

Mount Saint Vincent University
Department of Family Studies and Gerontology

**Not All Positive: A Feminist Phenomenological Analysis of Women's Experiences of
Botox Treatment and Other Injectable Facial Fillers**

by Sandi Berwick

A Thesis
submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Family Studies and Gerontology

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Halifax, Nova Scotia

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Abstract

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Non-cosmetic procedures to the face (e.g., Botox and other injectable fillers) have been widely popularized in the media for how they reduce facial signs of aging, yet significantly misunderstood with respect to their impact on women, particularly those who have negative experiences. To fill this research gap, seven women who had negative or mixed emotions about having had Botox or other facial injectables were interviewed. The women were from Canada and the United States, and ranged in ages from 38 to 62 years old. Data was analysed using feminist moral theory and a hermeneutic phenomenological method, focusing on corporeal modes of being, as well as temporal and relational modes. Four women had serious physical and psychological side effects (e.g., heightened sensitivity to noise, anxiety, problems sleeping, and depression) (The Fractured Body), and others had impacts ranging from minor and unwanted physical skin changes to fear of potential, future side effects (e.g., fear of potential addiction) (The Reflective Body). Participants acknowledged influences of sexism and ageism and recognized the impact of patriarchal and capitalistic ideologies (The Commodified Body). Questionable ethical practices were evident in the medical profession, plastic

surgery industry, and pharmaceutical industry (The Abandoned Body). Results also explore their transformations in terms of their relationships to their bodies and themselves (e.g., guilt over having had the procedure done yet a more positive outlook on aging), to others, to society (e.g., trust in the medical profession), and to the future (The Transformed Body). Although most people seem to not have negative side effects, there needs to be more room for these women's voices, as well as a responsive and supportive medical industrial complex, rather than one that silences them.

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I will always be grateful to the women whom I have known, those whose paths are currently crossed with mine, and those I anticipate meeting in my future. It is these relationships that have sustained me, contributed to the development and growth of my inner-self and will continue to provide strength, moral understanding and unconditional support as I continue through my journey with all its new opportunities, challenges, and adventures.

Finally, I would like to thank Rhonda who has been for many years a mentor, previous colleague and friend, and shared my passion about doing this study. You gave encouragement, unconditional support, and believed in me and what I wanted to accomplish. Thank you for helping me to achieve one of the greatest experiences of my life—an incredible journey of learning and self-discovery. I will always be grateful for your inspiration over the years. You were an example of a truly moral individual of the highest regard, and I am a better healthcare professional for having known and worked with you over the years in continuing care.

Dedication

With fond memories of unconditional love, moral guidance, and much humor throughout my life, I dedicate this study, a *journey of relationships over time* to:

Margaret Ellen MacKinnon 1917 – 2008

and

Lawrence Henry Brown 1921 – 1980

Thank you for my roots.

As well, I dedicate this study to the women who opened their lives to share their lived experiences about facial injections in relation to their perspectives, feelings and thoughts about positive aging. Thank you to *Lysandra, Vivienne, Lane, Tabia, Gabby, Amber, and Safara*.

I also dedicate this study to my darling daughter, *Brandy Alexandra Laperle*,

One relationship across time.

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Chapter 1: Introduction

When I was forty-two I gave birth to my second child. A typical response to this event, from other women, was one of disbelief that I would consider such an option *at my age*. Another memorable encounter occurred when I turned 50 and decided to celebrate my second half of life by getting my first tattoo. Once again, I was surprised when my son's young friend, upon seeing my colorful, sunflower tattoo remarked, "Wow, your mom is 50!" These two personal experiences were indicative of the widespread ageist and sexist attitudes, and societal constructs (subtle and unconscious, or overt and glaring) prevailing in society at that time. Approximately thirteen years later, as a self-perceived mid-life woman, I am now interested in knowing how aging women experience sexism and ageism in their lives.

A long-established patriarchal history has devalued women socially simply because of the aging process. Centuries of actual social inferiority for women, and the inevitable psychological feelings of inferiority that result when full human development is both materially and spiritually restricted, have long-term effects that women continue to battle today (Drage, 2005). The loss of youth, thus the perceived loss of functionality and societal contribution has resulted in a demeaning, ageist second half of life for many aging women. This view of aging as a steady, habitual non-growth routine of living is common (Drage, 2005), and more research is needed regarding how women respond to sexism and ageism in their lives.

Cosmetic surgery, in particular, has been widely popularized in the media yet significantly misunderstood in respect to the impact on positive aging for women. The incidence of cosmetic procedures is escalating (American Academy of Facial Plastic and

Reconstructive Surgery, 2011; Bayer, 2005; Singh, Hankins, Dulku, & Kelly, 2006; Rohrich, 2003; Rosen, 2004; Singh & Kelly, 2003; Thornberry, 2011), and women increasingly continue to feel the need to undergo these facial procedures.

Overview of the Research

I mentioned previously that I was interested in knowing how aging women today experience ageism and sexism in their lives. In thirteen years, since my own personal revelations concerning my past experiences with dominant social influences and ideologies I am both alarmed and fascinated by what is occurring socially and culturally today. As an aging woman I am alarmed by the unprecedented phenomenon and growth of the cosmetic surgery industry that targets women of all ages and as a researcher I am fascinated by the realization that this phenomenon does influence how women perceive positive aging. My own personal and professional values and experiences centered on caring for an older demographic of mostly aging women have also been instrumental in my decision to do this study.

The purpose of this study is to explore mid-life women's experiences, feelings, and perceptions about their decision to have anti-aging injections to the face such as Botox, which is reported as being the most preferred of all non-surgical, cosmetic facial procedures followed by various facial fillers (International Society of Aesthetic Plastic Surgery, 2010). Specifically, I was interested in interviewing women who had had Botox or other facial filler injections but had regrets or mixed feelings about their decision. Had these regrets and mixed feelings created moral impacts in their lives from a positive aging perspective? I used an interpretive phenomenological methodology and semi-structured interviews as the method for this qualitative study.

The rationale for deciding to research this specific faction of women is because they have not been given a voice about their experiences. According to a 2007 on-line survey by Mediacard Finance Inc. of 1,500 respondents, 33% had had a non-surgical procedure (such as Botox or injectable fillers). Of those, more than half (56%) said they were satisfied with the results (Zintz, 2007), but what of the remaining 44%? What were their responses, and why were they not reported?

This statistic contrasts with apparently reported satisfaction of women who have had Botox represented by the staggering statistical growth of this anti-aging procedure reported world-wide. For example, in 2009 the International Society of Aesthetic Plastic Surgery revealed trends from a global survey. The total number of non-surgical cosmetic procedures was estimated at 8, 759, 187, with Botox ranking as the top procedure carried out.

However, this figure did not take into account procedures performed by non-cosmetic surgeons (International Society of Aesthetic Plastic Surgery, 2010). Based on current compound annual growth rates, it is predicted that total cosmetic surgery volume (including surgical and nonsurgical facial procedures) will exceed 55 million annual procedures by 2015 in the United States (Liu & Miller, 2008). This astounding projection alone gives just cause for further inquiry into current moral impacts of cosmetic surgery from the perspective of women, yet very little is documented in the literature. From a feminist moral lens are we to assume that all women who participate in facial injections are happy about the outcome? Billions are spent annually on the anti-aging industry. Should we accept that this is how all women perceive positive aging? And although there is no research on women who have had mixed feelings or regrets related to facial

injections, conflicts related to different values have surfaced in reference to Botox in findings from various studies (Heyes, 2007a), which allude to the importance of this research study.

The political economy of aging is a critical theoretical framework emphasizing the broad implications of structural forces and processes that contribute to constructions of old age and aging as well as to social policy (Estes, 2001). I discuss the aging of women within the context of societal and cultural pressures, and influences of this theoretical, social framework. I use a feminist moral framework to underpin my research (Gilligan, 1982; Held, 1993; Jagger, 2000a; Jagger, 2000b; Walker, 1989, 1992, and 1999). This feminist moral framework reflects on concepts that represent concerned moral inquiry, understanding from a feminist point of view, identifying and explicating better social constructions than those currently existing in a patriarchal and capitalistic society, and making recommendations on behalf of women. Feminist moral theory as a critical lens explains how a socio-cultural influence exerts pressure on women to appear youthful in a society that devalues the second half of life as one of supposed decline. From an epistemological standpoint, feminist moral theory requires distinctive types of understanding for women, described best as contextual and narrative rather than formal and abstract (Walker, 1989).

Significance of the Research

This is an important research field considering the imminent boom of aging women in Canada who will continue to face challenges related to an ageist, patriarchal society, and who will participate in Botox or other facial injections as an option to defying the natural aging process and to retain a sense of youthfulness. Speculation

related to future growth rates for facial injections is a cause for concern if the desire for these treatments increases similarly to the following reported past growth rate. In a mere decade (between 1982 and 1992) the number of people surveyed who said they approved of cosmetic surgery increased by 50%, and the number who disapproved declined by 66% (American Academy of Cosmetic Surgery, 2011).

Since 1992 cosmetic surgery procedures based on American statistics have been performed at dramatically increased rates (Rohrich, 2003; Rosen, 2004). Botox injections, facial fillers, face-lifts, and eye-lid surgery, to name a few aesthetic facial procedures, have become a panacea for many women. Cosmetic surgery has also gone global. For example, there is increasing acceptance of such practices in China, particularly a procedure to create creases in Asian women's eyelids to give their eyes a rounder, more Westernized look (Rosen, 2004). Of the varied cosmetic procedures of the face, the previous four (surgical and non-surgical choices) have been the most popular, and projections of future treatments show a phenomenal increase along with other cosmetic procedures (American Society for Aesthetic Plastic Surgery, 2010).

Two key concepts are relevant to this research and require definition as they are mentioned comparatively throughout this paper in relation to the popularity of non-surgical facial injections as is indicated in other studies in the literature review. *Cosmetic non-surgical facial procedures* consist of minimally invasive cosmetic procedures. They include (but are not limited to) Botox, facial fillers, treatments with non-ablative lasers, cosmetic tattooing, light-based therapies, and light-to-medium strength chemical peels. Since the introduction of spas, these procedures are growing more and more accessible to the average person looking to improve his or her appearance. Of all the nonsurgical anti-

aging procedures available, Botox has emerged as the uncontested leader, enjoying a 3,387 % increase in use from 1997 to 2003 (Bayer, 2005). This procedure and other facial fillers are the treatments I researched specifically but I also report on the others for general statistics and current research mentioned in the literature compared to Botox.

In contrast, *cosmetic surgical facial procedures* involve techniques intended for the enhancement of appearance through surgical and medical techniques. These are concerned with maintaining, restoring or enhancing one's normal appearance beyond the average level toward some aesthetic ideal through procedures such as face lifts, brow or forehead lifts, and rhinoplasties.

The face as a focus of research in cosmetic surgery is poignant because for those who have plastic surgery, the relationship between the physical face and the construction of individual identity has always been and continues to be central (Haiken, 2000). These facial procedures result in some level of facial rejuvenation but biological age, hormonal gravity, and the effects of the environment will continue to occur. Thus, one wonders how many cosmetic procedures will suffice or how much the human body and person can accept physically, emotionally, and mentally. Huge financial burdens are also an issue to consider.

The World Health Organization estimates that by the year 2025, the planet will consist of 8 billion residents. At that time, the number of people age 65 and older will reach 800 million; one of every ten persons and the average life expectancy will be 73 years (Katz, 2001/2002). The majority of this historical aging demographic are women and it will be problematic for many due to widespread ageism and sexism, which will result in pressure to participate in cosmetic facial procedures in developed countries

worldwide.

Conclusion

If women do experience age bias and gender discrimination in the present day, what are the implications considering the burgeoning demographic involving women and aging? This research permits a closer view of the challenges and social pressures facing aging women in society, and the reasons that compel many women to have Botox and facial filler treatments. Specifically, my study recruited mid-life women who have had Botox and other facial injections but regret their decision or have mixed feeling about their decision. From a feminist moral perspective, I was also interested in learning more about moral impacts in this study, such as whether or not there had been any moral impacts on the lives of the participants, and if so, in what way?

Chapter 2: Literature Review

There is new kind of war being waged in America and throughout the world, the war against aging: the “anti-aging industry.” With society’s constant emphasis on youth and beauty, it is no wonder women are being bombarded to the possibilities offered by cosmetic surgery. This literature review examines the phenomenal growth of cosmetic surgical and non-surgical procedures as well as the influence from the medical-industrial complex and informationalism that perpetuates the anti-aging industry of aesthetic facial surgery. In particular, the section on Botox explores why this non-surgical facial procedure is the most popular anti-aging procedure of all cosmetic procedures worldwide. The final sections look at the various perspectives of why women participate in cosmetic interventions and the experiences of women reported from various studies in the literature. Although not researching on moral outcomes of Botox and filler injections, moral conflicts, moral dilemmas, and values have surfaced in reference to these procedures in findings from various studies, which allude to the importance of this research study.

Cosmetic Surgical and Non-surgical Facial Procedures

Cosmetic modifications of the body have expanded in number, type and, scope; however, Canadian statistics are not available from Canadian sources and minimal Canadian research has been published on Botox specifically. Contact with the Canadian Academy of Plastic and Reconstructive Surgery did not result in any explanation why statistics are not documented and published. For instance, in the United States in 2005, however, there were nearly two million aesthetic operations; more than quadruple the number in 1984, along with over eight million nonsurgical procedures and patients

getting cosmetic surgery are increasingly having multiple procedures (American Society for Cosmetic Plastic Surgery, 2010). And with the vast expansion in the number of cosmetic procedures; cosmetic surgery has been democratized, with the majority of patients now in the middle class (Pitts-Taylor, 2007).

The history of cosmetic surgery is fascinating and complex, closely tied to war and migration, to developments in medicine and surgery, and to cultural changes in perceptions of what it means to be a fulfilled human being or a woman (Haiken, 1997; Jones, 2008). Historically, the cosmetic surgery realm has been shaped by pressures and priorities within the American culture as well as within the profession of medicine, and its history illuminates the complex interplay between medical and cultural imperatives. Patients at the turn of the century were as much interested in their external appearance and facial features as they seem to be today, but in different ways. Advertisements for “facial prostheses” in medical journals of that period and in papers written on the then current vogue of paraffin injection for the correction of facial imperfections have been documented. The following excerpt written in 1907 from one of Chicago’s first cosmetic surgeons, Dr. Charles Conrad Miller, who attested to the very early interest in cosmetic surgery for rejuvenation and attractiveness:

This class of work [cosmetic surgery]. . . is a special field worthy of the closest study of the ablest of our profession, for he who operates or treats these cases have the future happiness and peace of mind of the patient at stake.

Operations for improving the appearance cannot be botched. The operator must be skillful and fully capable in this field more than in any other. . . it is my earnest desire to encourage men throughout the country to give this subject careful attention, for

it promises to be, before many years, a most profitable and satisfactory specialty.

(Rogers, 1971, p. 268)

Modern surgeons trace their history to India, where as early as 600 B.C., the Hindu surgeon Sushruta described a method of reconstructing a nose from a patient's cheek. It was not until World War I, however, that plastic surgery was "reborn" as an art and as a profession. As in other medical specialties, education training and credentials constitute one set of variables that create the plastic surgeon's professional authority. In the case of cosmetic surgery, however, authority derives as much from the realm of consumer culture, the patient both inhabits and embodies, as from the surgeon (Haiken, 1997). This consumer culture can be likened to the political economy of aging presented in Chapter 2.

The medical industrial complex identifies aging as being a disease that can be controlled by changing the visible signs of aging such as wrinkles and sagging skin. Thus, the aging enterprise construct aligned with this concept identifies aging women as a commodity in a lucrative market of cosmetic surgery procedures with promises of restored youthful appearance and thus, more accepting in a society that deplores an aging, and older person. Older people are being blamed for the rising costs of healthcare and income security programs, for the poverty of children, the national deficit, and the increase in real estate prices (Minkler & Estes, 1991). The pressure to not be associated as being or looking old is phenomenal, and the predominantly-male cosmetic surgery field encourages and perpetuates this ideology for financial interests. The central political issue is the dominant ideology of the cosmetic surgery industry convincing women that they need and want anti-aging beauty enhancements while the reality is the need and

want of the industry to expand its financial intake (McKnight, 1977, as cited in Robertson, 1997). Robertson argues that this modern welfare state involves a commodification of need itself, and the emergence of services fetishism. This commodification of need has been called an “aging enterprise” (Estes, 2001). The rise of “anti-aging medicine” is one case in point, and under this umbrella is the cosmetic surgery and non-surgery industry, which is thriving. To cite only one dismaying statistic: there are more medical doctors who are members of the American Academy of Anti-Aging Medicine than there are members of the American Geriatrics Society (Moody, 2004). Are women even aware they are considered a commodity with such lucrative market value in this anti-aging enterprise?

The vast amount of cosmetic surgery information including statistics comes mainly from the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS). To a lesser degree is the international Society of Aesthetic Plastic Surgery (ISAPS), which offered global statistics for the first time in August of 2010. There are no statistics published by the Canadian Academy of Facial Plastic and Reconstructive Surgery (CAFPRS). The one-time only published Canadian statistics in 2002-2003 was from Medicard Finance¹ and Plastic Surgery Statistics Canada (PSSC), a subsidiary of Medicard Finance Incorporated created in 2004 to provide a measurement of the growth of cosmetic enhancement in Canada. That report indicated that 85% of all cosmetic procedures performed in Canada were carried out on women, with the highest percentage of procedures being carried out in Ontario (42%), followed by British Columbia at 26%, Alberta at 11%, and the rest of Canada with a combined 20%. Moreover, non-surgical

¹ Formed in 1996, Medicard Finance, Canada's Patient Finance Company.

procedures represented the area of cosmetic enhancement with the greatest increase at 325% between 2002 and 2003. Botox injections had increased 19% and other injectables were up 23%. Most recently, in September 2007 Medicard and PSSC also conducted an online survey to directly poll consumers about their attitudes toward cosmetic enhancement. Prior to this, the industry relied solely on American statistics. Even minimal Canadian research is unavailable and Canadian statistics are not kept by cosmetic plastic surgeons.

Survey results for 2010 from the American Academy of Facial Plastic and Reconstructive Surgery showed that 75% of the procedures performed by the Academy's surgeons were non-surgical procedures. The most common non-surgical procedures were Botox and hyaluronic acid injections. The most common non-surgical procedure for women under age 35 were Botox injections (65%, up from 58% in 2009). Women between the ages of 35 and 60 most commonly underwent Botox, chemical peels, and filler injections, which all showed at least a 5% increase since 2009. To break this down further, in 2010 the average percentage of Botox performed per surgeon by age was as follows, ages 22 to 34 was 22%, ages 35 to 60 were 58%, and ages 61 and older were 19% (American Academy of Facial Plastic and Reconstructive Surgery, 2011). The Canadian Medicard Financial Company survey (Willemsen & Kennedy, 2007) also indicated that women predominantly underwent surgical cosmetic enhancement procedures (85.5%), while men only underwent 14.5% of all cosmetic procedures. American data for non-invasive surgeries indicated that most common procedure for both men and women was Botox, undertaken by 3.8 million women and 284, 000 men in 2006 as reported by ASAPs in 2007 (Ricciardelli, & White, 2011).

As previously mentioned, Botox is the most preferred non-surgical cosmetic procedure among women worldwide (Carruthers & Carruthers, 2001; Staffieri, 2011; Thornberry, 2011). This incredible statistic warrants further explication of this phenomenon. Botox is a purified crystalline form of exotoxin type A produced by the bacterium *Clostridium botulinum*. For the past 50 years its principal use has been in the treatment of spastic dystonias (involuntary movements and prolonged muscle contraction resulting in twisting body motions), although other therapeutic uses continue to expand. It is the serendipitous observation that Botox eliminate dynamic facial wrinkles that propelled the drug's status to almost omnipotent regard in both the medical and paraprofessional organizations. Its principal appeal is to eliminate frown lines of the forehead, the glabellar region between the eyebrows, the "crow's feet" wrinkles around the eyes, and the area around the mouth. Injected Botox causes muscles to relax, smoothing out the vertical lines. The results last from four to six months, sometimes less (Man & Faye, 1998) at which time the procedure can be repeated. This can become costly as Botox injections range from approximately \$400 to \$600 Canadian (Cooke, 2008; Eckler, 2011).

A recent addition to non-surgical procedures on the market is dermal (facial) filler. Dermal filler is an injectable gel made from naturally-occurring substances, including collagen and hyaluronic acid. It is injected just under the skin in order to add volume to aging skin, lips and to fill and lift wrinkles and folds adding volume for a more *natural* youthful appearance. Since it is a recent procedure there is currently minimal literature on its acceptance or popularity among women although the reported draw is its longer-term effects, but ultimately higher costs as well. The two most popular products

are Juvéderm and Restylane and some women are injected with both Juvéderm and Botox (advertised as the *Soft Lift*) to treat different “problem areas” of the face.

ISAPS News, the official newsletter of the International Society of Aesthetic Plastic Surgery (ISAPS), recently boasted of members in 90 countries (Thornberry, 2011). Further to this, on August 9, 2011, ISAPS released its first biennial global survey of plastic surgeons and procedures in the top 25 countries and regions representing 75% of all procedures in 2009. Of the ranking hierarchy of countries, the United States ranked first and Canada ranked fifteenth. Within these 25 countries, of the top five nonsurgical procedures, toxin or neuromodulator injections (Botox, Dysport) were the most popular procedure chosen by women (Staffieri, 2011), at 32.7%. Similarly, the statistics reported by Mediscan in 2004 also cited Botox as leading in injectables in Canada with over 100,000 treatments on 50,000 patients in 2003. Geographically, the survey was led by Ontario having 42% of cosmetic procedures performed in the province, followed by British Columbia at 26%, Alberta with 11%, and the rest of Canada with a combined 20%.

Specific statistics for Nova Scotia are not available. This fact was verified when in late May, 2011, I contacted several local establishments (Atlantic Skin Care Inc., Gentle Touch: Skin & Laser Centre, and The Landings Surgical Centre) that offer aesthetic, non-surgical facial procedures. All confirmed that they did not submit statistics or data to any Canadian source and none were aware of any existing Canadian statistics within Canada. In fact, few studies have monitored physician supply in Canada, and no studies have specifically examined the Canadian plastic surgery workforce (MacAdam, Kennedy, Lalonde, Anzarut, Howard, & Brown, 2007). At the same time, I also contacted

the Canadian Academy of Facial Plastic Surgery to inquire if statistics were kept and to ask if there was any Canadian source I was not aware that was tracking cosmetic aesthetic Canadian trends. The executive contact for CAFPRS assured me that Canadian statistics and trends were similar to its American counterpart the AAFPRS and there were no known sources of Canadian statistics except for Medicard Finance.

I question the ethics and agenda of a finance company doing research (surveys and statistics) to promote cosmetic surgery. It is even more astounding because industry statistics reported by Laurie Essig, a sociology professor at Middlebury College, in her book *American Plastic: Boob Jobs, Credit Cards and Our Quest for Perfection* observes that plastic is about who Americans are. She goes on to say that a staggering 85% are in debt because the average cost of the average cosmetic work is \$8,000 (Essig, 2010). Moreover, although such procedures may be more likely with those who have higher incomes, the working poor's access to facelifts is made possible by what Essig calls the predatory lending practices of medical credit at 30% interest (Essig, as cited in Kingston, 2010). One such credit institution is *Medicard* advertising in a variety of popular Canadian magazines offering "plastic surgery loans" and promoting itself as "Canada's Patient Finance Company." I refer to the consumer survey by Medicard Finance identifying trends in decision making. Participants were drawn from industry-related consumer and trade shows across Canada, with more than 2,000 individuals sending an e-mail link to the survey in September, 2007. There was a reported response rate of 75%; 97% were female with an average age of 44 years. The most poignant question and response related to "informed decisions" indicated that information gathered by prospective consumers came from the doctor's office, magazine articles, the Internet, and

reality TV.

The emergence and vastness of this anti-aging industry attests to the power of the marketplace in an aging society in which anti-aging products and procedures are based on ageism and age-denial. Endangered are the ethical foundations of medicine, including the commitment of physicians to put the needs of the patients ahead of personal gain, to deal with patients honestly, competently, and compassionately, and to avoid conflicts of interest that could undermine public trust in the altruism of medicine. Yet, many physicians have contributed to this transformation by accepting the view that medical practice is also a business (Relman, 2008).

This change in attitude has important moral impacts. I refer to the previously reported financial statistic from Liu and Miller (2008), which predicts that the medical profession will perform 55 million cosmetic procedures (surgical and non-surgical) annually by the year 2015, in the US alone. In business, increasing shareholder value through increased revenue and increased profit is the primary goal. When physicians (inclusive of those who practice in the cosmetic surgery field) think of themselves as being primarily in business, professional values recede and the practice of medicine changes (Relman, 2008). Relman continues:

The fundamental ethos of medical practice contrasts sharply with that of ordinary commerce and market principles do not apply to the relationship between physician and patient. Such insights have not stopped the advance of the medical industrial complex, or prevented the growing domination of market ideology over medical professionalism. (p. 34)

This new domain has become a lucrative and thriving business for physicians in

their new role and sadly the shallow concern of many is limited to measuring the quality of life results following procedures only with forms and surveys, rather than through narrative experiences that might better convey any moral impacts (Alsarraf, 2000).

Comparatively, Ringel (1998) suggests this segment of the medical profession may not be able to change society's obsession with enhanced youthful facial appearance but they also need not promote facial procedures for financial gain. This perspective adds to the ethical concern for women who participate in non-surgical cosmetic procedures because they are exploited for market value in a male-dominated business opportunity.

An additional concern is the looming threat of non-core trained physicians in the non-invasive marketplace (Boon & Tan, 2007; CBC News, 2008; Findlay, 2011; Jewell, 2011). The practice of cosmetic medicine that centers on non-invasive facial procedures with injectables such as Botox seems to be adopted by general physicians, gynecologists, and spa operators who rely upon a proxy physician as their medical director rather than a cosmetic surgeon. Specialty training is available but ranges from weekend workshops to in depth courses (Jewell, 2011). This growing trend is appealing for its reduced wait times, lesser costs, and still acceptable outcomes from the patient's perspective. Other strategies include having trained professional staff such as aestheticians and nurses, cosmetologists, and skin care specialists who are promoted as being certified to perform injectables. However, this erosion of the market place by non-core-trained physicians who offer cosmetic medicine, injectables, and other non-invasive treatments is a serious matter because the unique qualifications to achieve the safest and best outcomes may not be happening as regulation cannot be guaranteed. This is because membership is voluntary. The foremost regulatory concern appears to be the practice of the minimally

invasive facial injections by general practitioners and possibly paraprofessionals (Boon & Tan, 2007).

Informationalism explains in more detail how and why women are influenced and seduced by the cosmetic surgery field. Anti-aging claims enticing women to participate in Botox or filler treatments are seductive, convincing and extensive across many depictions of social media. One exemplar is “mentor testimony” that “provides clients with personal mentors or women who can offer invaluable ‘girlfriend’ advice”:

Hello, I am 40ish. That’s close enough. I have been a flight attendant and facilitator for a major airline for the past ten years. I am also single and have no children. I had my first breast augmentation about 15 years ago. I just had my first Botox injection about a week ago (yes, it hurts, and yes, I love the results) and scheduled an eye lift for early January. If I can offer any advice, answer any questions or you just want to talk, contact me at kathy@enhanceme.com or call me at 1-877-7enhance (1-877-736-4262). (King & Calasanti, 2006, p. 148)

Finally, on the “mentor/it happened for me” page from the same site, a woman says,

I just wanted to thank you so much for making it possible or my dream to come true. You and your staff were very helpful and made everything so easy! I’m lying in bed recovering right now and I feel great about myself! And thank you for the beautiful flowers! That was very thoughtful of you and it made a big difference to me. You really are a different kind of financing company. Your help has been invaluable to me. (King & Calasanti, 2006, p. 149)

This is meant to be a very humanistic and empowering approach. This subjective

connection strategy can be very seducing to potential clients. It puts faces to cold figures and illustrates its claims with personal stories of validation. Anti-aging advertising is generous with its pictures of smiling consumers (King & Calasanti, 2006). Marketing of the youthful female body has become unprecedented in developing and promoting a gendered stereotype of aging and many consider this obsession not only acceptable advertising but a standard of natural aging. Informationalism occurs on many cosmetic surgery websites when cosmetic surgeons provide before and after photographs, inviting feedback from prospective female clients regarding the types of non-surgical, cosmetic facial procedures they may be considering. The cosmetic surgeon returns an enhanced facial photograph with a projected image of the applied facial cosmetic procedure: an example of the post-modern, technological consulting service (Gibson, 2006).

I recently discovered a book called *The Internet Guide to Cosmetic Surgery for Women* (Wood, 2005). This resource guides prospective clients through the mountains of information on the internet with the alluring question of: "Where can you go to find what is right for you?" The "what" refers to a thorough listing of Web sites detailing every aspect of plastic and cosmetic surgery for every body part, as well as where to find quality information on the costs of surgery, selecting a cosmetic surgeon, liposuction, tummy tuck, facelifts, jaw augmentation, laser skin resurfacing, lip augmentation, nose surgery, Botox injections, facial fillers, wrinkle treatment, chemical peels, and much more. This is yet another example of how women are the focus of market values for others: authors selling their internet guides about the cosmetic surgery industry. It is also representative of a mode of social media for promoting and advertising of cosmetic surgery monopolies to women. This is the enabling role of informationalism.

Several studies have examined how popular women's magazines portray cosmetic surgery and associated emotional health. This is especially significant considering the previous identified influence of media communications on women's perceived beauty and their subsequent 'need' for cosmetic beauty procedures. Articles regarding cosmetic surgery were analyzed from the top five most circulated English-language magazines in Canada (*Chatelaine*, *Cosmopolitan*, *Flare*, *Oprah*, and *Prevention*) between 2002 and 2006 (Polonijo & Carpiano, 2008). The articles were related to type of procedure, patient demographics, risk information, and indicators of emotional health, and the findings indicated that women's magazines contribute to the medicalization of the female body because although the magazine articles portray cosmetic surgery as risky, it is also depicted as worthwhile to enhance both physical appearance and thus emotional health. The researchers also reported that the articles tended to use beauty standards of female attractiveness from male perspectives.

Similarly, Brooks (2004) conducted an American content analysis of articles on cosmetic surgery in *Vogue*, *Harper's Bazaar*, *US Weekly*, and *People* magazines from October 2001 to June 2003. Brooks reported that most articles, in all four magazines, depicted cosmetic surgery in a favorable light. One narrative theme referred to new technologies with descriptors such as scientific wonder, innovation, and progress; casual accessibility; medical expertise and health. A second narrative theme was of personal candid accounts, and included themes of courage and virtue; a gift or treat to oneself; heroic stories of independence and rebellion; and as a rational, pro-active step towards self-improvement or economic success.

These two studies demonstrate how the current widespread advertising and

communication culture changes the natural process of aging into a realm where women who read these magazines are made to feel that they must alter their looks. At no time during my search of the literature on this topic did I find any magazine advertisements that challenged or negated the use of age-defying procedures such as Botox. I also became more aware that the articles and advertisements were targeting midlife to older women more frequently than younger women which did cause some moral concern because it seems as if the second half of life is being devalued and targeted as decline, thus requiring enhancements. Cultural influence on behalf of facial, aesthetic techniques by means of informationalism are seductive, coercive, and extensive across many depictions of social media.

Botulinum Toxin

As noted, Botox injection is the fastest growing non-surgical cosmetic procedure worldwide, and it is the universally accepted gold standard treatment for facial rejuvenation (Carruthers & Carruthers, 2001). The revenue from the global sales of Botox increased from \$25 million US in 1993 to \$310 million US in 2001 attesting to the seductive appeal of this “elixir of youth” as an added therapeutic indication (Singh & Kelly, 2003; Singh et al., 2006).

The short-term physiological adversities of Botox have been extensively reviewed (Singh & Kelly, 2003). Local complications such as pain, edema, a ruptured blood vessel, and short-term hyper-sensitivity to the skin may be related to the injection site.

Immunological complications such as acute type 1 reactions have been reported, and systematic reactions include nausea, malaise, and distant rashes. Dose-related complications include the unwanted loss of facial expression (“mask-like” faces) and

incomplete muscle paralysis, leaving residual muscular contractions. The Allergan Company website, which manufactures several facial injection products states that Botox cosmetic may cause serious side effects that can be life threatening but that there has not been a confirmed serious case of spread of toxin effect when BOTOX® Cosmetic has been used at the recommended dose to treat frown lines or crow's feet lines (Allergan, 2014). What is compelling is the fact that the psychosocial impacts of Botox (or other facial fillers) have been largely ignored in the literature.

Little is known about the discrepancies between the perceived and the actual outcomes of treatment. Women may become dependent on repeated treatments to maintain the illusion of perpetual youth in an aging face and body. Is there a certain point, when the usual dose of Botox is no longer effective and the number of injections or the dosage amount is increased? Because of this does safety become an issue? Is it time for an eye-lift, or a face-lift or other cosmetic intervention (facial fillers) to maintain the anti-aging “look”? Even more of a concern is the resulting moral implications of these outcomes. Media hype for the substance is unprecedented; physicians of all specialties are embracing Botox for its ease of administration, and even high-street chemists (pharmacists approved for offering extended medical services) are competing for any opportunity to deliver Botox to anyone who appears even slightly interested or curious (Singh & Kelly, 2003). Recently, a colleague informed me that at her last hair appointment, her hair stylist announced that she had hired someone to give Botox injections, once a month, at her hair salon. It is probable that this new addition of a non-invasive facial treatment will be given by a paraprofessional.

In January, 2011, a MACLEAN's magazine article caught my eye. The article,

“You can’t tell my husband!” was about wives who hide their Botox injections from their husbands, attested to by Dr. Romy Saibil and Dr. Francine Gerstein, co-owners of a Toronto-based spa. Many women, said Saibil, will schedule injections when they know their husbands will be away on business (Eckler, 2011). Dermatologist, Dr. Paul Cohen, who also treats women with Botox injections, said he has heard every lie under the sun, with women hiding Botox. He has also dealt with interesting payments: “Women will say, put \$200 on the credit card this month and \$200 next month. They don’t want their husbands seeing anything too large, because they know they’ll be questioned” (Eckler, 2011). The behavior of the women written about in this magazine article signifies significant moral dilemmas to be able to obtain Botox treatment. These women lie, accumulate debt, are deceitful to their husbands, and are conflicted and stressed in their personal partner relationships assuming their spouses do not want them to have Botox. Is it that the husbands do not think their spouses need Botox or that they do not want them spending these large amounts of money on the treatments? What are the moral impacts these women incur by these behaviors and “assumed” conflicting perspectives of their spouses?

This section on Botox substantiates that it is the most sought-after intervention by women to avoid the signs of aging. My research identified that there is an alternate perspective about the psychosocial impacts of Botox and other similar procedures largely ignored in the literature. The final sections review the literature related to studies of women and the cosmetic surgery industry.

Perspectives on Cosmetic Surgery

A review of the literature on cosmetic surgery uncovered a variety of perspectives

related to different disciplines and standpoints. The relevance of sharing these perspectives highlights the research gaps related to women's experiences with Botox and other injection treatments and perceived positive aging that this study addressed.

Anthropologists Reischer and Koo (2004) define the current body ideals as symbol or agent. This dual capacity gives women the opportunity to both reflect and challenge their social position in relation to the body beautiful. For example, reflecting on the social values and beliefs embodied in the post-modern cultural ideals of female beauty, consider Barbie at 50! In 1997, Mattel's most famous doll emerged from the factory operating room with a wider waist, slimmer hips and a reduction of her legendary bust line. The original Barbie of the 1950s has undergone a radical alteration representing current cultural influence of the female body pertaining to the evolution of beauty trends. On one hand, the values and beliefs of current culture have demonstrated an influence of overturning a naturalistic approach to the body as biologically given by various beauty work expressions which represent dominant social and cultural beauty ideals or symbolism. On the other hand, women display their agency by choosing the product or procedure that best represents and defines the beauty look they wish to attain (Reischer & Koo, 2004).

Davis (1995) and Morgan (1991) debate their perspectives of liberating agency versus coercive subordination. In her book, *Shaping the Female Body*, Davis claims that women who participate in cosmetic surgery are not submitting to the power of patriarchal ideology but rather are aware of it and actively participate to reap the benefits. Morgan, on the other hand, suggests women are coerced into cosmetic surgery by "conforming" to hegemonic cultural beauty norms, seen most obviously with Hollywood celebrities.

Women believe they are cultivating their bodies but in reality they are being colonized by men (plastic surgeons) (the power of patriarchal ideology). Similarly, both authors write about cosmetic surgery as the pursuit of beauty ideals and these discourses relate to cosmetic surgeries of face and body more so than non-invasive facial procedures such as Botox. The departure is noted in terms of the modes of investigation: Davis has done research spanning several years inclusive of three empirical studies, whereas Morgan's inquiry has been limited to a review of magazines featuring interviews with cosmetic surgeons (Wijsbek, 2000). My qualitative study encompassed women's actual lived experiences related to Botox and fillers, which are more pertinent and current than these studies.

Fraser (2001) discusses cosmetic surgery in terms of its naturalness whereby the concept of nature legitimates science, thus are we to assume that nature underpins the scientific/medical field of cosmetic surgery? The natural is situated at the center of a system of dichotomies. The first assumption is that nature is self-evident, a closed category that exists prior to culture and defies historical change. The second is that, within the modernist body politic, women make cultural life possible, yet they are not part of it (Fraser, 2001). Fraser's examination involves the analysis of a number of feminist texts to demonstrate the frequency with which notions of the natural are used in discussions of cosmetic surgery. To assist her analysis of feminist meanings of nature in accounts of cosmetic surgery, Fraser uses the theorization of interpretive repertoires. Fraser argues that in cosmetic or aesthetic surgeries, the use of the word natural in the analyzed works is applied both to those women who do undergo surgery and those who do not, and as a result of this debate, it often obscures what is most at stake in cosmetic

surgery: the expense, the consumption of time, and personal dilemmas. Fraser sees this central concept of nature legitimizing science (cosmetic surgeries) requiring further debate, and recommends as a solution: feminist research. However, Fraser's investigation consisted of text analysis rather than actually interviewing women who have had Botox and filler injections.

Heyes (2007a), a feminist political philosopher, offers an ethical lens as she draws us back to an important issue to consider: that constant intrusive thoughts of one's own embodied ugliness, the aesthetic failure of a particular body part or parts, or the constant comparative and unfavorable evaluation of one's own body with others is quite typical of a lived experience of femininity in Western countries that deserves more sustained ethical attention and critique. The subject of normalization and cosmetic surgery is discussed by comparing works of Bordo (1998) and Davis (1995) in relation to Heyes's own work, *Self-Transformations: Foucault, Ethics and Normalized Bodies* (2007b).

Heyes (2007a) sees cosmetic surgery increasingly represented and experienced not only as an intervention in beauty but also in identity that is accepted as normal. In other words, cosmetic surgery is sold to women as the procedure(s) to transform women's bodies into the person one feels is inside or being normal. The moral implications in this situation represent the values-conflict. Is the embodied younger and more attractive self what women truly perceive or is it the coercion of a culture obsessed with youth and beauty? Do aging women desire to look younger from Botox and filler injections but have feelings of guilt about not wanting to age naturally? Heyes identifies cosmetic surgery as a fascinating theme through which to study emerging rhetoric of self-transformation and also remarks on the ethics of cosmetic surgery whereby everyday

feminist dilemmas involve an ethical level, and the important role that the practice of consciousness-raising will continue to play in these personal conflicts (Heyes, 2007a). In these two works, Heyes draws attention to the importance of sustained ethical attention and critique, as well as the values conflict women may experience in relation to cosmetic surgery.

Suissa (2008) writes about the connection between addiction and cosmetic surgery specifically, based on the theory that addiction refers primarily to a search outside oneself for something that is lacking on the inside. Suissa adds that it does take specific psychosocial conditions to trigger this cycle of addiction. She explains further that addiction to surgery is part of the relationship to one's own body and the reaction to personal suffering, on the one hand, and to contextual social demands, on the other.

Among the other social factors that influence addiction to cosmetic surgery, Lorenc and Hall (2005, as cited in Suissa, 2008) mention at least three: (a) impact of informationalism: exposure to television, special programming, Hollywood spokespersons, artistic representations, and fashion; (b) impact of technology: the huge technological strides in medical procedures, such that patients require less anesthetic and post-operative recovery, is much faster; and (c) impact of culture: the socialization process that increases the acceptability and desirability of surgery in a society that has become more and more tolerant of the idea. Are women even aware of these subtle and coercive influences that target them to participate in Botox?

From a male, positivist perspective, Ching, Thoma, McCabe, and Antony (2002) participated in a comprehensive review of the aesthetic cosmetic surgery literature to determine patient satisfaction outcomes measured quantitatively. The study, which

examined the end results of these medical interventions based on the accounts of patients' experiences, preferences, and values, was determined to be especially pertinent because patient satisfaction as an outcome in this type of surgery is the predominant factor in determining success. This scientific perspective identified the standardization of outcome assessment as being extremely advantageous yet, difficult since the nature of aesthetic surgery is subjective and eludes clear definition. The finding from the authors' review indicated that no appropriate instruments to directly evaluate patient satisfaction in aesthetic surgery were found, but that the Multidimensional Body-States Relation Questionnaire, a psychological assessment of body image, was selected as a potential form for further study. This type of research based on the patriarchal stand point of traditional science is an example of how men's values and philosophical position differentiate from that of women's values; comparatively, feminist moral caring is knowing that narratives explain experiences that women want to talk about.

Of the perspectives written about in this section, Heyes (2007a) aligned most with my moral lens. Two thoughts especially were relevant to my reflections. First, because ethics is construed, broadly, as the art of living and the relationship to ourselves, feminist engagement with cosmetic surgery requires a set of richer ethical strategies for talking about our own psychic lives in a context of normalization. Second, practices of consciousness-raising, in which personal experiences are externalized and shared with others contributes to a broader understanding within a larger socio-political context, and this will continue to play an important role (Heyes, 2007a). This perspective by Heyes has been the only work discovered during the literature review that identified ethical concerns about the cosmetic surgery industry. The need to apply a moral lens is inherent

in the journal article by Heyes. The next section discusses studies about women's experiences with cosmetic procedures, which identifies the gaps in the literature related to this study's focus.

Women's Experiences of Cosmetic Procedures

The lived experiences of women are required to fully understand the moral impacts of participating in Botox and fillers, the topic of this study, and which also contributes to feminist perspectives in epistemology. Of the studies in this section related to women's experiences of cosmetic procedures, three are from American sources (Brooks, 2010; Delinski, 2005; Gimlin, 2000), two are Canadian studies (Clarke & Griffin, 2007; Clarke, Repta, & Griffin, 2007), and one is European (Askegaard, 2002). I chose these specific studies to present a reference to the countries where the most to least research about cosmetic surgery is occurring and also to place Canadian content in context of the existing literature.

The pursuit of beauty through alteration of physical beauty is a growing trend (Delinski, 2005). In this quantitative study 302 female undergraduate students were surveyed. The average age of these psychology students was 20 years of age. The purpose of this study was to measure current attitudes toward cosmetic surgery as being more normalized. Various hypotheses for the normalization of cosmetic surgery were tested. These include that normalization occurs when a family member or peer group has had a procedure performed and attitudes of women are influenced by the amount of positive information available about cosmetic surgery through informationalism. Personality characteristics of body-image satisfaction, self-esteem, importance of appearance to self-worth, and internalization of sociocultural attitudes toward

appearance, indicate that the cosmetic-surgery patients have greater feature-specific body-image dissatisfaction, and finally, limited data suggest ethnic minorities utilize cosmetic surgeries less than do Caucasians.

Personal experience with cosmetic surgery was relatively rare in the college-aged sample, but half of the participants reported knowing someone personally who had undergone elective cosmetic surgery. Media exposure was commonly reported, and only a small number had never seen advertisements, television programs, or read articles about cosmetic surgery. A large number of participants seemed to reflect a negative stereotype about cosmetic surgery, and the majority of respondents felt that they would never have it in the future. Contrary to the hypothesis, no statistically significant differences were found between the ethnic groups and Caucasians. Cosmetic surgery of family and friends predicted greater approval of cosmetic surgery. Body-image dissatisfaction did not predict approval of cosmetic surgery, which supports the hypothesis that feature-specific dissatisfaction rather than global-body dissatisfaction might be more of a predictor of cosmetic surgery. Internalization of sociocultural attitudes toward appearance also predicted likelihood of future cosmetic surgery.

I question the usefulness of using 20-year-old undergraduate students for this study. Current advertisements are meant to appeal to an older population, rather than a young age group to alter their physical appearance thus, the study is lacking in the appropriate age group to obtain pertinent information for the proposed research focus. In contrast to my study, this quantitative study used a broad term of cosmetic surgery, not specifically attitudes to Botox injections. An interesting finding was the strong inverse relationship between approval of cosmetic surgery and the importance to self-worth,

which is a basic moral value. From an ethics perspective, it is interesting, yet disconcerting that when appearance was related to self-worth, greater approval to cosmetic surgery was predicted.

Gimlin (2000) interviewed 20 female patients ranging in age from 24 to 50 who had surgical procedures such as breast augmentations, nose jobs, face lifts, eye reshaping, tummy tucks, and liposuctions. The women were either Asian American or European American. Gimlin captured the autobiographical accounts of these women to investigate critical claims of theorists and social critics of cosmetic surgery as being the ultimate symbol of invasion of the body for the sake of physical beauty. The purpose of the study was to understand from the participants' experiences their reasons for participation in what is perceived as the most difficult to justify of all body work forms. The research involved field work in a plastic surgery clinic rather than recruiting participants through a snowball sample of surgery clients. The researcher contacted a plastic surgeon she had met previously at a local gym, and after obtaining his patients' approval supplied 20 names of his clients for the study. This procedure may have biased the sample in favor of successful cases, a consideration that must be noted.

All 20 women denied altering their bodies for an intimate partner but rather were for self-satisfaction conceptualized as a normal appearance, and all claimed adamantly they had benefited from participating in this procedure. The researcher stated she believed the procedures worked to normalize women but in the context of a culture of appearance that has highly restrictive notions of normality. For example, one woman had breast augmentation and experienced more confidence to participate in activities she previously felt excluded from previously. Few of the participants could actually afford

their chosen cosmetic procedure. Nearly all sacrificed some other large purchase or experienced some financial hardship and some accrued considerable debt while others requested financial assistance from families.

Once again, in this study, reference was made to moral values. Some women in the study worked hard at weight reduction in exercise classes and rigorous gym regimens as evidence of moral value and as the basis for their entitlement to cosmetic surgery. Yet, these women still felt unsatisfied with the physical and moral results of the cosmetic body work. In other words, the cosmetic surgery failed to position the transformed body as a convincing and legitimate representative of the normal self, instead the body was transformed to what society and culture deemed as normal appearance, thus creating a moral dilemma for these women, which is addressed in my study.

As mentioned, the study was skewed in favor of the most positive cases, as was substantiated by all participants insisting adamantly they had benefitted from participation in the procedures. It is also noteworthy that women were willing to assume such huge financial debt to pursue goals such as self-confidence and acceptance to a higher social class attainable only, they believed with cosmetic surgery. However, reference to moral conflict and moral dilemma occurred with some women who could not rectify the physical and moral results of the cosmetic surgery. They felt unable to escape the social and moral meanings they attributed to their own bodies (Gimlin, 2000). More information is needed about the personal moral conflicts women experience.

Brooks (2010) interviewed American women between the ages of 47 and 76 to investigate their attitudes about and experiences of cosmetic interventions. The women had one concern in common, which was the health of their bodies and all were committed

to taking care of their bodies through healthy eating and physical exercise but all varied in their attitudes and approaches to growing older. The research question asked was in what ways does increasing availability, accessibility, advertising, and use of anti-aging surgeries and technologies interact with and inform women's perceptions and attitudes about growing older?

The author purposively recruited women using a snowball technique. The sample consisted of 16 women who were receiving anti-aging surgeries and technologies, 22 women who neither had any procedures done, nor planned to do so, and six women who were undecided. The anti-aging interventions included plastic surgeries (neck lifts, eye lifts, brow lifts, and face lifts) and the injectables (Botox, Restylane, Collagen, Perlane, and Juvéderm). All the women were white except for one Latina woman. Approximately three-quarters of the women were financially secure, which is noteworthy considering that anti-aging aesthetic surgeries and technologies in the US are not covered by medical insurance and the costs of these surgeries range from hundreds of dollars for the injectables to thousands of dollars for surgeries. The availability of long-term financing and payment plans makes the accessibility of the varied anti-aging surgeries and technologies more available to women across class lines (Brooks, 2010).

Respondents articulated that aging successfully meant health work on the body in the context of aging was incorporated into youth/beauty work on the body through surgeries and injectables with aims to minimize, reverse, and even prevent signs of aging altogether (Brooks, 2010). Brooks posited that although these aesthetic anti-aging surgeries and injectables were welcomed by many women, they may also have created a denial and acceptance of "things ending" than their naturally aging counterparts (Brooks,

2010).

Because aging is increasingly portrayed as pathological and in need of fixing and repair (Brooks, 2010), the women admitted to feeling guilty and responsible for not choosing the alternative. No questions were asked about positive aging as a perspective in relation to cosmetic enhancements and in comparison to successful aging; both adjectives in describing aging are fundamentally different. For example, criteria of successful aging are not intrinsic in nature and ignore values such as freedom of choice as an aging woman, respect of gender issues from a woman's perspective, and validation of self as a unique and diverse individual. For women, these dissimilar views (cultural ideal of successful aging versus a woman's perspective of positive aging) could create a conflict of moral values because they are not conforming to the cultural ideal. Aging becomes their fault (Brooks, 2010). Further research is warranted as these issues of moral concern are paramount to women.

Askegaard (2002) interviewed 15 Danish women who had had cosmetic operations. The purpose of the study was to investigate the motivations of these women to have cosmetic surgeries; the feelings and thoughts of the women before, during, and after the cosmetic operations; and the ways in which the aesthetic surgeries had impacted their lives and subsequent self-identity. Askegaard applied Gidden's (1991) work on self-identity in late modernity as the conceptual framework. The framework implies that cosmetic surgery is understood to be part of the individual's reflexive construction of self-identity, and leads to a focus on issues such as self-determination, self-esteem, and the relationship between body and identity.

Five interviews were carried out initially with cosmetic surgeons, industry

suppliers, and health authorities to obtain an overview of the industry in Denmark.

Following this, in-depth interviews with 15 women who had had cosmetic surgeries were completed. This was a purposeful sample recruited through contact with friends, acquaintances, and doctors. Most respondents presented complex and sometimes partly self-contradictory reflections when asked what plastic surgery meant to them.

Findings indicated an increasing reflexivity about self-presentation in social relationships. The owner or manager of the body (the self) is responsible for health, fitness, thriving, and appearance but there is interplay of the psychology of self-images and the social institution of marketing. The women identified that their bodies were the site for self-identity, self-esteem, and self-determination. Because self-esteem is deeply embedded in social interaction, the managed self is very sensitive to the response from others; hence the self becomes the marketed self. But the site of the body is also the site for self-determination, which creates a conflict or moral dilemma between the inner and outer aspects of the self. Consumerism presents appearance (bodily and otherwise) as the prime arbiter of values and conceives of self-development in terms of display of the outer self (Askegaard, 2002). In contrast, the women spoke of self-determination as control that would separate the inner self from extrinsic moral considerations. Other informants expanded on the connection between inner and outer values: social reality of the market influence means being obliged to engage in the construction of the inner as well as the outer aspects of self-identity. In other words, the self-determination to retain a positive inner self about natural, intrinsic beauty which is true beauty based on personal values is conflicted with the market values that compel a woman's inner self to conform to market values, which may be different from how one looks (Askegaard, 2002).

This study was interesting for two reasons: First, I was drawn to the researcher's focus on determining feelings and thoughts prior to, during, and after cosmetic surgery which was a question posed in my research. Second, Askegaard was interested in the impacts from interventions of cosmetic interventions, as was I. However, this study did not include mid-life women who participated in Botox and filler injections, which my study did. There is very limited research on aesthetic interventions overall in this European market, and a need for Canadian research.

However, one Canadian study, Clarke et al. (2007) interviewed 44 women aged 50 to 70 examining their perceptions of and experiences with non-surgical cosmetic procedures such as Botox injections, laser hair removal, chemical peels, microdermabrasion, and injectable fillers. Approximately eight to ten years ago, these non-invasive techniques were considered a relatively new and growing area of aesthetic procedures with women's experiences not yet researched. Twenty-one women had used a range of procedures; 23 women had not. The goal of the interviews was to illicit opinions about non-surgical cosmetic procedures as being oppressive or liberating. Except for two individuals, all the women were interviewed twice for an average of three hours and a total of 147 interview hours.

The purpose of interviewing the two different groups of women was to determine if past choices and direct experiences of non-surgical cosmetic procedures were influential with regard to attitudes toward beauty interventions. The assumption was that those women who had already participated in cosmetic procedures would voice a positive opinion about beauty interventions as a choice for women. In contrast, those women who had not participated in beauty interventions would have a negative or critical opinion

about beauty interventions. The paper employed symbolic interactionism and feminist theory to situate the meanings that women ascribe to aging and aged bodies within a gendered and ageist social world. Both groups of women were similar in age, education, income, marital status, and country of origin. The age range was between 50 years and 65 years of age, the majority had attended college or university, average household income was \$50-60,000 (Canadian), and approximately half were married. Overall, the women who had had beauty interventions tended to have tried more than one intervention.

Some of the women used cosmetic procedures to increase their physical attractiveness, and consequently, their self-esteem, whereas others viewed the procedures as excessively risky. Still, others argued that the procedures stemmed from and further entrenched the social devaluation of women, women's bodies and later life. Twenty-two women, of whom 10 had had procedures and 12 had not, indicated that they were in support of non-surgical cosmetic procedures such as microdermabrasion, photo facials, and chemical peels that treated the outside of the body. However, these women were strongly against injecting Botox fillers under the skin. For these women, injecting substances into the body as opposed to working on the outside of the body crossed a boundary from acceptable beauty work to a level of intervention that they referred to as risky, unhealthy, crazy, radical, invasive, and extreme. However, some of them voiced that participation in non-surgical cosmetic procedures represented an important form of agency in contemporary society, and did not align their use of these beauty interventions within the broader social context of patriarchal oppression or ageism. In contrast, others openly challenged anti-aging medicine and why it was not acceptable to age naturally and without cosmetic enhancements to the body. There are tensions between feeling agency

of self and the belief there is no free will in a social context that is shaped and constrained by societal obsessions of youth and appearance (Clarke et al., 2007). Comparatively, the participating group expressed slight satisfaction to significantly positive feelings due to increased self-esteem and confidence from looking younger and feeling more attractive. The abstaining group admitted to feeling fearful of unexpected outcomes such as the Botox leaking into other surrounding tissue and the unknown long-term effects of using a toxin. These women also expressed a fear of becoming unnatural looking like prominent Hollywood figures such as Joan Rivers or Cher (Clarke et al., 2007).

Summary

The section on cosmetic surgery gives astounding statistics about the expanding number, type and scope of both surgical and non-surgical procedures women use to modify their faces and bodies. In today's current culture, the pressure to not be associated with being or looking old is phenomenal. Statistics from Canadian sources were not found in the literature and very few Canadian studies exist, yet the AAFPRS, ISAPS, and Medicaard Financial Incorporated claim that cosmetic non-surgical facial procedures are just as popular as the leading global cosmetic markets. This revelation makes a current Canadian study such as this even more compelling.

Concerns related to moral behavior surface in relation to the involvement of Medicaard Financial in the support and promotion of the cosmetic surgery industry, inclusive of their own research in an industry where regulation is not guaranteed. In addition, this vast industry is perpetuated by the medical industrial complex, which is in many cosmetic facial situations delivered by non-core trained physicians and paraprofessionals. Popular media such as magazine advertisements do not challenge or

negate the use of age-defying procedures such as Botox which sends a consumer message that the second half of life is devalued and targeted as decline, thus requiring facial enhancements. To fill in this research gap, this study therefore examined the experiences of women who participated in facial injections and experienced negative or mixed experiences, feelings, and perceptions about their decision to have facial injections. From a feminist moral perspective, I chose to focus on this group of women because they had not been given a voice about their experiences and every woman deserves to be heard.

Chapter 3: Conceptual Framework

In this chapter I will explain the conceptual framework guiding my study about aging. The first section provides a brief overview of critical gerontology. Feminist moral theory, my chosen conceptual framework, is a critical theory that gives aging women the opportunity to give voice to their personal lived experiences, which in turn gives value to feminist epistemology and feminist research. As well, critical gerontology informed by feminist moral theory promotes critical consciousness through self-reflection for the purpose of challenging the existing cultural ideologies of aging within the context of the anti-aging industry.

In the second section I discuss a major social theory of aging, the political economy of aging, because the aging of women is a key focus of my proposed research. Defining feminist empowering research, Ray (2008) argues for the need for critical gerontology informed by feminist theories because empowerment as a fundamental mechanism allows people to grow the way that they choose.

The remaining section provides both an introduction and understanding of the relevance of feminist moral theory as my chosen conceptual framework. I explain my understanding of feminist moral theory as the critical theory that best addresses the social constructions of ageism and sexism of women and how these constructions are connected to the unprecedented growth of Botox and other facial injections in which aging women feel compelled to participate.

Critical Gerontology

Critical gerontology derives from the core beliefs of the critical paradigm, which states the world is structured on the basis of unequal power relations and consists of

competing interests (Daly, 2007; Kincheloe & McLaren, 1994). Similarly, feminist theorizing and research is part of the critical paradigm offering explanations of unequal power relations between women and men in various contexts.

Feminist research has been instrumental in shaping the fundamental beliefs of the critical paradigm inclusive of an action orientation, attention to power, attention to history and context, emphasis on inclusivity and social justice, and an emphasis on self-critique and reflexivity (Avis & Turner, 1996; Kincheloe & McLaren, 1994). The intent of researchers using reflexive practices in this paradigm is to bring values issues to the foreground (Daly, 2007) such as values derived from feminist moral theory.

Historically, this critical lens has been informed by the critical theories of Marxism and political economy, the Frankfurt school of Philosophy, the postmodern theories of Foucault, and various feminist theories of the late 20th century (Crotty, 1998). Critical gerontology looks inward as well as outward, critiquing the structures, assumptions, concepts and practices of mainstream gerontology, along with the sociopolitical environments in which individuals age (Ray, 2008). For example, the current notion of successful aging significantly affects gerontological thinking and practice. The term *successful* is used to describe older individuals whose age may imply both connotational and denotational problems. The word connotes a fixed standard, one that seems to have translated into rather precise denotative criteria (Scheidt, Humpherys, & Yorgason, 1999). From a critical gerontological perspective, however, the question can be asked whether the term *successful*, while promoting aging as being active and fully productive in society, also contributes to the underlying cultural and social ideology to look and feel young, hence providing additional pressure to participate in Botox

treatments.

Phillipson (2005) comments on critical gerontology in the tradition of political economy as follows: “critical gerontology provides a much needed supplement to the study of the biological and psychological aspects of aging, which, for all their contributions reveal little about the social construction of aging in a broader sociopolitical context” (p. 504). This perspective fits well with the political economy of aging discussed in the next section.

Political Economy of Aging: A Social Theory of Aging

The political economy of aging is a critical theoretical framework emphasizing the broad implications of structural forces and processes that contribute to constructions of old age and aging as well as to social policy (Estes, 2001). The theoretical model of the political economy of aging is a multilevel analytical framework that attempts to explicate the socially and structurally produced nature of aging. Specifically, the political economy perspective is sensitive to the fundamental connectivity between societal, organizational, institutional, and individual levels (Estes, 2001).

Comparatively, this is where I would situate a culture in which marketing of the youthful female body has become unprecedented in developing and promoting a gendered stereotype of aging. Older people have come to be viewed as a burden on Western societies, with demographic change (especially the declining ratio of younger to older persons) blamed for contributing to economic decline (Phillipson, 2005; Johnson, 2005; Estes, 2001). Perpetuated by a dominant system of power in a patriarchal and capitalistic society, this perspective has resulted in aging women experiencing a loss of worth and functionality. Many feminist political economic scholars concur that the value

systems, normative orientations, moral codes, and belief systems of society are connected to the larger process of class rule and domination (Knuttila, 1996). There is a strong element of gender authority playing a leading role in the perceived self-worth of women as they age (Connell, 2005). This powerful cultural, ideological and historical influence has also shaped negative attitudes of aging through aspects of the *medical industrial complex* and the *aging enterprise*.

The medical industrial complex refers to the vast health industry, which includes doctors, hospitals, nursing homes, drug manufacturers, real estate and construction businesses, health systems, consulting and accounting firms, and financial institutions. It is suggested that the primary function and focus of this huge conglomerate is not the assumed delivery of health services to clients but, rather, the pursuit of profits (Estes, 2001). Medicalisation affects all ages but it has particular implications for women in an ageist society that promote youthful bodies as the norm (Joyce & Loe, 2010).

The aging enterprise is a closely related construct first introduced by Estes in 1979. Estes' concern is the way people are treated as commodities within the welfare state especially the older person (Phillipson, 2005). The aging enterprise recognizes the role of the state and institutional action that extends beyond health and into all arenas of health-related activities such as the realm of cosmetic surgery. Promoting the belief that aging ("disease") can be controlled with promises of being able to alter or slow the process, increases the pressure to not appear old (i.e., have visible markers of aging) hence, the phenomenal growth of cosmetic facial procedures (American Academy of Facial and Reconstructive Surgery, 2011; American Society of Cosmetic Surgery, 2010; International Society of Aesthetic Plastic Surgery, 2010). Doctors who traditionally have

been the trusted gatekeepers within the health care system increasingly see women as potential consumers with market value in the market industry of the cosmetic surgery field (Sarwer & Crerand, 2003).

Such commodification of women in today's global societies is promoted and perpetuated via a macro process identified as *informationalism* representative of the current network society, and new capitalistic values that shape and influence the social processes and constructs of aging. Informationalism is a particular way of organizing the material base of society across a full range of social contexts. To connect this specifically to my research focus: equally important is the rise of the network enterprise driving production (Botox and facial fillers), multiple modes of promotion and advertising (cosmetic surgery monopolies), and consumption (cosmetic procedures of the face by women). In all of this informationalism plays an important, enabling role. Without information and communication technology the recent surge in cosmetic facial procedures over the past ten years could not have reached such lucrative, financial heights. No doubt aging women are influenced to have Botox and filler treatments, in part, because of the seductive coercion of the extensive communication web of the network society.

One assumption perpetuated by informationalism is that individuals should be able to overcome personal barriers such as perceived declining looks (wrinkles) and work toward looking younger (by having facial injections). Implicit in the meaning of this rhetoric is the need to have self-discipline and a commitment to *age well* and moderate the burden of welfare risk (be productive) (Angus, 2000; Angus & Nay, 2003, as cited in Angus & Reeve, 2008). Successful aging and productive aging are dissimilar to positive

aging, which was the concept of interest in my research. Research is required because successful and productive concepts are accepted by many in society as representing positive aging (Bowling & Dieppe, 2005; Fischer, Norberg, & Lundman, 2008). From a critical gerontological perspective, I suggest that the term “successful aging” promotes aging as being active and fully productive in society, and also contributes to the underlying cultural and social ideology to look and feel young, hence providing additional pressure to participate in facial injections. The underlying message is that being productive equates to being successful.

Alternately, the positive aging I envision appears to be elusive in the successful aging model for two reasons. First, the indicators or criteria of successful aging are not intrinsic in nature and ignore values such as freedom of choice as an aging woman, respect of gender issues from a woman's perspective, and validation of self as a unique and diverse individual. For women, this different societal perspective could create a dilemma of moral values. Women may be conflicted by different messages about aging and how they are valued as women. Thus, they may experience internal conflict or tension between some of the values that they hold. Second, the right to define and live a subjective perception of positive aging without the overwhelming influence of looking younger is paramount to women everywhere from a feminist moral perspective.

The reality, though, is that aging is promoted as a disease requiring technological intervention if positive aging is to be realized. This creates a moral dilemma because of a difference between internal values and external market values. Botox and facial fillers are heralded as the intervention to wind back the biological clock, and are assumed to be a matter of preference among consumers but in fact the political economy of aging

perpetuates the market by creating the necessary conditions for the anti-aging medical industry (Petersen & Seear, 2009).

Feminist Moral Theory

I chose Feminist Moral Theory as the conceptual framework to explain how the state (the macro-level of society) exerts an influence on women as they age in the context of social constructions of sexism and ageism, and the resultant pressure to appear youthful in a society that devalues the second half of life. This critical conceptual framework brings passion, commitment, and vision to inquiry and is focused on outcomes of conscious self-reflection, empowerment, and social change, which relate to my values as well.

Philosopher and social psychologist George Herbert Mead (1863-1961) postulated the thought that every person is a social construction (Crotty, 1998). Social forces influence human behavior thus, the role of ethics is necessary in knowing about these social forces that influence cosmetic procedures, and whose values are being represented in these procedures. For example, is it the aging woman or ageist, sexist societal attitudes and marketing profits? In this research, ethical perspectives were considered in relation to the “why” behind cosmetic procedures for women, and the subsequent, perceived consequences versus benefits that follow. Feminist ethics in various contexts looks at the impact of intersections and distributions of social authority, privilege, and power both on morality as an aspect of social life and on ethics as the reflective and systematic representation of morality (Walker, 2003). Being morally reflective about a social and cultural practice such as cosmetic facial procedures and the long-term moral impacts on aging women is an important research field considering the imminent and historical

demographic boom of aging women in Canada and elsewhere in the world. This is the context or frame of reference from which feminist moral theory will be applied.

Ethical work has not much addressed situations and experiences of women, or the ways that gender in our society distinctively shapes the reality, experience, and meaning of aging (Walker, 1999). Thirty years ago there was no field called feminist ethics.

Although much of the work originates in philosophy, other fields including sociology, psychology, education, medicine, theology, and business have entered the debate about the meaning and application of feminist ethics.

Most of the great western philosophers assigned a higher ethical priority to men's interests than to women's, contending that women's proper role was to support men in their undertakings. Jagger (2000b) writes about one theme originating from ancient times that has had a bearing on modern western ethics: that women were incapable of the same moral perfection as men. Aristotle wrote that women's temperance, courage, and justice were of a different and lesser kind than men's, whereas Rousseau asserted that women's merit consisted in such "feminine virtues" as obedience, silence, and faithfulness. In general, many philosophers argued that women's capacity for reason was also different from and inferior to men's. Because the western tradition typically regards rationality as the essential human characteristic, often defining moral agency in terms of the capacity for reason, arguments that women's reason is inferior to men's are deeply damaging to women's aspirations for equality. Moreover, by entailing that women had less moral authority than men, they provided a strong rationale for placing women under men's political authority.

The history of ethics in the modern period has continued to evolve with male

citizen-administrators, still working in a deep historical context of patriarchy, to enable their governing (Frye, 1990, as cited in Walker, 1992). During the 1980s, from a feminist point of view, challenges to the standards by which moral rationality and subjectivity were judged began to develop. The two next sections will describe the assumptions and concepts of feminist moral theory based essentially on the following perspective expressed by Walker (1992): "Feminist work on ethics attends specially to the ways in which ethics in the Western philosophical tradition is not only not *by* or *about* women, but not *for* women either: neither faithfully reflective of women's many different, actual lives nor helpful to their projects of self-discovery and political change" (p. 23).

Assumptions. The history of philosophy, including the history of ethics, has been constructed primarily from male points of view and has been built on assumptions and concepts that are not gender-neutral. From a feminist point of view, moral theory will have to be transformed to take adequate account of the experience of women; in part, by taking an approach to moral epistemology that is simultaneously feminist and naturalist (Cole & Coultrap-McQuin, 1992; Gilligan, 1982; Held, 1993; Jagger, 2000a; Jagger, 2000b; Jagger, 2008; Walker, 1989, 1992, 1999). The focus is on concerned moral inquiry, on understanding from a feminist point of view, on making recommendations on behalf of women (and other social groups who experience marginalization), and on identifying and explicating better social constructions than those currently existing in a patriarchal and capitalistic society. In other words, the aim is to construct moral views that are more reflective of the interpretations and beliefs of women. Two basic assumptions derived from this focus that are relevant to a feminist conception of moral life are as follows: (a) women and their values are of profound moral significance in and

of themselves, and (b) social institutions and practices have encouraged discrimination against women and the suppression of their moral views (Cole & Coultrap-McQuin, 1992).

To further explain, traditional moral philosophy has been dominated by men. Consequently, their values have transcended many social institutions and practices. Male values and perspectives are disparate with women's values because historically the lives and experiences of women have not been considered or included in the development of ethical theories. And as Walker (2003) has succinctly stated, feminism represents women on moral grounds against the economic, political, social, sexual, epistemic, discursive, and symbolic power that has denied to them by individual, institutional, and cultural male dominance.

Concepts. From these assumptions, concepts have been developed, keeping in mind that different contexts and a variety of feminist disciplines with diverse perspectives help to shape concepts relevant and meaningful to a particular area of feminist thought. For example, Jagger (2000b) writes that in healthcare ethics, feminists charge that prevailing conceptualizations of the "normal" patient as male and white led to inappropriate treatments being given to women, especially women of color, and to construing women's normal bodily experiences, such as menstruation, pregnancy, birth, lactation and menopause as illnesses. The context of my inquiry, as previously mentioned, is located in the social and cultural constructions of sexism and ageism that influence the aging experience of women by a capitalist and patriarchal dominance. Several concepts from feminist moral theory guide this inquiry: (a) reason and emotion, (b) the ideology of the public versus the private domains, and (c) the concept of self.

Traditional male-biased approaches to moral theory such as Kantianism or deontology and Utilitarianism posit that emotional attitudes toward moral issues themselves interfere with rationality and should be discarded. Both of these approaches promote the rules of reason in moral contexts, and both denigrate emotional responses to moral issues (Held, 1993; Jagger, 2000b). Putting this into the context of the decision to have Botox and then experiencing mixed feelings or regrets, feminist moral theory attempts to understand from the voices of these women because feminist moral agents respect that there is a difference between male and female approaches to knowing. Moral agents can and should discover, assess and weigh everyone's preferences, needs and interests in an unbiased way (Thompson, 1994).

In reevaluating the place of emotion in moral theory, feminist philosophers consider two aspects. First, many think morality requires the development of the moral emotions (in conjunction with moral reasoning), in contrast to moral theories emphasizing the primacy of reason alone. Second, emotion will be respected rather than dismissed by many feminist moral philosophers in the process of gaining moral understanding. Modern moral philosophers have offered a variety of recommendations for achieving impartiality, such as disregarding one's self-interested motivations or adopting others' points of view, but a number of feminist critics have argued that these recommendations are unhelpful and unattainable because they cannot be operationalized in practice such as in the plastic surgery industry.

The decision to have Botox or facial filler treatments may seem rational based on the underlying premise that informed choices are rational decisions. This includes explanations by the medical-cosmetic professional about the technique, success and

complication rates, risks, alternatives, the relative risks and complications of alternatives, costs and the role of each team-member in the procedure. Being informed is the cornerstone of autonomous decision-making. Capacity or the ability of the client to grasp the essentials of these explanations, to rationally deliberate and then choose to have the facial injections or not, is the central determinant of autonomy (Roubaix, 2011). The final step is the un-coerced choice to undergo or refuse such procedures. Herein is the concern of feminist moral theory: Do women do feel coerced to have their bodies altered to comply with patriarchal notions of the ideal: beautiful or normal, and youthful? The underlying dynamic is a culture that shames and devalues women who deviate from this unrealistic aesthetic ideal. The question then is do women truly make free choices in favor of Botox and other filler treatments under these conditions?

The ideology of patriarchal values within the male-dominated cosmetic surgery industry manipulates women's emotions as a motivation to participate in self-improvement by aesthetic surgery. It is noteworthy that in the United States, in 2006, of the 7,003 doctors who were board certified in plastic surgery just 623 were women (Singer, 2006), and information from the American college of Physicians in 2004 indicated only 25% of practicing physicians were women (Levinson & Lurie, 2004). The ratio of male to female cosmetic surgeons in Canada is not available. Following is a summarized account of personal autonomy, applicable to current notions of informed choice:

I wish my life and decision to depend on myself, not on external force of whatever kind. I wish to be the instrument of my own, not other men's act of will.

I wish to be a subject, not an object; to be moved by my reasons, by conscious

purposes which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody, a doer, deciding, not being decided for, self-directed and not acted upon by external nature or by other men.

(Roubaix, 2011, p. 12)

Respect for personal autonomy is central to feminist moral theory, but is this common practice in the cosmetic surgery industry? As a researcher, a healthcare professional, and a mid-life woman with a commitment to an ethic of caring about the well-being of others, I have concerns that the ethical principles of beneficence (to do good) and non-maleficence (to do no harm) may be unattainable for some women who choose to have facial injections.

Feminist moral theory on behalf of women and in contrast to traditional moral philosophy dominated by men offers more appropriate understandings of “private” morality and “public” life. The personal or private life is highly affected by the political power within the public sphere. Concepts for thinking about the private and the personal, the public and the political are required but they need to be very different from the traditional concepts ruled by patriarchal thought in the public domain, in which women are viewed as belonging in the private realm of the household. These historical standards and ingrained concepts are pervasive, and transcend social thought and cultural ideals reinforcing certain patterns of behavior and/or assumptions. Feminist theorists are rethinking and reorganizing the private and the public, the personal and the political, and thus morality by paying attention to real-life practices of moral inquiry, including those used by women (Held, 1993; Jagger, 2000a).

The personal aging experience and natural biological process of aging has become

a very public event because of the anti-aging industry as evidenced by the phenomenal growth of cosmetic surgery, inclusive of Botox and facial filler treatments. Billions are spent annually on the anti-aging industry, and the words “eternal youth” produce more than 1.25 billion Google responses (Goh, 2009; Roubaix, 2011). Control over how women wish to experience and celebrate their aging bodies has become a societal obsession. Feminists argue that aesthetic surgery exists because sexism and ageism are linked to capitalism and the medical industrial complex within the political economy of aging. Aging females are bombarded with messages to preserve their youthful appearance to retain jobs, have feelings of self-worth or be valued by a culture that disdains wrinkles on an aging face. The journey towards and through the second half of life is perpetuated as one of decline and disease by the medical profession that markets many non-surgical cosmetic procedures of the face.

As mentioned previously, the traditional emphasis on healing as the central concept in healthcare has transcended over the past twenty years into lucrative and highly-advertised businesses with physicians involved in for-profit entrepreneurships (Werhane, 1990). The development of this “market place” mentality of the healthcare system by cosmetic surgeons raises moral concerns on behalf of women. The traditional aims of medicine such as prevention, healing, alleviation, and empathy underpin the respect that physicians have been allotted. The adoption and promotion of cosmetic facial procedures as a monetary benefit from the commoditization of women’s aging faces challenges the moral responsibility of these physicians. Consumer-driven medicine in the public domain is promoted by industry-driven medicine with a strong motivation for profit which, in turn, leads to questionable practices. As the concepts of beauty undergo

changes, and wrinkles, fat deposits and sun-damaged skin are no longer acceptable as real or perceived aging issues by clients and doctors, the ethical considerations also need to be focused upon. Enhancement versus therapy, risks, patient autonomy, and informed consent are issues that need to be reconsidered and emphasized when considering aesthetic surgery (Mousavi, 2010).

There is increased interest among medical and dental practitioners offering aesthetic procedures for which they were never trained during their medical training, and there are an ever-increasing number of beauty parlors and charlatans providing scientifically unproven aesthetic services and making unproven claims (Goh, 2009). Professionals have a moral duty to protect clients from practitioner-associated risks such as impairment, incompetence, and inexperience. These professionals may be neglectful and unconcerned due to improper training (evidence-based aesthetic dermatology practice) (Goh, 2009; Mousavi, 2010). Publication of complication rates and occurrences may prevent undue moral impact on women who participate in Botox and facial fillers but these calculations are not routinely performed (White, Tanzi, & Alster, 2006). For example, are women informed that Botox, a neurotoxic protein causes temporary muscle paralysis beginning one to three days after an injection and lasts for three to four months? A consequence during this time period is the slowed response of facial emotions possibly putting the client at social disadvantage (Bower, 2010).

Most concerning is a revelation by Goldacre (2012) that certain studies are not published or made public by pharmaceutical companies within the medical industrial complex. Although not focusing specifically on Botox or other facial injections, Goldacre reports on the expansive and very lucrative pharmaceutical companies, worldwide,

producing billions in profits annually, who appear to suppress negative results (side effects) of their products. This medical industrial complex likely includes cosmetic pharmaceutical companies. And because negative side effects are suppressed or not published, targeted, uninformed women consumers are unaware they are at risk of the product's potential for harm.

The power of morality in the context of women participating in Botox and filler treatments promote moral reflection about the dominant ideology behind the vast cosmetic surgery industry; the ideology that determines aging women should look youthful and attractive by eliminating the appearance of wrinkles. In addition, the goal of feminist moral theory in reference to the new relational self is describing the opportunity for women to become aware of an alternative enlightening-feminist consciousness in which they can connect to where the focus is relationships that form and sustain individuals (Brennan, 1999; Sherwin, 2008; Walker, 2001). For example, women who may choose to celebrate natural, biological wrinkles but do not want to be devalued or demeaned for this decision can be supported by a feminist ideology that empowers women to make these individual and personal choices from an ethics of caring and of responsibility to the self.

I have concerns about a cosmetic surgery profession that purports to know the facial ideal for women who are aging and the evident need for these women to participate in Botox to fashion a different and youthful face. In a 2008 article from POST-OP, a Canadian cosmetic surgery newsletter from Stony Brook University Medical Center in Ontario, one medical practitioner wrote that even minor changes to the face can be beneficial whether it is a matter of having more confidence in one's ability to interact

with others in personal life; helping to enhance impressions in professional and career situations; or simply feeling better overall by retaining or regaining a youthful look. Yet, there can be serious risks for women who are influenced and coerced by this widespread rhetoric associated with this type of power or assumed moral authority. I refer to the social constructs of sexism and ageism that are perpetuated by the vast number of cosmetic surgery enterprises. The alternative as mentioned is a feminist morality that provides a lens to look at and understand what women with mixed feelings and regrets have experienced within the cosmetic surgery realm.

Conclusion

As societies or groups become more complex, modernized, and stratified, the nature of moral consensus becomes equally complex and multifaceted such as evidenced by the vast medical industrial complex. Critical gerontology on behalf of aging women is the lens through which to critique these complex networks of domination and exclusion in postmodern times. I refer to the coercive cultural influence that perpetuates a youthful embodiment of aging women, and exclusion of personal values that could challenge the prolific anti-aging industry, which encompasses the phenomenal growth of Botox and facial fillers to hide the natural effects of facial aging.

Consider the influence of the political economy of aging on the cosmetic surgery field. The influence on this field, in particular, elicit questions about the moral impact on experiences and lives of individual women and their consciousness, and inevitably because of these influences how women perceive positive aging. Conventional ideology praises egoism, self-reliance, independence, and gainful productivity as the measure of worth. Currently, age is not inclusive enough to understand what happens as women

become older but attention to moral economy provides additional insight into how life unfolds (Hendricks, 2005). The existing system of power and domination in an advanced capitalist society offers a broader view about growing old as a woman: she is part of a socially constructed process with market value for the cosmetic surgery market.

In summary, feminist moral epistemology is more than simply a set of negative critiques against traditional male-biased moral theory. The naturalistic challenges that feminists have applied to ethical rationalism do not mean a rejection of moral reason; instead feminists seek rather to reinterpret moral reason in light of empirical investigation into the practices of real moral agents, inclusive of women. As naturalists, feminists begin from the empirical recognition that the insights of moral agents are always conditioned from their own social experiences and locations (Jagger, 2000a).

Recognizing the importance of contextual and narrative experiences rather than formal and abstract investigations is a key tenet of this study. This is the basic premise underpinning the methodology of phenomenology that I used, which is discussed in Chapter 4.

Chapter 4: Methodology

Feminist moral theory is distinguished by its exploration of the ways in which cultural devaluation of women and the feminine may be reflected and rationalized in the central concepts and methods of moral philosophy (Jagger, 2000b). As a critical theory, “feminism empowers and requires us to think very differently about the purposes and methods of social science than we have been able to do within the confines of hegemony of androcentric science and world view” (Dubois, 1983, as cited in King, 1994, p. 21). Research based on the patriarchal perspective of traditional science, both past and present has contributed to the perpetuation of women’s position of subordination within society (King, 1994).

A feminist moral orientation (Jagger, 2008) and Heidegger’s (1962, trans. 2008) strand of phenomenology supported me in perceiving and understanding women’s lived experiences of facial injections. As a researcher using a feminist moral framework to inform my methodology, my research questions are pertinent to women, are of interest to women, and were developed from the social and cultural context of the anti-aging industry within a patriarchal society. Moreover, I also acknowledge that from an epistemological standpoint it is only through women’s personal experiences and voices that we, as perceived learners, can truly come to understand the gendered world and its implications and moral impacts.

Accordingly, consistent with a feminist moral orientation, the methodology of interpretive phenomenology was deemed as most appropriate for this research study. Interpretive phenomenology as a methodology offers a descriptive, reflective, interpretive, and engaging mode of inquiry from which the essence (meaning) of an

experience may be elicited. Experience is considered to be an individual's perceptions of her presence in the world at the moment when things, truths, or values are constituted (Richards & Morse, 2007; Stewart & Mickunas, 1974; van Manen, 1990). The remainder of this chapter is devoted to describing this chosen strand of phenomenological methodology.

Research Design

Phenomenology aims at a deeper understanding of the nature or meaning of people's everyday experiences (van Manen, 1990). Specifically, it is the study of the lifeworld, the world as it is immediately experienced it pre-reflectively rather than how it is conceptualized, categorized, or reflected on. van Manen (1990) offered six approaches for interpretative phenomenological inquiry and analysis of the data, which I used as a guide. His approach represents a dynamic interplay among six research activities. The first approach is turning to a phenomenon, which seriously interests one and commits one to the world. Second, the phenomenological experience is investigated as it is lived rather than as it is conceptualized. Third, the essential themes, which characterize the phenomenon, are reflected upon. Fourth, the phenomenon is described through the art of writing and rewriting (re-thinking, reflecting, re-cognizing), which aims at creating writing that has depth. Fifth, a strong and oriented pedagogical relation is maintained to the phenomenon. Finally, consideration is given to balancing the research context by considering parts and wholes (conceptualized as the hermeneutic circle). These practical approaches by van Manen have been adopted by other researchers as well (Hentz, 2002; Ray & Vanstone, 2009).

My research design involved in-depth interviews, using semi-structured and open-

ended questions (see Appendix A) with Canadian and American women between the ages of 35 to 65. Initially, an age range of 40 to 65 was chosen because it represented the age cohort most targeted by age-defying advertising, as well as the age cohort that participates most in Botox (American Academy of Facial Plastic and Reconstructive Surgery, 2011; Thornberry, 2011). From my perspective it also seemed the best representative age range in referring to mid-life, although I concur that ultimately it is each woman's own personal perspective to determine if they are in mid-life. It was also my perspective that this age range of women was most appropriately able to define positive aging, which was a focus of this study from a gerontological standpoint. The age range was broadened out to age 35, however, due to difficulties in finding participants. Moreover, I originally planned to interview only local women, but this was then broadened out to Canada and the United States, also due to difficulties finding participants.

Interpretive Phenomenology

Phenomenology is both a philosophy and a research methodology. As such, I will expand on the philosophy behind interpretive phenomenology drawing particularly from Heidegger (Dowling, 2007; Merleau-Ponty (1948, trans. 2004); Smythe, Ironside, Sims, Swenson, & Spence, 2008; Stewart & Mickunas, 1974; Toadvine & Lawlor, 2007; van Manen, 1990). Implementing a method without an examination of its philosophical basis can result in research that is ambiguous in its purpose, structure, and findings (Lopez & Willis, 2004).

In earlier phenomenological methodology, the natural attitude (preconceptions and assumptions) was bracketed because it was believed the researcher's perceptions

would be distorted and biased as to what to see and how to see it (Stewart & Mickunas, 1974). Failing to suspend one's taken-for-granted presuppositions represented the existential "kiss of death" in researching lived experiences (Garko, 1999). Alternately, Merleau-Ponty posited the natural attitude of common sense (rationality) led researchers to overlook the phenomenon of the perceived world (Merleau-Ponty, 1948, trans. 2004) such as women's perspectives described within the assumptions and concepts of feminist moral theory. Interpretive hermeneutic phenomenology does not bracket out pre-understandings of the phenomenon, to better articulate the essence of the phenomena. Heidegger believed as do I that one's understanding is already there and cannot, nor should, be unconnected from our thinking and interpreting (Smythe et al., 2008), which is supported by Dowling (2007) and van Manen (1990). The ability to put aside personal feelings and preconceptions is more a function of how reflexive one is rather than how objective one is. "Bracketing and reflexivity are fruit from the same tree" (Ahern, 1999, p. 480). Moreover, in terms of a feminist orientation and the phenomenology of Heidegger (Dowling, 2007; Smythe et al., 2008), reflexivity allows researchers to perceive and understand women's lived experiences with greater existential depth and breadth, and to see hidden sides and meanings of women's lived experiences.

I did journal throughout the research process, with the intent to enhance my ability to be reflexive and understand how my experience and knowledge enhance my interpretation of the data rather than bracketing to eliminate it. This is existential bracketing and it is a critical shift from the historical phenomenological bracketing (Gearing, 2005). Following is a further description of interpretive phenomenology that has emerged from Heidegger (Morse, 1994; Welton, 1999) and drawn from his insights

of existentialism.

Existentialism

The chosen lifeworld existential of *corporeality* (or *lived body*) as an existential contribution to interpretive phenomenology was chosen to be the most appropriate guide to reflection. The three other life-world *existentials* can be addressed as they emerge during the research process. These four existentials can be differentiated from each other but not separated. The two additional existentials that were used for guides to reflection in this research process were *lived time (temporality)*, and *lived human relation (relationality or communality)* regardless of the historical, cultural, or social situatedness (Merleau-Ponty, 1948, trans. 2004; van Manen, 1990).

These existentials (modes of being-in-the-world) all form an intricate unity referred to as the lifeworld or our lived world (lived experience) (see Appendix B). In studies, the researcher can study a specific lifeworld existential, while realizing this one existential always calls forth the other aspects (van Manen, 1990). Merleau-Ponty helps us understand that embodiment is essential to life situations where the presence of the body gives the other life existentials their meaning (time, space, and relation) because the experience of one's bodies is an interpersonal or relational experience (Ray & Vanstone, 2009; Todres, 1998).

I believe it is important to indicate the lines of compatibility between interpretive phenomenology and a feminist moral research perspective, which is the perspective of this study. The life-world is the foundation upon which phenomenological thought and research is built. Investigating and understanding the everyday world of women's experiences is paramount to feminism and feminist research. The methods and

procedures of phenomenology intend to describe and understand phenomena as lived experiences rather than to explain experiences to predict and control them. The latter sentence captures precisely what feminist moral scholars say has happened to women's lives and experiences, and has been addressed in earlier sections of this study describing traditional male-approaches to moral theory. A phenomenological perspective of consciousness is what connects humans to existence. It is how beings relate to and intentionally give meaning to phenomena. What is essential to feminist morality also is the possession of feminist consciousness (Stanley & Wise, 1983). This means to have a radically altered consciousness about oneself, others, and the world. The primary reason for transforming society's patriarchal values is because women's lived experiences of sexism and ageism have historically and socially been embodied in their consciousness, which derives from the cultural values of men (Lopman, 1988). Like feminist moral philosophy, the ultimate objective of phenomenology is not theoretical justification, but the awakening to a special way of life, usually called authentic existence (Spiegelberg, 1960). Interpretive phenomenology and a feminist moral research perspective both assume the researcher and researched are interdependently and humanly linked, that existential truth and meaning are gained through the intersubjectivity of the subject and the object and that the relationship is a dialectical and dialogic relationship. This is a basic tenet of my qualitative research study.

Participant Recruitment

Recruitment posters (see Appendix C) were posted at the beginning of March, 2012 at many different venues throughout the Halifax Regional Municipality. These included but were not limited to the following: libraries, grocery store chains, coffee

shops, university campuses, women's washrooms at restaurants and dinner theatres, large fitness centers, ferry terminals, to colleagues and friends for disbursement at their work places, and limited spa and hair salons. The study was also promoted through word of mouth.

I recruited and interviewed only one participant for my study within a time period of six months of research promotion. Although this stage did take longer to recruit study participants it was a valuable and interesting experience of reflection, and increased awareness of existing issues of aging women within an ageist and sexist culture. For example, I was aware that pull tabs had been taken from some of the recruitment posters but still I received no calls for participation. It seemed to me that women within the initially stated age range were hesitant or fearful to come forward and talk about their lived experiences.

As well, opportunities for recruitment were denied by many establishments, which seemed to be a conflict of interest for them in their marketing to these potential participants (addressed further in the discussion chapter). This knowledge made the study more compelling but the challenge to encourage women to participate in my study was one that necessitated additional recruitment strategies for analysis to move forward. These included the following: an editorial and photograph in the Dartmouth Snap (local paper), an interview and ad in the Chronicle Herald newspaper, an interview on CTV Morning Live television program, on-line Kijji notices (a large advertising site), public speaking opportunities, (e.g., Sheet Harbour Lea Centre where 20 women between the ages of 22 and 80 years of age came to hear about my research study), and telephone-networking with various cosmetic industry venues with para-professionals or physicians

giving Botox. During this earlier stage the university Research Ethics Board (UREB) approved changes for expanding the title to include the addition of facial fillers (Juvéderm, Restylane), and to add pull tags to the posters. One more participant was recruited during this expansion.

Eventually, two major geographical criteria changes approved by the UREB did benefit recruitment. Initially, the geographical area for this study was the Halifax Regional Municipality, which then was expanded to all of Canada following an extensive and varied promotion stage for recruitment. This geographical change expanded the sample size to three participants. The final extension was to the United States via participant interest from an online Botox Community Support website. The age range was also extended to 35 years of age, as this was the age of one earlier interested woman although she did not participate in the end. Finally, criteria naming Botox as the product for facial injection was extended to reflect popular market additions (Dysport), and participant preferences for facial fillers (Juvéderm, Restylane, and Fortelis). I recruited one more Canadian woman and three women from the US by recruitment on the Botox Community website. The final sample size was seven women: four from Canada and three from the US.

I conducted five interviews by telephone, and two in person. Although the option of Skype had been offered, all distance participants declined. The two face-to-face interviews were within the Halifax Regional Municipality. I explained in more detail about the purpose of the study, and provided examples of questions from the interview guide so the participants could determine if the questions posed any concern or risk of upset to their personal lives. As well, it was explained that the questions were framed

within the context of women's perspectives on positive aging within current society inclusive of the culture of anti-aging.

Each participant involved in the face-to-face interviews was given the opportunity to choose where and when the interviews would be conducted to ensure privacy, and to promote an atmosphere of relaxation and comfort. It was important to develop rapport and trust, which occurred in two different settings: face-to-face and telephone interviews. Each initial contact prior to the interviews was precipitated by conversation that was individualized depending on how I and the participants perceived each other. I shared with all participants that although I had not participated in any non-surgical cosmetic procedures of the face, I did identify with their age and gender cohort, which was the focus for the research study. Ultimately good rapport connected us by virtue of being women living within the same social and cultural influences. All were interested in the research questions, although from different perspectives. I wanted to give all women a voice, not only those who heralded the benefits of Botox (or other market choices). Each participant was given an explanation of the process for each interview, and they signed an informed consent letter (see Appendix D) prior to commencing with the interview.

Interview Process

Women were interviewed using semi-structured interviews (see Appendix A). When several participants are interviewed for descriptions of a specific phenomenon being studied, it is expected that each participant will respond according to their individual standpoint from where they perceive the phenomenon and that different perceptions, at different times and places, which cross each other in inter-subjectivity and present common meanings, which in turn will enable the researcher to understand

through interpretive thematic analysis the structure of the phenomenon (Sadala & Adorno, 2002). The interpreted structure obtained from one person should be found in the experience of other persons if it has empathic generalizability (Osborne, 1990). Finlay (2005) reports the term empathy is the English translation of the German term *Einfuehlung*, which means 'feeling into' or gently sensing another person or object in the process of trying to appreciate it. When this idea is applied to the human world, empathy is generally understood as entering another world. It is a relational process of acquiring knowledge of an existing, other lived-experience, and relating to it.

The lifeworld, the world of lived experience, was both the source and the object of phenomenology, and the lived-experiences were the data, or material on which to work (van Manen, 1990). It is important to understand how researchers learn to conduct interviewing for the purpose of data generation (Roulston, de Marrais, & Lewis, 2003). As a novice interviewer in a qualitative research study, my goal was to enhance my interview skills, which would benefit data collection. My readings for telephone interviewing were *Internet Recruitment and E-Mail Interviews in Qualitative Studies* (Hamilton & Bowers, 2006), and *Interviewing by Telephone: Specific Considerations, Opportunities and Challenges* (Block & Erskine, 2012).

The initial interview guide evolved with the addition of new questions because I followed the trajectories that some participants took or similar concepts emerged among participant interviews, which directed me to follow that line of thought. All these trajectories (parts) were significant and contributed to the over-arching research question. This realization caused the focus to deviate slightly but definitely within the context of the research questions, and which I knew was what was perceived as being beneficial to

capture rich data (Hansen, 2006). I was able to see three existentials (body, relations, and time) emerge from the data via the participants, as early as in the first transcription, and this participant information gave direction to my questions. When I received the data findings from the first woman who experienced life-altering side effects, it caused me to reflect on, and develop different interview questions for the follow-up interview. The lived experiences and outcomes were completely unexpected by me, and necessitated new interview questions to draw out this new data.

The interviews were digitally recorded and transcribed verbatim by myself. I believed as a novice phenomenologist I would benefit from transcribing to maintain the connection already established with the participants. As well, as I transcribed I wrote up my observations, comments, and further questions from recall of the interview while listening to the interviews.

Observations through field notes documenting thoughts, impressions, and preliminary interpretation of the data were recorded, with permission of the participants, during the interviews, to provide context for the discussions and to guide the interpretation of the data. The technique for knowing the full story of the participant meant developing visual, audio, and sensory skills. This tactile strategy promoted a full embodied participation and presence with the participants (Sandelowski, 2002). All participants were accommodating with the observations and recordings. Because there were only two face-to-face-interviews, additional time was spent cultivating interviewing and communication style in more depth for the five participants interviewed by phone (Miller, 1995).

As a healthcare professional working with mostly midlife women over a number

of years, there was a comfortable and natural atmosphere speaking across a table as researcher with the participants or over the telephone. I conducted two interviews per participant, each lasting approximately one hour. Each initial interview commenced for each participant with the same introductory sentences: Can you share with me what your thoughts and feelings are about growing older? How do you think society views women as they age? And finally, how do you perceive yourself at 70 years of age? The age for reflection varied depending on the actual age of the participants. These questions framed the context of the research.

The second interview commenced with me reviewing specific responses from the first interview. The initial interviews identified emerging themes, meanings, and inconsistencies. This follow-up interview offered the participants the opportunity to expand on comments, or to clarify previous responses that were intended to embellish and enrich the data from the interview. Two participants did ask to have certain pieces of information removed from the transcript, which I complied with. Transcribed data from the first interview also directed me to add questions that could give deeper meaning to the lived experience of having facial injections to reduce signs of aging. For example, following the first participant interview I added: "What has been your most valuable experience or outcome from having participated in Botox or facial filler?" An additional goal of data collection was to be attentive to the trajectories, ideas, and feelings introduced and expressed by the women. Following the final interview the participants were asked to respond to a brief demographic questionnaire (see Appendix E).

Data Analysis

The core process of qualitative analysis was carried out in Microsoft Word. It

began initially with the first interview and was followed by the reading and re-reading of the transcribed interviews. van Manen's (1990) four lifeworld existentials were applied as a theoretical coding framework to assist in organizing and developing the meanings related to the phenomenon being studied. The format of the analysis throughout the study maintained a staggered pattern of analysis. For example, I was engaged with two to three participants each at different layers of my coding pattern, and this process on a continuum directed me to new views of the collected data. The various coding levels follow: reading through and pulling out data connected to the existential modes of each participant, aligning the similarities but noting the differences of each, sorting the existentials into before Botox and after facial injections categories, and then aligning the like data (the initializing of the themes) of the participants. To know the participants better, I also coded unique terms and words of each participant and any observer questions and comments of mine were noted in the transcript margins to explore and reflect on later.

This stage of the analytical process involved returning to the women for review and clarification about what had been said in response to the initial interview questions, and then rewriting to include any additional comments or clarification from them prior to commencing with the second part of the interview (remaining questions). Analysis also directs the researcher to go back and refine questions, and pursue emerging prospects of inquiry in further depth (Hansen, 2006). This insight guided my decision to add a question about relationality with mothers, which had been introduced by participant one during her interview, and then again with the second participant but on this occasion both parents were identified with having meaning about influences in decision making from

the past (relationality and temporality). This is how I allowed the data to speak for itself. My initial draft of themes evolved over time as I went deeper into the data. As I developed the themes, I identified quotes that reflected each theme for every participant. Some themes had many quotes, others less but this was how the analysis continued and evolved until the finalized themes were clarified.

During this reflective part of the analytical process many ideas, perceptions, and realizations came to me. Thus, as recommended by Peters and Wester (2007), I began an intensive, daily habit of journaling, which developed my memory recall and depth perception as I progressed deeper into the data (Koch, 2006). My journal was compulsively maintained throughout the study with dates and times, and consisted of interview notations inclusive of non-verbal communication such as voice intonations and varied emotions, thoughts about alternate interview questions to be added, the evolution of themes in the analysis, and reflections about my own personal feelings regarding the personal information I was privy to during the interviews. Journaling during the promotion and recruitment stage was significant for identifying the challenges and insights about being an aging woman within certain aspects of the medical industrial complex and the aging enterprise (anti-aging industry).

I collected and analyzed data until saturation occurred with seven participants. Guest, Bunce, and Johnson (2006) note that is an appropriate number for saturation. During this analytical period, I discovered I had to pull back from the analysis on a few occasions as I was becoming immersed with the experiences, and the reality of the meanings of the participants' lived experiences, as a whole. I learned first-hand about the meaning of the "parts and the whole" or the hermeneutic circle (van Manen, 1990;

Whitehead, 2004). I became so involved with the analyzed data that I no longer could make sense of the parts and whole. I was also affected by the social injustice I was hearing about, as well as the reported unethical behavior of the physicians, and recognized that I needed to gain some distance and perspective on this to ensure my own views were not overly influencing my connection with the participants and their interviews.

Trustworthiness, Validity, and Faithfulness to the Phenomena

There are varied and multiple perspectives on validity and reliability in qualitative research. One perspective is that validity and reliability are enhanced in smaller-sized studies (Guest et al., 2006). The manageability (smallness) of this study sample permitted greater participation and observation by me: certain reports by participants (fears of future potential addiction to facial injections, suicide attempts) were confirmed by more than one participant in the small study where I had established rapport and trust. This relationship is difficult to explain to those who are used to eliminating or reducing observer bias but there is credibility in knowing the researcher is known and trusted by the study participants, thus, reports are reliable (Morse, 1994).

Moreover, qualitative research can be considered reliable and validated if researchers purport to following a particular phenomenological philosophy and methodological tradition and then proceed to do so (Finlay, 2009). Incorporating phenomenological literature into the phenomenological findings makes it congruent (Richards & Morse, 2007). Additionally, if research claims to be strictly traditional “Husserlian” phenomenology but there is no reduction of the data by traditional bracketing, it is not reliable. Similarly, such as in this study, using the Heideggerian

stream of phenomenology I did not “bracket” and thus did not “transcend” the assumptions of the participants (Finlay, 2009). My claims are valid and reliable from this methodological perspective.

During data collection, analysis, and interpretation I did check back with the participants for “goodness of fit” (Marshall & Rossman, 1999). This refers to follow-up with the second interview and clarifying any comments, or questioning a particular statement made by the participants, which would embellish the data. As well, one participant requested that I remove some personal information and another was concerned about her overuse of ‘ums’ and other poor grammar but I assured her these would be removed.

In addition, a crucial means of validating interpretations of phenomenological data is the juridical process of presenting coherent and convincing arguments. Acceptance of the interpretive process is dependent upon rhetoric that convinces members of the research community, which did occur for me at a conference presentation in 2013 (Berwick & Humble, 2013).

Validity of the interpreted structure of the phenomena also depends upon the extent to which the structure resonates with the experiences of other women outside of the study who have experienced the phenomenon, which is an example of empathic generalizability (Osborne, 1990; Shapiro, 1986). After posting a copy of the research study poster (Berwick & Humble, 2013) on the Botox Community website, I received an e-mail from a woman who had suffered severe side effects from facial injection. She expressed gratitude for this research study, which she felt could possibly prevent other women from becoming ill in a similar way.

Finally, a qualitative research audit trail serves to establish credibility through validity and reliability, and is one of the ways trustworthiness of a study is demonstrated (Rodgers & Cowles, 1993; Wolf, 2003). I created and maintained a large file of substantiating documents (audit trail) as I had become aware of the social injustice aspect and a strong bio-ethics theme flowing through the words of the participants as the data evolved from the analysis. Specifically, I validated certain comments (e.g., black box labeling in the U. S. and Canada) from the news media, and from a bio-ethics perspective, I attended public-interest sessions on Impact Ethics facilitated by Novel Tech Ethics, Dalhousie University to further understand the moral impact being felt by some participants who reported experiencing demoralization and loss of trust from certain factions within the cosmetic surgery industry.

I collected and maintained accurate and connective articles and information related to the contextual background of the evolving data such as new information about the products used in participant injections and reports about pharmaceutical fraud (e.g., Qureshi, Sartor, Xirasagar, Liu, & Bennett, 2011). The article was reporting on pharmaceutical fraud and abuse in the United States from 1996 to 2010. In 2010, Allergan from Naperville, Illinois was fined \$600 million for off-label marketing. Specifically, a physician and five sales representatives were charged and fined.

As well, a number of articles drew attention to the interest of facial injections as follows: Brush, floss and Botox about dentists now offering Botox injections in British Columbia MACLEANS magazine (Counter, 2012). (Hampson, 2011) printed an article in The Globe and Mail called: Will Botox or defying it make you happy? And then in 2012 another article by Onstad stating, The wrinkle revolution: Are women embracing their

age?

Ethical Considerations

Diligence was exercised to ensure that the participants understood fully about the research study and freely gave informed consent. As well, the participants were told that their participation in the study was entirely voluntary, and that they could discontinue their involvement at any time throughout the study without any penalty or prejudice.

I did encounter some emotional situations due to the gathering of personal, intimate, and upsetting recollections about the women's lives. At these times I offered to discontinue the interviewing, and inquired how I might be able to offer emotional support. In addition, names of counselors or appropriate human resources were recommended in the informed consent form (refer to Appendix D) for guidance and support. An article by deMarris and Tisdale (2002) offered some insight and approaches, and specifically about phenomenological interviewing in studies of emotions, which participants could experience such as personal feelings related to the context of the research. I thought it might be limiting with no visual for the participants thus, I scanned and e-mailed a small colored photo of myself in a recruitment ad for the study from a local newsletter. This connection was instrumental in developing an intersubjective bond of rapport and trust.

I related emotionally to some participants experiences, and found support from the above article in knowing these personal emotions were normal but required stepping back from the data to contemplate how best to support the participant but also for myself, as the researcher, to take some time for reflection regarding this unexpected occurrence. Reading from other phenomenological sources (Finlay, 2006) dispelled my concerns of

an ethical dilemma in regards to this unique and emotional connection between the participant and the researcher. van Manen (1990) has described this researcher intersubjectivity as “We live this question, we become this question” (p. 43).

All possible precautions to protect identity and confidentiality were undertaken. As a healthcare professional licensed by the Nova Scotia Dietetic Association as a solidified the required ethical protection that represented the participants’ involvement, perspective, and confidentiality. Participants were given a pseudonym to protect their identity. Personal identifying information was recorded only on the informed consent forms. All audio tapes were erased following the transcriptions and at no time were any identifying information made available to anyone other than myself and my thesis advisor. All documents connected to the study were kept in a locked safe accessible only by me; any electronic files were password protected including electronic copies sent to my thesis advisor. In essence, this meant acting in ways that not only protected participants from harm but also meant committing to respecting their values and dignity and to preserving and enhancing their sense of well-being and integrity (Daly, 2007). For example, as a way to further protect them, in the findings chapter I do not connect the women to the type(s) of facial injection they received.

My years of interacting and participating in a care relationship with an aging, mostly female population in long-term care facilities contributed to my understanding of the importance of relationship-building. My commitment to the belief that the second half of life is not about decline and is due unconditional respect and dignity has solidified my relationship with many older women. This long-standing ethic of care was instrumental in building trust and confidence with the women in this study. Understanding that ethics

involves trustfulness, openness, honesty, respectfulness, carefulness, and constant attentiveness means ethics should not be treated as a separate part of our research (Davies & Dodd, 2002).

Being authentically interested in the participant's experience, being non-judgmental, sensitive to their body language, and mentally prepared to give emotional support were researcher skills that did benefit the women during their interviews. Because of the context of the research study, and respecting the participants' courage to share personal information, I reflected and contemplated about my exit strategy following the final interviews. I felt the importance of relaying gratitude and respect to the women for their courage in coming forward to share their experiences of a topic that I came to understand as being most important to their lived experiences. I became aware of a moral and ethical imperative to close the dialogue with care and appreciation (Morrison, Gregory, & Thibodeau, 2012).

The interview process has been documented as being likened to a healing process or a rewarding experience for participants (Corbin & Morse, 2003; Kvale, 2005). For example, being able to unburden or share thoughts and feelings that have been causing turmoil or guilt may offer a purging of negativity. As well, the opportunity to share an experience in a study that may theoretically, help others could illicit feelings of increased self-worth or purpose for the participant. Others in the study, as well, attested to this ethic of caring, which did give some positive meaning to their lived experience.

Final Reflections

As a researcher, I was pleased to have had such a broad view geographically and an amazing spectrum of diversity with which to illuminate the research question

following a challenging, yet compelling recruitment period. After six months of recruitment I had only two interested participants. It took approximately ten months, and three separate ethics submissions to find the participants for my study.

I was unprepared for the findings, spoken about in the interviews: the significant mind, body, and spirit damage, and transformations due to horrendous embodiment disruption, which dismantled lives but also was the lived experience that changed their values and gave hope for their futures. This is where in the research I experienced reflexive embodied empathy by what I was hearing from the participants (Finlay, 2006). I felt a myriad of various emotions from what I was hearing, and what they were feeling. During my private reflective thoughts about the data during analysis, I was overcome emotionally, at times.

I also experienced a memory recall (temporality and relationality) listening to one participant's forthright sharing of her realization about the tension between being seen as a grandmother persona when her relational-self felt more like a younger women. Her reflections produced an autobiographical memory (Finlay, 2009) of when I turned 42 years. I recalled experientially at 42 years old being a mom for the second time to a son, and his older sister being twenty years older. Wanting to be seen as the 42-year-old mom was important to my real-self and values, not the grandmother-self, which did occur when my 20-year-old daughter and infant son were out together. I must admit it was a memory recall of some very special earlier years. This embodied experience between researcher and participant has been described by Finlay (2009) as the greatest richness. Just as important as it was for me to be recognized and accepted as an older mom, so was it the same for this woman not wanting to be thought of as a grandmother because her

lived experience taught her elderly women were devalued because of the aging process.

Chapter 5: Findings

The intent of interpretive phenomenological analysis is to explore how participants make sense of their personal, social, and cultural lives, and the meanings particular experiences hold for them. In this section I present five themes that emerged from the participant interviews by adherence to the hermeneutic circle (Crist & Tanner, 2003; van Manen, 1990) and the interactive reciprocity between myself, as the researcher, and the participants. The themes relate to issues of sexism and ageism within a patriarchal and capitalistic society, physical and psychological effects, questionable ethics and loss of trust, changed views on aging, and views about the future: transformed lives. Figure 1 shows the themes as (a) the commodified body, (b) the fractured body, (c) the abandoned body, (d) the reflective body, and (e) the transformed body. Reflecting on these five essential themes characterized the phenomenon being studied, and the findings indicated overall that participants had transformed lives as a result of their experiences.

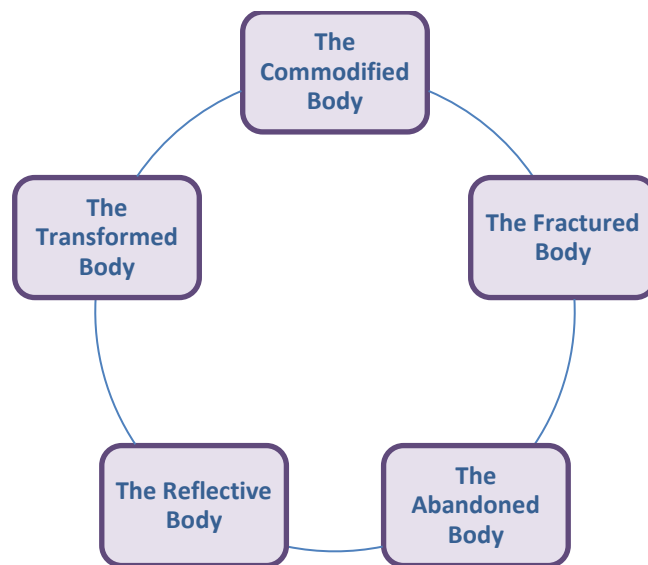


Figure 1. Lived Existential Lives in Relation to Facial Injections

Within the themes, phenomenological existential modes of being were used to

explore the participant transformations in terms of their relationships to their bodies and themselves (corporeal) over time (e.g., guilt over having had the procedure done yet a more positive outlook on aging), to others in their lives (relational) (e.g., trust in the medical profession), and to the past or future (perspectives on time) (temporal). The lived body lifeworld existential was the most appropriate mode for reflection because the body discloses the world just as the world discloses itself through the body (Finlay, 2009). Along this vein, I acknowledge and refer to an inclusive experience of body, mind, and spirit to truly appreciate the meanings within the themes (Hentz, 2002). “We think about our bodies all the time. How do they look? What is their state of health? Are they aging? Are they sufficiently strong, attractive, and impressive? What self is there that is not the body?” (Fischer, 2013, p. 33).

The life-world existentials of relationality and temporality were addressed as they emerged during the research process and in varying means and degrees with each participant. The results show how the existentials of corporeality, temporality, and relationality contribute to and further explicate the lived experiences of the study participants. Heidegger’s phenomenology incorporates a truly holistic understanding of the world, in which understanding any aspect requires knowledge of the greater context of which it is a part (being in the world) (Berglund, 2007).

I have noted many similarities among the experiences and meanings of the participants but, as well, the experiences of three participants who had different experiences speak to the research question and broaden the conceptual linkages (Thorne, Kirkham, & O’Flynn-Magee, 2004). The women who had different outcomes refer to the participants who did not experience serious side effects. Two of them had no side effects

from facial injections and one woman had no concerns about undissolved product beneath her skin. Their experiences will be presented as findings as well, and then discussed in the next chapter.

Participants

A sample of seven participants represented a fairly diverse population of women. The women were between 43 and 64 years at the time of their interview, and had been between 38 and 62 when they received their injections. Four participants lived in Canada and three in the United States. Overall, they represented rural (a bedroom community) and urban areas, small towns and large cities. Two women were single and with no children. One participant was divorced with a child. Two were separated with college-aged children. Finally, two women were married, with adult children and grandchildren. All of the women except one were in the paid labour force, which encompassed self-employment, and positions in government (municipal and provincial), business, and healthcare.

Lysandra was a 49-year-old Canadian woman and embodied for me what “freedom and defender of mankind” meant. At the time of the initial interview, she was in the process of separating from her husband, and was living in a bedroom community. A passion for yoga and a divine sense of humour were her hallmarks.

Vivienne was a 61-year-old Canadian, and single (unmarried). She was full of life and ambitious and her laugh was infectious. She lived in a large city, and had a small circle of female friends with whom she had socialized with for many years. She observed male dominance as the ruling ideology but her strong-willed and defiant personality adhered to a belief of equality of the sexes, which is how she defined being in the world.

Lane, as her name means, espoused simplicity and groundedness and was also Canadian. She was married had a grown daughter, and lived in a small city. She was 64 at the time of her interview although she felt younger and engaged attentively to a healthy lifestyle, and enjoyed participating in different facial enhancements. Lane was the only participant who continued with facial injections.

Tabia, living in a large American city, was very talented and bright. She was only able to work part-time when we did the first interview. She was 53-years-old, and recently single following the ending of a long-term relationship. Her tenacity of spirit was a driving force in her life, and a ray of hope for many other women who had also experienced side effects from facial injections.

Gabby was also American and aged 49 when I interviewed her. She lived in a small town, and was married with three grown daughters and four grandchildren. Her consistent spirituality ("God is my strength") was a contributing factor to her resilience that was a presence in her life. I recall feeling respect for her forthrightness, honesty, and transparency when she proclaimed about herself and her perceived corporeality, "Mine is mostly about the face."

Amber, the final American, was 44-years-old and lived in a large city. She had a close relationship with her college-age daughter and was in a relationship with a boyfriend as well. At the time of the interview, she was not able to work in her achieved profession in the arts because of her remaining symptoms (anxiety, sore joints, headaches, and food sensitivities) as a result of her one-time injection. Her personality reminded me of the jewel's description: "light the amber jewel, fiery." She was gentle and reflective, yet fiery with a passion to get the participants' voices (lived experiences)

out to other women considering facial injections.

Safara, the final participant, lived in the largest Canadian city of those participants who were interviewed. She was 43-years-old, divorced and shared custody of her daughter with her ex-partner. When I reflect on the interview with Safara, the words “her place” come to mind, which is not a geographical concept but rather a reference to her newly-realized grounding “on the other side.”

Prior to participating in facial injections, these women felt they had bodies that were whole in mind, body, and spirit. They shared their varying reasons for participating in facial injections to reduce their individual signs of aging to their faces. Vivienne was fine with being 53 years of age but she did not necessarily want to “look old “and she did not think anybody had to look old if they did not want to.

Lane had a similar perspective. She felt younger (around 50 years) than her chronological age of 62, and thought the injections might make her look younger. “I do it for myself. I feel better about myself.”

Lysandra felt the influence of going back to work with a younger generation. She was 45, separated, and working with younger men. “I wanted my body to be attractive or thinking that this would make me look more attractive.”

Tabia participated for several reasons: she concurred about feeling and looking younger than her 49 years, and had wanted to “stay ahead of the game.” Another influence was the end of a long-term relationship, and being out in the dating scene with competition. “It’s hard to compete as a woman in your fifties.” She actually had the opportunity to participate as a model for facial injection demonstrations, and she felt honored to be chosen to represent the trusted products to doctors attending these

conferences. She said, "I am normally the type of person who puts much thought in making decisions. I kind of got caught up in it."

Gabby's response was: "It was hard at 42 to become a grandmother for the first time. I had a hard time with the word grandma; talk about feeling aged. That's what did it." She had her first injection three years later. "I think that was probably harder than finding the lines on the face, and the gravity that starts to take over; being called grandmother was very difficult."

Amber was happy with her chronological age (44 years old), and loved the way she looked, but her goal was to break a feedback loop of holding her muscles in tension. She had heard that the facial injection she was interested in relaxed the muscles and when it wore off the muscles "forgot" to be tense. She believed if she broke the visual tension it would break the mental tension that she was experiencing.

Safara at age 38 indicated there was a social and cultural expectation of looking a certain way or keeping up a certain amount. Genetically, both her grandmother and mother were very wrinkly, and Safara wanted to prevent that. Thus, she had injections for that reason.

These women had their facial injections two to eight years prior (between fall 2004 and winter 2011) to being interviewed, and the five different types of injections they received reflected two general classes of injectables for the face: neuromuscular toxins and soft tissue fillers. Botox and Dysport were the two types of *neuromuscular toxins*, each manufactured by drug companies in different countries. One participant noted that the only difference between Botox and Dysport was that Dysport is a smaller molecule and it is produced by a different company, stating, "Most people feel Dysport

causes more bad reactions. It crosses the brain barrier easier because it's a smaller molecule. And I think that's true." Juvéderm, Restylane, and Fortelis were in the category of *soft tissue fillers*. Most recently, as mentioned, the marketing of facial injections has introduced and promoted the "Soft Lift." The idea behind Soft Lift is that by combining the treatments the results are optimal, keeping the client's own natural look in balance. Two participants chose this approach. Following is an itemization of type of injection and frequency over time.

Two women had both Juvéderm and Botox injections (carried out at the same appointment, and only the one time). One woman had one Botox injection only once. Another had Botox injections every three to four months for three years. One woman had five Botox injections over a period of one year. Another woman had two Restylane procedures and three Dysport procedures over a 20-month period. The final participant received two Fortelis injections, followed by two Botox injections over two years.

Four participants had significant life-altering side effects, as well as related symptoms three years later (discussed in the next section). Three participants had no life-altering side effects. Of these three, the first participant felt the procedure did not work for her, which disappointed her. The second participant was disappointed that her injection did not meet her expectations especially because the treatment was so expensive. She had been enticed by the before and after photos in the pharmaceutical pamphlets at the spa. She was not concerned about side effects because the company brochure stated the product was safe, and although she experienced tiny, undissolved granules beneath her skin from the injected product, she believed that the integrity of the product, written about in company brochures, outweighed the possibility of harms that

might occur to her body. As well, this participant had unwavering faith in the family-practice medical practitioner, who administered the injections, and had taken courses to learn the correct technique. The third participant, who also did not experience physical side effects, had been exploring a communal connection to an ontological meaning of living (yoga), which eventually changed her perspective of positive aging in relation to facial injections. In the next section I convey the themes that emerged from the data.

“I Finally let my Hair go Grey and I’m Invisible”: The Commodified Body

All the participants acknowledged embodied ageism and sexism in their lives by a patriarchal and capitalistic society although in varying intensities and extents. They described their lived bodies as both subjects and objects in a culture in which women were expected to conform to rigid beauty ideals. Merleau Ponty (1945/1962) highlighted that there existed a fundamental ambiguity of one’s body. He describes the lived subjective body as “most intimately ‘mine’ or ‘me’, but that it is also an object for others” (Merleau-Ponty, 1945/1962, as cited in Finlay, 2006, p. 3).

The specific interview questions asked of the participants to engage reflection were: How do you think society views women as they age? Do you think women are expected to conform to rigid beauty ideals? The participants described how their subjective bodies and values responded to a society and culture that demeaned and devalued them because they were aging.

Lysandra’s perspective about social media perpetuating ageism and sexism was poignant. The words she used as descriptors were “unnecessary, someone else’s ideal of perfection, which is out of whack and overdone Hollywood hype.” Lysandra’s choice of words explained the coercion at play in framing the face of the aging woman’s body as a

lucrative commodity in the cosmetic surgery industry and she concluded, "If you were a lady in Africa [an African woman], in a tribe and not being bombarded by social media [having facial injections to reduce facial aging] would never enter your mind." Safara acknowledged, "It's that old cliché where men's bodies get better as they age, when they have grey hair and fine lines, and women's bodies just get old."

This is where in the data I began to see the first glimpses that the participants realized they were essentially an object of monetary benefit from the commoditization of their aging bodies. Gabby shared her perspective about the subjective values of her aging body as seen by society: "I don't think it's kind. I think that instead of it being a state of mind, and how we feel about our lives, and encouraging and celebrating the wisdom that comes with that I think they look down on it." Then she shared her feelings about her body being the object of the cosmetic surgery industry: "I think it's wrong. It's all about the bottom dollar is what it is. . . shame on these doctors for putting the almighty dollar ahead of the patient care. Because that's what it all comes down to. It's a cash cow for doctors."

Women have succumbed to this convincing marketing of anti-aging by celebrities and the continuous Hollywood hype as reliable and validated information about aging well, which then becomes the reality and the goal for positive aging for many trusting women. The women experienced what Csordas (1994) calls the consumer body: the creation and commercialization of bodily needs such as for facial injections, a process in which doubt about the self is created in order to sell the benefits of the product, which became very lucrative for the cosmetic surgery industry. Safara said: "I used to think, oh, my gosh, I've got to keep myself up. And Oprah says, it is high maintenance when you

get older to, you know, do everything you need to do to keep yourself up.” Safara was typical of most of the participants caught up in the consistent, unrelenting informationalism of the aging female body that penetrates most days of most lives via social media. And Amber stated, “When these messages are so steeped into the culture sometimes you can be more affected than you think you are.” Knowledge exists in the world already, and it enables our embodied practices (PHENOMENOLOGYONLINE, 2013, paragraph one). All participants acknowledged these influential and coercive anti-aging messages that were ubiquitous. Ads for injections made promises of generating positive self-esteem or simply improving many aspects of a woman’s well-being and without any serious side effects. However, although some participants openly acknowledged the pressure, others denied any influence or were unaware of the mass subliminal messages infiltrating their subjective perspectives and values. Vivienne maintained, “I probably didn’t pay any attention to it. I just thought one day ‘just go and do it’.”

How aging beauty myths influence and coerce the female body was depicted by Lane’s lived experience, and the embodiment of current cultural hype, which creates the object body overshadowing the subject body. She watched a TV show called *Entertainment Tonight* and based on the show’s reports about the movie stars and Botox she developed her belief that having a lot of money (like the movie stars) increased the financial opportunities, but also the career pressures of having injections in excess, and consequently much higher risk for getting side effects such as disfigurement of the face. Because of this media information, Lane decided to be cautious with her body. She would not get injections every three to four months as recommended. Instead she planned to

have an injection once a year and believed this strategy would safeguard her against getting side effects those other women who injected too much could experience. Safara shared her experience as an objectified body. She believed in the myth that wrinkles would not even form once she started getting Botox, yet she discovered the truth: "But no, the injection result wears off. You would need to keep getting it for the rest of your life if you want the effects to last. It's not permanent in any way, thank God, or otherwise we would never recover from this thing." Gabby agreed: "It goes back to the original aging condition; mine looks just like it did before I was getting my injection."

When probed on how ageism and sexism made them feel, the participants shared individual perspectives. Lysandra believed it was getting better because more women were standing up for themselves due to positive internal aging values, but she did admit that the societal perspective of youth being more beautiful was still a constant message in advertising. Amber agreed somewhat with Lysandra's perspective of the existing subjective female body. She said, "I think now, older women are viewed as really strong, and very, you know, beautiful and like it's a powerful time in your life, and believes that society accepts that more but questions celebrities who may allude to aging well but really it is aging 'fakely' [*sic*] because the anti-aging facial interventions gave the illusion of aging well."

Vivienne's view of her subjective body perspective involved an awareness of the devaluing of age by a patriarchal ideology. She noted how female news anchors had their faces retouched with photo shop. She stated, "They certainly want women to look beautiful and glamorous and that's really what men are attracted to." Lane believed there was more pressure on women who were in the work force [like herself] to look good, and

women tried to look perfect because of the hype about anti-aging. Tabia and Gabby both used the words sad to describe the emphasis on looking younger, and Tabia added, "It's wrong."

Safara stated she did not experience ageist or sexist behavior because she was younger (i.e., 38-years-old) when she got her injection, and she was really attractive or told she was. Although she did not think it was right, Safara did not personally embody the lived-experience of demoralization from sexist-ageist messages and inferences, and therefore, she could not really speak to that particular internal devaluing experience of her body. She explained further what other aging women said to her about their ageist and sexist experiences, "I finally let my hair go grey and I'm invisible. Nobody sees me." Frank, 1993, as cited in Clarke and Kissane (2002), explain a person's self-esteem is damaged, and rejection is felt from others because of failure to meet their expectations. Safara's experience did, however, expose the current myths about facial injections that had been promoted: that they would prevent wrinkles from forming, facial muscles would stay as they were. Injectables were being sold in a Natural Health Care setting, thus the message that these products were natural and safe seduced women into believing they would not experience negative side effects.

Women's subjective bodies were embodied and transformed into objective bodies because of current cultural and social forces. The felt-invisibility of the subjective self of the participants, which contributed to the development of the objective body, is supported also by Dolezal (2010) about invisibility. She states that in order to fulfill the social expectations of her body, the female subject renders herself an anonymous, normalized subject, individuated and hence unnoticed and unobtrusive, which was experienced by

these women within the medical system. They felt shamed into participating by sexist, ageist cosmetic rhetoric, and then shamed again following their side effects by the very ideology that had coerced, and influenced them initially. Moreover, Tabia, Gabby, Amber, and Safara discovered how a decision to erase a few signs of aging could dramatically change one's life forever, as the next theme describes.

“It’s a Poison Travelling Through the Body”: The Fractured Body

I commence this section of bodily fracture (physical and psychological) with a quote from Fischer (2013): “As well, the actual functioning human body is a marvel. No one manufactured it. No patents exist for it. No one knows where it comes from or exactly how it is produced.” This quote describes the bodies of the participants prior to having facial injections. They each reported that they had a marvelous functioning, whole body before their injections. This is understood to be general and overall subjective well-being, and they were able to conduct their typical, daily female lives. Tabia described her previous self: “I was just a normal, healthy, active, educated and professional woman who wanted to gently hold off the hands of time.”

Four women had serious physical and psychological fracture from facial injections such as heightened sensitivity to noise and lights, felt acute anxiety, panic, crippling fear, intense fatigue, and insomnia. They suffered with severe depression and thoughts of suicide, and with no support by the medical system because the medical professionals denied their side effects initiated with their injections. Others had impacts ranging from minor and unwanted physical skin changes to fear of potential, future side effects (e.g., fear of potential addiction to the injections), and for some, possibly permanent symptoms.

The fracture of the body was experienced differently by each participant who suffered the more serious side effects. The onset of symptoms varied between two days and two weeks, and was related to multiple factors influencing the onset for each woman. Amber said, "It's very systemic, and when it goes wrong, it's monstrous." Safara, another participant thought she might die, and had her will prepared. For example, she made arrangements with a friend to take care of her daughter. "I might need you if I feel like I'm going to die, or if I need to go to the hospital. I feel it spreading; well, you're poisoned. It's a poison travelling through the body." Gabby said, "I mean just complete illness like I've never known. I'm telling you four and a half years ago, I didn't think I'd live another minute." Tabia shared: "I couldn't be outside, I couldn't watch television, and I couldn't sit in a room with any kind of light. I just sat in a dark room for hours on end. I had to leave work; I had to move out of my home, and move in with my mother." The fractured body or living with a body separate from the self (Osborn & Smith, 2006), fittingly describes the experience of these women. They had lost their body functionality, its wholeness of mind, body, and spirit, and their bodies did not feel marvelous, like before. The relationship between their current bodies, their lived experiences of multi-varied side effects and their sense of self combined to create a negative association causing a distorted perception of their body image (identity).

Other participants had on-going medical symptoms related to side effects from the injections. Gabby's lasting symptoms had made her much more sensitive to temperature than before her injections, and the cold weather bothered her significantly more. She suffered from much muscle and joint pain, and had completely changed her diet to gluten-free, which made a significant difference to her body's autoimmune response

(celiac response) although nothing tested positive for autoimmune symptoms. She was also very sensitive to medications now and tried not to take anything because any medication could trigger a relapse.

Tabia shared the lived experience of her fractured body related to the psychological aspects her body was confronted with along with dealing with something for which no one had answers. She experienced intense anxiety attacks that came on suddenly and could last five minutes or five hours. It could be a horrible head pressure or something else (related to the side effects she developed) following her last facial injection, yet she said that “The doctors will say this is all psychological or this is all hormonal, and then there’s that that you have to deal with on top of it.” Tabia’s body experienced profound demoralization as described by Clarke and Kissane (2002):

By their very nature physical illnesses are demoralizing, particularly if prolonged or difficult to treat. Such illnesses threaten the integrity of the body and the mind, and challenges the person’s mastery and control. Continuing illness causes patients to reduce social roles, and deprives them of avenues for satisfaction and competence, with reduction in personal efficacy, and uncertain prognosis, patients easily became demoralized. This can be further intensified through isolation if important ‘others’, as a defense against their own discomfort, withdraw emotional or material support. (p. 736)

Some participants’ bodies had significant side effects that persisted three years, and there was no pattern or criteria for whose bodies developed side effects from injection of Botox or other facial injection products. Safara explained it as a “Russian roulette kind of thing.” Everyone was at risk. Anxiety and insomnia were the most common symptoms of those participants who had side effects. The lived experience of

anxiety was instrumental in contributing to the fracturing that occurred to their bodies. Anxiety is multi-dimensional, with causal roots in evolutionary, psychophysiological, cognitive, and behavioral mechanisms, and phenomenology. It is basically subjective, and is constructed qualia, which contributes to its complex nature, and finding a viable model for treatment (Corr, 2010). The women's bodies had to contend with this fracture of anxiety (knowing there was no treatment) along with their primary life-altering side-effects and other related symptoms. Heidegger emphasized that the primordial meaning of anxiety is to feel not-at-home-in-the-world (Watts, 2001). At its very elemental meaning, states Heidegger, anxiety has the capacity to disconnect and decenter one's being to the extent that one may withdraw from many of the basic norms of existence such as self-care and care of others, which typically gives human existence more meaning and makes a person's life really matter to them. Amber shared, "I had to go on medication, you know, for the anxiety just to function, just to not be suicidal, and just to not give in to the crippling panic."

The following comment was shared to some degree by each of the participants during their interviews. This was their reality on a daily basis: "One of my Botox friends, for lack of any other way of saying it, actually had a relapse and it was worse than the first time and that's my fear." One participant described it as always being hyper-vigilant. "You think, oh God, of everything you do, is this going to make my body worse?"

The topic of suicide came up during two interviews. The discussion was centered on the impact on women's lives when they suffered debilitating side effects to the self, and yet had to manage their bodies in their expected other roles of wife, mother, and employee. This is where the knowledge emerged that some women's bodies had

experienced such an overwhelming fracture and hopelessness as a consequence to their body transformations, and lack of medical support, they experienced suicidal thoughts. Tabia acknowledged her lived experience with suicide, “It also terrified me to know that this horrendous poison that permeates your entire being actually does drive people to the point of trying to end it all.” Demoralization and the wish to die have been more strongly correlated with embodied feelings of hopelessness more than other feelings such as depression (Clarke & Kissane, 2002; Corr, 2010). Amber shared:

And the [side effects from injections] also makes you suicidal. And I’m going to tell other women that one of the side effects to that are extreme panic and terror, depersonalization, and suicide attempts. And I think one of those things I would definitely stress is that it makes you want to commit suicide and probably succeed. I believe that many people have died. I believe that many people have committed suicide but it is not reported. That’s my personal belief.

Depersonalization as a chosen descriptor by Amber referred to her felt-body. From an existential lens, Colombetti and Ratcliffe (2012) explain such depersonalization as experiencing the world strangely and wholly bereft of all practical significance. In the face of such unrelenting fracture, the women turned to the medical system for answers about what had gone terribly wrong with their bodies, and hoped the physicians could help them to resume their normal lives. Yet as the next theme shows, this did not occur.

“The Doctors Aren’t Doing it for us”: The Abandoned Body

The experience of some participants described embodied feelings of dejection, devaluing, and more fear and anxiety of being made to feel crazy and alone within the medical system, which had been turned to for answers, solutions, and supportive care. In

this section I explain the questionable ethics and loss of trust by the participants that occurred at several levels of the medical industrial complex representing this vast health industry: (a) the traditional medical system, (b) the medical-cosmetic surgery realm, and (c) the drug companies that manufactured the facial products for injections.

All of the participants went to qualified physicians because of their unwavering trust in the medical profession to administer a safe product, especially because it was an injection into the face. And as Lysandra said, that was not something to take lightly. Gabby offered the following perspective: “They make it sound so wonderful. You know, it’s temporary, and according to them completely safe. Nothing can happen.” This relational trust in the medical profession by the participants was built on their belief in the ethical principles of physicians and their practices, and a supportive, reliable client-physician relationship but soon this relational mode changed related to new realizations (truths) by the participants. Gabby stated emphatically, “Mine was always ‘okay doctor’ but not anymore. The members on the Botox Community Support website are the only ones trying to solve this, and trying to cure this, and you know, get the word out because certainly, the doctors aren’t doing it for us.” Safara had stated emphatically, “I had no reason to get the injections”, and believed it was the doctor’s moral obligation to have said to her, “You have no reason to get these injections.”

Tabia’s bodily experience of abandonment occurred following her last injection and subsequent life-altering changes to her whole body. She was trying to find answers to what had gone wrong with her subjective body, which had become fragmented and unfamiliar to her previous whole self. She went to various physicians and specialists but was given no support. She said, “A lot of them denied that [my symptoms] were related,

but suggested it was hormonal. You get so angry, and again I think it is being a woman.” Tabia’s lived experience of being devalued and demeaned as well as facing tremendous bodily changes terrified her. I describe these experiences as gendered body experiences because although the woman’s subjective bodies did participate in embodying the ideal image of aging women they still experienced sexism and ageism as a transformed object body. They were still invisible. As Butler (1988) notes, “The gendered body acts its part in a culturally restricted corporeal space, and enacts interpretations within the confines of already existing directives” (p. 526). The lessons learned by the participants not only derived from embodiment but from the knowledge that the normative cultural practices and structures of meaning still existed (Oksala, 2006), but now within the medical system.

None of the four Canadian participants were offered any informed consent document to sign by the injecting physician prior to having their facial injections. Other participants were either not given an informed consent to sign or the consent form given did not include any potential side effects. Tabia said:

I was given a document to sign, which was considered an informed consent, and I made an assumption that it was complete but the only side effects that you could have was a little swelling, a little bruising, a little drooping of the eyelids but there wasn’t anything on there about the spread of the toxin that could cause these system effects. I mean there was just complete trust, there was complete trust that I was being told of all the possible risks just like you’re told when you sit down and have surgery. The doctor has to say this could possibly happen, and that could possibly happen so, no, I had no idea that this could happen to my body.

Gabby's experience of what she was told was very similar. Flu-like symptoms and temporary, slight drooping were the two worst things on the disclaimer she signed, and yet over the next two years, she had multiple tests and saw many specialists as a result of her bodily side effects. Safara's relational experience with her injecting physician was slightly different. Promotion of anti-aging injections at a holistic healthcare center where she went as a client for natural facial treatments was a major influence for her because she also worked in the natural healthcare industry and paid close attention to what she put into her body. She admitted being enticed by the physician and owner, and his declaration of a natural product, and she trusted him. "He was a General Practitioner, and he was athletic and fantastic and young, and he said it's the greatest thing for prevention because your body doesn't even form wrinkles, and it just stays right there and if you don't like it, you don't ever have to get it again." Safara had trust in truth telling about the product and especially from a trusted medical source, but instead was seduced with this myth about her facial injection.

Botox was on the market for a few years prior to the FDA granting a petition in April of 2009 clearing the way for black box warnings² on botulinum toxins. All four participants who developed the life-altering side effects concurred that they were told nothing about the black box warnings³ prior to their injections. Amber said, "It's

² A black box warning is the sternest warning by the U.S. Food and Drug Administration (FDA) that a medication can carry and still remain on the market in United States (Drug Watch, 2012; Counter, 2012).

³ The RealSelf website (www.realself.com) was created in 2006 (Griffith, 2013), and is endorsed by different cosmetic surgery organizations representing 5000 active doctors. RealSelf makes money with a subscription ad product for the doctors. "If you hold a four or five star rating and are in good standing with the community, you can buy presence in search results" (Griffith, 2013, p. 3).

mindboggling to me. The black box warning was put there for a reason. Evidently, at some point, there was enough medical evidence to show all these things can happen [to your body], and you can't hold anybody responsible for them. We're the ones who have to find our own solutions, and our own answers." Lack of disclosure by the physicians who had performed the procedures was experienced by each woman.

In desperation, following their initial lived experiences of denial by the medical system the women began carrying random searches on Google. The "Real Self" website espousing trust and transparency was found but then described as terrible and misleading. This particular website was visited by hundreds of women posting problems following anti-aging injections, but they experienced being ignored by the site physicians. Amber stated, "I went to the RealSelf website, which was really terrible. I don't recommend [the website] to anyone. It's very misleading." The three American participants said it was typical that occasionally a doctor would respond in an open forum, and deny the side effects were related to Botox or other fillers, but rather it had to be related to other issues changing their bodies.

The women who described their experiences of significant total body fracture also described rejection by the medical profession at different levels. Although the experiential and medical versions of the body overlap and inform one another, the medical version of the body can be extremely alienating (Walker, 2003). Optimal or normal health is not an objective condition that can be understood by science or medicine alone, and in some situations is significantly related to the mental attitude by which each person's values are deemed as essential to their individual selves (Existential Medicine, n.d.). The women reported that the medical system did not acknowledge or value their

requests. These women wanted and needed support but experienced denial and devaluation. They wanted and needed caring physicians who believed them, acknowledged their symptoms, would monitor them, and make them feel protected but instead doctors and specialists refused to talk about it, and one participant was told never to call again. It was terrifying for them. Amber said, of the cosmetic surgery industry: "So people just don't get the real picture. They are overly trusting but that's because the picture that's provided is that this is nothing." As Toombs (1993) explains in Finlay (2009), "Illness engenders a shift of attention." Illness creates a different self, a body separate from the self. If it is a critical illness or a chronic critical illness fracture occurs. In the context of this statement and Amber's lived relationality with the medical system following her bodily fracture she summarized how being abandoned or ignored embodied additional demoralization by the self:

If you're having a terrible illness, at least, the fact that some doctor cares about you and is willing to say, this is going to be very bad but I will stay with you, I'll monitor you, I'll watch your symptom; that's reassuring. But for them just to say, "don't ever call me again; you have a virus," that's really frightening.

It is care that makes human existence meaningful, and makes a person's life really matter to them (Watts, 2001). From Heidegger's perspective, attentive care and protectiveness assists others to take responsibility for their own life. In other words, authentic caring has the potential to respond to the concerns of the fractured body, which empowers them via advocacy and facilitation. In the context of the women's experiences they were abandoned and felt disconnected with being in the world (McConnell-Henry, Chapman, & Francis, 2009). Aligned with this are thoughts from Carolan and Bell (2003)

stating that the loss of trust (a basic human need) in an individual's lifeworld could create an ontological crisis in this aspect of the person's relational self.

Disbelief was expressed by the participants' family physicians resulted in feelings of dismissal, and abandoned in a former relationship of trust, and feeling safe or secure. "It's just the lack of support and doctors not believing people when they come in with these symptoms." One participant decided to start looking on her own for answers because of what she described as a ridiculous retort from her physician, who was "pretty much hands off" except for offering anti-anxiety medication, which only resulted in exacerbation of her anxiety. At one point, her doctor told her she was bi-polar. Gabby said, "I just think [my doctor] couldn't believe medically that this really happened because there are no real studies out there." She admitted that the first person she felt truly diagnosed by and made to feel like she was not crazy was probably a pharmacist.

All the women who suffered side effects to their bodies and continued to suffer with side effects or on-going symptoms had no element of proof. By their very nature (Clarke & Kissane, 2002), physical illnesses are demoralizing, particularly if prolonged or difficult to treat. The women had no substantiating tests to support the physical and psychological changes that had occurred such as blood work, botulism tests, or MRIs. "We have all these symptoms but there's nothing to physically show that we've gotten these symptoms from the injections. This is why the drug companies are getting away with all of this." Gabby had reported her adverse experience on the company website but was ignored.

There has been no documented case of spread of the toxin in cosmetic doses. They're still saying that, right on the advertisement. There has been no documented case.

Why has there been no documented case? Because when we all report it, they won't pay attention. (Amber)

Gabby also expressed feeling anger related to an experience with the *Dr. Oz* show two years following her last injection. She had reached out to the Dr. Oz show because she wanted other women to know that serious side effects could happen to their bodies from facial injections. She admitted to being more desperate to get the word out because she was experiencing more acute episodes of her own side effects at that time. "I wanted somebody to know or I wanted somebody on that damn TV to do a show about this myth, and the ads to make you look better by getting the injections." The producer sent Gabby an e-mail requesting pictures. "We need to see the results of what you're talking about." In response, Gabby explained her reaction was a physical-medical reaction rather than a physical-cosmetic reaction and she never heard back from them.

A few months later Dr. Oz featured a segment on Botox, and it was sponsored by Allergan, the pharmaceutical manufacturer of Botox. "And they never mentioned anything about possible side effects in the entire show." Gabby explained how her body felt following this experience. "I'm angry about it. It makes me angry that they continue to tell this as the miracle cure-all for aging but not telling what really happens." This lived experience with the Dr. Oz producer following her facial injection and subsequent side effects created a sadness and disappointment for Gabby. She wanted to share her experiences with other women, to possibly prevent an impact on their lives, as she had experienced, and to send the message that there was support for those who were suffering, and feeling alone as she had also experienced, but she was denied this opportunity.

Tabia discovered the drug company that produced her injectable product only deemed serious adverse events as those that required hospitalization. That meant even if a person went to the hospital Emergency Department five times but never was admitted, they would never even report that adverse event to the U. S. Federal Drug and Food Administration. “Even though the adverse events, and I think there are 30,000 now on Botox alone, and probably double that of people who are having issues that aren’t reported because they weren’t deemed serious enough.” Gabby stated, “We are the ones trying to solve this, and trying to cure this and get the word out [to other women] because certainly the doctors aren’t doing it for us. They don’t care.”

Helping a demoralized person is the role of every health care professional and is achieved most importantly through a relationship characterized by empathic resonance, combined with good physical care and symptomatic relief (Clarke & Kissane, 2002), yet, this was not representative of these women’s lived relationality. The lifeworld perspective (Dahlberg, Todres, & Galvin, 2009) provides a theoretical framework when exploring and unfolding lived experiences of phenomena in caring science by highlighting patients’ lived experiences (Olausson, Lindahl, & Ekebergh, 2013). This phenomenological 2013 study of the body and spacial modes over time (patient rooms when life is fragile) demonstrated the similarity to what women with side effects experienced within the medical system: feelings of being alone and abandoned in a medical environment when patient needs were met led to well-being, and satisfaction of care, through supporting their needs for healing. van Manen (1998) wrote that increasingly the health science profession is becoming aware that people require not only health care assistance, surgical treatment, or pharmaceutical treatment, and that

professionals are becoming much more involved in the way people experience and live with their problems in a different, sometimes deeply personal and unique manner. Yet, this optimal relational experience is in contrast to what these women experienced with the medical system. I recall at the end of this part of the analysis, reflecting on the meanings within the data, and I offer a quote from Thomas and Johnson (2000), which closely resembled my thoughts at that time: "If there is no one who understands and no place where one fits, is this not a kind of living death?" Nevertheless, having experienced a fragmented body that was abandoned by the medical system these women discovered inner strength, a sense of corporeal resilience and reflected on the implications of their changed bodies, which contributed to new introspections on the meanings of an altered relational self.

"I'd Rather Feel Good Than Look Young": The Reflective Body

Critical illness or a fractured body was described previously by some of the women as an intense life event entailing physiological, psychological, and cognitive aspects that had a profound effect on their being (the self). "Little is known about the long-term imprint of critical illness on the holistic self in survivors" (Papathanassoglou & Patiraki, 2003, p. 13). This study may be unique in reporting the additional consequences of feeling abandoned with a fractured body, and also how this lived experience contributed to changed views on aging for most of the women.

Lane now believed age was just a number, and eating healthy and being active was paramount to getting older. "It doesn't bother me because it is gonna happen. I'm just going to try to do things that will keep me young." After reflecting, she admitted that facial enhancements (injections) contributed to a body that felt younger. Although her

chronicle age was 64 years, her subjective body felt more like 50. Lane's reflection and statement about her spouse's perspective of her facial work was significant considering the media hype about men being more attracted to younger-looking women. She said,

I think probably a lot of women do it for themselves because the husbands hardly ever notice anything. My husband doesn't notice anything. I don't tell him anything. They're in another world. No, he doesn't know. I figured if he noticed I would be fine but he didn't. I do it more for myself. And if my husband wanted me to stop? I wouldn't listen to him.

Vivienne's response (said lovingly and with undertones of humour) was, "Oh my God, now I look like my mother." Later in the interview, however, she was more candid about how she experienced her body. She said, "Everything hurts, we look like hell, and I'm constantly dying my hair. No, there's nothing glamorous about it at all. I'm okay with being how old I am. I don't necessarily want to look old. I don't think anybody has to look old if they don't want to." Following this statement, she reflected on how frustrating her own mother's aging had been. Time was evoked as a past memory of her mother, which embodied Vivienne with concerns about her own aging. She felt how the loss of control over one's body increased frustrations about aging. The vivid and unwanted consciousness of her mother's body was one of disease, distress and dysfunction, which she wanted to avoid. Vivienne felt and looked young but her face was showing wrinkles and lines. A study by Clarke and Griffin (2007) suggest that mothers are important influences on their daughters' socialisation into body image and beauty-work, and exert, or are perceived to exert, accountability across the life-course such as in Vivienne's memory recall and Lane described her mother as a role model because she

embraced similar beauty practices over the years. While the media, education and peer influences are important, the primary agents of socialisation of cultural norms and values are family members, especially parents (Tepperman & Curtis, 2004, as cited in Clarke & Griffin, 2007).

Reflecting on their aging bodies following facial injections, for the three participants who did not have really negative experiences, presented new and somewhat different realities or truths. Lane would continue to exercise, eat healthy, and get her injection once a year because her lines and wrinkles did not show that much. I recall how Vivienne's facial expression and her chosen words conveyed feelings of disappointment that the procedure did not work. She believed if she had participated in a facial injection 20 years sooner, then it might have made a difference but at a certain point, she said, "If you've got a permanent crease and no matter how much you pull it [stretch it], you're still gonna see it." It was at this point in the interview that Vivienne stated she was trying to talk her young niece into it before she got too much older and the wrinkles and lines became etched in her skin. Vivienne also believed the myth about starting early, then stopping at a certain point, and thought it would take much longer for those creases to reappear because of injections.

Lysandra, who did not experience any side effects, generated her own beliefs that aligned with her values. The serious practice of yoga resonated with her, in relation to fundamentally what it meant to her being-in-the-world. Yoga often provides a radical form of engagement with mind, body, and spirit, which can prove deeply influential on the practitioner's understanding of their embodied selfhood, with many practitioners describing the practice of yoga as a mirror for the self (Smith, 2007). Lysandra's new and

evolving “journey to awareness” through her communal relationality with yoga was a turning point to accepting aging naturally (loving herself, and being able to let go of her wrinkles and age gracefully). Her transformation helped her redefine facial injections to reduce the signs of aging as putting on a mask or a veil. Lysandra’s comment of acceptance was unique to her developing beliefs as she described following, “I see the lines and wrinkles differently now. I don’t dwell on them because the more we hang on to our wrinkles the worse our wrinkles are going to be. I really don’t think I want to go down that path.”

Alternately, the women who experienced the systemic side effects from injections had different reflective thoughts on future aging of their bodies now that they had lost their functioning and whole bodies of the past. The need to retain a valued and coherent self-concept in chronic pain sensation, distress, and disability is a phenomenon that is also evident in the ongoing experience of the body (Osborn & Smith, 2006). Because of life-altering bodily side effects, values about their own body aging perspectives had changed for the participants creating a new relational self. What Amber had learned the most about what makes a person young is their smile and the fact that they are healthy and their eyes sparkle, rather than how many wrinkles they have.

Safara’s reflective comment demonstrated a significant shift from her previous values, “I don’t want to buy into that any more. And there are people who don’t, so I want to go over to that side. I shouldn’t have been so vain that I injected something to stop forming wrinkles that I didn’t even have.” She stated there had been a real grounding and growth process in terms of realizing what was important to aging. Another similar response came from Safara: “I really look forward to embracing those lines and those

wrinkles and that I don't worry about what other people think so much anymore, in terms of what I look like." Safara's perception of her future older body now embodied her new values of natural and holistic aging. Gabby said:

I reflect more on that now than I did before I got sick from the injections. I think I'm more hopeful that I make it that far. I know that sounds probably a little dreadful but having been through what I have, I have been able to learn about what this could have done to me, I'm just more aware of what it takes to get to that point in life. I look in the mirror and I do the makeup and hair and everything, but probably first and foremost, the one thing I learned from somebody from this journey from the very beginning I would rather feel good than look young. And it's something that I hear myself saying all the time. I don't know that I would have said that before this happened.

Gabby reflected further on the embodiment of feeling like a grandmother, which to her was negative not because of being in a grandmother's role to her daughter's children, but rather because her lived being (identifying as Gabby, the young and attractive woman) was what she felt (not the negative, ageist grandma persona society and culture attached to women as they aged and became a grandmother). She was not ready for that yet.

Tabia shared how her intrinsic values had changed. She described her previous values as being caught up in the whole aspect of looking good and buying the most fashionable items. It was different for her now; none of that was important. "It's just being healthy, and being accepting of a gift that I was born with." I recall her tearful voice as she proclaimed: "I'm lucky just getting dressed in the morning, and my boxes of 150 shoes I have, I only wear 10 of them now, and it is okay." Both Tabia and Gabby

believed their lived experience may have happened for a reason, for a purpose. Tabia concluded, "Or even a change in how I see things. People say your perception is everything in just that little shift." And stated by Schuster (2013, p. 196), "Understanding always starts with experiencing." Heidegger, states Warnock (1970), would call this the awakening to authentic existence, whereby the person becomes aware of his own personal potential, once this differentiation to the masses is realized.

Butler (1988) described the normal body as a continual and incessant materialization of possibilities. She contends that reconceiving the gendered (objective) body for some women evolves from sedimented acts such as experienced by Amber and the other women following their facial injections. Following a long, reflective pause, Amber stated that the most valuable awareness to her was being even more aware of the importance of having a natural body: "I always appreciated natural beauty but I do even more now." All the women had reflected on the meanings of their past experiences in relation to an unknown future with their changed bodies, minds and spirits, and how those possibilities could transform them as a result of their lost embodied ownership.

"It's all Scary. Where Will I end up?": The Transformed Body

Temporality took on a different meaning for the four women who experienced serious side effects as a result of a loss of embodied agency or body ownership (Coole, 2005). They now wondered about potential outcomes (future time), and shared their views about the future based on the unknown possibilities of their changed bodies, such as uncertainty about the progression of their side effects, support for them in the future, impacts on their lives, and fear of potential addiction. The way they related to others was also changed (relationality), with a sense of responsibility and caring to inform others of

potential risk.

The paradox of time—meaning the many possibilities for the future—is felt with fear: an aging body in today's ageist and sexist culture but now with disabilities, loss of trust in their former relationship with the medical industrial complex for their unanswered questions and non-support, loss of dignity, and denial by the cosmetic surgery industry, which contributes to feelings of being disembodied or fractured and demoralized by feelings of shame and guilt, which frequently co-occur after experiencing a moral dilemma (Coole, 2005). Chronic conditions over time influence the embodiment of self-negativity (distress) (Osborn & Smith, 2006), much like the participants in this study reflecting on their unknown futures.

Both Gabby and Amber had been aspiring to live healthy, live well, and live long into their 90s, inclusive of being very vital (living independently and being self-sufficient), as this was a strong genetic trait in their respective families. They both had always believed that their future bodies would be like that as well someday. Amber noted: "And I really loved myself, respected the fact that I had survived a lot of things in my life. My thoughts and feelings about having an older body were really extremely positive." She never thought she would have medical problems when she got older but now she was very worried about all of that. She said, "I'm very afraid. My whole image of what my old age is going to be like, in the future, is completely changed because the injection impacted my health so much." She never thought she would end up in a nursing home, and now she expressed being extremely worried about that possibility.

Gabby expressed fearful thoughts and feelings about what her future self could be like at 70. "Will I look like the person I always thought I would be and wanted to be?"

She also expressed fear about future consequences from facial injections affecting her mind, which had always been clear with total recall, and genetically what she always envisioned because of strong familial traits. Gabby was living her life needing to be more guarded of everything she was putting into her body so that she would be able to live to the age she initially thought she would attain. She was having no caffeine, going organic, and using herbal remedies. “It’s like your body fights these positive changes, and can overcome their benefits.” Gabby described feeling desperate because no matter what interventions she tried relapses occurred, and she did not experience symptom relief from her side effects. “I’ve been on probably every anti-anxiety medicine you can try through the course of this, and every one of them made it worse. There’s this feeling of desperation! I’ll do anything. Just make it stop.”

Tabia’s future fear for her aging body was thought provoking: “As far as caretaking where will I end up? Will I end up with family? Will I end up in a nursing home? With society’s attitude about the older generation, you know, they’re just tossed aside and forgotten. And it’s all scary, it’s all scary.” Her perceived choices for the future now felt limited and she was afraid. The participants had embodied fears of becoming dependent bodies when they reflected on future aging possibilities of their fragmented bodies. The view of the body from the lens of existential medicine explains the idea of felt body, and how the experience of bodily illness can pervade an entire body, “The way one feels in one’s bodies is not only how one feels in one’s minds but also who one feels oneself to be, a bodily sense of self or body identity” (Existential Medicine, n.d., paragraph 7), which ultimately for the participants transformed who they thought they were, and would become bodily in the future—patients with chronic conditions or aging

with disabilities and being dependent.

Hentz's (2002) study of body memory from past experiences (memory time) found that the memory from the past was relived as it was originally lived. In this study, each time the women recalled their decision to inject and the consequences of the transformed body, they experienced post-traumatic stress disorder-like memories. Remembering time was the body perceiving "that time", and the memories were unpleasant each time they were relived.

Shame and guilt are called the reflexive emotions because they belong to the self-related and self-evaluating emotions that are closely related to the development of self-consciousness (Fuchs, 2003). Fuchs suggests the corporeal body is prone to cause feelings of embarrassment, shame, and guilt (the felt body) when the body is closely related to the interpersonal sphere (relationality): the body becomes an object when it is seen by the other. The person feeling the shame experiences an elementary self-devaluation. Fuchs posits that this depersonalization of the lived body is essentially felt as unworthiness and the body experiences guilt when the social norms are internalized as one's own feelings of value. He continues that this guilt, if unresolved or irreparable, such as what occurred for some of these women in this study, ties the participants to the past especially if surrounded by a world of contempt or remorse, as well, experienced by participants from the physicians, family and friends in this study. Tabia's relived shame and guilt centered on her relationship with her mother: "My mother watched her grown child scream in agonizing pain. . . hour upon hour. . . night after night. . . week after week. . . month after month. She just held my hand and cried. It was tortuous." Gabby also chastised herself for being stupid enough to inject herself in the first place because

she was aging.

Nevertheless, these same women found faith and hope in spite of the embodied fear for their future that also co-existed in their lived body. Tabia talked about how everything that happened from the side effects was just so scary. "You hang on to that hope; you just hang on to it." Otherwise, for Tabia, the future seemed too scary to contemplate. The wish and the phenomenology of the wish written about in *The Principle of Hope*, by Gekle (2001), states that its theme about hope was the dream of a better life and it is initially the directionality (the future-orientation) of the intentionality of the wish. Tabia's wish was to have a normal body again in her future. Hope has also been worded by Clarke and Kissane (2002) as a basic, fundamental and integral part of life. Nunn, Lewis, Walton, and Carr (1996) mentioned in the above journal article by Clarke and Kissane, defined it as "that construction of, and response to, the perceived future in which the desirable is subjectively assessed to be probable" (p. 521).

Although hope is a difficult concept to describe it is basic, fundamental, and integral to life. It is an attitude, yet a belief that in an uncertain future hope creates the belief in the possibility for better outcomes, and in this context as voiced by Tabia, faith maintains this possibility for the future. She spoke about having nothing to rely on but faith because her body experienced an illness that disabled her so much, and the medical profession either did not understand or denied it could be possible, all she really had left was faith. She said, "It's the only thing that really keeps you going."

Gabby's corporeal resilience, a result of her embodied spirituality, supported her through her reaction to the fateful final injection. She said, "I didn't realize the strength I had until I went through this." I recall asking her how she had endured her lived

experiences with a fractured body. “There had to be a purpose, you know, why I suffered through this. I’m a religious and spiritual person. I believe there has to be some kind of reason why I had [this experience], why I’ve gone through this.”

All seven participants believed there could be potential to addiction of facial injections, and how that addiction could be very impacting in relation to the existential modes of temporality and relationality. Within the context of their experiences, these women framed the criterion of addiction as a loss of will (mind, body, and spirit) that could develop over time, at any time, and which could result in significant harm to the individual body. The thought of potential addiction to having facial injections in addition to a currently fractured body and abandonment by the medical system conjured an additional vision of the unknown future, but now with a component of dread reflecting on the meaning of addiction. As a result, the idea of addiction presenting itself in their bodies, as a latent side effect in the future, was what created fear for their future selves.

Addiction to facial injections was seen by the participants as loss of will (agency and control) that could create a moral dilemma related to subjective perspectives about responsibility, autonomy, rationality, and freedom. However, the concept of addiction has been a complex and contested term (Coole, 2005), thus, would there even exist a reliable treatment intervention if addiction to injectable products could potentially occur?

Lysandra described the addiction as possibly becoming used to the younger looking self, and then not wanting to lose that look, if this view of the body is what is valued. She described it as almost a high, and the body had to keep going back, and then she said how terrible it would be from a personal lived body perspective to be addicted to having facial injections. Additionally, from a relational perspective a financial burden and hardship

could occur for a family since facial injections could be expensive. For example, she paid \$2800 for six vials of two product combinations that promised improved results compared to a single formula. Within the relationality of the family was it not also the expectation that it was the family's money or should be? Thus, Lysandra reasoned that addiction to facial injections could have terrible consequences to this relational mode.

Vivienne had noticed, generally, that if some part of some woman's injection only partially worked they kept doing the injections to attain that certain look [a transformed positive view of her body]. Being more specific, Vivienne shared this awareness about her own situation: "Whatever it would have taken, whatever the longest term was if I had liked it, I would have gone back and gotten it done permanently." Previously, Vivienne had expressed significant disappointment and belief that the procedure results did not work. When asked if she might consider another treatment at some time in the future, she replied: "I might change my mind tomorrow but right now, no. Not unless I thought it would work." There exists the possibility that Vivienne would participate in facial injections in the future because there have been new additions of products to the market, which profess to be better than previous products. Moreover, there are new innovative marketing strategies that can be very convincing and seductive because they are backed by supposedly ethical and knowledgeable physicians who receive bonuses for promoting the companies' products.

Lane believed that only affluent women were at risk for addiction to facial injections to look younger because the expense would not be an issue, and that it was completely safe when the procedure was done by a qualified doctor. Like Lysandra, Gabby proclaimed it as a "high", and the euphoria being almost instant afterwards for

doing something that exciting for her relational-self. I had wondered if the euphoria was an addictive bodily response. When asked if she would have continued with the injections had she not experienced the side effects, Gabby responded, "Oh, absolutely." She felt the injection was the answer to all her personal body-aging issues, and she had trusted it was safe until she experienced her side effects. Tabia and Amber also explained that getting a treatment and having a good result perpetuated wanting more and more. Amber had heard from other women that a certain point occurs where the treatment effect on the face is going away or it feels like it is going away, and it is hard not to go back. Tabia concurred that it did or had the potential to become addictive. She stated, "The drive or the desire for [having facial injections] just goes beyond all reason." Safara said her mood was better following an injection and felt she needed it again because her mood was not as good. She said, "I think there's a little bit of that element to it, in terms of people potentially getting addicted to it, even if they don't realize it."

From a phenomenological lens, Schlimme (2010) explains addiction as an embodied custom that is learned and developed. Becoming addicted, he contends, is from repeatedly performing the custom (in this case, a facial injection) creating a deep change in one's personal identity and alters a (free) agent's self-effectivity. Schlimme calls addiction a loss of self-determination, and shares this quote from Burroughs (1914-1917), "Time has meaning for him [the addict] only with reference to his need" (p. 170). "It is where the bodies act and suffer" (Coole, 2005, p. 128). These two poignant statements in reference to addiction describes both the compulsion of the self to gratify the incessant need of the particular addiction, which once satisfied informs the self that there is no will to control the addiction. The suffering that occurs is between the self that does not want

to be addicted with often potential debilitating consequences, and the self that needs to satisfy the addiction but is incapable of stopping, at whatever cost.

Finally, the women had changed relationships with others outside of the medical system as a result of their experience. Toward the end of each participant interview I asked: "If another woman was to ask your opinion about whether to have facial injections to reduce the signs of aging or not, what would you say to them?" The responses ranged from: "Oh my God, don't do it!" to "Yes, definitely." Women often pay attention to feelings of empathy and caring to decide what to do rather than relying as fully as possible on abstract rules of reason (Cole & Coultrap-McQuin, 1992; Gilligan, 1982; Walker, 1989, as cited in Held, 1993). Safara commented: "I hope this study might make some women look into the side effects, possible side effects of an injection. Just because they've had it before without any problem doesn't mean they won't one day have a severe reaction, and really most people just aren't aware of that." Amber had three top points to share: "They need to know how it really works and they need to know how bad it can really get, and they need to know that there isn't a cure if something goes wrong. Women need to know so they can make a better informed decision." Amber also identified the irony of actual costs: "For all of the people who paid \$350 for this facial injection, it cost thousands and thousands of dollars in subsequent medical tests and investigations."

Gabby's advocating to other women about her experience made her feel like she was paying it forward. "I'm very vocal. I've never hid it from anybody." She explained further that she always tried to make her advocacy against facial injections less of a complaint about what happened to her body, and more of a promotion of awareness about

the possibilities that could occur from injections. Gabby shared her sister's reaction, "I'm so grateful you were able to tell me about [your experience] because when I was getting [similar] injections, I think I may have been having symptoms, mild ones. You have saved more people than just yourself by telling them what happened to you."

From a phenomenological feminist moral perspective, this display of caring and responsibility brings to mind what Butler (1988) said of women, "The feminist impulse has often emerged in the recognition that my pain or my silence or my anger or my situation is finally not mine alone, and that it delimits me in a shared cultural situation which in turn enables and empowers me in certain unanticipated ways" (p. 522). "Indeed, the ethic of caring has a distinctly feminine face, it is uniquely a feminine ethic" (Tronto, 1993, as cited in Jung, 1996, p. 13).

I recall reflecting on new insights Tabia and Gabby had made from a relational perspective about their "hard lessons learned" (Tabia). Both participants noted changes in their relational modes with friends. Both had learned who their real friends were, those who supported them, and those who judged them and cut their friendship ties. Gabby also added that the one great thing that happened was the wonderful people she had met along the way, who cared about her transformed self, and supported her unconditionally. "We discover what we know in our relations because some of our knowledge resides intangibly in our relations." (PHENOMENOLOGYONLINE, 2013, paragraph one).

Summary

Participants described their lived bodies as both subjects and objects in a culture in which women were expected to conform to rigid beauty ideals because of sexism and ageism within a patriarchal and capitalistic society. Subjectively, and prior to facial

injections they all had positive perspectives about aging in terms of having whole and normal bodies. Corporeally, from a capitalistic and patriarchal lens they were objectified as essentially a monetary benefit from the commoditization of their aging bodies.

Physical and psychological effects were experienced by many of the women who underwent unprecedented and total lived body fractures (mind, body, and spirit) from the side effects of their facial injections, experiencing an embodiment of demoralization (feelings of helplessness and diminished self-esteem) (Clarke & Kissane, 2002). They each had functioning and whole bodies prior to facial injections, yet following injections fractured bodies were experienced differently by the participants who suffered the more serious side effects. Others had ongoing symptoms, and still others had no physical or psychological reaction.

As a result of lack of information and silence (questionable ethics and loss of trust) in response to their inquiries about what had gone terribly wrong with their bodies, these women experienced a changed trust relationship with various levels within the medical system. They felt demoralized and abandoned and they were left on their own to find their own supports, answers, and meanings related to their lived experiences of side effects from facial injections.

They now wondered about potential outcomes (future time) based on the unknown possibilities of their bodies (e.g., fear of potential addiction, uncertainty about the progression of their side effects). The women spoke of the many possibilities of their future bodies, which was very scary, because they had transformed into unknown and fragmented bodies. The way they related to others was also changed (relationality), such as a sense of responsibility to inform others of potential risks.

However, changed views on aging occurred from negative or disappointing experiences with facial injections that led to altered bodily experiences, and also contributed to more positive views of aging for most of these women, with revised interpretations of their current bodies (present corporeality) and of aging (future corporeality—bodies in future time). The participants reconnected to their real selves, representing a change in values from external-market values to redefined, intrinsic subjective values about positive aging.

Chapter 6: Discussion

This discussion chapter is framed in three ways: (a) this is what I attempted to answer, (b) this is what I learned, and (c) this is why it matters (Richards, 2009). In terms of what I set out to answer, the goals were twofold.

Previous research on facial injections to reduce the signs of aging is limited. First, there is very little recent literature on women who have had Botox and facial filler injections, which indicates a critical gap in research considering that these facial enhancements are identified as the most preferred procedure of all non-invasive facial cosmetic procedures. Second, the majority of research and statistics are from the United States, and less from the global community. Canadian statistics are not available from Canadian sources, and minimal Canadian research has been published on Botox and fillers specifically. Third, a review of the literature has not found any Canadian research connecting the political economy of aging or the medical industrial complex as being an influence on women's participation in Botox and filler injections. Fourth, no researchers have applied a theoretical framework of feminist moral theory to their studies and current academic studies did not research my particular focus within the cosmetic surgery industry. Although not researching on moral outcomes of facial injections, moral conflicts, moral dilemmas and values have surfaced in reference to Botox in findings from various studies, which alludes to the relevance of my research study because the moral impact on women who participate in facial injections is of significant importance from a feminist moral perspective. Finally, various wide-spread media types (informationalism) portrayed only positive outcomes for women who have had Botox or other facial fillers (Juvéderm, Restylane, or other products).

This study contributes to the research by giving mid-life women a voice about their negative or mixed experiences, feelings, and perceptions about their decision to have facial injections. I chose to focus on these women because they had not been given a voice about their experiences, based on my literature review. Moreover, as an aging woman I was alarmed by the unprecedented phenomenon and growth of the cosmetic surgery industry that targeted women of all ages, and as a researcher I was fascinated by the realization that this phenomenon did influence how women perceived positive aging. For example, billions of dollars have been spent annually within the cosmetic surgery industry, and market projections for the United States, alone, by 2015 are 55 million annual procedures (Liu & Miller, 2008).

From a feminist moral lens and a phenomenological methodology the research question can now be answered. And so, what did I learn? The themes and their key points follow: the commodified body depicts the participants' acknowledged embodied ageism and sexism in their lives by a patriarchal and capitalistic society although in varying intensities and extents. The women described their lived bodies as both subjects and objects in a culture in which women were expected to conform to rigid beauty ideals.

The fractured body defines four women who had serious physical and psychological fracture (mind, body, and spirit) from facial injections such as heightened sensitivity to noise and lights, felt acute anxiety, panic, crippling fear, intense fatigue and insomnia. Some women had on-going and related symptoms years later (temporality). They also experienced an embodiment of demoralization, such as feelings of helplessness and diminished self-esteem.

The abandoned body is about the experiences of some participants who described

embodied feelings of dejection, devaluing, and more fear and anxiety of being made to feel crazy and alone within the medical system (relationality), which had been turned to for answers and solutions but had turned them away or did not know how to care for them. As a result of lack of information and silence in response to their inquiries, the women experienced a changed trust relationship with the medical system.

The reflective body centers on critical illness or a fractured body and is felt by some of the women as an intense life-changing experience entailing physiological, psychological, and cognitive aspects that had a profound effect on their being (the self) (corporeality). These negative or disappointing experiences with facial injections that led to altered bodily experiences contributed to more positive views of aging for most of the women, with revised views of their current bodies (present corporeality) and of aging (future corporeality—bodies in future time).

The transformed body describes participants who wondered about potential outcomes (future time), and shared their views about the future based on the unknown possibilities of their changed bodies (corporeality). The way they related to other women was also changed (relationality). Because of a sense of caring and responsibility they wanted women who may be considering facial injections to be aware of the potential risk of anti-aging facial injections.

Initially, my learning began with the promotion and recruitment stage, which as mentioned was challenging and frustrating but compelling and rewarding following reflection. My attempt at various recruitment methods created a deeper understanding of women's lived experiences over time of the phenomenon of facial injections. I became more aware during the recruitment stage of the value of mid-life women in this anti-aging

culture. Women's subjective bodies were objectified as lucrative market profits for the medical industrial complex and anti-aging enterprise. For example, some fitness centers would not allow posters. I wondered if their reactions were due to protecting their own market interests. This issue draws attention to what Estes (2001) has described as a powerful ideology of patriarchy and capitalism that has shaped negative outlooks of the aging female body such as aging is disease but can be altered or transformed (over time) to a restored younger self (corporeality) by aspects within the medical industrial complex and the aging enterprise (relationality) such as the cosmetic surgery industry.

I begin this discussion with my thoughts on the significance of the face, which is prominent throughout the study. I cannot do justice to describing the phenomenon of the face. I leave this to Black (2011) who wrote the following journal article, *What is a Face?* Black writes:

The face is a shifting multiplex, distributed and layered phenomenon. It cannot be understood as something simple, predictable, fixed or self-evident. Rather, this inescapable foundation in biology and neurology provides the mechanisms which allow the face to be as dynamic, unstable, and multiplex as it is. (p. 1)

The relationship between the physical face and the construction of individual identity has always been and continues to be central and historical (Black, 2011; Haiken, 2000). The mask of aging (the face) is presented as the central problematic focus for an aging identity by Biggs (1997), who notes that a mask motif is employed to interpret the management of an aging face in an uncertain world. One participant used the analogy of creating an illusion of the face when injections are done. She described the transformed face as the mask. Lived body is prominent, and deserves foremost mention because the

body is related to everything we say and think, as well as being the umbilical cord to the social world. The concept of the body as embodiment is one of the most original and privileged features of phenomenology (Jung, 1996). The body described by me as “the self” incorporates the phenomenological associations of mind, body, and spirit.

Feminist moral theory as a critical lens explains how a socio-cultural influence exerts pressure on women to appear youthful in a society that devalues the second half of life as one of supposed decline (disease) (Walker, 1989). Age-based stereotyping of aging female bodies have been pervasive and persistent historically (Cuddy, Norton, & Fiske, 2005), although it has taken different expressions in different times (Oberg & Tornstam, 2001). Women's subjective bodies with their individual intrinsic values embody the objective focus of a patriarchal and capitalistic society and culture, which I refer to as the relational-self (personal identity) becoming the gendered consumer body. In current consumer society the aging female body has become the focus of the cosmetic surgery industry within the realm of the medical industrial complex.

How we conceptualize things and what kind of epistemic inquiry standards we use are socially and historically decided (Jiang, 2005). Black (2011) as well conceptualizes that the face observed by our conscious minds is socially and historically perceived by the relational self. The decision depends initially (pre-injection) on subjective perspectives of the self, which are influenced by external objective influences and coercions (Goodman, 1996; Liechty & Yarnal, 2010), and the participants confirmed this. Gabby felt that her subjective body had first become the object body as the physician's cash cow before injection and then had become a superfluous body to him when looking for answers about her side effects. Authority derives as much from the

realm of consumer culture, the patient both inhabits and embodies, as from the surgeon (Haiken, 1997). This comment by Haiken references the aging enterprise that extends beyond health and into all arenas of health-related activities such as the realm of cosmetic surgical and non-surgical procedures. This is essentially the anti-aging enterprise, and the offer of medical beauty has been given by physicians, paraprofessionals, and now dentists with promises and guarantees of improving many aspects of life's well-being components: personal and professional relationships, or feeling better about the personal-self overall by retaining or regaining a youthful look, and women are told their facial injection products are reliable and safe. This assertion was the deciding trust factor with their decisions to inject. Safara admitted she did not have any mistrust of the product or its claims to actually prevent wrinkles from forming solely because her injection came from a medical practitioner who she believed knew explicitly all about the product and its bodily effects because physicians she had always thought held a high standard in this particular ethic of care.

There is a tension between sadness over the loss of youth and promises of continual youth (albeit medically induced). This tension between internal subjective values of the self and consumer market values also has different philosophical consumer perspectives. Psychological perspectives (Diduch, 2012; Eibach, Mock, & Courtney, 2010; Mock & Eibach, 2011) suggest that people often resist seeing themselves as old, which become ingrained in their psyches when they are younger and more active. From this psychological stance, it is thought people with the most pessimistic views of old age resist seeing themselves as elderly the most.

From a consumer perspective, Szmigan and Carrigan (2006) suggest that media

stereotypes are less important than more localized group norms, and this sense of community among women will be an important bridge in bringing them together to understand the possibilities and share the problems of aging. I recall the remarks of Heyes (2007a), mentioned previously in an earlier section of this paper, in which she stated that when personal experiences are externalized and shared with others, it contributes to a broader understanding within a larger socio-political context, and this will continue to play an important role (also related to practices of consciousness-raising). All participants with side effects willingly maintained a supportive relational connection to others on the Botox Community website, and initiated other relational community contacts with women currently living with functioning whole bodies. The intent of sharing the reality of their fractured bodies following injection was for awareness and prevention of possible fracture to the bodies of these women at any possible time in their own lived current or future time.

There has been an increase in literature on the concept of self-subjugation from a feminist perspective, which leads to exploration of the conflation between bio-medicine and the beauty industry (Dolezal, 2010). Dolezal contends that women are coerced by normative standards of medical discourse to engage in bodily practices that can be detrimental to their bodies and spirits; appearance has become pathologized (medicalized) and incorporated under a medical context, thus, women may choose facial injections out of a need for improved health (aging) and social power rather than for superficial aesthetic concerns. Because of this accepted interpretation, Dolezal posits that it is not surprising that intelligent, educated, and feminist women (characteristic of the women in this study) choose facial injections not because they see themselves as duped

but rather as being empowered. In reference to this study, I interpret the concept of self-subjugation by Dolezal as the body conflict (tension) between invisibility and visibility, which was identified by the participants in the section about the commodified body. They described their lived bodies as both subjects and objects, which was expressed as a fundamental ambiguity of their bodies from a capitalistic and patriarchal influence.

Calogero and Jost (2011) posit that self-objectification occurs as a direct consequence of the need to justify and support the ingrained and subliminal system of gender inequality. They suggest that by increasing self-objectification encounters with benevolent and complementary forms (informationalism) of sexism and ageism, women will become active participants in their own self-subjugation. This perspective has been substantiated by the phenomenal growth of the cosmetic surgery industry and by the women from this study related to their awareness of the widespread aging beauty myths that do influence and coerce the subjective body. For example, Amber acknowledged that over time the body could be unaware it has unknowingly been seduced to becoming the objectified market body because the anti-aging rhetoric is so steeped and subliminal within the sociocultural arena.

Brown (2008) counters with perspectives about justifying cosmetic surgery, citing the feminist perspective of Davis (2003) who defends cosmetic surgery for women altering their appearance to hold on to their jobs. She states it is their way of exhibiting control over their lives. Noel, a cosmetic surgeon and feminist who no longer practices, maintained that facial enhancements were a social necessity for women in their right to work (Davis, 2003). Lane for one experienced this social expectation about her body within her workplace relationships. She worked with the public and the standard was that

her body was expected to look good. She also worked with a large cohort of various aged women and acknowledged that the presentation of the bodies was competitive. Although Negrin (2002) believes women submit to patriarchal debates, she also argues that women know its risks and benefits. Additionally, Clarke and Griffin (2007) argue that some women accept the physical realities of growing older whereas other women assert beauty work interventions should be used from available preferred choices that are considered to be needed (by the relational self).

Studies from social theorists (Dolezal, 2010; Turner, 1984) agree with and support this study and its findings. For example, Dolezal purports the possibility of engagement of bodily practices being detrimental to “bodies and spirits” (p. 370), which did occur but not to the extent and significance of the women’s fractured bodies. For example, the normal functioning and whole bodies were fractured to the extent that some women had to quit work and be taken care of by family, some women believed they would die, and some women described a body that had never known such illness. Moreover, some women continued to have significant symptoms from side effects three years later. The women had no control over these unknown bodies so consequently they developed fractured lives over time.

As well, Dolezal, from a phenomenological perspective, agrees with my view that the body as the “organ of will” (p. 370) facilitates its successful relation with the lifeworld. She adds that if facial injections benefit the individual (as per the medical-market messages) by “facilitating improvements in the patient’s psychological functioning” (Pruzinsky, 1993, as cited in Fraser, 2003, p. 33) then women are empowered, self-determining, and in control. I acknowledge these pre-injection

perspectives but differ with the perspective women feel empowered, self-determining and in control, not that *they are*. This idea identifies the tensions women experience daily between internal values, and external market influences. The dilemma relates to how one grapples with this tension, which is a major force of contention or personal conflict of the self as described by the women, such as Lane and Vivienne. Moreover, I disagree with Dolezal's opinion that phenomenology fails to take into account social forces that delimit and define embodied experiences.

Ultimately, the decision to inject or not is a personal choice, and a private decision related to the self's identity, and what is meaningful for the relational self at any time during the life course (temporality). Women are in different existential places with their bodies, at different times with different subjective aging perspectives by the body, and with different others (relationality) thus, decisions and choices are influenced by all of the above perspectives in varying means and degrees as substantiated in this study. For example, Lane's subjective body felt like 50 years old although her chronicle age was 62 years and this empowered her to engage in anti-aging interventions because she liked that her subjective-self looked younger. It made her feel good and she wanted to extend that good feeling about her body. Tabia was entering the dating field following the ending of a 10 year relationship. And Gabby's young subjective self at 42 years was not accepting of her grandmother persona that perpetuated negative feelings throughout her subjective self because of the ageist connotations of the word grandmother from historical and present devaluing of aging women. Participants concur that the private and personal aging experience and natural biological process of aging has become too public an event because of the conflation of biomedicine with the cosmetic surgery industry. Anti-aging

interventions, like other medial and pseudo medicinal products and services are a cause for concern. The free market regulation, as noted, is unsuccessful in identifying risky, ineffective and fraudulent anti-aging treatments and products (Mehlman, Binstock, Juengst, Ponsaran, & Whitehouse, 2004).

Transformed lives occurred for four of the women in this study who experienced an unprecedented fracturing of their bodies inclusive of their minds, bodies, and spirits. Prior to facial injections all of the participants described their bodies as normal, whole, and familiar. Overall, they defined their pre-objective bodies as feeling subjective well-being. Yet, following injections they experienced side effects that fashioned a body unfamiliar to the self. Their experiences were devoid of normalcy, wholeness, and familiarity. They contended with physical side effects invalidated by the physicians, specialists, tests, or procedures of any kind. They concurred that the most prevalent and lasting symptoms of these side effects were panic, insomnia, anxiety, and unpredictable relapses. Exacerbations of side effects and their symptoms were common, and they were told there was no existing treatment model. They felt alone, they experienced compounded anxiety, and when they shared their experiences of being demoralized, it was further suggested such reactions were their imagination (psychological) or hormonal (being a woman).

These unprecedented experiences mirror the phenomenon of fibromyalgia and chronic fatigue syndrome that occurred some years ago. At that time women experienced severe chronic pain that also affected their lived bodies and fragmented their lives for many years. In medical terms, fibromyalgia and chronic fatigue syndrome are described as “an undefined or unexplained disorder” (Cho, Skowera, Cleare, & Wessely, 2006;

Steihaug, 2005, as cited in Råheim & Håland, 2006, p. 36). At that time as well, women were doubted and demeaned with, "It is all in your mind." With a problem of definition, the women had trouble legitimizing their pain. And similar to the women with the side effects, the physicians could only understand the bodies from a biomedical perspective, and could only identify with the body as an anatomical-physiological object.

Further discussion on the topic of emotions is warranted in relation to women's perceived well-being as well as the emotional fragmenting of the feeling body that was experienced initially from significant health issues, on-going symptoms, and medical system demoralization and depersonalization, which contributed to suicidal thoughts for two women (contemplating death as an escape from the experience of a fractured body). I was unable to research this trajectory via statistics search (suicide attempts, actual suicides) because medical records are not available, and this was not a medical research study. It did create further reflection about the possibilities of the horrific damage being done to women. Sharing contextual background is important to understand this very dark aspect of side effects reported in this study. Suicide has historically been confined to psychiatric illness, and been a taboo subject, but Pompili (2010) states his belief in suicidal thoughts and tendencies to be the result of fracture with aspects such as oneself, other people, and nature. He contends that suicide as a phenomenon emerging from the individual requires an understanding of that person's emotions, personality, and experiences. He stresses the need to better understand the suicidal dimension, as opposed to the psychiatric dimension, and to avoid myth and stigmatization. Discussion around suicide with two of the participants permitted only a glimpse into the realities of possible consequences related to facial injections and subsequent fracture of bodies that has gone

terribly wrong.

To truly comprehend the depth of the body fracture some participants experienced, it is first necessary to understand the significance of their emotions, which they reported were very atypical with their normal bodies. As pointed out by the four women with fractured bodies, anxiety was the most common and one of the worst emotions because it brought their bodies close to death. Heidegger notes that anxiety as “extremely disturbing because it reveals this *Nothingness* lying at the heart of human existence” (Watts, 2001, p. 44). He distinguishes between two kinds of anxiety; one is likened to an “uneasy and background feeling” (p. 44). The other, which the women experienced, overwhelms and disrupts one’s normal sense of existence. This mood states Heidegger reveals the naked truth about oneself and the world, by stripping away all one’s familiar ways of perceiving things in the world (Watts, 2001). Happiness, embarrassment, surprise, sadness, fear, shame, and guilt are believed to occur more in women, and anger, contempt, and pride more in men (Plant, Hyde, Keltner, & Devine, 2000). Inevitably, these gendered emotions contributed to the further fracturing of the women’s bodies and the demoralizing feelings of abandonment because men dominate and rule the arena of rationality and cool objectivity whereas all things that are emotional and concern feelings are what women experience.

Held (1993) wrote about the defining importance of women’s emotions to the relational self in contrast to the historical perspective of male dominance that reason by deduction or rational calculation is superlative to feelings of emotion. Current morality in medicine requires the development of the moral emotions, in contrast to moral behaviors emphasizing the primacy of male reason, which did not benefit the women in their search

for answers. Emotion, expressed historically by women should be respected rather than dismissed in the process of gaining moral understanding, and support in relationships of care within the medical system. The women experienced degrading assumptions of psychological demeaning or hormonal imbalance within the medical system. From a social perspective, with gender and emotion in context, stereotypes are also emotion-specific.

As mentioned previously, anxiety, panic, and insomnia were the most experienced side effect but participants could not find appropriate or effective relief from the medical system. The treatment of anxiety falls within a clinical psychological field thus, doctors did not believe the side effects could possibly be caused from facial injections, and they did not have a treatment model for this type of anxiety (of this nature). In other words, there was no appropriate model of care. The issue is that physicians either do not believe the side effects are from facial injections or do not bother to investigate further such as Amber's physician who told her she was imagining that her functionality had decreased, that she could not get out of bed, that she could not eat, and that she did not have crippling headaches for the first time and crippling panic because he stated emphatically that the injection could not do that. Gabby believed physicians were not telling the truth or they were not coming out and saying anything. She believed that the focus was on profits rather than morality.

Öhman (1993) purports that fear and anxiety overlap, are aversive and centered on threat. He states they both involve intense negative feelings and strong bodily manifestations. The significance of this chronic lived body experience (fear and anxiety) from side effects, and symptoms from side effects make it more traumatic and life-

threatening based on participant interviews. Because it is clinical and not situational, the former means it was more recurrent and persistent, its intensity was unreasonable and it tended to paralyze the women, making them helpless and unable to cope, and that resulted in impeded psychosocial or physiological functioning (or both) (Marks & Lader, 1973), which supports explicitly what occurred with previous whole and normally functioning bodies of these women.

Hopelessness, the hallmark of demoralization, is associated with poor outcomes in physical and psychiatric illness, and importantly yet sadly, with suicidal ideation and the wish to die from experiencing existential despair and meaninglessness. Four women felt hopeless during their lived experiences of fracture and abandonment, some more so than others. Two women were familiar with suicidal thoughts. Although they all had caring and supportive family and friends, it was the medical system that did not offer what they wanted or needed to help heal their fractured bodies.

Clarke and Kissane (2002) describe the onset of demoralization as occurring in the context of a severe threat such as the body being fragmented then, abandoned. The experience causes marked anxiety because the person does not know how to make the experience stop. For example, the assumption by the women who were experiencing different degrees of demoralization was that they would have a medical relationship characterized by empathic resonance, combined with good physical care and symptomatic relief, which the authors define as existential distress. It occurs in patients suffering from both mental and physical illness, specifically ones that threaten life or integrity of being such as the women in this study. Dahlberg further illuminates that patients need their carers to allow themselves to be affected, touched and moved by the

patients and their suffering. She suggests patients fear detached impersonal care, which promotes potential withdrawal compared to authentic personal caring, which has been the lived experience of some study participants. The phenomenological approach is a crucial challenge to the assumptions of the medical model, which assumes a clear division between mind and body, rejects the subjective experience of the patient as irrelevant to treatment, and approaches the body as simply a collection of parts (Turner, 2001).

The women described feelings of being abandoned by the system responsible for injecting their faces to promote anti-aging. It is especially poignant to the participants' *looking glass self* (Cooley, 1902), whereby dignity-of-self is created through interaction (relationality with trusted physicians). The dignity the participants felt (lived body) often mirrored the dignity they failed to see in the eyes of others (embodiment) and it manifested in a social context (the medical industrial complex of the aging enterprise). It is suggested that mattering to others is actually essential to our sense of self (all human beings want to matter to others) and to society (as an element of social bonding) (Elliott, Kao, & Grant, 2004; Rayle, 2006). The participants experienced loss of dignity both bodily and relationally with these physician interactions at all levels including the injecting physicians, family practice physicians, specialists, emergency room visits, and pharmaceutical companies who had manufactured the product. The on-line medical searches resulted in connections to physicians who denied any connections. These same women are still looking for acknowledgement of the harms their bodies experienced through fracture from side effects.

Social dignity is grounded in human dignity (Jacobson, 2007). Jacobson's review states that the importance of trust in social life cannot be understated. She writes about

the concerns related to the ways in which dignity is either maintained or threatened through social interactions (relationality) in specific health-related interactions. She asks, "Is there a causal relationship between social dignity status and health status?" (p. 299). Findings from this study indicate an affirmative reply to this important query. I concur with Jacobson's closing thoughts that the significance of human dignity is likened to a moral value underlying the ideal of "the good" as an obligation in society (healthcare). For example, Tabia's experience of devaluing because she was a woman seeking information about something for which no one had answers elicited comments from doctors stating it had to be psychological or hormonal because it did not fit any known disease criteria, and then Tabia shared she had to deal with "*that*" on top of everything else.

I think it is most appropriate to interject here with part of a journal article title from a study by King, Finlay, Ashworth, Smith, Langdridge, and Butt (2008): *Can't Really Trust That, So What Can I Trust?* This question represents the women who experienced fragmented bodies and abandonment by the medical industrial complex. The authors from this article put forward a provocative thought and question, which requires further reflection and research. "Pervasive and destructive impact of mistrust and embodied self-identity, and relationality with others could be a critical feature of the phenomenon of mistrust. Does mistrust of others get irrevocably intertwined with mistrust of self?" (p. 98). By disregarding personal accounts, Boyd (2011) states that doctors risk missing important clinical information but more seriously, they disregard the patient's humanity, which is a moral offense that is often perceived negatively. Boyd's comment is noteworthy because the focus of biological medicine is the clinical body but

from an existential view of the women's bodies they did not have clinical bodies they had actual bodies, which had fractured. The physicians' perspectives derived from medical books, clinical training, and similar mentoring and continued education and research within the medical system. "It is a purely clinical gaze—one, which turns the body into an object of medical-scientific examination and clinical testing!" (Life Medicine and Life Doctoring, n.d., paragraph one).

Moreover, from a psychological perspective on mattering to others, Elliott et al. (2004) offer that mattering is defined by the perception that, to some degree and in any of a variety of ways, we are a significant part of the world around us. The authors' viewpoint aligns with Heidegger's phenomenology and existentialism, which begins its analysis with the individual engaged in a particular world with one's characteristic form of life (Wrathall & Dreyfus, 2000). A fundamental concept from the philosophy of Heidegger is related to caring, which is explained as taking over another's concerns and empowering those others with advocacy and facilitation because they do matter; someone does care. For example, Amber recalled how frightening it was when she had her terrible illness following injection, and the doctor did not express his caring and did not say it could be very bad but he would stay with her, monitor her, and watch her symptoms. This would have empowered her with reassurance and hope but rather he insisted it was a virus and not to call again.

Currently there is more speculation in the media about the powerful pharmaceutical companies, and most recently the relationality (questionable ethical practices) between many physicians and these big companies (monetary gain and resulting consequences to women who receive facial injections). In spring 2013, two

separate articles were written in the Chronicle Herald. The first article was titled, *Doctors, drug firms may be too close for comfort: Practices like sponsorships, speaking fees might prompt tougher rules*. One highlight from the article shared that in 2012 pharmaceutical companies from America's largest healthcare-market spent more than \$24 billion, alone, marketing drugs to doctors (Chronicle Herald, 2013). The second article headlined as, *Survey: MDs lack data on drug dangers; Canada among nations polled on influence of pharmaceutical firms' visits*. In summary, it was found that sales reps who visit doctors to promote their medications (Canada, France, and U.S.) gave information on the product in less than two percent of their promotions and there had been 1700 visits by the pharmaceutical reps between May 2009 and June 2010 (Ubelacker, 2013). Participant comments supported this bioethics focus through knowledge from lived experiences, such as the big manufacturers of facial injection products had so much money and were so powerful, and because they have been powerful for a long, long time, they do whatever they want, and they do not care.

The women in this study advocate now for much stricter health and safety production rules and safer injectable products, in particular. Following their lived experiences they had strong sentiments that doctors needed to be regulated, and that regulation should include the actual training, and who is allowed to inject. But the question that comes to mind is, "How does one regulate morality? For all of the people who spent \$350, it cost thousands and thousands of dollars in subsequent medical care. This was a significant reality and substantiated by both Canadian and American participants. Goldacre's (2012) *Bad Pharma* exposes the harsh reality of a myriad of unethical and illegal practices occurring daily and across many networks within the vast

medical industrial complex, such as data on side effects being suppressed or *sanitized* and doctors' education being funded by pharmaceutical companies. Facial fillers were not mentioned as examples in the book, and the pharmaceutical companies that manufacture these products lists various negative side effects on their websites and with their products, but this study clearly shows the need for more research in this area and a need for patients' voices to be listened to, both by the pharmaceutical companies and by the medical practitioners who treat the women.

One participant shared that it was mind-boggling that so much damage could be done yet, one does not hear about it. She recounted she had never come across anything in the literature that represented women who had similar experiences rather, it was always positive. Goldacre writes that the whole edifice of medicine is broken because the evidence one uses to make decisions is hopelessly and systematically distorted (2012), which addresses issues brought forth by the abandoned women such as lack of informed consent or misrepresentation of the minor expected side effects (flu-like symptoms and temporary slight drooping). One participant shared that for any other minor procedures full disclosure is given and is reliable.

Not all women were fortunate enough to have good health coverage and one participant had none. Safara decided to try a different intervention to help heal her fractured body but had to pay for the treatment at a private center because the referral criteria for treatment did not recognize or acknowledge her side effects from facial injections as legitimate. Safara paid \$2240 for seven months of treatments and, she also lost time from her work. She tried alternative treatments such as acupuncture, massage or other interventions for some temporary relief thus, the total costs were enormous. She

was also financially responsible for a young child.

The abandonment by the initial contacted physicians set in motion a long trail of searching for answers, which culminated for some a huge debt of specialty interventions, and specialists in various medical fields not covered by adequate healthcare, as well as personal costs for loss of work, special diets and products that might offer some small amount of relief to the fractured body. Some women trialed many new medications and natural alternatives never knowing if their bodies would reject the intervention and cause a horrific relapse, and how long that might last or maybe it would give relief for a while but the next time the opposite could happen. The body with side effects and accompanying varied symptoms was unpredictable and frightening. It was difficult to envision how one could cope for any length of time with debilitating anxiety, fear, and insomnia. Some women, like Amber remembered when she could not move out of bed because of the intense panic and the torturous headaches that began following her only injection.

Nevertheless, because individuals can reflect on experience and explore how they interpret their bodies, the potential for new understandings emerge (Pace, 2011). Women who experienced side effects from injections (the fractured body) changed their views on aging, and developed a new relational self (the transformed self), which had occurred from embodiment of their new values. This internal introspection that occurs can be tied to the concept of self-enhancement and autobiographical memory (Conway, 2001, 2005; D'Argembeau & Van der Linden, 2008; McAdams, 2001). These authors suggest the self and memories must form a coherent system in which each component informs and constrains the other such as fear versus hope. The coded, retrieved, and maintained

information (the past memory–temporality) requires consistency between an individual's goals, self-images, self-beliefs, and knowledge about oneself in relation to future expectations (temporality) grounded in memories of specific experiences, such as with the women's facial injections and consequences (side effects) versus their pre-injection recall of how they expected their bodies to be like based on family genetics and their own personal expectations related to how they took care of their bodies.

Human selfhood is reflexive (McAdams, 2001). The dichotomous experience of the fractured and abandoned body over time contributed to further transformation by a change in personal values (moral reflection), which ultimately contributed to changes about the concept of self and authentic living. For example, in the context of this study some women learned that the traditional medical and standard approaches of care by physicians, and others who perform facial injections require a culture of change. For example, there needs to be more inclusion and support of different narratives, needs, and preferences. In other words, to engage in beneficent (to do good) and non-maleficent (to do no harm) attitudes and practices from a woman's perspective is vitally important. The personal concept of self within the relationship of medical care was paramount to the healing of the women with the fractured bodies but that ideal relational experience did not occur.

In contrast, to the reported medical care and experience by the fractured and abandoned bodies of the women, current literature from a medicine, healthcare, and philosophy lens promotes a culture of change in the medical system. It is called *lifeworld-led healthcare*, and the authors (Todres, Galvin, & Dahlberg, 2007) offer a more appropriate understanding and perspective of healthcare, and in my belief, this approach

encompasses the concepts of feminist moral theory. The authors describe the value and philosophy of lifeworld-led healthcare as having a philosophically coherent base and its core value as a humanizing force that moderates technological progress. In essence, it provides a more holistic perspective on being human. Many writers have discussed the potentially dehumanizing implications of technological progress. Heidegger (1966) was one of the early thinkers to apply himself to this topic (Todres et al., 2007). Heidegger wrote:

What it [the traditional medical system, which the women experienced] cannot and does not even seek to offer the patient is a way of managing to understand the meaning of that pain and suffering – not just as an expression of the life of their bodies or brains but as an embodiment of their life world as whole. Biological medicine has not begun to understand the true origin or etiology of illness, obsessed as it is with finding and treating its biological causes and failing completely to explore its life meaning, life purpose and life origin (Existential Medicine, n.d., paragraph two).

McAdams (2001) argues that identity consists of an internal and evolving story of the self-based on autobiographical memories (past time and future time expectations). Based on findings from this study the women did not embody a holistic experience of body healing. For example, in generalizing the concept and philosophy of lifeworld-led healthcare to this study, the women could expect to be fully understood with reference to their personal narratives and concerns; their body image (the self), their perceptions of their spatial and temporal possibilities of their fragmented bodies, and the importance of meaningful relationships with significant others such as those in the medical system.

Self-transcendence (transformation) is defined as the capacity to reach out beyond

oneself and discover or make meaning of experience through broadened perspectives and behavior (Coward, 1996, as cited in Wiggs, 2010). Incorporated in this concept are triggers or turning points (relational modes, temporal modes) that may be transformative, self-renewing (new relational self) and signal change in a person's life course (King et al., 2008). Within this change is the development of inner knowledge and the development of the self (Levenson, 2005, as cited in Wiggs, 2010). Heidegger contends that the individual experience of anxiety has the potential to "enlighten" one's being. He portends it can make a person re-evaluate one's existence and see all the other possibilities available to them. "In the mood of anxiety everything seems stripped of significance" (Watts, 2001).

The concept of self in women resides in three core elements: (a) an interest in and attention to others outside her inner being and in order to make connections; (b) the expectation of mutual sharing of experiences with others, leading to an enhanced sense of inner knowing and knowing of others; and (c) the expectation of interacting and relationship with others, at core the empathetic mutual sharing of stories that foster growth of empowerment and self-knowledge (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991, as cited in Wiggs, 2010). This concept of self in women is supportive of what the women with side effects required for healing of their fractured bodies inclusive of their minds, their bodies and their spirits. Taking a medical history of the women's perceived clinical body and comparing it to a standard disease model for validation of its existence throughout their bodies did not enable the women because the clinical information from an existential medicine lens does not lead to genuine insight into the essence of a lived body, "let alone awaken sensitivity to their lived body, something inseparable from one's

life and lived world” (Existential Medicine, ,n.d., paragraph 4). It is worth considering a Heideggerian look at well-being (Sarvimäki, 2006). She states that both health and quality of life have commonly been defined as well-being or being-well-in-the-world, which supports the findings in this study. Sarvimäki contends that Heidegger’s philosophy opens new ways for empirical health researchers and medical practitioners to view and understand well-being differently.

Holistically, transcendence or transformation involves the entire body (Runquist & Reed, 2007). Jung (1957/1965) as cited in Wiggs (2010) describes this gaining of wisdom in terms of turning inward to view the inner being. Such self-transcendence or transformation is primarily viewed in relation to a life crisis. A link is made between emotional well-being in the face of a life crisis (side effects from facial injections) and self-transcendence (transformation) (Wiggs, 2010). All four fractured and abandoned bodies lived this experience of transformation in particular ways, which connected accordingly to each woman’s modes of being in the world. For example, there was a change in their values about positive aging. Tabia’s comment following reflection was a realization about her vanity. She had reflected about having injections to prevent wrinkles she did not have. Safara shared that her life world view of the future would not be influenced by what others thought regarding her external self. Her new relational self-anticipated embracing her lines and wrinkles. I liked Gabby’s response of, “I’d rather feel good than look young.” And Amber became more aware of the importance of having a natural body. She had learned to appreciate natural beauty even more.

Anticipatory fear of potential outcomes (future time) based on the unknown possibilities of their bodies (e.g., Will there still be existing side effects, or a supposed

illness, which is really a side effect? Will the symptoms have diminished or exacerbated? Will I be able to work? What will future elder care be like and now with a fractured body? Will there be impacts on relational lives; fear of potential addiction or worse?) was experienced by some participants. The way they related to others was also transformed (relationality), such as a sense of responsibility and caring to inform others of potential risk. All four women began advocating to foster awareness of potential harms in ways that would “get the word out” such as Gabby attempting to speak out on the Dr. Oz show. The women participated in this study for the same reason. All four were supportive contacts on the Botox Community website⁴ for many other women, and still others attempted to bring awareness to various public citizen groups on behalf of social justice for women, and other opportunities that presented themselves for opportunities of advocacy and empowerment.

Participant accounts from other studies support the notion that chronic conditions affect self-negativity over time (Osborn & Smith, 2006). The affected body parts were not part of the preferred self, the previous whole self, the real self. As well, from a philosophical and phenomenological perspective of body wholeness (mind, body, and spirit), the traditional existing medical literature tends to focus on the separate parts rather than on its interrelated wholeness. Anxiety, depression, fatigue, helplessness, fear, insomnia, feeling isolated and alone affects all the body, not one separate part in isolation (Csordas, 1994; Thomas & Johnson, 2000). This was the approach from the physicians

⁴ This website's aim is to provide support for people suffering from adverse side effects after receiving Botox.

Web address: www.botoxcommunitysupport.com/

the participants went to for answers, support, and collaborative management of their fragmented bodies. The physicians' inability or unwillingness to treat them or offer any suggestions and then abandon them with no support exacerbated their distress of an unknown future.

All seven participants feared there was potential for addiction to facial injections, and how that addiction could be very problematic in relation to the existential modes of temporality and relationality. For the purpose of reflecting on the meaning of each response I refer to Schlimme (2010), who gives the words a point of reference for understanding from a phenomenological study on addiction and self-determination. Schlimme describes addiction as an embodied custom, highly effective with changing one's lived experience, which is learned and developed while becoming addicted. He states this repeatedly performed custom implies deep changes in one's personal identity and alters a free agent's self-effectivity. This could mean the loss of one's agency (control), which would have in that context of addiction to facial injections, and additional life-altering experiences if addiction were to dominate all customary situations in daily life such as family life, work life, and social life, as Schlimme indicated.

There is a curious void at the core of addiction science, states Weinberg (2013), who challenges Schlimme's theory above. He suggests the void stems from the historical practice of considering the human biological body as separate from human social life. Weinberg promotes two thoughts. First, post-humanism dictates expanding the understanding of addiction to include combinations of intra-personal, interpersonal, and social structural dynamics that contribute to addictions and recoveries, such as well-being. Secondly, post-humanism calls for collaborative exploration on advocating

medical practitioners to inquire if a treatment is oppressive or empowering, and make changes according to individual need rather than a universal standard. Sadly, this approach was lacking for the participants and the potential for addiction to facial injection products has not been acknowledged or made public to my knowledge. As mentioned previously what might be the possibilities if addiction became a future side effect or latent symptom? Consequently, if there was potential to addiction of facial injections (physically or otherwise), it would be unfathomable considering what the findings have reported without addiction as a known side effect.

The participants who had less negative outcomes than the others did not embody any fear for their futures. Lane will continue with facial enhancements because it makes her feel good, and it contributes to her perceived sense of subjective-wellbeing. However, she has revised, somewhat, her unwavering trust in the facial products, and the integrity of the medical system to protect her from medical harms of the product. Rather than receive injections as recommended she plans to reduce the frequency of treatments to protect herself from any adverse reactions. As well, that kind of management would reduce the costs. Lysandra's comment about the future indicated possible tension she could experience. I recall asking her if she thought she might participate in a facial injection in the future. Her reply was that she was not sure. She had said that maybe she would like to do that (facial injection) again but then she had let that go because she really didn't think she wanted to go down that path, citing a belief that her money could be spent better elsewhere but also noting that people sometimes change their minds. She was not thinking about it (current time) but thought she was just going to love herself and work that way.

Vivienne was disappointed that her facial injections did not result in what she perceived she wanted the result to look like. She reported she could not perceive having injections again (future time) unless she thought it would work, and without a whole lot of pain. At that current time she was unsure if she wanted to put the money and effort into it again. But this time she would want to see a “real good” before and after photo so she would know it was authentic. She contends that because the cameras alter the before and after facial images seen on TV or in magazines, she could not discern if it was actual work or touch-up work. Vivienne had no previous knowledge (past time) of people who had reported side effects from injections. The remarks of the three women identify the tensions that exist internally about the decision to participate in facial injections.

I suggest that based on awareness of reported unethical practices, billion dollar marketing ads, and improved marketing strategies (Hampson, 2013; Mehlman et al., 2004; Merianos, Vidourek, & King, 2013; Qureshi et al., 2011), the women are at potential risk (future time) for participating in facial injection procedures. Although companies list potential side effects, such as Allergan Incorporated's web page (which manufactures Botox and Juvéderm), I am suggesting that women might be at risk beyond the ways in which the companies have formally and publically documented. Both Qureshi et al. (2011) and Goldacre (2012) illuminate unethical pharmaceutical strategies and practices within the medical industrial complex that could influence women to participate in facial injections. For example, Qureshi et al. (2011) reports that the largest recovery from Pfizer, at \$2.3 billion in 2009 was centered on charges of illegal marketing, misbranding, and payment of kickbacks to physicians. The second-largest recovery, also during 2009, was \$1.4 billion, paid by Eli Lilly and Company for off-label

marketing. Qureshi et al. (2011) reported that the FDA had approved the drug for use in bipolar disorder and severe schizophrenia, but Lily reportedly encouraged off-label use for children who were under foster care, for elderly people, and for people with insomnia.

In spite of their unknown futures participants chose to reach out and tell others to prevent any possible side effects to their whole and normal functioning bodies. The women wanted others to be aware of the potential risk. I think it is most appropriate to give voice from the participants that embody the meaning behind doing this study, and from the perspective of all the women who have been disembodied in mind, body, and spirit of their former whole and normal functioning bodies. Fisher (2010, as cited in Ryan & Fuller, 2013) noted how voice has been a powerful metaphor for women's empowerment. Fisher goes on to share her perspective that phenomenology's contribution has been "soft spoken" (paragraph three) but Fisher admonishes it is worth investigating its distinctive voice, which has been the foundation and focus behind this study. Fischer urges feminist phenomenologists to turn up the volume by applying phenomenology to feminist analyses on social and political questions about gender, which was the intent of this study on behalf of women who have had facial injections but with mixed feelings or regret.

Limitations

Limitations, as used in the context of a research study, refers to limiting conditions or restrictive weaknesses (Rudestam & Newton, 2007). A common limitation in qualitative research is the inability to generalize to a larger population but the intent of this study was to seek meaning rather than generalization.

I was unprepared for the amount of time it might take to reach successful

participant recruitment, which required changes to the recruitment poster and geographical criteria. The time required to submit to the ethics board on two separate occasions to broaden the criteria for recruitment, particularly the extended age cohort by five years from 40 to 35 made me wonder if I had missed a number of participants before extending the age criteria.

Although I did achieve saturation with seven participants, I wonder if one or two more participants might have added different side effects that would have illuminated the significance of the implications to a greater degree or shared more of the mixed feelings. This change might also have included more subtle feelings that did not come out (not just physical aspects). For example, there may have been issues related to significant financial matters or women who had actually required hospital admissions not only emergency department visits, which did occur with a few women although they were released without any diagnosis or follow-up.

I faced barriers at various venues within the medical market community, which I consider a limitation to the study. I was denied opportunities to post recruitment posters and to present about the study to various businesses. I believe this was a market mentality whereby the business (fitness centers, hair salon, and spas) did not want to risk losing current and potential customers by allowing research on a topic women may wish to keep quiet about and these establishments support that reasoning (profit over possibly harms). In addition, physicians who had contracts with different beauty establishments to inject various market products may have considered cooperating with me to be a conflict of interest. In these situations, I was declined permission to post my recruitment posters, and in some establishments my repeated telephone requests were ignored.

One limitation I had not considered before the study because it was related to the data findings was the element of trust that would need to develop because of the lost trust four of the women had experienced within the medical system. They needed to feel they could trust me to do what the goal of the study purported: to give all women a chance to have their voices heard about their regrets and mixed feelings following facial injections. My ability to develop that trust could have been a limitation, and trust is very important to these participants. I thought it might be limiting with no visual for the participants thus, I scanned and e-mailed a small colored photo of myself in a recruitment ad for the study from a local newsletter. This connection was instrumental in developing the intersubjective bond of rapport and trust.

Finally, one change I thought might become a limitation was the long distance interviewing, which turned out to be by telephone (all participants were offered Skype but refused). I prepared by reading journal articles on telephone interviewing because I was concerned this type of audio interviewing might be limiting, which was not the case. It is amazing what one can hear, feel, and sense when the visual is removed. As well, coordinating appropriate times amenable to women who were experiencing fracture and therefore unknown bodies, there were planned interview times that required rescheduling. In summary, I would say my limiting factor overall was time constraint.

Potential Contributions of the Research

This is the section where I share why this study matters. It appears that most people who have such treatments do not have any negative side effects. However, there needs to be room to hear the voices of those who do have negative outcomes, such as these women. Moreover, there is a need for a more responsive and supportive medical

industrial complex, rather than one that silences them. The reality is that some women report significant side effects that change their lives in terms of not only how they experience their bodies on a daily basis but also how they view the future and relate to others and to the world. Some women develop acute or chronic health issues for which there is no rational medical or scientific reason. The fractured body may continue for years for some, yet less for others.

There are reports of fears of potential addiction and suicidal situations. No known answers exist for these concerns because physicians and manufacturing companies deny that they occur. There are no appropriate treatments or relevant answers or solutions offered by the physicians who injected facial products into the faces of women who believed it was safe because they were told this information from a previous relationship of trust of the medical system.

There is no current Canadian literature on women, who have had facial injections to reduce signs of aging but with mixed feelings or regrets, and specifically no studies exist, to my knowledge, related to the moral impacts women may experience and this is the first empirical study to explore this serious issue.

Trusting women have been transformed into patients within the medical industrial complex and are experiencing lack of respect, devaluing and dismissal, and authentic caring as women needing understanding and support. They want to live as their previous normal and functioning selves albeit with a newer relational self, and new values learned from this lived experience. Women speak about hope and faith that gives them inner strength and resilience to carry them through these unprecedented relational experiences over time. These findings from a feminist moral perspective and a phenomenological lens

draw attention to many opportunities for consideration.

Findings from this research will contribute to the expanding literature on the social science theories of aging and the social and cultural influences of the medicalized cosmetic surgery industry (offering medical beauty) on an aging female body by explicating the phenomenon of cosmetic facial procedures as a gendered requirement to retain youth and value in a patriarchal and political economy of aging. This ageist and sexist exploitation is not unfamiliar but the findings draw attention to the dangerous risks placed on women, and the vast costs associated with injections and an already overburdened healthcare system. Given the looming phenomenon of aging women the implications from these findings are cause for concern.

This research draws attention to the assumptions and concepts of feminist moral theory as a critical lens from which to study women's lived experiences of participation in non-surgical, cosmetic facial procedures, and challenging traditional, positivistic approaches to knowledge such as current attitudes and treatments in a model of medical and scientific care that requires a moral lens to reflect why women experience devaluing and disrespect in their need for holistic and alternate understanding from a woman's perspective. As such, human dignity may serve as an important function in research and advocacy for a "right to health" (Jacobson, 2007, p. 299).

There is additional attention to the significance of the relationship between phenomenology and feminism, which has only begun to be explored quite recently (Fisher & Embree, 2000). In particular, other healthcare disciplines within the caring domain in the medical system have identified the benefits of this collaborative phenomenological lens in their varied practices. Interpretive phenomenological analysis

has proven to be particularly suitable in health psychology research and particularly at illuminating processes operating within models as opposed to the traditional focus on outcome measures (Brocki & Wearden, 2006). Health psychologists as well have recognized the importance of understanding patients' perceptions of and interpretations of their bodily experiences, and the meanings which they assign to them.

The lifeworld-led healthcare philosophy and practice supports and treats women as respected and equitable clients, and offers a unique alternative approach to a health care dominated by capitalism and patriarchy, and a medical-market mentality to aging and women's personal lives. I suggest the acknowledged benefit of hope versus hopelessness by Nunn (1996) is characteristic of this new model of care:

The role of hope is thus seen as self-evident in behavioral treatments which promote mastery, insight-oriented psychodynamic psychotherapies which provide meaning, supportive therapies which reduce anticipated isolation or alienation, and all forms of therapy that increase one's sense of dignity and self-worth to face the future positively. (p. 240)

This study offers a unique perspective to the existing academic research on Botox and other injectables as well as to current literature in the public sphere of informationalism. As noted, there is very little Canadian research and specifically related to women who have Botox but have regrets or mixed feelings about their decision. These research findings also draw awareness to the fact that no reliable Canadian statistics are documented on women who have Botox and other similar treatments. Canadian statistics need to be maintained from multiple sources in the industry.

The emergence of expressions of value conflicts and moral concerns between

women who want to age naturally (i.e., with wrinkles) and a dominant cultural ideal of youth and anti-aging from various studies has opened the door to further research within the moral terrain of midlife women and aging in relation to perceived positive aging. I concur choices are a personal decision but within the known ethical confines of beneficence and non-maleficence of what is available to choose from. As well, exploring feminist moral epistemology and perspectives of difference within the cosmetic surgery domain identifies the need for further review and discourse about the bioethical cornerstones of respect for patient autonomy, beneficence, non-maleficence and justice within the anti-aging industry of the medical industrial complex.

Another related point may be that the research in this area challenges the predominant framing of Botox thereby encouraging further moral evaluation of Botox, and other facial injection products, as their processes and outcomes can, as evidenced in this research study, put women's bodies and lives at significant risk. It is apparent the primary function and focus of this huge health conglomerate is not the assumed delivery of health services to clients but rather the pursuit of profits (Estes, 2001). Medicalisation affects all ages but it has particular implications for women in an ageist society that promote youthful bodies as the norm (Joyce & Loe, 2010).

Conclusion

Critical gerontology and feminist phenomenology on behalf of aging women is the lens through which to critique complex networks of domination and influence such as the medical industrial complex and the anti-aging enterprise. I had the opportunity, as a researcher, to promote a change in consciousness by conducting and presenting empowering research data from the participants in this study. As Drage (2005) states,

“Unhappily, it is not just that our culture tends to reject this inner spark of questing, but also that many of us do not even know there is anything to be rejected” (p. 114). Ageism and sexism continue to thrive but the shared, lived-experiences of the women who participated in this study have contributed to new knowledge with which to address this growing phenomenology of anti-aging facial injections in relation to women’s perceptions of positive aging. Since this study, and to admonish ongoing concerns for the future of all women who experience tensions between aging as they choose (for their own individual reasons), and the marketing strategies and reported influences and coercions of a vast, medical industrial complex. I present additional information related to decision-making and informed choice.

I share my concerns about a recent publication by Finzi (2013) who promotes Botox for depression based on clinical trials. Finzi argues that Botox helps control the flow of negative emotions by inhibiting frowning, and how this feeds back to our brains to make us happier. As presented earlier, Amber had noted that she had her facial injection to reduce a frown feeling, yet within two weeks of her one injection, she experienced life-altering side effects and ongoing health-related symptoms. Critical gerontology and feminist phenomenology encourage women to be aware of the benefits of informed choice, which will promote positive aging and challenge current questionable behaviours and practices within the medical industrial complex and their marketing affiliations.

I close with thoughts from Heidegger about consciousness raising, which is also the goal of the critical paradigm (critical gerontology and feminist moral inquiry). Heidegger describes human reality as “being in the world”, and the analysis of human

reality as ontology or what is there to know. When individuals freely choose their way of being-in-the-world, they live an authentic life. But when people choose to live by what they say and shapes their choices by anonymous mass opinion, they are living inauthentically (Stewart & Mikunas, 1974). Since existence is not built on truth or authenticity, there is conflict of values and potential for moral dilemma if not resolved.

The goal then of consciousness raising is enlightenment and empowerment, thus to encourage and support women to age as they choose. Empowerment is conceptualized as a narrative of self-transformation (Britt & Heise, 2000, as cited in Drury, Cocking, Beale, Hanson & Rapley, 2005). The focus of empowerment in collective action is on knowledge of the self, which applied to this study, refers to the importance of sharing knowledge regarding informed choice in decision-making about choosing facial injections or not. Women have the right to choose to take risks in creating or exploring new selves but it is also their right not to have their bodies and lives be put at risk in so doing such as has been reported in this study. The goal of a feminist and phenomenological approach in reference to a new relational self is describing the opportunity for women to become aware of an alternative, enlightening feminist consciousness in which women can connect to where the focus is relationships that form and sustain individuals (Sherwin, 2008; Walker, 2001) rather than relationships that foster social and cultural constructions of ageism and sexism that devalue women and compel them to participate in facial injections. The question remains: What does it really mean for a woman to grow old? Healey (1994) says:

For me, first of all, to be old is to be myself. No matter how patriarchy may classify and categorize me as invisible and powerless, I exist. I am an ongoing person, a

sexual being, a person who struggles, for whom there are important issues to explore, new things to learn, challenges to meet, beginnings to make, risks to take, endings to ponder. Though some options are diminished, there are new paths ahead". (p. 83)

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Appendix A: Interview Guide

1. Can you share with me what your thoughts and feelings are about growing older?
How you think society views women as they age? How do you perceive yourself at 80 years of age?
2. Why were you interested in participating in this study?
3. When did you first start thinking about having a Botox injection?
4. Can you tell me about the reasons why you decided to have the Botox injection?
5. Why was Botox your choice of a facial cosmetic procedure?
6. Did you share what your plans were with anyone (partner, family member, friend, work colleague) prior to going for a Botox treatment?

If so, who? Can you tell me what the responses were?

7. How long after you began thinking about having a Botox injection, did you go for a treatment?

Where did you have the treatment done? Who gave the Botox injection?

What was this professional person's attitude and manner like?

Can you share with me some general information about your personal experience immediately before, during, and after the Botox injection?

8. What were your feelings and thoughts prior to going for the treatment?
9. What were your first thoughts and feelings about your face when you saw the results of the Botox treatment?

Did you receive any responses from others? If so, what were they? How long did the Botox effect last?

10. Do you recall being aware of seeing any Botox advertisements on any social media such as television reality shows, anti-aging advertisements in magazines and on television and popular Hollywood hype about celebrities?

Do you think these ads played any role in your decision to have Botox?

11. Did you have any follow-up injection to maintain the Botox effect?
If so, can you tell me if the additional treatment was different in any way? For example, was the experience different, in any way, the second time?

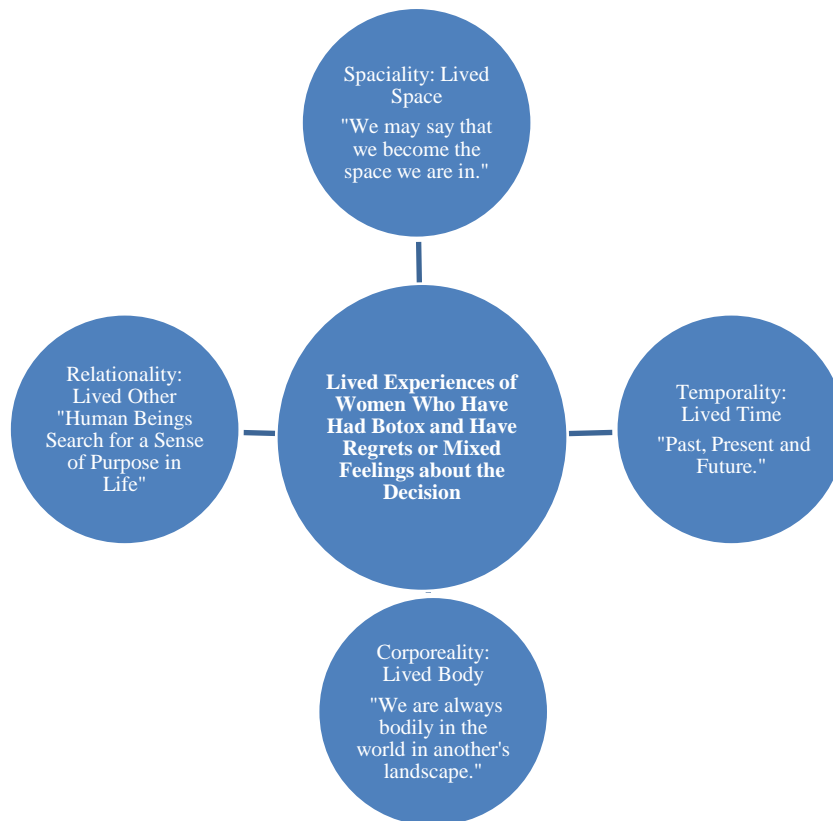
What were your feelings and thoughts prior to having a second injection done?

What were your feelings and thoughts when you first saw your face following this treatment?

12. If another woman was thinking about having a Botox injection what might you say to her?
13. Do you have any final thoughts or comments you would like to share with me?

Appendix B: Life World Existential Guides to Reflection in the Research Process

How All Human Beings Experience the World but with Different Modalities



RESEARCHING LIVED EXPERIENCES: van Manen (1990)

Appendix C: Participant Recruitment Poster



**Study on Botox and other injectable
facial fillers
(e.g., Juvéderm, Restylane)**

If you are a woman aged **35 – 65** who has had injections to reduce the signs of aging to your face but **have mixed or negative feelings about your experience** (for example, maybe you didn't like how you felt emotionally or physically afterwards, you didn't like how it looked, or other reasons),

**You may be interested in participating in this study on
Women's experiences with injectable facial procedures**

**Participants will be Interviewed Privately and
Confidentially** (in person, on-line Skype, or by telephone)

To find out more about the study or to participate, please contact:

OR call 889-4130 and leave a confidential message

Appendix D: Informed Consent Letter



Department of Family Studies and Gerontology

Title of Study: Women's Experiences of Botox Treatment and Other Injectable Facial Fillers: A Feminist Moral Analysis

Researcher: Sandra L. Berwick

I am a graduate student in the Master's Program of the Family Studies and Gerontology Department at Mount Saint Vincent University (MSVU). I am conducting research under the supervision of Dr. Áine Humble, in partial fulfillment of the requirements for a Master's degree from MSVU.

Please read this form carefully and sign if you choose to participate in this research study. Your participation is entirely voluntary and you should feel free not to sign this form if you do not wish to participate. You may withdraw from the study, without penalty, at any time even if you do choose to participate.

The purpose of the study is to ask women between the ages 35 to 65, who have had Botox or other facial injectables for cosmetic purposes to share their experiences and feelings about their decision to have this cosmetic, non-surgical procedure to the face to reduce the signs of aging. My focus is on women who have regrets or mixed feelings about having had these procedures done. The benefit of participation in this study will be a contribution to Canadian and American research literature on a topic that has received much attention in the media because of its phenomenal growth but little attention given from researchers.

I will interview you for approximately one to two hours, asking questions related to your participation in these facial injections. I will converse with you for one initial interview, and possibly a second one for clarification or further details on any topics discussed in the first interview. The interviews will be audio-taped and transcribed. At all times, the study will be conducted to protect your confidentiality and privacy. This includes a time and place chosen by you as most convenient and confidential if we are meeting in person, otherwise a private and confidential phone interview or on-line Skype audio-interview will occur. The transcript will not contain your name and no personally identifying information will be recorded anywhere except on this informed consent form. All audio tapes will be erased following completion of my Master's thesis and at no time will any identifying information be made available to anyone other than myself and my thesis advisor. All documents connected to the study will be kept in a locked drawer accessible only by me and any electronic files are password protected.

As a researcher, there are legal limitations on information that I am able to keep confidential. In exceptional and compelling circumstances, researchers are subject to obligations to report information to authorities to protect the health, life or safety of a participant or a third party. As a researcher I am expected to be aware of ethical codes (such as professional codes of conduct or laws) that may require disclosure of information obtained in a research context. As a researcher, I shall maintain my promise of confidentiality within the extent permitted by ethical principles and/or law.

Although there are no foreseeable risks to you, it is possible that some questions about your own experiences may feel sensitive to share. You may decline to answer any question. I can assure you that understanding of and respect for your decision is guaranteed. If any of the interview questions elicit unpleasant memories, upsetting recollections, or an adverse emotional experience you may wish to contact a counselling resource for support such as the following national organizations:

Canadian Mental Health Association
www.cmha.ca

American Mental Health Counselors Association
www.amhca.org/

Canadian Association of Social Workers
 Toll Free Number in North America
 1-855-729-2279

National Association of Social Workers
www.socialworkers.org/

These initial organizational contacts will refer you to the appropriate provincial, or state Division and Branch, or Chapter to address your particular need or request.

Following the interview sessions you will be invited to read a copy of the interview transcript to ensure that the final document accurately portrays your experiences, feelings and perceptions. If you have any disagreements or identify discrepancies in the written material, you may contact me at: sandi.berwick@msvu.ca or (902) 889-4130 (confidential work telephone), with the requested changes.

A summary of the research findings will be offered to you, if desired, following completion of my Master's thesis.

If you have any questions about this study or if any aspect of the outlined procedures remain unclear, please contact me, the researcher:

Sandra L. Berwick

Graduate Student
Department of Family Studies and Gerontology
Mount Saint Vincent University
Halifax, NS, B3M 2J6
(902) 889-4130 sandi.berwick@msvu.ca

You may also contact my thesis advisor:

Dr. Áine Humble
Department of Family Studies and Gerontology
Mount Saint Vincent University
Halifax, NS, B3M 2J6
(902) 457-6109 aine.humble@msvu.ca

If you have any questions or concerns about this study and wish to speak to someone who is not directly involved with this study, you may contact the University Research Ethics Board, by phone at 902-457-6350 or by e-mail at research@msvu.ca.

By signing this consent form, you are indicating that you are providing your free and informed consent and you fully understand the above information and agree to participate in this research study.

X

Participant's SignatureDate: _____

X

Researcher's Signature

Date: _____(Please see third page for information about reviewing transcript and receiving results)

I would like to review my transcript at a later date : ____ yes ____ no

I would like to receive a copy of the results : ____ yes ____ no

If yes to either of the above statements, please provide your contact information (email address and/or mailing address):

This informed consent form will be destroyed within 1 year following completion of the thesis.

One signed copy to be kept by the researcher, one signed copy to the participant.

Halifax Nova Scotia B3M 2J6 Canada

Tel (902) 457-6117 Fax (902) 457-6494 / msvu.ca

Appendix E: Participant Demographic Questions

1. What is your marital status?
 - a. Married b. Common-law/cohabiting
 - c. Single d. Widowed e. Separated
2. What is your date of birth (day, month, and year)? _____
3. Do you have children? If yes, how many do you have? _____
4. What would you consider your primary racial/ ethnicity identity? (please circle one)
 - a. White European d. French Canadian
 - b. "Just Canadian" e. Middle Eastern
 - c. Asian f. Black, African Nova Scotian g. Other (please specify)
5. Are you currently employed? _____
6. If employed, what type of employment are you involved in? _____
7. What is the highest grade/ level of schooling you have completed?
 - a. Less than high school d. Some university
 - b. Some high school e. Completed Diploma or Bachelor's Degree
 - c. Completed high school f. Completed graduate or professional degree
8. Where do you currently reside?
 - a. Rural area b. Urban area