INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

THE MEDICALIZATION OF FEMININE BEAUTY:

A STUDY OF COSMETIC SURGERY

by

Marie E. Mark

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2001

Bell & Howell Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

12/5/00
Date

Chair of Examining Committee

November 29, 2000
Date

Executive Officer

Roslyn Bologh

Dean Savage
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Preface

I was initially drawn to this topic when the breast implant controversy reached the headlines. The notion that the fastest-growing medical specialty in the U.S. is based on the proliferation of medical procedures that are performed for non-medical reasons seemed fascinating, particularly since the majority of cosmetic surgery patients are women. Out of this interest, I developed my dissertation proposal which focused on the undertaking of a qualitative study of women who had undergone cosmetic surgery. I specifically excluded those who opted for breast reconstruction following mastectomies as I felt that there were significant factors that differentiated them from women who had cosmetic surgery for purely cosmetic reasons.

Just a few weeks before submitting my proposal for approval, I was diagnosed with breast cancer. After consulting with a surgeon, I opted for a mastectomy. However, I resisted his suggestion to undergo immediate reconstructive surgery, and decided to live with the results for awhile. Some two-and-a-half years later, I tired of dealing with the prosthesis, and decided to undergo breast reconstruction which took place some time after completing my interviews.

During the course of the face-to-face interviews I conducted, it became apparent that some of the issues these women were dealing with were similar to the ones I faced, especially those concerning pressure from doctors to undergo surgery as well as self-image issues. However, I decided not to mention my diagnosis (and

related issues) to the women I interviewed until the interviews were completed. I was concerned that if I mentioned it early on, too much attention might focus on my breast cancer experience, at the expense of the experiences of the women I was interviewing.

Although there are some differences between those women who undergo cosmetic surgery and those who undergo reconstructive surgery, there are also similarities between them. Thus, throughout the analysis, I have interjected my own observations that are relevant to the themes and issues that emerged from the interviews. Ironically, my personal experience with reconstructive surgery did not increase my understanding of why women opt for cosmetic surgery; if anything, I am more puzzled than ever as to why, given the pain and discomfort associated with surgical procedures, anyone would opt for surgery for entirely cosmetic purposes. I do not regret having undergone reconstructive surgery, but if not for the mastectomy, I would not have chosen breast augmentation for myself.

Table of Contents

List of Tables

Ch.1 - Theoretical and Historical Overview of Cosmetic Surgery

There are a number of sociological and feminist theoretical issues arising from cosmetic surgery that make it a compelling topic. Among them is the increasing medicalization of women's bodies and continuing conceptualization of it as intrinsically defective, and, therefore, needful of surgical transformation. In essence, the medical profession has medicalized appearance, and cosmetic surgery is being offered as the best means to correct perceived physical deficiencies related to one's appearance.

Secondly, there is the theoretical issue of choice and its role in the decision-making process, and the extent to which it reflects social constraints. That is, pressure to alter one's appearance through cosmetic surgery comes from a variety of sources: advertising sponsored by the surgeons themselves; the popular images of women reflecting the ideal cultural type that abound in the media; the cultural emphasis on appearance, particularly for women; and the opinions of significant others, including family, friends, and co-workers, to name a few. Given the sociocultural influences women experience concerning their appearances, the conditions under which women make decisions concerning cosmetic surgery are not exactly clear.

Third are homogenizing and normalizing tendencies. While cosmetic surgery is often promoted as a means of self improvement that focuses on the individual, it also imposes a cultural standard of beauty on its beneficiaries. Consequently, differences are

minimized and often erased.

A plausible explanation as to why so few sociologists have examined the topic of cosmetic surgery in a critical spirit may be attributable to their oversight of the connection between structural forces (in the form of sociocultural factors) and an individual woman's decision to undergo cosmetic surgery. That is, cosmetic surgery and the decision-making process leading to it are perceived as personal matters, occurring at the level of the individual. However, the fact that just over one million people in the United States, the majority of whom are women, underwent cosmetic surgery in 1998 (the latest year for which data are available) (American Society of Plastic Website, 2000) seems to be indicative of what Mills (1959) terms a structural issue; a matter "that transcend[s] these local environments of the individual and the range of his inner life" (p. 8), and is related to the intersection of personal biography and history within society. Indeed, Bordo (1993) echoes this very theme when she argues that contemporary understandings of body-perfecting behaviors "reproduce...a construction of life as plastic possibility and weightless choice, undetermined by history, social location, or even individual biography" (p.250).

Cosmetic Surgery: An Overview of the Literature

As evidenced in the literature, the subject of cosmetic surgery has only recently been studied by sociologists and feminist scholars. Indeed, a preliminary review of the literature revealed only a few articles that examine cosmetic surgery critically (Dull

& West, 1991; Gillespie, 1996; Hyman, 1990; Morgan, 1991; Spitzack, 1988; Sullivan, 1993). Moreover, a search of dissertations published from 1982 through 1996 disclosed that while cosmetic surgery has been addressed as a subject of inquiry by the fields of clinical psychology, philosophy, cultural anthropology, and mass communications, it remains largely unexamined by sociology. Subsequently, a sociological analysis of cosmetic surgery will offer insight into those factors, both structural and individual, that play an important role in this popular, yet troublesome, phenomenon.

Support for the contention that cosmetic surgery has not received sufficient attention comes from Morgan, who deplores the lack of discussion "feminist or otherwise, of the normative and political issues that might be raised in relation to women and elective cosmetic surgery" (1991, p. 28). Moreover, the National Women's Health Network suggests that even "women's health activists have paid scant attention to cosmetic and reconstructive surgery" (Zones, 1989, p. 2), despite the increasing incidence of cosmetic surgery procedures and problems associated with them. Morgan (1991, p. 28) also proposes that a feminist framework and critique is crucial to understanding why so many adult women undergo elective cosmetic surgery.

In contrast, other issues that relate to women's bodies -- eating disorders, body image, reproductive technologies, abortions, and hysterectomies -- have been subjected to much sociological theorizing and scrutiny. According to Dull and West (1991, p. 67),

much in the sociological literature to date has focused primarily on the medicalization of deviance, on natural processes (such as childbirth), and on the social and historical construction of the body. However, they contend that a third arena of medicalization encompassing cosmetic surgery is emerging, that of "the expropriation of the aesthetic realm" (Dull & West, 1991, p. 67). That is, medical doctors are expanding the use of medical knowledge and technology to encompass what are, essentially, non-medical concerns; namely, appearance issues. Zones concurs, asserting that "plastic surgery appears to be moving strongly in the direction of making appearance a bona fide medical problem" (1989, p. 4).

Thus, the medical profession offers medical intervention (in the form of cosmetic surgery) as a solution to what is not necessarily a medical problem; namely, the perception of one's body as imperfect and deformed. As Deborah A. Sullivan, a sociologist observes, cosmetic surgery "is an unusually extreme form of medicalization...[which] involves altering healthy anatomy that falls within the normal range of variation" (1993, p. 98). Furthermore, physicians (and not patients) define and legitimize illness and health, and "their domination over the definition of illness and the practice of medicine contributes toward the growing trend toward medicalization..." (Fisher, 1986, p.134). Consequently, the process of "medicalizing" many aspects of everyday living [such as one's appearance] reinforces medicine as a major institution of social control (Zola, 1990, p. 398).

Altering one's appearance through cosmetic surgery represents

the newest area of medicalization affecting mostly women. By undertaking an exploratory study of cosmetic surgery, I hope to provide some insight and understanding of a phenomenon that reflects the complex interaction between sociocultural forces and individual behavior. Although cosmetic surgery has become available and widely used in a number of industrial nations, it originated in the United States, and American surgeons remain at the forefront of the introduction of new surgical techniques and methods. Furthermore, because of the gap in sociological knowledge concerning this topic, I feel it is important for my purposes to study those who are most greatly affected by cosmetic surgery, namely, women. In fact, the overwhelming majority of cosmetic surgery patients -- 91 percent -- are women (ASPRS Website, 2000), thereby making gender central to this topic.

The Historical Construction of Gender

According to Bordo (1993), the historical construction of gender "is always homogenizing and normalizing, erasing racial, class, and other differences and insisting that all women aspire to a coercive, standardized ideal" (p. 169). Others have also expressed concerns regarding the normalizing and homogenizing effects, noting the predilection evident among some to submit to cosmetic surgical procedures designed to alter racial and ethnic features, in an effort to make them more Anglo-like in appearance (Hyman, 1990; Dull & West, 1991, p. 56).

For example, there is much controversy today among Asian-Americans concerning the prevalence of eye surgery among college-

age Asian-American women; more specifically, eye surgery designed to make the eyes more western-like in appearance. In Brazil, breast reduction is the most common cosmetic surgery procedure among middle class women, which is attributable to the desire to Anglicize the South American shape of big breasts. Moreover, nose jobs have become popular among affluent Mexicans, in an effort to erase traces of their Indian heritage and more closely resemble Europeans. And in the U.S., despite the increasing diversity of its population, Anglo appearance standards still dominate; for example, the most popular hair color for women is still blonde. Regarding eye color, the most popular color for non-prescription contact lenses is blue, even among African-American women (Bordo, 1993). However, as Bordo (1993) notes, Americans are not conscious of the connection between the desirability of Anglo appearance traits and the dominance of Anglo standards of appearance, even on people of color. Even cross-culturally, then, cosmetic surgery has become available to, and employed by, increasingly larger numbers of people who are disproportionately female.

Speaking specifically of cosmetic surgery and normalizing from a radical feminist perspective, Daly (1978) asserts that the growing popularity of cosmetic surgery in the form of reconstruction following mastectomies during the seventies led to "The routinization and normalizing of the mutilation of women [which] peaked to the point of glamorizing such mutilation" (p. 286). From my point of view, this represents a provocative but extreme position on the topic.

As Connell (1987) notes, "the body is never outside history, yand history never free of bodily presence and effects on the body" (p. 87). That is, the body is not some "thing" standing outside and apart from society, affecting but not affected. On the contrary, "The body - as - used is a social body that has taken meanings rather than conferred them" (Connell, 1987, p. 83). Thus, it is not the body that imposes, for example, femininity on a woman. Rather, it is society that imposes its meanings of femininity on the female body. Similarly, in her analysis of anorexia, hysteria, and agoraphobia, Bordo (1993) rejects the notion of the body as a "brute biological or material entity...it, too, is a culturally mediated form" (p. 181) whose activities can render a variety of meanings.

Decision-making and Choice

An important question that emerges concerns why women subject themselves to "disciplines of the body" (Foucault, 1978, p. 139) like cosmetic surgery at all. Formulating an answer to this requires exploring the roles of choice and coercion in the decision-making process. Focussing specifically on cosmetic surgery, Morgan (1991) notes that one consequence of the increasing popularity of cosmetic surgery is normalization, in that "women who contemplate not using cosmetic surgery will increasingly be stigmatized and seen as deviant" (Morgan, 1991 p. 28). Thus, as cosmetic surgery becomes increasingly popular and prevalent, those who resist having it done will face increasing pressure to conform to the norm.

Drawing from the literature on reproductive technology, Morgan (1991) argues that there are two choice-diminishing dynamics at work which affect women's choices in this area, as well as in the area of cosmetic surgery. The first is the "pressure to achieve perfection through technology" (Morgan, 1991, p. 39), a pressure engendered in part by surgeons themselves: In a 1983 public relations campaign, the American Society of Plastic and Reconstructive Surgeons (ASPRS) characterized 'body sculpting' as safe, affordable, and necessary (cited in McCall's, 1992).

Additionally, advertisements sponsored by cosmetic surgeons tend to be untruthful and misleading (Rome, 1991), and "make nip-and-tuck look as easy as highlighting one's hair" (Regush, 1992, p. 26). No mention is ever made of possible complications and side effects that may result from such surgery. For example, an advertisement for an Upper East Side plastic surgery center that appeared in The Daily News (September 27, 1993) featured several procedures, including: "Breast Enlargement (Safe Saline Solution)." In fact, saline implants have not undergone rigorous testing; therefore, potential safety issues remain unexamined.

It should be noted that contemporary popular culture also contributes to this pressure, in that "the very advertisements whose copy speaks of choice and self-determination visually legislate the effacement of individual and cultural difference and circumscribe our choices" (Bordo, 1993, p. 250). Moreover, these images of acceptable femininity "are extremely powerful, because they are presented as the only reality" (Orbach, 1978, p. 8). That

is, the images of women that proliferate in our culture feature a particular prevailing body type: thin, fit, and well-endowed.

Interestingly, the pursuit and maintenance of an attractive appearance in contemporary society has become inextricably linked with health. Many popular women's magazines offer feature articles equating health with beauty, as do most of the advertisements promoting gyms and health clubs. As Lynn Chancer (1998, p. 91) notes, we cannot ignore the pleasure and self-satisfaction that people experience in their pursuit of a fit body through disciplinary practices, including, for example, exercising and athletics. But involvement in disciplinary bodily practices is often motivated by concerns other than those relating to health. Chancer (1998) asserts that the current interest in both fitness and cosmetic surgery "frequently transcends simple considerations of health" (p. 91), and that such behaviors often become obsessive and actually endanger health. Indeed, she surmises that "such efforts may become symbolic rituals to find, through looks, forms of love and attention originally frustrated or denied elsewhere" (Chancer, 1998, p. 91).

This very theme was expressed by Cushman (1990) in his conceptualization of the empty self, which he attributes to the dissolution of community and tradition in America, and describes as a "gnawing sense of internal emptiness [that] drives individuals to be filled up" (p. 246). Furthermore, he associates the notion of the empty self with consumerism, a hallmark of the postwar era predicated on the belief that purchasing and consuming the "right"

products would fill the empty self, thereby liberating the core self and leading to individual salvation (Cushman, 1991, p. 246). Sullivan (1993), drawing on Turner (1984), takes this line of reasoning even further by connecting consumerism with appearance, asserting that late capitalism can be characterized by a "hedonistic consumerism in which physical appearance is an important cue to an internal disciplined, fit body. As a result, the thin, taut youthful appearance of a fit body became an essential element of the cultural definition of attractiveness" (p.102). In this light, then, the current emphasis on altering one's appearance through disciplinary practices (including cosmetic surgery) can be seen by many as an attempt to infuse one's vacuous existence with meaning and self-fulfillment. That is, the loss of traditional sources of social connection that historically bound society's members to one another (community, church, extended families) has impelled individuals to look narcissistically inward -- rather than outward -- to find the means of fulfillment, and disciplinary practices of the body have become one of those means.

The Role of the Medical Profession and Choice

The second dynamic is "the double-pathologizing of women's bodies" (Morgan, 1991, p. 39), in that scientists (including medical practitioners) have historically viewed women's bodies as inferior and imperfect, and treated them accordingly. Indeed, Foucault (1978) traces this tendency back to the eighteenth century, to what he terms "a hysterization of women's bodies...whereby the feminine body was analyzed...as being thoroughly saturated with sexuality;

whereby it was integrated into the sphere of medical practices, by reason of a pathology intrinsic to it..." (p. 104). This notion is readily evidenced today in the statement from the American Society of Plastic and Reconstructive Surgeons (1982, July 1) asserting that small breasts are "deformities" and a "disease:"

> There is a common misconception that the enlargement of the female breast is not necessary for maintenance of health or treatment of disease. There is a substantial and enlarging body of medical information and opinion, however, to the effect that these deformities [small breasts] are really a disease which in most patients results in feelings of inadequacy, lack of self-confidence, distortion of body image and a total lack of well-being due to a lack of self perceived femininity. The enlargement of the under-developed female breast is, therefore, often very necessary to insure an improved quality of life for the patient.

Furthermore, as Haiken (1997) notes, while plastic surgeons didn't create medicalization, they have constructed new names for yan increasing number of deformities:

> An entirely new category, "hereditary lipodystrophies," derived from liposuction alone: "bat wing deformity" is characterized by "redundant skin and tissue hanging from the upper arm"; "spare tire deformity" is defined by excess adipose tissue around the waist and abdomen; most commonly, "violin deformity" ...is characterized by deposits of adipose tissue on the lateral (outer) thigh where it meets at the hip. (p. 299 to 300)

Interestingly, these terms stand in stark contrast to the text of cosmetic surgery advertisements, which speak not of deformities, but of "body contouring" (NY Daily News, 1998) and "new techniques [which] allow you to trim and tone your body..." (Newsday, 1998). Even an overview of surgical procedures found on the ASPRS website and written for the public describes liposuction in benign terms, promoting it as "an excellent technique for removing localized fat deposits i.e. Saddlebags, Love Handles, Knobby Knees, Turkey Neck,

or Pear shaped Bodies" (ASPRS Website, 1996).

Evidence that the conceptualization of physical characteristics as deformities has found acceptance is apparent in the interview survey conducted by Dull and West (1991). In these interviews, "surgeons and patients alike alluded to technically normal features as "flaws," "defects," "deformities," and "correctable problems" of appearance (Dull & West, 1991, p. 63).

Another matter that pertains to the medical profession and choice concerns the dissemination of information and knowledge. As Fisher (1986) notes, physicians exert control over patients' access to, and understanding of, information. They are authorities who "act as gatekeepers, providing options to some, denying them to others" (Fisher, 1986, p. 4), thus compromising women's ability to choose.

Additionally, self-improvement practices that relate to women's bodies, including skin care, hair care, cosmetics, and clothing, as well as cosmetic surgery, require the expenditure of resources, including those of time and money. Moreover, studies show that women are allocating more time to such practices than they had for quite some time (Bordo, 1993, p. 166). By devoting so much energy to the disciplines of the body, women "are rendered less socially oriented and more centripetally focused on self-modification" (Bordo, 1993, p. 166). Ironically, even at the individual level, women do not profit from their efforts, in that through the disciplines of the body (including dieting, makeup, and dress), they "continue to memorize on [their] bodies the feel and

conviction of lack, of insufficiency, of never being good enough" (Bordo, 1993, p. 166). The pervasive sense of bodily deficiency that many women experience can be attributed, at least partly, to the images of women featured in the visual media; images of perfect female beauty (Bartky, 1988, p. 71), as well as to peer pressure and even parental pressure during girlhood. Thus, the pursuit of female perfection "is a 'setup': It requires such radical and extensive measures of bodily transformation that virtually every woman who gives herself to it is destined to fail" (Bartky, 1988, p. 71).

Feminist Perspectives on Beauty Practices

From what has been written on the subject, there appear to be three major feminist positions on beauty practices. The first is that of the hegemonic oppressor/oppressed model, which posits the objectification and sexualization of women's bodies within the unequal power relations evident between men and women in our patriarchal society. For example, Finkelstein (1991) ascribes women's heightened vulnerability to cultural expectations of ideal body appearance to their subordinate position to men. "The status of men in industrialized societies," she contends, "is more closely attached to their labor value, and this can account for their physical appearance being of secondary value" (Finkelstein, 1991, p. 182-3). But women's status, she notes, has been historically linked to changing definitions of beauty, femininity, and sexual seductiveness, not to their labor value.

One of the major criticisms of this perspective is that it

appears to depict women as being passive and inactive members of the culture, or as "cultural dopes," a term coined by Garfinkel. Additionally, it seems to overlook the role that the participation of women in the beauty culture plays in the maintenance and reproduction of said culture. Indeed, structures of domination, including that based on gender, may be the result of collusion between those who dominate and those who are dominated. This model has also been criticized for ignoring the multiplicity of meaning embodied in the behaviors and activities associated with beauty practices (Bordo, 1993, p. 23). In sum, although patriarchy is a significant factor in the development of the beauty culture and its related practices and industries, it is not in and of itself a sufficient explanatory determinant.

The second feminist view is the postmodern perspective. According to Davis (1991), beauty can no longer be viewed in the context of male domination and female oppression as "women are not merely the victims of the terrors visited upon them by the 'fashion-beauty complex'" (1991, p. 33), but actively engage in beauty practices, including that of cosmetic surgery. Moreover, she perceives the social practices of body improvement as providing avenues of action for women, as well as imposing limitations on them. Agency is an integral component of this model, which portrays women as being active and knowledgeable actors who always have some degree of awareness "about their situation as well as the consequences of their actions" (Davis, 1991, p. 33).

The postmodern perspective assigns much emphasis to the

multiplicity of meanings -- and readings -- that can be made of the body. One criticism of this model is that it does not distinguish among the social practices of body improvement, and thus fails to address the dangers inherent to some forms (i.e., cosmetic surgery and severe diet regimens), as well as the deeper meanings and implications of these practices. Cosmetic surgery, for example, entails more than body decoration and surface enhancement like the application of makeup and use of hair coloring agents. That is, regarding cosmetic surgery, "bodies are not merely adorned and altered, but physically reconstructed in accord with prevailing cultural conceptions" (Dull & West, 1991, p. 67).

Another criticism of the postmodern perspective centers on the level of awareness among women concerning the consequences of their actions. For example, it is doubtful that most adolescent and college-age women who are obsessed with their weight and experience eating disorders were cognizant of these dangers when they initially undertook dieting practices. Furthermore, it could also be argued that those breast implant recipients who are experiencing adverse health conditions ostensibly linked to silicone were not aware of the consequences of their actions, either.

Additionally, the postmodern view has a tendency to treat the body as pure text, "giving a kind of free, creative rein to meaning at the expense of attention to the body's material locatedness in history, practice, culture" (Bordo, 1993, p. 38). Consequently, the relationship between the disciplinary practices that women impose on their bodies and the larger sociocultural forces (such as

values and beliefs) from which they emerge is largely ignored.

Within the postmodern framework, then, cosmetic surgery can be perceived as a means of offering possibilities for women, of empowering them to change something about themselves that causes them pain. From my perspective, however, the limitations of cosmetic surgery (such as its need to be repeated) and the problems it engenders (for example, its homogenizing effects), remain unexamined and hidden from view.

The third perspective, and the one I feel provides me with the most significant analysis of beauty practices, is that of the feminist cultural model. Bordo (1993, p. 30) is a leading advocate of this perspective, which she posits as a reconceptualization of the oppressor/oppressed model. For example, while acknowledging that this older model overlooks the multiplicity of meaning of body behaviors, and pays scant attention to the role of female agency in perpetuating patriarchal culture, it does, she asserts, "offer a systemic critique capable of rousing women to collective action..." (Bordo, 1993, p. 31). Postmodernism, on the other hand, celebrates the role of individual agency in contemporary society. Consequently, cosmetic surgery and other aesthetic practices are viewed as the means whereby women, at the level of the individual, can reinforce or improved their statuses as valued members of society. In this light, then, these practices are seen as empowering women. However, this perspective ignores systemic pattern, which Bordo describes as a complex and dense "institutionalized system of values and practices within which

[people] come to believe that they are nothing...unless they are trim, tight, lineless, bulgeless, and sagless" (1993, p.32). Other proponents of this view include Chancer (1998, p. 107) and Haiken (1997, p. 9), both of whom advocate the analysis of the social conditions and factors that contribute to the cosmetic surgery phenomenon.

The goal of feminist cultural criticism is not to provide guidelines for personal living, nor to tell women what to do. Rather, its goal is to effectuate an awareness and understanding of the "power, complexity, and systemic nature of culture, the interconnected webs of its functioning" (Bordo, 1993, p. 30).

In her analysis, Bordo employs a Foucauldian framework which incorporates his conceptions of power and control. From this perspective, power must be viewed, not as something people or groups possess and impose on others from above, but "as a dynamic or network of non-centralized forces" (Bordo, 1993, p. 26) which works 'from below.' Thus, disciplinary practices of the body are maintained, for the most part, by self-imposed adherence to norms, and not by violence and force. Furthermore, within a Foucauldian frame of reference, power and pleasure can coincide with each other. For example, exercising often alters one's mood, inducing pleasurable feelings of well-being. Moreover, the physical changes effected by exercising promote a sense of having acquired control over one's body. This sense of control, in turn, can lead to a feeling of power.

For Bordo, such a conceptualization allows for an

understanding of how disciplinary practices by which women's bodies become docile and obedient to cultural norms simultaneously come to be experienced in terms of power and control. It also assists in the understanding of women's willingness to actively participate in the reproduction and maintenance of practices that sustain their subordination to men (Bordo, 1993, p. 262). That is, many times the efforts that women expend in the maintenance of disciplinary practices produce the desired results, although only temporarily. For example, unwanted weight is shed by a diet regimen; some signs of aging are alleviated by a facelift. Subsequently, women may experience the sense of having attained control and mastery over their bodies, of having acquired a form of power in their lives. As Bordo (1993) points out, though, women's participation in the behaviors that contribute to their subordination does not mean "that they have 'power' in the production and reproduction of sexist culture" (p. 262). It only means that women experience an illusion of having power.

An Historical Overview of Cosmetic Surgery

Plastic surgery is an ancient branch of medical treatment that originated centuries ago. Indeed, evidence suggests that skin grafts were performed as early as 800 B.C. in India (ASPRS Website, 1996). However, it remained relatively stagnant for hundreds of years until the onset of World War I, which marks the beginning of the modern period of plastic surgery ("History of..., 1994). The emergence of the modern era of plastic surgery during this time is directly attributable to the horrors of war inflicted

on soldiers by newly developed armaments: "Shattered jaws, blown-off noses and lips and gaping skull wounds caused by modern weapons required innovative restorative procedures" (ASPRS Website, 1996, p. 1).

Despite the wartime development of numerous surgical techniques and procedures, both reconstructive and aesthetic, plastic surgery struggled with its identity as a branch of medicine in the years following the war. Recognizing the need for a means of formally organizing those medical doctors specializing in plastic surgery, Drs. Aufricht and Malianiac established the American Society of Plastic and Reconstructive Surgeons in 1931 (ASPRS Website, 1996, p. 3).

Both were eminent European-born surgeons who honed their craft and specialized their techniques during and after World War I. By the late 1930's, the American Board of Surgeons established an American Board of Plastic Surgery for the medical certifying of plastic surgeons (ASPRS Website, 1996, p. 3). Today, 97% of the members of the ASPRS are certified by the American Board of Plastic Surgery (ASPRS Website, 1996, p. 2).

With the advent of World War II, many plastic surgeons dedicated their skills to those wounded and maimed by the weapons of destruction employed during this conflict (ASPRS Website, 1996, p. 4). Following the war, plastic surgeons changed their focus from aiding war victims to reconstruction for cancer patients ("History of," 1994, p. 11a). Many new surgical techniques (including internal wiring for facial fractures and rotation flaps

for skin deformities) developed in the 1950's, and it was during this era that the specialty entered the realm of public relations in an effort to reach the public (ASPRS Website, 1996, p. 5). In the sixties, even more techniques were developed, and the first breast implant device was introduced by Thomas Cronin, MD (ASPRS Website, 1996, p. 5). During the seventies, owing to evolving and even more sophisticated advances -- as well as public relations -- "plastic surgery, the reconstructive caterpillar, began its metamorphosis into an aesthetic butterfly" ("History of," 1994, p. 67a). It was at this time, then, when cosmetic surgery as a medical specialty, moved further into the public's consciousness.

> According to the ASPRS (ASPRS Website, 1996, p. 1):
> Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Cosmetic surgery is usually not covered by health insurance because it is elective. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve functions, but may also be done to approximate a normal appearance. Reconstructive surgery is generally covered by most health insurance policies although coverage for specific procedures and level of coverage may vary greatly.

For the profession, the eighties were largely characterized by two important circumstances. First, young plastic surgeons were given a more vocal role in the ASPRS and second, the organization greatly expanded its marketing efforts ("History of," 1994, p. 81a), which can be ascribed, at least in part, to the infusion of younger surgeons. Furthermore, brochures designed to educate potential patients about cosmetic surgery procedures were produced and sold to Society members and met with great success. Also, a

new logo -- 'the circle of perfection that can never be achieved' -- was launched (Source: "History of," 1994, p. 77a).

A number of factors have contributed to the growth of cosmetic surgery in the U.S., including the proliferation of specialty areas in medicine, as well as increasing numbers of physicians over the last 30 years (Sullivan, 1993, p. 105). Another important factor has been the demand for cosmetic surgery from the public, caused in part by the belief that attractiveness is essential to both economic and social success (Haiken, 1997; Sullivan, 1993), as well as to mental health (Haiken, 1997). Indeed, Haiken (1997, p. 108) contends that the conceptualization of the inferiority complex by some psychologists in the 1920's and 1930's led to the not uncommon belief that looks are linked to mental health. Specifically, the notion that physical defects could impair one's economic status, because of an erosion in self-confidence caused by their looks. Furthermore, those whose ability to find work was hampered by their appearance could develop inferiority complexes because of their inability to support themselves (Haiken, 1997, p. 115). Even today, cosmetic surgeons associate appearance with psychology: "Many who choose to use their considerable skills for such nonfunctional outcomes justify their actions in terms of the mental health of patients" (Sullivan, 1993, p. 105).

Still another factor which has increased demand for cosmetic surgery is advertising sponsored by the surgeons, which often features extremely attractive and shapely young women posing in swimsuits. Much of this advertising has come under fire: As

Haiken (1997) notes, the advertisements generated by this specialty "features a disproportionate share of misleading and fraudulent ones" (p. 294) in comparison to advertising sponsored by other specialties. Additionally, cost is also a factor in the growing popularity of cosmetic surgery. Although insurance companies do not cover the costs of surgery that is purely cosmetic in nature, most surgeons offer payment plans and accept major credit cards, thus making cosmetic surgery readily affordable for many, especially the middle classes. Cosmetic surgery is extremely popular among baby boomers (age 35 to 50) who accounted for 41% of all cosmetic surgery procedures performed in 1998, while those age 34 and under accounted for 25% of all said procedures (ASPS Website, 2000). Race is another significant variable: While only 11% of all cosmetic surgery patients are non-white (ASPS Website, 2000), people of color comprise about 25% of the U.S. population (Kendall, 2000, p. 275).

Certification Issues

Currently in the U.S., any medical doctor in any specialty can practice cosmetic and reconstructive surgeries: There are no laws requiring medical specialists to meet certain criteria for the practice of these specialties. Moreover, a group of doctors in any specialty can establish a medical board and declare themselves as being board-certified.

However, the American Society of Plastic Surgeons (formerly knows as ASPRS), the largest professional organization of plastic surgeons in the U.S., has established certain criteria for its

members, including having graduated from an accredited medical school and completing "at least five years of additional residency, usually three years of general surgery and two years of plastic surgery" (ASPS Website, 2000, p.2). Furthermore, many ASPS members are also certified by the American Board of Plastic Surgery (ABPS), which requires that a physician "practice plastic surgery for two years and pass comprehensive written and oral examinations" (ASPS Website, 2000, p. 2).

Cosmetic Surgery Demographics

The statistics that appear below were compiled by the ASPS and are based on data provided by its approximately 5,000 members. Although these statistics are the only ones available regarding long-term trends for cosmetic procedures, they are not entirely accurate as those medical doctors not certified by the ASPS and ABPS are not required to compile data concerning the cosmetic surgeries they perform.

As mentioned previously, cosmetic surgery is becoming increasingly popular in the U.S. More specifically, cosmetic surgery procedures nationwide increased from 413,208 in 1992 to 1,045,815 in 1998 (the most recent year for which data is available), representing a change of +153%. Even more startling is the fact that from 1996 to 1998, cosmetic surgery procedures increased 50%. The top five cosmetic surgical procedures in 1998 were, in order of popularity, liposuction (172,079), breast augmentation (132,378), eyelid surgery (120,001), facelifts (70,947), and nose reshaping (55,953). This reflects a dramatic

shift from 1992, when the most popular surgical procedures were eyelid surgery (59,461), nose reshaping (50,175), liposuction (47,212), facelifts (40,077), and breast augmentation (32,607). It is interesting to note that despite widespread concerns about possible health problems associated with breast implants, this procedure increased 306% 1992 to 1998, from 32,607 procedures to 132,378.

Looking at age, we find, not surprisingly, that baby boomers (age 35 to 64) accounted for many of the cosmetic surgeries performed in 1998. However, some of these procedures were more popular among a younger group, age 19 to 34. For example, 60% of breast augmentations were obtained by women age 19 to 34. Additionally, most nose reshapings (46%) were among those age 19 to 34, and 77% were performed on women. It should also be noted that people 18 and under accounted for 14% of the nose reshapings in 1998.

Regarding liposuction, which is currently the most popular cosmetic surgical procedure, 50% occurred among those age 35 to 50. However, more than one-fourth of liposuctions (27%) were in the 19 to 24 age category. Again, we find evidence of a strong gender influence -- 88% of those who underwent liposuction in 1998 were women.

The third most popular procedure, eyelid surgery, was immensely popular among baby boomers, in that those age 35 to 64 accounted for 72% of these procedures. Further, 87% of those who sought this procedure were women.

Lastly, 55% of facelifts in 1998 occurred among people 51 to 64. More than one-fourth, though (26%), were among those age 35 to 50. Again, gender was an important factor, in that a distinct majority (92%) of those who sought facelifts were women.

When all the cosmetic surgery procedures for 1998 are combined, those age 35 to 50 accounted for 41% of them, while those age 51 to 64 represent 24% of those who underwent these procedures. Close behind are people age 19 to 34, who accounted for 23% of cosmetic surgeries, while 9% were among those age 65+ and 2% among those 18 and younger.

Although 2% may seem to be an insignificant amount, cosmetic surgery is increasing among those 18 and under: Overall, the total number of procedures for this age group increased from 13,314 in 1992 to 24,623 in 1998. In particular, liposuction in this age group rose from 472 in 1992 to 1,645 in 1998. Breast augmentation also increased significantly, almost doubling from 978 in 1992 to 1,840 in 1998.

The table below illustrates the changes, both subtle and dramatic, in cosmetic surgery trends among different age groups. Overall, the top five cosmetic surgeries more than doubled in number, from 229,532 in 1992 to 551,357 in 1998, and there were significant increases for all age groups, except the youngest. Looking at specific procedures, breast augmentation has become very popular, especially among women 19 to 34. In 1998, for example, it accounted for more than half (51%) of the top five procedures in this age group. Nose reshaping, however, has remained constant,

while the other cosmetic surgery types increased their share (i.e., grew rapidly in raw numbers).

In 1996, among the 35 to 50 age group, liposuction surpassed eyelid surgery as the most popular top five procedure. Indeed, by 1998, liposuction represented 42% of the cosmetic surgeries in this age group. Among those 51 and over, the changes over time have been far more subtle, but interesting nonetheless. For example, while facelifts have declined in popularity, from 39% of the top five cosmetic surgeries in 1992 to 30% in 1998, the share of liposuctions has increased, from 12% to 21% over that same period of time.

Top Five Cosmetic Surgeries
(by age and type of surgery)

	1992 %	1994 %	1996 %	1998 %	% of change 1992-1998
Age 18 or less					
Breast aug.	14	8	18	16	
Eyelid sur.	0	0	4	<1	
Facelift	0	0	0	<1	
Liposuction	7	10	12	14	
Nose reshape	79	83	66	69	
TOTAL	100	101	100	100	
	(6,969)	(5,214)	(6,540)	(11,719)	+68%
19 to 34					
Breast aug.	30	39	46	51	
Eyelid sur.	5	4	3	3	
Facelift	<1	0	<1	<1	
Liposuction	23	27	31	30	
Nose reshape	42	30	20	16	
TOTAL	100	100	100	101	
	(65,642)	(65,652)	(122,292)	(155,992)	+138%
35 to 50					
Breast aug.	13	16	19	22	
Eyelid sur.	30	29	24	20	
Facelift	14	12	11	9	
Liposuction	27	31	37	42	
Nose reshape	16	12	9	8	
TOTAL	100	100	100	101	
	(85,954)	(77,994)	(141,501)	(208,063)	+143%
51+					
Breast aug.	1	1	3	3	
Eyelid sur.	43	43	38	43	
Facelift	39	37	37	30	
Liposuction	12	14	18	21	
Nose reshape	5	4	5	4	
TOTAL	100	99	101	101	
	(70,967)	(60,507)	(102,378)	(175,583)	+147%
GRAND TOTAL	**(229,532)**	**(209,367)**	**(372,711)**	**(551,357)**	+140%

The popularity of particular cosmetic surgery procedures varies not only by age, but by geographic region as well. Below is a table showing the most popular cosmetic surgical procedures by selected states, compared to the national rankings:

National	California	New York
1. Liposuction	1. Liposuction	1. Liposuction
2. Breast augmentation	2. Breast aug.	2. Nose reshaping
3. Eyelid surgery	3. Eyelid surgery	3. Eyelid surgery
4. Facelift	4. Facelift	4. Breast aug.
5. Nose reshaping	5. Nose reshaping	5. Facelift

Florida	Texas
1. Eyelid surgery	1. Liposuction
2. Breast aug.	2. Eyelid surgery
3. Liposuction	3. Facelift
4. Facelift	4. Breast aug.
5. Nose reshaping	5. Nose reshaping

Some of the observed differences are readily understandable, while others are not. For example, it is not surprising that breast augmentation is more popular in California and Florida than it is in New York and Texas, given that the former are coastal states characterized by extensive beaches and ample warm weather, both conducive to extensive bathing suit seasons. In New York, the high ranking of nose reshaping is probably attributable to the popularity of this procedure among certain racial and ethnic groups who are strongly represented among New York residents, particularly in New York City. What is puzzling, however, is the fact that this procedure is still very much in demand in New York, given the increasing diversity of racial and ethnic groups. It is reasonable to assume that in a multicultural environment, pressure to alter one's nose to resemble a prevailing type would not be considerable,

but that is certainly not the case in New York.

Average Surgeon Fees

One of the factors that has contributed to the growth of cosmetic surgery as a medical specialty is the profitability of the procedures. Surgeon fees vary from state-to-state and by type of surgical procedure. Below is a table that compares the national average fees for some cosmetic surgical procedures with those from selected states in 1998. In general, fees do not include anesthesia and operating facilities.

	National Average	CA	NY	FL	TX
Liposuction (single site)	$1,872	$2,281	$2,250	$1,490	$1,461
Breast augmentation	3,077	3,234	4,417	2,616	2,851
Eyelid surgery (both)	2,942	3,234	4,200	2,764	2,415
Facelift	4,991	5,540	6,633	4,463	5,304
Nose reshaping (primary)					
-Open	3,434	3,730	4,917	3,303	3,183
-Closed	3,023	3,117	4,167	2,973	2,417

Overall, surgeons in New York charge the highest fees, which are considerably higher than the national averages. Surgeons in Florida and Texas tend to charge the lowest fees. California, in terms of fees, ranks second, behind New York. These figures offer strong evidence of the financial benefits enjoyed by those medical doctors who practice in this specialty.

In sum, cosmetic surgery is a growing phenomenon that has many implications for sociologists, including normalizing and

homogenizing issues, medicalization of appearance and choice issues, and, of course, gender issues. The future chapters of this study will confront all of these issues in detail.

Ch. 2 The Personal is Political: Feminist Theory and the Aesthetic Realm

A number of scholars representing a variety of academic disciplines have contributed to feminist discourse concerning the body. Among them is Bordo (1993, p. 181), who utilizes the Foucauldian terms 'useful body' and 'intelligible body' as they are useful to such discourse on the body. She defines the intelligible body as comprising "our scientific, philosophic, and aesthetic representations of the body -- our cultural conceptions of the body, norms of beauty, models of health" (Bordo, 1993, p. 181). However, she further asserts that these representations engender normative prescriptions which serve to mold and fashion the body into a [socially] useful body. Looking back the nineteenth century, Bordo conceives the hourglass figure body shape as representing the intelligible body of that era. She further contends that a distinct feminine praxis, comprising a variety of behaviors and activities (i.e., wearing tight corsets, eating small amounts of food) made "the female body unfit to perform activities outside its designated sphere" (Bordo, 1993, p. 181). The result, then, was the useful (or what she calls practical) body as it corresponded to the aesthetic ideal of that time.

Turning to contemporary culture, Bordo (1993) links the slender images and representations of women's bodies arising out of our cultural obsession with thinness to the "transcendence of female appetite and its display in the slenderness ideal in terms

of power, will, mastery, the possibility of success in the professional arena" (p. 182). She further notes, though, with more than a touch of irony, that many of the girls and women who aspire to attain today's intelligible body experience eating disorders and obsession with body image and size, and thus do not have mastery over their lives. Indeed, for these women, body obsession becomes a time and resource-consuming passion that exerts mastery over them.

Although Bordo makes some compelling points here, I think her definition of the contemporary intelligible body as merely slender is too narrow. That is, the aesthetic norm for woman's body today is slender, well-toned, and big-breasted, as reflected in many images of women that abound in our society. Interestingly, Bordo acknowledges as much in a footnote to another chapter in her book when she says: "Large breasts may be making a comeback, but they are attached to extremely thin, often athletic bodies" (1993, p. 333). However, she failed to integrate this notion into her discussion of the intelligible body, and focussed solely on the thinness aspect.

In light of this, I would take her argument further, and propose that contemporary representations and images of woman's body are not only symbolic of transcendence of female appetite, but of the transformation of female body type as well. Subsequently, the feminine praxis of today requires not only dieting and exercising, but also cosmetic surgery, as many body-altering effects (bigger breasts, less body fat, elimination of

wrinkles) cannot be achieved by diet and/or exercise alone.

Moreover, just as the nineteenth century hourglass figure was a symbolic form that reflected the acute differences between the male and female forms, as between the male (public) and female (private) spheres, the contemporary thin and big-breasted figure can also be conceptualized as a symbolic form. Thinness in today's intelligible body, for example, represents discipline, self-control, and constraints exerted and imposed over one's self. Big breasts, on the other hand, personify sexiness and desirability. The aesthetic norms of today, then, would appear to produce an intelligible body that is dichotomous: controlled and disciplined/sexy and alluring. However, these seemingly disparate aspects do share something in common: They both symbolize femininity, a femininity that is socially constructed. As Bartky (1988) notes, "normative femininity is coming more and more to be centered on woman's body...its sexuality [or] more precisely, its presumed heterosexuality and its appearance" (p. 81).

I would add to this that although appearance is becoming an increasingly important component of normative masculinity, men are still largely measured in terms of aspects and traits not related to their sexuality, appearance, or location in the social structure. Consequently, body-enhancing efforts play a far more significant role in women's lives than in men's. Furthermore, the practical body that corresponds to today's prevailing aesthetic norm vividly differentiates the male and female forms, much as the hourglass figure had. It also serves to distinguish masculinity

from femininity, and thus reinforces the notion of difference between the sexes. Moreover, it should be noted that as women have moved further and further out of the private sphere and into the public one, the achievement of the practical body has become more time-consuming, expensive, and prevalent, while the techniques themselves have become increasingly invasive.

In her book, Paradoxes of Gender (1994, p. 17), Lorber asserts that anatomical differences had to destine women for an entirely different social life than men, and that bodies are gendered and transformed by social practices to fit the "female" and "male" and "women" and "men" categories. This made sense during the Victorian era when bourgeois women were tied to the home, their identities inextricably linked to their domestic and social responsibilities. During that time, the phrase 'angel of the house' enjoyed widespread popularity and aptly personified the role expectations for bourgeois women. Thus, the fashion dictates of the day (corsets, multiple layers of clothing, bustles, and high-laced shoes) performed an important function. That is, they limited the physical activities women could participate in, thereby reinforcing the norms of behavior imposed on Victorian middle and upper class women. It is paradoxical, however, that although women today participate far more extensively in public sphere activities that women's appearance norms are no less compelling than they were a century ago.

In addition to viewing the body as a text, it can also be seen as a locus of social control. Referring specifically to women's

bodies, "the discipline and normalization of the female body...has to be acknowledged as an amazingly durable and flexible strategy of social control" (Bordo, 1993, p. 166). That is, appearance-enhancing behaviors women engage in voluntarily have meanings far deeper than the surface inscriptions that arise from them. "They must," Bartky (1988) intones, "be understood as aspects of ...an oppressive and inegalitarian system of sexual subordination" (p. 75). She further argues that "this system aims at turning women into the docile and compliant companions of men" (Bartky, 1988, p. 75), in the same way the army turns recruits into soldiers. Bordo (1993) concurs, asserting that the preoccupation with appearance which, as noted earlier, still affects women far more than men, "may function as a backlash phenomenon, reasserting existing gender configurations against any attempts to shift or transform power relations" (p. 166).

In their analyses of the social control of women's bodies, both Bordo and Bartky, among others, incorporate ideas drawn from the writings of Michel Foucault. Among them are those of the disciplined and docile body, which Foucault (1978) attributed to the perception of the body as a machine, beginning in the seventeenth century:

> One of these poles -- the first to be formed, it seems -- centered on the body as a machine; its disciplining, the optimization of its capabilities, the extortions of its forces, the parallel increase of its usefulness and its docility...all this was ensured by the procedures of power that characterized the discipline: an anatomo-politics of the human body. (p. 139).

Another concept of Foucault's they borrow is that of bio-

power, which comprises "numerous and diverse techniques for achieving the subjugation of bodies and the control of populations..." (Foucault, 1978, p. 140). Biopower assumes two forms; one relates to the control of the population, while the other is "disciplinary power...a knowledge of and power over the individual body...[which attempts] to render the individual both more powerful, productive, useful and docile" (Sawicki, 1991, p. 67). According to Sawicki (1991, p. 67), disciplinary practices are located at both the macrolevel, within institutions, as well as at the level of the individual, in everyday activities and routines. Furthermore, these practices are insidious, in that they exert control not through the "threat of violence or force, but rather by creating desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviors and bodies are judged and against which they police themselves" (Sawicki, 1991, p. 68).

Although Sawicki employed the Foucauldian concepts of disciplinary practices in her analysis of the new reproductive technologies, Bartky (1988, p. 65) and Bordo (1993, p. 130) related them to the appearance-related activities and behaviors of women. For example, Bartky (1988, p. 65) identifies three categories of disciplinary practices which produce a recognizable feminine body. The first category encompasses dieting and exercising, both of which are disciplines "imposed upon a body subject to the 'tyranny of slenderness'" (Bartky, 1988, p. 65). Although both women and men participate in these behaviors, differences exist between the

two groups, in terms of both participation and motivation. As Bartky (1988, p. 65) observes, women dieters vastly outnumber men dieters, and eating disorders still primarily affect women. Moreover, in light of women's obsession with weight in our culture, Bartky (1988, p. 65) suggests that women work out for different reasons than for men; that is, as a means to accelerate weight loss.

The second category of disciplinary practices concerns women's body movements and gestures, of which she notes: "Women are far more restricted than men in their manner of movement and in their spatiality" (Bartky, 1988, p. 66). That is, women tend to sit with their legs close together, and arms close to their bodies whereas men often sit with legs apart, arms out at some distance from the body (Bartky, 1988, p. 66). Thus, the postures and positions that women assume are more constricted than those of men, and require more discipline and constraint. The third category involves those disciplinary practices that relate to the ornamentation of women's bodies, including skincare, haircare, cosmetics, and the selection of clothes. Interestingly, Bartky neglects to include cosmetic surgery in her discussion, a disciplinary practice that has consequences for women that go far beyond surface ornamentation and enhancing.

All of the aforementioned disciplinary practices require the continual investment of resources. For example, most weight loss programs are unsuccessful over time, and exercise regimens must be consistently adhered to, or the hard-won results will dissipate.

Furthermore, as many cosmetic surgery advertisements targeted at women point out, exercise and diet alone will not yield the socially desirable body, but liposuction and breast augmentation will. However, what these advertisements fail to disclose is that even surgical techniques are temporary. That is, weight gain can result in new deposits of fat, necessitating more liposuction, breast implants have unpredictable and limited life expectancies (in my case, it will have to be replaced in about 10 years), and several surgeries may be necessary to make adjustments. Additionally, facelifts must also be periodically redone. And hair coloring efforts must be repeated every several months at best, while cosmetics and skincare products may require reapplication several times over the course of a single day. Indeed, virtually all the disciplinary practices that relate to women's bodies are unceasing, and even if they are followed religiously, their effects are only temporary. Thus, the quest to attain the aesthetic ideal body is a continuous (albeit ultimately fruitless) process for most women, one which consumes time and attention that could be devoted to other endeavors.

An important matter that pertains to choice concerns the dissemination of information and knowledge. As Fisher (1986) notes, physicians exert control over patients' access to, and understanding of, information. They are authorities who "act as gatekeepers, providing options to some, denying them to others" (Fisher, 1986, p. 4), thus compromising women's ability to choose. Speaking specifically of cosmetic surgery, Davis (1995) asserts

that "physicians systematically withhold information or downplay the risks of surgery" (p. 157). This is not to say that agency plays no role in the decision-making process; on the contrary, it is, as Davis notes in her study of cosmetic surgery, "central to understanding both why women decide to have cosmetic surgery and how they experience its outcome" (1995, p. 157). However, she concludes (and I would agree) that women's decisions to undergo cosmetic surgery are bounded by the conditions imposed on them "by a social order which is organized by gender and power" (Davis, 1995, p. 158).

However, Davis (1991) perceives cosmetic surgery as being potentially liberating, "within the disciplinary and normalizing feminine beauty practices" (Davis, 1991, p. 22). Indeed, she even goes so far as to assert that cosmetic surgery "may be, first and foremost, about being ordinary, taking one's life in one's own hands..." (Davis, 1991, p. 23).

Instead of focusing on the individual in relation to beauty practice as Davis does, Bordo seek to examine the sociocultural forces outside the individual that engender the belief systems which support the prevailing practices, an examination which I feel is more useful than an approach situated at the level of the individual.

Furthermore, Davis (1991, p. 37) envisions cosmetic surgery as being a measure of last resort that most women do not employ. However, the fact that more than one million people a year (most of whom are women) undergo cosmetic surgery clearly refutes Davis'

contention that "cosmetic surgery is not regarded as a general solution to women's problems with their appearance" (1991, p. 37). But many middle-aged and older women use cosmetic surgery as a means of erasing the culturally undesirable physical manifestations of aging, while sizable numbers of younger women use it to achieve culturally-desirable physical attributes, such as big breasts and thin thighs.

As mentioned previously, the medical profession plays an important role in socializing women to believe that surgical transformation of their appearances is both desirable and necessary. As Spitzack (1988) notes of this in her analysis of cosmetic surgery, "before a woman can be 'cured' of an unhealthy exterior/interior, she must recognize herself as diseased...[and] understand that an absence of feminine beauty is a form of disease which adversely affects her entire network of social interactions..." (p.9).

In her book, In Labor, which concerns the medicalization of childbirth, Rothman (1991, p. 41) explains how the medical profession deliberately -- and ultimately successfully -- convinced women that medical intervention is necessary to ensure the birth of healthy babies. As evidenced by the public relations campaigns of the ASPRS, cosmetic surgeons have been making a concerted effort to persuade women that medical intervention in the form of cosmetic surgery is necessary to ensure not only an improved sense of well-being, but an improved quality of life as well. For example, in a brochure I picked up at my plastic surgeon's office titled: "What

to Look for in a Plastic Surgeon" published by the ASPRS, in a section concerning appearance and its (supposed) significance:

> Studies have shown that how you look greatly affects how you feel...In many ways, low self-esteem is every bit as debilitating as a physical injury or illness. It can have adverse effects on your home and social life, your career -- even your emotional and psychological well-being. Our plastic surgeons can change your whole outlook.

Another issue important to this discussion of cosmetic surgery concerns resistance. As mentioned previously, Bordo (1993) draws heavily on Foucault, and supports his contention that resistance is an historical process; constant and conceivable even under the most oppressive domination. She further maintains that subversion is contextual, historical, and social, and that "whether texts are subversive or recuperative...cannot be determined in abstraction from actual practice" (1993, p. 294). Referring to cosmetic surgery, she questions whether people who undergo corrective procedures (on racial and identity features) do so as a form of resistance against prevailing norms or because those norms are so powerful (Bordo, 1993). In applying her argument to breast augmentation, I think it is clear that women who opt for this procedure do so because the prevailing norms are so powerful.

In sum, Bordo (1993) asserts that women should use bodily disciplinary practices "in the service of resistance to gender domination, not in the service of docility and gender normalization" (p. 184). To do so requires that women develop a healthy skepticism of those practices that are embedded with promises of power and control, but may ultimately prove futile and disappointing.

More insight on resistance comes from Bartky (1988), who believes that widespread resistance is not likely to occur in today's political climate. She does, however, acknowledge the recent emergence of oppositional discourses and practices; for example, the rejection of hegemonic images of femininity by radical lesbians and the growing popular literature of resistance, including Kim Chernin's The Obsession and Marcia Hutchinson's Transforming Body Image: Learning to Love the Body You Have (Bartky, 1988, p. 83).

Another form of resistance to the prevailing aesthetic ideal of femininity is evidenced by the many mastectomy patients who decide not to undergo breast reconstruction; according to Siegel (1990), a surprising 75 percent. Although age is a factor in the resistance to reconstruction (older women are less likely to choose breast augmentation than younger ones) (Siegel, 1990), it is not the only one. Another factor concerns the acceptance by some women of their post-mastectomy bodies. For example, Matuschka is an artist/breast cancer awareness activist who appeared on the cover of The New York Times Magazine (August, 1993) with her mastectomy results in full view. Some response to the cover was negative, but women's health activists applauded her efforts to bring the reality of breast cancer into the public consciousness. Her actions and the consciousness-raising that followed in its wake comfortably fits Bordo's (1993) description of a systemic critique that provokes women to collective action, an issue to be discussed further in the next chapter. It is a critique still in embryonic

form, but one that I think is certain to grow.

Ch. 3 The Sociology of Female Beauty: Mirror, Mirror, on the Wall...

Both the concept and definition of beauty have undergone considerable change throughout the centuries. Today, Chapkis contends, beauty is strongly related to woman's body, and that a woman "will be valued and rewarded on the basis of how close she comes to embodying the ideal" (1986, p. 14). Moreover, Western standards of beauty have been far from static. Indeed, as Chancer notes, "criteria of feminine beauty and fashion shift from historical era to era...or from society to society...or both" (1998, p. 100). Consequently, the criteria of beauty that dominate a particular place and time are immensely shaped by culture-specific influences and forces. A prime example of this would be our contemporary culture's ideal of thinness in women, an ideal that has only gained prominence in recent decades.

Although in the United States beauty has long been presumed to be an attribute only women could possess, the criteria for feminine beauty in the have not always been based on physical attractiveness and surface appearance. In the early twentieth century, both feminists and beauty experts surmised spiritual qualities as being more important to the appearance of beauty than physical attributes (Banner, 1983, p. 206). Additionally, the belief in the moral superiority of women, Banner (1983, p. 206) asserts, contributed to the notion of democratic ideals of beauty -- the idea that every woman could be beautiful. As also noted, this was an ideal embraced by both feminists and beauty experts, which included the

manufacturers of beauty products and proprietors of salons and stores that offered beauty products and services. Interestingly, the majority of beauty experts at that time were women.

By the 1920's, however, the moral superiority of women argument dissipated (Banner, 1983, p. 207), and with it, the spiritual element of beauty. As mentioned in an earlier chapter, consumerism was a major factor in the shift from inner beauty to external beauty. Subsequently, the outward appearance of women came to be regarded "as more important than their inner character, and external means could become central to improving their looks" (Banner, 1983, p. 208). Thus began the commercial exploitation of woman's physical appearance, and the idea that every woman could be beautiful -- with the help of cosmetics and lotions and other products (Banner, 1983).

Both Chapkis (1986, p. 10) and Wolf (1991, p. 10) assert that the more gains women have made in our society, the more stringent the standards of beauty have become. As a result, appearance-related issues (including dieting, exercise, cosmetics, cosmetic surgery, and apparel) dominate much women's discourse, both public (i.e., the media) and private. Chancer agrees, remarking that "evidence from many sources suggests that women's concern about looks has intensified in recent years" (1998, p. 84). While the appearances of women who possess power are often subjected to examination and criticism, those of men in comparable positions are not. For example, while media accounts of Marcia Clark, lead prosecutor in the O. J. Simpson case, Sandra Day O'Connor, Supreme

Court Justice, and Hilary Clinton, candidate for the New York Senate sometimes included references to their hairstyles and dress, their male counterparts are never discussed in those terms in the media. It is not surprising, then, that despite the many advances women have made, many of them still define themselves primarily by their physical appearances and ability to attract a male partner (Banner, 1983). An analysis of these issues can be found in Naomi Wolf's popular but controversial book, The Beauty Myth (1991). In her book, Wolf (1991) defines the beauty myth as the belief that beauty is a universal, unchanging quality that "women must want to embody and men must want to possess women who embody it" (p. 12). The myth also maintains that beauty is necessary and natural for women. This belief is supported by Simmel (1984/1911), who asserts that "the quality of beauty is more closely related to the female phenomenon than to the male, even if only in the sense that the woman possesses a greater natural disposition to beauty" (p. 89).

Freedman (1986) contends that the myth of female beauty developed out of the myth of female deviance: the notion that women are inferior and lacking in comparison to men. According to this perspective, then, female beauty disguises women's perceived inadequacies and compensates for their lower status. Interestingly, Freedman (1986) also asserts that the beauty transformations achieved through beauty rituals serve to reinforce the myth of female deviance by linking femininity with phoniness (i.e., false nails, silicone breasts, bottled blush, etc.). Thus, the surface enhancements required to meet contemporary standards of

female beauty indeed appear to perpetuate the mistaken belief that women's most important attributes are physical and superficial in nature.

In a similar vein, Wolf (1991, p. 14) claims that the beauty myth has long existed, but has flourished with the development of technology of mass production which allows for women's continual comparison to a mass-disseminated physical ideal, which first occurred through photos, then advertisements and forms of mass entertainment. She also says that, in reality, beauty is not universal or unchanging, and that it involves assigning value to women based on a culturally imposed physical standard (Wolf, 1991). The current standard, though, according to Wolf (1991) and Bordo (1993), is impossible to achieve, as it is based on a standard of "perfect" female beauty. Further, the attempts undertaken to achieve the contemporary ideal involve much time, money, and effort. The weight-loss industry alone grosses more than $33 billion each year in the U.S., and over 80 percent of those in diet programs are women (Zones, 1997). Furthermore, the cosmetics industry grosses over $20 billion annually (Wolf, 1991), while "cosmetic surgery generates over a third of a billion dollars per year for practitioners" (Zones, 1997, p. 98).

These attempts also entail more risk to one's health, and, as Davis (1995) observes, pain: "Beauty hurts, and it appeared that modern women were willing to go to extreme lengths to improve and transform their bodies to meet the cultural requirements of femininity" (p. 41). Cosmetic surgery techniques, for example, are

becoming increasingly more invasive; some facelifts involve altering the underlying bone structure of the face. Additionally, chemical peels, which increased +246% between 1992 and 1998 (from 19,049 procedures to 66,002) (ASPS Website, 2000) are very painful, and entail burning off several layers of facial skin. According to Freedman (1986), the pain involved in many beauty rituals becomes synonymous with feeling bad, which in turn becomes a prerequisite to looking good. Besides morality, power is another attribute historically linked to beauty in women. As Banner (1983, p. 13) notes, nineteenth century literature reflected two major themes: beauty as morality, and beauty as power. Indeed, writers of that era scrutinized historical records for evidence of beautiful women whose physical appearance gave them power over important men; for example, Delilah, Cleopatra, and the Queen of Sheba. Moreover, beauty-related power was viewed "as a narcissistic device; women should use their beauty to advance their own interests...in the context of relationships with men" (Banner, 1983, p. 13). Interestingly, the notion that women should exploit their beauty for self-serving ends still endures today in advertising. That is, contemporary advertising directed towards women still relies on the feminine model; a model "based on passivity, complacency, and narcissism..." (Barthel, 1988). And, as reflected in much advertising today, women are still encouraged to use beauty to entice and keep a man. Thus, I would argue that even those advertisements that ostensibly encourage women to engage in beauty practices (whether they involve makeup, dieting, exercise, or

cosmetic surgery) for their own benefit are actually encouraging women to make themselves more attractive, appealing, desirable, etc., to men. This point is amply demonstrated by the many advertisements directed at women concerning exercise clubs, diet plans, diet foods, and exercise videos which tout their supposed body-shaping and toning benefits while remaining strangely silent about health-related issues. Thus, with few exceptions, women are strongly encouraged by advertising to engage in certain disciplinary practices of the body solely to enhance their appearances, and not their physical health. Ironically, though, any changes in women's bodies that result from disciplinary practices are perceived as being healthful.

In a contemporary discussion of power as it relates to beauty, Freedman (1986) identifies two types of power evident today: direct power and indirect power. According to Freedman (1986), men possess much direct power, which has aggressive overtones, while women are socialized to utilize indirect power. This indirect power, she claims, is based on attractiveness, charm, and personal magnetism. Indeed, many contemporary advertisements targeting women urge them to become empowered by improving their appearances with cosmetics, diet foods, and fashion, thereby conceptualizing empowerment on a superficial level. Furthermore, beauty enhances the power of women while diminishing it (Freedman, 1986). That is, while beauty can attain some rewards for women, too much dependency on beauty and charm can effectuate feelings of insecurity, even after experiencing success (Freedman, 1986). These feelings of

insecurity probably arise from the knowledge that one's achieved rewards may have resulted from superficial, surface enhancements, rather than from deeply embedded personal qualities and traits. Freedman (1986) also contends that beauty-related power is a false power, in that although a decorated surface implies an assertive self-confidence, it is only a facade concealing an internally vulnerable woman full of self-doubts.

While the prevailing conception of beauty today is strongly related to a woman's external appearance (rather than personal qualities), it still, paradoxically, emanates from what Wolf (1991) identifies as the beauty myth; the belief that beauty is a quality intrinsic to women. Furthermore, this belief has become the rationale used for justifying the gender bias evident in today's standards of beauty. Thus, the popular belief that women are predisposed to be valued for their physical appearances rather than their virtues is attributed to beauty's "natural" origins.

Another consequence of the presumption that beauty is rooted in biology is that women's sexuality and reproductive capacities are thought to be inevitably linked. Hence, the high value placed on young women's bodies in contemporary society is attributable to their ability to reproduce, an ability older women have lost (Chancer, 1998, p. 102). Therefore, the idealization of young women's bodies (youthful and taut) has, according to this perspective, become strongly linked to species survival.

But Chancer (1998) offers a provocative counter-argument to the assertion that sexuality and reproduction are necessarily

related, noting that "the trend in advanced industrial societies has been to sever ancient bonds between sexuality and reproduction. Sexuality has become associated with far more varied joys that simple reproductive ones..." (p. 103). It is her contention, therefore, that biology does not explain the high value contemporary societies still place on young women's bodies. Instead, it is power--as possessed by affluent men in our patriarchal society--that explains the persistence of the supposedly biologically-based preference for the young female body-type. According to Chancer (1998), these men have the power "to put forth their own social constructions of biology" (p. 104). She further asserts that these social constructions become actualized as self-fulfilling prophecies, in that if men believe that young women's bodies provide more pleasure, "then that social construction itself can begin to create self-fulfilling effects in the minds and bodies of those very same men" (Chancer, 1998, p. 104).

Two women who personify beauty-related power today are Cher and Jane Fonda. As Chapkis (1986, p. 11) and Bordo (1993) note, these women are changing cultural expectations of what women of their respective ages should look like. However, both women are devoted disciples of disciplinary body practices: Their physical appearances are the result of continual cosmetic surgeries, as well as rigorous and time-consuming exercise regimens. Additionally, the source of the preponderance of their personal fortunes has been the fashion/beauty industry itself. Thus, although both are

perceived as being powerful, I would argue that the power they possess is the indirect beauty-related type that Banner (1983, p. 23) ascribes to women, and not the direct type that men possess. Indeed, if neither of these women had dieted extensively; undergone cosmetic surgery; or exercised a day in their lives; would they have become as powerful as they are today? I don't think so, as the power they possess can be attributed to their willingness to embrace -- and exploit -- the contemporary cultural ideal of "perfect" feminine beauty.

However, celebrities are not the only ones who undergo cosmetic surgery; as mentioned earlier in this study, millions of women have undergone cosmetic surgical procedures in the United States. Indeed, while women's roles and statuses have increased and expanded tremendously during this century, the significance of beauty in the determination of a woman's value--on both the personal and societal levels--has surprisingly remained unchanged. That is, physical appearance still plays an important role in her social value, while men's attractiveness is based on several factors, including "the possession of power, intellect, and prestige" (Chancer, 1998, p.99).

Moreover, it should be noted that women willingly and often assertively turn to cosmetic surgery. To Haiken (1997, p. 10), it is more than a little ironic that while the economic gains made by women since World War II have enabled many to afford more things for themselves, included among them are surgically-enhanced body parts. Chancer (1998, p. 129), however, regards women's increasing

propensity to undergo cosmetic surgery as the logical means of insuring their value in a still-gendered society. Given the continuing importance contemporary society ascribes to women's appearances, cosmetic surgery does--on the face of it--seem to provide a rational solution to a vexing problem for women; namely, how to reinforce one's status in the social hierarchy.

While women play a crucial role in the demand for cosmetic surgery, the role of cosmetic surgeons in this increasingly popular phenomenon should also be addressed. For example, by identifying correctable "defects" and recommending surgery, "plastic surgeons reproduced and replicated a definition of beauty that clearly derived from and relied on Caucasian, even Anglo-Saxon traditions and standards" (Haiken, 1997, p. 10). The willingness, then, to label certain physical characteristics as deformities and offer particular surgical changes to "correct" them has enabled cosmetic surgeons to impose their ideas of beauty on women, thus reinforcing contemporary standards of beauty.

While many cosmetic surgeons would deny their influence in perpetuating appearance standards, these surgeons, like all doctors, exist within a particular culture, not outside of it. Thus, they "are both products and producers not only of a culture of medicine but of a culture that is unique to modern America" (Haiken, 1997, p. 221), and, I might add, a culture still dominated by men. According to a New York Times article, women surgeons comprise only about 4 percent of all the board-certified plastic surgeons in the U.S. (Kuczynski, 1998). The overwhelming majority

of plastic surgeons, therefore, are men, and such an "imbalance would seem to have ramifications for the ever-shifting concept of American feminine beauty" (Kuczynski, 1998, p. 6). However, whether or not women surgeons would behave differently has yet to be explored.

The assertion that cosmetic surgeons impose their own ideas of attractiveness on patients finds support from an interview study of both cosmetic surgeons and their patients conducted by Dull and West (1991, p. 58). In this study, surgeons' own accounts revealed that under certain conditions, they offer their own recommendations as to what aesthetic changes women patients ought to consider. Moreover, several women interviewed for my study disclosed that the surgeons they consulted strongly recommended changing physical features other than--and in addition to--the ones that prompted them to consider cosmetic surgery in the first place. One woman, who I interviewed in person, for example, related that the first two surgeons she consulted both recommended major facelifts, when she specifically sought their opinions only regarding laser surgery for the area surrounding her mouth:

> I didn't care about my eyes or my chin or my face; I was just concerned with the area around my mouth. And the other two [surgeons], they wanted to do facelifts, and like really major, and we were talking, like, $20,000. And I thought, you know, I've never been beautiful; I'm not asking you to make me beautiful. I just wanted--you know--[to] tidy up my face.

At the urging of the third surgeon she consulted with and finally chose, she had laser surgery done to her entire face. Ironically, she was very unhappy with the results as they were only temporary.

Another woman I interviewed in person told the first surgeon she met that she wanted her eyes done, and he suggested doing her whole face:

> At that point, I was devastated...I didn't think I looked that bad...I walked out of there very annoyed at him for saying that, because it wasn't that bad, that I needed all this and that, tucked and pushed...I was forty two; can you imagine?

The second surgeon she consulted also recommended a facelift, which she refused. Finally, the third surgeon she consulted suggested a rhinoplasty in addition to eye surgery, to which she agreed.

Despite their protests to the contrary, it is apparent that these doctors do impose their own ideas of attractiveness and beauty on their women patients. Of course, it should be noted that the women mentioned here actively sought out cosmetic surgeons for their opinions. But there are differences apparent in their assessments as to how much or how little needed to be done.

Chancer (1998, p 96) suggests that we move beyond questioning and criticizing those women who have had cosmetic surgery, and instead, examine the underlying social conditions that contribute to this phenomenon. Further criticism, she feels, should be directed "on collective practices and representations and not simply on individual decisions..." (Chancer, 1998, p. 96). On this point, Wolf (1991) concurs, asserting that a new-found sense of female solidarity--a feminist third wave--should address the appearance and beauty issues confronting contemporary women. Historically, the pursuit of beauty has been the strongest link connecting women from different classes and ethnicities (Banner,

1983). But it need not be the only one.

Obviously, criticism alone of the prevailing standards of appearance will accomplish little; women must take action to effect change. On a practical level, Wolf (1991) suggests that women:

> ...make "beauty" harassment, age discrimination, unsafe working conditions such as enforced surgery, and the double standard for appearance, issues for labor negotiation; women in television and other heavily discriminatory professions must organize wave after wave of lawsuits; we must insist on equal enforcement of dress codes, take a deep breath, and tell our stories. (p. 276).

Moreover, she further suggests that women turn away from the numerous unrealistic advertising and fashion images of women, and instead "find alternative images of beauty in a female subculture..." (Wolf, 1991, p. 277). In other words, women should strive to abandon the prevailing definition of beauty which is based on external appearances and qualities that are superficial in nature, and instead focus on beauty that is inner-generated and created. In her book, Love or Greatness, Bologh (1990) offers just such an alternative definition of beauty--a notion of what it could be for women:

> By aesthetic I mean appreciative of and responsive to beauty-not just visual beauty, but anything that affects the senses and enriches our lives internally...Beauty refers to the power of a thing to affect our feelings not by what it does but by how it does it. The effect comes from the play or interplay of its elements or features...Aesthetic rationality joins together mind and body, thinking and feeling, intellect and senses. By aesthetic rationality I mean thinking that aims at re-creating beauty in our everyday world, re-creating a world that attracts and affects us, a world that re-creates, enriches and empowers us. (p. 240).

Reconceptualizing beauty in terms quite different from the conventional ones will enable women to appreciate themselves--and

others--on a more holistic plane. Furthermore, by moving towards a definition of beauty no longer dependent on surface appearances but contingent instead on qualities more profound, the concept of beauty will inevitably become more diverse, and therefore, more inclusive.

The concept of beauty in women is strongly linked--as suggested earlier--to outward appearances. In my study, one of the research questions addresses this topic by exploring the perception of the socially desirable body type; more specifically, how women describe it and their relationship to it. Questions included in my study also address the role that others played in the decision to undergo cosmetic surgery. Specifically, the extent of their surgeon's influence was explored in full.

Ch. 4 Methodology

Introduction

This study entailed qualitative research, as this approach is useful for providing a better understanding about something of which little is known. Moreover, it is exploratory in nature, as few studies regarding cosmetic surgery have been undertaken by sociologists.

Several important elements of qualitative research are incorporated in this study, including data, analytic procedures, and written and verbal reports (Strauss & Corbin, 1990).

1. Data

The major part of this study employed indepth semi-structured interviews with twenty-five white women and one black woman of different ages who underwent various types of cosmetic surgery procedures. The inclusion of women of varying ages allows for comparisons not possible if the sample had been limited to any particular age group and/or surgery type. It should be noted that the sample was limited to women who had opted for cosmetic surgery (and not reconstructive procedures) as the research questions important to this study could best be answered by members of this group. Furthermore, indepth interviews were utilized as they provide a useful method for collecting data that derives from people's words and actions (Maykut & Morehouse, 1994).

2. Analytic or interpretive procedures, including techniques for conceptualizing data.

From the research questions, a list of concepts and themes

important to my study were developed, and from the interviews themselves, explanatory or pattern codes were developed. As Miels and Huberman note, "patterns coding is a way of grouping these [first level coding] summaries into a smaller number of overarching themes or constructs" (1984, p. 68).

3. Written and verbal reports

Interviews were conducted in person, over the phone, and via e-mail. Regarding the email interviews, the questionnaire guide was emailed to the respondents in its entirety. The in person interviews were tape recorded and subsequently transcribed. I also made a hand-written account of my own thoughts, feelings, and observations soon after conducting each in person interview.

Several other interview studies pertaining to cosmetic surgery have been done. For example, Dull and West (1991), both sociologists, interviewed nineteen women and two men who underwent cosmetic surgery, as well as two other men who consulted with a surgeon but decided against it. They also interviewed ten surgeons, one woman and nine men, all white. The major focus of this study concerned what the researchers identified as being the central dilemma of cosmetic surgery; namely, how patients evaluated and assessed what needed to be altered, and how they handled these pre-operative assessments. The researchers also examined patients' post-operative assessments which "must be negotiated in relation to <u>what</u> 'aesthetic improvement' might consists of, and to whom" (Dull & West, 1991, p. 54).

In their analysis, they determined that gender is central to

understanding how this dilemma is resolved. Among their findings were that surgeons characterize cosmetic surgery as a normal and natural pursuit for women, but not for men. Indeed, the surgeons interviewed regarded women's concern for their appearance as being intrinsic to their nature, but for men, as being extrinsic to it. Moreover, many of these surgeons saw men as displaying inappropriate levels of concern for particular patient problems, thus making them [men] more difficult to deal with. Dull and West also discovered that both surgeons and patients have a tendency to engage in reductionism: the process of reducing the patients' faces and bodies to individual components. Reductionism is commonly reflected in advertisements directed towards women that are sponsored by the beauty industry. In particular, these advertisements focus on a particular body part or feature, to the exclusion of the body as a whole. Dull and West subsequently speculate that reductionism enables surgeons to conceptualize cosmetic surgery more as a reconstructive endeavor than as an aesthetic one. They also propose that reductionism provides a mutual mechanism by which both patients and surgeons can identify and classify the parts in need of correction.

In another interview study done on this topic, Goodman (1996), a gerontologist, hypothesized that idealized images of women in the media correlate with the increasing popularity of cosmetic surgery in U.S. culture. Her interview data was drawn from twenty-four white women ages 29 to 75, half of whom underwent cosmetic surgery. Goodman found that the media depictions of women during

adolescence and early adulthood correlated with their self-evaluations. That is, she discovered that body satisfaction decreased proportionately to age: Older women (who had been exposed to media images over a longer period of time than younger women) were more likely to be dissatisfied with their bodies than younger women. This may, however, be more a function of age itself rather than of longer exposure to media images. Age (or more specifically, age cohort), was a significant factor in the assessment of body image.

In her book, Reshaping the Female Body: The Dilemma of Cosmetic Surgery, Kathy Davis (1995), a clinical psychologist, presents the results of a study on this topic she conducted in the Netherlands. Although there are similarities between the U.S. and The Netherlands concerning the dominance of Anglo Saxon appearance standards as well as the increasing medicalization of both societies, there are some differences as well. For example, until recently, cosmetic surgery was included in The Netherlands health care package, thus making financial considerations an irrelevant factor in women's decisions to undergo cosmetic surgery procedures. Moreover, as Davis (1995) points out, cosmetic surgery was something of a taboo there, compelling both the women who opted for cosmetic surgery as well as their surgeons to justify their decisions and actions.

Davis's study actually comprised three studies: an exploratory study, a clinical study, and field work. For the exploratory study, she employed the snowball sampling technique,

and conducted a number of informal conversations with both women and men, in addition to constructing ten extensive biographical interviews with women who had undergone cosmetic surgery. From her interviews, she concludes that while the decision to undergo cosmetic surgery is problematic for women, it may serve as a means of changing one's circumstances and "exercising power under conditions which are not of one's making" (Davis, 1995, p. 163). Therefore, while acknowledging the significance of agency for women who decide to have cosmetic surgery, Davis also recognizes the constraints imposed on women by cultural beauty norms -- constraints which limit their ability to freely face the decision of cosmetic surgery.

The major strength of the methodology employed by Davis (1995) was the insight produced by the indepth interviews she conducted during the exploratory study. Among its weaknesses, however, was the fact that for the exploratory component of her study, the majority of the sample comprised professional women. In contrast, my sample was more heterogeneous, and included stay-at-home moms as well as women employed in a variety of occupational positions. Moreover, the clinical study she conducted focused solely on women who had undergone breast augmentation, to the exclusion of other types of cosmetic surgery procedures. Finally, the findings from the third study, which involved participant observations in consultations between applicants for cosmetic surgery and medical inspectors, are not generalizable to the United States, given that cosmetic surgery in The Netherlands was covered by its basic health

care package. Under this system, women had to negotiate with medical inspectors who would only approve of cosmetic surgery if the woman's "appearance was classified as falling 'outside the realm of the normal'" (Davis, 1995, p. 6). This differs dramatically from the profit-driven and consumer-oriented specialty of cosmetic surgery as it exists in the United Sates.

As mentioned previously, Dull and West (1991) interviewed both people who had undergone cosmetic surgery as well as cosmetic surgeons. However, their study findings concerning the women they interviewed -- while enlightening -- must be viewed cautiously, as all their participants lived in California. Thus, the geographic range of their study was very limited.

Participants

Purposive sampling was utilized in this study, and a total of twenty six women were interviewed. Of these, nine interviews were conducted in person; one was a phone interview; and the other sixteen interviews were conducted via e-mail. Specifically, the snowball sampling method was used to identify those women interviewed in person and over the phone, while the participants of the e-mail interviews composed a convenience sample.

Because this study was exploratory in nature and employed purposive sampling, a relatively small sample was used. Purposive sampling "increases the scope of range of data exposed...as well as the likelihood that the full array of multiple realities will be uncovered" (Lincoln & Guba, 1985, p. 40). Random sampling, on the other hand, "tries to achieve variation through the use of random

selection and large sample size...[while] purposive sampling increases the likelihood that variability common in any social phenomenon will be represented in the data" (Maykut & Morehouse, 1994, p. 45). It was my intent, then, to examine the individual experiences of women who had undergone cosmetic surgery as fully as possible and not generalize to a specific population.

By word-of-mouth, I initially found the first few women I subsequently interviewed in person. At the conclusion of each of these interviews, I asked the participant if she knew anyone else who had undergone non-reconstructive cosmetic surgery and might be wiling to be interviewed. If "yes," I then asked the participant to contact that individual and inquire about their willingness to be interviewed. Only if the individual contacted expressed interest in participating did I telephone them myself and explain the purposes of my study as delineated in the informed consent form. In addition, I mentioned to a class I taught that I was seeking interested women to interview for my research which itself generated several leads and consequent interviews.

Before beginning the in person interviews, each participant was asked to read and sign the informed consent form that had previously been approved by the Office of Sponsored Research of the Graduate School, a copy of which appears at the end of this chapter. Furthermore, I also sought each participant's permission to record the interviews before actually starting them. None of the women interviewed objected to having their interviews tape recorded.

As for those interactions conducted by e-mail, I first did an exhaustive search of internet discussion groups in Dejanews, in an effort to identify those whose topics of interest related to cosmetic surgery. Specifically, I sought out cosmetic surgery newsgroups and women's newsgroups. Among the discussion groups where I consequently posted a message in Usenet concerning my study were: alt.fashion, misc.fitness.misc., misc.health.aids, alt.support.breast-implant, sci.med, and alt.self-improve.

It should be noted that all the participants in my study were assured that the interview data would remain anonymous. The e-mail participants were also promised anonymity as I informed them that revealing their names was not required of them. Regarding the confidentiality of the data produced by the in person and phone interviews, the tapes of these interviews were secured in my home office. Additionally, each participant was assigned an identification number which appears at the top of each typed interview transcript. All of the transcripts and relevant written notes were also secured in my home office.

Measures

As is typical of qualitative studies, semi-structured interviews were used as a means of eliciting responses to the research questions I wanted to explore. Among the areas investigated were gender issues, decision-making issues, and the perceived and actual benefits and risks of cosmetic surgery.

Regarding gender issues, the research questions that served as the basis for this study included:

a. What are the conscious motivations and feelings of women who undergo cosmetic surgery in an effort to surgically reconstruct themselves according to a culturally-imposed ideal body type?

b. What (to these women) is the ideal body type?

c. Moreover, do they perceive this body type as an ideal for themselves? If "yes," has the ideal image been learned, and to what degree has it influenced their decision to undergo surgery?

To explore these issues, I asked the participants how they thought others saw them, both before and after undergoing surgery. Additionally, the women were also asked to describe their perceptions of the socially desirable woman's body, and their thoughts about this ideal body type.

With respect to the decision-making issues relevant to cosmetic surgery, the research question I investigated concerned the conditions under which women opt for cosmetic surgery. Among the questions relevant to this issue were those that illuminated the factors influential in their decisions to undergo cosmetic surgery. For example, the women interviewed were asked when they first thought about cosmetic surgery for themselves, as well as what--and who--motivated them to seek surgery. Other questions explored whether anyone discouraged them from having surgery, as well as their surgeon's role (if any) in influencing their decisions. Participants were also asked if their assessments concerning what needed to be changed were similar to those of the surgeons they consulted with. If the doctor's view differed from theirs, I then inquired how the differences were resolved.

Other issues relevant to this study included the benefits and risks associated with cosmetic surgery. Particularly, I wanted to assess the level of awareness concerning the medical risks involved with the procedures the participants underwent, as well as to identify the source(s) of information about the potential risks. This was accomplished by asking the women interviewed if they were aware of any medical risks associated with their procedures prior to undergoing surgery. If they answered in the affirmative, I asked them to specify what the risks were, and how they became aware of these risks. Additionally, I was especially interested in identifying any discrepancies between the negative effects that were expected and those that these women actually experienced.

I also explored the aesthetic, social, and emotional benefits associated with cosmetic surgery. For example, participants were asked what they thought would be the benefits of their procedures, and were encouraged to discuss both the aesthetic as well as emotional ones. Other questions pertinent to these issues concerned the participants' level of satisfaction and dissatisfaction (if any) with the results and whether they would repeat their experiences again, if given the chance. I also asked if they would recommend cosmetic surgery to others and probed for an understanding of why or why not. A copy of the Interview Guide appears at the end of this chapter.

Limitations and Delimitations of Study

This study utilized a sample comprised entirely of women as cosmetic surgery is a highly gendered phenomenon, in that the

overwhelming majority of those who undergo cosmetic procedures are women. Although the sample was small (twenty-six women) and thus inappropriate for the development of a quantitative statistical analysis, it is of sufficient size for an exploratory qualitative study.

Furthermore, supplementing the in person interviews with an e-mail interview survey enabled me to expand the geographic range of the study. That is, all the women interviewed in person lived in New York City or its surrounding suburban areas. The internet survey, however, generated responses from as far as Ohio, Florida, and California. Altogether, fifteen of the twenty-six participants live beyond the New York metropolitan area, and the inclusion of women from such a diverse range of geographic areas served to expand the variability of the sample. For example, all the major religions were adequately represented in the sample: ten of the participants were Catholic; six were Protestant; six were Jewish; and four None/Other. Also, although most of the participants were in the 35-44 age category (eight), the other categories were also represented: 18-24 (five); 25-34 (seven); 45-54 (four); 55+ (two), again demonstrating variability of the sample. On the other hand, responses to the questions and topics probed during the in person interviews tended to be longer than those acquired through the email interviews.

Data Analysis

Before undertaking the analysis procedure, photocopies were made of all the data. Following this, the material was unitized.

This consisted of identifying small units of meaning in the data, which was accomplished by first reading through the data carefully, drawing a line separating each unit of meaning from the one that followed. Then, the essence of the unit's meaning was denoted in a word or phrase. Further, every piece of written data was unitized. These steps were recommended by Maykut and Morehouse (1994), who assert that "what becomes important to analyze emerges from the data itself, out of a process of inductive reasoning" (p. 127).

After the unitizing stage had been completed, the resulting information units were categorized, and the categories were based on the similarity of meaning evident among the units. Eventually, all the units of meaning were placed in categories. Regarding my study, the semi-structured interview format I employed lends itself well to the identification of suitable categories. Subsequently, the topics that served as the basis for the questions asked were employed as the categories. Among these categories were factors in the decision-making process; the role and influence of the surgeon; before and after self-perceptions; benefits and risks--perceived; benefits and risks--actual; satisfaction with results; dissatisfaction with results. Following this, relevant quotes from the interviews which comprise the units of meaning were placed in the appropriate category. Since coding is an ongoing process, more categories had to be developed as the units of meaning were scrutinized, while others had to be combined or eliminated altogether.

Ultimately, the categorizing process allowed for the identification of themes common to the experiences of the women interviewed, as well as the patterns of behavior shared among them.

This study employed both indepth semi-structured in-person interviews as well as interviews completed via e-mail with a total of 27 women who had undergone various types of cosmetic surgery, excluding reconstruction following mastectomy. Before undertaking this study, it had been reviewed and approved by the Committee of the Graduate School and University Center of the City University of New York.

Message Posted on Usenet for Internet Survey

Cosmetic Surgery Study - Needs your help.

My name is Marie, and I am a doctoral student in the Sociology Department at the Graduate School of the City University of New York. I am undertaking a study of women who have had cosmetic surgery that explores the social and cultural factors related to this type of surgery. Most of what's been said about cosmetic surgery has come from the surgeons themselves. My study, however, is based on what women themselves have to say.

If you are a woman age 18 or over who has undergone cosmetic surgery (other than reconstruction following mastectomy), please e-mail me at: jusmark@aol.com I will then send you the questions that can be answered at your convenience and returned to me via e-mail. It is not necessary to reveal your name, so all information will remain confidential. Thanks for your help.

Ch. 5 Analysis - Part I

Introduction

A number of factors influence a woman's decision to undergo cosmetic surgery, some of which are situated at the level of the individual, while others are situated at the societal level. One of the factors concerned what motivated the women I interviewed to consider cosmetic surgery. Another factor addressed here includes the influence of others in the decision-making process. Interestingly, while several women denied that the opinions of others played a role in the choices they made, their narratives contradicted this assertion. One of the other issues explored concerns the cultural appearance norms imposed on women, and how those interviewed feel about them. Additionally, women were interviewed extensively about their levels of satisfaction and dissatisfaction regarding their surgical outcomes. Throughout this chapter, I am also going to offer insights from my own experience with plastic surgery; namely, post-mastectomy reconstructive surgery. Although I feel there are significant differences between women who undergo reconstructive breast surgery and those who have cosmetic augmentation procedures, there are some similarities evident among them as well.

Conditions Under Which Women Opt for Cosmetic Surgery

Decision-making and Choice Issues: Motivations

For some women, the desire for cosmetic surgery arose from unhappiness with a physical feature dating back to their childhoods. Indeed, three women reported teasing by peers as the

main reason for wanting to change a particular physical feature. Another woman, who was only 16 at the time of her surgery, and enrolled in college at the time of the interview, identified her family as the source of comments about her nose:

> I never liked my nose. And everyone in my family told me that, 'cause my mother had two nose jobs, so they said, "Oh, isn't it funny you're the only one who got mommy's old nose?" That's what everyone told me. (In person interview)

Another motivation was poor self-esteem as it related to relationships with men. As one woman (interviewed via e-mail) who had breast implants noted, it was her husband's encouragement that convinced her to undergo surgery: "I figured if he wanted me to have it, I must need it. Now I know how stupid this is!" Divorce was cited by another woman as the cause of poor self-esteem, while a homemaker in her forties experiencing serious marital problems identified them as the motivation for her surgery:

> ...honestly, he was seeing a younger woman, ok? And I was like, whoa, my son was getting married, I was like, "Oh, yeah? I'll fix him. I'm going to have my eyes done for this wedding." Cause that's what really started me going. (In person interview)

Still others mentioned a desire to improve their appearances, offering reasons ranging from wanting to look better in clothes (breast implants), to improving chances of career advancement (multiple procedures). One young woman, who was in college when interviewed, even identified an eating disorder as the primary cause of her dissatisfaction with her body, which eventually led her to undergo breast reduction surgery at the age of 18.

Several other women (four, to be exact), conceptualized their desire to undergo breast implant surgery more as a need, owing to

the negative changes in their bodies caused by breastfeeding. For these women, surgery had never even been considered before. As one woman, a suburban homemaker interviewed in person asserted: "I was never large, you know, and before the children, never, ever would it have been a consideration. Never, you know, it was never even an issue..." Another woman, who was 25 at the time of surgery, was informed by a woman doctor that obstetricians are fully aware of these possible negative changes, yet withhold this information from women patients: "It's not that you're not going to do it [breastfeed], but be aware of what can take place...I was very, very, self-conscious. I didn't get undressed in front of my husband -- it just kind of ate at me." (In person interview)

For her and the others with similar stories, knowledge of what to expect from breastfeeding would probably lessened the emotional pain they experienced. Moreover, it seems more than a little ironic that breastfeeding -- which is strongly endorsed by the medical establishment as being both natural and beneficial to mother and child alike -- should in fact compel at least some women to undergo the insertion of unnatural breast implant devices, which are not without health risks.

Influence of Others

Another factor that emerged from the interviews concerned the influence of significant others in the decision-making process that led to cosmetic surgery. In my study, "significant others" was defined to include one's spouse, partner, friends, children, and co-workers. The narratives focusing on this issue reflected

varying degrees of support and disapproval. This finding differs from that of Davis (1995), who reported in her interview study of cosmetic surgery in The Netherlands that "most women had to overcome considerable opposition in order to have cosmetic surgery" (p. 161). In my study, while twelve women claimed to have not been pressured at all by significant others, seven reported having undergone cosmetic surgery largely because of the influence of others, and four indicated that their decisions to have surgery was supported by others.

Of these, several specifically mentioned the influence of friends, particularly those who had already undergone cosmetic surgery. One woman (the homemaker with marital problems mentioned previously) who at the time was contemplating eye surgery to correct droopy eyelids, recalled the blunt comments of an acquaintance as one of the major factors in her decision to have more extensive work done:

> ..."If I were you, before I go for my eyes, I would go for a nose job." Well, I almost fell off the bike! I was like, WHAT! My nose! I never thought I had a problem with my nose...I said to her, "What's wrong with my nose?" She said, "The first time I saw you walk into the gym, I thought you were a very attractive woman, but your nose overpowers your whole entire face." (In person interview)

For other women, however, the role of others in the decision-making process could not be readily identified, thus underscoring the point that the division between self-fulfillment and the need to please others was not always clear. However, while some of the women interviewed denied having been influenced by anyone else, their narratives revealed persuasive forces at work. For example,

one woman who underwent a nose job while attending a private, urban high school (and was interviewed in person while in college) said of her school: "Everybody in my school was very into their self-image, body image. Half the school was anoretic -- they had doctors come in all the time...it [cosmetic surgery] wasn't uncommon among students; it was more common than uncommon."

When asked if she felt pressured to have cosmetic surgery, her reply was surprising: "I don't think so. I don't thinks my attitude was, well, I go to this school where everybody else had it. I just did not like my nose. And once I made the decision, I had made up my mind." However, the fact that so many of her peers in high school were concerned with body image issues and that a significant proportion of them had even undergone cosmetic surgery is strong evidence of the normalizing effect of cosmetic surgery; namely, the more common these procedures become, the more they become the norm. Under these conditions, then, those who do not have cosmetic surgery become increasingly viewed as deviating from the norm.

Another woman, who is employed full-time and attends graduate school, underwent facial dermabrasion in her twenties because of acne scarring reported having always wanted to do it [dermabrasion] for herself, but then recalled an incident involving a former boyfriend and his role in all this:

> But I had a boyfriend at the time, and he said to me one day, "What happened to your face?" Now, he didn't know at the time how much that -- that's like the worst thing anybody can say, but it was really good for me, because he said it, and most of my friends who I had always known, and my family, would never say that, maybe because they truly don't see it...I probably wouldn't say this to a lot of people, but this is what made me decide that I'm going to find out about this.

(In person interview)

Family members also played an important role in the decision-making process, both in terms of encouragement in some cases, and discouragement in others. Indeed, most of those who reported having been actively discouraged by others identified family members as those most opposed to the procedure being contemplated. A woman who was only 18 at the time of her surgery (breast reduction) and was interviewed in person while attending college noted:

> ...My mom was really for it; my dad was a little...but my grandmother was very against it 'cause she was very nervous but...like, obviously, I needed it. A lot of people thought I shouldn't but I didn't feel comfortable.

Another young woman, also in college when interviewed in person, recalled facing a similar situation:

> ...Everybody, even my parents, didn't want me to do it. Nobody tried to influence me; everybody tried to discourage me, up until the year I actually had it done, until they saw how serious I was. 'Cause they were afraid because it's still surgery, and you're under anesthesia, and they thought -- you know -- they wanted me to really want it before undergoing it...I had just turned 18.

In a couple of cases, women cited family members who had undergone cosmetic surgery in their responses to questions concerning the influence of others. Davis (1995), who also discusses the important role played by others in the decision-making process, alludes to the normalizing issue when she asserts that "by sharing their experiences [women who had cosmetic surgery], cosmetic surgery seems more acceptable -- literally, closer to home" (p. 125). In other words, as more women opt for cosmetic surgery, the more viable and acceptable an alternative it

becomes. One woman interviewed readily acknowledged the influence of others who had cosmetic surgery on her own decision to do likewise when she was in her twenties:

> A gorgeous girl I worked with, who all the men absolutely ogled constantly, had the surgery [breast implants], and we became friends. Some of the women she hung out with had been implanted, as well as the friends of our business partner's wife. These were very impressive women. Needless to say, I was sufficiently impressed! (E-mail interview)

Two women I interviewed in person, however, initially denied the influence of others who had surgery on them, and yet later in their narratives, affirmed that very same influence. When asked if anyone close to her had influenced her decision, one woman remarked: "No, except to the extent that I know others who have had this procedure [breast implants] done, making me more comfortable and knowledgeable in my decision." The other woman, who had breast implants in her twenties after breastfeeding her youngest child said:

> No, not really. Everybody was pretty unbiased; they just kinda let me make the decision on my own. My husband...didn't want to be the decision-maker on it...I had some family member who had it like ten years ago, so she at least gave me some insight on it. She didn't influence me, but she helped me understand the whole procedure better...I knew a few other people -- I used to work at a country club -- so I knew a lot of people who had plastic surgery done.

In my study, several questions asked of the respondents were designed to generate insight into the influence of cosmetic surgeons in their decision-making processes. To this end, I asked what, specifically, each woman thought needed surgical change. If the surgeon's assessment was different, I asked how the differences were resolved. While twelve women reported no differences in the

assessments of what needed to be changed, ten did. In several of these cases, the surgeons consulted recommended more procedures than the women thought was necessary. In addition, three women who had breast implants recounted that their surgeons recommended larger implants than they wanted, and all of them acquiesced. Only in one instance did a cosmetic surgeon recommend less than what was sought; in this case, the surgeon recommended smaller implants than the patient requested.

In other cases, one woman interviewed in person who sought limited laser surgery for her face and another who only wanted to get her eyes done were both urged to undergo complete facelifts by the first two surgeons each consulted with. Based on my own observations of these women, both were attractive, and I could not understand the basis for the surgeons' recommendations. However, my definition of attractiveness may be much broader than that of cosmetic surgeons, who assess appearances in terms of perfection: no wrinkles, lines, or imperfections whatsoever.

For another woman, age may have been a factor in her decision to have more surgery than she initially sought as she was only 16 at the time of her consultation. When asked about the cosmetic surgeon's assessment, she recalled:

> Well, he's the one who suggested, you know, the chin part, which is strange -- a 16 year old to get her face redone? Because once he takes pictures of you -- they send you to a photographer to take pictures, and then they start showing you exactly what's wr--what's what. And the nose was definitely what I wanted, but he also suggested the chin...well, you think he knows more. He started...said "your chin has to be the same. If you turn to the side, it should be at the same angle as your nose...it should be matching up...you have a receding chin." I don't have a receding chin, but my mother

kept saying, "Do you want it? You can have it; it's not a big deal."

In the end, she had both her nose and chin done. At the time of the interview, however (which took place several years after her surgery, while in college), this woman regretted having had the chin surgery, as the final result was not what she had hoped for.

These narratives raise several important issues. First, the experiences of those women whose surgeons recommended more procedures or something different from what they sought substantiates the assertions made earlier in this study in Chapter 3 that cosmetic surgeons are both influenced by our culture's norms regarding appearance standards, and, in turn, assume an active role in imposing those same norms on women. Thus, those physical traits currently valued as being socially desirable are reinforced not only by the images of women that abound in the media, but by the recommendations of cosmetic surgeons as well.

In my case, I deliberately sought out a woman plastic surgeon and found one though my breast surgeon. Although I found her personable and easy to talk to, she -- after hearing what I wanted to accomplish with surgery -- suggested doing more than I wanted. That is, I wanted to stay the same size I was before; my reasons for considering saline implant surgery was to look better in clothes and eliminate the need for a prosthesis. The surgeon, however, wanted me to consider increasing my size, which would necessitate inserting an implant into the healthy breast as well. I declined, and she did not attempt to change my mind on this.

The second point to be made here is that surgeons' assessments

(of what needs to be surgically altered) that differ from those of their patients may have a negative impact on the self-images of those women. Thus, a surgeon's assessment of a woman's appearance that is more critical and negative than her own may undermine that woman's self-regard and consequently, affect her self-confidence. This is an issue that needs to be further examined, by both cultural analysts and the cosmetic surgeons themselves.

Social class is another factor related to cosmetic surgery. Cosmetic surgery has become increasingly affordable -- and sought after -- by the middle-class, particularly women. According to Haiken (1997, p. 135), this trend started when plastic surgeons began to actively market themselves and their skills specifically to middle-aged, middle-class women in the years following World War II. This era saw the emergence of the celebrity culture, and with it, increasing popularity of cosmetic surgery among women movie stars. As Haiken further notes, this era also marked the emergence of the youth culture, when older women came to be seen (at least in the U.S.) as unattractive and undesirable. Subsequently, the face-lift was accepted by both surgeons and their patients as being a viable solution to rectifying the visible signs of aging. Thus, the surgeons "became both producers and products of the modern 'culture of narcissism' and created powerful incentives toward cosmetic surgery today" (Haiken, 1997, p. 136). That cosmetic surgery is still mostly a middle-class phenomenon but one that frequently encompasses younger women than in the past was discernible among the women I interviewed. For example, 18 of the

26 women interviewed reported annual household incomes of $50,000 or more, two were in the $35,000 to $44,999 range, four in the $25,000 to $34,999 range, and one woman reported an annual household income of $15,000 to $24,999. Regarding age, six were age 45 and over at the time of their surgeries, while 20 women in my sample were under the age of 45, and half (13) were under 35 years old. Moreover, two women were only 16 when they underwent cosmetic surgery.

Despite its increasingly popularity among the middle-class, cosmetic surgery is not inexpensive: Surgical procedures cost anywhere between several thousand dollars and tens of thousands of dollars, depending on the procedures involved, the reputation of the cosmetic surgeon, and region of the country where it takes place. Furthermore, only those surgeries undertaken for reconstructive purposes (to correct birth defects and cancer surgeries, for example) are covered by health insurance policies. In order to ensure that cosmetic surgery is affordable for the middle-class, cosmetic surgeons accept credit cards for payment, and many even offer "in-house" payment plans whereby patients can pay for their procedures in monthly installments. However, most of the women surveyed (12) paid by check or cash. One woman in my sample took out a loan to finance her surgery, while a few paid with credit cards.

As mentioned previously, cosmetic surgery is the fastest-growing medical specialty in the U.S. Although a number of factors contribute to this, the profit motive is certainly one of the most

significant. Indeed, the profitability of the specialty and its influence on cosmetic surgeons' opinions regarding the necessity for surgery was mentioned in a couple of narratives. As one woman interviewed in person who had breast implants said when asked about her surgeon's opinion: "He would have put them into anyone who was a reasonable candidate and had the money, I think." And from another woman who underwent dermabrasion and was also interviewed in person: "...the doctor certainly didn't say to me, 'You don't need it'...I don't know that a doctor would. I have to think... that that's how they make their money."

Appearance and the Ideal Body Type

The prevailing cultural norms regarding women's appearances are reflected, as mentioned earlier in this study, in the numerous images of women that appear in the media. In an effort to explore women's feelings about these appearance norms, I asked them to describe what they thought the ideal woman's body looks like as represented in media images. Only one of the women interviewed denied the existence of an ideal body for women. Most, however, readily acknowledged an ideal body type, and offered similar descriptions of it. As one suburban woman in her thirties who was interviewed over the phone described it: "Very tall, very thin, very blonde. Hate to say it, but everyone wants to be a size 5 jeans. It's a stereotype."

Interestingly, the narratives of a couple of those interviewed specifically identified society's role in the perpetuation of the ideal body type, as well as the effect this had on them. For

example, from a woman in her mid-forties who underwent both eye and nose procedures and was interviewed in person:

> Society has the picture of a Barbie girl -- you have to have a nice bust; you have to have a small waist; you have to have nice hips; this is it, you know. 36-24-26, this is what always grew up in my head, even as a child, this was the figure from years ago. You had to have a 36-24-36...that was the ideal perfect woman.

Another woman, who had breast implants in her twenties and was interviewed via e-mail, stated it just as succinctly: "I guess I was socialized to believe in the 36-24-36 concept."

Several other women specifically mentioned models as representing what the ideal woman's body looks like. Two women in their early twenties who were both interviewed in person while attending college described in detail the influence fashion models have on adolescent girls: "At that time, Kate Moss was 'in' and all these other beautiful, skinny, skinny models, and I wanted to be very, very thin and beautiful, and to try to look...like, it was a natural look; it was a beautiful look." It seems more than a little ironic that this woman describes extreme thinness as being a "natural look," when for most women, even models, ultra thinness is almost always the result of "unnatural" behaviors, such as semi-starvation dieting, diet pills, and purging.

The second young woman said of models:

> They have this sunken-in, anoretic look, and [they look] bulimic. They look like they have major eating disorders... when you're a teenager, you think, "Wow, I want to look like that!" ...that's a big thing, 'cause people, with these models, are like, "I want to look like that." They won't eat and they starve themselves...

And from a woman who underwent breast augmentation in her

twenties and overcame eating disorders, but not the commonly-held perception of what the ideal woman's body looks like:

> After having fought anorexia/bulimia in my early years, I am probably not the best one to ask. My idea of a perfect woman's body has not changed, even with all this: big bust, narrow waist and shoulders and hips, gorgeous legs, all without a wrinkle or a bump in the wrong place. It's very sad to say that, but it's the truth. (E-mail interview)

In general, whereas younger women (in their 20's) tended to cite thin models as reflective of what the ideal woman's body should look like, older women (those in their 30's and above) mentioned Barbie and/or the 36-24-36 figure as the ideal.

Several women interviewed were critical of the appearance standards imposed on women, particularly as they relate to weight issues. As one woman interviewed via e-mail who had breast implants in her early thirties said:

> I think that's [ideal body type] very sad...I think that women should not be judged, but unfortunately, I also know a decent amount of overweight women who are judged for that -- for being overweight, and not being the perfect body, so I don't agree with that at all...

Interestingly, five women rejected the notion that the ideal body type is contingent on thinness, height, and breast size. Instead, their descriptions focused on fitness and health. For example, another woman who had augmentation surgery in her thirties and was interviewed by e-mail said:

> The ideal woman's body is a healthy looking, exercised body. I like to see some muscle tone, good skin quality, and I prefer a lean, athletic look. I do not like the anoretic model image, or even thin without looking like one exercises. Not too skinny, like she eats a decent meal when out on a date...

From two others, both e-mail interviews who also had breast

implants: "I think the ideal woman's body looks fit and healthy, no matter what size," and "Toned, fit, healthy, strong."

These descriptions and others like them illustrate a puzzling paradox. That is, all of the proponents of a healthy and fit body type utilized surgical means to alter their own bodies. Specifically, all of them (five total) were breast implant recipients, yet none of them recognized the irony in having had artificial breasts implanted into their otherwise natural bodies. The inability, or unwillingness, to see the contradiction evident between their stated beliefs and actual behaviors is well-illustrated in the statement of a woman who had multiple cosmetic surgeries in her fifties: "I think the ideal woman's body is healthy and fit. It can be large or small, whatever her genes dictate." (E-mail interview) In these examples, then, we see evidence of women's active participation in the imposition of their culture's standards of appearance.

Another factor concerning appearance standards is the role that cosmetic surgeons themselves play in defining these standards. Their notions of which physical features are attractive, unattractive, desirable, and undesirable have long been reflected in the standards of beauty, especially those relating to women. Commenting on the many nose jobs performed by early-twentieth century surgeons, Haiken (1997) asserts that "in their readiness to label certain nose shapes and types as deformities, surgeons helped to cement not just standards of beauty but standards of normality and acceptability in American minds" (p. 177). Today, with the

ever-increasing development of cosmetic surgical techniques (which tend to be increasingly more invasive as well), the medicalization of the aesthetic realm is expanding to include even more physical traits deemed in need of surgical correction.

In my case, my breast surgeon offered to refer me to a plastic surgeon during the same meeting at which we discussed my options for cancer treatment, just two days after the diagnosis was confirmed. Although I explained that I did not want to undergo reconstructive surgery immediately following the mastectomy (it would have been done the same day, in the same operating room), the surgeon insisted that I think about it, and call his office in a few days. To be honest, I did not give it a second thought during those days as my main concern was coming to terms with my diagnosis and its ramifications. When I informed him a few days later that my decision was final, I did not want to consult with the plastic surgeon, he never raised the topic again with me.

However, during a routine annual exam some months later, my gynecologist offered his unsolicited advice concerning my appearance. Specifically, he commented that he had seen some "really aesthetically beautiful results" in women who had undergone reconstructive surgery. Apparently, I did not meet his criteria for attractiveness, prompting him to urge me to undergo reconstructive surgery. I declined his offer for a referral to a plastic surgeon and found another gynecologist to replace him.

Despite the influence they have in prescribing standards of appearance, cosmetic surgeons are reluctant to engage in cultural

analyses of cosmetic surgery. In her analysis of eating disorders, Bordo (1993) contends that situating eating disorders within a medical model ensures that "those who are entrusted with the conceptualization of anorexia and bulimia will be medical professionals who have little experience in or inclination toward cultural interpretation and criticism" (p. 69). Appropriating this idea to the realm of cosmetic surgery suggests that any meanings, interpretations, and analyses of it must be generated by cultural observers, as cosmetic surgeons are similarly disinterested in making such analyses, given that their perspective is grounded in medical terms and concepts, not sociocultural ones. Cosmetic surgeons may avoid engaging in cultural analyses of their profession in part because, as mentioned earlier, they don't see themselves as being affected by the culture they live in. Another factor concerns economic self-interest, in that the demand for cosmetic surgery rests on culturally-created and imposed standards of appearance, and not on any medical need. It is in cosmetic surgeons' best interests, then, to avoid any potentially critical analysis of cosmetic surgery, which runs the risk of discouraging people from utilizing their services.

Despite the fact that cosmetic surgery is the fastest-growing medical specialty in the U.S., conceptualizing it as a legitimate medical specialty has been problematic, even for the practitioners in this field. By virtue of being medical doctors, cosmetic surgeons must justify performing aesthetic procedures (which have many of the risks inherent to other types of surgeries) on healthy

people whose physiological condition will remain unchanged. One way cosmetic surgeons accomplish this is by focusing on self-esteem and appearance issues, a trend Haiken (1997) dates back to the 1920's, when the presumed link between plastic surgery and psychology became increasingly publicized and popular. By the 1930's, the inferiority complex notion had become well-established in the U.S.. Subsequently, the medical literature regarding plastic surgery drew heavily on this psychological concept, directly correlating cosmetic surgery with the alleviation of the inferiority complex (Haiken, 1997). Eventually, "its [inferiority complex] widespread applicability -- made it vague, unwieldy, and dangerous in practice" (Haiken, 1997, p. 119). Consequently, while many in the field of psychology disassociated themselves from the supposed relationship between one's appearance and self-esteem, cosmetic surgeons continued to embrace it.

Actually, the inferiority complex - appearance link is still apparent in some cosmetic surgery literature today. For example, many of the promotional materials developed and disseminated by the ASPS link physical appearance to emotional health. Even today, then, we find evidence of cosmetic surgery being offered as a means of alleviating emotional and psychological issues related to low self-esteem.1 Support for this contention comes from Davis (1995), who heard a well-known Dutch plastic surgeon at a conference delineate what he thought was a new syndrome: inferiority complex due to racial characteristics. For example, increasing numbers of young Asian-American women are undergoing surgical eye-fold

modifications, which has generated much controversy within the Asian-American community. As Davis points out, this diagnostic category offers plastic surgeons "a medically acceptable reason for intervention as drastic as surgery" (1995, p. 2). In The Netherlands, as in the U.S., cosmetic surgeons endeavor to justify the aesthetic but medically unnecessary procedures they do by associating self-esteem issues with appearance issues.

In sum, although many of the women I interviewed regarded the pursuit of cosmetic surgery as a matter of choice, their own narratives revealed the complex interaction of various factors, both personal and external to the individual woman. As Davis (1995) noted, "the choice to have cosmetic surgery may be genuine, but it is also bounded. Women's relation to their appearance is constrained by cultural definitions of feminine beauty" (p. 157). The issue of choice for women who consider cosmetic surgery, then, is never entirely personal. Rather, choice is strongly influenced by factors outside or ourselves which arise from social conditions, and find expression through cultural norms imposed by society on its members.

1 Orthodontics is another specialty that links appearance with esteem: According to the American Asociation of Orthodontists (2000), "Orthodontists can be credited for dramatic improvements in the careers and personal relationships of millions of people..."

Ch. 6 Analysis - Part II
Before and After: Expectations and Outcomes
Self Image Issues

Several self-image issues emerged from the interviews. For example, women were asked to describe how they thought others saw them before undergoing surgery, as well as how they thought others saw them after surgery. Most women, not surprisingly, formulated their responses in terms of physical traits and characteristics, which encompassed a wide range of feelings.

Among the "before surgery" responses were descriptions of being "average-looking" "plain to ugly" and, at the opposite extreme, "absolutely beautiful." In addition, several women said that the way they are perceived by others did not change as a result of surgery. Two women among them attributed the lack of awareness about their surgical changes to their own unhappiness with how they looked. Said a suburban homemaker interviewed in person who had breast implants in her twenties because of the effects of breastfeeding: "I don't think [they see me] any different...I think it was basically me -- I didn't like me." And from the woman interviewed in person who had a nose job and chin implant at age 16:

> I never heard a comment about having a bad nose. When I told people, they thought it was really...crazy...I mean, everyone that I told went, 'What? You? Why are you getting one?' But I mean, if you see pictures of me, you could tell the difference, but it really wasn't other people.

Among those women who reported changes in the perceptions of others before and after their surgeries, these changes were, for the most part, relatively minor. However, for a few women, the

change in perceptions was startling. For example, one young woman, a college student from Florida in her early twenties interviewed via e-mail who said others saw her as average looking before having a nose job and breast implants, now feels that others see her as beautiful. Furthermore, cosmetic surgery, she asserts, affects both a woman's self-worth and social worth:

> [Cosmetic surgery] makes you feel better about yourself. The sad thing is, good-looking people are given more opportunities. Since my surgery, I've been pulled into the modeling business, and am doing great. People are nicer to good-looking people.

The most striking changes in others' perceptions were recounted by a woman who had breast implants at the age of 26 that were later removed because of health problems and was interviewed via e-mail:

> For the sixteen years I had breasts, I know for a fact (because I was told a lot) that I was very sexy, exotic (I am very olive-skinned, dark hair and eyes). Men hit on me constantly -- all ages. I was asked to model (never did). It was a completely new life that I had never known. It's very hard to describe. Sort of being a movie star or a princess for awhile. Very intoxicating!

After undergoing explantation, however, men's reactions to her changed: "I would be lying if I said I didn't still want that kind of response. You don't have to work as hard at life or relationships. It's very bizarre, and very destructive to an ego when it's gone." However, she did not regret having the implants removed because the health problems she experienced were so severe that she was unable to continue working, and subsequently qualified for disability compensation.

Another woman, a business executive who resides near

Washington, D.C. and underwent multiple procedures (including a tummy tuck, liposuction, an eye job and chin implant) also reported significant changes in the perceptions of others. This is not surprising, given all the procedures she underwent (over a two year period) and the fact that she lost a significant amount of weight by dieting. Before having all these surgeries and losing weight, she felt that others saw her as "coarse, [with] unrefined features, very obese. Plain to ugly." Afterwards, she felt that others now see her as "moderately attractive." (E-mail interview)

In sum, the narratives revealed a wide range of responses to the surgeries women had. In large part, this reflects the different expectations women had before their procedures, and whether or not those expectations had been fulfilled.

When asked to describe how they want to be seen by others, responses included both physical appearance references ("attractive," "fit," and "beautiful"), and non-physical traits. Two women, both e-mail interviews, for example, specified "competent" and "intelligent." Still another woman, also interviewed via e-mail said: "I would like to be seen as a formidably intelligent woman, a wit, and a caring person. I'd like to be 'seen' as in viewed as having a healthy glowy look; radiant would do quite nicely, too!" Interestingly, she had undergone breast augmentation but later had the implants removed because of unwanted attention from men.

Of the non-physical traits reported most frequently by women (four, to be exact) were "kind" and "caring." Other traits

reported by one or two women each were "creative," "responsible," "healthy," and "strong." By far, however, the most frequently mentioned trait was attractiveness. As the woman who underwent dermabrasion in her twenties noted:

> I like who I am, but it does matter to me that people find me attractive. I wouldn't want to be categorized as "she's all right looking." I want someone to say that I'm pretty. That is a cultural thing...I know I'm not what I think is the cultural pretty.

Further into her narrative, this same woman alluded to the importance men attach to physical attractiveness, thereby introducing the idea that they [men] are influential in at least some women's perceptions of themselves:

> I think that on an individual basis, they [men] probably have notions of what their sisters and mothers look like and...they know that that's fine, but what they want to be seen with, or what's considered success or making it, they want their women to be pretty, to be good-looking. That comes from -- not their family -- that comes from other things...I guess that comes from magazines and tv, things like that...models.

Additionally, a number of women (all interviewed by e-mail) specified both physical and non-physical traits to describe how they want to be seen by others. As one woman remarked: "I would like to be seen as positive, encouraging, and of course, aesthetically pleasing." From a woman who was unhappy with the results of breast augmentation, "As an attractive, intelligent female..." And from woman who had a nose job at 19), "Competent, strong, trustworthy, and attractive"

It is interesting to note that while all of the women who included both physical and non-physical traits in their descriptions of how they wanted to be seen by others hold a college

degree (A.A., B.A., or B.S), those women (with only one exception) who described how they want to be seen by others in only physical appearance terms are high school graduates. This suggests, therefore, that a strong correlation exists between how women want to be seen by others and their level of education. That is, college-educated women want to be viewed as being more than the sum of their appearances -- they want to be seen as multi-faceted individuals possessing traits that go far below surface appearances. Furthermore, it may be the case that pursuit of a college degree, which utilizes personal traits and characteristics, to the exclusion of physical traits, may explain, at least in part, why college-educated women have a more holistic conceptualization of how they want to be seen by others. Lastly, a college student who underwent breast reduction surgery at age 18 and was interviewed in person offered a philosophical response to the aforementioned query:

> I think the way I see myself is the way I'd like other people to see me. And I have a pretty realistic...view of that. I wouldn't want people to see me as something that I'm not, just like, straight out, here I am!

Awareness of Risks

The women I interviewed were also asked if they were aware of any medical risks associated with the procedure(s) they underwent. Most (16 of the 26) said they were informed of the possible risks beforehand by the surgeon, or read of the risks in the consent form that required their signature. Six women, however, all of whom had complications, reported that they were not informed about potential problems arising from their surgeries. Five of these women had

breast implants. Said one, a nurse from Georgia:

> I knew nothing about device risks or problems...was told by [my doctor] that the implants would last a lifetime and that only a force similar to a hard baseball bat to the chest could rupture the device. As a nurse, I can definitely say that I was not given the correct information about this procedure. There was no effort on the part of [my doctor] to determine whether I was making the decision out of an emotional situation, and no real efforts to determine informed consent. Complications and risks were not discussed at any level, and I was promised a perfect device that would look and function great in my aged years. It was a "quick fix" for my self-esteem that put fast cash in the till and ultimately cost me much more that those few thousand.

Eventually, her implants ruptured, necessitating their removal. A similar experience was noted by another implant recipient, a former marketing representative who later underwent explant surgery because of health problems (autoimmune disorders) and is now on disability:

> I am from a medical family; I asked all the right questions, got all the right answers. Other than being aware that anytime you undergo general anesthesia is a risk, I was told it was not as bad as having an ingrown toenail removed. I was told they would "survive a fall chest-first from the Empire State building." I was told that if they dug me up after I died, the implants would still be intact. I was told when I was a grandmother, my boobs would still stop traffic. Really pathetic, huh? I marvel that I believed it all, but it was a different time, and I was only 26 or so. It made perfect sense to me. (E-mail interview)

In a recent court decision regarding the supposed health problems associated with silicone implants, a scientific panel concluded that these implants do not cause disease (New York Times, June 22, 1999, A, 26:1). However, the report also asserted that women who consult with plastic surgeons about this procedure are often not informed about the known risks associated with them. Among these risks are rupturing of the implants, hardening of the

breast, loss of sensation (sometimes permanent), inability to breastfeed, and possible impairment of mammographic screening, as the implants may conceal breast tumors from detection.

In a couple of cases, women reported having been informed about some, but not all, of the potential side effects associated with their procedures. As a woman who had laser surgery on her face notes:

> There were a lot of things he didn't tell me about, that I wish he had...such as the needles...the anesthetic. There were so many needles, it was absolutely incredible, all round the mouth and around the hairline, and they were so painful, and also afterwards, I was in agony for about three days, and especially the first 24 hours, you had to keep changing the dressings. It was like a burn...So I really didn't expect it; he really didn't explain. You know, when you see it advertised on television, they call it painless, well, they obviously haven't had it done. Or if they had, they just had one or two spots...They're on TV and they're smiling away, you know, well, it's really not true. It's extremely painful. (In person interview)

Regarding my experience, my plastic surgeon gave me several brochures to read which detailed the side effects, both common and less common, associated with saline implant surgery. In addition, she reiterated some of them during my initial consultation with her, making it clear that I would experience some pain and discomfort afterwards. However, what I experienced upon coming to in the post-op recovery room was intense pain that lasted for hours. I later found out from my surgeon that the anesthesiologist had not administered enough of the pain killer during the latter part of the surgery. Thus, the pain I experienced had been avoidable; it resulted from human error.

Satisfaction and Dissatisfaction

When asked if they were happy with the results of the procedures they had done, most (16) implied that they were. One woman who underwent multiple procedures (including liposuction, a tummy tuck, eye job, and chin implant) said that cosmetic surgery changed her life. Another woman, who had several procedures done in her fifties and is now retired, was equally enthusiastic:

> I am extremely happy with the surgery I had. I should have had it done at a much younger age. I would have been able to do many things that I now do such as long distance running. After my first surgery, I hired a personal trainer, and after 10 months of very hard work, ran my first race at the age of 56. I still train five days a week and am fitter than I have ever been in my life (and happier, too). (E-mail interview)

It seems ironic that all of the fitness gains are attributed here not to the energy and considerable time she invested in fitness endeavors, but, rather, to the cosmetic surgeries she underwent. That most women, though, were satisfied with the outcomes of their procedures is not surprising, given the enormous emphasis assigned to women's appearances in contemporary culture. As Bordo (1993) asserts about our culture, "...a high level of physical attractiveness is continually presented as a prerequisite for romantic success and very often is demanded by employers as well" (p. 32). Appearances also count, apparently, for women candidates for public office. For example, a recent two-page feature article in the New York Daily News (July, 1999) on Hillary Clinton (a potential candidate for the Senate) focused entirely on her appearance. It traced (with accompanying photos) her so-called fashion and hairstyle evolution over the last seven years. No male candidate for high public office has ever been subjected to such

scrutiny concerning his appearance.

Not everyone I spoke to, though, was entirely happy with the results of their surgeries. Several expressed mixed feelings on the subject. For example, one woman who had breast implants was glad she had it done, but wishes the implants weren't quite so large. Another woman, who had both eye and nose jobs in her forties and was interviewed in person also expressed mixed feelings:

> To be honest with you, I'm happy with my eyelids, you know, 'cause I feel nothing; the weight is gone...he did a very good job, an excellent job...[but] I look in the mirror, I turn sideways, I try to see my nose, and I don't really see anything, 'cause I really didn't see anything wrong with my nose before, so I don't know about the changes that people see now...But yet, all my friends now say to me, "Wow, your nose looks great -- you're so cute! You have a cute little nose, you know," and I say to myself -- what are they talking about? I don't know what they see.

In another case, the graduate student who had dermabrasion in her twenties acknowledged experiencing improvement in her appearance, yet was not certain if she was happy with the outcome:

> I don't know...I guess I think there was improvement, definitely. I'm still very self-conscious about my skin. And I'm still very, very...it's a very emotional thing for me, so it's not like I feel, for example, my cousin had a nose job... and she's thrilled with her results, like she never thought about her nose again. I don't have that. I still think about my face everyday...I still think that's the first thing people notice about me -- she has bad skin.

In contrast, several women were decidedly unhappy with the outcomes of their surgeries; all but one of these had breast implants. In my study, this procedure generated the most negative comments from those interviewed. There was a perception evident among these women that silicone from leaking implants caused the

medical problems they report. However, disfigurement was another negative outcome of this procedure, usually necessitating repeated surgeries for women. As one woman, a PC/LAN administrator from Ohio recalled:

> I had an awful experience and will have to undergo more surgery to correct my breast. The surgery and scarring were bad enough that it almost caused a divorce. My husband didn't want to touch me. He does now, but it's more so that I don't feel bad, but you can tell when he feels like he's touching Frankenstein. (E-mail interview)

Like some of the other implant recipients I interviewed who developed problems, she blames her surgeon for them. In fact, when asked if she would do it again (undergo cosmetic surgery), she replied that with a different surgeon, yes. Another woman interviewed via e-mail who reported encapsulation (hardening of the breasts) was faulted by her surgeon for supposedly not massaging them correctly, and said that "it was undoubtably the single worst decision of my whole life, up to this point." But when asked if she would undergo cosmetic surgery again, she replied: "Yes, believe it or not, I would. But only if it did not involve putting a foreign object in my body." Apparently, she feels the implants themselves were to blame, and not the surgeon who implanted them.

Similar feelings were shared by the college student who, at the age of 16, had a chin implant inserted at the insistence of her surgeon, when what she wanted to have done was only a nose job. The implant shifted, causing tremendous swelling and discomfort, and had to be replaced with another, smaller implant: Her surgeon eventually admitted he had initially inserted an implant too large for her face. Although she, too, blames her surgeon for the

problems she experienced, she indicated a willingness to have the nose job again, but not the implant.

Other women who endured side effects were just as adamant about not undergoing cosmetic surgery again. Said one, interviewed by e-mail: "If I had known just the fact that the implants would not last and have to be replaced...I would not have opted for surgery. That's not even counting the local complications and loss of health I experienced."

In Davis's study of cosmetic surgery (1995), women who had problems with breast implants, including those who required additional corrective surgeries and had experienced much pain and discomfort did not, for the most part, blame their surgeons. Indeed, most of them felt that they were responsible for their decision to undergo the procedure. Therefore, they viewed the negative side effects as just something they would have to live with.

Surprisingly, two women in my study (both e-mail interviews) who had breast implants and did not experience any negative side effects opted to have them removed because they wanted to revert back to their former selves:

> The results are ok, but I have matured since my original surgery and realized a lot about myself since then. I do not like the bulk associated with implants. I feel like I committed a fraud and that I am really not so vain as to live with some foreign thing in my chest just to make me look supposedly more sexy.

Another woman noted: "No, it just wasn't me. I got them taken out a year later (I had no complications) because I missed my small breasts...I'm more pleased with myself now that I reversed the

enhancement."

Unlike the others who were happy with the results and adjusted to the implants, it seems that for these two women, the artificiality of the devices effectuated a corresponding artificial sense of self. Thus, they could not adapt to them and incorporate them as part of their "real" bodies. Based on my own implant experience, I can readily identify with these feelings: No matter how "natural" my clothed appearance is, I am, at times, very cognizant of the unnatural device I carry within me.

When asked if they would undergo cosmetic surgery again and recommend it to others, six women replied no to both. Not surprisingly, three of the six had developed health problems which they attributed to their breast implants. Additionally, two other breast implant recipients who did not experience any health problems also would not undergo surgery again, and would not recommend it to others. As one woman interviewed via e-mail noted: "I would not have cosmetic surgery again to enhance any body part. I prefer to age gracefully." Another woman, who had facial laser surgery and was interviewed in person, cited the pain she endured in her answer: "I would never have the whole face done ever again, and never, ever, recommend it to anyone else unless they like pain."

Of those who indicated they would have cosmetic surgery again and recommend it to others were a couple of women who also experienced much pain and discomfort. Said one young woman who had breast reduction surgery at the age of 18 and was interviewed in

person:

> But it's hard -- it hurts; it's painful; it's uncomfortable. I really didn't sleep so well after 'cause I used to sleep on my stomach, and you have to learn how to sleep on your back. It's not a pleasant thing, but it's so worth it...you know, when I showered for the first time...it was ugly and disgusting, but I didn't freak out...I was just like I wanted it done; I wanted it taken care of; I didn't care what it looked like after...I was so stubborn about it.

That women would willingly subject themselves to elective surgical procedures that sometimes entail pain and discomfort aptly reflects Foucault's notion of pain coexisting with pleasure, within the context of disciplinary practices of the body. Thus, the pain resulting from these surgeries is simultaneously experienced as pleasure owing to the seeming control over one's body making alterations to it effects. As one woman succinctly remarked:

> If something was bothering me a great deal, I would have surgery again. It's my body, and I feel I should have full and total control over how I decide to shape it and alter it. As long as I don't feel that urge to alter my body is the result of consumer manipulation, whether it be through the incessant media rebukes toward women about their images, etc., I would do it. (E-mail interview)

In this narrative, we find evidence of the empowerment issue as it relates to cosmetic surgery -- the idea that within the constraints and boundaries imposed on women by society, cosmetic surgery is perceived as enabling at least some to acquire a sense of control over their bodies. The same can be said of body modifications (including body piercing and tattooing) that women tend to experience in terms of exerting power over their bodies (Pitts, 1998, p. 82). Davis (1995) also reported this finding in her study of cosmetic surgery in The Netherlands. This sense of control, however, reflects what Freedman (1986) identified as

indirect power, which, in regards to cosmetic surgery, is based on beauty-related (and thus, superficial) qualities. As mentioned in Ch. 3, this type of power is deceptive because although it can generate rewards for those who possess it, it can create insecurities as well. These insecurities are, I believe, the primary motivations of women's desires to reshape themselves according to prevailing cultural beauty norms.

One of the narratives offers insight into the insecurities cosmetic surgery can create. Said one woman in her thirties who had a nose job at the age of 20:

> I've noticed one problem with cosmetic surgery. Even though the "I-have-a-big-nose" issue is gone, I've replaced it with others over the years...now I have time to dwell on, for example, "my-too-small-deepset-squinty-eyes, if only I had big, head-turning, almond-shaped eyes my life would be better." I haven't fallen into a cosmetic surgery trap where I keep throwing money at physical shortcomings to try to make myself happy, but I can understand how that could happen and sympathize with folks caught in that.

In sum, my analysis reveals a wide range of experiences with cosmetic surgery, ranging from extremely satisfied to remorseful. The next chapter will summarize the study findings and consider the implications of this research.

Ch. 7 - Discussion

Overview of Significant Findings

A number of findings emerged from my study, including insight into the factors that influence a woman's decision to undergo cosmetic surgery. Among these are sociocultural pressures, pressure from significant others, and the role that the medical profession plays in the dissemination and reinforcement of contemporary appearance standards. Other findings concern the implications of cosmetic surgery, as conceptualized on both the individual and social levels. Before delving into these issues, however, I think it is important to examine the relationship between American values and cosmetic surgery, including individualism and self-improvement.

Throughout much of American history, the Protestant work ethic, which emphasized hard work as the socially-desirable means of achieving success, had a major impact on American values. In its original form, which dates back to the sixteenth century, the Protestant ethic required people to work hard, without thought to amassing personal wealth and material possessions. As noted by Weber in his analysis of the Protestant ethic (1958, p. 181), however, as capitalism swept across the Western world, the spiritual and ascetic elements of the Protestant ethic eventually dissipated. Consequently, this ethic emerged in a more secular form, a form that emphasized profit for profit's sake and materialism. Subsequently, the Protestant ethic was usurped by

another ethic, one engendered by consumerism.

Today, instant gratification has become an important component of this ethic. As a result, many people seek to achieve gains in life while expending the least amount of time and effort in the process of attaining them. Thus, diet pills, short-term diets, thirty and even fifteen minute exercise workouts have gained enormous popularity, as has cosmetic surgery, which is frequently touted by its proponents as the fastest and easiest means of achieving physical alterations. Diets and exercise, in contrast, take months before substantial results are achieved. In reality, however, cosmetic surgery often involves discomfort, risk, and pain, which was reflected in a number of narratives of the women interviewed for this study. However, those women who expressed the most satisfaction with their outcomes rationalized that the positive results of their surgeries outweighed the negative side effects.

Thus, the transformation of the Protestant ethic into its current form has influenced appearance issues, as well as those values that pertain to physical appearance. The pursuit of physical perfection and the quest for self improvement by Americans are not new phenomena, but have undergone fundamental changes over time. For example, although the physical culture movement of the late nineteenth and early twentieth centuries also emphasized the pursuit of physical perfection, its advocates "framed this project in terms that, if not specifically religious, were at least imbued with spiritual and moral meaning" (Haiken, 1997, p. 3).

Accordingly, when cosmetic surgery emerged as a medical specialty in the early part of the twentieth century, most Americans viewed it with suspicion. But just as the Protestant ethic eventually lost its spiritual element, so, too, did the pursuit for physical perfection and conceptualization of women's beauty. Indeed, both of these phenomena have become valuable commodities in and of themselves in our consumer-driven materialist society.

According to Haiken (1997), the transformation of the U. S. from a mostly rural culture to a predominately urban one was characterized by the emergence of an "ethos of acquisitive individualism that...encouraged Americans to rethink their attitudes toward cosmetic surgery" (p. 7). Moreover, the shift from a rural to urban culture also corresponded with the development of consumer culture. Thus, women's beauty, which during the Victorian era had been based on inner, spiritual qualities, became increasingly commodified as external qualities during the twentieth century (Banner, 1983, p. 208). In this context, cosmetic surgery in the U.S. can be viewed as the almost inevitable outgrowth of the multi-billion dollar beauty industry in a society that continues to attach considerable significance and value to the physical appearance of women.

It is important to note, however, that not all women are potential candidates for cosmetic surgery; social class is an important factor to be considered in any discussion of this phenomenon. That is, medical insurance policies specifically exclude coverage for surgical procedures considered to be cosmetic

in nature; thus, cosmetic surgery is only affordable for the middle and upper classes. As noted in an ASPRS survey of cosmetic surgery patients cited by Sullivan (1993, p. 101), most of them were members of the middle and upper classes. This finding was confirmed by my own study in that virtually all the women included in my sample were members of the middle and upper middle classes.

Because affordability is an important factor in determining eligibility for cosmetic surgery and women of the lower classes are subsequently excluded, cosmetic surgery serves to undermine the egalitarian values that Americans purportedly hold dear. Thus, the issue of affordability serves to "reinforce the beauty 'caste system' whereby a hierarchy of beauty leads to greater social power for those who can afford to invest in their bodies" (Gillespie, 1996, p. 77).

Historically in the U.S., different aspects of appearance have served as markers of social class, with fashion being the most notable among them. However, even bodily appearance itself has been a marker of social class, for example, weight. That is, overweight and obesity are far more prevalent among the poor and working classes than among the more affluent classes. At the other extreme, anorexia is closely linked to the middle and upper classes; it is relatively rare among the lower classes. Indeed, in the lower classes, food may be seen as a readily available and affordable means of enjoyment and satisfaction, unlike the rewards of upper class status which are beyond their means.

Cosmetic surgery can also be seen as a social marker, in that

while it is affordable for the middle and upper classes, it is beyond the means of those in the lower classes. In the last twenty years, the rapid expansion of the specialty, increasing competition among its practitioners, and growing use of credit by Americans led to the development of a variety of payment options (including acceptance of credit cards) which make it affordable for even the middle class, despite the relatively high costs of the procedures themselves. Therefore, not all members of society have equal access to this particular means of altering one's physical appearance.

In sum, the body itself in contemporary society has become a marker of social class; a locus of status and power. However, because the means of altering the body are becoming not only more numerous, but more costly and time-consuming as well, these practices are becoming increasingly limited to those who can afford to invest in them: namely, the upper classes.

However, while egalitarian values are undermined by the availability and prevalence of cosmetic surgery procedures among members of the middle and upper classes, other American values are apparently reinforced by it. In recent decades in American culture, for example, there has been much emphasis on, and value attached to, success, achievement, and fulfillment at the level of the individual. The 1980's in particular personified this -- it was aptly known as the "Me Decade." Practitioners and proponents of cosmetic surgery typically frame the recreation of the self through cosmetic surgery as individualism (Haiken, 1997, p. 275), and as

mentioned earlier, several women interviewed for this study framed their decisions to undergo cosmetic surgery in terms of having been an individual decision, free of outside influences. Cosmetic surgery, then, becomes a means by which women are encouraged, as individuals, to sculpt and shape their physical selves in accordance to cultural standards of appearance, thereby increasing their individual social values. Therefore, women who undergo cosmetic surgery "may be seen as collaborating with the normalizing practices that serve to maintain their subordination" (Gillespie, 1996, p. 78).

Indeed, a number of the narratives from my study revealed pressure from others (mostly women) that was both overt (as expressed through comments encouraging women to undergo cosmetic surgery) and, in other instances, far more subtle. Thus, for the woman I interviewed who attended a private high school where cosmetic surgery was commonplace, its prevalence there created an environment not only supportive of those who opted for cosmetic surgery, but one that actively encouraged it as well.

Another influence on young women in particular that emerged from my study concerns the myriad images of models and actresses featured prominently in the media. Several women in their twenties I spoke to attributed their perceptions of their physical selves directly to the influence of these images, while a couple of women in their thirties noted the influence of the popular Barbie doll on the cultural ideal of what a woman should look like. A number of social observers, including Bordo (1993, p. 57), have recognized

the influential role these images play in the widespread eating disordered behaviors of young women. But these images may also explain, at least in part, the increasing popularity of cosmetic surgery among young women who employ it as a means of achieving the dominant standards of appearance.

Another finding from my study concerns the increasingly accepted perceived connection between physical health and beauty. That is, several women interviewed who described the ideal woman's body type in terms of fitness and health had themselves utilized cosmetic surgery to surgically alter their own bodies. Two of these women had breast implants, while another one had undergone multiple procedures, including liposuction. The tendency to equate physical health with beauty appears to be a direct consequence of contemporary representations of the fit, taut body as being a reflection of a disciplined body which our culture currently values, particularly in women.

Another significant influence on women is the medical profession. Women's bodies have historically been conceptualized as inferior and imperfect, and as requiring medical care and treatment. For example, the twentieth century was characterized by the medicalization of women's processes and life stages, including pregnancy, childbirth, premenstrual discomfort (in medical terms, premenstrual syndrome), and menopause. As a direct consequence of the medicalization of women's appearance, though, "women are encouraged to see bodily 'imperfections' as illness" (Gillespie, 1996, p. 74). One consequence of medicalization concerns the

utilization of medical treatments and procedures for management of the medicalized condition. In regards to women's appearance, cosmetic surgery has become the dominant type of treatment used to manage perceived physical imperfections. As noted previously in this study, the ASPS (and its individual members) invest substantial sums of money in advertising and promotional brochures designed to encourage women to employ surgical means to attain physical attributes in accordance with prevailing cultural appearance standards. Promotion of the specialty serves to stimulate demand for the services of its practitioners. This affirms Riessman's assertion that "physicians seek to medicalize experience because of their specific beliefs and economic interests" (1998, p. 47).

The recently enacted federal legislation that compels health insurers to cover the cost of reconstructive surgery for mastectomy patients provides a good illustration of this. On one hand, the mandatory coverage offers insured women the option of undergoing reconstruction without concern for the expenses involved. On the other hand, because doctors know insured mastectomy patients are covered for this surgery, it is in their economic self-interest to encourage women to undergo this procedure. What is open to debate, though, is whether these doctors have their patients' best interests at heart, or their own. As mentioned earlier, I had experienced such pressure myself from doctors.

Regarding cosmetic surgery, the fact that a variety of payment options make it affordable for members of the middle and upper

classes also raises the issue of whether cosmetic surgeons are primarily motivated to practice in that specialty mainly because of economic interests.

One finding from my study that was both unexpected and surprising was the apparent lack of awareness among most of those interviewed of the influence of sociocultural factors on their decisions to undergo cosmetic surgery. For example, several women mentioned that their primary motive for having cosmetic surgery stemmed from their relationships with men, while others expressed the desire to improve their appearances. Moreover, even those women in my study who acknowledged the existence of the ideal body type failed to recognize its influence on their decisions.

By focusing on the level of the individual, it may be construed that these women are self-involved and overly concerned with their personal appearances. However, as mentioned previously, contemporary society attaches much significance to women's appearances. As Sullivan (1993) observes, not only has the pursuit of a youthful, fit, and taut body become "an essential element of the cultural definition of attractiveness" (p. 102), it is also a "political and economic imperative" (p. 102), especially for women.

For example, while a youthful appearance is valued in both men and women in the workplace, middle-aged women are far more pressured than men of the same age to appear younger than their years. Thus, many cosmetics advertisements directed towards women over the age of forty frequently urge women to use a particular product to turn back the clock, or erase years from their faces, or

even hide their true age from others. As a consequence, many women know that a youthful, attractive appearance is an important asset in the workplace. Even on a personal level, in regards to heterosexual relationships, physical attractiveness (as defined by the prevailing contemporary standards of beauty), is a highly valued commodity in women.

Moreover, ours is a consumer society which centers on the individual, and puts a great deal of emphasis on individual satisfaction, achievement, and success, as measured in terms of material objects and physical appearance. As mentioned in Ch. 3, however, cosmetic surgery represents only one means by which women can alter their appearances and increase their individual social values, albeit, the most extreme. At the other end of the continuum and along it are the other means, including the dieting industry, fitness industry, and cosmetics industry. Taken as a whole, the beauty industry encompasses most women living in contemporary society.

On the individual level, cosmetic surgery may be seen as empowering women -- as offering them the means to acquire a socially desirable and valuable appearance. That is, "through reinventing and investing their bodies, women may raise their social value through creating an appearance that conforms to dominant images of beauty" (Gillespie, 1996, p. 81). With its emphasis on individual aesthetic self-improvement, cosmetic surgery appears to represent a rational choice available to many, although not all, members of our consumer culture.

Haiken (1997, p. 15) asserts that it is much easier to change the self than it is to effect change in our increasingly complex world. In essence, conforming to societal standards of appearance serves to reinforce the inequalities intrinsic to our social system while simultaneously individualizing problems of inequality. This tendency, she says, "suggests just how fundamentally we have lost faith in the possibility that commitment and collective action can transform the society in which we live" (Haiken, 1997, p. 15).

By failing to challenge these norms, then, women unwittingly contribute not only to their continuing significance, but to the reinforcement of social inequalities as well, including those related to age, class, and race. However, given the significance society attaches to feminine beauty and the widespread participation of women in the disciplines of the body that relate to appearance, it is unlikely that any significant collective challenge to the appearance norms is going to occur any time soon. There is evidence that resistance to appearance norms, including those in the form of extremely thin and unrealistic body types as reflected in images of women, is growing. On the collective level, women should insist that a more diverse range of women be depicted in media images, including those of different body sizes, shapes, and ages. Some fashion magazines and catalogues are moving in this direction, but far more needs to be done. Also, more awareness of how the prevailing unrealistic media images of women impact on the self-images of young women and even girls needs to be developed. It has long been suspected that these images play an important role

in the prevalence of eating disordered behaviors evident among women and girls. My research indicates that these images, which strongly reflect the dominant appearance norms, may even influence young women to consider cosmetic surgery as a means of altering themselves to adhere to these norms.

On the individual level, women should develop a healthy skepticism about cosmetic surgery and its supposed benefits as heavily promoted by the ASPS. Certainly, women also need to become better informed about the risks associated with these procedures, as well as obtain accurate information concerning the after effects.

Recommendations for Future Research

Given that my study was exploratory and qualitative in nature, several issues emerged which suggest future avenues of research. First, a study could be designed to explore the apparent link between media images of women and their influence on the body images of young women. More specifically, it would be interesting to see whether exposure to these images has contributed to the increasing demand for cosmetic surgery evident among young women as was indicated by my study. Second, future research should also focus on whether or not women who have (or had) an eating disorder are more likely to undergo cosmetic surgery than those who don't. Given that women with eating disorders have unrealistic images of their bodies, it seems logical to assume that they would be predisposed to employing surgical means (in addition to dieting and other efforts) to attain the body shape they desire. Although only

one woman in my study fell into this category, it is, nonetheless, a topic that lends itself to further study.

Third, given the increasing popularity of cosmetic surgery among men, a comparative study could be undertaken of women and men who have undergone cosmetic surgery. In particular, the study should focus on identifying the motives (both similar and dissimilar) that exist among them.

Lastly, in light of the influence of cosmetic surgeons, both in the decision-making process that women contemplating cosmetic surgery undergo as well as the imposition of their definitions of beauty on women, future research should be designed around them. More specifically, is it true (as mentioned previously in this paper) that, given the medicalization of the aesthetic realm, cosmetic surgeons only see themselves--and the work they do--as situated in a medical framework, and are unaware of the cultural implications of their profession? That is, are they cognizant of their role in the imposition of cultural appearance norms on women; of the disturbing normalization and homogenization issues raised by cosmetic surgery? These are just a few of the issues raised by my research, which offers some insight on the increasingly popular--and for some, including myself--problematic phenomenon of cosmetic surgery.

Bibliography

American Association of Orthodontists (2000). Website: aaortho.org

American Society of Plastic and Reconstructive Surgeons (1982, July 1). Comments on the proposed classification of inflatable breast prothesis and silicone gel filled breast prothesis. Pp. 4-5.

American Society of Plastic and Reconstructive Surgeons (1996). Website: plasticsurgery.org

American Society of Plastic Surgeons (2000). Website: plasticsurgery.org

Babbie, E. (1998). The practice of social research (Eighth Ed.). Belmont, CA: Wadsworth Publishing Company.

Banner, L. (1983). American beauty. New York: Alfred Knopf. Philadelphia: Temple University Press.

Barthel, D. (1988). Putting on appearances: Gender and advertising. Philadelphia: Temple University Press.

Bartky, S. L. (1988). Foucault, femininity, and the modernization of patriarchal power. In I. Diamond & L. Quincy (Eds.), Feminism and Foucault: Reflections on resistance. Boston: Northeastern University Press.

Bologh, R. W. (1990). Love or greatness: Max Weber and masculine thinking - a feminist inquiry. London: Unwin Hyman Ltd.

Bordo, S. (1993). Unbearable weight. Feminism, western culture, and the body. Berkeley: University of California Press. Alameda, CA: Hunter House.

Chancer, L. (1998). Reconcilable differences. Confronting beauty, pornography, and the future of feminism. Berkeley and Los Angeles: University of California Press.

Chapkis, W. (1986). Beauty secrets: Women and the politics of appearance. Boston: Southend Press.

Connell, R. W. (1987). Gender and power: Society, the person, and sexual politics. Stanford, CA: Stanford University Press.

Cushman, P. (1990). Why the self is empty: Toward a historically situated psychology. American Psychologist, 4-5, 599-611

Daly, M. (1978). Gyn/ecology: The metaethics of radical feminism.

Boston: Beacon Press.

Davis, K. (1991). Remaking the she-devil: A critical look at feminist approaches to beauty. Hypatia, 6(2), 21-43.

Davis, K. (1995). Reshaping the female body: The dilemma of cosmetic surgery. New York: Routledge.

Dull, D., & West, C. (1991). Accounting for cosmetic surgery: The accomplishment of gender. Social Problems, 38(1), 54-70.

Finkelstein, J. (1991). The fashioned self. Philadelphia: Temple University Press.

Fisher, S. (1986). In the patient's best interest: Women and the politics of medical decisions. New Brunswick, NJ: Rutgers University Press.

Foucault, M. (1978). The history of sexuality, volume 1. New York: Pantheon.

Freedman, R. (1986). Beauty bound. Lexington, MA: Lexington Books.

Gillespie, R. (1996). Women, the body and brand extension in medicine: Cosmetic surgery and the paradox of choice. Women & Health, 24(4), pp. 69-85.

Goodman, M. (1996). Culture, cohort, and cosmetic surgery. Journal of Women and Aging, 8(2), 55-73.

Haiken, E. (1997). Venus envy. A history of cosmetic surgery. Baltimore, MD: The John Hopkins University Press.

History of the American Society of Plastic & Reconstructive Surgeons, Inc. (1994, September). Journal of Plastic & Reconstructive Surgeons, pp. 1A - 109A.

Hyman, D. A. (1990). Aesthetics and ethics: The implications of cosmetic surgery. Perspectives in biology and medicine, 33(2), 190-202.

Kendall, D. (2000). Sociology in our times: the essentials. (2nd. ed.) Belmont, CA: Wadsworth/Thomson Learning.

Kuczynski, A. (1998, July 12). Why are so few plastic surgeons women? The New York Times. pp. 1,6.

Latest breast implant verdict. (1999, June 22). New York Times, A, 26:1 NY.

Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic inquiry. Beverly

Hills, CA: Sage.

Lorber, J. (1994). Paradoxes of gender. New Haven: Yale University Press.

Maykut P., & Morehouse, R. (1994). Beginning qualitative research: A philosophic and practical guide. London and Washington, DC: The Falmer Press.

Miles, M. B., & Huberman, A. M. (1984). Qualitative data analysis: A sourcebook of new methods. Beverly Hills, CA: Sage Publications, Inc.

Mills, C. W. (1959). The sociological imagination. London: Oxford University Press.

Mithers, C. M. (1992, April). Why women want man-made breasts. McCall's, pp. 83-86, 88, 90, 141.

Morgan, K. P. (1991). Women and the knife: Cosmetic surgery and the colonization of women's bodies. Hypatia, 6(3), 25-53.

Orbach, S. (1978). Fat is a feminist issue. New York: The Berkley Publishing Group.

Peden, L. D. (1993, November). Real men do get nose jobs. American Health, 12, 29-30.

Pitts, V. L. (1998). 'Reclaiming' the female body: Embodied identity work, resistence and the grotesque. Body and Society, 4(3), 67-84.

Regush, N. (1992, January/February). Toxic breasts. Mother Jones, pp. 25-31.

Riessman, C. K. (1998). Women and medicalization. In (Ed. Rose Weitz) The Politics of Women's Bodies (pp. 46-63). New York: Oxford University Press.

Rome, E. R. (1990). Silicone breast implants. For the Boston Women's Health Book Collective.

Rothman, B. K. (1991). In labor: Women and power in the birthplace. New York: W. W. Norton & Company.

Sawicki, J. (1991). Disciplining Foucault: Feminism, power, and the body. New York: Routledge.

Siegel, P. (1990, January). Breast reconstruction: The options. Self, pp. 121, 124.

Simmel, G. (1984/1911). Female Culture. In Georg Simmel: On

women, sexuality, and love. Trans. by Guy Oakes. New Haven: Yale University Press.

Spitzack, C. (1988). Under the knife: Self-knowledge through effacement. Quarterly Journal of Ideology, 12(1), 1-18.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory, procedures and techniques. Newbury Park, CA: Sage Publications.

Sullivan, D. (1993). Cosmetic surgery: Market dynamics and medicalization. Research in the Sociology of Health Care, 10, 97-115.

Sustendal, D. (1991, March). Youth lifts: Men. Harper's Bazaar, 88.

Turner, B. (1984). The body and society: Explorations in social theory. New York: Basil Blackwell.

Weber, M. (1958). The Protestant ethic and the spirit of capitalism. New York: Scribner.

Wolf, N. (1991). The beauty myth: How images of beauty are used against women. New York: William Morrow and Co., Inc.

Zola, R. C. (1990). Medicine as an institution of social control. In P. Conrad & R. Kern (Eds.), The sociology of health and illness: Critical perspectives. New York: St. Martin's Press.

Zones, J. S. (1989, July-August). The dangers of breast augmentation. The Network News, pp. 2, 4, 6, 8.

Zones, J. S. (1997). Beauty myths and realities and their impact on women's health. In S. B. Ruzek, V. L. Olesen, and A. E. Clarke (Eds.), Women's health: Complexities and differences. Ohio State University Press.