. This is particularly an issue in the context of uncertainty that characterizes the current labor market.

Economic Restructuring. The number of people electing to have cosmetic surgery is increasing in response to economic restructuring and the competitive job market. Under stress by corporate downsizing, many women and men are looking for any edge to get or keep their job, and cosmetic surgery is viewed as in investment in their careers in a culture that values youth and attractiveness in the job market (Turner, 1996; Wespic, 1996).

In summary, a number of economic factors can be seen as external forces that may impact women's decisions to undergo cosmetic surgery. These economic factors such as economic feasibility, changes in occupational structure and economic restructuring are embedded in a cultural context that may also have a bearing on women's decisions to seek cosmetic surgery.

Cultural Factors

A consideration of cultural factors is essential for exploring how cosmetic surgery emerged as an acceptable method of body modification for contemporary Western individuals, particularly women. This discussion proceeds with an exploration of consumer culture, the media, the construction of femininity, beauty and the double standard of aging.

Consumer Culture. In a consumer culture obsessed with appearance, the status of the body has been transformed from a fixed natural given, to a malleable cultural product (Tseelon, 1995). Body qualities are regarded as plastic. With hard work, effort and the consumption of goods and services, individuals can achieve their desired appearance (Featherstone, 1991). This transformation of the body has made cosmetic surgery more acceptable in Western societies. Body maintenance and improvement are phenomena in Western consumer culture (Featherstone, 1991). The vast range of services and products that are "produced, marketed and sold point to the significance of appearance and bodily preservation within late capitalist society" (Featherstone, 1991: 170).

Commodity producers induce uncertainty about bodily appearance in order to promote consumption, otherwise there would be limited saleability of commodities associated with bodily transformation, such as cosmetic surgery (Freund, 1982). The management and molding of the body has become increasingly central to the presentation of self-image, and in the US, this has been backed by "the $33 billion a year diet industry, the $20 billion cosmetics industry, the $300 million cosmetic surgery industry and the $7 billion pornography industry" (Wolf, 1991: 17). Furthermore, advertising "helped to

create a world in which individuals are made to become emotionally vulnerable, constantly monitoring themselves for bodily imperfections which could no longer be regarded as natural" (Featherstone, 1991: 175). The images from the media make individuals more conscious of their external appearance. Women are seen to be "most clearly trapped in the narcissistic, self-surveillance world of images" (Featherstone, 1991: 179). As such, the media plays an influential role in creating idealized images of women.

The Media. According to Goodman (1994: 376), "[t]hat women of all ages...are willing to undergo painful, intrusive medical procedures in the name of self-enhancement is not surprising given the media drive to socialize women in that direction." The media abounds with features on body image, cosmetic surgery and how to keep the body looking young, sexy and beautiful (Shilling, 1993). In addition, "[t]he cultural message of how women should look and act is endlessly disseminated" in the mass media, endorsing "a value system that preaches bodily perfection and deny [sic] women the right to age" (Goodman, 1996: 376). As noted by Wolf (1991: 259), "[w]omen have face-lifts in a society in which women without them appear to vanish from sight." The growth of cosmetic surgery is aided by the media idealization of women in our culture.

The Construction of Femininity. Tseelon (1995) discusses the construction of femininity in a consideration of two theoretical explanations. First, theological descriptions define the essence of woman as dissimulation– femininity is represented as synonymous with artifice, inauthenticity and duplicity. Second, psychoanalytic accounts and contemporary social theory define the essence of femininity as an inessential social construction. The main difference between these two positions is moral (Tseelon, 1995). In theological discourse, femininity is fake, in psychoanalytic discourse, femininity is a

masquerade and a social construction. In both of these positions what is implicit is the issue of authenticity, in other words, the relationship between appearance and essence (Tseelon, 1995). Davis (1995: 39) claims that "[s]ince Plato, feminine beauty has been idealized as representing moral or spiritual qualities." Numerous examples in children's fiction can be found to support the contention that beauty is equated with good, and old and ugly with bad (Synnott, 1993). For example, it is the amazingly beautiful and remarkably good Cinderella who wins the heart of the prince, not the ugly old stepmother who is obsessed with her mirror image (Synnott, 1993).

An account of cosmetic surgery cannot be given without exploring the cultural discourses and beauty practices. Drawing upon Foucault's notion of power, Bordo (1989: 16) treats the female body as a text which can be "read as a cultural statement, a statement about gender." To understand why women are preoccupied with their appearance, Bordo (1989) describes intersecting cultural discourses and how they converge in contemporary bodily phenomena associated with femininity such as hysteria, eating disorders, agoraphobia and routine beauty practices. Beauty practices, according to Bordo (1989), belong to the disciplinary and normalizing regime of body improvement and transformation. Women have a long tradition of enduring pain for the sake of beauty. Bound feet, constraining corsets, surgical alteration of the face and body, all demonstrate the extreme lengths to which women will go to improve and transform their bodies to meet the cultural requirements of femininity, even if in the process they may compromise their health. Bartky (1999: 121) discusses three categories of the disciplinary project of femininity: "those that aim to produce a body of a certain size and general configuration; those that bring forth from this body a specific repertoire of

gestures, postures and movements; and those that are directed toward the display of this body as an ornamented surface." She argues that "[t]he disciplinary project of femininity is a "setup": it requires such radical and extensive measures of bodily transformation that virtually every woman who gives herself into it is destined in some degree to fail" (Bartky, 1999: 125). She further argues that "[t]he disciplinary power that inscribes femininity in the female body is everywhere and it is nowhere; the disciplinarian is everyone and yet no one in particular" (Bartky, 1999: 128). Moreover, it is women themselves who practice this discipline on and against their own bodies. Women practice this self-surveillance and are under surveillance in ways that men are not. Implicit in this discussion is that the construction of femininity is tied to cultural constructions of beauty.

Beauty. Beauty appears to be a gender-related category (Tseelon, 1995). Physical appearance is important but relatively inconsequential for men, but is a defining feature of women, both in terms of how others respond to them and how they experience their own self (Tseelon, 1995). One of the norms of femininity in our society is being preoccupied with one's physical appearance, and consequently, masculinity in contrast means not caring very much about one's physical appearance. Women are judged for attractiveness more critically and rejected more severely when they lack it and these judgements have real consequences for them both within the labor market and the marriage market (Tseelon, 1995). As women move into middle age, the pool of potential partners is reduced by higher rates of male mortality as well as by men's culturally accepted marriage and re-marriage to women in younger age cohorts. Consequently, patterns of marriage, divorce and re-marriage mean that single women who want a partner face an increasingly tight market as they age.

Even though men are increasingly undergoing cosmetic surgery, the practice is not gender neutral (Kirkland & Tong, 1996). A common misconception is that the increasing numbers of men electing to have cosmetic surgery are catching up to women in this regard. Yet, the overwhelming majority of cosmetic procedures are performed on women.

While standards of female beauty have varied greatly from culture to culture and have shifted drastically over the years, the underlying assumption seems to be that beauty is worth spending time and money on, and enduring pain and sometimes even sacrificing life itself. Standards of beauty are cultural creations that are "narrow, restrictive and set impossible expectations for most females all of the time, and by virtue of human aging, are impossible for all women at least some of the time" (Abu-Laban & McDaniel, 1995: 108). The "universal" ideal of beauty mirrors Caucasian characteristics and neglects the diversity of women's bodies and appearance. One only needs to consider, for example, the large number of Asians who get their eyes "Westernized" (hollows created in the upper eyelids to "open up" the eyes and make them appear larger) to see a Western aesthetic operating (Lefebvre, 1995). This standard of beauty is also influenced by age. As a woman ages, the failure to replicate society's ideal becomes all the more apparent (Todd, 1984). Beauty and youth tend to be seen as synonymous in our society.

Double Standard of Aging. While it can be argued that the search for the fountain of youth has been a long-standing goal of both men and women, the argument presented here deals with the specific female predicament illustrated in the double standard of aging. The double standard of aging denounces women with special severity. Bodily changes are an expected part of human aging, however, they have different

consequences for females compared to males (Abu-Laban & McDaniel, 1995). Cultural forces in Western society assign a more negative value on aging women than aging men (Kogan & Mills, 1992). Facial lines in men are seen as signs of character whereas in women these same lines are seen as blemishes, imperfections, or flaws. Standards of physical attractiveness are less stringent and less connected to youth for men, whereas for women, any sign of advancing age is an indicator of diminished attractiveness (Deutsch, Zalenski & Clark, 1986). While both men and women may dread aging, it is women who are expected to prevent it (Tseelon, 1995). One only needs to consider the number of anti-aging products targeted exclusively at women as evidence for women being expected to prevent aging. In many respects, older women are being compelled to see the signs of aging as a "need" for cosmetic surgery (Wolf, 1990). Face-lifts, once an indulgence for wealthy women, are rapidly becoming one of the normal rites of passage into middle age (Lakoff & Scherr, 1984). Face-lifts are temporary and have to be redone, typically every 5-10 years and cosmetic surgeons are pushing 'preventive' cosmetic surgery (Barringer, 1992). They argue that getting a facelift before you actually need it allows faster healing and better results than if you wait (Barringer, 1992). While it used to be recommended that the first face-lift be done around 50, more recent advice is for women to consider the procedure at age 40, or even 35. As a woman lives on average to 80 years of age, the possibility of having this procedure repeated four to eight times exists with a cost of $2,000-$10,000, two weeks of discomfort, and pain and seclusion for each of the four to eight surgeries.

According to Morgan (1991), women who refuse to subject themselves to the knives, needles, anesthetics and bandages of cosmetic surgery will come to be seen as

deviant in one way or another. She argues that "[w]omen who refuse to use these technologies are already becoming stigmatized as "unliberated," and "not caring about their appearance" (a sign of disturbed gender identity and low self-esteem according to various health professionals)..."(Morgan, 1991: 40). More and more people, particularly women will be labeled "ugly" and "old" in relation to the more select population of surgically created beautiful faces and bodies that have been contoured, augmented, lifted and tucked into a state of achieved excellence (Morgan, 1991).

In summary, cultural factors– consumer culture, the media, the construction of femininity, beauty and the double standard of aging– have been identified as potential external forces that may influence women's decisions to seek cosmetic surgery. These cultural pressures were shown to influence how women judge themselves and are judged by others.

This discussion considered the social, economic cultural context in which women's decisions to have cosmetic surgery occur. Social, economic and cultural factors were explored as external forces that may influence women's decisions to have cosmetic surgery. This discussion, however, does not adequately explain why women are actively engaging in cosmetic surgery. What is notably absent in the literature reviewed up to this point are studies based on the voices of women who have undergone cosmetic surgery.

Past Research

This discussion is organized into two parts. In the first part, I examine women's involvement with cosmetic surgery by drawing upon a priori themes identified in past studies. The second part critically assesses this literature.

A Priori Themes

To gain an understanding of why women decide to have cosmetic surgery, attention must be paid to the meaning of cosmetic surgery from the perspective of women themselves. This necessitates hearing and taking seriously the voices of women who elect to undergo these procedures. However, with few exceptions, researchers have not relied on the accounts women give regarding their decisions to have cosmetic surgery (Davis, 1995; Goodman, 1994; 1996). Rather, the typical feminist approach to cosmetic surgery has been to view it as oppression, normalization and ideological manipulation (for example see Morgan, 1991). As a consequence, the voices of women are not represented and women are presented as victims of the beauty system. It is difficult to explain cosmetic surgery without undermining the women who opt for it (Davis, 1995). Drawing upon the key findings from the work of Davis (1995) as well as Goodman (1994; 1996), this section examines the themes identified in previous research: psychological issues and body image, identity, and agency and choice.

Psychological Issues and Body Image

There is no denying that for some women, cosmetic surgery can improve their body image. Cosmetic surgery not only has the potential to produce remarkable changes on the body, "but also on the mind, and the sense of self" (Synnott, 1993: 2). Pruzinsky and Edgerton (1990: 217) contend that "the purpose of aesthetic surgery is to facilitate positive psychological changes...the only rationale for performing aesthetic plastic surgery is to improve the patient's psychological well-being." For Pruzinsky and Edgerton (1990), psychological well being is tied to positive body image.

Goodman (1994) examined how women of different ages perceive themselves in relation to societal biases about youthfulness and beauty. Twenty-four women, between the ages of 29 and 75 were interviewed, 12 had undergone cosmetic surgery and 12 had not. She found that circumstances of childhood development might have more, or at least as much, to do with forming and maintaining body image than social pressures to conform to ideals of womanhood. Goodman (1994) found that women who developed an appreciation of their merit as females through their appearance carried this value into middle age and late adulthood. This issue has a direct bearing on her study's most important finding that women who opted for cosmetic surgery generally were the ones who, in retrospect, felt better about their appearance and themselves before their decision to have surgery (Goodman, 1994). However, Goodman (1994) notes that the younger the women in either group, the less these findings applied.

In addition, Goodman (1994) found that women who were equivocal about or refused to have cosmetic surgery appeared more nonchalant about the effects of aging on their appearance. These women exhibited an acceptance of the aging process rather than a denial of the aging process. Her findings point to a possible factor that may distinguish women who have cosmetic surgery and women who do not; women who did not have cosmetic surgery had a greater acceptance of age-related body changes. However, Goodman (1994) also found that regardless of age and type of procedure performed, or their satisfaction with the results, women who had undergone cosmetic surgery exhibited a self-assurance that was missing in the non-surgery group. In other words, the acceptance of age-related body changes did not correspond with women in the non-surgical group having a more positive body image which was present in the surgical

group both before and after their surgery (Goodman, 1994). Goodman's (1994) findings that most women in the surgical group seemed more satisfied with and in command of their projected image both before and after their surgery suggests that body image is connected to identity.

Identity

The most comprehensive study on cosmetic surgery is Kathy Davis' *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (1995). Davis spoke to women who had undergone cosmetic surgery and her selection criteria included only those for whom the surgery was done purely for 'looks' thus eliminating women who had reconstructive surgery. The focus of Davis' Dutch research (1995) was on women's decision-making to have cosmetic surgery, and their satisfaction with the outcomes of the procedures.

Davis (1995) argued that cosmetic surgery is about identity. She found that for a woman who felt trapped in a body that failed to match her sense of self, cosmetic surgery was a way to renegotiate identity through her body. Davis' respondents did not have cosmetic surgery because they wanted to be more beautiful. Cosmetic surgery, rather, was embarked upon to become ordinary, normal or just like everyone else.

The theme of identity was also raised in Goodman's (1994) study of North American women's receptivity to cosmetic surgery. Reporting on older women (age 55 and over) who all had undergone facial cosmetic surgery, she found "cosmetic surgery enabled them to stop the clock; to put their faces in synchrony with their inner feelings of youthfulness" (Goodman, 1994: 380). This theme of identity is repeated in many magazine and newspaper articles on cosmetic surgery, particularly with reference to older cosmetic surgery recipients. According to Dr. Peter Adamson, a Toronto-based plastic

surgeon, the major drive for cosmetic surgery is that people want to have their outer appearance reflect their inner spirit (Turner, 1996).

As such, identity appears to be a key theme in accounting for why women have cosmetic surgery (Davis, 1995; Goodman, 1994) and may be especially important in later life. The theme of identity is reviewed by Featherstone and Hepworth (1991) in their discussion of the 'mask of aging.' The mask of aging is used to describe:

> ...the possibility that a distance or tension exists between the external appearance of the face and the body and their functional capacities, and the internal or subjective sense or experience of personal identity which is likely to become more prominent in our consciousness as we grow older (Featherstone & Hepworth, 1991: 382).

Similarly, Turner (1995: 250) notes, "[i]n phenomenological terms...the inside of the body remains subjectively young or youthful while the outside body becomes both biologically and socially old." The theme of identity is clearly intertwined with notions of agency and choice.

Agency and Choice

Agency and choice are two themes that have been raised in the work of both Davis (1995) and Morgan (1991). While Davis (1995) and Morgan (1991) both begin by asking why women want to have their bodies altered by surgery, they reach two different conclusions. Morgan's (1991) argument involves three paradoxes of choice which affect women who elect to undergo cosmetic surgery. The first paradox is the choice of conformity. Morgan argues that even though it may appear that women are demonstrating their freedom of choice, in most cases they are conforming to norms of beauty. For example, conformity to a white, Western Anglo-Saxon standard of beauty is evident in the number of Asian women who get their eyes "Westernized" or the number

of Jewish women who seek reductions of their noses. In the second paradox, liberation into colonization, Morgan says:

> In electing to undergo cosmetic surgery, women appear to be protesting against the constraints of the "given" in their embodied lives and seeking liberation from those constraints. But I believe they are in danger of retreating and becoming more vulnerable, at that very level of embodiment, to those colonizing forms of power that may have motivated the protest in the first place.

Cosmetic surgery is camouflaged by the rhetoric of liberation– of taking care and making the most of oneself– but in reality it represents domination by the medical profession, mainstream bioethics and the patriarchal social order. (Morgan, 1991). Morgan (1991: 41) argues in relation to the third paradox "that the technological beauty imperative and the pathological inversion of the normal are coercing more and more women to "choose" cosmetic surgery." Morgan (1991) concludes that women's decisions to have cosmetic surgery are made under circumstances which preclude genuine choice. While Morgan suggests that women who seek cosmetic surgery are conforming, oppressed and ideologically manipulated, and thereby not knowledgeable agents, Davis (1995) argues the opposite.

Davis (1995) argues that women have to actively "do femininity" which requires knowing what needs to be done, assessing the possibilities and acting upon them. Cosmetic surgery, according to Davis (1995), becomes a way for women to become agents and to take action to remedy their dissatisfaction. Davis (1995) contends that cosmetic surgery is a way for women to exercise power under conditions which are not of their own making and as such, it becomes a way for women to give shape to their lives by reshaping their bodies.

In summary, past research on women's involvement with cosmetic surgery suggests several themes– psychological issues and body-image, identity, and agency and choice– which offer some understanding of women's involvement with cosmetic surgery.

Critique

To date, the literature on cosmetic surgery is characterized, on the one hand, by the growing medical market and the role of consumer culture in fashioning bodies, and on the other hand, by feminist analyses which have resulted in a view of cosmetic surgery recipients as victims of the beauty system (Davis, 1995). Morgan (1991) contends that we need to listen to the voices of women who have elected to undergo cosmetic surgery before an assessment is made on the extent to which the conditions for genuine choice have been met and the consequences of these choices are understood. However, Morgan's research is based on descriptions of women who have been cited in newspaper and magazine articles.

There is also a failure to link women's experiences with theory in the literature on cosmetic surgery. While both Goodman (1994) and Davis (1995) listened to the voices of women who had undergone cosmetic surgery, Goodman (1994) fails to include theoretical discussions in her findings and Davis' (1995) theoretical position is problematic (Klein, 1997). Davis' (1995) theoretical framework incorporated three themes–identity, agency and morality– to analyze women's accounts of cosmetic surgery. Contrary to feminist scholarship, which situates cosmetic surgery in women's involvement in the beauty system (Bordo, 1989; Morgan, 1991; Wolf, 1990), Davis (1995) contended that for her participants, cosmetic surgery was about identity, i.e., cosmetic surgery could be an occasion for a woman to renegotiate her identity and

become an embodied subject rather than "just a body." With respect to agency, Davis argued that cosmetic surgery was a way for women to become agents and a possible remedy for their dissatisfaction with their appearance. She found that cosmetic surgery was about exercising power and control over conditions which are not of women's own making. The women Davis spoke to "treated cosmetic surgery as something which was morally problematic for them and had to be justified" (1995: 165). Using the three themes of identity, agency and morality, Davis developed a framework that allowed her to explore cosmetic surgery as a dilemma– being critical of cosmetic surgery without uncritically undermining the women who decide to have cosmetic surgery. This framework enabled her to listen and take women's reasons seriously without having to agree with, or critique, what they said.

Despite Davis' major contribution to the developing literature on cosmetic surgery, there are a number of disadvantages to her approach. Her claim that cosmetic surgery is first and foremost about agency, i.e., taking one's life into one's own hands, deflects attention from the cultural context in which women's agency operates (Davis, 1995). More importantly though, Davis' work is problematic because of her non-committal position on cosmetic surgery and her discussion of women's agency. According to Davis (1995: 153), cosmetic surgery is both "profoundly disempowering and a road to empowerment at the same time." Despite her recognition of the potential negative as well as positive impacts of the procedure, and despite her claims to the contrary, Davis remains uncritical of the beauty system and her conclusions can be used to endorse cosmetic surgery. I find this author's endorsement of cosmetic surgery to be misguided as she focuses almost exclusively on individual factors related to women's

decisions to have cosmetic surgery. As Davis herself admits, the systematic or structured patterns of women's involvement in the cultural beauty system have not been taken into account (Davis, 1995). In addition, the importance of age and aging issues were not addressed.

This failure to incorporate structure and age into an investigation of women's use of cosmetic surgery supports the need for a wider cultural exploration, the point of departure for my research study. In contrast to Davis' exploration of cosmetic surgery- primarily breast surgery– and her inattention to aging issues, this study focuses exclusively on facial cosmetic surgery and considers how age and aging influences women's decisions to have cosmetic surgery.

A conceptual problem in the literature is the lack of simultaneous consideration of the social, economic, cultural and individual factors and their relationship to women's decisions to have cosmetic surgery. Both Goodman (1994) and Davis (1995) tried but failed to uncover the social and cultural influences on women's decisions to have cosmetic surgery. Moreover, the literature to date has predominantly focused on social and economic factors in relation to supply and demand, without exploring how these factors are implicated in women's decision-making process. Furthermore, with the exception of Goodman (1994; 1996), the relationship between age and cosmetic surgery has been not been adequately explored.

Theoretical Insights

This third section examines the theoretical insights which inform this study on women's involvement with cosmetic surgery. More specifically this section proceeds with a discussion of the sociology of the body and the body's dual status in sociology. I

then turn to the dominant perspectives in the sociology of the body, namely the naturalistic perspective, the social constructionist perspective, and the phenomenological perspective. In addition, recent developments in the sociology of the body are discussed. I conclude this section with a commentary on how this work has informed my own study.

Sociology of the Body

According to Turner (1995: 245), "in sociology we have few adequate paradigms for integrating research on the biological dimensions of life with the social and cultural factors." Few sociologists have attempted to understand the interaction between various forms of human embodiment, the physiological processes of aging and the socio-cultural definitions of aging. Drawing upon the work in the sociology of the body sensitizes me to consider and problematize the physiology of the body, the lived experiences of women, and social constructions of attractive bodies, including notions of beauty and youth.

In recent years, there has been a growing academic and popular interest in the body. The sociology of the body has emerged as a distinct area of study which is reflected in the growing amount of literature published specifically on the body since the 1980's. The sociology of the body is much more than simply examining the body from a sociological perspective. It involves a theoretical sociology which takes full account of the body. Synnott (1993: 6) describes the sociology of the body as "a new way of 'looking' at sociology and doing sociology and experiencing sociology personally; beyond that it is a new way of exploring our embodied selves and our relations with others in society." A number of authors have advocated that the body be a focal concern of sociologists and social gerontologists (Oberg, 1996; Shilling, 1993; Synnott, 1993;

Turner, 1984). This growing interest warrants a consideration of the status of the body in sociology.

The Body's Dual Status in Sociology. The body's dual status in sociology is explored by Shilling (1993). According to Shilling (1993), instead of being completely neglected, the body has had an "absent presence" in sociology. While classical sociology was not concerned explicitly with the body, it has had an implicit concern with the body. Classical sociology's concerns with structure, the functioning of societies and the nature of human action resulted in a consideration of human embodiment and the consequences of embodiment. Moreover, the implicit presence of the body is illustrated by the amount of recent work on the body that has drawn upon classical sociology (c.f. Synnott, 1993; Turner, 1984).

To comprehend why the body in sociology has, until recently had only an implicit presence, a consideration of the emergence of sociology is necessary. Turner (1984) explains that the epistemological foundations of modern sociology are rooted in a rejection of 19th century positivism, especially biological determinism. The body did not occupy a central position in the foundation of sociology because classical sociologists were concerned with identifying and establishing a disciplinary field distinct and separate from the natural sciences. Equally important though, is the fact that sociology has been, and continues to be, dominated by the Cartesian legacy in implicitly accepting a rigid mind/body dualism (Turner, 1984). With the emphasis placed on the socially constructed nature of the social being, the body of the social actor was implicitly relegated to an inconsequential feature (Turner, 1984). This dualism has also permeated gerontological research where the physical, psychological and social dimensions of aging are separated.

As Oberg (1996: 703) describes, "[t]he body as subject of research belongs to geriatrics (physical), while social gerontology is concerned with other aspects of aging (psychological and social)."

In summary, both classical sociology and social gerontology have not granted adequate attention to the body. Moreover, while classical sociology's interest in the body has been implicit, a number of perspectives have been explicitly concerned with the body and this is where our attention shall now turn. The three main perspectives on the body are the naturalistic, the social constructionist and the phenomenological perspectives.

The Naturalistic Perspective

The naturalistic perspective emerged during the 18th century. The naturalistic perspective "assumes that the body is a real biological entity which exists as a universal phenomenon, irrespective of the social context in which it resides" (Nettleton, 1995: 104). While naturalistic perspectives are not identical, "they share an analysis of the body which views it as the pre-social, biological basis on which the superstructures of the self and society are founded" (Shilling, 1993: 41). Naturalistic views are composed of two basic principles. First, they are reductionist, in that the structure of society is explained as a result of some aspect of individuals' physical or genetic constitution (Shilling, 1993). Second, after having established the essential features of individuals' corporeality, these are then classified into social categories (such as male/female, black/white, rich/poor) which have the tendency to ignore overlaps in, and stress the differences between, human bodies (Shilling, 1993).

According to Shilling (1993), naturalistic views are important because of the repeated attempts that have been made by dominant members of society to justify their

position with reference to the allegedly inferior biological make-up of those dominated (Shilling, 1993). As Nettleton (1995: 105) states, "[t]he reality of the body has long been used to account for, and justify, inequalities between men and women." Bodies are signifiers, with varying degrees of accuracy, of class, gender, age, and a host of social meanings which affect social interaction (Scott & Morgan, 1993; Synnott, 1993). As Synnott (1993: 4) describes, the body is many things: "the prime symbol of the self, but also of society; it is something we have, yet also what we are; it is both subject and object at the same time...". Moreover, "[b]iological, physiological and anatomical theories of the body tell us as much about prevailing political ideologies as they do about the body itself" (Nettleton, 1995: 105).

The strength of the naturalistic perspective is that "it takes seriously the idea that human bodies form a basis for, and contribute towards, social relationships" (Shilling, 1993: 41). This aspect is what Shilling (1993) maintains is worth developing and tends to get lost in social constructionist accounts of the body.

The Social Constructionist Perspective

The social constructionist perspective is, in fact, a range of approaches (Nettleton, 1995). There are those who contend that the body is an effect of the discourses which describe it. Others maintain that the body is shaped and altered by social practices and its social context (Nettleton, 1995). Social constructionist approaches, however, "are united in their opposition to the notion that the body can be analyzed adequately purely as a biological phenomenon" (Shilling, 1993: 70). Furthermore, social constructionist approaches challenge the tendency of the dual approach to the body that has traditionally characterized sociology by bringing society into the body (Shilling, 1993).

Michel Foucault is the most influential writer in the social constructionist perspective. Nettleton (1995) describes the central theme that runs through Foucault's work as the shift from sovereign power in pre-modern forms of society to disciplinary power in modern forms of society. Sovereign power resided in the body of the monarch, whereas disciplinary power resides in the bodies of population. Disciplinary power is most evident in social institutions and refers to the way in which bodies are regulated, trained, maintained and understood (Nettleton, 1995). Disciplinary power operates at two levels: the individual level and the level of populations. Foucault (1979: 137-8) saw society as essentially disciplinary and physical:

> The historical moment of the disciplines was the moment when the art of the human body was born....What was then being formed was a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A 'political anatomy,' which was also a 'mechanics of power,' was being born....Thus discipline produces subjected and practised bodies, 'docile' bodies.

What is unique in Foucault's work is his analysis of the mechanics of power in every sector of society (Synnott, 1993).

For Foucault, the body is wholly constituted by discourse (Shilling, 1993). The body ceases to be a biological entity and "becomes instead a socially constructed product which is infinitely malleable and highly unstable" (Shilling, 1993: 74). Discourses can be seen as sets of 'deep principles' incorporating specific 'grids of meaning' which underpin, generate and establish relations between all that can be seen, thought and said (Dreyfus & Rabinow, 1982).

Shilling (1993) finds a fundamental tension in Foucault's approach to the body, which makes Foucault unable to overcome the dual approach traditionally adopted by

sociologists of the body. "On the one hand, there is a substantive concern with the body as a cultural *product* of constructing discourses...On the other hand, Foucault's epistemological view of the body means that it disappears as a material or biological phenomenon" (Shilling, 1993: 79). In other words, while the body is present as a topic of discussion, it is absent as a focus of investigation (Shilling, 1993). Moreover, Shilling (1993) criticizes Foucault's work for failing to be concerned sufficiently with lived experience. Turner (1984) notes that despite all Foucault's references to pleasure and desire, he ignores the phenomenology of embodiment. Although the body is affected by discourses, "we get little sense of the body reacting back and affecting discourses" (Shilling, 1983: 81).

The Phenomenological Perspective

The phenomenological perspective is concerned with the 'lived body' in which the core characteristic is intentionality (Nettleton, 1995). According to Turner (1995: 247), phenomenological sociology can be characterized "as an attempt to describe the structure of the everyday world and the life-processes of individuals in such a life-world." Phenomenological approaches to the body are concerned with the lived experiences of individuals and how individuals interpret and create their worlds in meaningful ways (Nettleton, 1995). James and Gabe (1996: 27-28) point out that "[t]o date, much of the sociological discussion has been about bodies (i.e., issues of regulation, representation, etc.) rather than from bodies (i.e., a more phenomenological emphasis on the body as a structure of ongoing lived experience)." In other words, the literature on the sociology of the body has not yet adequately focused on studies of the lived body. As a consequence, the theoretical underpinnings characterizing this literature have not been grounded in the

lived experiences of the body. In sociology, there has been a tendency to ignore the embodiment of human agency (Nettleton, 1995). However, this is one of the main issues that sociologists of the body, such as Shilling (1993) and Turner (1984; 1992), have tried to address using a synthesis between the naturalistic, the social constructionist and phenomenological perspectives.

Recent Developments in the Sociology of the Body

Recent developments in the sociology of the body appear promising in studying facial cosmetic surgery. Turner (1984: 1) states that "[t]here is an obvious and prominent fact about human beings; they have bodies and are bodies." Nettleton (1995) asserts that people's bodies are changed and shaped by their actions, physical intervention, cultural expectations, and socio-biological processes. Her assertion reveals the multidimensional nature of bodies, and provides a compelling point of departure for understanding the various factors that may influence women's decisions to undergo facial cosmetic surgery.

For a study of facial cosmetic surgery, Shilling's (1993) notion of *the body as a project* which compliments Featherstone's (1991) discussion of *the body in consumer culture* is the most promising development in the sociology of the body. Shilling (1993: 12) argues that the body is best "conceptualized as an unfinished biological and social phenomenon which is transformed within certain limits, as a result of its entry into, and participation in, society." From this idea that the body is in a state of "unfinishedness," Shilling (1993) develops the notion of the body as a project. In contemporary society, there is a tendency to view the body as a project which should be worked on and comprises a significant part of an individual's self-identity (Shilling, 1993). His analysis of the body as a project is based on two propositions. First, we have the knowledge and

the technical ability to intervene and alter substantially the body. Second, a growing number of people are increasingly aware of the body as an unfinished entity which is shaped partly as a result of lifestyle choices. According to Shilling (1993: 7), "[i]nvesting in the body provides people with a means of self-expression and a way of potentially feeling good and increasing the control they have over their bodies."

However, investing in the body also has limitations. The effort expended by individuals on the body is doomed to failure because bodies age and decay, and death is an inescapable reality (Shilling, 1993). Bodies are also limited by their refusal to be molded in accordance with our intentions (Shilling, 1993). Shilling's (1993) idea of the body as a project does not mean that everyone has the desire or the ability to transform radically the body. Instead, he presupposes that people are generally aware of the transformative developments and that there is a strong tendency for people in contemporary Western societies to become associated increasingly with and concerned with their bodies.

Shilling's (1993) notion of the body as a project offers a theoretical insight for this study on facial cosmetic surgery. More specifically, women's physical bodies can be situated in the naturalistic approach. Social constructions of the body which incorporate what is seen as beauty can be explored using the notion of the body as a project. In addition, the body as a project enables an examination of how cosmetic surgery can be sought as an expression of an individual's identity.

Research Questions

In reviewing the literature on cosmetic surgery, a number of gaps in the literature were identified. We still do not adequately understand why women go through the pain,

anxiety and cost of cosmetic surgery. From these gaps in the literature, the following three research questions were developed.

1. How do women account for their decision to have facial cosmetic surgery?
2. Is the decision to have facial cosmetic surgery influenced by social, economic, cultural and individual factors?

From the literature on the sociology of the body, it was noted that theoretical discussions are not grounded within the lived experiences of the body. This research endeavor seeks to rectify this problem by granting attention to how women's bodies are both presented and experienced by them. Accordingly, an additional research question draws on women's experiences with, and accounts of, facial cosmetic surgery.

3. What does cosmetic surgery tell us about the relationship between women and their bodies?

Summary

The critical assessment of the literature has identified the concepts, themes, ideas and theoretical insights that have informed this study. The ideas that are brought to this research project include social factors (the rise and emergence of cosmetic surgery, technology, medicalization of appearance, and manipulation of discourses of health); economic factors (economic feasibility, changes in occupational structure); and cultural factors (consumer culture, the media, the construction of femininity, beauty, and the double standard of aging). A priori themes identified in the literature include psychological issues and body image, identity, agency and choice. The critical assessment of the literature as well as the discussion of external forces and a priori themes point to the need to consider the interconnections between the subjective experiences and meanings of women, on the one hand, and on the other, the external

forces such as the role of culture, institutions, power and social relations to gain a better understanding of women's involvement with cosmetic surgery. In this sense there is a need to focus on the ties between agency and structure in social life and the connections between macro and micro levels of analysis. Only by considering these connections can we hope to gain a better understanding of women's involvement with cosmetic surgery.

The process of theorizing has been a continuous aspect of this research study. Theorizing started before the data were collected. It has also occurred in close association with data analysis. Theorizing is about providing explanations of social phenomena (Layder, 1998) and in this study, the aim is to explain women's involvement with cosmetic surgery rather than simply to describe women's involvement with cosmetic surgery.

One of the objectives of this study is to contribute to the development of theory. This will be done by utilizing elements of prior theoretical ideas from both the sociology of the body and past research on women's involvement with cosmetic surgery in conjunction with theory that emerges from the data collected in this study. More specifically, the analysis will tease out what cosmetic surgery can offer in terms of understanding the relationship between women and their bodies. Chapter three will describe the research design of my study and the data analysis strategies I used to theorize women's involvement with cosmetic surgery.

CHAPTER THREE

Methodology

In chapter two, I identified the need to consider the interconnections between the subjective experiences of women and the external forces such as the role of culture, institutions, power and social relations to gain a better understanding of women's involvement with cosmetic surgery. In addition, I also described my process for theorizing women's involvement with cosmetic surgery. In this chapter, I describe my research design and data analysis strategies.

Research Design

A purposive sample of 10 women, who had undergone facial cosmetic surgery, participated in this study. Establishing contact with the women was more difficult than anticipated. I wanted to ensure that the women's participation was confidential and voluntary. I placed signs to advertise my study in various places women frequent to use services and access resources (see Appendix A). Initially, I went directly to several of these places to explain my study and request permission for my sign to be placed there. The response was often negative. I also wrote letters to a number of physician offices and other agencies such as the Fort Garry Women's Resource Centre and the Women's Health Clinic to inform them of my research and to elicit their support for my study (see Appendix B for signs and Appendix C for letter). Receiving little response from my letters, I made phone calls to the appropriate person. Those places that did respond were supportive. I was, however, unable to gain support from any of the physician offices I contacted. Advertisements also were placed in a number of local community papers including *Coffee News*, *The Uptown* and *The Manitoban*.

I also designed referral cards that women could take from my signs or be given by mutual friends. The cards briefly described the study, listed my name and telephone and were small enough to conceal. Through both advertisements and the referral cards, I wanted to provide an inconspicuous way by which women could become informed of my research. On my voice mail, I left a message about the study asking women to either leave a number where they could be reached or leave a time that they may call me back so I could be there to take their call. With the newspaper advertisements and the referral cards, I slowly began to receive calls for the study. As none of the respondents identified that they had learned about my study through signs placed in any of the locations, this method of recruiting participants was deemed ineffective. Of the 10 women who participated in this study, five were recruited through advertisements in local newspapers and five women were recruited through personal referrals. It took 14 months to locate 10 women who were willing to participate in this study.

I conducted in person, open-ended, semi-structured interviews with women who had undergone facial cosmetic surgery (see Appendix D for Interview Schedule). The interviews were conducted in a variety of settings including the women's homes, a university office, and coffee shops.

My first contact with each woman was over the telephone. When a woman phoned, I briefly described the nature of my research, her involvement and answered any questions. At the initial phone call, I explained that her participation was completely voluntary and all the information she provided in the interview would be confidential. I also explained that her identity would not be revealed to anyone at any time.

Confidentiality was assured by several means. First, with the women's permission, the interviews were audio-recorded and then transcribed verbatim. Recording the interviews allowed me to listen to women without being distracted by note taking. Having the interviews on tape also gave me the opportunity to play the tapes several times to assure that my reading of the transcribed interviews more accurately matched the women's intentions. It also assured that the women's words were not taken out of context. Access to the tapes and transcripts were restricted to me alone. All tapes and transcripts were stored in a locked filing cabinet. Second, I used pseudonyms for the women to help ensure that their identity was unknown. Third, in my analysis, I refrained from including any information that could reveal a woman's identity.

Before each interview began, I briefly described the purpose of my study, reassured her of confidentiality and provided her with an information sheet on the study and a consent form (See Appendix E for Information Sheet and Appendix F for Consent Form). All 10 women freely gave informed written consent and gave their permission to use anonymous information from the interview in this study and any publications derived from it. The consent form indicated that the study was approved by the Ethical Review Committee in the Department of Sociology and followed the guidelines set out by the Department of Sociology at the University of Manitoba.

Each interview took a life of its own. The questions I asked and the responses provided did not occur in a linear fashion, in a similar way across the interviews. I did, however, try to assure that I had gathered information or asked questions on the major themes of the interview guide from each of the women. The interviews ranged from 45 minutes to over two hours, with the average interview lasting just over one hour.

All women were asked if they would like to receive a copy of the transcribed notes of the interview. Three of the ten women requested to see the transcribed notes and two mailed them back to me with their comments. When I followed-up with the third woman, she had no additional comments but asked to keep the copy of the transcript. In addition, all 10 women were offered a copy of the summary report which all women wanted and received (see Appendix G for Summary Report).

Sample Criteria

The sampling population consisted of women who had undergone facial cosmetic surgery. In framing the scope of my study, I was interested in exploring women's decisions to have facial cosmetic surgery and decided not to interview women who had undergone reconstructive surgery. Instead of using one of the many definitions offered on cosmetic surgery, among my criteria for this study was that the women themselves saw the procedure(s) they underwent as cosmetic surgery. This was a critical issue given that some women who participated in this study had procedures that clearly fall within the rubric of reconstructive surgery. Nonetheless, these women defined their surgery as either solely cosmetic surgery or a combination of both reconstructive surgery and cosmetic surgery.

Research Focus

The objective of this study was to explain women's involvement with cosmetic surgery. The following specifically describes the research questions this study addressed.

1. **How do women account for their decision to have facial cosmetic surgery?**

   Here my aim was to gain an understanding of how women account for their decision to have facial cosmetic surgery. My understanding was guided by such

questions as: What are the stories of women's involvement with facial cosmetic surgery? How is the decision to have facial cosmetic surgery reached? How do women interpret and articulate their decisions? This segment considered women's own interpretation and experience, in their own words.

2. **Is the decision to have facial cosmetic surgery influenced by social, economic, cultural and individual factors?**

My goal here was to understand the factors that influence women's decisions to seek facial cosmetic surgery. My aim was to locate the women in the social-cultural context in which their decision to have facial cosmetic surgery was made. In doing so, I attempted to expose the social, economic and cultural forces that may have influenced their decisions. Moreover, I examined the interconnections between agency and structure in order to explain women's involvement with cosmetic surgery.

3. **What does cosmetic surgery tell us about the relationship between women and their bodies?**

This component considered the theoretical and social implications raised from this study on facial cosmetic surgery among women. Of importance here was what can be learned about the relationship between women and their bodies based on their involvement with cosmetic surgery. In addition, the goal here was to further theorize women's involvement with facial cosmetic surgery by drawing upon theoretical insights from the sociology of the body as well as theoretical ideas that emerged from the data analysis.

Data Analysis Strategy

To guide the data analysis, I have drawn upon an approach offered by Derek Layder (1998) in his book, *Sociological Practice: Linking Theory and Social Research.*

In this book, Layder (1998) introduces the approach "adaptive theory" to both generate new theory as well as develop prior theory in conjunction with data collection and analysis. Layder (1998:5) explains:

> The word 'adaptive' is meant to convey that the theory both adapts to, or is shaped by incoming evidence, while the data itself is [sic] simultaneously filtered through, and is [sic] thus adapted by, the prior theoretical materials (frameworks, concepts, ideas) that are relevant to their analysis.

In other words, there is a constant interchange and dialogue between prior theory and emergent theory.

Interview tapes were transcribed as soon as possible following the interview. Analysis of the transcribed notes of the interviews involved an interplay of coding, categorizing and abstracting. I began preliminary analysis and coding of transcripts after the first four interviews were completed. Analysis of the interview data followed the strategy outlined in the adaptive theory approach, which includes: pre-coding and provisional coding; developing core and satellite codes; theoretical memo writing; and theory-generation. Pre-coding involved underlining parts of the text or putting an asterisk by certain sections to highlight its importance. This is pre-coding in that no labels or formal codes are applied but interesting answers or quotations are noted. In provisional coding labels or names are applied to parts of the transcripts that triggered some association to a particular concept or idea. This provisional coding is the first attempt to order and classify the data in a manner which was either revised or confirmed in subsequent coding.

Pre-coding and provisional coding are similar to open coding in grounded theory in that there is an openness to discovery at the early stages of the analysis. However, there are marked differences between adaptive theory and grounded theory. The purpose

of provisional coding in adaptive theory is not to generate as many codes as warranted by the data, as is the case of open coding in grounded theory. In addition, provisional coding and pre-coding do not necessarily give way to a more restricted type of coding as a result of developing core categories or concepts. Pre-coding gave rise to provisional codes, which were subsequently 'validated' by ongoing data collection and analysis and some of which were adopted as core codes or categories. Pre-coding and provisional coding were retained throughout the analysis and took place in the context of a dialogue with emergent theory and prior theory.

Developing core and satellite codes followed the traditional sense of coding whereby labels or names are used to classify the sections of the transcribed interview notes. Coding in this sense involves noting patterns and themes that shape the data. Using prior theoretical ideas is one method used to establish code names to relate easily the codes to past theoretical ideas. Nonetheless, a number of code categories also emerge directly from the data.

Memo writing is used to trace thoughts and ideas throughout the process of analyzing the interview data. Memos are also used to note theoretical ideas, to raise questions and to explore various connections such as between codes and categories and the theoretical ideas from the literature.

Extended memos from my memo writing were used to develop discussions of important concepts and ideas. This involved continually rethinking the meaning of the data as well as teasing out concepts and ideas that were playing a significant role in the analysis and interpretation of the data. In this sense, data analysis and theorizing occurred in conjunction with each other.

I have analyzed the data with the aim of generating theory, which has involved being mindful of prior theoretical ideas as well as being open to theoretical ideas that emerge in the data. I have used prior theoretical ideas as a means to give focus to the collection and analysis of data. In chapter two, I presented the theoretical influences on my work in order to assure that they did not unwittingly distort the data analysis or findings from this research. I have explored the overlaps as well as the differences in the theoretical ideas I have borrowed from others.

Theorizing the Data

I have borrowed a number of techniques and strategies from Layder's (1998) adaptive theory approach to help me think conceptually and analytically about the interview data and to develop a theoretical discussion in this study. One of the features of adaptive theory is that it focuses on the interconnections between agency and structure in social life. I used this approach to explore the ties between on the one hand, women's decisions to have facial cosmetic surgery, and on the other, the influence of the social, economic and cultural context. According to Layder (1998: 19), "adaptive theory attempts to combine an emphasis on prior theoretical ideas and models which feed into and guide research while at the same time attending to the generation of theory from the ongoing analysis of data." In other words, adaptive theory simultaneously privileges (prior) theory and research data in the emergence of new theory. This approach is the framework for the analysis presented in chapter five whereby I weave women's involvement with cosmetic surgery into a theoretical discussion of the women's bodies by drawing upon prior theory, as well as theory that is generated from the data collected in this study.

CHAPTER FOUR

Findings

The purpose of this chapter is three-fold: firstly to provide a contextual basis in which women's decisions to have facial cosmetic surgery were made; secondly, to outline women's accounts of their decisions as discussed by women themselves; and thirdly to explore the relationship between women and their bodies based on their involvement with cosmetic surgery. Before examining the nature of women's involvement with facial cosmetic surgery, the women as a group must be situated in terms of their biographies and social location.

Women's Biographies

As a group the women in this study are relatively homogenous, sharing in common the experience of facial cosmetic surgery. All the women, either at present or previously, lived within the City of Winnipeg. All 10 women were Caucasian. In class terms, all the women described themselves as being middle to upper-middle class. Three of the women were university students, two women worked in a professional occupation, one woman was employed full-time and attending university part-time, and the remaining four women were retired. Of the 10 women, two had graduated from university, five had some university education and the remaining three had graduated from high school. The ages of the women interviewed range from 23 to 73. All of the younger women (ages 23 to 35) in this study (N=6) were single, and all of the older women (ages 57-73) were married (N=4).

Types of Surgery. Of the ten women in this study, five of the women had undergone one procedure each of type-changing cosmetic surgery, i.e., surgery designed

to create a new appearance. Procedures included: nose-reshaping (N=3), dermabrasion to remove acne scars (N=1), and eye muscle tightening (N=1) for cosmetic reasons. One woman had multiple type-changing cosmetic surgery which included jaw, chin and lip surgery. The remaining four women had undergone multiple restorative facial cosmetic surgeries i.e., surgery to restore the person to her previous appearance. Multiple restorative procedures included: face-lift and eyelid surgery on separate occasions (N=2), two face-lifts at separate times (N=1), and simultaneous eyelid surgery and neck liposuction (N=1). The women who had type-changing facial cosmetic surgery were younger than the women who had restorative facial cosmetic surgery (age range 23 to 35 versus 57 to 73 respectively). A summary of the participants' ages and procedure(s) is shown in Table 1.

TABLE 1

Participants by Age and Type of Cosmetic Procedure

*Participants**	*Age*	*Type of Cosmetic Procedure*
Amy	23	Nose-reshaping Surgery
Grace	25	Nose-reshaping Surgery
Stephanie	27	Jaw, chin and bottom lip surgery
Victoria	29	Dermabrasion
Tamara	30	Muscles in eyes tightened
Sharon	35	Nose-reshaping surgery
Marlene	57	Face-lift, eyelid surgery
Rachel	58	Mid-line face-lift, eyelid surgery
Rose	66	Eyelid surgery, neck liposuction
Lillian	73	Two face-lifts

*Pseudonyms

The women who participated in this study are not representative of all women who have facial cosmetic surgery. While no Canadian data are available, American data report nose-reshaping surgery to be the most common type of facial cosmetic surgery among

women under 35 years of age, and eyelid surgery followed by face-lifts the most common types of facial cosmetic surgery among women 35 years old and over (ASPRS, 1994). In this respect, the types of surgery performed on the study participants appear to follow a similar pattern reported in American statistics on cosmetic surgery recipients.

To understand women's decisions it is important to highlight the context in which their decisions were made. As such the following provides an introduction to how women's decisions to have facial cosmetic surgery were reached.

Amy's Story

Amy is a university student in her early 20s. After graduating from high school she did not know what she wanted to do with her life and "was more into [her] social life than anything else." She was "hanging around" friends who were very "superficial," "*Cosmo* type people" and "ostentatious." Once she gained a focus on what she wanted to do with her life and made plans to pursue a university degree, she wanted to perfect herself in every aspect possible. Being under the influence of a lot of superficial people she thought, "what can I do to try and perfect the way I look?" Her view of perfection was a "piggy-nose"– a nose that has an upturned angle, and she decided to undergo nose-reshaping cosmetic surgery.

Grace's Story

Grace is 25 years old and works full-time while attending school part-time. She described herself as a "fitness fanatic" and plays a number of sports. Grace was involved in a sporting accident which left her needing reconstructive surgery on her cheekbone and nose. Since she was already having her nose corrected due to the accident, and she had always felt that her nose was too large, she decided to have it made smaller. She viewed

changing the shape of her nose following the accident to be cosmetic rather than reconstructive surgery. These unique circumstances provided Grace with an occasion to have cosmetic nose-reshaping surgery at no cost, given that her physician could, and in fact did, bill Medicare for the surgery under the claim that it was reconstructive surgery.

Stephanie's Story

Stephanie is 27 years old and is employed full-time in a professional occupation. About two years ago, Stephanie created a "wish list" of things she wanted to accomplish in her life and one of the items on her list was having facial cosmetic surgery because she hated the profile of her face. She had no angle to her chin. When she was seeing an oral surgeon about having her wisdom teeth removed, he suggested jaw, chin and lip surgery to repair what he termed her "facial deformity." Since she always wanted the surgery done, she felt this was an opportunity she could not pass up and decided to follow the surgeon's suggestion and have surgery on her jaw, chin and lip.

Victoria's Story

Victoria is 29 years old and is pursuing a university degree. She said that right now she is really feeling good about herself but there was a time in her life when she was not and that is when she had dermabrasion. Since the age of 14, she had severe facial acne. When she was younger she was really self-conscious of her acne. This time of her life was characterized by depression, low self-esteem and a sense of hopelessness. When she was 21, she decided to finally "do something" about the acne and went on the drug Acutane. She related how she was raised in a controlling family and the starting point of her gaining control over her life and feeling better about herself was the decision she made on her own to take Acutane. The drug helped remedy the acne but left her with

scars. For Victoria, the acne scars were reminiscent of the psychologically upsetting time in her life. At the age of 25, Victoria decided to again "do something" and underwent dermabrasion.

Tamara's Story

Tamara is a 30 year old graduate student at university. After having the muscles in her eyes tightened so that they would be straight, Tamara, with her new increased level of self-confidence, made a number of changes in her life including pursuing a university education. Tamara described that she had always dreamed of someday getting her eyes "fixed" but no one had ever suggested it until she was in her early 20s when a physician asked if she ever thought about getting her eyes fixed. It was this doctor who connected her with a physician who specialized in that type of surgery and "that's how the ball started rolling." Tamara was "sick and tired" of everyone making comments about her eyes and just wanted to be normal. She related how, while working as a bank teller, people could not tell that she was talking to them because her eyes were "crooked." When she would say "Can I help you over here, please" customers would look around and ask "are you talking to me?" These types of social interactions served as a constant reminder to Tamara that her "eyes weren't right."

Sharon's Story

Sharon is 35 years old and is employed full-time in a professional setting. She described that her first visit to an ear, nose and throat specialist in 1996 as not for cosmetic purposes but for some sinus trouble she was having. Her first consideration of nose-reshaping surgery came at the suggestion of the surgeon. Sharon said that she never, ever, at any point in her life thought of having her the shape of her nose changed. At this

first visit, it was the physician who said "we can make some changes to your nose." He told her to give it some thought and that it would cost $700. Since the money was not an issue for her at the time, three months later, Sharon elected to have the nose-reshaping surgery at the same time she was undergoing the sinus surgery.

Marlene's Story

Marlene is 57 years old and has had two experiences with facial cosmetic surgery. In 1989, she had eyelid surgery because her eyelids "were literally hanging down to [her] eyelashes" and this was "a family trait." Her sister had eyelid surgery years before her and she thought since it worked for her, she would do it too. Her second experience, a face-lift in 1992, was more complicated because at the time she was undergoing intensive psychotherapy to deal with child abuse issues from her past that surfaced in her later life. She explained that every morning when she would look at herself in the mirror, there were bags under her eyes and deep lines on her face which to her were an outward sign of the agony she was going through. She thought, "Oh God, what a way to face the day." However, the main reason Marlene decided to have a face-lift, was because she did not want to look like her mother who was in total denial of the abuse.

Rachel's Story

Rachel is 58 years old and is retired. In November of 1996, she had surgery on her lower eyelids and a mid-line face-lift and then again in May of 1997, she had surgery on her upper eyelids. The thought of having facial cosmetic surgery entered Rachel's consciousness eight years before she had the surgery when she went through all the preliminaries and then "chickened out." She spent the next eight years wishing she had done it. When she gained up enough courage again, Rachel went to see another cosmetic

surgeon who happened to have a cancellation and she took the cancellation scheduled for three weeks later. She was completely stunned when she left his office and asked herself, "what have I done?" She went ahead and actually did have her surgery on her lower eyelids and a midline face-lift. After her first surgery, she thought she would never do it again. Then on a follow-up visit, her physician and she were talking and reached the conclusion "why half do it?" and they decided she should have her upper eyelids done as well. She was just as mystified at how she got to the point of having cosmetic surgery again as she was when she scheduled her appointment for her first surgery.

Rose's Story

Rose is 66 years old and is a retired hairdresser. Weight fluctuations left her with a lot of excess skin and fat on her neck which she described as being like a "turkey neck," with a feeling of "crepe paper" and giving the appearance of having no chin. She hated the way her neck looked which made her unhappy with the way she looked more generally. Rose first got the idea of having liposuction on her neck after seeing the procedure performed on television. She went and saw a cosmetic surgeon in 1996 before following through with her decision a year later to have neck liposuction. At the suggestion of her cosmetic surgeon, she had eyelid surgery as well.

Lillian's Story

Lillian is 73 years old and divides her time between travelling with her husband and friends, and volunteering. She said that she would like to gain more information on cosmetic surgery in consideration of the possibility of having a third face-lift. Lillian is very centered on her physical appearance and has always liked to "look good." She attributes this to the influence of her mother who was someone who always "kept up" her

physical appearance and instilled this norm of femininity within her. She explained her desire for a third face-lift as "even at age 73, a woman wants to look as good as possible."

In summary, this discussion has provided the context in which women's decisions to have facial cosmetic surgery were made. The context helps one to understand how women reached their decisions to have facial cosmetic surgery. What becomes apparent in hearing the women's stories is the influence of a number of external forces in their decisions. I now want to turn attention towards these influences by examining the themes that were raised in women's accounts of their decisions to have facial cosmetic surgery.

Women's Accounts

In this section, a number of themes identified in women's accounts to have facial cosmetic surgery are presented to reveal the nature of women's involvement with facial cosmetic surgery. These themes are organized around individual, social, cultural, and economic factors that influenced women's decisions to have facial cosmetic surgery. At the level of the individual, themes included, decision justification and normalization; identity; and agency and choice.

Decision Justification and Normalization

All the women interviewed sought to normalize and defend their decision to have facial cosmetic surgery. They justified their decisions in a number of different ways. Lillian (73) felt that cosmetic surgery falls into the same category as other forms of body improvement, such as losing weight, wearing make-up or coloring your hair. She felt more women would have cosmetic surgery if they had the financial resources and more information. Similarly, Amy (23) said in reference to her nose-reshaping surgery:

> *I expected just really an increase in the angle. It seems so tedious, stupid, lame, but a nose can do so much for your face. It can and I know it can because I've always*

studied faces. And I wanted, by increasing the angle between my upper lip and my nose, [to] accent the rest of my face and bring out the good features. Like make-up or anything else would. For me it was an extension of make-up. I guess the same principle of putting on make-up. And that's why I wanted to. I've always done shading along my nose and I thought I won't have to shade my nose any more.

Cosmetic surgery was often viewed as one of many, and no different from, other body maintenance techniques and practices. This normalization of a potentially dangerous procedure is not surprising given that the vast range of services and products that are "produced, marketed and sold, point to the significance of appearance and bodily preservation" within North American society (Featherstone, 1991: 170).

While body maintenance was an important factor, heredity and genetic destiny were also used as a justification for a woman's decision to have facial cosmetic surgery. Marlene (57) explained that she had her eyelids tucked because they were "literally hanging down to my eyelashes" and that this was a family trait. Using the same argument, Rachel (58) explained that she had the same deep lines under her eyes as her father. Inherited ethnic features were also invoked as justifications for nose-reshaping cosmetic surgery. As Amy (23) explained, "I'm of German descent and we come from a family with large noses and it grows as we get older." Similarly, Sharon (35) stated: "I always thought my nose was a lot longer because I'm Ukrainian and a lot of us have a typical long thin nose."

One might deduce from such statements that the women's decisions to undergo cosmetic surgery may be empowering to them, for their surgery provides them with a more permanent solution than "make-up" for "personal" dissatisfaction they have about their features. However an examination of their descriptions of the natural appearance of

their features reflects the larger social-cultural negative evaluation of certain inherited ethnic features as well as aging in women.

In addition to body maintenance and heredity as justifications for surgery, unique personal circumstances were also cited. For Grace (25), her decision to have nose-reshaping surgery coincided with reconstructive surgery following an accident. She rationalized that since she was already having her nose corrected due to the accident, she would have it made smaller as she had always felt that her nose was too large. For Grace, coincidence led to cosmetic surgery and she was adamant in asserting that she would never have undergone nose-shaping surgery if she just simply did not like her nose.

A common belief is that cosmetic surgery is a decision based on vanity. The women who participated in this study both rejected and feared this notion. Statements such as "I don't associate vanity with trying to look good" (Amy, 23) or "it's okay to look good sometimes and it's okay to feel good about the way you look and it doesn't mean that you're vain" (Victoria, 29) suggested that women's decisions to have cosmetic surgery are not reached based on vanity. At the same time, a number of women expressed fears of people judging them as vain. Victoria (29) explained with reference to her dermabrasion for acne scars:

> *The vain thing was a problem with me when I decided to do this. That was [the] whole justification or legitimacy from it being covered in Medicare was that they saw it as a psychologically upsetting traumatic thing for a person to go through and that's why it was covered and that was acceptable because I've always had a problem that somebody might think I'm vain.*

Sharon (35) described how the fear of people judging her as vain is the basis for her withholding the fact that she elected to have facial cosmetic surgery. She stated:

> *I would have a hard time telling people I don't know very well that I had nose surgery done because I didn't like the way my nose looked. I think that I'm lucky in the sense*

that I was able to just say it was part of my sinus surgery thrown in. And to tell you the truth, I haven't told a lot of people that I paid for it because I think I'd be embarrassed to tell them I did because they'd think I'm vain.

For a number of women, justifying their decision also involved the need to present themselves as not vain because that is what they felt the larger culture perceives them as being. Tamara (30) explains, "A lot of people would think it's due to vanity. I guess you can say so, but I wouldn't say vanity in that negative connotation. I would say vanity, in how does it make me feel? Do I feel like a stronger more confident person?" The fact that many of the women in this study felt a tension between their desires to look good and feel good about the way they look and their fears of being judged as vain for it, points to the primacy of appearance in their lives.

Identity

The literature on cosmetic surgery suggests identity is an important concept that helps to account for women's involvement with cosmetic surgery. Davis' research on women who had cosmetic surgery in the Netherlands found that for a woman who felt trapped in a body that failed to match her sense of self, cosmetic surgery was a way to renegotiate identity through her body (1995). The theme of identity was also raised in Goodman's study of American women's receptivity to cosmetic surgery. Reporting on older women who all had undergone facial cosmetic surgery, she found "cosmetic surgery enabled them to stop the clock; to put their faces in synchrony with their inner feelings of youthfulness" (Goodman, 1994: 380).

The theme of identity was also supported in my analysis of transcripts from the interviews. More specifically, identity was raised in relation to reconstructing one's identity. Marlene (57) said the main reason she underwent a face-lift was in order not to

look like her mother. At the time of deciding to have cosmetic surgery, Marlene was undergoing intense psychotherapy to deal with child abuse issues from her past that surfaced in her later life. Her mother and her sister were in total denial of the abuse. She explained, "In order to gain my own identity, in order to, to just try to find out who I was after being so connected to them for so long, that's what I had to do." Her decision to have a face-lift was based as much on wanting to be herself as not wanting to look like her mother. For Marlene, cosmetic surgery was part of the process of reconstructing an identity different and separate from her mother.

Identity was also raised in relation to "ideal" versus "real" identity. Rachel (58) explained her decision to have eyelid surgery and a mid-line face-lift as, "You just want to come out looking more like your image of what you think you look like. And I guess I only wanted to remove the bags under my eyes and get back to the way I looked before they started to appear." Lillian (73) explained that she wanted a younger looking face to match her more youthful appearing figure. When asked if she had other expectations of the surgery beyond the physical change, Tamara (30) responded:

> *I knew that once I had this surgery I was going to be like everybody else. And once I'm on the same par as everybody else, it was sort of like the real me could show through. That's what I think I wanted. I wanted people to see the real me because I had this tendency to be shy before and I knew that I wasn't shy.*

For these three women, cosmetic surgery enabled them to reconcile the discrepancy between their "real" and "ideal" identities.

Agency and Choice

In keeping with Davis' findings (1995), agency emerged as an important theme in the analysis. Davis (1995) contends that women who have cosmetic surgery are not victims of the cultural beauty system but rather can be seen as competent and

knowledgeable subjects who act upon conditions which are not of their own making. Davis (1995) argues that cosmetic surgery is a way for women to be active agents and to take action over their dissatisfaction with their appearance. In this study, agency surfaced in relation to the decision-making process and carrying that decision through. This is captured by Marlene (57):

> *It's kind of like the surgery for me was a symbol, or the doing of it, not so much the effect, but the doing of it, the deciding to do it and the carrying out of my decision. And having the courage to discuss the financial situation with my husband, all those sorts of things, the doing of that was a very brave act for me.*

Victoria (29) also expressed how carrying through her decision was more important than the results of her cosmetic surgery. She explained:

> *Just saying this is what is going to make me feel better, I'm going to admit that, and I'm just going to do it. And I'm just going to take charge of it and that's I think what gave me satisfaction as opposed to the percentage of improvement. That was a big part of it. Because that helped me understand that I can do whatever I want...It kind of broke that barrier to me sitting and wishing and wondering too, like me doing, and feeling better and taking charge.*

Some of the women expressed how cosmetic surgery was a decision they reached on their own and that making the decision to proceed rather than the cosmetic surgery, *per se*, was the key factor that gave them confidence in their decision-making abilities. In this sense, making the decision was what made some of the women agents; however, cosmetic surgery itself is not about agency. In fact, for a number of women, the conditions of genuine choice were questionable, particularly given the influence of social and cultural forces such as the medical profession, social relationships and the pervasiveness of cultural images of beauty and aging.

The Role of the Medical Profession

Some women make their own decisions, others wait for powerful others. It was not uncommon for women in this study to be influenced to have cosmetic surgery on the recommendation of a physician. Tamara (30) discussed how she always dreamed of someday getting her eyes fixed because they were not straight but how no one, not even her eye doctor, ever suggested it until she was in her early 20s. She said:

> *It wasn't until I went to went to see another doctor, I think it was about my acne or something and the doctor just came out and said, 'Have you ever thought about getting your eyes fixed?' And I did. It was always on my mind. It was like, I think it was everyday, I thought about my eyes. I am sure of it. And when he said that to me, it was like, it was just like, I couldn't believe it. It was like somebody actually sort of finally suggested it. And I said, 'Yes I have, but I don't know how to go about doing it.' And he got me hooked up with a guy who specializes in this particular type of surgery. And that's how the ball started rolling.*

Similarly, Stephanie (27) hated her profile as she had no angle to her chin and also thought about some day getting it fixed. If she saw a picture of herself displaying her profile, she would immediately rip it up. The opportunity arose when she was seeing an oral surgeon about removing her wisdom teeth and he offered to fix her jaw. Stephanie (27) elected to have jaw, chin and lip surgery, which required her mouth being wired shut, and an eight-week recovery. Rose (66), who had liposuction on her neck and eyelid surgery at the same time, related how the eyelid surgery was the physician's suggestion. She recalled, without comment on the inappropriateness of the remark, that the physician said, "do you want these bags removed or are you packed to go away somewhere?" And he said I'll just do them and I said okay....So I didn't go there for that." Rachel (58) recalled how after she had her lower eyelids done and a mid-line face-lift she thought:

> *Oh God, I'll never do this again and for some reason or another I was going back for my follow-up and we started talking about my upper eyelids and we came, him and I*

came to the conclusion, why half do it? You might as well do it. So I went ahead and did it again and I couldn't believe it.

Sharon (35) described her visit to an ear, nose and throat specialist, not for cosmetic purposes but for some sinus trouble she was having. However, her first consideration of nose-reshaping surgery came at the suggestion of the surgeon. As Sharon described:

I never ever at any point said, 'Oh, I'd like to get my nose changed.' NEVER. And he's the one that said 'we can make some changes to your nose.' I didn't think anything of it. He said to give it some thought and I asked him what it would cost and he said $700. So I left it at that.

Later Sharon elected to have the nose-reshaping surgery at the same time she was undergoing the sinus surgery. Consequently, for a number of the women in this study, the medical profession had a strong influence on their decision to have facial cosmetic surgery.

A further reason supporting my contention that the conditions for genuine choice were not met is the amount of information available to women in this study to equip them to make an informed decision. While the medical profession has been actively promoting cosmetic surgical procedures, the women's accounts in this study suggest that a number of women were hampered in their choice by the lack of information available to them. Lillian (73) who is considering a third face-lift said, "other than what the physicians tell me, I don't have any other source of information." A number of the women who participated in this study expressed dismay over the information provided by cosmetic surgeons as they felt they were not adequately informed as to what to expect from the surgery. When I asked Tamara (30) whether the results were what she expected, she said:

The first little while, no. I almost regretted the surgery for the first little while. Actually that was one of the first things when I woke up, cause you know the doctor

assured me that this won't be so bad and I think that I said when I woke up was 'You told me that this [wouldn't] be so bad.'

Amy (23) described her anger at her physician for failing to inform her of the risks associated with her nose-reshaping surgery:

I'm just saying when you pay $2,000 and put your trust in someone who is supposed to be a specialist in the area and have, I believe they have a duty to inform you of all the risks and I wasn't informed my nose could come out larger than what I went in with. He said, at the worst, this is an exact quote, 'At worst, your nose will be the same.' I knew there was a risk of death with the anaesthetic...And that is kind of ironic, I guess the fact I would have acknowledged the fact that 'yes, I know I could die, but no, my nose is not going to come out worse.' Because he didn't tell me that, that just didn't cross my mind.

Her surgery left her with a nose that is classified as a severe secondary deformity and in order to get it repaired she would have to see a specialist in the United States at a cost of approximately $20,000. Other potential risks of cosmetic surgery include infection, hemorrhaging, and blood clots, all of which can cause severe impairment and in rare cases, even death (Human, 1987). It is estimated that 10 percent of cosmetic surgeries entail some unexpected and negative outcomes (Cobb, 1988). The lengthy duration of recovery from the swelling and bruising left most women anxiety ridden over what the actual results would look like. For four of the 10 women interviewed, the anxiety was justified when results required additional cosmetic surgery.

Grace (25) was told by her cosmetic surgeon, "Three things could go wrong with the surgery but I have never experienced any of them. One, you could get and infection, two, you could end up being rushed into emergency and three, you could need more surgery." All three of the potential risks she was informed about happened to Grace. Two other women who participated in this study also had infections and had to be rushed

into the hospital for emergency care, one of whom was rushed to the hospital on three separate occasions due to her surgery.

The women who participated in this study were often in a position where they had to trust their surgeon's skills and the amount and type of information he or she provided. As Sharon (35) explained, "I mean, you're really trusting your surgeon and I never saw his work, nothing. And that was the scariest part. I had a lot of anxiety in general, to the point where I almost didn't do it...but he seemed very confident and I had to trust him." Rose (66) put a remarkable amount of trust in her physician and did not want to be an informed consumer of cosmetic surgery. She related:

> *He [the surgeon] wanted to explain to me exactly what he was going to do. And I said I really don't want to know...as long as you do what I tell you to do, what I would like to be done. And I said how you do it, I don't care. I'm sure I'm not your first patient here. I didn't really want him to go into details.*

Amy (23) said she was left with "such a feeling of deception and betrayal" when the results of her nose-reshaping surgery were disfiguring.

For a number of women, aside from their surgeon, their only other source of information for cosmetic surgery was the media. By her own account, Rose (66) was introduced to the idea of having liposuction on her neck from watching a program about liposuction on TV. A few women interviewed were led to believe, by relying on media as a source of information, that cosmetic surgery was a "piece of cake." Women's magazines often glorify cosmetic surgery as a means to improve appearance and resist the ravages of time (Lupton, 1994). Among the before and after photographs, there is no trace of "between" stage photographs showing bruised faces and bodies, rent with surgical stitches (Lupton, 1994). Rachel (58) described her expectations and experience of cosmetic surgery:

I felt that there was probably not much to it and I think that was an image I got from listening to other people like on TV that said 'Oh, I've had facial surgery or I've had my eyes done and I was back out on the street in two days.' And I thought there can't be much to this. NOT TRUE! It took six weeks before I felt that people wouldn't ask me what happened to me.

Likewise, Sharon (35) warned that, "if some of these women saw what they might look like or feel, a lot of them wouldn't get it done. I guarantee it." The lengthy periods of pain and the unintended deformities are absent from the photographs in magazines (Sullivan, 1993). Reading women's magazines, a woman might learn of possible complications and risks of cosmetic surgery, but not their probability (Wolf, 1990).

While some women drew upon media as a source of information, social relationships were not often used as most women did not know anyone who had undergone cosmetic surgery. Rachel (58) said, "The one thing I feel was lacking with me was I didn't talk to anybody who had surgery." Nonetheless, social relationships appeared to have a bearing on women's decisions to have facial cosmetic surgery.

Social Relationships

While all the women dismissed the influence of significant others on their decision to have cosmetic surgery, many women's decisions were indirectly, if not directly related to social relationships, particularly family relationships. As mentioned above, Marlene (57) underwent a face-lift in order to look different from her mother. Grace (25), who underwent nose-reshaping surgery, explained that when she was a young child she had a cousin who had a large nose. Her father often said to her that if her nose turned out like her cousin Kim's, they could get it fixed. Grace said, 'he always put this bug in my head that my nose was going to be so hideous. And so, when I got my surgery he said, 'You definitely don't look like Kim.'"

Lillian (73) explained that the importance she placed on her physical appearance was greatly influenced by her mother. Her mother was someone who had invested a lot of time and energy to keep up her own appearance. This modeling of appearance from her early adolescence was something Lillian felt she carried with her throughout her life. She explained her desire for a third face-lift as "even at age 73 a woman wants to look as good as possible." Similarly, Goodman (1994) found that women who developed an appreciation of their worth as females through their appearance carried this value into middle age and late adulthood. Tamara (30) said that both her parents are "very much centered on the way they look," and that she thought she was brought up that way too.

Amy (23) recounted how her peers greatly influenced her decision to have nose-reshaping surgery. She said, "being under the influence of a lot of superficial people, I thought, well, what can I do to try and perfect the way I look?" Amy and her peers, like a number of women in this study felt the pervasiveness of cultural images of beauty and aging.

Cultural Images of Beauty and Aging

More readily than older women, younger women in this study acknowledged the social pressures on women to conform to standards of physical attractiveness. Amy (23) explained:

> *What I guess I really wanted to do, why I did the surgery, was you know, you just have to open a magazine and go walking through a mall and you see so much emphasis put on the way people look and people are very superficial and pretentious. You see men going after the best looking, the smartest, this and that and you want to be the best you can be....But I think society really puts more importance on the way you look rather than living or dying. And I think I got sucked into that.*

Only a few women discussed feeling societal pressures to conform to standards of physical attractiveness for both personal and economic reasons. Sharon (35) said, "I've done a lot of reading through some of the classes I've taken and they have always commented on how more attractive people tend to get the more successful jobs and all that kind of thing. And you know what, I wouldn't say that's not true." Even if a woman cognitively resigns herself to the fact that she is unable to match up to these standards of beauty, or even if she rejects them outright, the larger culture still judges her by these cultural images of beauty. The cultural messages of how women should look and act is endlessly disseminated in mass media endorsing "a value system that preaches bodily perfection and deny [sic] women the right to age" (Goodman, 1996: 376).

The women in this study often expressed their reasons for cosmetic surgery in terms of a desire to "look better" rather than "beautiful." For Amy (23), "looking better" involved reshaping the tip of her nose to achieve the perfect proportion in order to emphasize all her best features. A number of women explained that their surgery did not change the way they looked but rather it improved the way they looked. Sharon (35) explained that the surgery "didn't really change the way I looked in the first place. But I would say it improved the way I looked." Lillian (73) explained that her face-lifts greatly improved the appearance of her face and that a lot of women with "wrinkles" could really improve their appearance as well by having cosmetic surgery. The women in this study were influenced by cultural images of aging and beauty in such a way that they evaluated themselves and other women in general with a critical eye. Their judgments were based on standards stemming from the larger social-cultural context.

The four older women in this study (age 57 and older) often expressed their motives for cosmetic surgery in terms of dissatisfaction with particular facial parts or features rather than dissatisfaction with the aging process. As Rachel (58), who underwent eyelid surgery remarked, "I was really unhappy with these bags under my eyes. I've got lots of other lines and I can live with those, but these, I could not live with the bags." For Marlene (57), who at the time of undergoing a face-lift was in therapy dealing with child abuse issues from her past, the bags under her eyes and the facial lines were an outward sign of the agony she was going through, rather than as a result of aging. She knew she would get through the agony part, but she did not want to be left with the evidence of the agony staring her in the face every single day of her life. The women interviewed often referred to how these signs of aging, such as bags under their eyes, wrinkles and lines made them look ravaged or tired. However, overt reference to these characteristics as a sign of aging or that they contributed to looking old was not made.

The transcribed notes revealed conflicting references to the role of aging. On the one hand, the women in this study did not see cosmetic surgery as an age concealment technique citing for example, their non-dyed gray hair as supporting evidence. Rose (66) discussed her fear over the degree of change the surgery would make. She said:

> *What bothered me is that I didn't want it to be a big, big difference. I didn't want to turn from 65, I didn't want to look like I'm 30, you know what I mean? It doesn't fit the rest of my body. That was, I didn't want people to look and say 'OH, MY! What did you do to yourself?' But the doctor said, 'It's not a good job if people can notice it.' But that was my biggest thing. I didn't want it to be such a drastic change.*

Rose, like a number of other women, did not want the results of the surgery to make her look too much younger than her chronological age. The women who participated in this study denied trying to defy the aging process or mask their chronological age. On the

other hand, many women interviewed expressed fears of looking older than their chronological age. As Rachel (58) described, "I guess my biggest fear was being like 50 and looking like 65. And as long as people look at me and don't think that I'm getting on towards 60 and they think I'm 75. I just want to look my age, that's all." The social pressures on women to maintain a "youthful appearance" did not escape these women, even though by their own account, they looked younger than their age-peers even before their surgery.

The six younger women (ages 23-35) in this study often expressed concern over the physical signs of aging. When asked whether there were changes in her appearance that she's noticed over the last few years and how she viewed these changes, Tamara (30) responded:

> *I've got wrinkles on my neck now. I never thought I would, but I've noticed I've got wrinkles on my neck and around my eyes...I don't like them. I don't like them at all. No. I feel that if I could age without them I'd be all the better for it. No, I really don't enjoy these changes at all. I don't see these wrinkles as a sign of wisdom, I see them as wrinkles.*

Amy (23) saw her nose-reshaping surgery as a preventive measure as she came from a family with large noses that grow in size with age. She explained, "My aunt stayed single most of her life and she had a very, very, very large nose. So, I think I was influenced by that...I was scared that it was going to get bigger and everything I guess."

The younger women's concerns about age-related changes suggests that these women may resort to having more cosmetic surgery in the future and, by their own accounts, a number confirmed this possibility. Sharon (35), for instance who had recently seen a dermatologist for age spots, explained that she would not rule out the possibility of having a face-lift when she is 50 or 60 and that her decision "depends on

how horrible it [her face] looks." The younger women in this study were also more receptive to the idea of having more cosmetic surgery than were the older women. Even Amy (23), whose surgery left her disfigured, explained that she would consider having more surgery in the future. She said, "I know what happened to me was rare. I know there's a lot of good things that come out of surgery."

The inclusion in this study of both younger and older women underlines clear age group differences in women's acceptance of physical aging and their physical appearance. Older women generally felt better about aging and their physical appearance than younger women did. With the aging of the "baby boomers" and the continual increase in the number of women who are electing to have cosmetic surgery, further research exploring the relationship between aging and cosmetic surgery is needed.

While this discussion so far has considered the influence of individual, social and cultural factors on women's decisions to have facial cosmetic surgery, another factor that needs to be examined is economics.

Economic Issues

Economic factors did not play a uniform role across women's accounts of cosmetic surgery. However, several economic issues were implicated in women's decisions to have facial cosmetic surgery. Economic feasibility played a role in some women's decisions. For example, Marlene (57), whose surgery cost more than $6,000 said, "that was probably one of the biggest concerns...feeling am I worth that much money; that is an awful lot of money." Rose (66) was happy to learn that she could claim a portion of the $6,000 she spent having neck liposuction and eyelid surgery on her personal income tax. Victoria (29) whose dermabrasion was covered under Medicare,

explained that the coverage under Medicare was a deciding factor in her choice of procedure for acne scars. She explained, "There are other treatments out there. There's laser surgery and all that stuff and that's really expensive and you know what, I couldn't justify doing that....I couldn't justify doing something that expensive, paying that much money for a physical cosmetic thing." All of Tamara's (30) surgery and a portion of Stephanie's (27) surgery were also covered under Medicare. This influenced the timing of their surgery rather than their decision per se, in that they had both hoped someday to save enough money to have the surgery. Financial costs of the surgery were a concern for some women. So was the potential loss of wages from work due to the lengthy recovery time. Sharon (35) explained that her nose-reshaping surgery, "required me being off three weeks from work where I would have normally been off only a week for the sinus surgery. So that too was an issue to consider." However, when possible, the women arranged to have the surgery coincide with their vacation time in order to accommodate the recuperation period following surgery.

Only Amy (23) acknowledged the potential for economic benefits that could be gained by having cosmetic surgery. She explained:

> *I think maybe that was a little bit part of the reason why. Just the fact that there seems to be so much competition in every aspect of living, career, competition to get the best man, there's so few...And, I believe that being attractive helps you in employment. People like looking at attractive people. And I know that.*

It is not surprising that economic benefits were seldom raised by the study participants given that most participants were not employed full-time in the paid labor force. In the literature, economic restructuring is found to be a strong influence for the growth of cosmetic surgery among both men and women, but particularly men. In this study, only three of the younger participants were employed full-time and the remaining three were

attending university full-time. All four older women were retired from the paid labor force. Consequently, economic restructuring in a culture that values youth and attractiveness in the job market, was not raised as an influence in these women's decisions to have facial cosmetic surgery.

In summary, I have discussed a number of findings from this study. Thematically, individual, social and cultural factors were found to influence women's decisions to have facial cosmetic surgery. Economic factors were found to play a limited role in women's decisions. At the level of the individual, decision justification and normalization, identity and agency and choice were identified as key themes. These individual factors, however, were clearly integrated into both society's negative evaluation of age-related changes in women and prevailing cultural images of beauty. Indeed social and cultural forces such as the role of the medical profession, the influence of social relationships, and cultural images of beauty and aging were clearly implicated in the decision-making process.

Women's Faces and Bodies

This section examines the relationship between women's faces and bodies and their decisions to have facial cosmetic surgery. This entails examining women's accounts of their faces and bodies. Themes that were identified include: the physical body, disciplinary practices, and the body as a project.

The Physical Body

The physical reality of the appearance of women's faces and bodies was the foundation for women's body image in this study. In other words, physical appearance

was a potent determinant of a woman's self-perception. The acne on Victoria's (29) face affected her body image and self-esteem. She stated:

> *I remember going shopping when I was younger. I used to really hate it because when I had acne on my face, I used to think I didn't deserve to buy this kind of clothing. It wouldn't look good on me anyway and people would see my face and think ugh, so what she's wearing a dress, look at her face!*

The women in this study often discussed the change in their body image following cosmetic surgery. When I asked women how satisfied they were with their physical appearance, a number of women responded that they were satisfied now but were not satisfied before their surgery because of certain physical features of their faces. Amy (23) was the only woman whose surgery made her feel worse about her body because her surgery left her disfigured. Unlike a number of other women who underwent additional surgery to correct disappointing results, Amy's (23) has not had additional surgery to correct the disfiguring results. Clearly, the physical features that were negatively perceived among study participants affected how they perceived their entire body.

Women's physical bodies also formed the basis for a number of social interactions. Tamara's (30) account of the physiology of her eyes demonstrated how this feature of her body was constantly implicated in her social encounters. She said:

> *I can't understand why they would like, you know, verbalize it to my face so much....People would say you know, "Are you looking at me? Are you blind in one eye?" It was like they had no problem and these were adults. These weren't children, but it was funny how adults could say that. When I was a child, I'd get it from the other school kids, I'd be made fun of all the time and you know, a lot of people thought I was weird or something like that. I'd get picked on a lot and stuff like that. So, that happened, that's right from elementary to up into my 20s when I finally got my eyes done.*

Some of the women related stories of how significant others and acquaintances pointed out their "large nose," "crooked eyes," "lack of chin" and "acne." Victoria (29)

explained, "some people would say to me, you know you are so pretty but you have acne. I had a few people say something like that when I was younger, and that kind of thing stays with you." Bartky (1999) explains that these intrusions on women's bodies are often softened by reference to the natural prettiness just waiting to emerge. These intrusions by people– friends and casual acquaintances alike– act to enforce prevailing standards of beauty. These social encounters and relationships had a lasting effect by making women in this study insecure about various facial features. A number of women in this study related how, after the surgery, they felt more self-confident in social encounters and interactions. Prevailing standards and cultural images of youth and beauty were implicated in the disciplinary practices the participants pursued.

Disciplinary Practices

All the women in this study, in varying degrees, subjected themselves to a number of disciplinary practices. Bartky (1999) describes the disciplinary project of femininity by examining the disciplinary practices that produce a body which is feminine in both gesture and appearance. She considers three categories of such practices: "those that aim to produce a body of a certain size and general configuration; those that bring forth from this body a specific repertoire of gestures, postures and movements; and those that are directed toward the display of this body as an ornamented surface" (Bartky, 1999: 121). All three of the these categories were found among women in this study.

All the women in this study expressed concern over the size and shape of their bodies. Weight was the most common concern for women in this study. For Sharon (35) her concern over her weight was a combination of weight she had lost and weight she had gained in other areas. She said, "I've lost weight which is a problem for me...but in the

last year, I've gained weight in areas that I've never wanted to gain it. And I'd be lying if I told you it didn't bother me."

When the women in this study were asked if they could change one thing about their bodies right now, what it would be, all the responses related to the size and shape of a particular part of their body. Grace (25) quickly responded that she would have liposuction on her thighs. Tamara (30) wished for "longer, skinnier legs" and Rose (66) said she would have the "rolls" removed from her stomach.

Most of the women also described exercise as part of the steps they take to keep up their physical appearance. Grace (25) described herself as a "fitness fanatic." She stated:

> *I do work out like everyday and recognize the fact that if I don't work out I'm in a very bad mood. And that's just things people have said to me in the past about you're going to be fat, you're going to be this and you're going to be that and once you stop working out you are going to gain all the weight back. I was never fat. I've always been the exact same size I am now....*

Social relationships were found to have an influence on women's decisions to have facial cosmetic surgery and these same influences affected how women struggled with other parts of their bodies as shown above by the comments of Grace (25). Marlene (57) discussed how the influence of her mother affected not only her decision to have cosmetic surgery but also the impact it had on how she views other areas of her body. Marlene (57) described that, "after Lynne [her daughter] was born which would be 1950, she [her mother] just kind of let her abdominal muscles go and got this awful pot. And I am very conscious about that too. And I try really hard to, to not gain weight and do exercise and things." Bartky (1991) discusses that is often difficult to decipher whether women's involvement in diet and exercise was done for the sake of health and fitness or

whether it was done in obedience to the requirements of femininity. This was the case for women in this study. In this study, women often described disciplinary practices that related not only to health, fitness, body shape and size but also to gestures and movements.

Bartky (1999) describes significant gender differences in gesture and movement that are far more restricted for women than for men. Norms of feminine gestures and movements were often raised among this study's participants. Lillian (73) described the influence of her mother in instilling the norms of femininity. She stated:

> *I can remember when I had my first pair of high heels. They were probably about this high [an inch]. She was quite intent on the way I walked. I had to walk properly if I was going to wear high heels, I had to walk like a lady. She was intent on how you conduct yourself, what you looked like...You had to be lady-like and courteous.*

All four of the older women made reference to norms of femininity in gesture, posture, and movement that were instilled in them in their adolescence and early 20s.

Some of the participants discussed how they modified their bodily comportment to conceal particular facial features. Stephanie (27) described how the lack of angle to her chin affected her bodily comportment in this way: "If I liked somebody, you know, I'd never wanted them to see me from the side, you know only head on. I hated driving my car, people could see it and I hated it." Tamara (30) while working as a bank teller, described the modifications she made in her movements and gestures to customers to mask the fact that her eyes were not straight. "[W]hen I would call somebody over, I would purposely sort of put my head down a little bit or you know, I'd pretend I was looking over the room and I would point to them. And a lot of times I would do pointing so that they knew that I was talking to them."

The women in this study also described how their confidence level increased and body language changed when they felt they "looked their best." They would carry themselves with an aura of high self-confidence, sit more erect and stand up straight, with their head held high. However, when women did not feel "put together" they often modified their movements when out in public. They would avoid eye contact with other people and avoid people more generally. Looking their best and feeling "put together" was often related to the ornamented surface of femininity discussed by Bartky (1999).

Bartky (1999) argues that a woman's body is an ornamented surface which involves a tremendous amount of disciplinary practices, products and services. Tamara (30) described her production of a feminine face as:

> *I never used to leave the house without my full face on. I call it that. I put on the whole face you know, like it used to be a joke, you know, I'd say "Okay I'll be ready in a minute I just have to put my face on" like everything- the whole make-up regime. It wasn't just put on a little lipstick; it was you know, the foundation, the blush, the eyeliner, the whole business...cause I thought I was hideous without my make-up, like I just was not somebody that could go in public without my make-up.*

It was not until last summer when she was employed at a job that involved working outdoors that Tamara (30) became more lenient in her make-up regime. She said, "it was almost like another reversed peer pressure because I noticed most of the other girls weren't wearing make-up and I felt funny because I was the only one all dolled up...." Lillian (73) also described that while she does not wear make-up around the house, she makes sure she applies it before leaving the house. She stated "...before I'll go to the laundry room to do my laundry, I'll put some lipstick on and some make-up." Grace (25) noticed how, whenever she had to write a final exam for university, she would get herself "all dolled up" because somehow she felt she would do better.

A few of the women in this study made reference to how their surgery allowed them to modify their hair and styles of dress. For example, Stephanie (27) always wanted short hair but never cut her hair because she always wanted to cover up the whole area to her neck to conceal the lack of angle she had on her chin. Now that she has had the surgery, she felt she could cut her hair. Rose's (66) surgery changed the types of clothes she would wear. She explained:

> *If it wasn't just hanging there like that, like a turkey neck, well then that wouldn't bother me...That's why I never use to wear something like this [scoop neck]. It was always up to here [her chin], which didn't help, which made it look worse. But is it? Nobody looks, nobody really cares. But I did.*

A number of women commented that once they had the surgery, they knew they would not have to spend time camouflaging or trying to conceal their "flaws."

In summary, women often discussed disciplinary practices of femininity. These practices included practices that produced a body of a certain size and shape, practices that that guided their bodily comportment, and practices that displayed an ornamented surface. This discussion shows the involvement of women in this disciplinary project of femininity which extended beyond their decision to have facial cosmetic surgery.

Women's decisions to have cosmetic surgery can be understood within Bartky's (1999) discussion of the disciplinary project of femininity. Bartky (1999: 130) explores the contradictions between a women's desire to have a body that "is felt to be 'feminine'– a body socially constructed through appropriate practices– is in most cases crucial to a woman's sense of herself as female and, since persons currently can be only as male or female, to her sense of herself as an existing individual." In other words, Bartky (1990) grapples with the contradictions between these disciplinary practices that are at the same time oppressive and desirable and are also essential to a woman's sense of identity.

Women's decisions to have cosmetic surgery in this study were connected to some degree with their involvement in the cultural-beauty system. However, women in this study did not confront the inherent contradictions in the disciplinary practices of femininity that Bartky discusses. This is not surprising given that Bartky (1999) contends that these practices are so internalized and threats to dismantle this project would in turn threaten a woman's sense of self.

In summary, this discussion examined the relationship between women and their bodies to help explain their involvement with cosmetic surgery. The themes of the physical body and disciplinary practices were identified in women's accounts to help understand the relationship between women and their bodies. The next chapter provides a social and theoretical discussion on both cosmetic surgery and women's bodies.

CHAPTER FIVE

Discussion

The purpose of this chapter is to provide a social and theoretical discussion on women's bodies and cosmetic surgery. Firstly, this chapter summarizes the key findings of this study presented in chapter four. Secondly, this chapter addresses a number of social issues raised from this study to explore what cosmetic surgery offers in terms of understanding the relationship between women and their bodies. Thirdly, these issues are elaborated in a theoretical discussion that draws upon both insights from the sociology of the body and insights from this study. Finally, this chapter concludes with the limitations of this study, practical implications and recommendations for further research.

Summary of Findings

This discussion is organized around the three research questions that guided this study. For each question, a summary of the relevant findings is presented.

Research Question One: How do women account for their decision to have facial cosmetic surgery?

The decision to have facial cosmetic surgery is often carefully thought out and is usually made only after a long period of weighing the advantages and disadvantages. Reaching the decision to have facial cosmetic surgery was not easy for most women. The decision making process required that they confront both surgical concerns and their fears and anxieties over potential negative results. Once the decision to have facial cosmetic surgery was reached, all women who participated in this study felt the need to justify and normalize their decision.

The theme of decision justification and normalization was a key theme identified in chapter four that described how women account for their decision to have facial cosmetic surgery. All the study participants sought to normalize and defend their decision to have facial cosmetic surgery. The study participants justified their decision in three different ways. First, some women saw their decision as no different from other forms of body maintenance techniques and practices. Second, heredity and genetic destiny were used as a justification for women's decisions to have facial cosmetic surgery. Third, unique personal circumstances were cited to justify their decisions. As Davis (1995) found in her study, justifying cosmetic surgery was a complex matter and often entailed explaining why the surgery was legitimate in their particular case, but also why it was not acceptable in other cases. In both this study and Davis' study, the women were aware of possible objections which could be leveled at cosmetic surgery, in general, and their own decisions, in particular. In addition to justifying and normalizing their decision to have cosmetic surgery, the women who participated in this study often argued that their decision was not based on vanity. The women in this study both rejected and feared this notion. The potential negative feedback from others often kept women silent about their decisions.

Secrecy often surrounded women's decisions to have cosmetic surgery. While most women claimed they were not secretive about their surgery, many women only told their immediate friends and family that they had surgery or were even considering surgery. The basis for women's secretiveness surrounding their decisions to have facial cosmetic surgery was often related to a fear of negative feedback from others and a fear of being seen as "vain."

Overall, most women did not give an over-arching recommendation of cosmetic surgery; however, they would all recommend cosmetic surgery to other women while providing certain qualifications. The participants felt women should be informed of what to expect and the risks involved. They were interested in the reasons why women were seeking cosmetic surgery and some believed many women are influenced by others in their decisions, despite rejecting the influence of others in their own decisions. Many participants were weary of "frivolous" cases of cosmetic surgery. Many women also felt that cosmetic surgery has a potential benefit in helping a woman feel better about her face or body and this was the case for most women who participated in this study.

With the exception of one woman, all women were satisfied with the results of their surgery. Many women expressed how this was a gradual process. For four women, this process took longer than just waiting for the swelling and bruising to heal as they required additional surgery to correct unsatisfying results. Most women, looking back at their decision, claimed given a second chance that they would probably do it again.

Only one woman was not satisfied with the results of her nose-reshaping surgery. This is not surprising given the fact that her surgery left her with a severe secondary deformity and her surgeon not only was negligent in treating her post-surgery infections, but also has refused to pay to correct the damage inflicted upon her. Eight of the women expressed difficulty dealing with side effects and/or disappointing results following the surgery.

In summary, this discussion showed that women accounted for their decisions to have cosmetic surgery in a number of ways. Firstly, the decision to have cosmetic surgery is only reached after a lengthy process of weighing out the disadvantages and

advantages. Secondly, the women in this study felt the need to justify and normalize their decisions. Thirdly, secrecy also characterized the decision-making process. Fourthly, all the women would recommend cosmetic surgery to others but only provided that certain conditions or qualifications are met. Finally, with the exception of one woman, the remaining nine women were satisfied with the results of their surgery, but they often expressed that the satisfaction occurred gradually as the bruising and swelling healed or after mistakes were corrected. This discussion of how women account for their decisions is further elaborated in research question number two.

Research Question Two: Is the decision to have facial cosmetic surgery influenced by social, economic, cultural and individual factors?

In chapter four, a number of themes were discussed that suggested the influence of social, economic, cultural and individual factors on women's decisions to have facial cosmetic surgery. Presented below is a summary of the findings and a brief discussion of how these factors influenced women's decisions to have facial cosmetic surgery.

With respect to social factors, social relationships and the role of the medical profession were two themes identified in chapter four that influenced women's decisions to have facial cosmetic surgery. While all women rejected the influence of others on their decisions, social relationships, particularly family relationships were often indirectly, if not directly, related to their decisions. Social relationships had a powerful influence in shaping women's feelings about their faces and bodies. Some of the women related stories of how significant others and acquaintances pointed out their "crooked eyes," "lack of chin" and "acne." These social encounters and relationships had a lasting effect, making women in this study feel insecure about various facial features. Moreover,

the medical profession was also implicated in enforcing prevailing standards of beauty by suggesting to women that they consider cosmetic surgery on various facial features.

The medical profession was found to have a strong influence on women's decisions to have facial cosmetic surgery. It is alarming that five out of the ten women who participated in this study related the influence of the medical profession on their decision. In fact, two of the women never even thought about having surgery prior to it being suggested by their physician.

Most women in this study were to a certain degree limited in their ability to make an informed choice by the amount of information provided by their physician. This was often their only source of information on cosmetic surgery.

While a number of economic issues were raised in women's accounts, no overall themes emerged in relation to economic factors. This was attributed in part to the characteristics of the sample of women interviewed. Most women were not employed full-time in the paid labor force and consequently, they did not experience economic restructuring in a culture that values youth and attractiveness in the labor market.

Cultural factors influenced how women viewed various facial features. Women's dissatisfaction with facial features stemmed largely from the cultural standards of beauty and youth. The extent to which women have internalized standards of femininity is best exemplified in the fact that these women feel more self-confident in social interactions as a result of an alteration of certain facial features. However, these were only minor alterations in their whole anatomy and changes which others may not even notice.

More readily than older women, younger women recognized the influence of these cultural images of beauty in both their decisions to have facial cosmetic surgery and

the social pressures on women to conform to standards of physical attractiveness. While social, economic and cultural factors were often only implicitly raised in relation to women's decisions, individual factors were explicitly used as a basis for women's decisions to have facial cosmetic surgery.

Individual factors characterized how women accounted for their decision to have facial cosmetic surgery. They justified their decision based on their individual situations. In addition, identity was found to be an important theme in chapter four that influenced women's decisions. Identity was raised in relation to reconstructing one's identity and in relation to "ideal" versus "real" identity.

The issue of agency and choice was addressed in chapter four as an individual factor that influenced women's decisions to have facial cosmetic surgery. In this study, agency surfaced in relation to the decision-making process and in carrying that decision through. Making the decision to proceed was what made some of the women agents.

In summary, the findings of this study suggest a number of social, cultural and individual influences on women's decisions to have facial cosmetic surgery. While economic issues were raised in women's accounts, economic factors played a limited role in women's decisions to have facial cosmetic surgery. Moreover, I have argued that cosmetic surgery is not about agency, but making the decision to have cosmetic surgery did make some women agents. However, I also contend that the conditions for genuine choice were not met given the influence of external forces and the lack of information available to women to equip them to make an informed decision.

Research Question Three: What does cosmetic surgery tell us about the relationship between women and their bodies?

The themes of the physical body and disciplinary practices were identified to help understand the relationship between women's faces and bodies, and their decisions to have facial cosmetic surgery.

The physical reality of the appearance of women's faces and bodies was the foundation for women's body image. Moreover, physical appearance was found to be a potent determinant of a woman's self-perception. The women in this study often discussed a change in their body image following cosmetic surgery. Not only was the physical body the basis for women's body image, the physical body also formed the basis for social interactions.

All women in this study, in varying degrees, subjected themselves to a number of disciplinary practices. These disciplinary practices incorporated three categories of practices identified by Bartky (1999) that involved managing the size and shape of their bodies, movements of their bodies and the display of their bodies. All the women in this study expressed concern over their weight. Most of the women also described exercise as part of the steps they take to keep up their physical appearance. The women in this study also related how their concern with exercise and weight also stemmed from the influence of social relationships.

Norms of feminine gestures and movements were often raised among this study's participants. All four of the older women made reference to norms of femininity in gesture, posture, and movement instilled in them in their adolescence and early 20s. Some of the participants discussed how they modified their bodily comportment to

conceal particular facial features. The women in this study also described how their posture, gesture and movements changed in accordance with how they felt they looked.

A number of the women discussed how they managed the "ornamented surface" or display of their bodies through make-up, hairstyles and clothing. A few of the women in this study even made reference to how their surgery allowed them to modify their hair and styles of dress.

In summary, women often discussed disciplinary practices of femininity. These practices included those that produced a body of a certain size and shape, practices that guided their bodily comportment, and practices that displayed an ornamented surface. This discussion shows the involvement of the women in the disciplinary project of femininity which extended beyond their decision to have facial cosmetic surgery.

The themes of the physical body and disciplinary practices help us to understand the relationship between women's faces and bodies and their decisions to have facial cosmetic surgery. However, the findings presented here only begin to answer research question three. The discussion that follows in the remainder of this chapter seeks to answer this research question by drawing upon social issues raised from this study and a theoretical discussion on the women's bodies.

Social Issues

This discussion addresses a number of social issues raised in this study. This includes a discussion on defining cosmetic surgery, as well as a discussion of women's choices that considers the interconnections between agency and structure.

Defining Cosmetic Surgery

There is no common understanding of cosmetic surgery and several definitions appear in the literature. The term itself and definitions of cosmetic surgery are problematic as I quickly learned when I began interviewing women who had undergone facial cosmetic surgery. I will draw upon the findings of this study to demonstrate how problematic these definitions are.

Plastic surgery offers elective aesthetic improvement through surgical alterations of facial and body features (ASPRS, 1994). As noted in chapter two, medicine delineates two kinds of plastic surgery: reconstructive and cosmetic. Reconstructive procedures "restore or improve physical function and minimize disfigurement from accidents, diseases, or birth defects" (Dull & West, 1991: 51). Cosmetic procedures purport to offer elective aesthetic improvement through surgical alterations of facial and bodily features on otherwise healthy bodies (Dull & West, 1991). Despite the clear distinctions made in the literature, the study respondents blurred the lines between the two types of surgeries. Four of the women in this study had what most physicians and Medicare classify as reconstructive surgery but the recipients themselves identified their surgeries as cosmetic surgery. Stephanie (27) pursued jaw, chin and lip surgery to improve her profile, however, these procedures were seen as reconstructive surgery as they are intended to improve functioning between the mouth and jaw and as such were covered under Medicare. It would appear that Tamara (30) who had the muscles in her eyes tightened to correct a condition she has had since birth had reconstructive surgery, but she viewed the surgery as cosmetic since she had no impairments in her vision. The lines between reconstructive surgery and cosmetic surgery are also blurred in the case of Grace (25)

who, following an accident required reconstructive surgery on her cheek and nose but saw her nose (reshaping) surgery as cosmetic surgery because she elected to change the shape of her nose rather than have it corrected to look the same as it did before the accident. Victoria (29) had a difficult time deciding whether or not her dermabrasion was cosmetic or reconstructive because, on the one hand, acne is a medical condition and dermabrasion is a form of treatment for acne scars, and on the other, the procedure does improve your facial appearance and in this sense is cosmetic. Not only was the distinction between reconstructive and cosmetic surgery often unclear for these women, this was also the case with the distinction between type-changing and restorative cosmetic surgery.

In chapter four, I classified the procedures of the women who participated in this study, according to the distinction offered in the literature between type-changing and restorative cosmetic surgery. However, this distinction also is problematic for a number of reasons. Firstly, the categories of type-changing and restorative cosmetic surgery are not mutually exclusive and exhaustive. For example, classifying Victoria's (29) dermabrasion as type-changing was arbitrary in the sense that it neither improved parts of the face that are perceived to be an undesirable shape or size, nor did it attempt to rejuvenate and minimize the effects of aging. Secondly, classifying the women based on the procedure(s) alone does not necessarily reflect the intended result. All cosmetic surgery involves a change of some magnitude and therefore in this sense is type changing. Thirdly, a common misconception is that restorative cosmetic surgery, such as a face-lift, does not change one's appearance. Marlene (57), for example, underwent a face-lift, not to rejuvenate or minimize the signs of aging as is implied by this type of

surgical procedure, but rather to change the appearance of her face. In this sense, Marlene's face-lift is more accurately defined as type-changing surgery. Fourthly, restorative cosmetic surgery presumes the motivation for the surgery is to rejuvenate or minimize the signs of aging, which is not necessarily the case. For example, Rose's neck liposuction was pursued, not because of signs of an aging neck, but because weight fluctuations left her with folds of excess skin on her neck. Finally, restorative cosmetic surgery implies a bias against older women. Using this classification system, all the four older women (age 57-73) fall within the category of having restorative cosmetic surgery and all the younger women (age 23-35) fall within the category of having type-changing cosmetic surgery. This age bias is inherent in the definition of restorative cosmetic surgery. Classifying Victoria's (29) dermabrasion as type-changing surgery was an artifact of this age bias. On one hand, dermabrasion changes one's appearance to something one has not previously had. On the other hand, it minimizes acne scars and restores the appearance of the skin but the referent is not to aging, the referent given in the definition found in the literature.

In summary, these findings suggest that the distinction between reconstructive and cosmetic surgery was often unclear for the women in this study. In addition, the distinction between the two types of cosmetic surgery– type changing and restorative– is problematic and overall not very useful given the discussion above. It would seem that these basic definitions identified in the literature are in need of reconceptualization.

A recent attempt to re-classify the distinction between reconstructive surgery and cosmetic surgery by the American Society of Plastic and Reconstructive Surgeons (1999) is presented below:

> Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem....Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve functions, but may also be done to approximate normal appearance.

These definitions offered by the American Society of Plastic and Reconstructive Surgeons [ASPRS] (1999) further blur the distinction between reconstructive and cosmetic procedures as "normal" bodies are culturally determined. However, medicine has a legitimate domination of the categorization of normality (Turner, 1987). This definition of cosmetic surgery differs from definitions offered in the past by the ASPRS and other organizations, in that cosmetic surgery is relegated to the realm of psychological issues as well. This definition could be used to market cosmetic surgery as an appropriate therapy for dissatisfaction with one's body. The expansion of medicine into new realms is an issue that will be discussed further below in the context of critically examining the interconnections between agency and structure in women's "choices" to have facial cosmetic surgery.

Women's Choices

While cosmetic surgery is clearly an individual choice, the choice has a number of social, cultural and personal meanings. This section will examine the interconnections between agency and structure to understand women's involvement with cosmetic surgery by drawing upon the findings of this study as well as past research. This entails examining, on the one hand, the women's experiences, decisions and actions and on the other hand, culture, institutions, power, reproduced practices and social relations.

Structure. Modern medicine has become one of the most powerful institutions in North American society (Conrad & Schneider, 1985). Medicine has a long history of

defining and constructing pathology in women. In this study, the medical profession played a role in labeling facial features as "abnormal" and "in need of repair." Two of the women in this study had never even considered cosmetic surgery until their physicians suggested it. Two additional women had surgery for what their physician characterized as "abnormal" features. As such, cosmetic surgeons can be seen to act as agents of social control by enforcing cultural standards of beauty.

Cosmetic surgery is seen to represent a new frontier in the expansion of the medical mandate into the realm of the aesthetic. The medicalization of appearance constitutes an area in which female bodies are recreated according to dominant social and cultural norms (Dull & West, 1991). In a study by Dull and West (1991: 57), cosmetic surgery was described by surgeons as "normal" and "natural" for women and equated with "having their hair done" or "wearing make-up," while similar parallels between shaving and other male appearance related activities were not made. Dull and West (1991: 68) argue that by medicalizing appearance, surgeons act as "co-participants in the accomplishment of gender...and as cultural gatekeepers" in the construction of femininity."

As noted by Gillespie (1996: 76), "[c]osmetic surgery can also be seen to reinforce other structural inequalities" such as race, ethnicity and class. Western societies place a higher value on Caucasian characteristics than other characteristics and non-Caucasian characteristics are frequently seen as pathological (Gillespie, 1996). In the study by Dull and West (1991) race and ethnicity were found to be "objective grounds" for cosmetic surgery among both recipients of cosmetic surgery and cosmetic surgeons. Lip reduction in Black women, nose re-shaping surgery among Jewish women and eyelid

surgery to westernize Asian women's eyes, all demonstrate that beauty is often defined in Caucasian, ethnocentric and racist terms. Similarly, the findings from this study showed that inherited ethnic features were used as a justification for women's decisions to have facial cosmetic surgery. However, as Morgan (1991: 36) contends, what appears to be a desire for a more beautiful body or face turns out to be compliance to "white, western Anglo-Saxon bodies in a racist, anti-Semitic context." In addition to race and ethnicity, class is another structural inequality that is reinforced by cosmetic surgery.

Income can be a factor in cosmetic surgery as it is excluded from Medicare as well as from most other countries' national health care programs. The costs of cosmetic surgery make it inaccessible for many women and even with financing options available to women, "those with marginal economic status can certainly not afford the elite surgeons who reconstruct the rich and powerful" (Abu-Laban & McIrvin, 1995; 115). In this study, four of the younger women had some or all of their surgery covered by Medicare which influenced their decisions to some extent. For one woman, her choice of dermabrasion to remove acne scars was made on the basis that it is covered under Medicare whereas laser surgery and other procedures were not. Two women had always wanted to have cosmetic surgery on certain facial features and hoped someday to have the financial resources to have the surgery. When the opportunity arose to have the surgery at little to no cost, they felt they could not let the opportunity pass them by. Without the coverage from Medicare for their procedures, it would appear that the costs of surgery would have prohibited these four women from having surgery when they did. Four of the ten women in this study had a portion or all of their cosmetic surgery covered by Medicare. This finding is not the norm as cosmetic surgery is typically a cost paid for

out of pocket. Consequently, cosmetic surgery "reinforces the beauty 'caste system' whereby a hierarchy of beauty leads to great social power for those who can afford to invest in their bodies" (Gillespie, 1996: 77).

In the last decade, Western societies have witnessed a significant increase in emphasis on the body in relation to shape, appearance, body maintenance, self preservation and health (Featherstone, 1991; Shilling, 1993; Turner, 1984). Within the economic framework of late capitalism, in a consumer culture obsessed with appearance, the status of the body has been transformed from a fixed natural given, to a malleable cultural product (Tseelon, 1995). There has been a shift in viewing bodies as producers of things to bodies as consumers of things, such as health foods, exercise videos and cosmetic surgery. Within consumer culture, individuals must assume responsibility for the way they look (Featherstone, 1991). Bodily imperfections and lack of attention to self-presentations carry penalties in everyday social interactions (Featherstone, 1991).

Consumer culture presents a range of stylized images of the body which are associated with social power. These images make individuals more conscious of their external appearance and women are "most clearly trapped in the narcissistic, self-surveillance world of images" (Featherstone, 1991: 179). Women are bombarded with images that the majority can never attain which perpetuate consumption of products and services to construct and maintain a desirable appearance (Wolf, 1991). In addition, these dominant images of women's bodies convey powerful normalizing texts of femininity (Wolf, 1991).

While Bordo (1993: 24) argues for the need to focus on multiple interpretations of women's bodies, she cautions that we must at the same time not lose sight of the leveling

effect of "the everyday deployment of mass cultural representations." The representations homogenize women's bodies by erasing differences between women and smooth "out all racial, ethnic, and sexual "differences" that disturb Anglo-Saxon expectations and identification" (Bordo, 1993: 24-25). In addition, Bordo (1993: 25) states "these homogenized images normalize– that is, they function as models against which the self continually measures, judges, "disciplines" and "corrects" itself" (Bordo, 1993: 25). Bordo (1993) views cosmetic surgery as a case in point given that ethnic and racial styles of beauty are not asserting their "differences" through surgery and in fact, the opposite is true.

Within this discourse of femininity discussed by Bordo (1993), there is a discourse of "repair" that operates in marketing of products and services targeted at women (Spitzack, 1988). The discourse is to "repair" herself for herself rather than for others (Spitzack, 1988). A number of women in this study related how they had facial cosmetic surgery for themselves and no one else. In addition, women often stated how cosmetic surgery was something they did to make themselves feel better about their bodies. Women in this study, adopted the prevailing market discourse that characterizes the use of body maintenance services and products. Cosmetic product promoters tell women to become attractive for self-pleasure (Spitzack, 1988). For example, a L'Oreal hair color advertisement shows successful, fulfilled women explaining their decisions to color their hair with the phrase "because I'm worth it." Spitzack (1988) contends that, by playing to the general cultural value of individual distinction, advertisers promise independence and freedom from domination.

Once the decision to change the body is made, a woman "voluntarily" offers her body to the clinical community for diagnostic purposes. As described by Spitzack (1988: 11), "[i]n recent years, technological advancements have permitted a merging of beauty standards such that women are assessed within a comprehensive set of criteria leaving the acceptability of no single feature to chance." With the use of computer video imaging, a cosmetic surgeon can manipulate the "digitized image of the prospective patient in order to visually illustrate possible surgical transformations... [which] enables the codification of surgical 'goals'–goals which effect, in short, the inscription of cultural ideals of Western beauty" (Balsamo, 1993: 226). Cosmetic surgeons and other cosmetic experts accomplish diagnoses with the aid of computers and "[t]he final judgement is then removed from a particular individual coming instead from a network of discourses centered on feminine beauty/health" (Spitzack, 1988: 11) However, there is often no realization on the part of the consumer that the technology is programmed by humans who have as their goal financial gain (Spitzack, 1998).

Shilling (1993) argues that in a society which is dominated by risk and uncertainty, the body has come to form a secure site over which individuals are able to exert control. He states: "If one feels unable to exert control over an increasingly complex society, at least one can have some effect on the size, shape and appearance of one's body" (Shilling, 1993: 7). In a society characterized by patriarchy, it is not surprising that women try to control their lives by controlling their bodies which is manifested through anorexia, bulimia and cosmetic surgery (Davis, 1995; Wolf, 1991).

This discussion has only examined the structural components– medicine as an institution of social control, consumer culture and cultural discourses that surround

women's involvement with cosmetic surgery. What is missing from the discussion is an examination of the agency components– women's experiences, decisions and actions. The discussion that follows will weave in the interconnections between agency and structure by critically examining women's choices to have facial cosmetic surgery.

Agency. The issue of agency and choice was raised in chapter four as an individual factor that influenced women's decisions to have facial cosmetic surgery. In keeping with the findings of Davis (1995), agency surfaced as an important theme. In this study, agency surfaced in relation to the decision-making process and carrying that decision through. Making the decision to proceed was what made some of the women agents; however I argued that cosmetic surgery is not about agency. For a number of women, the conditions for genuine choice were questionable given the influence of social relationships, the medical profession and cultural images of beauty and aging on women's decisions. The findings suggested that a number of women were limited in their ability to make an informed choice based on the amount of information available to women. Moreover, social and cultural discourses present an illusion of choice in that the options are both constrictive and controlling.

My position differs remarkably from the work of Davis (1995) on this issue. Davis (1995) argues that cosmetic surgery is first and foremost about agency– taking one's own life into one's own hands. She contends that women who have cosmetic surgery are agents who creatively and knowledgeably negotiate their lives under circumstances which are not of their own making. Her argument has three dimensions. Firstly, women's decisions to have cosmetic surgery are rarely made under conditions of perfect knowledge or absolute freedom. Secondly, women routinely make decisions over

conditions of which they are only partially aware and have at best limited control. Thirdly, informed consent is not to be regarded as an absolute right but should be viewed as a process by which an individual draws upon the information she has and deliberates her options. Consequently, her argument allows her to maintain her position that cosmetic surgery is about agency. Her discussion tends to address only the individual level rather than incorporating a more systematic account of women's involvement in the cultural-beauty system and the social-cultural context more broadly. Davis (1995) argues that women have to "do femininity" actively which requires knowing what needs to be done, assessing the possibilities and acting upon them. Cosmetic surgery, according to Davis (1995), becomes a way for women to become agents and to take action to remedy their dissatisfaction with their bodies. Davis (1995) contends that cosmetic surgery is a way for women to exercise power under conditions which are not of their own making and as such, it becomes a way for women to give shape to their lives by reshaping their bodies.

According to Davis (1995) both the oppression and cultural discourse models of beauty assume that women are passive victims of the cultural beauty-system. Moreover, Davis (1995) contends that understanding women's use of cosmetic surgery as 'normalizing practices' that treat women's bodies as inferior and constant need of improvement suggests the process can never be satisfying or seen as a possible solution for a particular woman under the circumstances. However, as acknowledged by Bordo (1993: 30), "[r]ecognizing cultural forms exist does not entail, as writers have argued, the view that women are "cultural dopes," blindly submitting to oppressive regimes of beauty.

My findings also do not suggest that women are passive victims of societal norms and dictates, but rather that as social actors, women are embedded in social and cultural discourses that are oppressive to them. I borrow from the work of Bordo (1993) to show that within a cultural discourse approach, women can in fact be seen to "act" rationally. Bordo (1999: 31) agrees with Davis that cosmetic surgery can be liberating as an individual choice that seeks to make life as livable and enjoyable as possible within certain cultural constraints, however, Bordo does not view cosmetic surgery as being first and foremost about self-determination or self-deception. Her focus is the complex and densely institutionalized systems of values and practices that make women feel inferior and worthless unless they have a body that mirrors cultural standards of beauty. Bordo's approach has allowed me to both acknowledge and recognize the influence of the cultural and social discourses on women's decisions to have facial cosmetic surgery, without neglecting the fact that the women in my study had "elected" themselves to have facial cosmetic surgery.

Bordo (1993: 189) contends that an approach that sees women as the "done to not the doers" and "men and their desires are the enemy and that our obedience to the dictates of 'fashion' is better conceptualized as bondage rather than choice" is misguided. According to Bordo (1993), this approach fails to recognize the ways women are often willing to participate in cultural practices which objectify and sexualize them. Bordo (1993) acknowledges that in certain situations women's conformity may function subversively and enable them to achieve social power. Bordo (1993: 81) suggests that power is less the "possession of individuals...[but] is a dynamic or network of non-centralized forces" and is manifest and maintained not through "physical restraint and

coercion but through self-surveillance...[and] self-adherence to social and cultural norms." Consequently, cosmetic surgery can be seen to produce tensions between disempowerment and at the same time empowerment, experienced as 'power' and 'control'.

Both the work of Davis (1995) and Bordo (1993) acknowledge the complexity surrounding choice and recognize that domination and resistance, power and control, are multi-faceted issues that women are themselves involved in reproducing. In this study, choice was a contested issue given that a number of factors impeded women's ability to make an informed choice. However, all the women "elected" to have cosmetic surgery typically only after considerable thought. In a society that values women according to their physical characteristics, actions to improve physical appearance such as cosmetic surgery may be seen by women as an investment in their physical capital and a means of achieving social power.

While cosmetic surgery is clearly an individual choice at the individual level it can be a rational action for women to increase their social power in a culture that gives women few avenues to power (Gillespie, 1996). However, at the social structural level, cosmetic surgery is disempowering in that women may be seen to be collaborating in the dominant discourses and ideologies that disadvantage them (Gillespie, 1996).

In summary, this discussion has examined the interconnections between agency and structure in order to further understand women's involvement with facial cosmetic surgery. A theoretical discussion elaborates the issues raised by considering insights from the sociology of the body as well as findings from this study.

Theoretical Discussion

The aim of this discussion is to theorize women's involvement with facial cosmetic surgery by drawing upon theoretical insights from the sociology of the body as well as theoretical ideas that emerged from the data analysis. This discussion considers the contribution of this study in terms of supporting insights from the sociology of the body. In addition, this discussion considers what this study offers in furthering our understanding of the relationship between women and their bodies.

The Body as a Project

Several aspects of the women's accounts of cosmetic surgery support Shilling's (1993) notion of the body as a project. In contemporary society, individuals are encouraged to work on the body through consumption practices and to perceive the body as an ongoing project on which self-identity is cultivated (Shilling, 1993). This project is also pursued in accordance with prevailing standards of beauty and youth and has a bearing on women's choices of cosmetic surgery. For example, Amy's (23) nose surgery involved reshaping the tip of her nose to achieve the perfect proportion in order to emphasize all her best features. A number of women explained that their surgery did not change the way they looked but rather it improved the way they looked. Women in this study were encouraged by views of the body disseminated in consumer culture. They invested in their bodies and saw their bodies as an on-going project that should be worked on as a means of self-expression and self-improvement.

The notion of the body as a project helps to explain how cosmetic surgery can be sought as an expression of a woman's identity. Recall the case of Marlene (57) whose face-lift was part of the process of reconstructing an identity separate and different from

her mother. Moreover, the increasing normalization of beauty ideals brought about in modern societies creates a disparity among women between their idealized self and reality. This was clearly the case for both Tamara (30) and Lillian (73) whose surgeries help them reconcile the discrepancy between their "ideal" versus "real" identity.

Cosmetic surgery is a bona fide example of Shilling's notion of the body as a project. As a society, we are increasingly relying on knowledge and technology to intervene and alter our bodies and the growth of cosmetic surgery is a case in point. Moreover, an increasing number of women and men are becoming increasingly aware of the possibility of intervening surgically through the aggressive advertisements of cosmetic surgeons and through the media dissemination of information on cosmetic surgery. With advances in medicine and technology and the proliferation of media images, the number of different selves one can become appears arbitrary and infinite to many North American women. We live in a consumer culture that encourages us to invest in our bodies as a means of increasing control over our lives and self-expression. It appears that cosmetic surgery has become another means of self-expression.

The findings of this study contribute to the sociology of the body by providing support for Shilling's (1993) notion of the body as a project. Moreover, this study offers a valuable contribution to this body of literature by incorporating the three main perspectives of the body in a study that begins from the point of women's bodies. Using an approach advocated by Shilling (1993), the interconnections between the physical body (naturalistic perspective), the socially constructed body (social constructionist perspectives) and the lived body (the phenomenological perspective) are explored. These three theoretical ideas from the sociology of the body form the basis for theorizing further

on women's involvement with cosmetic surgery. On their own, these perspectives on the body are limited in their ability to offer a comprehensive understanding of women's involvement with cosmetic surgery, and the body more generally. However, the interconnections between these three perspectives have the potential to offer rich insights into women's involvement with cosmetic surgery. My aim is not to provide a more comprehensive "sociology of the body" but rather to show how sociological research in the substantive topic of cosmetic surgery might be informed by and contribute to a more embodied sociology as a whole.

The Physical, Socially Constructed and Lived Body Interconnected

The interconnections between the physical body, the socially constructed body and the lived body is evident throughout women's accounts of their involvement with cosmetic surgery. The findings of this study suggest that women's physical bodies do indeed form the basis for social relations. Women in this study often related stories of how their "lack of chin," "crooked eyes," and "acne" was the basis for a number of social interactions. The discussion in this chapter also highlighted how gender, race and ethnic identity of the physical body structures the way the body is subjectively and culturally reproduced and "disciplined" through various practices including cosmetic surgery. Moreover, cosmetic surgery literally transforms the physical body into a sign of culture whereby cultural ideals of femininity and Western beauty are inscribed.

The body is also socially constructed by social and cultural discourses as well as being shaped and altered by social practices. The social and cultural discourses only make certain behaviors and appearances culturally intelligible; those that fall outside the dominant discourses are seen by others as abnormal. Social constructions of women's

bodies affected women's "choices" of cosmetic surgery. Bordo (1993) suggests that we do not really choose the appearances we construct in that these images are strongly racially, ethnically and heterosexually inflicted.

Women in this study who fell within the "gray" areas of reconstructive and cosmetic surgery drew upon the medical discourse of "normality" to justify their decisions while rejecting this same discourse in defining their experiences as cosmetic surgery. In this sense, women both shape and are shaped by social and cultural discourses.

The connections between agency and structure show a complex interplay of social control and regulation and individual self-surveillance. Women's lived experiences of their bodies were characterized, to varying degrees, by suffering or anxiety over certain facial features. This suffering was often raised as a motive for women's decisions to have facial cosmetic surgery. The lived experience of women suggest that they interpret and thereby create their world in meaningful ways and this became clear in women's need to normalize and justify their decisions to have facial cosmetic surgery.

This study on women's involvement with facial cosmetic surgery shows how women are active agents in society but are also subjected to powerful social forces specifically dominant discourses of femininity. These dominant discourses of femininity formed the basis on which women evaluated themselves as well as other women, and were shown to be a powerful force in shaping women's involvement with facial cosmetic surgery.

The approach I have adopted demonstrates how studying the lived experience of women can offer insights to the sociology of the body by utilizing the interconnections

between the three dominant perspectives of the body to further our understanding of the body.

In summary, this discussion has illustrated how women's involvement with facial cosmetic surgery can be woven into the interconnections between the physical body, the socially constructed body and the lived body. While to date much of literature on the sociology of the body has been about bodies rather than from bodies, this study helps to rectify this gap by using women's lived bodies and experiences as the point of departure. Moreover, this study contributes to the literature by grounding theoretical underpinnings of this work within the lived experiences of women's bodies.

This study contributes not only to a greater understanding of women's involvement with facial cosmetic surgery but also provides insights for the sociology of the body by highlighting the significance of embodied social action. This study fits neatly into the theoretical literature on the sociology of the body in that it combines naturalistic, social constructionist, and phenomenological perspectives. Women's experiences of their bodies can contribute to our understanding and theoretical developments of the body. It is only through empirical studies such as this study that we are most able to appreciate the relationship between women and their bodies.

Limitations

This study is limited in several ways. Firstly, self-selection is problematic. Those more willing to participate may have had particularly negative or positive experiences with cosmetic surgery. However, in defense, I would argue that this was not the case for most of the women in this study. Most women described both negative and positive components of their involvement with cosmetic surgery. Only one the women had a very

negative experience with cosmetic surgery and none of the women had an experience that was solely positive. The similarities across women's experiences, despite the diversity among the women themselves, suggests that even with a different sampling strategy, similar results would have been found.

Secondly, it would have been beneficial to re-interview each of the 10 women to ask them about issues that arose in initial interviews. Time and financial constraints prohibited such an undertaking.

Thirdly, there are several drawbacks to research of this nature. Qualitative research allows participant input into the process. Thus, I was limited to whether and when the women called and how much time they were willing to invest.

Fourthly, this study represents only ten women's voices. This study is not representative of all women who have had facial cosmetic surgery. It is authentic in that each woman's account represents one woman's involvement with cosmetic surgery. The authenticity is further supported by the continuity of themes across the women's accounts. In addition to the four limitations discussed above, the social context of this study was also a limitation.

Social Context. At the beginning of data collection, Winnipeg was probably unlike other major North American cities in that cosmetic surgery was a relatively private and secret event. Locating participants was difficult and time-consuming. Over the course of discussing my study with others, many friends and acquaintances often suspected someone they knew had cosmetic surgery but had never had their beliefs confirmed. Referral cards and an information letter were passed along to at least a dozen additional women who, for whatever reason, did not contact me. Part of their reluctance

to speak to me, however, may be attributed to how cosmetic surgery was perceived and marketed in Winnipeg.

At the time of conceptualizing this study, most plastic surgeons in Winnipeg did not overtly advertise that they performed cosmetic surgery. More recently, cosmetic surgeons in Winnipeg have become more aggressive in advertising and marketing their services. Television commercials and advertisements in *The Winnipeg Free Press* are now commonplace. Several cosmetic surgeons now have web sites whereas two years ago cosmetic surgeon's websites in Winnipeg were nonexistent. In addition, a number of Winnipeg cosmetic surgeons have recently opened cosmetic surgery and laser surgery clinics. Future research would likely result in more participants given the current social context of cosmetic surgery in Winnipeg.

Practical Implications

On a practical level, as an increasingly greater number of women elect to have cosmetic surgery more information needs to be available to equip them to make an informed decision. The stories of the women interviewed in this study clearly indicate the urgent need for the dissemination of information and education about the realities of both the positive and negative effects associated with facial cosmetic surgery. This could be done through seminars offered at women's clinics, women's resource centers and through continuing education classes offered through various school divisions.

Future Research

Future research needs to address the many questions remaining from this study. While this study included both younger and older women, the sample size prevents making any definite conclusions. However, the findings from this study and the work of

Goodman (1994) suggest there are age differences in how women view their bodies, and in women's receptivity to cosmetic surgery. As well, further research is needed to enrich theorizing women's involvement with cosmetic surgery.

Conclusion

This study has examined women's involvement with facial cosmetic surgery. I have added a Canadian dimension to the work done previously in the United States (Goodman, 1994; 1996) and the Netherlands (Davis, 1995). I have listened to the voices of women and learned from their accounts about their decision-making process. I have explored not only how women account for their decisions but also the influence of social, economic, cultural and individual factors in their decisions. I have used women's accounts of their decisions and their lived experiences as the basis for my own theorizing in order to explore what cosmetic surgery offers in terms of understanding the relationship between women and their bodies. I have also contributed to the literature on the sociology of the body. In doing so, I have started from the point of women's lived experience and have grounded the theoretical underpinnings of this work within the lived experiences of women's bodies. In these ways, this project makes an important contribution to the social science literature.

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APPENDIX A

List of Sites for Advertisements

Community Newspapers

Coffee Time News

The Manitoban

Uptown

Additional Sites

Asper Centre

Billboards at Community Club Centers

Fort Garry Women's Resource Centre

Garden City Shopping Centre

Magic Room St. Vital

Polo Park Shopping Centre

Shapes Fitness Centre

Women's Health Clinic

YM-YWCA

APPENDIX B

Signs to Advertise Study

In the last 5 years have you had one or more
of the following types of

Facial Cosmetic Surgery?

Eyelid surgery
Face-lift
Forehead-lift
Retin-A treatment for facial lines
Wrinkle injections or wrinkle removal

A graduate student at the University of Manitoba seeks participants for a study of women who have had facial cosmetic surgery. Women who are interested in this research and are willing to be interviewed on their decisions to have cosmetic surgery, the subject of body image, and their experiences of aging, should please contact *Diane* at 474-8298. Confidentiality is assured.

Facial Cosmetic Surgery

A graduate student at the University of Manitoba seeks participants for a study of women who have had facial cosmetic surgery. Women who are interested in this research and are willing to be interviewed on their decisions to have cosmetic surgery, the subject of body image, and their experiences, should please contact *Diane* at 474-8298. Confidentiality is assured.

APPENDIX C

Sample Letter to Contact Places

To Whom It May Concern:

I am writing to you to request your support for a research project I am conducting to fulfil my requirements for my Master of Arts degree. I am a graduate student in the Department of Sociology at the University of Manitoba. My master's research is exploring women's decisions to have facial cosmetic surgery.

The support of your organization _____ is important for my research as I have chosen to obtain my sample using an advertisement whereby interested women who are willing to be interviewed initiate contact with me. As such, I am requesting permission to place a sign within your organization to advertise my research. Please see the enclosed copy of my sign. I would also benefit from verbal support of my study within your organization. Ideally, if at all possible, I would like to meet with yourself and other staff at your convenience to discuss further my research and the potential for your involvement.

I thank-you in advance for giving my request your upmost consideration.

I can be reached at 474-8298 or 474-7043 or via e-mail at umcepane@cc.umanitoba.ca

Yours truly,

Diane Cepanec

APPENDIX D

Interview Schedule

Introductory Comments:

First, I would like to thank you for agreeing to meet with me today. As you know, the focus in my study is women's decisions to have facial cosmetic surgery. I'd like to cover a number of topics such as body-image, your experiences of aging and then go on to talk to you about how your reached the decision to have cosmetic surgery as well as your experiences of undergoing cosmetic surgery.

Begin taping now

Please feel free to respond to the following questions as extensively or briefly as you like.

1. To start off, could you please tell me a little about yourself to give me a good sense of who you are? (PROBES: education, occupation, children, living arrangements, relationship status, age)

Next, I'd like to ask you some questions that are related to how you feel about your body and then go on to how you feel about aging.

Body-Image

2. How satisfied are you with your physical appearance?
3. How would you rate your physical appearance in comparison to other women your own age?
4. Would you describe yourself as someone who always cares a lot about how she looks?

5. While you were growing up did you feel pressure to conform to how other girls your age looked? In what ways did you conform? In what ways did you refuse to conform?
6. When you think about your body as a whole, what comes to your mind?
7. Do you like your body? With what parts are you most satisfied? Least satisfied? (**NOTE:** if respondent discusses her body in terms of a whole or as a series of parts)
8. Do you like your face? (If not offered) With what parts are you most satisfied? Least satisfied?
9. If you could change something about your body right now what would it be?
10. Women sometimes sense they are in the spotlight, that they are being observed or assessed for their attractiveness. Do you ever feel as if you are the object of interest in that respect? (If Yes, What is it like for you to feel that way?)
11. How much does your appearance determine how you approach a situation? Do you feel more confident if you look good? If yes, how would you describe "good"?

Reactions to Aging

12. How do you feel about aging?
13. Are there changes in your appearance as you age? How do you view them?
14. In what ways have your feelings about your appearance changed over the years?
15. What changes in your appearance have you noticed in the last 5 years?
16. Have these changes precipitated change in other areas of your life?
17. Have you ever felt discriminated against because of your age?
18. Do you ever feel you are aging more quickly than other women are? Do you ever feel you are aging more quickly than men are?

Media

19. From what sources do you get information about trends in how women should look?
20. Do you ever feel conflict between your appearance and the appearance of women you see on TV or in magazines?
21. How do you think the media portrays older women and aging?
22. How do you react to advertisements for cosmetics, youth restoring face creams, etc.?

Beauty Routines

23. What steps do you take to keep up your appearance? Tell me about your beauty routines. (Probe for difference between staying at home, going shopping, going out for the evening, etc.)
24. What routine(s) is (are) least enjoyable or most tedious for you? Why do you continue to do it (them)?
25. Are there things you've stopped doing because of your age?
26. Are there things you've begun to do because of your age?
27. Do you ever feel you have to "compensate" in any way for your age?

Cosmetic surgery

Next, I'd like to have some history of your experiences with cosmetic procedures.

28. How many times have you had cosmetic surgery? What type of surgery was it? How old were you at the time?
29. How much did the surgery (ies) cost?
30. Can you tell me the story of your facial cosmetic surgery?

(**Note**: Ask the following if not covered above)

31. When did the thought of having cosmetic surgery first enter your consciousness?

32. Can you tell me about the circumstances that lead to your decision to have the surgery?
33. What were the most critical reasons for it?
34. Were there any concerns you needed to overcome to follow through your decision to have cosmetic surgery?
35. Were the results what you expected? Were they consistent with your physician's expectations?
36. Besides physical change, did you expect to get anything else from having the operation?
37. How satisfied were you with the overall results?
38. Did the surgery change your life?
39. Do you ever feel the need to be secretive about your surgery?
40. How did significant people in your life react to your decision to have cosmetic surgery?
41. How did significant people in your life react to the results of your cosmetic surgery?
42. If you had the same decision to make again, would you still choose to have cosmetic surgery?
43. Do you think you may have any other type of cosmetic surgery in the future?
44. Would you recommend having surgery to other women?
45. Is there anything else, or any other thoughts you would like to share with me about any of the topics we have discussed?

Closing Questions

Overall, how do you feel about the interview?

Has the interview stirred up any negative feelings?

Do you see the interview experience as positive or negative? Why?

Can I contact you again if I have any further questions?

Would you be willing to participate in a second interview if the need arises?

Would you like to review transcribed notes of the interview?

Would you like to receive a summary report of the study's findings after I complete my study?

Do you know any other women who have had facial cosmetic surgery? Would you be willing to give her (them) my card on the study?

APPENDIX E

Information Sheet

A Study of Women's Decisions to have Facial Cosmetic Surgery

My research focuses on women's decisions to have facial cosmetic surgery. Cosmetic surgery is the fastest growing medical specialty in North America and over 80 percent of cosmetic surgery recipients are women. Despite the increased attention given to cosmetic surgery in both academic and popular literature, very few attempts have been made to hear the voices of women who have undergone cosmetic surgery. In addition, no studies of women's experiences with cosmetic surgery have been reported in Canada. What I propose is to explore the reasons women undergo facial cosmetic surgery. The information gathered in this study will be used for my master's thesis and publications derived from this study.

In conducting this research, I will be interviewing a sample of women who have been solicited through advertisements to participate. You have volunteered to be interviewed about your decision to have facial cosmetic surgery. The interview will consist of questions concerning your experiences with cosmetic surgery, body image and experiences of aging. In addition, I will be asking some personal information such as marital status, education and career.

All information will be kept completely confidential. However, if child abuse is disclosed I am obligated by law to report the abuse. The interview will take approximately 2 hours and with your permission will be audiotaped for later transcription. No one but myself will have access to the tapes and any identifying records. The tapes and all records containing identifying information will be secured separately in locked files and will be destroyed after the completion of this study. You have the right to review transcribed notes of the interview to ensure that your meaning was captured. A summary report of the study's findings will be made available to you after the study is completed. You are free to refuse to answer any of questions asked in the interview. You are also free to withdraw your participation in this study at any time without prejudice or consequence.

The Department of Sociology Research Ethics Committee has approved this study and any complaint regarding a procedure used in this study may be reported to the Head of the Department of Sociology (474-9260) for referral to the Research Ethics Committee.

Your participation in this study is invaluable and is appreciated.

Diane Cepanec 474-8298
Dr. B. Payne (Advisor) 474-8903

APPENDIX F

Consent Form

A Study of Women's Decisions to have Facial Cosmetic Surgery

Consent Form

I, _____, agree to participate in this study about women's decisions to have facial cosmetic surgery.

I have received and read the attached information sheet on this study. I understand that the interview will be audiotaped and later transcribed. I understand that a summary report of the study's findings will be made available to me. I understand that I have the right to review transcribed notes of the interview to ensure my intended meaning was captured. I understand that my identity will not be revealed at any time or to any one. I am also aware that if child abuse is reported, Diane Cepanec is obligated by law to report the abuse. I understand that my participation in this study is entirely voluntary. I understand that I have the right to refuse to answer any questions with which I feel uncomfortable. I understand I have the right to withdraw from this project at any time. I give permission to Diane Cepanec to use anonymous information from the interview in her study, and in any publications derived from it.

Signature_____Date_____

Researcher_____Date_____

APPENDIX G

Summary Report

Below is a brief summary of the findings of the study. This summary report is organized around the key themes that were identified in 10 women's accounts of their decisions to have facial cosmetic surgery. I would like to extend my sincerest thanks to the women who so willingly shared their stories with me. I would be pleased to share more information with you. If you are interested in receiving more information, please do not hesitate to contact Diane Cepanec at (204) 452-7505.

The Women

Ten women living in Manitoba, Canada shared with me their stories of their decisions to have facial cosmetic surgery. The ages of the women interviewed range from 23 to 73. All of the younger women (ages 23-35) were single and all of the older women (ages 57-73) were married. Table one presents the participants by their age and type of surgery.

Table 1: Participants by Age and Type of Cosmetic Procedure

*Participants**	*Age*	*Type of Cosmetic Procedure*
Amy	23	Nose reshaping surgery
Grace	25	Nose reshaping surgery
Stephanie	27	Jaw, chin and bottom lip surgery
Victoria	29	Dermabrasion
Tamara	30	Muscles in eyes tightened
Sharon	35	Nose reshaping surgery
Marlene	57	Face-lift, eyelid surgery
Rachel	58	Mid-line face-lift, eyelid surgery
Rose	66	Neck liposuction, eyelid surgery
Lillian	73	Two face-lifts

*Pseudonyms

The identity of the women was protected by giving women pseudonyms as well as by omitting any information that may reveal their identity.

Reaching the Decision

The decision to have facial cosmetic surgery is often carefully thought out and is usually made only after a long period of weighing out the advantages and disadvantages. The decision making process required that they confront both surgical concerns and their fears and anxiety over potential negative results.

Women's Decisions

The women interviewed accounted for their decisions to have facial cosmetic surgery in a number of different ways. All the women justified or rationalized their decisions. Cosmetic surgery was often viewed as one of many, and no different from, other forms of body maintenance or beauty practices. Heredity and genetic destiny and unique personal circumstances were also cited as justifications for facial cosmetic surgery.

A common belief is that cosmetic surgery is a decision based on vanity. The women who participated in this study both rejected and feared this notion. Statements such as "I don't associate vanity with trying to look good" or "it's okay to look good sometimes and it's okay to feel good about the way you look and it doesn't mean that you're vain" suggested that women's decisions to have cosmetic surgery are not reached based on vanity. At the same time, a number of women expressed fears of people judging them as vain.

Identity

Identity was a common theme in this study. More specifically, identity was raised in relation to reconstructing one's identity and in relation to "ideal" versus "real" identity.

Agency

Agency (i.e., taking control or action) was a common theme in women's accounts. Agency surfaced in relation to the decision-making process and carrying that decision through. Some of the women expressed how cosmetic surgery was a decision they reached on their own and that making the decision to proceed was the key factor that gave them confidence in their decision-making abilities.

The Role of the Medical Profession

It was not uncommon for women in this study to be influenced to a certain degree to have cosmetic surgery on the recommendation of a physician. While the medical profession has been actively promoting cosmetic surgical procedures, the women's accounts in this study suggest that a number of women were hampered in their ability to make an informed choice in their decision to have facial cosmetic surgery by the amount of information available to them.

For a number of women, aside from their surgeon, their only other source of information for cosmetic surgery was the media. A few women interviewed were led to believe, by relying on media as a source of information, that cosmetic surgery was a "piece of cake." While some women drew upon media as a source of information, social relationships were not often used as most women did not know anyone who had undergone cosmetic surgery.

Social Relationships

While all the women dismissed the influence of significant others on their decision to have cosmetic surgery, many women's decisions were indirectly, if not

directly related to social relationships, particularly family relationships. Social relationships had a lasting effect on how women felt about their faces and bodies.

Cultural Images of Beauty and Aging

More readily than older women, younger women in this study acknowledged the social pressures on women to conform to standards of physical attractiveness. The women in this study often expressed their reasons for cosmetic surgery in terms of a desire to "look better" rather than "beautiful."

Both younger and older women expressed concerns over the signs of aging. The younger women's concerns about age-related changes suggests that these women may resort to having more cosmetic surgery in the future and, by their own accounts, a number confirmed this possibility.

Recommending Surgery

All women said they would recommend having cosmetic surgery to other women, provided certain conditions or qualifications were met. These conditions included that the surgery had to be done for oneself and not for anyone else and women should be informed what to expect from the surgery and the risks involved. While most women described certain cases of cosmetic surgery as "frivolous", they also thought that cosmetic surgery has the potential to help a woman feel better about her face and body.

Level of Satisfaction

With the exception of one woman, all women were satisfied with the results of their surgery. Many women expressed how this was a gradual process. For four women, this process took longer than just waiting for the swelling and bruising to heal as they required additional surgery to correct unsatisfying results. Nonetheless, most women,

looking back at their decision, claimed given a second chance that they would probably do it again.