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**Aphrodite's Bosom: An analysis of how breast
augmentation is constructed at the site of cosmetic
surgery websites in New Zealand**

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Abstract

Cosmetic surgery, such as breast augmentation is made possible by the intersections of dominant understandings and practices of gender, medicine, and consumerism. In contemporary western world societies, the female breast is increasingly drawn into medicalized processes of commodification. Through practices of breast augmentation, the breast is able to be exchanged and transformed. The breast as a commodity is understood and (re)produced as a cultural object of femininity. Dominant understandings of femininity not only shape constructions of subjectivities for women, but also act to normalize other social arrangements, and practices of gender, embodiment, medicine, and consumption. This study provides an analysis of the discursive understandings that surround practices of breast augmentation, at the site of cosmetic surgery websites in New Zealand. The World Wide Web is a key knowledge technology and marketplace, and provides an important source through which processes of breast augmentation are represented. In an analysis of texts on New Zealand websites for cosmetic surgery, two representations of breast augmentation were identified, 'breast augmentation as solution' and 'breast augmentation as choice'. Breast augmentation was represented as a solution to small or 'problematic breasts' and a loss of femininity and self-esteem, and as a choice of self determination for women. Together these representations indicated that processes of breast augmentation hold in place dominant notions of femininity. These notions of femininity were drawn upon to construct women as their bodies, and their bodies as idealized objects. Notions of this ideal female breast and body were further and authoritatively held in place by the male, and medicalized knowledges of the cosmetic surgeons in these representations of breast augmentation. These notions of femininity reproduced in these websites representations were employed to limit possibilities of choice, for breast implant size, shape and position for women in practices of breast augmentation. These representations were understood, and discussed for what they may mean for women as well as in relation to wider social understandings, and relationships in contemporary New Zealand society.

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Chapter 1: Introduction

The female body is an important commodity in modern western world societies. As such a commodity, the female body is understood and produced as a cultural object. This cultural object is central within constructions and symbolisms of femininity. Surely, the most tangible signifier of femininity is the breast which is understood as iconic of female sexuality, maternity and womanhood. In contemporary times, the female breast is increasingly drawn into processes and commodifications of medicalization. The breast can be exchanged and transformed through practices of cosmetic surgery such as breast augmentation. A growing trend for this surgery is indicated, as more and more western-world women are enlarging their breasts. Enlarging the breast can be thought of, as a negotiation by some women with dominant cultural notions of femininity. These dominant understandings of femininity not only shape women's experiences of themselves but also co-constitute and normalize other socio-cultural understandings, and practices of embodiment, gender, subjectivity, medicalization, and consumption. This chapter discusses intersections of these understandings and practices of embodiment, gender etc in terms of a 'landscape' which constitutes practices of breast augmentation. The first of these understandings and practices within discussion of this 'landscape' is to do with embodiment.

Embodiment

The body is a rich and complex entity, which can be understood in diverse and multiple ways. The body can be thought of as a physiological vehicle for how we know the world as well as emblematic of the world it experiences. This idea of the body as a physiological vehicle can be understood as an "individual's interactions with their bodies and through their bodies with the world around them" (Davis, 1997, p. 9). As such interactions, a state of embodiment can be considered as a simultaneous experience of mental consciousness and physical materiality. Our existence and consciousness in the world is undertaken, and enabled from the physical form that we inhabit. Experiences of living are 'grounded' in our bodies, through which perception, thinking, interpretation, and feeling is made possible (Merleau-Ponty, 1962). As Carey (2000, p. 29) suggests "only a being with eyes to see and ears to hear can perceive the visible and hear the audible". It is through our embodied states that we are able to experience ourselves, the world, and know others. In turn, it through such embodied states that the individual is known and experienced by others in the world.

However experiences of embodiment can be understood as much more than just physiological interactions within a particular social sphere. States of embodiment are understood and given meaning through our engagements with the social world. Such a world can be considered as an interpretive landscape within which the individual makes sense of embodied states. Within such a landscape meanings of embodiment are produced within commonly shared social and cultural understandings (Gergen, 1985; Gergen, 1999; Burr, 1995; Pancer, 1997; Merleau-Ponty, 1962; Cromby & Nightingale, 1999; Foucault, 1980). These socio-cultural understandings of the body are constructed within intersections of dominant and abstract representations of race, class, gender, age and sexuality operating in any particular time and place. As such, the body is understood as black, white, male, female, old or young and so on. Thus as MacLachlan (2004, p. 2) argues, embodiment can also be thought of as “the identification of an abstract idea with a physical entity”. These abstract ideas or constructions of gender, race or class not only bring about understandings of embodiment, but also work to produce possibilities for cultural practices for the body. Cultural practices surrounding embodiment can be interpreted as how the materiality of bodies are understood and engaged with. Bordo (1993, p. 165) proposes that the body is rendered as “a powerful symbolic form, a surface on which the central rules, hierarchies and even metaphysical commitments of a culture are inscribed”. The material body is inextricably entwined with socio-cultural understandings, and can undoubtedly be read as what Bordo (1993, p. 165) defines as, a “text of culture”. However, Bordo’s proposal that culture is inscribed on the body can be taken as somewhat prescriptive as an understanding of embodiment. Cultural understandings can instead be thought of as diffused across, rather than inscribed onto, the body. These understandings are not only imposed on the body but also offered to individuals as a means through which to negotiate and structure their embodied existence. These understandings are taken up, resisted, mediated, deflected, transformed and often contradicted within particular possibilities and limitations operating within a certain time and place. (Davis, 1997; Butler, 2003). Therefore, processes of negotiating socio-cultural understandings can be understood as shaping, rather than instilling conditions of embodiment for individuals.

However, this is not to say that dominant representations of embodiment are not highly powerful and instructive, acting as constant presentations of idealized cultural standards. Most individuals are continually experiencing their embodied states in some relation to dominant and pervasive sociocultural representations surrounding the body. Therefore,

embodiment is not so much a state of impartial physiological being, as a site of complex social constructions, images, and organized practices within a cultural world (Bordo, 1993; Synnott, 1989; MacLachlan, 2004; Merleau-Ponty, 1962). The complexity of these social constructions and practices towards embodiment can be understood in the constitutions, and enactments of gender.

Gender

Gender can be considered as the socially constructed meanings, and ways of being which are informed by biological sex differences (Beasley, 2005; Oldersma & Davis, 1991; Synnott, 1993). Meanings and practices of being male and female are brought about within social understandings of feminine and masculine qualities. Tong (1998) argues that masculinity is predominately expressed in qualities of rationality, activity, logic and strength, whilst femininity is customarily expressed in qualities of passivity, softness, emotionality and nurture. These qualities are revealed within common understandings of gendered embodiments. Female embodiment is often represented as nurturing, soft and passive whilst male embodiment is typically understood as strong and active. These understandings of masculinity and femininity not only shape practices and presentations of the body, but also wider social processes of gender. Sydie (1988) and Tong (1998) both trace such social processes of gender as typically constructed around notions of men with culture and women with nature. Masculine qualities such as rationality and logic are usually understood as associated with the mind. Notions of the mind and reasoned intellectual thought are further bound up with ideas of culture. Culture is often thought of in terms of a “refined understanding of the arts and other human intellectual achievements” (Collins English Dictionary, 1995). Culture is further constructed and prized as a fabric of social living. It is the values and structures of culture which drive the customs and ‘civilization’ of individuals in a particular time and place. Qualities of masculinity are understood to possess these notions of culture. These associations of masculinity and culture work to constitute men as logical, thinking, fair and rational human beings.

In contrast, feminine qualities such as emotionality and nurture are connected with ideas of nature. One understanding of nature is as the “phenomena of the physical world” (dictionary). A natural state can be thought of as “uncivilized and uncultivated” in the context of existing within organizations and practices of the physical world (Collins English Dictionary, 1995). Feminine qualities such as emotionality and nurture are also understood as expressions and

conditions of nature. Associations of femininity with nature are further strengthened by making biological and therefore natural processes of menstruation, childbirth and lactation highly significant. Prominence given to the body and bodily issues within constructions of femininity helps to constitute women as emotional, nurturing and natural creatures (Tong, 1998).

However, such connections of femininity with nature, and masculinity with culture, can be argued as bringing about hierarchical understandings and practices of gender relations. These hierarchical understandings within western world ideologies go far back to the philosophies of Aristotle. An Aristotelian worldview proposed that the 'natural' bodily processes of woman, especially menstruation rendered her as inferior and weak (Lange, 1983). The premise for this belief was that a being whose bodily secretions were greater than another was considered to be lacking in vital or heat. This concept of heat or vital was seen as interchangeable with notions of the soul. The soul was regarded as giving consciousness to the flesh and blood body (Lange, 1983). Furthermore, the soul and consciousness were considered to be the source of rational thought. Therefore the greater heat/vital of men was perceived as bringing about a higher level of consciousness for men. These associations of masculinity with rationality, consciousness and the soul were further strengthened by the Aristotelian argument that the reproductive role of men, and the purpose of semen was to awaken the soul of the child at conception (Lange, 1983; Synott, 1993). These ways of constructing masculinity with rationality and profound consciousness brought about possibilities of social authority for men. Possibilities for higher social status and domination over others are produced for those through to possess and exercise rationality. As Harding and Hintikka (1983, p. xi) argue, there is widespread social understanding and acceptance that "the rational elements in society should have authority over the irrational elements". The unique male ability to initiate, materialize and enable the conscious soul along with an ultimate social prizing of a rational capacity worked to privilege masculine qualities over a feminine persona. The subsequent concept of Cartesian dualism further reinforced hierarchical differences between genders. In this view, human beings are accounted for in terms of matter (the body) and immateriality (the mind). Within such dualisms notions of the mind were positioned as superior to matters of the body. These Cartesian concepts further reproduced constructions of masculinity as associated with notions of rationality and the mind. Similarly understandings of femininity as connected with matters of the body were held in place. A privileging of mind-over-body and therefore notions of masculinity over

femininity worked to strengthen hierarchical differences between genders (Clarke, 2003; Foster, 1991; Ortner, 1974).

These ideas continue to inform current social representations of gender and resonate throughout contemporary practices of gender relations. Notions of rationality, logic and mental consciousness are still given prominence within practices of social authority. Good and Sherrod (2001) argue that typical contemporary constructions of masculinity reiterate historic notions of men as logical, strong, rational, autonomous and successful. These ways of casting masculinity continue to strengthen associations of masculinity and rationality, and by doing so engender possibilities of social advantage and domination for men. In contrast, perceptions that women have a lesser capacity for rational thought have been largely held and reinforced across time. This reduced ability towards rational thinking is typically (re)produced through associations of women with their bodies and biological processes, rather than their minds. This prominence of the body within constructions of femininity can be understood as continuing to give rise to a potentially subordinate social positions for women. Cultural understandings of masculine and feminine qualities not only engender possibilities for wider social positioning of men and women, but also for how gender is interpreted and performed by individuals. Abstract masculine and feminine qualities are drawn upon to make sense of personal embodied experiences of gender, as well as towards shaping presentations of bodies within the public arena.

Subjectivity

The body can be understood as a visible and public presentation of gender as well as the form through which personal constructions of masculine or feminine subjectivities are enabled. As Stam (1998, p. 6) argues, the body is the “source of experiences of subjectivity but is also the object seen, stylized and acted upon...”. Seen this way, the body is at once the means for enabling individual constructions of gendered subjectivity as well as simultaneously known as a cultural and gendered object. The body as a cultural object is understood as constituted within dominant representations of class, age, gender, race or sexuality. These representations are located changing historical, cultural, and social contexts which mediate possibilities on how the body is understood within constructions of subjectivity, and performances of gender (Butler, 2003). Oberg and Tornstam (1999, p. 630) consider that “[subjectivity] is a negotiated process whereby the individual “...draws upon cultural resources for making sense of who they are, and whom they may become”. These constructions of subjectivity are

caught in ongoing engagements with the always varied ways in which the physical male or female body is socially known. These knowledges of embodiment shape how an individual negotiates and presents their materiality within public and private experiences of life. As Synnott (1993, p. 37) argues “any construction of the body, however is also a construction of the self as embodied; and as such, influences not only how the body is treated but also how life is lived”. However, as Featherstone (1991) proposes, many individuals struggle with negotiating dominant notions of gendered embodiment. This struggle is played out within individual’s constructions of subjectivity and their performances of gender. Dominant representations of embodiment and gender such as, skin colour or body shape are often unattainable and invariably exclusionary for many individuals (Butler, 1993). Regardless of how unattainable or exclusionary these dominant ideals may be, they remain powerful forces in shaping how the individual understands themselves, and is known by others.

The body is not only experienced as a personal subjective entity, but also as an object which is observed, and understood by others. As Oberg and Tornstam (1999, p. 630) express, “we see, experience, and imagine both our own, and other people’s bodies and relate to each other through the visible body”. The object body, or body that can be known by another brings about conditions of conscious and ongoing visibility for individuals. Conditions of visibility bring about understandings of individual’s bodies in some relation with dominant notions of embodiment and gender (Radley, 1998; Sampson, 1998). Possibilities for public readings of the body, and awareness of how the body might be interpreted shape constructions of subjectivity, and productions of individual gender performances. Interactions with the social world can bring about tension for the embodied self existing simultaneously as individual construction, and cultural object (Synnott, 1993; Schilling, 1993). These tensions between subject and object states of embodiment gives rise to constant (re)constructions of subjectivity. Therefore, ongoing constructions of subjectivity are brought about within public and private experiences of negotiating a coherent sense of self in relation with dominant notions of gendered embodiments.

Within both traditional and contemporary understandings, dominant notions of female embodiments draw upon feminine qualities as, passivity, softness, emotionality and nurturance. Feminine embodiments, whether maternal, erotic, or other are invariably shaped by discursive representations, and physical enactments of these qualities. Women’s skin, hair, hands, lips, eyes, touch, voices, and manner of being, are typically stylized in notions of

gentility and softness. Their bodies are often identified as places of refuge and sanctuary yielding both comfort and protection. This positioning of bodies as places of solace gives rise to meanings of care, nurture, comfort, and protection foremost towards others. Embodied conditions and experiences of women can be understood as negotiations within such frameworks of feminine meanings. Butler (1993) proposes that such frameworks delimit, reproduce and normalize the meanings of femininity across states of female embodiments. Pregnancy can be understood as an example of the reproduction and normalization of femininity within an embodied state. Notions of pregnancy are caught up in constructions around the primacy of nurture, care, and protection of an unborn child. Women's bodies are located in the service of others, with matters of their own bodily autonomy contested, and politicized through discourses surrounding pregnancy, abortion, and childbirth. Certain notions of maternal embodiments operating in a particular time and place are normalized and bounded. The delimiting of meanings of early maternity produces and offers certain possibilities and limitations for individual performances of pregnancy, and childbirth. Norms of diet, blood pressure, weight gain, and birthing procedures govern the materiality of women's bodies, and as such the embodied practices of motherhood.

Dominant notions of femininity also work to shape and materialize representations, and practices of other femininized embodiments. Female sexuality is predominately constituted within compliant and passive forms of heterosexual practices (Gavey, 1992; Bartky, 1988; Rich, 1980; Jackson, 1984). As Crawford, Kippax, and Waldby (1994) argue, heterosexual normativity, which centralizes phallic-centered practices works to position women foremost as sexual objects rather than as actively desiring subjects. Inequalities between male and female sexualities are, as MacKinnon (1982, p. 515) claims, "founded on heterosexuality which institutionalizes male sexual dominance and female sexual submission". Further, sex is often represented in discourses of lust for men, and love for women (Hollway, 1984). Within these discourses, female sexuality is constructed as an expression of love, intimacy and commitment rather than connected to physical gratification of 'biological sex drives' as attributed to notions of male sexuality (Unger, 2001; Lazar, 2002). Women's bodies become appropriated objects of loving compliance for satisfying 'innate male needs' and feminine heterosexuality is produced as what Lazar (2002, p. 113) defines as "other centered". These strong emotional connections made with representations of female sexuality further reinforce qualities of nurture and passivity, as well as offering limited ways of embodying sexual practices for women. However, representations of female embodiments are also offered in

other multiple ways. Emergences of Queer theories, feminist standpoints, and masculinity studies have presented other ways of conceptualizing and performing female embodiments (Beasley, 2005; Connell, 2000; Whittle, 1996; Butler, 1993; Hollway, 1984; Tong, 1998; Gavey, 1992; Bartky, 1988; Rich, 1980; Jackson, 1984; Bordo, 1993; Daly, 1978). Feminists such as Gill and Walker (1993) and Kitzinger (1994) have called for social and political change to support redefinitions of female/male sexualities which are free of dominance and submission. Hollway (1995) has also offered an alternative viewpoint which raises possibilities for heterosexual practices as emancipatory for women. Furthermore, woman is not understood as a universal category. Intersections of age, race, class, ethnicity and imperialism/colonialism are further crucial and definitive forces shaping female embodiments and gender practices (Spivak, 1987; hooks, 1998; Lorde, 1984; Jeffreys, 1991).

Regardless of such multiple understandings of embodiment as Benhabib (1999, p. 217) points out, sociocultural “processes of uniformization and homogenization” are powerful pressures towards producing dominant representations of female embodiments operating in a particular context. These dominant and current understandings of femininity continue to be constructed around women’s bodies. As Davis (1995, p. 59) argues, “women participate in a gendered social order where they are continually defined through their bodies”. For most women, constructions of subjectivity are bound up with negotiations of both ongoing public scrutiny of their bodies, and dominant cultural representations of embodied femininities. As Bartky (1988, p. 39) eloquently expresses, “to have a body felt to be ‘feminine’ - a body socially constructed through the appropriate practices is in most cases crucial to a woman’s sense of herself as female, and since persons currently can only be male or female, to a sense of herself as an existing individual”.

As the female self is often bound up with existence and presentations of the personal body, possibilities are enabled for certain bodily signifiers of gender to be brought to prominence. Undoubtedly the most visible and common marker of gender for woman are her breasts. Young (1998) explains that in both her private and public worlds, a woman’s breasts are a continuous and tangible signifier of her womanhood. Breasts are the most visible form of her femininity. The experiences of being breasted are intensely personal as well constituted within processes of public objectification. Considerations and judgments of a woman’s body by herself and others, are regularly, and often intrinsically, connected to the size and shape of her breasts. Young (1998) further proposes that socio-cultural symbolisms and

objectifications of the breast brings about for most women, if not all, breasts as a significant part of subjectivity. A woman may be ambivalent about her breasts but she is seldom neutral.

The breast

Throughout the ages the breast has been a symbol of womanhood which has been long tied to social and cultural representations of fertility, nurture, love, beauty, femininity, and sexuality (Yalom, 1997; Young, 1998; Brownmiller, 1984). Within these representations the breast has been inherently valued as an object of maternal being and erotic desire. These representations of the breast as maternal or erotic are drawn upon within social practices of mothering, education, art, literature, fashion, intimacy, sex, pornography, commerce, and religion. Within such social practices, the ways of the breast being either maternal or erotic breast have varied over historical and social contexts. In Renaissance times the erotic breast was idealized to be “small, white round like apples, hard, firm, and wide apart (Yalom, 1997, p. 54). In contemporary times, an idealized erotic breast is described by Young (1998, p. 125) as, “high, hard and pointy” and somewhat akin to the breast of a Barbie doll. However, within whichever socio-historical context, representations of the breast can be understood as forces which normalize conditions of the breast. These forces of normalization idealize a certain physical presentation of the breast. As such a particular size and shape of the breast is constructed and offered, as a dominant and desirable breasted experience. In contemporary understandings, there is the “one perfect shape and proportion for breasts; round, sitting high on the chest, large but not bulbous, with the look of firmness” (Young, 1998, p. 126). This shape is held constant as an ideal norm within practices of media, art, and literature. Although, the shape of the breast can be understood as an unequivocal ideal, notions of ideal breast size are more variable.

Breast size is commonly understood within a range of possibilities, rather than as a definitive and single ideal size. However, in saying this, any possibilities offered towards an ideal breast size are constrained by the limitations imposed by normalizing breast shape. There are only a certain cluster of breast sizes within which large, round, firm, and upright breasts which are not bulbous are possible. Currently, breasts are known as standardized measurements of chest size (32, 34, 36, 38 etc), as well as through constitutions of breast size (A, B, C, D cup). This quantification enables processes and practices of objectification towards the female breast. These processes of objectification enable the body to be regarded as a sum of discrete and separate parts (Maclachlan, 2004). The breast is made possible as an

object through definition and separation from its immediate context (Young, 1998). Rather than being perceived as a curve or contour of an embodied self; breasts as objects become constructed as discrete parts situated on women's bodies.

This positioning of the breast as a separate quantifiable object enables possibilities for normalizing reconfigurations of the material breast. These breasted reconfigurations are most frequently (re)produced through the physical possibilities and constraints of clothing. The brasserie can be considered as the single most important and widely used tool for normalizing the breasts of modern women. The bra functions to produce consistent presentations of the breast through immobilizing and shaping breasts to be uplifted, firm and pointy. The bra may be padded, coloured, lacy, practical, or cleverly constructed to push breasts up and together, but still achieves what Brownmiller (1984, p. 42) defines as "the containerized [and uniform] breast that greets the world". However, such greetings are illusory productions which seek to re-present processes of aging, postpartum and breastfeeding changes, and the very individuality of women's breasts (Young, 1998; Brownmiller, 1984). Rather than the breast existing as a signifier of individuality, aging or motherhood, the bra molds the breast into a solid, definite and often homogenous object. This uniform shape is typically replicated across the chests of many women. These processes of uniformization can be understood as acting to (re)authenticate the breast within experiences of embodiment. Normalizing processes and practices of objectification around the breast work to produce certain socio-cultural understandings about women's bodies, and their femininity. Women whose breasts fall outside of the socially accepted variations of normality are often caught up with challenges to their femininity. A small busted woman may be considered as flat-chested and boyish, whilst a large busted woman may be stylized as a caricature of maternal nursing or sexual wantonness. These and other prevailing notions of femininity are typically negotiated within women's everyday experiences of being breasted. For many women these negotiations amount to an ongoing struggle between reconciling experiences of their own breasts with dominant representations of an ideal breast. Brownmiller (1984, p. 40) explains that while "breasts are a source of female pride and sexual identification ...they are also a source of competition, confusion, insecurity and shame". In her public and private worlds a woman's breasts are evaluated governed, and experienced in relation to a norm which is often unattainable. As Young (1998, p. 127) points out "even those women whose breasts do approximate the ideal can do so only for a short period in their lives. It is a pubescent norm from which most women deviate increasingly from each year".

Deviation of other sized and shaped breasts from notions of ‘normal’ size and shape often renders such breasts as problematic. As such, this deviation from ideas of ‘normality’ may be further as deficient or even abnormal. Given the significance of the breast, any problematizing of it enables possibilities for the breast to be a “site of reflexive construction” (Askegaard, Gersten, & Langer, 2002, p. 800). The breast as such a site gives rise to possibilities of reconstructing breasted experiences. These possibilities of “reflexive construction” for the breast are both enabled and constrained within interactions of social understandings, and physical possibilities. Current social understandings construct the body as a somewhat malleable project within an individual’s jurisdiction and as such within a “field of human action” (Askegaard et al., 2002, p. 800). It is widely understood and accepted that individuals in the modern western world are able to exercise some degree of control towards states of embodiment. This degree of control is bound up with notions of choice towards how an individual constructs and presents themselves (Giddens, 1991). However as Giddens (1991) argues, choice is not an unfettered or ‘free’ state but rather processes of decision-making engaged within interactions with others and institutions of society. These institutions of society can be understood as political, social and economic possibilities and structures which produce and reproduce dominant representations and practices towards embodiment. Currently notions of the body are caught up with ever increasing forces of medicalization towards the human condition.

Medicalization

Medicalization as defined by Tiefer (1996, p. 253) “is a major social and intellectual trend whereby medicine with its distinctive ways of thinking, its models, metaphors, values, agents, and institutions come to exercise practical and theoretical authority over particular areas of life”. At this time, within western world cultures the medical model is a dominant way through which health, well-being, and the body have come to be understood and represented (Mintzes, 2002). Medicalized representations of the body are made possible by engagements with medical understandings, language, and interventions towards the body, and bodily issues (Conrad, 1992). This shift to medicalized understandings and practices is as Clarke, Shim, Mamo, Fosket, and Fishman (2003, p. 161) argue, “one of the most potent social transformations of the last half of the twentieth century in the West”. This significant transformation towards experiences of the human condition has been brought by possibilities which medicalized representations hold for social and cultural practices towards the body.

Experiences of the body such as childbirth, menopause, or sexual impotence are increasingly caught within medicalized understandings and authoritative medical practices. These processes of medicalization offer certain possibilities for individuals towards understandings, and practices of their bodies. Such negotiations of embodiment can be illustrated through contemporary understandings and practices constructed around male sexual experience. Male sexuality may have long been understood in discourses around 'erectile function' and phallic-centered sexual practices. Within these discourses and practices any 'erectile dysfunction', especially age-related decline was typically considered as a 'normal' and inevitable part of life. However, within medicalized understandings 'erectile dysfunction' is mostly constructed in terms of organic dysfunction or physical failure (Gross & Blundo, 2005). Male impotence is bound up with notions of blood flow, actions of the prostate gland and other physiological experiences. Within medicalized understandings any other influences on sexual functioning such as psychological and emotional distress are largely ignored. Medicalization of erectile dysfunction understood as a discourse of organic dysfunction, gives legitimacy to a medical perspective on male sexuality. An authoritative medical perspective enables dominant therapeutic practices which highlight physiological dysfunction of the body. Thus, therapeutic practices of erectile dysfunction medications such as Viagra or Cialis are enabled and held in place as dominant treatments for impotence.

Tiefer (1996, 254) proposes that medicalized understandings and jurisdictions are constituted from certain "pillars" of the medical model. These "pillars" offer particular ways-of knowing about health, well-being, and the body. Within such knowledges, neurophysiological functions and processes are brought to prominence, enabling the body to be known in several ways (Sherif, 1979). Foremost, the body is constituted as an individual physiological entity. As such an entity, the body can be understood as a 'sum of parts'. Parts of the body are understood as objects caught up within processes of organic function (Tiefer, 1996). The organic functioning of bodies is further considered to be universal amongst individuals, even across cultural divides. By highlighting the similar biological processes of individuals, universal knowledges of the body can be constructed within 'scientific' and 'empirical' understandings. As such, the scientifically known body is able to be objectively measured, investigated, and understood. This concept of objectivity is a cornerstone of the medical model, and is caught up in highly valued notions of reliability, and validity. These notions are deemed to permit scientific 'truth' about bodily experiences. Therefore, these empirical

approaches towards embodied experiences produce understandings of the body as constitutions of biological processes and object-like parts (Engel, 1977).

However this is not to say, that these medicalized understandings of the body are either fixed or static. The medical model is continuously negotiated and shaped by changing socio-cultural representations and practices. As Tiefer (1996, p. 254) also points out, alternative discourses and practices within a medicalized framework are constituted around notions of approaching the body in ways which are “non reductionistic, holistic and contextual”. Discourses of embodiment offer notions of the body, and mind as inseparable with interactions of psychology and biology understood as cohesive and inextricably interwoven.

However, regardless of any negotiations of the medical model, “the definitional center of medicalization remains constant” (Conrad, 2005, p. 3). Medicalized discourses and interventions consistently position the body as a universally and scientifically known physiological object made up from a collection of biological parts and functions. The “pillars” of the medical model although not fixed or static, are stable and continuously reproduced in dominant understandings and practices of the body. These dominant medicalized discourses and interventions not only encompass embodied experiences such as childbirth or sexuality but are expanding to include other embodied conditions (Clarke, et al., 2003). These other conditions of the body caught in expansions of medicalisation include, nose or breast size, skin blemishes and wrinkles, weight or height. Certain heights of individuals are increasingly drawn into medicalized understandings and have become understood in terms of physical dysfunction. Children who were previously understood as ‘short’ as a result of genetic inheritance are now open to possibilities of their height being treated as a medical dysfunction. As such, constructions of height as dysfunctional have brought about medicalized interventions, such as growth hormone therapy to ‘treat’ previously understood and accepted conditions of ‘shortness’ (Conrad, 2005).

The dominance and expansion of medicalization towards the body are held in place, and further strengthened by interactions with other economic, social and political forces. Within western world cultures political trends towards more secular societies have also allowed possibilities for scientific knowledges and practices to be brought to prominence. This prominence has enabled an increased confidence in medical technologies and medical experts, strengthening the social significance, power, and prestige of the medical profession

(Conrad & Leiter, 2004). This prestige is further replicated across international borders through medicalized understandings of the body as a biological, universal and objectively known entity. These understandings bring similarities between medical professionals and practices to the fore reinforcing scientific and medicalized discourses of the body as authoritative knowledges. Furthermore, these legitimated medical discourses of embodiment are continuously reproduced within globalizing processes such as the internet and television. These technologies not only offer wider access to medicalized knowledges but also make practices of medicine towards the body highly available and possible within a global scenario. Social and political forces around medicalization are further embedded in a hegemony of capitalism which Lunt and Livingstone (1992, p. 10) argue, has rapidly developed into a “global economic system” This system is constituted and reproduced by ideologies of individualism, freedom and choice which more often than not inform contemporary social and economic practices (Edwards, 2000). Such socio-economic practices are constructed within negotiations of particular marketplaces which offer commodities for consumer consumption.

Commodification and consumption

Consumption can be understood as the processes concerned with the commodification “acquisition and use of goods and services” (Warde, 1996, p. 303). These processes or experiences of consumption are constructed within interactions of cultural, social, economic, and political relationships. As Edwards (2000, p. 3) elaborates, experiences of consumption are “matters of money and economics, social practice and social division, political policy and political implication. In short a matter of consumer society”. At the heart of consumer society, and “underpinning all these notions of consumption, is the key idea of commodification” (Chamberlain, 2005). Commodification involves the processes and practices which open up possibilities for certain goods and services to be packaged exchanged and consumed (Lunt & Livingstone, 1992).

Within contemporary consumer societies there is a growing shift towards a commodification of human life and social practices. Featherstone (1991, p. 173) argues, there has been a shift of the “commodity form to more and more aspects of social life”. Health and education as well the body and bodily issues are increasingly commodified, commercialized and bound up within processes of consumption. This expanding commodification of social life and the body is driven in part by ideologies and practices of capitalism. These processes of capitalism

constitute the economic systems which dominate modern western societies. Such economic systems are fundamentally reliant on ever-expanding markets creating endless conditions of supply and demand. These expanding marketplaces are created by constructions of infinite and universal wants, needs and desires able to be exchanged freely (Slater, 1997; Stearns, 2001; Friedman, 1994).

However, practices of consumption can be understood as more than just constitutions of commercialized capitalist practices or a series of rational and utilitarian economic transactions (Edwards, 2000). Lunt and Livingstone (1992, p. 21) argue, that practices of capitalism have brought about a society “in which economic exchange provides the context for, and indeed the model of, social relations and personal identities”. Acts of consumption are an individual’s engagements with processes of consumer society. This society can be thought of as a “symbolic society or a society of signs and meanings stressing the significance of identity, psychology and the unconscious” (Edwards, 2000, p. 14) Within consumer societies, goods and services such as education, housing, art, jewelry and cars often function as signs which symbolize gender, race, class or sexuality. These notions of gender or sexuality can be understood as continuously (re)constructed within varying investments of cultural value in ever changing symbols. Culture itself can be understood as produced and reproduced through fluctuating processes of creation, appropriation, transformation and investment of meanings towards such cultural symbols (Mackay, 1997). Rather than processes of consumption simply reflecting contemporary socio-cultural values, consumption can be understood as shaping productions of culture. Hence, “consumption is not the end of a [cultural] process but the beginning of another and thus itself a form of production” (McKay, 1997, p. 7).

Throughout these productions of culture, individuals engage with the practices of consumption to make sense of themselves and the world they inhabit. Within practices of consumption, notions such as race, class or gender are negotiated and expressed within constructions of subjectivity. In this way, consumption can be understood as articulations of subjectivity “within a wider context of life strategies [and] constitutions of meaningful existences” Friedman, (1994, p. 1). Existence as an individual and articulations of subjectivity are increasingly bound up with commodified notions and practices of the body within today’s consumer societies. The body within consumer culture is typically positioned as a malleable project open to possibilities of change and reworking (Frank, 1991).

Featherstone (1991, p. 178) describes this notion of the 'project body', as caught up with "the tendency within consumer culture for ascribed bodily qualities to be regarded as plastic, with effort and 'body work' individuals are persuaded that they can achieve a certain desired appearance". The body is typically idealized as an object of beauty, fitness, and youth. These notions are commodified and offered to individuals through a growing array of commodified products such as diet and exercise regimes, and an ever increasing range of pill, creams, treatments, aids and devices (Featherstone, 1991). These practices of appearance and preservation of the body are typically framed within discourses of individualism, freedom and consumer choice (Edwards, 2000). Within such discourses the individual is situated as having personal autonomy over bodily experiences including weight, appearance, health and well being. These understandings are brought about by notions that individuals possess equal capacities of personal determination over constructions of subjectivity. However, such constitutions of agentic determinations of subjectivity held in place by discourses of consumer culture often ignore the unequal conditions and intersections of race, class, gender or sexuality which individuals continually experience in their everyday lives. Such conditions of race or gender work to bring about possibilities and limitations which both enable and constrain experiences of embodiment. However, possibilities and limitations for the body engaged with in constructions of subjectivity are neither static nor permanent, but rather understood as fluid and dynamic social practices (Merleau-Ponty, 1962). Understandings and practices of race or gender are continuously shifting through the ongoing negotiations of subjectivity by individuals. It is through these negotiations of subjectivity that the very practices of consumption towards the body are mediated, transformed and reproduced. However, practices of consumption in respect of the body are not only shaped and produced through constructions of subjectivity but are also made possible by wider socio-cultural processes. These processes include the growing medicalization of the human condition. Medicalized understandings of the body as a physiological object enables particular practices of surgical, medical, and pharmaceutical intervention. These interventions coupled with techno-scientific innovations which include advances in genomics, bioengineering and computer-assisted technologies facilitate further aspects of embodiment to be drawn into processes of consumption. These medicalized interventions towards the body fit readily into the commodity form as surgery, medications and technological treatments are able to be packaged, exchanged and consumed.

Cosmetic surgery

Cosmetic surgery is an extremely interesting example, of how the commodification of medical processes is enacted in practices concerning the body. Within almost all of today's western world cultures, cosmetic surgery is freely offered within the institutions of private health care, and is entirely at the consumers cost. Consumption of cosmetic surgery in the U.S alone is estimated to realize 300 million dollars annually and has an anticipated growth rate of 10 % (Wolf, 1991). Cosmetic surgery can be thought of as "surgery undertaken solely for reasons of appearance" (Davis 2003, p. 24). In terms of appearance, this surgery is undertaken purely for aesthetic reasons, rather than as reconstructive surgery to repair some damage to the body. Consumers of cosmetic surgery are usually understood as 'healthy' and 'normal' individuals who are dissatisfied or unhappy with some aspect of their appearance. This surgery is played out as practices of medicine brought and sold within a private marketplace. Medicalized understandings of the body as, an object and a sum of parts, informs, and enables cosmetic procedures which include surgery, laser treatments, and pharmacology such as collagen and botox. These practices of medicine are accessible and available for the most part, to those who can afford them. This accessibility is further constituted within discourses of consumer choice, individualism, and freedom. Within these discourses, the body is understood as a malleable project whose parts are able to be transformed, and exchanged (Gillespie, 1998). These practices of transformation are constructed as freely chosen expressions of an individual made within knowledges of risk, and informed consent. . Hence, the growing consumption of cosmetic surgery in contemporary times can be understood "inextricably connected to a market model of medicine and consumer culture" (Davis, 1995, p. 17).

However, practices of cosmetic surgery can be understood as more than just interactions of medicalized processes, and economic arrangements of consumer society. Wider social practices of gender are further and significantly (re)produced at the site of cosmetic surgery. Cosmetic surgery is the most gendered of all medical specialties in that 91% of all consumers are women, and in approximately 90% of all cases the surgeon is a man (Davis, 2003; Dull & West, 1991). Such surgery is produced within a "medical system [which] is gendered, at the level of interaction between practioners and patients, in the organization of its institutions and practices, an in the conflation of its discourses with symbolic notions of masculinity and femininity" (Davis, 2003, p. 55).

Common representations of the male practitioner are constructed around understandings of “rationality, objectivity and instrumentality [which] are the hallmarks of medical science and masculinity” Davis (2003, 55). Men’s professional domination of cosmetic surgery as well as a predominance of women as patients engenders possibilities of economic privilege and authoritative status for male practitioners. Prominence of men as cosmetic surgeons, and within the echelons of the wider medical system holds in place gendered arrangements and hierarchies of medical institutions. Dominance of both medicalization within practices of social life, and men within processes of cosmetic surgery enables discourses of masculinity and medicine to be held as authoritative and legitimate knowledges. As Davis (2003, p. 55) argues cosmetic surgery “produces and reproduces masculinity as a [dominant] feature of the historical, cultural, and institutional practices and discourses of medicine”. On the other hand typical understandings of the female patient constitute her as “tied to the life world through her emotions and her body” (Davis, 2003, p. 55). However, as previously discussed, notions of femininity with nature, emotions and the body are valued less than masculinized notions of rationality, and the mind (Clarke, 2003; Foster, 1991; Ortner, 1974; Synott, 1993). Hence, positioning of femininity and women in this way enables hierarchies within doctor-patient relationships given the sociocultural value, and privilege invested in both masculine qualities, and scientific understandings.

Overrepresentations of women as consumers of cosmetic surgery can be understood through exploring connections made between femininity, and the body. Dominant associations of women with nature, and constructions of femininity bound up with discourses of beauty and youth bring the female body to prominence (Young, 1990; Sydie, 1988; Tong, 1998; Morgan, 1998). The female body as a prominent and cultural object read according to the doctrines of femininity, is also the experience of subjectivity. For many women experiences and presentations of their bodies are woven within understandings of themselves as feminine beings. Being breasted is an embodied experience which is often highly significant for most women. This significance, and processes of objectification which permit the body to be known as separate parts, gives rise for reconfigurations of breasted experience. This reworking of the breast is enabled at the site of cosmetic surgery through procedures of breast augmentation.

Breast augmentation is the second, most frequently performed cosmetic surgical procedure after liposuction (Morgan, 1998). This surgery involves the permanent enlarging, and

reshaping of a woman's breast through surgical insertion of an implant device which is encased in a silicone shell and filled with either silicone gel or saline solution.

Didie and Sarwer (2003) reported that there were 206,354 breast augmentation procedures undertaken in the U.S in 2001, reflecting a 56% increase from 1998, and a 533% jump since 1992. Current estimates show, that as many as two million American women have breast implants with further projections of a 10-12% annual growth rate (Sarwer, Nordmann, & Herbert, 2000). Although data on breast implants in New Zealand women is very scarce, it was estimated in 1998 that around 3000 New Zealand women had undergone breast augmentation (Norris, Frost, Ryan, & Weenik, 1998).

Women have long sought to fill out their bosom, with a full breast a desirable and valued signifier of sexuality as well as maternity. Yalom (1997) and Fallon (1990) argue that with the exception of two brief periods in the 15th and 20th centuries, large breasts have for the most part been historically fashionable, and continue to inform notions of feminine beauty today. Women striving to capture the illusory ideal of the voluptuous breast used clothing such as corsets, and brassieres to emphasize, and reshape their breasts. However, from the 18th century up to the present day, practices of breast enlargement have been directly invasive and, intended to be permanent. Early attempts of breast enlargement involved the direct injection of substances such as ivory, glass, metal, rubber, olive oil, petroleum, and liquid silicone into the breast with largely unsuccessful and often disastrous results (Yalom, 1997; Haiken, 1997). However, continuing demand for breast enlargement coupled with scientific developments brought about the production of synthetic breast implants such as sponge, silicone and saline devices. In contemporary times, synthetic breast implants are predominately either of a silicone or saline substance (Sarwer et al., 2000). Although subject to significant controversy, silicone implants remain a widespread and popular choice as they are considered to produce a more 'natural' breast' in appearance and touch. (Kaufman, 2005). This controversy around silicone implants has been brought about by potential, although unproven associations with breast cancer, autoimmune disease, and concerns with implant rupture and leakage (U.S Food and Drug Administration [FDA] Handbook, 2004). This controversy produced strict regulations of silicone implants, which since 1992 have only been available to American women within clinical trials, and highly controlled conditions. In contrast, silicone implants are widely available in numerous other countries and have always been accessible for New Zealand women, and were re-offered to Australian women in 2001 (New Zealand Ministry of Health, 1994; Health Department of Victoria, 2002). In 1999, the

American Institute of Medicine (IOM) commissioned a report regarding the safety of silicone breast implants which involved the study of over three thousand articles, and multiple public hearings. At these hearings, the evidence of academic and industry experts, as well as women with experiences of silicone implants was reviewed. The major findings of this report were that there were no significant health risks associated with silicone implants, and no conclusive evidence of relationships between either silicone implants with breast cancer, or silicone in breast milk (Sarwer et al., 2000). Although silicone implants are effectively banned in the U.S, mounting pressure from industry, surgeons and consumers to allow American sales are gaining political and social momentum. Breast implants are a highly lucrative product and account for over half of the income of one of the only two companies authorized to sell breast implants in the U.S. It is further projected by market analysts that approval for sale of the more expensive silicone implant in the U.S market would be expected to generate incremental sales of between 50 million to 100 million dollars (Tsao, 2003).

However, women's breasts can be understood as a site of potential profit for manufacturers of breast implants at the potential expense of women's health. Although there are no conclusive links between breast augmentation and breast cancer or other serious illnesses, there are twenty-seven other serious risks and complications reported (FDA Handbook, 2004). These risks and complications include increased problems with breastfeeding, wrinkling, asymmetry, infection, toxic shock syndrome, scarring, and chest wall deformity. The touch and feel of the breast may also become adversely affected. Around 28% of women with breast implants reported either intense, or a lack of nipple or skin sensation, with a further 7-17% of women reporting ongoing experiences of breast pain. Furthermore, women with breast implants are unable to realize the benefits of preventive health technologies towards breast cancer as implants interfere with the diagnostic capabilities of mammography. However the most common and potentially serious complication reported is capsular contracture which occurs when scar tissue forms around and puts pressure on the implant. Degrees of capsular contracture vary from some detected firmness and lumps to hard, painful, and deformed breasts. Comprehensive studies indicated that capsular contracture rates range from 36-81% for women with silicone devices, and 8-41% of those with saline implants (FDA Handbook, 2004). However, these figures of rates of capsular contracture through breast augmentation have been disputed. Sarwer et al. (2000, p. 847) argues that "some researchers, however estimate that up to 100% of women with breast implants will develop capsular contracture to a certain degree over the life of the implant ...[and it is] suggested it

be considered a natural outcome rather than a complication of breast augmentation". Further pressure within the breast, from states of capsular contracture is also considered a catalyst for the implant to rupture. Such rupture causes the breast implant to leak its contents into the surrounding breast tissue and into the body. It is reported that leaked silicone gel may move away from the breast forming lumps which can become lodged in the chest wall, arm, armpit or abdomen (FDA Handbook, 2004). Rupture of an implant is also brought about by the age of the implant. Studies under FDA approval reported steady increase of rupture rate as per age of implant with a rupture rate of 69% by 17.8 years. Such a high prevalence of rupture has brought about a warning in the FDA Breast Implant Consumer Handbook which states that breast implants "will not last a lifetime" requiring removal and further surgery. However, it is not only implant rupture which brings about further surgery. These further re-operations are also undertaken due to capsular contracture, breast pain, wrinkling, asymmetry, and other cosmetic dissatisfactions. Surgery of any kind is a risk in itself for the individual and therefore it is of significant concern that the potential for multiple surgical interventions is brought about for women with breast implants. These further surgeries are reported as occurring for almost a quarter of all women with breast implants, within five years of their initial augmentation.

Regardless of such risks and complications breast augmentation surgery continues to be increasingly offered to, and taken up by women thus remaining the subject of much sociopolitical argument. From its very inception cosmetic surgery as a medical specialty for aesthetic reasons was controversial and such controversy continues to inform contemporary debate. Central to this dilemma and debate of cosmetic surgery are concerns and justifications of the "usefulness or desirability of surgery on an otherwise healthy patient for beauty reasons" (Davis, 2003, p 25-26). These concerns and justifications can be understood as brought about within complex interactions of constitutive and changing political, economic and sociocultural representations and practices. Such practices can be interpreted as statements of culture with understandings of breast augmentation played out in discourses of feminism, psychology, consumption, medicine and individualism.

Poststructuralist feminist theorists such as Bordo (1989), Morgan (1998), and Bartky (1988; 1990) argue that cultural discourses of femininity engender practices of discipline and control towards women's bodies. These practices are normalized and embodied producing what Foucault (1980) defines as "docile bodies". Bordo (1989, p. 14) proposes that such bodies

can be understood as “bodies whose forces and energies are habituated to external regulations, subjection, transformation [and] improvement”. Therefore women’s bodies become a site of social control through which prevailing notions of femininity are produced. From Bordo’s perspective, disciplinary practices of the female body are systematic of gender oppression and control and as such caught up in wider social practices of control and power. Predominance of men in medicine and within wider powerful political, economic and cultural positions, as well as social valuing of discourses of masculinity and science is considered to bring about dominant male and often medicalized understandings and practices of the female body. As Morgan (1998, p. 151) considers “women’s attractiveness is defined as attractive-to-men; women’s eroticism is defined as either nonexistent, pathological or peripheral when it is not directed to phallic goals; and motherhood is defined in terms of legally sanctioned and constrained reproductive service to particular men and [male dominated] institutions”. Hence, Bordo (1989) proposes surgery such as breast augmentation is a signifier of subtle but insidious gender oppression within which women’s bodies are constructed and organized in hierarchal practices of male-dominated social life. Male-ordered representations of femininity are instilled within a woman’s experiences of embodiment through coercive exercises of cultural control (Bordo, 1989; Morgan 1998; Bartky, 1988; 1990). From such a standpoint cosmetic surgery is represented as “colonization of women’s bodies” (Morgan, 1998, p. 147) with women who participate in such colonization being seen as largely duped by dominant representations of culture. Participation in cosmetic surgery is argued as a ‘choice’ for a normalized, homogenized, and standardized female body rather than a rational and free choice towards expressions of embodied individuality.

However these understandings of such arrangements of society, these notions of power as well as arguments around ‘choice’ at the site of cosmetic surgery can be read as overly oppressive. Within such understandings conditions of constraint are brought to prominence and any possibilities which are offered become overshadowed. Any possibilities for women to negotiate and exercise power or ‘choice’ in a way that benefits them are marginalized. From Bordo’s and Morgan’s viewpoints, women are continually fixed in a rigid and hierarchical position within a gendered social order from which there is no escape. Such gendered social arrangements always locate women as inevitably subservient and disempowered in relation to men. However, gendered social arrangements can alternatively be understood as always shifting, within conditions of authority and power which are continuously negotiated, exchanged and transformed in relations of men and women.

Understandings and practices of gender are constantly shaped, and produced within these negotiations of society by men and women. This is not to say that hierarchical practices of domination and subordination are not enacted and experienced within such shifting social arrangements of gender or that concepts of social power can be understood as free from coercive practices. Instead, rather than understanding power in terms of hierarchical practice, notions of power can be thought of as forces of regulation rather than oppression. This distinction permits possibilities for dominant social representations to be understood as highly instructive but negotiable within experiences of women. Butler (1993) argues that representations offered in a particular time and place are normalized and bounded producing certain possibilities and constraints towards practices of female embodiments. Such practices of embodiment may well be constituted as Bordo argues within gendered hierarchies of a male dominated social life. Men do predominately hold positions of status and power within society, and as such bring a male-ordered dominance within socio-cultural understandings and practices of gender. Women cannot stand outside of culture. Therefore any constructions of subjectivity can always be understood as experiences and productions of culture as women draw upon social representations of femininity to make sense of themselves. However, social representations of femininity are not blindly and passively adhered to: rather they are mediated, transformed, and even contradicted within constructions of embodiment. As Davis (1995, p. 5) argues rather than viewing women who engage with cosmetic surgery as “cultural dopes” such women can be understood as “agents who negotiate their bodies and their lives within the cultural and structural constraints of a gendered social order”. This concept of agency is not a representation of free choice as such a notion is not possible, but rather agency is understood as “active participation of individuals in the constitution of social life... Individual agency is always situated in relations of power, which provide the conditions of enablement and constraint under which all social action takes place. There is no “free space” where individuals exercise “choice” in any absolute sense of the word”. Davis (2003, p. 12) However, as Gavey (2002, p. 435) reiterates, that “...as subjects we are able to pull at the same time that we are pulled- never capable of truly free choice, but still able to exist in a form that feels like our own unique identity and to act in ways that feel like choice”. Hence the crafting of feminine embodiments through the technologies of breast augmentation can be understood as an action mobilized by social constructions of femininity, rather than action of subjectivity performed in compliance with dominant cultural representations (Butler, 1993). In this way breast augmentation offers possibilities for some women to

renegotiate conditions of their femininity and in doing so to actively shape constructions of subjectivity.

However, practices of breast augmentation on the bodies of women can be understood as contradictory and multifaceted. Davis (1997, p. 169) argues for “viewing cosmetic surgery as a complex dilemma: problem and solution, symptom of oppression and act of empowerment, all in one”. Breast augmentation can be thought of as offering a solution to unwanted changes of the breast as due to aging or experiences of maternity. Such surgery offers possibilities for a sense of loss to be regained, and for some women this can be understood as restoring coherence to a biographical narrative of embodiment. Breast surgery also offers the possibility for women who consider their breasts are too small or ‘abnormal’ to reconstruct their biographical narratives or understandings of themselves. Davis (1995) reports, that many women she interviewed who had undergone breast augmentation did so from a desire to be ‘normal’ and ‘ordinary’ as opposed to being beautiful. For many women tensions between the body-as-object and the body-as-subject brings about ongoing, and painful psychological struggle towards constructions of subjectivity (Davis 1995; 1997; 2003). Breast augmentation can be understood as a means to alleviate mental suffering, and enable re-appropriation of a previously disliked body. Thus, “cosmetic surgery can, paradoxically, provide an avenue towards becoming an embodied subject rather than remaining an ‘[abnormal]’ objectified body” Davis (2003, p. 85). Many women who undergo cosmetic surgery find overall pleasure with the results. These women report significant benefits across several dimensions of health and quality of life, including substantial improvements in psychological well-being (Askegaard, et al., 2002; Sarwer et al., 2000; Hovi, Hemminki, & Swan, 1999). Experiences of psychological well-being are also bound up with constructions of subjectivity as self-determined and chosen. These notions of self-determination and choice are understood as ‘empowering’ with such empowerment beneficial for psychological health. Such empowerment is brought about from possibilities for women to choose their bodies and gain personal control over experiences of embodiment. Askegaard et al. (2002, p. 802) argue, that “cosmetic surgery is frequently described as an act of self-determination; as a demonstration that a person is free to do what she likes with her body”. The offering of breast augmentation as ‘choice’ permits understandings of women as agents able to negotiate their embodied experiences in a personally rewarding way. Many women who have undergone breast augmentation report increased psychological well-being which is attributed to a sense of autonomy gained towards their embodied experiences.

However, cosmetic surgery as a practice simultaneously acts to sustain discourses of feminine inferiority. Women's bodies are objectified, and reworked against dominant social constructions of femininity which operate to normalize, standardize, and homogenize female embodiments. Normalizing processes and practices of objectification around the breast also work to exclude notions of the breast as a valued signifier of individuality, aging and motherhood. Women whose breasts fall outside of the bounds of normality are invariably caught up with challenges to their femininity and typically negotiate their breasted experience as problematic. These understandings of the breast as problematic are not only reproduced at the site of cosmetic surgery but are fundamental to the expansion of breast augmentation practices. Cosmetic surgery is also potentially dangerous, and carries significant and serious risk. The lived material reality of breast augmentation is that women's breasts are sliced open, implanted with a synthetic foreign body, and stitched closed. These rearrangements with knives and needles bring about possibilities of infection, unwanted or missing sensation, pain, hardening, abnormality, and maiming of the breast. The potential psychological well-being gained from breast augmentation is privileged over existing states of physical health and well-being. This privileging of the mind engenders notions and practices of hierarchy within experiences of gender as well as subtly working towards (re)productions of wider hierarchical orderings between genders. Women can never fully transcend their bodies and any meaningful connections which are made between women and their minds are inextricably bound up with bodily presentations of femininity. As such, notions of choice constructed within practices of breast augmentation can be understood as highly problematic. Choices which women make about embodiment are located within a wider social world which offers powerful and instructive representations of who and how to be. These representations are never value-free or neutral and are invariably reflective of certain economic, political and cultural forces which bring about advantage for particular social groups and institutions (Tong, 1998). Therefore discourses of 'choice' are bound in a complex interplay of political, economic and socio-cultural practices such as gender, capitalism and medicine. These discourses enable the expansion of practices of breast augmentation into growing numbers of women's lives. This expansion is not only made possible by dominant social representations of embodiment but also engendered within interactions with techno-scientific innovations and processes of globalization. The processes of globalization have enabled dominant knowledges of embodiment to be widely available and accessible across national borders. These knowledges are continuously produced and strengthened within global circulations brought about by knowledge technologies such as television and the internet.

The World Wide Web.

Since the 1990's, the Internet has revolutionized, and transformed practices of communication. "The Internet is at once a world-wide broadcasting capability, a mechanism for information dissemination and a medium for collaboration and interaction between individuals and their computers without regard for geographic location" (Internet Society [ISOC], 2006, p. 1). Technologies of the internet construct the world as a visual and auditory experience which, "radically alters the constraints, and lived meanings of space. In terms of space, distance becomes irrelevant for anyone willing or able to forgo being there in the flesh. The Internet transforms spatial experience such that one can instantly 'go' anywhere that is wired" (Garza, 2002, p. 190). This borderless world of the internet has brought about possibilities of unprecedented access to information on every aspect of human life. The internet as a knowledge technology involves all levels of society, and is estimated to have around a hundred million online users in the US alone (Levy & Strombeck, 2002). New Zealand users are rapidly engaging within this global information network, and currently three-quarters of the NZ population are reported as internet users. There has been a marked increase in internet use, up from 22.2% in 2000, to 76.3% in 2006 (New Zealand Internet Usage Stats and Telecommunication Reports, 2006).

The most commonly visited websites around the world are news, travel, and weather domains with health and medicine the fourth most popular topic online (Levy & Strombeck, 2002). It is estimated, that there are 20,000 websites on health and medical issues. These websites are constructed by individuals, groups, health care providers, professional organizations, and government agencies. Levy and Strombeck (2002, p. 496) advise that "e-Health has evolved as the primary term used by the information technology industry to describe the application of the Internet to all aspects of health and health care". As such, the internet has become a gateway for individuals to research medical issues and practices, including cosmetic surgery. Women considering breast augmentation are able to access information that was previously difficult, or even impossible to obtain. This potentially unlimited access to expert and other knowledges has certain implications for traditional practices of medicine (Broom, 2005). Possibilities arise for the internet-informed individual to challenge "...classic models of medical care where the doctor is the expert provider of information, and the patient is the passive recipient" (Broom, 2005, 321). Armed with greater awareness of medical practices, the patient is understood as 'empowered', and able to act with increased autonomy in decision-making processes about their bodies, health and well-being. As such, the individual

is understood as able to engage with health providers within a relationship of equality and respect.

As well as a knowledge technology, the internet also acts as a marketplace. These marketplaces consist primarily of the distributing, buying, selling and servicing of products, and services over electronic systems such as the internet” (Wikipedia Encyclopedia, 2006). Consumers are offered relatively unlimited access to health commodities within highly unregulated environments which often prove to be very lucrative. These practices of e-commerce are held in place within ideologies of consumer society which draw upon understandings of individualism, freedom, and choice. These practices of e-commerce have been widely taken up by health care professionals and access to cosmetic surgery is frequently offered within an internet marketplace. Cosmetic surgery offered as e-Health potentially holds several advantages for cosmetic surgeons. These surgeons are able advertise their services to potential customers in easily accessible, cost-effective, and less time-consuming ways. It is the potential customer rather than the surgeon or his staff which commits the time, and energy in reviewing information about surgical procedures and other related details. These websites offer conditions of anonymity which initially permit the individual access to processes of cosmetic surgery in highly private ways. For women seeking breast augmentation this privacy is likely to be immensely appealing, given that such surgery is typically sought by women who feel acutely embarrassed or ashamed about their breasts. Women are further able to compare and contrast the services of cosmetic surgeons. Through such comparisons, individuals are thought to be able to make informed choices about consumption of cosmetic surgery which best suits their needs and desires.

However, the internet as a knowledge technology and competitive service provider can also be understood as organizing and reproducing other social understandings and practices in authoritative ways. Rather than viewing the internet as a source of extensive and independent knowledges, the internet can be understood as part of “the whole range of practices that are oriented towards media, and the role of the media in ordering other practices in the social world” (Couldry, 2004, p.115). Cosmetic surgery websites can be interpreted as a medium which shapes and reproduces other social understandings and practices. Drawing upon these understandings and practices, these websites construct and offer certain versions of knowledges about gender, embodiment and subjectivity. These versions of knowledges work to inform practices of everyday living. An analysis of how breast augmentation is constructed within cosmetic surgery websites can highlight which discursive productions of embodiment,

gender, and subjectivity are brought to prominence. An exploration of these discursive productions may further highlight social, economic, political, and cultural understandings which shape social living. These understandings inform constructions of subjectivity, and normalize particular social arrangements. The intention of this research is to offer comment on what possibilities these websites offer towards constructions of subjectivity for New Zealand women. It is also intended that this research explore what particular social arrangements might be normalized in contemporary New Zealand society through website representations of breast augmentation. .

Chapter 2: Methodology

The research process undertaken to analyze how breast augmentation is constructed within internet websites comprised several steps. Firstly, the websites were identified. Next, these online sites were explored for commonalities and differences. It was evident that across these websites that certain discursive formations were occurring, and the material was grouped within these formations. These discursive formations as well as website text, and images were further explored for how breast augmentation was represented. There were two main representations identified. These were 'breast augmentation as solution', and 'breast augmentation as choice'. These representations were further analyzed for which social understandings, and practices might be informing these meanings of breast augmentation. The final stage of the analysis involved what the implications of these meanings might hold for individuals, as well as wider social practices and institutions. Throughout this analysis process, the website material was understood within a broadly discursive approach to research practice. This approach draws upon social constructionist understandings of the world, and employs theoretical framings which are constituted within such an epistemology.

Identifying websites

The decision to limit the collection of website material to New Zealand sites only, was arrived at for several reasons. It is considered that these websites will bring about a significant amount of rich, deep, and full material for analysis within manageable boundaries. It was also thought that a homogenous context may exclude ambiguities, and interpretation errors which can potentially occur when examining material which is located in other cultural contexts. As such, a homogenous context offers the potential for consistent meanings, and understandings to be recognized within the research findings. Consistencies across research findings may more readily highlight wider social understandings, and practices at work within the website material. Furthermore, the New Zealand context was chosen because it is relevant to the researcher's time, and place. For this researcher there is a strong conviction that an author's context contributes legitimacy to the research, especially within instances of woman-centered study. As cosmetic surgery websites are almost always designed for women, and considering the author's context this research has been limited to the possibilities for understandings of gender, subjectivity and embodiment as offered to New Zealand women. Therefore, within this New Zealand context it was decided to include national websites only. Although it was recognized that New Zealand women considering breast

augmentation may visit international websites it is believed that ultimately local providers of cosmetic surgery would be chosen for practical and financial reasons.

The keyword phrases 'breast augmentation surgery in New Zealand'; 'breast implants in New Zealand; and 'breast enlargement in New Zealand' was entered into four commonly used internet search engines- Google, Yahoo, MSN, and All the Web. The website pages resulting from these searches were scrolled through, with the names of cosmetic surgeons, and their practices noted. Scrolling through these pages was completed, until four consecutive pages showed no new listings for New Zealand surgeons. A total of 14 websites were found, with 10 of these websites being one surgeon only practices. The remaining four websites were multiple surgeon practices which ranged from two to seven surgeons per website.

These internet searches for breast augmentation surgery also yielded websites for the New Zealand Foundation for Cosmetic Surgery, and the New Zealand Association of Plastic Surgeons. Both of these organizations listed profiles, and information regarding their members. These profiles were further searched to gain wider capture of surgeons who perform breast augmentation in New Zealand. All of the 16 surgeons who were members of the New Zealand Foundation for Cosmetic Surgery had links to further websites which detailed their private practices. However, these linked websites had already been found in previous searches.

The other website for the New Zealand Association of Plastic Surgeons has 36 members, of which 25 surgeons had further internet links from this webpage to their private practices. The other 11 surgeons had no links or further information from this website, and were not found in any of the previous searches concerning breast augmentation in New Zealand. It is assumed that they are solely employed within the public health sector, and specialize in reconstructive plastic surgery, rather than elective cosmetic surgery. The 25 surgeons who were in private practice were either sole practitioners or in partnership with one or more cosmetic surgeons also listed as member of this association. Of these 25 surgeons, 24 had previously been included in the original search and collection of the initial 14 websites. However, by searching the linked pages from this association another website was found which brought the total of websites for analysis to 15 which are listed by name and address below.

Auckland Plastic Surgical Centre (www.plassurg.co.nz)
Body by Klein (www.bodybyklein.com)
Cary Mellow (www.plasticsurgerycentre.co.nz)
David Glasson (www.pssl.co.nz)
Gregory D. Taylor (www.cosmeticart.co.nz).
John. J. de Geus (www.jjdegeus.co.nz)
John de Waal (www.johndewaal.co.nz)
Julian Lofts (www.plasticsurgeon.co.nz)
New Zealand Institute of Plastic and Cosmetic Surgery (www.plasticsurgeons.co.nz)
Peter Walker (www.plasticsurgery.co.nz)
Plastic Surgical Masters (www.nzcosmeticsurgery.co.nz).
Plastic Surgery New Zealand (www.plasticsurgerynz.com)
The Surgical Clinic (www.4cosmeticsurgery.co.nz)
Tristram Clinic Ltd (www.tristramclinic.co.nz)
Wellington Plastic Surgery Institute (www.wpsi.co.nz)

All of the surgeons who were members of the New Zealand Foundation for Cosmetic Surgery were also members of the New Zealand Association of Plastic Surgeons, and 12 surgeons shared membership of both organizations. Of the fifteen websites which comprise the material of this analysis, fourteen sites feature surgeons who are members of either association, and in some cases are members of both. All of the surgeons are men, and appear to range from approximate ages of 35-65 with the majority, younger rather than older. The sole woman surgeon found within these websites offering cosmetic surgery is profiled as a breast surgeon. However, she specializes in breast disease, mastectomy surgery, and breast reconstruction following cancer. Similarly, the one female member of the 36 strong New Zealand Association of Plastic Surgeons is not listed within any private practices, and from preliminary internet searching appears to be engaged with reconstructive rather than cosmetic surgery.

Website framings

The material gathered from the fifteen websites ranged from short and concise, to in-depth offerings of the surgeons, their practices, and information regarding breast augmentation procedures, and issues. All of these websites also offered other cosmetic surgery services such as facial cosmetic surgery (facelifts, nose reshaping etc); body contour surgery such as

liposuction, and abdominoplasty, as well as breast surgery which included not only augmentation but also breast lifts, and reduction procedures. These websites typically included most, if not all of the of the following: a website homepage, logos, surgeon biography(s), practice details, photographs of the surgeons, clinic buildings and women, links to other information, frequently asked questions, contact details, breast augmentation surgery information, testimonials, feedback, disclaimer, and privacy statements as well as appointment information. All of the pages from the websites were downloaded, and collected in printed hard copy where possible, with the exclusion of any cosmetic surgery procedures other than breast augmentation. There was also a slideshow interactive movie that was featured on several sites which was unable to be printed. Therefore, each slide was viewed with all of the text detailed as well as images colour, and, background noted. All of the websites were soundless.

The analysis of these website images, and texts was engaged with at the beginning of the downloading process, and continued throughout the writing up stage. The beginning of the analysis involved viewing, and reading each website in order to gain familiarity with the material. This involved online browsing, and revisiting of the websites as well as reading and re-readings of the printed pages, and images. This immersion with the websites brought similarities, and differences between cosmetic surgery practices to the fore. It soon became evident that there were certain discursive formations occurring across the websites. These discursive formations became a way to understand, and order the material for interpretive purposes. These discursive formations included the portrayals of the surgeons and their expertise, presentations of cosmetic surgery as practice, how information was conveyed about breast augmentation, the tone, colours, and logos of the websites as well as how women were represented

Discursive formations:

Representations of the surgeons



With the exception of one website, photographs of all the surgeons were presented to the viewer and examples are included. This presentation was captured within a portrait type shot which was mostly in colour. This portrait format consisted of each surgeon directly facing the viewer, with his head and shoulders typically shown. Invariably, each surgeon was dressed in a



dark suit and tie, or a shirt and tie. These suits were all dark somber colours, and were well fitted to the surgeon's upper torso. The surgeon's facial expressions were either of the doctors looking serious or smiling. The only surgeon not dressed in a shirt or suit was photographed wearing surgical garments, or 'hospital greens'. These men all had short and tidy haircuts,

and for the majority were clean shaven. The surgeon as a highly professional expert is presented within all the websites. Within each website there are extensive biographies of the cosmetic surgeons. These biographies list the medical training, and experience of each surgeon as well as their particular areas of interest. Typically, the professional memberships, and current appointments of each surgeon are also listed. An example of the typical biographical information is included as follows:

Dr. John de Waal

**BHB, MB ChB, FRACS
Plastic & Reconstructive Surgeon
Auckland, New Zealand.**

I am a Plastic and Reconstructive surgeon practicing in Auckland, New Zealand. Having completed my medical and specialist training in New Zealand I went on to complete further postgraduate qualifications in England.

Medical School:

Qualifications:

- Bachelor of Medicine and Bachelor of Surgery MB ChB (1988)
- Fellow of the Royal Australasian College of Surgeons F.R.A.C.S. (Plastic) (1992)

Registration:

- The New Zealand Medical Council.

Speciality:

- Cosmetic surgery
- Reconstructive Surgery
- Hand Surgery

Professional Memberships:

- New Zealand Association of Plastic Reconstructive and Aesthetic Surgeons
- New Zealand Foundation for Cosmetic Plastic Surgery

Current Appointments (Public Hospital):

- Southern Cross Hospital, North Harbour

My particular interests are:

■GENERAL PLASTIC SURGERY

Skin & soft tissue tumours especially nose, ears, eyelids, etc.
Breast reconstruction, scarred/burnt/infected tissue. Maxillo-facial trauma.

Constructions of surgeon's expertise are further held in place through website pages which detail additional information. These pages advise that prospective candidates for surgery

should also ascertain the qualifications, experience, and registrations of the surgeon before proceeding with surgery. There are further numerous warnings about the dangers of using either unqualified surgeons, or unsanctioned treatments.

Presentations of cosmetic surgery as practice

Cosmetic surgery is presented as a highly professional medical practice. The listings of surgeon's biographies are heavily endorsed with details of their medical training, and experience. Within these biographies, details of publications and conference appearances are frequently noted. Further text about the skill, and the training of the surgeons was offered as the distinguishing yardstick between reputable, and non-reputable practitioners. Prospective patients were frequently advised to only select surgeons with certain letters after their names, and who are members of cosmetic surgery associations or foundations.

“A simple fact remains and this should remain imprinted in your memory long after you have finished reading this article- the only doctors who are comprehensively trained in cosmetic surgery and have a specialist qualification (FRACS) that is recognized by the New Zealand Medical Council are plastic surgeons”

Julian A. Lofts MB ChB FRACS (Plast.)

These associations and foundations are extensively listed on website link pages. These listings are presented, as professional and authoritative resources for potential patients to further seek information from. Cosmetic surgery is further represented as a medical practice for normal everyday people who are unhappy, or dissatisfied with some aspect of their appearance. This surgery is presented as suitable for those who are seeking improvement, rather than perfection. This improvement is represented as enabling individuals to construct normal and pleasant-looking appearances.

“Is Plastic Surgery only for the vain, the rich and the famous?”

Absolutely not! The vast majority of our patients come from everyday walks of life. They are normal people who have a problem that they are seeking help with. A few patients wish to transform themselves into supermodels but most patients wish to change a certain aspect of their appearance so that it fits more harmoniously with their overall appearance”

Plastic Surgical Masters

Cosmetic surgery is further represented within several websites, as a valid and legitimate choice that individuals may make about their bodies. This decision-making is framed within authoritative understandings of individualism, and the rights to free choice.

Conveying information about breast augmentation.

There were certain differences, and similarities as to how information about breast augmentation was conveyed within the websites. Four of these websites were developed by a company called 'Your Practice Online' which offers multimedia solutions for health professionals, and health organizations. This organization offers website development packages, logo design, website registrations with over 1000 search engines and CD-ROM presentations which include an information video regarding breast augmentation. The four websites who have engaged the services of 'Your Practice Online' have virtually the same website layouts which include a link to breast augmentation. This link brings up an interactive video option, print version option, and a case study option. The only information currently available on this webpage is the interactive movie option. This movie is a silent slideshow presentation of 41 slides regarding breast augmentation surgery, and issues. The opening page begins with a disclaimer statement which indicates that this movie is an educational resource only, and all decisions about breast augmentation must be made in conjunction with a licensed health care professional. The viewer is given the option of agree or disagree, however only by selecting the agree option can the viewer proceed. Slide 1 opens with comments that breasts have always been influenced by fashion trends with contemporary inclinations towards full, and natural looking breasts. There are three toolbar options across the top of the screen which is titled 'normal breast'; 'understanding your options'; and 'breast augmentation'. Within the 'normal breast' options there are sub headings of anatomy, breast development, and breast health. The anatomy slide argues that regardless of breast size, all breasts have the same basic anatomy which is helpful to know about so prospective patients can make informed choices, in conjunction with discussions with their surgeon. Using diagrams, the next slide details the physiological makeup of the breast, including breast tissue, fat, areola, chest muscles, rib cage, and inframmary fold. The viewer then clicks next, and enters slide 3 which is concerned with breast development. This slide explains that breasts develop in response to hormonal changes between the ages of 13 and 18. The next development slide is centered on pregnancy, and explains that during pregnancy the breast skin becomes stretched as a result of milk production causing breasts to shrink or lose shape. Following this, is a slide headed up as natural ageing process which

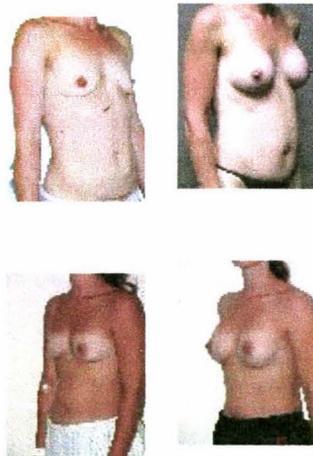
argues that through the processes of natural ageing gravity causes breasts to droop and lose volume “resulting in a smaller breast in a larger bag of skin”. On each of these slides there also a moving diagram type picture of a breast positioned on the left hand side of the page. During the ‘breast development’ slide the breast picture enlarges using three movements which push the breast picture straight out, then enlarged with the final picture of a full, upright, and firm breast. The ‘during pregnancy’ slide features the breast picture as enlarging, then sagging and the breast finally positioned as pointing downwards. The ‘natural ageing process’ slide shows the breast picture as pointing downwards, then severely drooping and finally depicted as a small breast which is almost horizontal with the chest wall. The remaining slide within the toolbar option of ‘normal breast’ is ‘breast health’ which discusses how, and what examinations etc are to be carried out following breast augmentation surgery. The toolbar option, titled ‘understanding your options’ has a slideshow presentation which includes information on breast implant size and shape, incision locations, implant locations, and type of implant both saline, and silicone. Within the ‘breast augmentation’ toolbar there are slides detailing surgical procedures, risks and complications, as well as recovery information.

On three of the other websites there is little or no information offered about breast augmentation, and potential candidates for surgery are invited to contact the practice directly for further information. This direct contact is made available through offering either a 0800 free-calling telephone number, or contact by email.

The remaining websites had some individual variation in the detail of information offered about breast augmentation. However, regardless of such variability such information typically conveyed certain information about breast augmentation. This information typically included; before, during, and after surgery details, advice about best candidacy for surgery, discussion of the risks and complications, as well as information about the implants, and anesthetic used. Details of the breast augmentation surgery included preparation for surgery through guidelines on eating, drinking, and smoking. The procedure itself was described as to how and where the implant would be positioned. Further information was advised as to where the procedure would be undertaken. This was either as day surgery, or an overnight stay with the operation performed under general anesthetic. The after surgery information was generally concerned with recovery, painkiller use, removal of stitches, drainage of wound site, what to wear and further do’s and don’ts of post surgery behaviour. Several of the

websites described the best candidates for breast augmentation as those who are looking for improvement, rather than perfection, and are physically healthy. The implant information offered consisted of implant type, usually either saline or silicone. There were also website links to the manufacturer for further information about implants. Details of the risks and complications ranged from very brief to more extensive information. Typically, this information included possibilities of scarring, capsular contracture, altered nipple sensation, infection, auto-immune disease, bleeding, bruising and implant malposition

Four of these websites also conveyed information about breast augmentation through the use of before, and after photographs of women. The shots were typically taken from the neck to the stomach, and showed the naked breasts of women before, and after their breast augmentation. One website also showed photographs of a woman in a bikini top as well as her naked breasts. All the women were photographed both directly facing the viewer, and/or within a side view shot. Before, and after photographs are included as follows.



Furthermore there was also information about breast augmentation presented within testimonials of women who had undergone this surgery on one website

Website tone, colour, and logos.

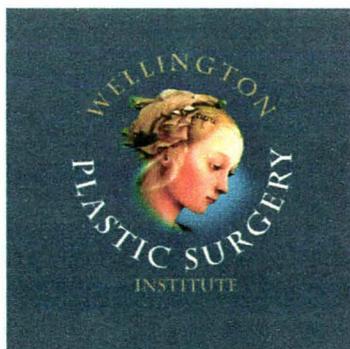
The information given across all of the websites is formal and instructive which is directly aimed at the prospective patient. A typical example of such directly aimed information is as follows: ***“During your consultation, your surgeon will ask about your medical history ...”***

The surgeon and practice is either written in the third person (e.g. Dr Walker will...), or using a personal tone by employing ‘I’ statements. There is usage of medical jargon which is sometimes, but not always explained in lay terms. The tone of the text is heavily structured

around the medical and physical aspects of breast augmentation with only a minimal consideration of any psychological issues which may be relevant. Typically, the website texts are authoritatively written in such a way which generalizes processes of breast augmentation to all women. There is little recognition of any individual differences or variability which might occur amongst women undergoing breast augmentation. In order to present information about this surgery, there is a tendency for the websites to offer a question and answer format for viewers. This format addresses similar questions and answers across the websites, and includes such details as possibilities of scarring, time off work, surgery risks, and breast size. The colours used for text, backgrounds, and images were predominately combinations of blue and yellow. The yellow used was often tones of mustard. Other websites used combinations of blue and purple, blue and red, as well as soft muted colours in tones of beige, and green. Text on websites was usually either, black or blue. The images used across the websites varied, and were mostly in form of logos. The most common logos used were various shots of naked or semi-naked women who were either drawn, or photographed. An example of such a logo is shown below.



However, other logos included a lotus flower, Greco-Roman statues (shown below), a butterfly, a reproduction of photographs of the cosmetic featured a figure with no of circles which give the well formed body somewhat bionic man. These logos the top, or down the side of the site.



the Mona Lisa painting, and surgery clinics. One website also face or skin and was composed appearance of a muscled and like a computer animation of a were usually positioned across each or most of the webpage's on

Representations of women.

Women on the websites were represented in two main ways. There were constructions of an abstract, idealized, and almost fantasy-like woman, and representations understood to be real, actual, and 'normal' women. The first of these, an idealized woman is depicted through drawings and silhouette figures, Greco-Roman statues, and photographs of parts of women's bodies. The drawings and silhouette figures were either of complete figure forms, or profiles of women's faces. However, these faces are never shown as their eyes, and head are always downcast. This notion of an idealized woman is further represented through using Greco-Roman type statues on two websites. One statue figure is of a face only, and is shown above as the logo for Wellington Plastic Surgery Institute. The other, is a statue figure of a woman sitting with her face upturned to gaze at a standing male statue figure. The photographs of the idealized woman are usually of parts of women's bodies which are presented to be perfect, desirable and ideal. Several of the websites use images which are diffused and

although the focus is enhanced with the



clear it is not sharp. This filminess is often photographs being presented in sepia tones.



Although the shots of real women photographs are

photographs of an idealized woman are often

they are also staged or posed. These

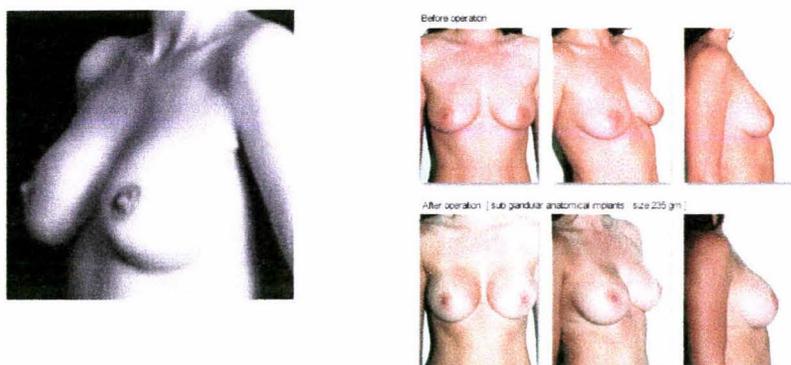
intended to be desirable symbols of femininity. rather than

depictions of everyday women. These photographs are invariable shots of naked parts of women's bodies, and if their faces are shown, they are down-turned.



In contrast, the other way that women are represented on these websites is as real, actual, and 'normal' women. This is done in several ways. The first of these is concerned, with the before and after shots of women's breasts who have undergone breast augmentation. This representation of 'real and normal women' can be understood as in direct contrast to the depictions of an idealized woman. As shown below, the shot of the breasts on the left hand side are quite clearly that of a real woman. However, they are perfectly symmetrical in size and shape, and presented within a professional looking photograph shot in black and white. The breasts shown within the picture on the right are quite clearly meant to depict, and symbolize breasts of 'everyday or normal' woman. These breasts are not the model-like or staged shots of the idealized women within other website images. These photographs use colour and lighting so that the skin tone appears real and normal. This realness is further

exemplified by the after shots which clearly show bikini lines. It would be extremely unlikely for a stylized shot of an idealized woman to show such swimsuit markings.



This representation of ‘normal and real’ women is further held in place with the testimonials reported from women who have undergone breast augmentation on one website. These testimonials discuss unwanted ‘realities’, such as limitations on what clothes could be worn, or how they felt about their breasts before augmentation. Following augmentation it is reported that these women were now able to engage with ‘normal’ everyday activities such as swimming etc. Lastly, representations of ‘normal and real women’ are constructed through certain website texts. These texts position women who undergo breast augmentation as ‘normal’ women who are dissatisfied with some aspect of their appearance. These women are presented as seeking improvement, and normality in their everyday appearance, rather than perfection or supermodel status.

Discursive approach

Analysis of how breast augmentation was constructed within these websites was undertaken using a discursive approach. This approach “addresses the ways in which language is so structured, as to produce sets of meanings, discourses that operate independently of the intentions of the speakers or writers”. (Banister, Burman, Parker, Taylor, & Tindall, 1994, p. 333). While language is central to the reproduction of certain sets of meanings or discourses “all of the world, as a world understood by us, can be described as being textual...” (Parker 1990, p. 321), and as such includes clothes, images, colour and architecture. Discourses can be understood as cohesive and coherent systems of meanings which are commonly shared and socially accepted through “...employing culturally available understandings as to what constitutes a topic”. (Parker, 1990, p. 320) However, “discourses do not simply describe the social world, but categorize it, they bring phenomena into sight... and as such can be

understood as continuously constitutive towards social life and cultural practices” (Parker, 1990 p. 319). Hence, representations and practices of social life are understood to draw upon dominant sets of meanings or discourses which are available in a particular time and place

However, these dominant discourses are neither fixed nor static, and through processes of social life are continuously negotiated, shaped, deflected, transformed, and even resisted. In this way, processes of social life can be understood as co-constituting rather than simply reproducing these dominant meanings. Nevertheless, regardless of how discourses may shift and change, their very dominance ensures that they are coherent, relatively stable, and highly instructive. As such, these dominant systems of meanings not only inform constructions of subjectivity but also operate to produce certain social arrangements. Discourses are often employed or implicated within the structures and practices of institutions. Parker (1990, p. 199) argues the “employment of a discourse is often a practice which reproduces the material basis of the institution”. These reproductions act not only to strengthen the legitimation and authority of institutions such as gender or medicine, but also act to structure relations of power within these institutions.

A discursive approach taken within this research is informed by these knowledges of how the social world is constructed, and can be understood. Located within this epistemology, this research has drawn upon theoretical framings which ‘fit’ with such understandings of the world. As such, these theoretical framings can be defined as poststructuralist and include the theories of such writers as Foucault, and Merleau-Ponty. Poststructuralism can be understood as an orientation which includes both social constructionist and postmodern theories. As both of these theoretical stances are poststructuralist in nature there are many similarities between them. Both approaches reject notions of essentialism, and accept ideas of plurality or multiplicity of social knowledges and practices. Although there is some variation in emphasis between these approaches as to fluidity and stability of knowledges and practices, both stances broadly accept that social understandings, and practices are constructed within constantly shifting and changing relations of power set in particular socio-historical contexts. However, there is an important difference between social constructionist and postmodern theories which is concerned with notions of agency. “While social constructionism has not abandoned a conception of social humanity or an account of human agency which interacts with social requirements, postmodern frameworks conceive humans as no more or less than a social product organized by power” (Beasley, 2005, p. 24). Within the analytical process both

social constructionist and postmodern theories have been drawn upon at different times in different places. These include interpretations around issues of agency for women within possibilities offered for breast augmentation. Both of these theoretical approaches are further employed to understand other discursive practices operating around processes of gender, medicalization, consumption, and embodiment. An exploration of the representations of breast augmentation on these websites is not necessarily intended to identify dominant discourses as such, but to point to how these discourses operate, and are constituted within these websites. This analysis consisted of studying the website texts, images, and colours with the aim of interpreting what representations of breast augmentation may mean for individuals, as well as wider social practices, and institutions.

Method

The analysis process was engaged from the collection of the website material, and progressed through several stages. Firstly, the website texts were explored for what was said as well as being mindful of what remained silent. During this stage it became apparent, that the texts across the websites were for the most part very similar. These similarities have been previously discussed as discursive formations in the earlier section of this chapter. Within this stage of analysis the website images and colours were also explored. These images and colours were approached as ‘text’ which could be interpreted. This text was understood as non-linguistic signs and symbols which act to convey certain messages, and meanings. Interpretations of these significations were undertaken by drawing upon theories of semiotics. Semiotics can be understood as the study of signs and their meanings, and therefore was considered a relevant approach. It was also found that these texts of images, and colours were often similar across several of the websites. These similarities were an indication that there were coherent, and dominant ways of understanding, and presenting breast augmentation. As familiarity, and immersion with the website texts deepened it was found that breast augmentation was represented in two main ways, across almost all of the websites. These were as, ‘breast augmentation as solution’ and ‘breast augmentation as choice’. These two representations were then explored for what these meanings of breast augmentation may hold for women. This was undertaken through examining what possibilities and constraints were offered. Exploration was further made as to which discourses, and representations of social life might be informing these possibilities, and constraints. During this part of the analysis it became apparent that the role of men at the site of cosmetic surgery was much more important than originally anticipated. This led to a broadening of the analysis to further focus

on the meanings of men's roles within processes of breast augmentation. Certain discourses of gender, consumption, medicine, and embodiment were interpreted as interwoven throughout the linguistic and non-linguistic website texts. The final stage of the analysis was concerned with how these discursive practices at work within processes of breast augmentation, act to sustain wider social understandings and practices. These understandings and practices were then analyzed for what social arrangements might be brought about, and what the implications of these arrangements might be for participants at the site of cosmetic surgery.

Chapter 3: Findings

During the analysis process it became evident that there were two main ways in which breast augmentation was represented within the website texts. These representations have been named, 'breast augmentation as solution' and 'breast augmentation as choice'. The first representation of 'breast augmentation as solution' was as a solution to notions of a 'problematic breast' and a 'loss of self-esteem and femininity'. The second representation of 'breast augmentation as choice' was constructed around notions of self-determination for breasted experience. Both of these representations draw upon discourses of gender, individualism, consumerism, medicine and psychology to construct breast augmentation in these ways. These two representations show how these discourses are employed to construct possibilities and constraints of actual practices for women's breasts. In turn, breast augmentation as an actual practice works to sustain wider social arrangements, especially gendered arrangements. These social arrangements were also apparent within these website representations of breast augmentation and can be shown to (re)produce advantages and differences in relationships between men and women

Representations

'breast augmentation as solution'

This is the notion that breast augmentation is offered as a solution for a 'problematic breast' and 'loss' of 'self esteem and femininity'. On these websites, the problematic breast is presented in one overarching way. This is as a deficient breast which is understood as a breast that is too small. Constructions of the breast as too small are further bound up with notions of a loss of self esteem, and femininity. Breast augmentation is offered as a solution whereby the individual is able to gain notions of self esteem through 'doing' femininity by enlarging her breasts. This notion of 'doing' femininity can be understood as a woman's personal understandings and performances as a feminine being. Most women in some way draw upon cultural constructions of femininity within constitutions of themselves as individuals. To be feminine as informed by dominant cultural discourses of gender is further represented as central to experiences of self-esteem and psychological well-being.

The problematic or deficient breast is constructed within two main conditions throughout the website material. There is an immature breast, and a breast damaged within experiences of maternity. The first of these, an immature breast can be understood as never having

developed properly. Breasts are represented as developing in accordance with physiological changes of puberty. The interactive movie which features on four websites explains: *“that breasts develop in response to hormonal changes that occur between ages 13 and 18”*. Over the top of this text is an animated drawing of a breast. This animated breast is continuously pulsating changing from smaller to larger. This text and image can be read that the breast is expected to increase in size, due to ‘normal’ and ‘natural’ biological development. Therefore a lack of development can be understood as a failure to biologically or physically mature. Such arrested development can be thought of as ‘unnatural’ and therefore ‘abnormal’ in biological considerations of the body. Notions of this immature and deficient breast are reproduced within the Peter Walker website, which explains that *“breast development at puberty may be absent, minimal or asymmetrical”* Similarly, Gregory Taylor’s website also proposes that immature or small breasts are those which *“have failed to develop properly”*

The other representation of a deficient breast is a breast which has experienced maternity. Within these websites, maternal experiences are typically constructed as detrimental and damaging. A slideshow presentation as shown on the interactive movie proposes that: *“during pregnancy breasts swell and prepare to produce milk. The suspensory ligaments and the skin brassiere are stretched. The fat may be dissolved away. After pregnancy breasts may shrink or lose shape”*. Likewise, the website for Gregory Taylor discusses post-pregnancy breasts as those *“who have lost breast mass after pregnancy”* or as Peter Walker describes such breasts, as those which have *“atrophied (shrunk) after breastfeeding* As such, the maternal breast is made problematic when the biological processes of motherhood cause the breast to shrink or lose shape. This loss of size and shape renders the breast as deficient through both its smallness, and lack of form. Hence, processes of reproduction are understood to damage the physical breast.

The websites draw heavily upon biological understandings of the breast. These understandings of the breast permit possibilities and practices of medicalization. Understanding the breast as a biological entity legitimates treatments which correct a physical deficiency. Thus, the intervention technologies of breast augmentation are enabled, as treatments or solutions for a physically immature or post-maternal breast. As the David Glasson website proposes: *“Breast surgery, augmentation [is] to enlarge naturally small breasts or restore breast volume after breast feeding”*. Similarly, the website for New Zealand Institute of Plastic and Cosmetic Surgery advises that: *breast augmentation is*

suitable for women with small breasts or those who have suffered shrinkage of breast tissue during one or more pregnancies". The breast as biologically considered allows dominant understandings about breast size to be constructed in such a way, which legitimates practices of breast augmentation. As such, processes of breast augmentation also act to sustain dominant socio-cultural understandings of the breast. These understandings invariably construct the breast as a sexual or maternal object. Constructions of the breast as these object states was found to be reproduced within the website texts.

The idea that breast augmentation brings about a restoration of the disruptive effects of maternity, or arrested physical development implicates 'another' state of being for the breast. This alternative state of being is brought around within processes, and practices of normalization. A contemporary and dominant norm or idealization of the breast is as a large, round, firm, full, and upright object. Stylization of the breast as such a norm is socially accepted, and commonly understood as a sexual object. As Young (1998, p. 125) argues "breasts are the symbol of feminine sexuality". The breast as sexual or erotic is simultaneously a symbol, of an ideal size and shape which is large and full. In turn, notions of this ideal size and shape work to produce the breast as erotic. Brownmiller (1984, p. 41) proposes, that large breasts represent "generous sensuality". Often there is as Brownmiller (1984, p. 41) argues, "the assumption of a ready-to-go sexual nature in big-breasted women..." A large and full breast is constructed as sexually desirable, and as such, is fantasized, fetishized and gazed upon as an erotic object. This idea of 'another' breasted experience which can be argued as erotic is interpreted within the website material. John de Waal: proposes that breast augmentation, "*is a surgical procedure to increase the size and/or alter the shape of a woman's breast ... It is usually done to balance a difference in breast size or improve body contour*". Likewise, Julian Lofts recommends breast augmentation for "*small breasts*" and "*asymmetry of breast size*". These texts imply that the size and shape of the breasts should be large, and symmetrical. An improvement in *body contour* as suggested by John de Waal gives rise to the breast as an aesthetic object. These notions of size, and shape, as well as aesthetic meanings of the breast implicate another and erotic state.

However, breasts are also important symbols of maternity which are usually understood in marked contrast to knowledges of the breast as erotic. As such, it is unusual within contemporary social understandings, and practices for the breast to be considered as an erotic object during experiences, and states of maternity. As Young (1998, p. 132) argues, the

“border between motherhood and sexuality is lived out in the way women experience their breasts and in the cultural marking of their breasts. To be understood as sexual, the feeding function of the breast must be suppressed and when the breasts are nursing they are desexualized”. The image of the mother is not one of sexual symbolisms, with sexual imagery of women rarely featured within maternal depictions, except perhaps in perverse ways.

Although, it is unusual for the maternal breast to be understood as a sexual object, one website opens up possibilities for the breast to be interpreted as erotic during pregnancy. Practices of breast augmentation within this website are offered as a solution towards regaining a desirable breasted experience as engendered by motherhood. As proposed by Plastic Surgery New Zealand: “*Most women who opt for breast enlargement have A or B cup breasts. Those who have had children may have enjoyed their breasts being larger during pregnancy and breast-feeding and may want to return to that size*”. This text suggests possibilities of desire for a ‘larger’ breasted experience understood in terms of maternity. .

The size of the maternal breast can be thought of as similar to constructions of the breast as erotic. The suggestion that women “*enjoy*” their breasts being larger can be interpreted as breasts being a source of pleasure. This pleasure may come about from experiences of touch, possibly sexual, as well as within experiences of the breast as a visible object whether naked or clothed. Understandings of touch within breasted experiences are often constructed around the nipple as a source of pleasure. Young (1998, p. 129) argues, that the nipple is bound up within sexualized processes which produce the “...the breasts [as] active and independent zones of sensitivity and eroticism”. States of maternity invariably bring about prominence of the nipple. The nipple and areola get bigger, darken in colour and becomes more sensitive to touch. Without doubt there is a commonly understood boundary between motherhood and sexuality brought to the fore by desexualization of the nipple during breast feeding. However, possibilities for the maternal nipple, and therefore the breast as erotic during pregnancy are offered on the Plastic Surgery New Zealand website. These possibilities are brought about by notions of two states for the maternal breast. This website suggests that women opting for breast augmentation often do so because they “*may have enjoyed their breasts being larger during pregnancy and breast-feeding*”. The maternal breast during pregnancy is not solely functional for purposes of motherhood and therefore is somewhat ambiguous.

Enjoyment of larger breasts attained through maternity may also be brought about within experiences of the breast as visible object. This visibility may inform experiences of pleasure for women within, both clothed and naked states. Women may enjoy the look of their naked full maternal breast. They may enjoy standing before a mirror, or looking down and seeing their breasts as, a size or shape they have never previously known. Women may also enjoy the look of their breasts in certain clothes during states of maternity. Revealing of the breast in particular ways, as well as certain clothes are understood to have sexual signification. Therefore enjoyment of breasts whether as a visible object and/or within experiences of touch during states of maternity, implicates the maternal breast as potentially erotic.

However, representations of breast augmentation at the Plastic Surgery New Zealand website can also be understood as, invoking processes of normalization. These processes of normalization hold in place boundaries between the breast as either an erotic or maternal object. Within this website, notions of the breast are offered as a certain size within a particular range with an A or B cup breast size, understood as the bottom limit. As explained within the website text, "*most women who opt for breast enlargement have A or B cup breasts*". A desirable and therefore 'normal' size of the breast is presented as large. As Plastic Surgery New Zealand proposes "*most women who opt for breast enlargement.....may have enjoyed their breasts being larger during pregnancy and breast-feeding and may want to return to that size*". Although, there is no one fixed or unilateral breast size, the breasted ideal can be understood as falling within a scale of 'normal' range. However, regardless of any limited variation of size, this breasted norm is as large. This ideal large breast size can be understood as reiterating notions of the breast as erotic, as it is such a state which is achieved by breast size. Representations of breast augmentation offers the possibility of recapturing this desirable and erotic breast size, as brought about within states of maternity. However, it is not the maternal breast which is erotic but rather its size and fullness. Thus, it is the largeness of the maternal breast which is erotic, rather than the breast being sexualized within states of maternity. As such the maternal breast is not a sexual object. Rather women are encouraged to recover a breasted experience which enhanced their breast size to that of the erotic ideal.

These dominant understandings of the breast as erotic or maternal are further held in place through common understandings of an aged breast. The bosom of an aged woman can be understood as a matronly object, which becomes maternal by proxy. Whilst the matronly

breast is no longer able to feed a child, it is still able to offer the other comforts of maternal nursing. As a matronly object, the aged breast is desexualized, and no longer recognized as an erotic object. Bildtgard (2000, p. 169) argues, that sexuality “seems to be a somewhat taboo or at least ambivalent subject in relation to [aged] people”. An absence of sexuality from dominant representations of the aged constrains possibilities for an aging breast to be eroticized. A lack of possibilities for notions of an aged and erotic breast can be interpreted as reproduced through what is *not* said, across the websites in this study. There is not one website, which overtly offers breast augmentation as solution towards the aged breast. Only the interactive movie has any mention of an aging breast. However, such mention is in relation to the normal biological and developmental life course of the breast in relation to puberty, maternity and then aging. Whilst, breast augmentation may be offered as a solution for problematic breasted experiences, there is no such offer for an aged breast. The aged breast is to be avoided as it becomes problematic to acknowledge such a breast as erotic, given contemporary understandings of age, and sexuality. Breasts as erotic are as Brownmiller (1984, p. 41) argues large “...high round breasts [which] are associated with youth”. This avoidance of representing an aged breast as erotic permits the status quo for dominant understandings of the aged breast, as an object of maternal comfort.

However, this is not to categorically declare that there are not further and multiple representations of the post-adolescent breast which are neither maternal nor erotic. At times, the breast may simply be seen as a point of difference between men and women. It is hard to imagine the breast of a celibate and religious figure such as Buddhist nun being represented or understood as a sexual or maternal object. Yet, typical notions of the breast are usually understood within constructions of either sexuality or maternity. However, these constructions of the breast are invariably hierarchical, whereas the breast as erotic is privileged against the breast as maternal. As such, the dominant ideal or norm of the breast is as erotic. This dominant norm is held in place within representations of breast augmentation. Throughout all these websites, breast augmentation is offered a solution towards the problematic breast which is ‘other’, than erotic.

The breast as erotic is continuously offered, as the dominant and desirable form of breasted experience within these websites. This dominant representation of the erotic breast is best illustrated on websites which use before, and after shots of women who have undergone augmentation. Websites for the Surgical Clinic, Body by Klein, and Julian Lofts feature such

before, and after shots of women's naked breasts photographed both side and front on. Images such as these are resource for surgeons to showcase their work, as much as being a point of reference for prospective women seeking breast augmentation. However, as Smith, (1990, p. 190) also argues, these before and after images "contain the co-ordinates of courses of action, the gap for desire created by the deficiency of the present and actual in comparison with the ideality of the image now represented as an objective". Within these websites the before shots, feature women who have widely varying breast sizes, and shapes. These before shots, act to construct the breasts of these women as deficient "present and actual". The after shots symbolize the ideal breasted image which is the objective of breast augmentation. These after shots, are remarkably similar across these three websites regardless of how the breasts looked before. Although, there may be some limited variation in size, the uniform round, firm, uplifted or erotic shape of the breast is held constant across these websites. In this way "the ideality of the textual image establishes a ubiquitous point of reference that is operative for anyone" (Smith, 1990, p. 175).). This ideal female breast as indicated by the before and after shots, is not only an erotic object, but plays a significant part towards idealizations of a female body. An ideal female body is central to dominant understandings of femininity. These dominant understandings of femininity not only produce women's bodies in certain ways, but also produce constructions of women as their bodies. As such, these understandings of femininity are held in place across all of the websites in an assortment of ways. Across several websites, parts of women's bodies are shown in various states of undress. The dominant logo on Howard Klein's website is of a female figure standing side on, from her neck to her knees wearing only underwear. There is another image of a female figure facing the viewer from the neck to the knee wearing sexy lingerie. Likewise, on Gregory Taylor's website there is a naked figure of a woman with her back to the viewer, and shot from the shoulders to the thighs. These sorts of images are reproduced across further websites which display women's naked, or semi-naked body parts. These images suggest that female body can be thought of, as idealized object parts which fit together to produce anatomical perfection. Nudity is understood as a powerful signifier of idealized anatomical perfection (Danesi 2004). Images of the nude including drawings, paintings, and sculptures are more often than not, attempting to symbolize "the inherent beauty of idealized human proportions" (Danesi, 2004 p. 185). As this, realization of idealized beauty "the female body is offered to the viewer purely as a spectacle, an object of sight, a visual commodity to be consumed" (Featherstone, 1991, p. 273).

Within these websites female nudity is not only associated with how feminine bodies should look, but also how feminine bodies should act. The logo on John de Geus's website features four naked women revealed from the nose to the collarbone, and who are all gazing downwards. Within almost all of the websites which show women's eyes and faces their gaze and/or their faces are averted or looking downwards. An averted and downwards gaze is often understood to symbolize passivity or submission. This passive stance permits possibilities for the female body to be understood as an object which is submitted for public scrutiny. Mulvey (1986, p. 203) argues that "women are simultaneously looked at and displayed with their appearance coded for strong visual and erotic impact so they can be said to connote to-be-looked-at-ness" These notions of women as erotic, physically perfect, and passive are further replicated across the websites of Plastic Surgical Masters and the Wellington Plastic Surgery Institute. The latter website uses a logo which appears to be a Grecian or Roman statue of a woman's head. On the Plastic Surgical Masters website, there are two Greco-Roman statues of a man, and a woman. The woman is bare breasted and sitting whilst the man has both his hands on her body, and is standing beside her. Danesi (2004) argues that sculptures of the female nude have traditionally depicted women's bodies as soft and submissive. This softness and passivity is most famously depicted in the "ancient Greek statue known as the Venus de Milo which represents Aphrodite, the Greek goddess of love and beauty" (Danesi, 2004, p. 185). The statue head, and figure depicted on these two websites appear to be representations of Aphrodite, the goddess of love and beauty. Understandings of femininity as passive, and in terms of women as their bodies are further held in place through representations of masculinity, within the websites. Within the fifteen websites in this analysis, all but one features the cosmetic surgeon in a portrait photograph. Typically, this portrait image is a head and shoulders shot, with the surgeon facing the camera directly, and wearing either a suit or a shirt or tie. A portrait can be thought of as "a visual representation of a subject whose facial appearance ... is typically interpreted as a signifier of the self- a sign that we interpret as betraying the subject's character, social position, profession etc" (Danesi, 2004, p 51). It is further argued by Fejes (1992, p. 11) that, "a tendency to portray men in terms of close face shots... may be a manifestation of deeply rooted cultural myths of men, pictorially represented by their faces, as intellect, and women, pictorially represented by their bodies, as heart or emotion". Invariably accompanying each portrait shot was an extensive biographical account of the surgeon's work history, and achievements. This extensive biographical information which was presented throughout these websites further works to reiterate traditional notions that "men are powerful and successful,

occupy high status positions, initiate action and act from the basis of the rational mind as opposed to emotions...” (Fejes, 1992, p. 2). The dress of these surgeons can also be understood to signify codes of traditional and dominant masculinity. As such a code, the business suit is often understood as a sign of seriousness, credibility and masculinity (Danesi, 2004).

This dichotomy of masculinity and the mind, as opposed to femininity with the body, may be further symbolized through the meanings of colour used within the website designs. Tones of blue and yellow were predominately used within the texts, images, and backgrounds of the websites. Blue and yellow are polarities on the colour wheel, and therefore always located in difference from each other. These colours can also be understood as gendered with blue as the masculine principle, and yellow as the feminine. Blue is considered a cool colour and can be easily associated with a ‘cool head’ or rational objective masculinity. Conversely, yellow as the feminine principle can be understood as “soft, cheerful and sensual” and therefore warm and emotional Gage (1999, p. 36).

These traditional understandings of men with their minds, and women as their bodies interwoven throughout these websites enables breast augmentation, as a ‘solution’ to a loss of femininity and ‘self esteem’. Throughout these websites, notions of femininity are closely bound up with breast size and shape. Breast size denotes notions of sexuality and maternity, and these notions are integral to constructions of femininity. As the Surgical Clinic website explains: *“breast size and shape are major factors in making women feel feminine”* Testimonials from a woman on the Plastic Surgical Masters website discusses how she felt a loss of femininity, as due to her breast size: FE – Breast augmentation- Wellington: *“The size of my breasts has been an issue which I have struggled with emotionally since being a teenager. I spent considerable years hiding behind padded bras and baggy tops to disguise my tiny imperfections which made me feel less of a woman than other woman that I daily came into contact with...”*. Most women in some way engage with highly instructive representations of how to be feminine. These ways-of-being feminine are negotiated by women in how they feel about and present themselves as individuals. To be able to feel and look feminine is further caught up with notions of self-esteem and psychological well-being. Self-esteem is understood as the capacity of an individual to feel worth, and confidence about themselves. Drawing upon contemporary discourses of psychology, self-esteem is constructed as central to psychological health and well-being. Reconstruction of breast size

and shape as offered by breast augmentation is represented as a means for enhancing femininity and gaining self-esteem and well-being. Text from FE- Breast Augmentation – Wellington on the Plastic Surgical Masters websites states that: *“Having my surgery ... has not only increased my breast size but has increased my ability to feel like a ‘complete woman. My self esteem has increased dramatically... This surgery has been a positive, rewarding experience for me. It has given me back my pride, dignity and belief to be and feel like a sensual, curvy woman for the first time ever”*. Similarly, Howard Klein advises that *“the most important and gratifying result of cosmetic surgery is not the surgery itself, but how the change affects the way we feel about ourselves. For many women, the result of breast augmentation can be satisfying, even exhilarating as they learn to appreciate their fuller appearance”*

Breast augmentation offers possibilities for women who wish to engage with dominant understandings of femininity, and do not necessarily see such understandings as subversive or demeaning. For some women, these possibilities may mean increased well-being and greater day to day enjoyment of themselves as feminine subjects. This enjoyment might be brought about by wearing clothes and participating in activities, that women felt were previously denied to them. The women who have undergone breast augmentation on the Plastic Surgical Website write such testimonials as: JB- Breast Augmentation- Auckland: *“Like most women I love clothes and shopping. I now think that clothes look better on me as they fit better and I don’t have to have them altered”*. Likewise, FE- Breast Augmentation- Wellington writes: *“Finding togs or bikinis that had padding that provided a natural ‘breast’ look was impossible and this resulted in choosing instead not to swim in the summer months.... My self esteem has increased dramatically and shopping for clothing is now a pleasure... I look forward to spending time purchasing many unpadded bikinis”*. Women may not only find pleasure in how their breasts look in clothes but how their breasts are experienced in practices of sexuality. The women on this website state that breast augmentation increased pleasure in experiences of themselves, as sexual beings. FE-Wellington expresses that she feels: *“like a sensual, curvy woman for the first time ever”*. Likewise text on the Julian Lofts website advises that: *“For many women, the result of breast augmentation can be very satisfying, increasing self-confidence and enhancing sexual enjoyment and social interactions”*. The practices of breast augmentation allow *“the individual woman to renegotiate her relationship to her body and in doing so construct a different sense of self (Davis, 2003, p. 85)*. Rather than seeing women as objects which are passive, lack agency and await definition by a man,

women can be considered as “skilled active subjects enjoying their own bodies” (Smith, 1990, 206). This enjoyment is understood within notions of what French feminist poststructuralist writers such as Irigiray, Cixous, and Kristeva call “écriture féminine” or writing the feminine body. Within understandings of “écriture féminine”, the focus is on women as sexual subjects and not objects of male desire” (Joy & Venkatesh, 1994, p. 348). As such, these writers have searched for alternative ways to “give expression to women’s bodies as the site of pleasure and arousal” (Davis, 1997, p. 9). Therefore breast augmentation represented as a solution to a loss of femininity, and self-esteem offers possibilities for women to construct themselves as active feminine subjects.

However, as much as breast augmentation may offer possibilities for women as active feminine subjects, the constructions of femininity within these websites also work to homogenize or standardize women’s breasts. Any possibilities for the breast to be a signifier of age, maternity or individuality are denied. The standardization of breasts enables possibilities for the commodification of femininity and to some extent self-esteem. This commodification brings about certain economic implications for both the surgeons and women who participate with practices of breast augmentation. Two websites advertised the cost of breast augmentation which was quoted as \$9800.00, and \$10,500 to \$11,500 respectively. Breast augmentation procedures are usually paid for at the time of consultation and surgery. As the Plastic Surgery Centre website advises: “*Fees will be reviewed with you at consultation visit. Payment during the consultation is appreciated. Bank cheques, personal cheques, cash or credit cards (MasterCard, VISA) are acceptable means of payment. We do not accept American Express cards*”. However, for women unable to afford a lump sum payment then: “*Financing plans through independent financing companies are available*” (Plastic Surgery Centre). These financing plans obtained through a private medical insurance company are also explained on several more websites. This commodification of femininity and self esteem as realized through breast augmentation brings about possibilities for debt, and economic disadvantage for women. However, such commodification of femininity permits significant economic advantage and therefore serves the interests of the surgeons who perform these procedures. Women’s breasts as a site of consumption are a growing, and worthwhile marketplace which is undoubtedly profit driven. These practices of consumption are held in place by authoritative medicalized understandings of the body, which in turn hold in place highly lucrative practices of breast augmentation. This increasing dominance of medicalized understandings of the body brings to prominence notions of small breasts as

deficient and problematic. Notions of the breast constituted this way are interwoven and (re)produced within dominant social understandings of femininity. These socio-cultural understandings of femininity are negotiated by women beyond those seeking breast augmentations, in their everyday constructions of subjectivity. Representations of small breasts as problematic and therefore lacking femininity work to strengthen wider contemporary understandings of women's bodies, and their breasts as erotic objects. An object state brings about conditions of passivity, and public scrutiny as well as sustaining traditional forms of gendered social arrangements. These arrangements are constructed on traditional forms of heterosexual practice which gives rise to notions of male dominance and female submission. Women's breasts as erotic can be understood as objects of visual desire and physical pleasure for men which locates women's bodies in the service of others. This location of service for others, works to marginalize the social position and status of women. Therefore breast augmentation understood as a solution to a 'loss of femininity and self esteem' shows that "social forms of consciousness including femininity can be examined as actual practices, actual activities, taking place in real time in real places, using definite material means and under definite material conditions" (Smith, 1990, p. 163). These actual practices using material means which are located in particular social, cultural and economic conditions are more often than not bound up in discourses of choice.

The second representation identified in the website texts was called 'breast augmentation as choice'. This representation was constructed around notions of self-determination for women in regards to breast experience. Discourses of individualism and freedom were drawn upon to construct these notions of self-determination, and present breast augmentation as a choice.

'breast augmentation as choice'

Practices of cosmetic surgery as elective procedures are understood as offering possibilities for individuals to directly choose particular states of embodiment. As stated on the David Glasson website: *appointments for cosmetic surgery can be made directly with Mr. Glasson. However for plastic and reconstructive problems... a GP referral is advised*". Ideologies of consumer choice typically position the individual as a free agent, engaging at will with practices of cosmetic surgery. Within these practices of cosmetic surgery, the body is regarded as a reflexive project of subjectivity. In short, "people are seen as designers of their own bodies" (Askegaard et al., 2002, p, 800). As such, breast augmentation is presented as an act of self-determination, of women freely choosing their bodies. The websites for Howard Klein, and Julian Lofts both venture that: *"Your decision to have breast augmentation is a highly personal one that not everyone will understand. The important thing is how you feel about it"*. This text suggests, that while the decision to undergo cosmetic surgery may be somewhat controversial and open to challenge from others, it is still an act of autonomy. Breast augmentation as such an act can be interpreted within text as reported on the Plastic Surgical Masters website. JB Breast Augmentation states *"I wanted plastic surgery for me and not other people"*. The choice to have cosmetic surgery is further represented as a carefully considered and highly thoughtful decision. Text on the Howard Klein website points out, that *"choosing to have plastic surgery is an important decision"*. The David Glasson website further sustains this notion that cosmetic surgery is a serious undertaking. It is cautioned that: *"sometimes a second consultation will be advised before making a definite decision to have surgery. It is important to take the time to make correct decisions and to have realistic expectations"*. Dull and West (1991, p. 57) reported, that many women they interviewed said that they "had agonized over their decisions to have surgery". In her extensive research with women who have undergone breast augmentation, Davis (1995) reflected that often it took years to decide to have surgery, and in some cases many more years to approach a surgeon. "The decision was presented as a long and often painful process involving various steps. It took considerable deliberation and struggle before their desire to have a different body moved from the realm of fantasy to reality" (p. 122). This

representation of breast augmentation as a highly considered and serious choice is further produced within the text on the website for Plastic Surgical Masters. MC- Breast Augmentation- New Plymouth says: *After thinking about breast augmentation for 13 years and thinking it was a dream and one day it may come true. I truly believe it has changed my life*". Similarly, it is reported that MF- Breast Augmentation- Wellington: "... *had been contemplating this for years*". Breast augmentation represented as a serious and considered choice works to legitimate women as free and able consumers responsibly making careful decisions about their bodies. Through choosing breast augmentation, women are understood as able to re-negotiate a sense of self in a way that treats the body as a means of self-expression. As such, breast augmentation is constituted as an act of autonomy through which self-determined constructions of subjectivity are enabled.

However, "the choice to have to have cosmetic surgery may be genuine, but it is also bounded... or constrained by cultural definitions of femininity" (Davis, 1995, p. 157). Breast augmentation as an act of reflexive self-construction is always negotiated within dominant ideals of the breast, and female body. Within such dominant ideals, the ways in which the body and the breast can be 'chosen' are limited to a small range of possibilities. As previously discussed, there is one overarching shape of the breast as round, large, and full which is offered to women on these websites. Within this analysis, only one website offers any choice for shape of breast implants. On the Julian Lofts website, this choice of implant shape is offered through text which advises that: "*breast implants are available in an extensive range of sizes, shapes and types of fill. ... There are round implants or anatomically (teardrop) shaped implants*". *I will give you more information so that you can decide which implant best suits you.* According to Hamas (1999, p. 370) "The vast majority of breast implants are round- a term that refers to the shape in front view, lying flat [while]... the teardrop-shape is " a- term that refers to their shape in side view, lying flat". However, it appears that there is very little difference between these two implant shapes when women are upright. It was found that due to the effects of gravity round implants become teardrop-shaped, and that any slight differences were only apparent when women were lying flat. It was concluded, that " round implants are actually more "anatomical" because they are teardrop- shaped with patients upright, and settle back evenly with patients recumbent as do normal breasts" (Hamas, 1999, p. 374).

Clearly, there is not an “extensive range” of breast shapes as suggested on this website. There are two choices which research indicates are more, or less the same shape. In essence, women seeking breast augmentation are only offered the dominant idealized shape of the female breast. However, it would seem that possibilities for breast size could be offered within an “extensive range”. Breast size is understood as the combination of chest size (30, 32, 34 etc) and cup size (AA, A, B etc). Bendon New Zealand advises that bra sizes available in their stores range from 30A to 46G. Therefore, the potential arises for women to make highly individual choices regarding the size of their implants from wide-ranging possibilities. The possibility for choice of any breast size is offered on the Surgical Clinic website: “*At the Surgical Clinic we seek to achieve a natural look and feel to your breasts which you choose and with which you are comfortable*”. However, it appears that wide-ranging possibilities for breast size are limited to this website only. Throughout several of the other websites, choice of breast implant size can be understood as highly constrained. Information on the interactive movie instructs the viewer that when choosing implants, “*the size you aim for depends on your current size and shape and your stature*”. On a similar note, the New Zealand Institute of Plastic and Cosmetic Surgery website suggests that: “*the aim of breast augmentation is to give you a pleasing balanced appearance in proportion to your shoulders, your rib cage and hips*”. Likewise, on the Gregory Taylor website it is advised that “*the aim of the operation is to produce a natural looking breast. Those who wish exaggerated enlargements, an artificial ‘Baywatch’ look or who are having the operation for reasons of fashion are usually not suitable*”. The Peter Walker website further advises that: “*it is unwise to have breast surgery before full natural breast development is complete except in severe cases of underdevelopment or asymmetry. Augmentation can be carried out in older women with a loss of breast tissue after breastfeeding. Enlarging the breasts for purely social or occupational reasons is a reversing trend. The benefits may outweigh the potential hazards. The surgeon will examine your breasts to see if you are suitable for the operation and discuss whether the operation is feasible and worthwhile*”. Within these website texts, breast augmentation is offered as a procedure to produce ‘normal’ and ‘natural’ looking breasts. These breasts ‘fit’ with notions of an idealized female body. This idealized body is understood as balanced and in proportion, as relative to bust, waist, and hip measurements. This ideal breast size and shape is so compelling, that it is to be obtained instead of waiting for ‘normal’ breast development in “*severe cases*”. These extreme cases which warrant such interference are only in instances of acute breast smallness or asymmetry. Within these websites, women are restricted to a choice of breast size which emulates an ideal understood

as quantifiable in proportion to their body stature, and type. However, this is not to say that for some women, this is a choice they wish to engage with. On the Plastic Surgical Masters website, text presented from FE- Breast Augmentation Wellington says: *“It was my personal choice to increase my breast size to a size that looked natural and suited my small frame”*. Ideals of beauty are commonly understood as constructions of anatomical perfection. Women may gain pleasure and enjoyment through producing such ideals within their experiences of embodiment. However, such notions of ideality are constraining, and any breast size which exceeds such idealized proportions of the female body is considered as unnatural or artificial. Women who wish to have their breasts enlarged to a size which fall outside of idealized constructions of the breast are not only discouraged, but may even be denied surgery. As such, these websites indicate that breast augmentation is not a procedure of choice for women dissatisfied with their breasts for whatever reasons. Rather, this surgery is offered as a means of constructing certain representations of the breast under particular restricted conditions.

Notions of an ideally proportioned body are utilized not only to constrain the size, but also the position, and type of implant that a woman might choose. These constructions of an idealized breast are further employed to give legitimacy to the surgeon, as an authority in decision making processes around breast augmentation. In this way, breast augmentation is presented as a choice which is made jointly between the surgeon and the patient, rather than an individual and autonomous act by the woman concerned. As Plastic Surgery New Zealand explains *“at your consultation, [the surgeon] will encourage you to try different implants within a range that is suitable for you. Most women request implants in the 250cc to 350cc range”*. On the website for Peter Walker this joint decision making about implant size is further produced. It is stated that, *“you need to talk through your ideas about the size you want your breast to be. In most cases the surgeon will try to meet your requests. Sometimes it may not be technically possible to do so and it may be necessary to reach a compromise solution. However the final decision on size is made during surgery and depends on the skin elasticity and how well the implants fits into the cavity created during the operation”*. Similarly on the interactive movie it is stated that: *“the location of your incision is based on your personal preference, your body type and your surgeon’s recommendations. Each location (in front or behind the pectoral muscle) has different advantages for each woman. Your surgeon will help you make the decision as to which placement is best for your body your surgeon will recommend the particular type of implant that he feels is most appropriate for you”*

It may well be that there are some physical limitations for breast implant position, type, and size. However, it may not be quite as limited as these websites suggest. The actress Pamela Anderson who is credited with making the so-called artificial “Baywatch” breasts famous, has measurements reported as 36DD-22”-34”, is 5” 7, and weighs 105lb.(Wikipedia Encyclopedia, 2006) Ms Anderson can be understood as having breasts which are outside of ‘normal proportions’ for her body size and shape, but which are still feasibly possible. Similarly, the model Jordan who is often known as “England’s Pamela Anderson” has had three reported breast augmentations to increase her bust size from 34B to 34FF (Wikipedia Encyclopedia, 2006). The breast sizes of these women indicate that there are possibilities for women to choose breast size which falls outside of notions of ideally proportioned bodies, and the authority of cosmetic surgeons. There is some acknowledgement of patient input, or ‘voice’ towards decisions of breast augmentation on these websites. As noted on the interactive movie this decision is also based on the “*personal preference*” of the women involved. Further to this, women are encouraged on the Howard Klein website to “*be sure to discuss your expectations frankly with Mr. Klein. He should be equally frank with you describing your alternatives and the risks and limitation of each*”. However, regardless of any acknowledgement of ‘patient voice’ women may find it extremely difficult to challenge the authority, and expertise of a cosmetic surgeon, and demand a breast implant size or placement contrary to their recommendations. The text on this website suggests that although women are encouraged to openly discuss their requirements and expectations, that the surgeon clearly plays an important role in the decision-making processes. The surgeon’s role in these decision-making processes can be understood as reproductions of wider hierarchical positions, often experienced between doctor and patient. Regardless, of these notions of patient choice it is likely that these notions have little impact on actual practices of medicine (Winefield, 1992). It was found by Tuckett, Boulton, Olson & Williams (1985) that, although doctors seemed extremely concerned with patient welfare, they were highly reluctant to concede control to patients. The authority of doctors is held in place by notions of expertise, experience, and professionalism. This authority and expertise is not only reproduced through the extensive professional biographies listed of each surgeon, but through other text offered on various websites. A slideshow on the interactive movie advises that: “*there are various decisions that you and your surgeons must make. Your surgeon will discuss these with you and will obviously make recommendations based on his experience and your particular needs*”. On the question and answer forum within the David Glasson website, it is advised

that: *“the surgeon can outline what procedure may be appropriate, and the expected outcome and limitations. You may be advised against having surgery or another procedure may be recommended to meet your needs and goals”*. On the website for the Auckland Plastic Surgical Centre it is noted that both surgeons are *“widely experienced, internationally respected specialists registered with the New Zealand Medical Council”*. Women’s bodies are not be entrusted to themselves alone, but are subject to the approval of the cosmetic surgeon. As the website for Cary Mellow espouses: *“this is, after all, the only body you have, and it deserves the attention of a highly qualified, specialist plastic surgeon”*. Therefore, practices of cosmetic surgery are neither completely elective procedures, nor acts of self determination. The surgeon is an authoritative and active force within choices of breast augmentation. At times, this authority can be thought of as total and final. The website for Peter Walker advises that: *“the final decision on size is made during surgery”* As this operation is conducted under general anesthetic, such final decisions about women’s breasts made during surgery are ultimately made by the surgeon alone.

Notions of the authority and expertise of cosmetic surgeons legitimates practices of cosmetic surgery and reproduces dominant ideals of the female breast. Breast augmentation represented as a means to gain ‘normal’ breasts in proportion to size and stature produces cosmetic surgery as a valid and worthwhile branch of medicine. Rather than viewing cosmetic surgeons as frivolous, and fad privateers of medicine they can be constructed as ethical and ‘proper’ medical practitioners. This representation of principled and ethical practices of medicine is appropriately summarized in a 2005 press release from the co-chair of the American Society for Aesthetic Plastic Surgery Breast Surgery Committee. This press release explains, *“that implants that are too large can leave a patient looking proportionally disfigured. If a patient demands a size unsuited to her body type, I cannot in all conscience perform the surgery”* (Cosmetic Surgery News, 2005). This authority towards women’s bodies can be understood as constructed within medicalized understandings, as well as located within wider practices of gender. Cosmetic surgeons are not only highly influential medical doctors, but also predominately men. As such, these surgeons bring possibilities of both medicalized and male understandings of women’s bodies to the practices of their everyday work. Millsted & Frith, (2003, p. 457) argue, that *“women’s bodies are objects of the male gaze, under which breasts are defined primarily as objects of male sexual interest and sexual pleasure”*. In this way, women’s breasts can be understood as objects which are augmented to constitute possibilities of aesthetic, as well as sexual pleasure in male

constructions of the female body. Authoritative medicalized and male understandings of the female body are illustrated in the example of the French performance artist Orlan (Davis, 1997). Since 1987, Orlan has undertaken eight cosmetic surgery operations as a means of 'self- portrait'. Each operation is portrayed as a themed performance which have been filmed and presented at conferences, and festivals under the motto of 'my body is my art'. However, "instead of having her body rejuvenated or beautified, she turns the tables and uses surgery as a medium for a different project" (Davis, 1997, p. 174). Orlan's project is about creating an 'ideal face', which is not necessarily conventionally beautiful. One operation which involved silicone implants in her temples to gain a Mona Lisa forehead has resulted in creating a slightly alien look to her face. However, such pursuit of cosmetic surgery for this woman has been experienced within constraints of male and medicalized understandings of her body. When Orlan's male cosmetic surgeons "balked at having to make her too ugly ('they wanted to keep me cute'), she turned to a female feminist plastic surgeon who was prepared to carry out her wishes" (Davis, 1997, p. 174-175)

Discourses of choice within practices of medicine are invariably interwoven with notions of risk, and informed consent. In order to make any 'informed' choice about surgical procedure it is understood that individuals must be fully aware of any risks, and complications involved. Understandings of informed choice are constructed around notions of comparing the known advantages, and disadvantages of surgery to health and well-being. Within these websites breast augmentation is caught up with understandings of a physically deficient breast. However, such a breast is never represented as physically harmful or life-threatening for women. Instead practices of breast augmentation are wrapped up with constructions of psychological well-being, and self esteem. As such, breast augmentation is understood as a surgical procedure which is performed on otherwise physically healthy patients, primarily to gain an aesthetic result. The risks of breast augmentation to these otherwise healthy women include increased problems with breastfeeding, wrinkles, asymmetry, infection, toxic shock syndrome, scarring and chest wall deformity. It was also found that around 28% of women report unwanted alteration in nipples sensation, and a further 7-17% of women reporting continuous breast pain. The most common complication is capsular contracture which is estimated at anything from 8-100%. Similarly, it is reported that rupture rate increases with the age of the implant, with a rupture rate of 69% by 17.8 years (FDA, Handbook, 2004).

The significance of these potential risks and complications are indicated on the website for Plastic Surgical Masters which warns, that *“before deciding to proceed with surgery every patient needs to seriously consider the risks as well as the benefits of surgery. During your pre-operative consultation(s) the surgeon will openly discuss the risks with you so that you can consider them. A full listing of the potential complications and risks of this procedure is beyond the scope of this website”*. Following this text is a list of general and specific risks of breast augmentation. However, within other websites risks and complications of breast augmentation are represented in ways which minimize unwanted side effects. The website for David Glasson advises that patients will be told of the risks common to all surgery, and complications specific to certain operations. It is stated that *“the majority of operations are free of problems. However, complications may occur and are usually minor and easily managed”*. Likewise Wellington Plastic Surgery website warns that: *capsular contracture occurs in 5-10% of augmented breasts, the sensitivity of the nipple is occasionally altered and there is a small risk of valve failure and leakage with saline implants*. Similarly on the Julian Lofts website potential patients are advised that: *“the most common problem, capsular contracture incidence is approximately 8%, unsightly scars are 2-5%, postoperative bleeding 1% and implant infection 1%. Occasionally breast implants may break or leak and there is no evidence that breast implants will affect your ability to breastfeed”*.

However, these website warnings fail to notify the potential patient of several complications of breast augmentation such as breast pain, toxic shock syndrome, or chest wall deformity. The website for Julian Lofts further claims that *“there is no evidence that breast implants will affect your ability to breastfeed”*, which is contrary to the findings reported by the FDA. It is also apparent, that rates of capsular contracture reported on these websites are the very minimum statistics reported within contemporary studies. Implant rupture or leakage is further presented as a small and unlikely complication of breast augmentation which is different to current findings. Although, it is reported that *“breast implants will not last a lifetime”* (FDA, 2004), only a minority of websites raise the possibility that implant rupture is a likely occurrence over time. The website for the Wellington Institute of Plastic Surgery states that *“the lifetime of the prosthesis is not known and it may be necessary at some stage to remove or replace them”*. Likewise, the Plastic Surgery New Zealand website indicates, that *“the silicone implants used are generally expected to have a 1-2% failure rate per year. This means it is extremely unlikely that the implant will fail within ten years. It is, however, safest to consider the implants may need to be replaced in your lifetime”*. Although these

texts can be read as raising possibilities for implant replacement, such possibilities are constructed as unlikely or rare. Furthermore, on these websites there is very little indication of the likelihood of further surgery. This further surgery involves almost a quarter of women with implants who require re-operations resulting from complications. The Wellington Institute of Plastic Surgery advises that further surgery may be required to address the “*small risk of valve failure and leakage with saline implants*”, as well as a “*further operation may be required to improve the result*” for women dissatisfied with their initial attempt. Similarly, within text on the interactive movie which address implant rupture it is stated that such cases “*would require a further small procedure re-opening the same incision line*”

However, when practices of breast augmentation fail there is enormous potential for women not only to be dissatisfied with their breasts, but to also experience tremendous suffering. Davis (1997) recounts the story of Irene, who over the course of twenty years has had eighteen operations on her breasts in attempts to counter to effects of continual infections, capsular contracture, and rejection of her implants. As a result of ongoing complications Irene’s right breast is so permanently disfigured that is unlikely to ever be ‘fixed’. However, such possibilities for long-term impairment or disfigurement are barely touched upon in these websites. David Glasson advises that “*rarely, complications may lead to further surgery and more expense*” Likewise information about risks on the Plastic Surgery New Zealand website discusses “*small risk*”, “*minor differences*” and how it is “*extremely unlikely that implants will fail*”. Julian Lofts explains that “*the majority of women do not experience complications*” In order to breast augmentation to be a ‘choice’ women require access to all knowledges of breast augmentation necessary for understandings, and practices of ‘informed consent’ It may well be that women still choose to undergo surgery after weighing up the risks, feeling that any potential benefits outweigh possibilities of unwanted side effects. Hovi et al., (1999) reported that over half of the women in their study felt they had insufficient knowledge of breast implants. Notwithstanding this, around three quarters of these women stated they would choose implants again. Davis (1997) also found, that although all the women she interviewed had some unwanted effects from surgery, the majority stated that their choice to have breast augmentation was not a decision they regretted. However “they were considerably less prepared to accept the context in which their decisions were taken however. They were more, not less vocal about their right to receive adequate information and to be treated as competent in making their own decisions... they emphasized the right to make their own decisions under conditions where their wishes were respected and they were provided

with adequate information” (Davis, 1997, p. 156). It can be argued that such adequate information is not forthcoming on these websites. Women are offered limited information regarding risks and complications. Further information provided through other website links on these sites is primarily for other cosmetic surgical associations, or for the manufacturers of implant devices. It is fair to say that these associations, and implant manufacturers offer information that best suits their own interests. Only a couple of websites indicate that there is a Department of Health booklet on silicone-gel implants which is available from the surgeon, or the ministry. However, the onus is on the women seeking breast augmentation to ask the surgeon for this booklet. As such, this information is offered quite differently to the easily and readily accessible website links of other surgical associations, and implant manufacturer’s. The only other information offered about the risks of breast augmentation is on the Peter Walker website. It is advised that: “*a women’s health information service has sponsored development of a breast implant support group which has been active in counseling women with implants*”. However, there is no further information or contact details supplied so it is unknown, as to what the position or purpose of this group may be.

Not only are risks and complications of breast augmentation inadequately represented on the majority of these websites, but it is also implicated that unwanted side effects may be the responsibility of women undergoing surgery. Text on the website for the New Zealand Institute of Plastic and Cosmetic Surgery warns that: *As with any surgery breast augmentation carries potential risk or complications including infection around the implant, capsular contracture, reduced nipple sensation, implant disruption of rotation, breast asymmetry and unwanted scarring. Fortunately the incidence of these problems is low in health co-operative patients*”. If the woman undergoing breast augmentation is “*healthy and co-operative*” then her chances for adverse effects following surgery are “*low*”. Within discourses of health, individuals’ are often understood as morally and personally responsible for their bodies. The body is predominately understood within socially accepted and approved ways of being healthy, and normal. Within such understandings individuals are expected to co-operate with these compelling, and powerful representations of well-being through organizations and practices towards their bodies. Women, whose bodies or behaviour falls outside of these instructive ways-of-being can be seen to be responsible in some way for any adverse complications. This notion of personal responsibility not only opens up possibilities for bodies to be regulated in certain ways but also limits challenges to the authority, and dominance of a medical model. This shift of responsibility for post surgery

complications to the individual within these websites works not only to legitimate practices of breast augmentation, but also to mitigate responsibility of the surgeon within possibilities of damaging the breasts, and health of women.

It may well be that any possibilities of damaging the breasts and health of women are clearly outlined in the pre-operative consultation process. Several of these websites indicate, that the surgeon will inform women of any risks at the time of the pre-operative consultation(s). These consultations are commonly one or two visits. The New Zealand Institute of Plastic and Cosmetic surgery when advising of risks, and complications states: *Your surgeon will discuss this fully with you during the consultation process.* The website for Gregory Taylor similarly advises that “*all surgical procedures have risks and there are some particular to breast augmentation which will be detailed to you preoperatively*” However, within the consultation process there is also a health evaluation, and a breast examination. There is further explanation of the anesthesia and hospital facilities, as well as some discussion of the costs involved. At this pre-operative consultation, decisions about implant size, type and position are also made, and information is also given regarding before and after surgery details. Therefore, it would seem that there is an extensive amount of information explained, as well as other thorough examination processes undertaken at the typical one or two pre-operative consultations allotted to women seeking breast augmentation.

Any failure to inform women adequately about the risks of their surgery is interpreted as constraining practices of breast augmentation, as a choice for women. Limitations of choice for women towards their bodies can be understood as brought about within interactions of wider social processes. Within wider social and often hierarchal understandings, and practices of gender, women are typically constituted in terms of their bodies. This tying of women to their bodies serves to separate women from notions of independence, autonomy, and rationality which are central to constructions of the masculinized, and privileged mind. Social understandings of femininity constructed as soft, passive, nurturing, and emotional further work to reproduce, and sustain the power and authority of men within the practices, institutions, and structures of everyday life. As Wearing (1995, p. 15) argues, “men, by reason of their culturally constituted gender roles had the power to define women’s roles and traits for them and to value these traits less highly than their own”. As such, women’s decision making abilities are often seen as inferior to men. Within these websites the authority and knowledges of the male surgeons are repeatedly presented as necessary towards

any choice women may wish to make about their bodies. These hierarchical positions of men and women permit possibilities for men to appropriate the bodies of women. This appropriation is not only produced within choices about breast augmentation, but also within wider heterosexual relations. Within these relations women's bodies are typically understood as belonging within the service of others, whether in practices of motherhood, sexuality, or marriage. The female body is understood as a means to nurture, sustain, and care for others rather than as an autonomous entity which belongs exclusively to women. Appropriations of the female body within "the heterosexual matrix" (Butler, 2003, p. 11) is illustrated on the Julian Lofts website with text regarding altered nipple sensation as a complication of breast augmentation. It is indicated that: *up to 15% will have permanent alteration of nipple sensation. You may also notice small patches of numbness near your incision (which may or may not improve). If nipple sensation is critical to your enjoyment of sex you should discuss this issue carefully with your partner and with me.* Female sexuality can be interpreted as subject to the authorities of both a woman's partner and the surgeon. Even though nipple sensation may be "critical" to a woman's sexual experience, she is urged to consult with others in choices about her sexuality. Within sexual practices, women's bodies are often appropriated in ways that foremost meet the sexual needs of others before themselves. Female sexual submission becomes normalized and reproduced through these understandings of women's obligations, and responsibility for the sexual needs of others (Jackson, 1998; Gavey, 1992). On this website women's breasts are not seen as a valuable or necessary experience of women's sexuality, as much as objects whose sexual value is determined within negotiations with others. As Young (1998, p. 127) argues that "phallogocentric culture tends not to think of a woman's breasts as hers... her breasts belong to others- her husband, her lover, her baby. It's hard to imagine a woman's breasts as her own, from her own point of view, to imagine their *value* apart from measurement and exchange". Therefore, breast augmentation as 'choice' for women can be understood as highly constrained. Discourses of femininity inform the choice of breasted experience through dominant ideals of size, and shape. These ideals of embodiment can be thought of as male constructions of a female body which serve to construct women as an object of male desire. These processes of objectification further hold in place the dominant authority of the surgeon in practices of choice within procedures of breast augmentation. However, for women to exercise any agency within these cultural constraints of breast augmentation they must have 'informed choice'. This not only involves access to the multiple and contradictory knowledges surrounding practices of breast augmentation, but women must be valued as autonomous, and

rational beings who are respected as competent decision makers about bodies which are understood as their own.

Conclusion

Breast augmentation can be understood as a practice which offers possibilities and constraints for social understandings, and practices of femininity. Women cannot stand outside of processes of culture and many women do not wish to. As reported in these website texts, breast augmentation offers the potential for some women to construct themselves as active feminine beings who feel that their lives are enriched as a result of this surgery. Breast augmentation may well be a life-changing experience that brings pleasure, fulfillment, and psychological well-being for women who undergo surgery. However representations of breast augmentation within these websites also offer constraints for women, and their experiences of embodiment. Breast augmentation as a choice of self-determination is highly compromised by the lack of information about risks, and complications on these websites. This reduction in possibilities for women to make an informed decision about potentially risky surgery on otherwise healthy breasts is extremely disturbing. Within these website representations women may only 'choose' breast implants that realize their bodies as anatomically correct within the paternal authority, and approval of the mainly male surgeons who perform breast augmentation. This realization of an anatomically correct body holds in place understandings of the female body as an erotic or sexual object. In this way, these website representations of breast augmentation act to sustain understandings of women's breasts, and their bodies as objects of sexuality. As objects of sexuality, women's breasts are understood as a ubiquitous size and shape. This normalized breast is continuously reproduced in the website texts, and any possibilities for the breast to be celebrated as a signifier of age, individuality, or motherhood are denied. This normalization of the breast which works to sustain traditional notions of women as their bodies further hold in place wider hierarchal social arrangements. The male surgeons on these websites are openly positioned as legitimate authorities that hold considerable power over women's bodies. As such, women are forced to negotiate with the surgeon's male and medicalized understandings of female embodiment in order to obtain breast augmentation. Therefore, these practices of breast augmentation are clearly positioned within a framework of traditional heterosexual relations. These heterosexual relations permit men to appropriate the bodies of women in practices of sexuality, medicine, and consumerism and are evident in these online constructions of cosmetic surgery in contemporary New Zealand society. By all accounts female breast

augmentation is a growing trend in western world societies and is likely to be taken up by increasing numbers of New Zealand women. To decry or condemn this practice would be to deny women possibilities of agency within constructions of themselves as feminine beings. However, in order to offer women greater possibilities of agency at the site of breast augmentation there needs to be widening of choice. This includes unconstrained choice of implant size, shape, and position wherever possible, and beyond the limitations of an idealized female body. Women must be treated as competent decision-makers, and be privy to all the possible risks and complications of breast augmentation. In order to gain this greater choice it may be necessary to displace the dominance of male surgeons, and actively reconstruct practices of breast augmentation so that they are developed, and determined in order to respect the autonomy, authority, and desires of women about their breasts.

References

- Askegaard, S., Gertsen, M.C., & Langer, R. (2002). The body consumed: Reflexivity and Cosmetic surgery. *Psychology & Marketing*, 19, 793-812.
- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Discourse analysis, Qualitative methods in psychology: A research guide* (pp. 92-107). Buckingham: Open University Press.
- Bartky, S. L. (1988). 'Foucault, femininity, and the modernization of patriarchal power'. In I. Diamond & L. Quinby (Eds.), *Feminism and Foucault: Reflections on resistance* (pp. 61-81). Boston: Northeastern University Press.
- Bartky, S. (1990). *Femininity and domination: Studies in the phenomenology of oppression*. New York: Routledge.
- Beasley, C. (2005). *Gender & Sexuality: Critical theories, critical thinkers*. London: Sage.
- Benhabib, S. (1999). Sexual difference and collective identities. The new constellation. In M. A. Farrell & L. Vallone (Eds.), *In Virtual gender, fantasies of subjectivity and embodiment*. Ann Arbor: The University of Michigan Press.
- Biltgard, T. (2000). The sexuality of elderly people on film-visual limitations. *Journal of Aging and Identity*, 5(3), 169-183.
- Bordo, S.R. (1989). The body and reproduction of femininity: A feminist appropriation of Foucault. In A. M. Jaggar & S. R. Bordo (Eds.), *Gender/body/knowledge: Feminist reconstructions of being and knowing* (pp. 13-33). London: Rutgers University Press.
- Bordo, S. (1993). *Unbearable weight: Feminism, western culture and the body*. California: University of California Press.

- Broom, A. (2005). Medical specialists' accounts of the impact of the Internet on the doctor/patient relationship. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 9, 319-339.
- Brownmiller, S. (1984). *Femininity*. London: Hamish Hamilton.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex"*. New York: Routledge.
- Butler, J. (2003). Performative acts and gender constitution: An essay in phenomenology and feminist theory. In C. R. McCann & S-K. Kim (Eds.), *Feminist local and global theory perspectives reader* (pp. 415-427). New York: Routledge.
- Carey, S. (2000). Cultivating ethos through the body. *Human Studies*, 23, 23-42.
- Chamberlain, K. (2005, March). "Consumption, consumer society, the health consumer and critical health psychology" *Invited Keynote Address to the Fourth Conference of the International Conference of the International Society for Critical Health Psychology*, Sheffield, England.
- Clarke, D. (2003). *Descartes's Theory of Mind*. Oxford: Clarendon Press.
- Clarke, A.E., Shim, J.K., Mamo, L., Fosket, J.R., & Fishman, J.R. (2003). Biomedicalization: Technoscientific transformations of health, illness and U.S. biomedicine. *American Sociological Review*, 68, 161-194.
- Connell, R. (2000). *The men and the boys*. Cambridge: Polity Press.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209-232.
- Conrad, P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behavior*, 46, 3-14.

- Conrad, P., & Leiter, V. (2004). Medicalization, markets and consumers. *Journal of Health and Social Behaviour*, 45, 158-176.
- Cosmetic Surgery News, (2005). *Choosing breast implant size: A matter of aesthetics*. Retrieved May 25, 2006 from [http// www. Cosmeticsurgery-news.com](http://www.Cosmeticsurgery-news.com).
- Couldry, N. (2004). Theorising media as practice. *Social Semiotics*, 14, 115-132.
- Crawford, J., Kippax, S., & Waldby, C. (1994). Women's sex talk and men's sex talk: Different worlds. *Feminism and Psychology*, 4, 571-587.
- Cromby, J., & Nightingale, D.J. (1999). What's wrong with social constructionism? In D. J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp.1-19). Buckingham: Open University Press.
- Daly, M. (1978). *Gyn/Ecology: The metaethics of radical feminism*. Boston: Beacon Press.
- Danesi, M. (2004). *Messages, signs, and meanings: A basic textbook in Semiotics and Communication theory* (3rd Ed.). Toronto: Canadian Scholars Press Inc.
- Davis, K. (1995). *Reshaping the female body: The dilemma of cosmetic surgery*. Great Britain: Routledge.
- Davis, K. (1997). Embodiment Theory beyond modernist and postmodernist readings of the body. In K. Davis (Ed.). *Embodied practices: Feminist perspectives on the body* (pp. 1-21). London: Sage.
- Davis, K. (2003). *Dubious equalities & embodied differences: Cultural studies on cosmetic surgery*. Maryland: Rowman & Littlefield Publishers.
- Didie, E.R., & Sarwer, D.B. (2003). Factors that influence the decision to undergo cosmetic breast augmentation surgery. *Journal of Women's Health*, 12, 241-253.

- Dull, D. & West, C. (1991). Accounting for cosmetic surgery: The accomplishment of gender. *Social Problems*, 38, 54-70.
- Edwards, T. (2000). *Contradictions of consumption: Concepts, practices and politics consumer society*. Buckingham: Open University Press.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129-136.
- Fallon, A.E. (1990). Culture in the mirror: Sociocultural determinants of body image. In T. F. Cash & T. Pruzinsky (Eds.), *Body Image: Development, deviance and change*. New York: Guilford Press.
- Featherstone, M. (1991). The body in consumer culture. In M. Featherstone., M. Hepworth, & B. S. Turner (Eds.), *The body: Social process and cultural theory* (pp. 170-197). California: Sage Publications.
- Fejes, F.J. (1992). Masculinity as fact, a review of empirical mass communication research On masculinity. In S. Craig (Ed.), *Men, masculinity and the media*. California: Sage Publications.
- Foster, J. (1991). *The immaterial self: A defence of the Cartesian dualist conception of the mind*. London: Routledge.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings 1972-1977*. New York: Pantheon.
- Frank, A.W. (1991). For sociology of the body: An analytical review. In M. Featherstone., M. Hepworth, & B. S. Turner (Eds.), *The body: Social process and cultural theory* (pp. 36-102). California: Sage Publications.
- Friedman, J. (1994). *Consumption and identity*. Singapore: Harwood Academic Publishers.

- Gage, J. (1993). *Colour and culture: Practice and meaning from antiquity to abstraction*. Singapore: C. S. Graphics.
- Garza, G. (2002). The internet, narrative and subjectivity. *Journal of Constructivist Psychology, 15*, 185-203.
- Gavey, N. (1992). Technologies and effects of heterosexual coercion. *Feminism & Psychology, 2*, 325-351.
- Gavey, N. (2002). I. To and beyond the discursive constitution of subjectivity. *Feminism & Psychology, 12*(4), 432-438.
- Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*, 266-275.
- Gergen, K. (1999). *The communal construction of the real and the good. An invitation to social constructionism* (pp. 33-61). London: Sage.
- Giddens, A. (1991). *Modernity and self-identity*. Great Britain: Acorn Bookwork.
- Gill, R., & Walker, R. (1993). Heterosexuality, feminism, contradiction: On being young, white, heterosexual feminists in the 1990's. In S. Wilkinson & C. Kitzinger (Eds.), *Heterosexuality: A feminist and psychology Reader*. London: Sage
- Gillespie, M.A. (1998). Mirror mirror. In R. Weitz (Ed.). *The politics of women's bodies: Sexuality appearance and behaviour* (pp. 46-64). Oxford: Oxford University Press.
- Good, G.E., & Sherrod, N.B. (2001). The psychology of men and masculinity: Research status and future directions. In R. Unger (Ed.). *Handbook of the psychology of women and gender* (pp.201-214). New York: John Wiley & Sons.
- Gross, G., & Blundo, R. (2005). Viagra: Medical technology constructing aging masculinity. *Journal of Sociology & Social Welfare, 32*, 85-97.

- Haiken, E. (1997). *Venus envy: A history of cosmetic surgery*. Baltimore: Johns Hopkins University Press.
- Hamas, R.S. (1999). The postoperative shape of round and teardrop saline-filled breast implants. *British Journal of Plastic Surgery*, 19, 369-374.
- Harding, S., & Hintikka, M.B. (1983). Introduction. In S. Harding & M. B Hintikka (Eds.), *Discovering reality feminist perspectives on epistemology, metaphysics, methodology and philosophy of science*. (pp. ix-xix). Holland: D.Reidel Publishing Company.
- Health Department of Victoria (2002). *Breast implants and your health*. Retrieved December 1, 2005 from [http:// www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au).
- Hollway, W. (1984). Gender differences and the production of subjectivity. In J. Henriques, W Hollway, C Urwin., C. Venn., & V. Walkerdine (Eds.), *Changing the subject*, (pp. 227-263). London: Methuen.
- Hollway, W. (1995). Feminist discourses and women's heterosexual desire. In S. Wilkinson (Ed.), *Feminism and discourse: Psychological perspectives* (pp. 86-105). California: Sage Publications.
- hooks, bell, (1998). Selling hot pussy: Representations of black female sexuality in the cultural marketplace. In R. Weitz (Ed). *The politics of women's bodies: Sexuality, appearance and behaviour*. New York: Oxford University Press.
- Hovi, S-L., Hemminki, E., & Swan, S.H. (1999) Cosmetic and postmastectomy breast implants: Finnish women's experiences. *Journal of Women's Health & Gender-Based Medicine*, 8, 933-939.
- Institute of Medicine (1999) In: S. Bonburrant., V. Ernster, & R Herdman (Eds.), *Safety of silicone breast implants*. Washington: National Academy Press.
- Internet Society, ISOC. (2006). *History of the Internet*. Retrieved May 10, 2006 from <http://www.isoc.org>.

- Jackson, M. (1984). Sex research and the construction of sexuality: A tool of male supremacy? *Women's Studies International Forum*, 7, 43-51.
- Jackson, S. (1998). Feminist social theory. In S. Jackson & J. Jones (Eds.), *Contemporary feminist theory* (pp. 12-33). Edinburgh: Edinburgh University Press.
- Jeffreys, E. (1991). What is difference in feminist theory and practice? *Australian Feminist Studies*, 14, 1-13
- Joy, A., & Venkatesh, A. (1994). Postmodernism, feminism, and the body: The visible and invisible in consumer research. *International Journal of Research in Marketing*, 11, 333-357.
- Kaufman, M. (2005). FDA panel opposes silicone gel implants. Retrieved December 1, 2005 from <http://washingtonpost.com>.
- Kitzinger, C. (1994). Problematizing pleasure: Radical feminist deconstructions of sexuality and power. In H. Radtke & H. J. Stam (Eds.), *Power/gender. Social relations in theory and practice* (pp.194-209). London: Sage.
- Lange, L. (1983). Women is not a rational animal on Aristotle's biology of reproduction. In S. Harding & M.B Hintikka (Eds.), *Discovering reality feminist perspectives on epistemology, metaphysics, methodology and philosophy of science*. (pp. ix-xix). Holland: D.Reidel Publishing Company.
- Lazar, M. M. (2002). Consuming personal relationships the achievement of feminine self-identity through other-centeredness. In L. Litosseliti & J. Sunderland (Eds.), *Gender identity and discourse analysis*. Amsterdam: John Benjamins Publishing Company.
- Levy, J.A., & Strombeck, R. (2002). Health benefits and risks of the Internet. *Journal of Medical Systems*, 26, 495-510.

- Lorde, A. (1984). Age, race, class and sex: Women redefining difference. *In sister outsider: Essays and speeches by Audre Lorde* (pp. 114-123). California: The Crossing Press/Freedom.
- Lunt, P., & Livingstone, S. (1992). *Mass consumption and personal identity: Everyday economic experience* (pp. ix-xix) Buckingham: Open University Press.
- MacKay, H. (1997). Introduction. In H. MacKay (Ed.). *Consumption and everyday life*. London: Sage Publications.
- MacKinnon, C. A (1982). Feminism, Marxism, method and the state: An agenda for theory. *Signs*, 7, 515-544.
- MacLachlan, M. (2004). *Embodiment clinical, critical and cultural perspectives on health and illness. Health Psychology*. New York: Open University Press.
- Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). London: Humanities Press.
- Millsted, R. & Firth, H. (2003). Being large-breasted: Women negotiating embodiment. *Women's Studies International Forum*, 26, 455-465.
- Mintzes, B. (2002). For and against: Direct to Consumer advertising is medicalising normal human experience. *British Medical Journal*, 324, 908-909.
- Morgan, K.P. (1998). Women and the knife: Cosmetic surgery and the colonization of women's bodies. In R. Weitz (Ed.). *The politics of women's bodies: Sexuality appearance and behaviour* (pp.147-166). Oxford: Oxford University Press.
- Mulvey, L. (1986). Visual pleasure and narrative cinema. In P. Rosen (Ed.). *Narrative apparatus ideology: A film theory reader*. New York: Columbia University Press.

- New Zealand Internet Usage Stats and Telecommunication Reports (2006). *Internet world Stats usage and populations statistics*. Retrieved June 5, 2006 from <http://www.internetworldstats.com>.
- New Zealand Ministry of Health New Zealand (1994). *Information for consumers' medical devices- silicone gel breast implants*. Retrieved December 1, 2005 from <http://www.medsafe.govt.nz>.
- Oberg, P., & Tornstam, L. (1999). Body images among men and women of different ages. *Aging and Society, 19*, 629-644.
- Oldersma, J., & Davis, K. (1991). Introduction. In J Oldersma & K. Davis (Eds.), *The gender of power* (pp. 1-18) London: Sage.
- Ortner, S.B. (1974). Is female to male as nature is to culture? In M. Z. Rosaldo & L. Lamphere (Eds.), *Woman, culture and society*. Stanford: Stanford University Press.
- Pancer, S.M. (1997). Social psychology: The crisis continues. In D. Fox & I. Prilleltensky (Eds.), *Critical Psychology- An introduction* (pp.151-165). London: Sage.
- Parker, I. (1990). Discourse: definitions and contradictions. *Philosophical Psychology, 2*, 189-204.
- Radley, A. (1998). Displays and fragments: Embodiment and the configuration of social worlds. In H. J. Stam (Ed.), *The body and psychology*. (pp. 13-29). London: Sage.
- Stam (Ed.). *The body and psychology*. (pp. 13-29). London: Sage.
- Rich, A. (1980). Compulsory heterosexuality and lesbian existence. *Signs: Journal of Women in Culture and Society, 5*, 631-660.
- Sampson, E.E. (1998). Establishing embodiment in psychology. In H.J Stam (Ed.). *The body and psychology*. (pp. 30- 53). London: Sage.

- Sarwer, D.B., Nordmann, J.E., & Herbert, J.D. (2000). Cosmetic breast augmentation surgery: A critical overview. *Journal of Women's Health & Gender-Based Medicine*, 9, 843-856.
- Schilling, C. (1993). *The body and social theory*. London: Sage.
- Sherif, C. (1979). Bias in psychology. In J.A. Sherman & E.T. Beck (Eds.), *The prism of sex: Essays in the sociology of knowledge* (pp. 93-134). Madison: University of Wisconsin Press.
- Slater, D. (1997). *Consumer culture and modernity*. Cambridge: Polity Press.
- Smith, D.E. (1990). *Texts, facts and femininity: Exploring the relations of ruling*. London: Routledge.
- Spivak, G.C. (1987). *In other worlds: Essays in cultural politics*. New York: Methuen.
- Stam, H.J. (1998). The body's psychology and psychology's body: Disciplinary and extra-disciplinary examinations. In H.J Stam (Ed.), *The body and psychology*. (pp. 1-12). London: Sage.
- Stearns, P.N. (2001). *Consumerism in world history: The global transformation of desire*. London: Routledge.
- Sydie, R. (1988). *Natural women, cultured men: A feminist perspective on sociological theory*. Toronto: Nelson.
- Synnott, A. (1989). Truth and goodness, mirrors and masks---Part I: A sociology of beauty and the face. *The British Journal of Sociology*, 40, 607-636.
- Synnott, A. (1993). *The body social: Symbolism, self and society*. London: Routledge.
- Tiefer, L. (1996). The medicalization of sexuality: Conceptual, normative and professional issues. *Annual Review of Sex Research*, 7, 252-282.

Tong, R.P. (1998). *Feminist thought a more comprehensive introduction* (2nd Ed.). USA: Westview Press.

Tsao, A. (2003). *Why Inamed is all pumped up*. Retrieved December 1, 2005, from <http://www.businessweek.com>.

Tuckett, D., Boulton, M., Olson, C & Williams, A. (1985). *Meetings between experts: An approach to sharing ideas in medical consultations*. London: Tavistock Publications.

U.S Food and Drug Administration (2004). *Status and availability of silicone breast implants In FDA Breast Implant Consumer Handbook*. Retrieved December 1, 2005, from <http://www.fda.gov/cdrh/breastimplants/handbook2004/statusavailability.html#2>

Unger, R. K. (2001). Women as subjects, actors and agents in the history of psychology. In R. Unger (Ed.). *Handbook of the psychology of women and gender* (pp. 3-16) New York: John Wiley & Sons.

Warde, A. (1996). Afterword: The future of the sociology of consumption. In S. Edgell., K Hetherington & A. Warde (Eds.), *Consumption matters*. Oxford: Blackwell Publishers.

Wearing, B. (1995). *Gender: The pain and pleasure of difference*. Melbourne: Addison Wesley Longman.

Whittle, S. (1996). Gender fucking or fucking gender. In R. Ekins & D. King (Eds.), *Blending genders: Social aspects of cross-dressing and sex changing*. London: Routledge.

Wikipedia Encyclopedia. (2006). *Jordan (Katie Price)*. In In Wikipedia, the free Encyclopedia. Retrieved May 18, 2006 from http://en.wikipedia.org/wiki/Katie_Price.

Wikipedia Encyclopedia. (2006). *Pamela Anderson*. In Wikipedia, the free Encyclopedia. Retrieved May 18, 2006 from http://en.wikipedia.org/wiki/Pamela_Anderson.

Wolf, N. (1991). *The beauty myth*. New York; William Morrow and Company Inc.

Yalom, M. (1997). *A history of the breast*. USA: Alfred A Knopf, Inc.

Young, I. M. (1998). Breasted experience: The look and the feeling. In R. Weitz (Ed.), *The politics of women's bodies: Sexuality appearance and behaviour* (pp. 125-136). Oxford: Oxford University Press.

Young, I. M. (1990). Humanism, gynocentrism, and feminist politics. *Throwing like a girl and other essays in feminist philosophy and social theory*. (pp. 73-91). Bloomington: Indiana University Press.

Winefield, H.R. (1992). Doctor-patient communication: An interpersonal helping process. In S. Maes, H. Leventhal & M. Johnston (Eds.), *International review of health psychology* (pp. 167-187). Chichester: John Wiley.