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Cosmetic Surgery of the Aging Face:
Social, Psychological, and Ethical Implications

by

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1993

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by

Kelly Ann Kieffer

Dedicated to

Seth Brooks
Kim Roberts
and
Ingeborg Schlate

with appreciation for their love and support.

Table of Contents

Chapter 1	An Introduction to Cosmetic Surgery as a Social Phenomenon	1
Chapter 2	The Milieu of Cosmetic Surgery	18
Chapter 3	Women and Appearance in American Society	45
Chapter 4	The Possessor of the Aging Face: Attractiveness and the Middle Aged Woman	64
Chapter 5	Surgery as an Intervention in the Visible Aging Process	87
Chapter 6	A Case Study of the Responses of Cosmetic Surgeons to Research on their Patients	112
Chapter 7	Conclusion: The Compromised Role of Cosmetic Surgeons as Healers	130
Bibliography		135

CHAPTER 1

An Introduction to Cosmetic Surgery as a Social Phenomenon

The Popularity of Cosmetic Surgery

More than ever, Americans are seeking cosmetic surgery to improve what they consider to be flaws in their appearances. The American Society of Plastic and Reconstructive Surgeons (ASPRS) estimates that the number of cosmetic procedures performed by its members increased by 61% from 1981 to 1990 (ASPRS, 1991a). Breast augmentation and suction lipectomy (liposuction) of the thighs, hips, and/or abdomen are currently the most popular of these procedures. When taken together, however, the various procedures designed to modify or diminish changes in facial appearance resulting from aging are far more common. These procedures range from the least invasive techniques with shorter-lasting results (e.g., collagen, fat, or fibrel injections), to moderately aggressive procedures (chemical peels and liposuction of the face and neck), to true surgical procedures performed under local or general anesthesia (eyelid surgery, forehead lifts, and facelifts). In total, nearly 260,000 of these procedures were performed by ASPRS members in 1990, over half of them falling

into the most invasive category (ASPRS, 1991a).¹ The estimated total cost to the recipients of these medical services is more than \$400 million (ASPRS, 1991c). About 90% of the patients were women (ASPRS, 1991b).

A variety of factors may contribute to this increased demand for cosmetic surgery. Technological advances and refinements of surgical techniques have improved both safety and outcome of many procedures, making them more desirable undertakings for the surgeon as well as the patient. Liposuction, for example, has only been available in this country since 1982, but is now the most popular of all cosmetic procedures. Because it is less invasive and results in fewer complications than surgeries such as tummy tucks and thigh lifts, liposuction may be a welcome alternative for people who wish to change the shape of their bodies but are not willing to submit to a more intensive procedure. Similarly, improved techniques in facial plastic surgery have made it possible for surgeons to achieve better, longer-lasting results than were previously possible. In the mid-70's, surgeons began developing techniques for raising not

¹These estimates are based on information from the American Society of Plastic and Reconstructive Surgeons, Inc. Physicians in a variety of specialty fields (for example dermatology and otolaryngology) perform such procedures and their patients may not be reflected in these numbers. It is therefore likely that these figures underestimate the incidence and total cost of cosmetic surgical procedures of the aging face, but it is difficult if not impossible to tally the many procedures performed on an outpatient basis and in physicians' private offices.

only the skin, but also the underlying tissue known as the superficial musculo-aponeurotic system (SMAS), resulting in more natural looking facelifts that last much longer than traditional lifts. Since that time, these techniques have become widespread and further refinements have been made (for examples see, Roach, 1992 and Psillakis, Rumley, and Camargos, 1988). It is likely that these improved results positively influence many patients who might otherwise consider the risks or costs to outweigh the potential benefits.

In addition to offering better and safer techniques, surgeons now can offer an improved appearance at cheaper rates. A woman might be unwilling to pay \$600 for wrinkle-reducing fat injections, but perfectly happy to spend \$250 to achieve the same effect with the more modern alternative, collagen. Since most cosmetic procedures are not covered by health insurance, the potential number of people who employ the services of plastic surgeons is limited by the number who can afford them. Affordability has been addressed by many physicians with payment plans similar to those available for the purchase of any high-priced consumer good. In addition, as one successful surgeon notes, "if cash is a problem, a new nose or breasts can always be charged on the Mastercard" (Scheer, 1991).

Increased numbers of plastic surgeons and of physicians in other specialties who offer cosmetic procedures have led to greater competition for patients. By making surgery

affordable to a broader spectrum of the population, these doctors can make the demand for their services expand to match the supply. A 1980 court ruling conferred on physicians the freedom to advertise, and plastic surgeons are among the most likely physicians to take advantage of this freedom. This trend has been documented (Peters, 1989; Wolf, 1991), and is obvious to the casual observer of national women's magazines or the newspapers or yellow pages listings in virtually any large American city. Through advertising, plastic surgeons are able to increase public awareness of their services, informing potential patients of the techniques available to them and of the costs and payment schedules they may be offered.

Consumer awareness may also be enhanced by reports about cosmetic procedures in the popular media. The style of these reports ranges from tell-tale stories about movie and television stars alleged to have had various forms of surgery, to pro-and-con formats, to more critical discussions of controversial issues surrounding procedures such as the placement of silicone breast implants. These stories draw the field into the public eye, and some may prompt people to seek more information or consult with a plastic surgeon. In the early 80's, when very few American physicians were trained in the techniques of liposuction, many plastic surgeons sought training in response to their patients' requests for "that new fat surgery," (Fuerst, 1983, p. 3004) which they had

presumably learned about through media reports.

In addition to changes in the visibility and availability of cosmetic surgery, increased social pressure to meet a cultural standard of beauty may also contribute to the popularity of these procedures. The growth of the mass media in the twentieth century has led to a flooding of our collective consciousness with images of the young and the beautiful as the most successful and productive members of society. Whether the message is unstated, as in movies and television programs which offer primarily beautiful people as heroes, or blatant, as in advertising which sells products that can supposedly improve the consumer's life by making her more beautiful, these images send a message that if one wishes to be happy, one ought to look as good as possible. Apparently, many cosmetic surgery patients believe this, since a common reason given by many for their desire to change their appearance is that it will contribute to their success in the business or social worlds (Dull and West, 1991; Edgerton, 1964; Goin, 1986; Marcus, 1984; Reich, 1975).

In addition to social pressures to be beautiful, societal acceptance of cosmetic procedures may also contribute to their increasing popularity. It has become especially common for images of health to be tied to images of beauty, which may contribute to society's approval of medical interventions in appearance. Certainly, cosmetic surgery is often marketed as just another aspect of a complete self-care or health

maintenance routine. One California surgeon's advertisement combines a photograph of an attractive woman with the caption "'It's important for me to look and feel the best I can. That's why I eat the right foods and exercise. And that's why I had plastic surgery'" (Glassner, 1988, p. 190). Long viewed as a luxury for the glamorous or frivolous, cosmetic surgery is now seen by many as a perfectly reasonable expense, an investment in one's social viability. This is probably influenced somewhat by the decreased costs of surgery, but also may have to do with an increased tolerance of self-indulgence in general. While America has always had a strong individualist tradition, only in recent years has this ideology been manifested by the "consumer politics in which 'what's in it for me?'" is a principal concern (Goleman, 1990). As baby boomers and subsequent generations reach their prime spending years faced with the cultural mandate to strive for a bodily ideal and comfortable with their right to self-indulge, facelifts and liposuction may increasingly be seen as both a practical necessity and a "form of self-actualization that goes beyond jogging" (Adler, et al, 1985).

Finally, it is possible that a growing number of Americans possess character traits which predispose them to choose cosmetic surgery. Cash, et al (1985) found that a considerably greater percentage of survey respondents were dissatisfied with specific aspects of their appearance and with their looks overall in 1985 as compared with 1972. Poor

body image is one of a number of traits which has been associated with a greater likelihood of seeking plastic surgery. Other such traits include emotional instability, dependence, anxiety, and low self-image in general. It is unclear how strong these associations are, but it is possible that a greater prevalence of these or other psychological characteristics in the overall population is related to the increased utilization of cosmetic surgery. It has been suggested that some of these traits might result in a greater likelihood that a patient is disappointed with the results of surgery, or a tendency to have a negative psychological response to the surgery (Goin and Goin, 1981). This too is unclear, and many surgeons argue that proper attention to the individual patient will result in positive psychological outcomes even in the presence of mild psychopathology (Reich, 1975 and 1982).

Beauty and the Medical Profession

Whatever the reasons for its growing popularity, cosmetic surgery remains a unique form of modifying one's appearance. It is far more invasive, irreversible, and costly than more common efforts to manipulate appearance, such as dyeing or bleaching the hair and wearing make-up. In this sense, surgery is comparable to methods of bodily alteration more typical of other cultures and seen by our own as bizarre, barbaric, and resulting in mutilation rather than

beautification -- practices such as tattooing, scarification, stretching of the lips by the insertion of wooden plates, and elongation of the neck with metal rings. Cosmetic surgery differs from these forms of bodily alteration in that it is generally used to "normalize" features, or at least bring them closer to an ideal of beauty which is not outside the realm of normally occurring human appearance. While practices such as tattooing, scarification, and body piercing are also becoming more prevalent in our society, they are still seen as rebellious acts done by individuals who wish to mark themselves as outside of mainstream culture. Thus, society sanctions permanent bodily alterations and considers them positive changes only when they "correct" appearance towards a specific ideal.

It is notable that in our society the practitioners designated to perform these alterations in appearance are also healers. In assigning both tasks to the same class of professional, we imply that an unfavorable appearance is detrimental to one's health. Cosmetic medical procedures are done not to heal the patient's body, but to improve her self-esteem, reduce her anxiety, enhance the quality of her social interactions -- in other words, to "heal" her psyche.

It may be useful to clarify some definitions at this point. Plastic surgery is generally divided into two categories: reconstructive and cosmetic. Reconstructive procedures include those which restore function and/or

appearance after injury or which correct congenital deformities. Cosmetic procedures are intended to improve the already "normal" appearance of the patient and do not improve physiologic functioning. This distinction is an important one sociologically. Reconstructive surgery has traditionally been seen in a more favorable light than cosmetic, both as a professional endeavor and a personal choice. It is often reimbursed by insurers, an indication that it is considered a valid, medically necessary intervention. The distinction also has implications for measurements of therapeutic effectiveness. In the case of reconstructive procedures, a pre-injury appearance or a standard level of functioning may be a guideline for measuring improvement. For cosmetic procedures, the standard is usually more nebulous and is a matter of aesthetic tastes; a nose may be measurably smaller post-rhinoplasty, but is it more beautiful?

Therapeutic success of a cosmetic intervention is therefore measured in terms of the judgment of the physician and the satisfaction of the patient. This is compatible with the procedure's non-physiologic curative role. In truth, however, even procedures which "correct" congenital or acquired deformities may have tremendous impact on psychological well-being and are often performed largely or solely for their reparative actions on the mind rather than the body. It is simply easier for most of us to imagine a physical cure when appearance is restored to its pre-injury

status or ceases to deviate significantly from that encountered in the average person's daily experience. The separation of procedures into these two distinct categories is ingrained in the literature as well as in the practice of plastic surgery. Yet the distinction can be quite blurry, and is dependent on what our culture allows to be termed a "deformity."

At one end of the spectrum, injuries and functionally limiting characteristics can be easily seen as in the domain of the reconstructive surgeon. The difficulty arises when we consider congenital deformities that do not affect function but may have an impact on body image. In these cases, the medical severity of the defect is determined by the way in which it is experienced by the patient. Thus, one individual (or his parents) may view a small hemangioma (a benign tumor that appears as a reddish, slightly elevated mass on the skin) as a serious defect in need of surgical correction, while another person with a similar appearance may find it tolerable and not warranting surgery. These cases are more similar to the cosmetic model of surgical decision making, in which the need for intervention, and hence the psychological significance of an appearance trait, is determined by the patient. Indeed, it is possible that for a given patient, a "cosmetic" procedure such as rhinoplasty may provide greater psychological benefit than does correction of a hemangioma for another patient. As one surgeon notes, "'A 16-year old with

a weak chin and a big nose can be suffering every bit as much as someone with a large burn scar'" (Clark, et al, 1985, p. 70).

Because they are culturally based, definitions of deformity may switch categories over time. Thus, "what was acceptably 'buck-toothed' in the 1950s has now become a 'dentofacial deformity,' and is treated with surgery and orthodontics." (Strauss, 1990, p. 233). In addition, society might be willing to accept variations of the same characteristic as normal or defective; implants for an adult woman with size AAA breasts might be seen as correcting a deformity, while for a woman with size B breasts the same procedure might be viewed as cosmetic. Why, then is the reconstructive / cosmetic distinction so important? Its existence suggests to prospective patients and to all members of society that certain characteristics are expected to cause anxiety, depression, self-consciousness, etc., while other characteristics may cause these feelings. The desire to correct characteristics in the former category, as well as actions based on these desires, are thus socially validated to a greater degree than those directed at characteristics in the latter.

Consider, for example, the current controversy over clinical trials of recombinant human growth hormone for short children without growth hormone deficiency. Growth hormone is standard treatment for children who, due to pituitary or

hypothalamic deficiency, do not produce the hormone endogenously. Until the recent introduction of recombinant versions of the hormone, its supply, and therefore potential uses, were quite limited. Its availability has now dramatically increased, and researchers have begun studying use of the hormone in non-deficient children who are projected to have adult heights significantly shorter than average. The proposed therapy is expected to be beneficial insofar as short children and adults experience negative social and psychological effects as a result of their height.

Critics of this research suggest that permitting therapy for physiologically normal children who happen to fall on the short end of the growth curve is tantamount to defining shortness as an illness or developmental abnormality. The psychosocial impact of shortness is often not yet experienced by the child at the early age when therapy must be initiated for maximum effectiveness. Thus, the "disease" must be treated before its symptoms are manifest. Furthermore, even if very short stature were considered a medical problem, a more specific definition would be required to determine just who qualifies for therapy. Should it prove effective and not prohibitively risky, will growth hormone be made available for only those children whose height is expected to be below the first percentile? What about the fifth percentile, or the tenth? As Hochberg (1990, p. 367) notes, if all the children below a given percentile were treated, "there would be a new

group of children below [that percentile]. These children, too, would want to be treated, so creating an ever-escalating demand."

Growth hormone therapy might also have its own negative effect on the psychological development of the children who receive it. "When we seek to change the height (or physical appearance) of a child, he may perceive that he is incomplete and unacceptable" (Diekema, 1990, p. 114). Children who are given years of growth hormone therapy after extended tests and analyses of their growth rates may grow taller than otherwise expected, only to feel intrinsically inadequate. The therapy itself, rather than the initial deficiency in height, might lead to the sense that one is diseased.

Growth hormone therapy thus serves as an example of a medical intervention with the potential to dramatically change our definitions of deformity, as well as our expectations for short individuals to seek treatment. It could validate the negative experience of shortness by classifying it as a treatable deformity, while progressively limiting what is deemed "normal" in terms of adult height. Certainly height is not a unique variable in this respect. Any feature which is considered more desirable than its alternatives, particularly if it is both a normal feature for some individuals and an achievable feature for others (i.e. through medical intervention), could come to be viewed as the accepted norm. Cosmetic surgery therefore has the potential to be viewed in

the more reparative sense currently reserved for its reconstructive counterpart. To a degree, this is already the case. Articles in medical journals and plastic surgery textbooks generally discuss the features that are the targets of cosmetic surgery as deformities, and patients are considered to be in need of the cosmetic procedures they request.

Implications for Physicians and Patients

This has important implications in light of the growing popularity of cosmetic surgery. It suggests that as demand for and utilization of cosmetic surgery increases, plastic surgeons are intricately involved in establishing standards of normalcy. Physicians evolve from being instruments of the social imperative that one be attractive to being agents that enforce this imperative. This necessitates new roles for both the physician and the patient in the therapeutic interaction.

First, when a physician becomes an expert on beauty and appearance rather than illness and disease, he² sets aside his role as a diagnostician and becomes instead an arbiter of beauty. A cosmetic surgeon uses his expert judgment to redesign his patients' features in a manner which he deems to

²While not all physicians are male, the majority of cosmetic surgeons are. Conversely, as previously indicated, most cosmetic surgery patients are female. For this reason, and for grammatical simplicity, the pronouns he, him, and his will be used in this paper in all references to a generic physician, and she, her, and hers will be used in references to patients.

be more attractive. While the patient may have input into specific changes she does or does not want made, the physician makes the final decision on how to make her more beautiful. In some cases the surgeon suggests additional changes to those she initially requests which he, again using his expert judgment, believes will further enhance her appearance. While this behavior is considered unethical and inappropriate by many plastic surgeons, in practice it occurs quite regularly (see Dull and West, 1991; Glassner, 1988; Goldwyn, 1985). Furthermore, cosmetic surgeons judge not only the faces and bodies that do walk into their offices, but also those who don't. By developing, teaching, and practicing specific techniques which they believe offer the best solutions to the "problems" they treat, they assert the sovereignty of their own aesthetic tastes.

When physicians adopt the power of arbitration over appearance, they compromise their ability to objectively assess illness and determine the need for treatment. Cosmetic surgeons may be experts on what is beautiful about human appearance, but each patient determines whether or not her deviant or non-ideal appearance constitutes an illness. Cosmetic surgery is medically necessary if, and only if, a patient deems it so. A surgeon may refuse to operate on a patient for a number of reasons, such as emotional imbalance, medical conditions which increase the risk of complications, or irrational expectations regarding surgical outcome. But he

cannot determine whether or not the one necessary element for considering therapy is present: the patient's desire to have it. The patient thus assumes the primary role and responsibility in determining medical necessity.

In addition to these implications for physician and patient roles, cosmetic surgery alters the very nature of medical intervention. Interventions become creative instead of therapeutic; rather than treat what is medically wrong, the physician constructs what he believes is socially right.

What are the consequences of this redefining of medicine and the therapeutic relationship? Surely, so radical a change dictates a reevaluation of the privileged position in our culture of the healer who uses his knowledge, skills, and training to modify appearance. Important aspects of this evaluation include a better understanding of the patients who seek surgery -- their motivations, health attitudes and behaviors, and psychological outcomes to surgery; as well as an understanding of cosmetic surgeons' motivations and perceptions of their own roles as physicians. The field of cosmetic surgery is a large one, however, and patients who request different types of surgery may be vastly different. In addition, as previously discussed, many types of cosmetic interventions overlap with similar types of reconstructive interventions, making a study of strictly cosmetic procedures a difficult undertaking. For these reasons, cosmetic surgery of the aging female face provides a useful case study.

Although not a uniform population, aging women who request cosmetic surgery are a more focused group than cosmetic surgery patients in general. Because aging and the physical changes which occur with it are natural processes experienced by all people, medical attempts to counteract these changes are among the most clearly classifiable as cosmetic interventions. As outlined before, these procedures are also among the most popular of all those done by cosmetic surgeons, and women patients far outnumber men.

Chapter 2

The Milieu of Cosmetic Surgery

As previously discussed, cosmetic surgery is a unique form of beauty intervention in that it is performed by physicians, our society's primary healers. In another sense, cosmetic surgery as a professional undertaking involves a unique form of medicine. No other field is so wholly devoted to the performance of procedures which are by definition medically unnecessary, and many of which are quite invasive. Because of the highly unusual circumstances and medical relationships involved, a number of important political and ethical issues, both theoretical and practical, regarding the practice of cosmetic surgery arise.

The Therapeutic Value of Cosmetic Surgery

First and foremost among the ethical questions about cosmetic surgery is, what is the true therapeutic value to the patients who receive cosmetic "treatments?" Part of the answer depends on how "sick" the individual patient is, and what is the nature of her "illness". Several researchers, employing a variety of instruments, have attempted to identify and quantify the incidence of psychiatric illness in cosmetic surgery patients. The most notable trend in this line of research is a decided decrease in the frequency of identified psychopathology in more recent studies as compared to earlier

ones (Wengle, 1986a). There are several possible explanations for this trend. An increasing social acceptance of cosmetic surgery may lead more "normal" people to seek it, so that the average patient today is less likely to exhibit symptoms of psychopathology than her counterpart twenty or thirty years ago. Conversely, changing standards for clinical diagnosis and differences in the research instruments available and chosen for study of patients may be such that the likelihood that a given individual is characterized to be psychologically "deviant" is reduced.

In those studies which have identified psychiatric symptoms in cosmetic surgery patients, the predominant symptomatology includes anxiety, symptoms of obsession or worrying, and paranoia (Robin, et al., 1988); unhappiness and distress (Marcus, 1984); and heightened self-consciousness and interpersonal sensitivity (Goin and Rees, 1991)¹. Again, most studies, particularly those conducted in more recent years, indicate that patients differ from controls or deviate from average scores on standardized psychological tests only slightly; psychosis or serious psychopathology is the exception rather than the rule (Wengle, 1986a). Thus, most cosmetic surgery patients fit well within the boundaries of what is considered psychologically normal. Furthermore, no

¹A more in-depth discussion of research on psychopathology and personality of patients seeking aging-related cosmetic surgery is deferred for a later chapter.

study has found a "simple causal relationship between the degree of psychopathology and the motivation for cosmetic surgery" (Wengle, 1986a, p. 439).

Noting this weakness in the association of psychopathology with desire for cosmetic interventions, researchers have recently begun to examine motivations for cosmetic surgery from new perspectives. Burk, Zelen, and Terino (1985) proposed that the typical female cosmetic surgery patient is a psychologically normal woman with average self-esteem in general, but lower than average physical self-esteem and particularly low esteem for the specific body part she wants surgically altered. Under this model, the patient is motivated to have surgery by an inconsistency between body-part esteem and overall self-esteem. In their study of 21 adult women surgery patients, average overall self-esteem was found to be higher than that of the general population (which includes "normal" people as well as disabled, neurotic, and psychotic individuals), while physical self-esteem was lower than for the general population. Furthermore, patients had higher general self-esteem than either physical self-esteem or body-part esteem for the body part being operated. These results are consistent with the hypothesis that surgery is an attempt to raise body-part esteem and physical self-esteem to the same level as overall self-esteem, rather than a behavioral manifestation of psychopathology.

Dull and West (1991) explained motivations for cosmetic

surgery using yet another framework. Through interviews with ten cosmetic surgeons and 23 cosmetic surgical patients, the researchers sought to determine how these individuals explained their reasons for participation in surgery. They found that subjects discussed surgery as if it were "natural" for women but not for men. Surgeons often labeled men "problem patients," because their desire for surgery was "inappropriate," and accepted men's desire for surgery as reasonable only when it was prompted by an external goal, such as the demand for youthful looks in a professional arena. Women needed no such external goal, but requested surgery as part of the "natural order to things." In their view, cosmetic surgery can be described as an "accomplishment of gender," a simple reflection of the essential nature of women; patients' and surgeons' reasons for requesting and performing cosmetic procedures are explained by "[t]he accountability of persons to particular sex categories," which "provides for their seeing women as 'objectively' needing repair and men as 'hardly ever' requiring it."

Whether cosmetic surgery is seen as a normal undertaking or one indicative of psychopathology, the goals of improved physical appearance and concurrent increase in self-image and/or enhanced social interactions remain the same. As purely elective yet quite invasive procedures, cosmetic surgical operations should be highly effective therapeutic tools if they are to be considered ethical medical practice.

Since the intended benefits of cosmetic surgery are psychological and social, not physical, success is more difficult to measure than for many interventions. Success of cancer therapy is readily measured in tumor recurrence or five-year survival. Attempts to lower serum cholesterol or control diabetes mellitus are measurable with simple blood tests. But the measurement of success in cosmetic surgery would require careful studies of psychosocial functioning, pre- and post-surgery and ideally several years later as well, with comparison to age-, sex-, and socioeconomically-matched norms. In practice, success is measured by less objective parameters, namely, the physician's assessment of whether the surgery resulted in an improved appearance and the patient's satisfaction with the results.

Both of these measures of therapeutic value are problematic. The first, physician assessment of results, does not even address psychosocial functioning, and hence does not attempt to evaluate success on the basis of surgery's supposed goals. Furthermore, this measure requires a substantial degree of subjective judgment on the physician's part regarding what is attractive. This is not to suggest that physicians should not or do not frequently make subjective assessments in the course of providing health care. The ability to evaluate health and diagnose disease are dependent on a physician's ability to see, hear, smell, and feel different aspects of his or her patients' bodies and to assign

meaning to these perceptions. In fact, in the standard format for medical case presentations, the presence or absence of such features detected by the physician are considered "objective" findings. But there is something distinctively different about a cosmetic surgeon's assessment of a patient's physical attractiveness. For example, when a surgeon states, "This woman's face is beautiful," he implies "just the way I like it." On the other hand, when a physician feels a patient's liver edge, the liver may be deemed "firm," but there is no implication about the physician's specific tastes regarding the texture of the liver. It could be argued that in the second case the physician is in fact expressing certain values, not regarding beauty but regarding a bias about what constitutes health. Given the goals of medicine, this type of judgment, based on the physician's knowledge and experience, seems appropriate and necessary. In assessing physical attractiveness, however, the cosmetic surgeon replaces the value of health with the value of beauty.

The use of the second common criterion for success in cosmetic interventions, patient satisfaction, is perhaps more disturbing. Patient satisfaction is used not only in the clinical setting, but also by many researchers as a measure of therapeutic benefit (Goin, and Goin, 1986; Pruzinsky and Edgerton, 1990; Reich, 1975; Wengle, 1986a). The patient's satisfaction with results, or increased happiness with her appearance, may be an indicator of improved self-esteem and

may lead to other benefits, but is not in and of itself a measure of improved psychosocial health. "Feeling good" is certainly one aspect of health, but is not always precisely or directly correlated with wellness. A doctor may prescribe amphetamines or morphine on demand to his patients, who in turn report feeling much better than before taking the drugs, but this could hardly be considered a health-promoting intervention (Hyman, D., 1990). While respect for patient autonomy argues in favor of patient involvement in medical decision-making, it does not argue that the patient should assume the primary role in diagnosing illness, prescribing treatment, and assessing outcome. In creating such a situation, cosmetic surgery "collapses any distinction between the health and the wishes or happiness of the patient" (Hyman, D., 1990, p. 193).

Patient satisfaction with results could theoretically be used as a simple measure of success if there were good evidence that it was directly related to actual positive psychosocial outcomes. In this case, assessing patient satisfaction would be a simple, inexpensive method of estimating therapeutic effect. However, while most research indicates that the vast majority of cosmetic surgery patients are satisfied with their results, it is unclear whether the level of satisfaction increases, decreases, or holds constant over time (Wengle, 1986a). Furthermore, there is no evidence which suggests that patient satisfaction does accurately

reflect changes in body image, reduced anxiety, improved social interactions, or any other parameter of psychosocial functioning. In fact, there is very little good evidence which quantifies changes in longterm psychosocial functioning after cosmetic surgery. While nearly all studies show that most patients have improved results on tests of self-image, mental state, happiness, and self-confidence post-surgery (Burk, Zelen, and Terino, 1985; Goin, 1982; Goin and Rees, 1991; Goin and Goin, 1981, 1986; Marcus, 1984; Pruzinsky and Edgerton, 1990; Robin, et al, 1988; Wengle, 1986a), this research is lacking in several important aspects. First, in many cases, controls (such as patients undergoing non-cosmetic elective surgery) were not used and the results are thus difficult to interpret. This is especially true since the pre-surgery period may be one of increased anxiety, depression, concern over appearance and negative body image, which might cause measures of psychological status for surgical candidates of any type to deviate from their personal baseline. Furthermore, characteristics which are influenced by a single medical intervention might also be influenced by other events in a person's social, occupational, or internal psychological life. These influences could simultaneously prompt the individual to seek an intervention such as plastic surgery. Thus, a pre-surgery assessment may in part reflect events which have contributed to the impetus to seek surgery rather than consistent traits suggestive of long-term

dysfunction. Controls receiving other forms of therapy or no intervention at all instead of the cosmetic surgery they request have not been used to show that changing the body is the best form of treatment for these patients.

Additionally, follow-up time for most of the studies is on the order of months, and it is possible that psychological benefits may be transient. Surgery can only be considered an efficacious form of therapy if its results are long-standing, supplying the patient with better psychological resources for years into the future. Transiency of effect may be a particularly important issue with respect to patients seeking surgery for aging-related change, since the aging process will continue to alter their facial appearances after surgery.

Finally, it would be useful to know whether surgery results in improved social interactions for the patient. Based on the apparent importance of physical attractiveness in perception of others and in social behavior, it would seem logical that improved appearance might result in a more positive social environment. Kalick (1978) found that surgery made a difference in observer speculations about personality characteristics of patients based on pre- and post-surgical photographs. The patients in this study were college-age females receiving rhinoplasty (nose surgery) and/or mentoplasty (surgery of the chin), and the judges were college-age males and females. The group of male judges gave higher ratings to individuals in the post-operative

photographs in several categories, including socially desirable personalities, promise as marital partners, potential for happy lives, poise, enthusiasm, sexual warmth, personal fulfillment, sociability, kindness, and friendliness. Female judges rated the postoperative photographs higher in fewer categories, including potential happiness, poise, enthusiasm, and personal fulfillment. Cosmetic surgery therefore seems to have the potential to change at least the first impressions of others. What is not known is how surgery affects already established relationships and if this change in perception by others is accompanied by a change in social response.

Risks to the Patient

The therapeutic value of cosmetic treatments is thus not well documented. The incidence and severity of negative consequences of surgery have also not been clearly quantified, although there are clearly numerous potential risks involved.

Medical risks involved with most types of surgery include infection, poor wound healing, skin necrosis, excessive scarring, and complications related to clotting. Some procedures have more specific risks, such as implant slippage (chin or cheekbone implants); inability to close eyes or vision loss (eyelid surgery); pigment changes, corneal or perioral burns (chemical peels); impaired breathing (rhinoplasty); asymmetry, hardening, pain, leakage, or reduced

ability to read mammagrams (breast implants); hair loss (forehead lifts) and temporary or permanent nerve injury, resulting in immobility of facial muscles or loss of sensation (forehead or facelifts). Some of these risks involve very real threats to the patient's health; others involve the chance that the patient will actually be less attractive, and almost certainly more discouraged by her appearance, post-surgery. For any procedure performed under general anesthesia, there are additional risks -- which should occur only rarely if patient selection is appropriate -- including liver toxicity, hyperthermia, cardiac complications, and death.

In addition to these risks of physical harm, cosmetic surgery may also have psychological complications. When a surgeon relies on statistics which suggest that most patients will benefit psychologically from a particular surgery, he must accept that "[t]he individual patient may or may not behave in accordance with the statistical findings" (Wengle, 1986b). Several psychiatrists and surgeons have addressed the issue of attempting to predict "problem patients" -- those individuals who will be unhappy with a "technically satisfactory" result or have a negative psychological response (Reich, 1982; Edgerton and Knorr, 1971; Knorr, 1972; Goin and Goin 1981, 1986, Pruzinsky and Edgerton, 1990). In some cases, these responses can be predicted and potentially avoided by the surgeon's careful determination of the

patient's expectations and ability to cope with an imperfect result. Other psychological consequences, including some serious ones such as loss of identity or insatiability for further cosmetic procedures, cannot be predicted (Edgerton and Knoww, 1971; Wengle, 1986b; Reich, 1982). Whatever physical risks a patient accepts in undergoing cosmetic surgery, she also must accept that there is a chance that the surgery will not improve her psychologically or may even lead to psychopathology.

The risk to benefit ratio of cosmetic surgery is impossible to calculate based on the paucity of good data on both sides of the equation. Even if this information were available, its meanings would no doubt be controversial. If different individuals were asked to weigh a certain percentage risk of wound infection, scarring, cardiac arrhythmia, or identity loss against an average expected improvement in MMPI or Beck's depression scores, each would invoke his or her own value systems regarding the relative importance of such consequences, and thus many different interpretations of the data might result. However the absence of such data indicates that the medical community has not even attempted to answer these difficult questions about the utility of cosmetic surgery. A recent major controversy involving silicone breast implants illustrates the dangers of this complacency.

Silicone breast implants were available in the United States for more than twenty-five years before the FDA ordered

their manufacturers to take them off the market due to safety concerns. In that time, over two million women underwent implant surgery, the vast majority choosing implants containing silicone, and over 80% for cosmetic reasons (i.e. not for postmastectomy reconstruction) (Zones, 1992; Blakeslee, 1991). In 1976, the passage of the Medical Device Amendments to the Federal Food, Drug, and Cosmetic Act brought implants under FDA regulation. Implants remained on the market during the following twelve years, while the FDA determined how they should be classified under this law. At that time, they were deemed Class III devices, and manufacturers were ordered to submit scientific evidence that implants were safe and effective. This information was to be submitted by July of 1991. The FDA reviewed this material and on April 16, 1992 announced that there was insufficient evidence to show that silicone implants were safe, and restricted their use to clinical trials or for reconstructive surgery (Burton, 1993). At this time, only one company continues to make silicone implants, and they are used only in FDA-approved clinical trials.

The lack of information about the safety of these devices is in itself disturbing. But the practical consequences of silicone implants are still being studied, and may turn out to be even worse than initially expected. Some implants (about 20%) are coated with a polyurethane foam which FDA data indicates may degrade in the body into a substance (2,4-

toluene diamine, or TDA) which is known to be carcinogenic to animals (Blakeslee, 1991; Zones, 1992). In addition, most implants either leak or rupture, resulting in the release of silicone into the tissues. Although manufacturers believed that silicone was inert and would cause no negative effects when released into the body in this fashion, current research suggests this is not the case. There is an increasingly strong link between silicone implants and autoimmune disorders, diseases in which an individual's immune system begins to attack certain tissues of her own body (Burton, 1993). Silicone implants are known to make the reading of mammograms more difficult, but it is not yet known whether this leads to an increased risk of breast cancer (Zones, 1992). It is also not known whether silicone, 2,4-TDA, or other substances are present in breast milk or if implants are detrimental to lactation or to infants who breast feed, a potentially important issue since 75% of women with implants are between the ages of 18 and 44 (Zones, 1992).

What is startling about the silicone implant controversy is not so much that implants may have such severe consequences, but that so many physicians exposed so many women for so many years to an undetermined risk of physical harm, without ever questioning the safety of these devices. In theory, "[t]he physician as a professional brings more than good intentions; he also brings knowledge and a commitment to do useful rather than harmful or useless things" (Yarborough,

1991, p. 270). Standards which condone the widespread use of cosmetic treatments with unknown and potentially serious risks can hardly be considered "professional." It is true that the risks of most other forms of cosmetic surgery are probably significantly less than those of breast augmentation with silicone implants, if only because the latter involves placement of a foreign body (or bodies) into the patient's tissues. But in principle, any instance in which a physician performs a procedure without a clear sense of what the potential benefits and risks are, he violates both a professional mandate and his patients' assumptions. It seems that particularly when the procedure in question is an elective, cosmetic one, a relatively small incidence of significant risks should be considered unacceptable, and standards of what constitutes a benefit should be high. Certainly, "patient satisfaction" should not be deemed an appropriate indication of successful therapy.

The Politics of Cosmetic Surgery: Who Protects the Patient?

The FDA's interventions in the marketing of silicone breast implants, albeit a quarter of a century too late for some women, have finally offered a measure of protection for women who are interested in undergoing breast augmentation. Unfortunately for other cosmetic surgery patients, there is no similar organization which monitors the safety and effectiveness of actual procedures. Because most cosmetic

operations are performed in private clinics on an outpatient basis and are not covered by insurance, hospital regulations or insurance company standards also do not govern how cosmetic surgeons do their work. Yet cosmetic surgery is a highly profitable undertaking -- the median net income of plastic surgeons in 1990 was about \$211,250 (Fernandez, 1992) -- and one which is ripe for abuse, because doctors have financial incentives to create demand for their services and to attempt to perform whatever procedures are desired by a large number of people.

For example, consider the use of injectable collagen as a temporary "cure" for facial wrinkles. Collagen was approved by the FDA for use in diminishing "soft tissue deformities," primarily of the type caused by acne scars. But once on the market, it rapidly became widely used instead as an anti-wrinkle treatment (Lehrman, 1991), and it is now the third most popular of all cosmetic procedures (ASPRS, 1990a). Setting aside accusations by some patients and physicians that collagen may cause autoimmune diseases similar to those which occur in some women with silicone implants², consider the implications of this use of collagen. There have been no

²When these concerns began to surface, the FDA required Collagen Corporation, the makers of injectable collagen products, to re-submit data regarding the safety of the safety of these products. After an extensive review of the data, the FDA has concluded that there is no evidence linking collagen with autoimmune disorders. Many doctors and patients still disagree, and believe that there has been insufficient time for the data to confirm this link. Several lawsuits against Collagen Corporation over this issue are still in progress.

studies which indicate that collagen injections "effectively contribute to the wellness of patients who receive them" (Yarborough, 1991, p. 270) for wrinkle reduction. The only studies of patients who have received collagen use "patient satisfaction" as the sole estimate of efficacy of the therapy (Yarborough, 1991). Although the FDA has jurisdiction over Collagen Corporation, the manufacturers of injectable collagen, and intervened when the company began advertising the products for uses for which they were not originally approved, physicians are perfectly within their legal rights when they use collagen to reduce wrinkles. When they do so, however, they must accept that the only known benefit of these treatments is that they please the patient, who

"may perceive, either correctly or incorrectly, that a more youthful appearance will promote happiness. For a physician to acquiesce in the pursuit is to send the message that treatment can promote happiness, restore youth, and the like. But does the physician know this? If so, how? And if there is no such knowledge, on what basis does he or she offer the injections as professional treatment? The answer appears to be because patients want such treatments" (Yarborough, 1991, p. 271).

Physicians may thus be tempted to perform any procedure which is in high demand, forgetting their obligation to do only what they know will improve the patient's health or well-being. And they may perform these procedures in any way they see fit, with or without any real training. "A weekend course in the midst of a ski excursion sometimes suffices for formal training in what are complex and potentially dangerous

procedures" (Scheer, 1991, p. A-42). Fuerst (1983) discusses the methods employed for teaching a large group of American plastic surgeons who sought training in the technique of suction lipectomy (liposuction) when it first became popular. Four hundred surgeons learned the procedure by watching a live broadcast of the surgery being done by experienced physicians. With no hands-on training, most of these surgeons felt prepared to attempt liposuction on their own patients. But one of the experts who demonstrated in this video session describes that "one problem with the procedure...is that it looks easier than it is" (Fuerst, 1983, p. 3005). Another discusses the possible complications of the procedure, including burning and tearing sensations that may last for months, skin discoloration and a "wavy skin indentation," persistent swelling, and damage to the subcutaneous nervous and vascular supplies and connective tissue support systems. When performed by "overzealous practitioners," fluid loss related to the operation has resulted in shock, and damage to vital organs has occurred in some cases. This expert felt that although mistakes and complications are unavoidable as plastic surgeons learn this new technique, these doctors "'should have no trepidation about adding another tool to their armamentarium'" (Fuerst, 1983, p. 3005). Plastic surgeons eager to learn this technique to meet their patients' demands were encouraged to perform an admittedly dangerous procedure in their own clinics without ever having received

expert supervision. Once again, the procedure in question had not even been shown to have therapeutic value; no long term follow up on patients had been done to determine what the eventual physical and psychological effects were. Liposuction is now the most popular of all cosmetic procedures (ASPRS, 1990a).

Despite the clear evidence that a great deal of what occurs in cosmetic surgery clinics may not be medically sound, the greatest controversy within the medical profession surrounding the lack of regulation of these procedures is not how or why they are done, but by whom. In one of the biggest "turf wars" in modern medical practice, many surgeons who are board certified in plastic surgery argue that untold numbers of unqualified physicians bill themselves as "cosmetic surgeons," and peddle their cosmetic services. These plastic surgeons believe that they are the only physicians who should be permitted to perform cosmetic procedures, by virtue of the training and testing necessary to receive the official title of "plastic surgeon". But other specialists, in particular dermatologists, ophthalmologists, and otolaryngologists (head and neck surgeons), believe that their training makes them more qualified to perform certain types of cosmetic surgery. They argue that certification by their own specialty boards verifies their expertise in the cosmetic procedures that they perform, and that plastic surgeons are as likely as other physicians to make mistakes or be lacking in skills. Legally,

there is no issue -- all that is required by law to perform cosmetic surgery is an M.D. The president of an organization which provides accreditation to plastic surgery clinics which voluntarily seek it (no such accreditation is necessary) laments that,

"'Even tattoo artists, hairdressers and manicurists need licensing and/or health board examination to practice their specific art, while a physician who decides to perform surgery in his office currently does not need licensing for any specific procedure'" (Scheer, 1991).

The Business of Cosmetic Medicine

While the cosmetic surgery turf war points out how poorly regulated and reviewed the whole field is and has been, it may have more to do with money than with ethical considerations of how patients are treated. A plastic surgeon who is a strong proponent of government regulations to limit who is qualified to perform cosmetic procedures admits that in part the controversy is a "'turf war for money'" (Scheer, 1991). The same surgeon is dismayed that good surgical skills and hard work are no longer sufficient to bring cosmetic surgery patients into his office. Competition from the increasingly large number of physicians who do cosmetic work has forced him, like many other plastic surgeons, to seek methods other than a good reputation and word-of-mouth to bring in patients. He grudgingly took out an ad in the yellow pages, and comments, "'It was time to change. I got wise too. The bottom line is that unless you do some form of self-

aggrandizement, you don't get the work'" (Scheer, 1991).

This doctor is not the only one who has compromised his standards in response to the perceived need to maintain a certain workload. One plastic surgeon interviewed by Glassner (1988) stated "'Fourteen years of expensive medical education to take off wrinkles from somebody's face is a travesty.'" Yet 25% of his practice consisted of cosmetic surgery patients, including facelift patients. Although this surgeon may feel that his relatively limited treatment of cosmetic "problems" (40% of plastic surgeons do nothing but cosmetic surgery [Glassner, 1988]) entitles him to take the moral high ground on the issue, it seems highly unethical to spend a quarter of one's professional life doing work that one considers a "travesty." It is not known how much the desire to run a profitable business affects physicians' decisions to perform cosmetic work.

Data collected by sales representatives for the company which makes tattooing equipment for ophthalmologists, who use the equipment to tattoo permanent eyeliner, suggests that financial concerns may indeed be influential factors in such decisions. These representatives report the highest sales of the equipment in areas where competition among ophthalmologists to perform cataract surgery is greatest (Margo, 1985). This indicates that increased competition for a finite number of "sick" patients may encourage physicians to offer cosmetic services.

The lucrative nature of a successful cosmetic surgery business inspires many physicians not only to supply these services to patients who seek them, but also to create demand through advertising. Despite the dictum which states that cosmetic surgery patients who expect the procedure to change their lives are "bad candidates" on the basis of these "unrealistic expectations" (Edgerton and Knorr, 1971; Goin and Goin, 1981), many advertisements suggest that surgery can result in improvements in a number of facets of the patient's life. A pair of advertisements -- one directed at men and the other at women -- created by a for-profit hospital company with several centers for cosmetic surgery nationwide tells prospective patients that "Life looks better when you do" (Lefton, 1985). The ads describe a new plastic surgery program, called "You're Becoming," as "the first step in the natural process of becoming your best -- successful, active, and self-assured."³ A surgeon who works in one of these centers notes that "at least half of his patients would not have sought a plastic surgeon were it not for the ads" (Lefton, 1985, p. 17).

Other surgeons may use different means of drumming up

³This text is quoted from the advertisement directed at men. The advertisement intended for women contains identical copy, with the exclusion of the words "successful, active and self-assured." The basic message of the two advertisements is essentially the same -- that cosmetic surgery will make one's life "look better." It is, however, interesting and important that the advertisers felt that men needed to be given specific examples beyond looking better to suggest why surgery could benefit them, whereas for women looking better is presented as a goal in and of itself.

business. In an editorial in the journal **Plastic and Reconstructive Surgery**, Goldwyn (1985) tells of a letter sent by one plastic surgeon to all his former patients, encouraging them to consider liposuction or breast augmentation or reduction in preparation for the "hazards of the beach." This concerned doctor avoided advertising fees and went directly to a source that he had good reason to believe would be more open and susceptible than the average person to his suggestions for cosmetic surgery -- his own previous patients.

Social Consequences

In performing and pushing cosmetic surgery, physicians not only suggest that patients' bodies and lives will benefit from restoration, they also reaffirm society's belief in the quest for the ideal appearance. They help to create the pressures on individuals to seek physical perfection, but "the quest for a perfect body may be unending, since it is based on a fictional norm. Normality actually includes bodily imperfections" (Stafford, La Puma, and Scheidermayer, 1989, p. 226). By denying the normalcy of bodily imperfections, physicians send a troubling message about appearance and disease. The interpretation of physical attributes which are deemed socially undesirable as somehow diseased is evidenced in journal articles on cosmetic surgery as well as advertisements and patient education brochures written by plastic surgeons. Facial wrinkles and loose skin, normal

features of the aging countenance become "aging abnormalities" (Psillakis, Rumley, and Camargos, 1988); Small breasts are "really a disease" (Porterfield, 1982); and some individuals are cursed with "deformities of the external nose, such as a hump on top of the nose, a nose that is too long or too wide" (AAFPRS, 1989).

Some of these "deformities" are characteristics common to persons of a particular ethnic heritage, and the treatment of them as deviant features is one of the most clear representations of the dangers of promoting a single beauty ideal. MacGregor (1974) outlines a study of elective rhinoplasty patients in New York in the late 1940's to early 1950's. 37% of the 89 patients studied were Jewish, most often second generation Americans, and many of them expressed wanting to change their appearance to look "less Jewish" and "more American." The reasons for this desired change included wanting to be more successful with the opposite sex, wanting to have a better chance in the business world, and not wanting to experience prejudice due to their identifiable ethnic background. Many also mentioned family or friends who had previously had the same procedure done, and said that "'Everyone is having it done -- it's a fad.'" Many of the non-Jews were people of other ethnic extractions (Italians, Armenians) who also sought the operation to prevent social and business difficulties associated with being identified as Jewish. Figure A, copied from a textbook in a series produced

by the American Academy of Facial Plastic and Reconstructive Surgeons, further indicates how much the "beauty ideal" promoted by cosmetic surgeons is in fact a very young, white, northern European beauty ideal.

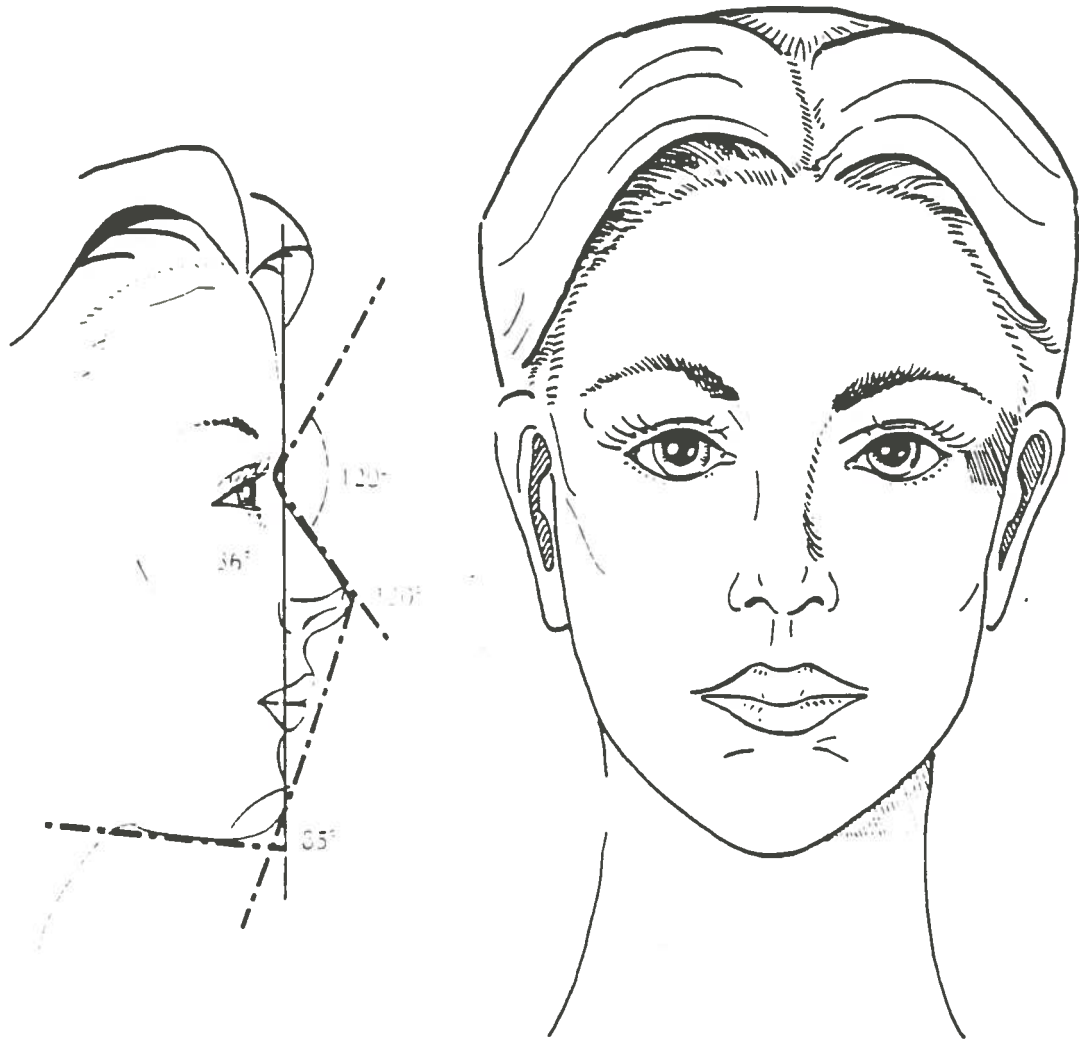


FIGURE A. The "ideal female face." From Powell and Humphreys, 1984, p. 64.

The cost to society of this limited acceptance of diverse appearances is immeasurable. In another sense, however, the cost of cosmetic surgery as a social phenomenon is more concrete. Medical schools spend over \$6 billion a year on instruction of students (Jolin et al, 1992). Currently, less than 4.2%, or just over \$882 million, of medical school revenues come from tuition paid by students (Ibid). Thus, each of the roughly 65,000 medical students in any given year (Jonas, Etzel, and Barzansky, 1992) is the beneficiary of over \$79,000 in revenues contributed from other sources. After four years of medical school, this comes to over \$300,000 per student, and after several years of residency, during which a new physician is paid while he or she is training, the monetary cost to society of educating a single plastic surgeon, dermatologist, ophthalmologist, or otolaryngologist is obviously extremely high.

The decision to invest this much money in physician education is undoubtedly based on a belief that physicians will, by virtue of their training, be able to contribute something valuable to society in return. Yet America continues to experience a grave shortage in primary care physicians, particularly in inner city and rural communities, but has an abundance of specialists (Council on Graduate Medical Education, 1988). Physicians who complete their medical training and choose to ignore the desperate health care needs of millions of Americans, instead applying their

training to the correction of cosmetic "problems" and bringing home over \$200,000 a year in the process, are getting more from the system than they are giving back.

Cosmetic surgery as it is practiced today degrades the medical profession to the extent that it acts against medicine's proscribed mission: to serve the health of individuals and the community. It permits physicians to perform procedures that fulfill non-medical goals, with little regard as to the therapeutic value of these services. Many cosmetic surgeons seem to be more concerned with maintaining their patient population (and thus their income) than with promoting and preserving health. By promoting a narrow standard of beauty rather than health, cosmetic surgeons, as physicians, send the message that the two ends are equivalent. This interferes with the goals of good medicine, robs the profession of its dignity, and contributes to the social problem that causes cosmetic surgery patients to seek help in the first place.

Chapter 3

Women and Appearance in American Society

The Psychology of Physical Appearance

The belief that plastic surgery will positively influence one's life or psychological well-being involves some assumptions about the effects of one's appearance. Both the patient and the surgeon must feel that physical attractiveness offers a significant degree of social or psychological benefit in our society. Until relatively recently, these assumptions were based largely on anecdotal evidence. Thanks to an enlarging body of research, the psychological implications of both facial and body appearance are becoming more clearly understood.

Physical attractiveness does seem to play an important role in the way individuals are perceived, judged, and treated. Several studies have shown that attractive individuals are believed to possess more positive characteristics, such as kindness, strength, sociability, sexual warmth, responsiveness, modesty, and flexibility, than their less attractive peers (Adams, 1982; Adams, 1977; Berscheid and Gangestad, 1982; Hatfield and Sprecher, 1986). Further, attractive people are presumed to have better jobs, more successful interpersonal relationships, and happier and more fulfilling lives (Berscheid and Gangestad, 1982). This association of physical attractiveness with a range of

positive personality traits and life circumstances is often summarized as "what is beautiful is good," an assessment based on an early and oft-quoted study of the phenomenon (Dion, Berscheid, and Walster, 1972). Subsequent research has supported the association, but indicates that the issue is not so simple. What is beautiful is often good, but not always, and beauty may have different social meanings for women and for men.

Appearance-based stereotypes affect human interactions throughout the life span. Cute infants get more attention and possibly more nurturing from adults (Adams, 1982; Berscheid and Gangestad, 1982). They are expected to be more sociable, easier to care for, more active and more competent (Karraker and Stern, 1990), as well as smarter, more likable, and well-behaved (Stephan and Langlois, 1984). Attractive children receive more frequent and focused attention from teachers (Adams, 1982), are expected by adults to have greater competence and social skills (Dusek and Joseph, 1983), and are judged by their peers as more socially acceptable and more desirable as friends (Berscheid and Gangestad, 1982). Teachers give better-looking children higher performance ratings, and the operation of an appearance based stereotype is implicated by the failure of these children to do better than their peers when tested by somewhat more objective means, such as I.Q. tests (Hatfield and Sprecher, 1986).

The appearance stereotype continues into adulthood, and

may affect many aspects of people's lives. Walster, Aronson, and Abrahams (1966) found that physical attractiveness, far more than intelligence, social skills, or personality, determined how much men and women liked their partners in a computer-arranged blind date situation. Longer durations of interaction (and presumed better knowledge of personality traits) may have surprisingly little influence on the importance of appearance in dating situations; Mathes (1975) found no significant influence of a negative personality characteristic (anxiety) on the importance of physical attractiveness in assessment of an assigned partner even after a five-session dating period. For either sex, greater physical attractiveness of a stranger of the opposite sex promotes greater liking of that stranger, but this effect is clearly more prominent when men make attractiveness judgments of women (Feingold, 1990).

Attractiveness also influences interactions between people in situations other than dating. Research suggests that attractive people are more likely to receive job offers, to be assessed as competent when performance is poor, and to be found innocent of crimes in mock trial situations (Adams, 1982). Observers expect attractive married couples to have more successful and satisfying marriages (Tucker and O'Grady, 1991). Students expect more attractive professors to be better teachers, to offer more assistance to their students, and to be less likely than unattractive professors to receive

blame if their students fail (Romano and Bordieri, 1989). Attractive male and female politicians are expected to be more competent (Lewis and Bierly, 1990). In a mock sexual harassment trial, Castellow, Wuensch, and Moore (1990) found that subjects of both sexes tended to vote in favor of an attractive plaintiff if the defendant was unattractive and in favor of an attractive defendant if the plaintiff was unattractive. In other words, an attractive woman is more believable as the victim of sexual harassment and an attractive man is more believable as the victim of a false sexual harassment claim. A similar benefit of physical attractiveness has been found for plaintiffs and defendants in rape cases (Jacobson, 1981 and Jacobson and Popovich, 1983).

Men and women are not always equal beneficiaries of the physical attractiveness stereotype, however. As stated earlier, attractiveness seems to be more important to men when they assess women in social settings than vice versa, and women are more likely to believe that physical attractiveness is an important personal attribute (Hatfield and Sprecher, 1986). The greater tendency of men to value physical attractiveness of the opposite sex may occur not only in the setting of interpersonal relationships, but also in other contexts, for example, evaluation of opposite sex politicians (Lewis and Bierly, 1990). In addition, attractiveness is less reliable in non-dating settings as an asset for women. Heilman and Saruwatari (1979) found that attractiveness helped

men receive higher evaluations as potential employees for either managerial or clerical jobs. For women, attractiveness helped when the job was clerical but hurt when it involved managerial work. A similar phenomenon occurred when MBA student subjects were asked to evaluate performance reviews and make personnel recommendations for supposed female employees: greater attractiveness enhanced the ratings for women in non-managerial positions, and diminished the ratings for women managers (Heilman and Stopeck, 1985b). For women who are successful as managers, attractiveness may lead others to attribute their success to reasons other than ability. Heilman and Stopeck (1985a) found that attractive females in managerial positions were judged less capable than their less attractive peers, and more likely to have advanced in their careers by means other than skill or talent. For men, attractiveness had the opposite effect, the one expected by the general "beauty is good" stereotype. That is, attractive male managers were assumed to be more capable, and their success was more likely to be attributed to ability, compared to unattractive men.

Appearance may be a double-edged sword for the physically attractive of either sex. Cash and Janda (1984) propose a "what is beautiful is self-centered" aspect of stereotypes about attractive individuals, based on the tendency for attractive people to be labeled as vain or egotistical. Men may also view attractive women as having less interpersonal

sensitivity and less social concern than unattractive women (Tanke, 1982). While attractive individuals are expected to have more satisfied marital partners, they are expected to be less satisfied or happy in marriage themselves (Tucker and O'Grady, 1991). Attractive men are seen as more likely to have affairs (Ibid), and attractive women are judged more harshly on a morality scale when they have premarital sex, especially when they have sex with a recent acquaintance (Hocking, Walker, and Fink, 1982). While a beautiful woman may be more likely to be believed as a victim of rape, she may also be judged as being more responsible for provoking the attack than a less attractive woman, and may have a more difficult time obtaining a conviction (Jacobson and Popovich, 1983).

In addition, it is not clear how advantageous good looks are psychologically. Attractive people have been found to be more assertive and self-confident and to have more positive self-concepts and better mental health status than unattractive people (Berscheid and Gangestad, 1982). Adams (1977) found that for both men and women self-acceptance was related to increased attractiveness, but Mathes and Kahn (1975) found that physical attractiveness was correlated positively with happiness and self-esteem and negatively with neuroticism for women only. Actual appearance may have less to do with self-esteem than satisfaction with one's appearance (Hatfield and Sprecher, 1986), and people who overestimate

their own attractiveness have been shown to have higher self-esteem than accurate estimators (Gurman and Balban, 1990). There may also be psychological hazards associated with being beautiful. For example, beautiful people are more likely to be interested or absorbed in their own appearance (Hatfield and Sprecher, 1986), and may actually be more worried about their looks and expend more energy on them than people of average attractiveness (Glassner, 1988).

In a meta-analysis of the physical attractiveness literature, Eagly and her associates (1991) found that while the "what is beautiful is good" stereotype held true, the strength of the effect varied greatly across different research settings. In particular, they found that "[g]ood looks induce strong inferences about social competence and weaker inferences about potency, adjustment, and intellectual competence, but have little impact on beliefs about integrity and concern for others" (p. 124). Judgments based on attractiveness may also be modified by the nature of the interaction between the subject and the person being judged. Tanke (1982) found that when men expected to meet with women whose photographs they viewed, differing levels of attractiveness had less influence on their assessment of personality than when they did not expect to meet the women. Thus, the expectation that one will have more contact with another person and thus be exposed to more variables by which to judge that person may reduce the emphasis one places on

attractiveness.

There are also aspects of attractiveness which may not be represented accurately by the photographs which are often given to research subjects for assessment of appearance. These characteristics include dynamic aspects of appearance, such as facial expressiveness, conversational skills, sense of humor, and other interpersonal abilities. Thus, it is possible that while the physical attractiveness stereotype is consistently reproducible in research settings, it may not be as applicable in real life situations. There is some support for this view. Riggio and his colleagues (1991) found that evaluations of overall attractiveness were strongly influenced by dynamic aspects of attractiveness as well as facial appearance. Infant cuteness and the positive attributes associated with it are in part based on facial expressions of emotion, not just general appearance (Karraker and Stern, 1990). Furthermore, when characteristics other than physical appearance are known, they may significantly influence observer ratings of individuals. Although appearance strongly affected observer expectations about marital stability, relative intelligence of partners in marriage had an even more profound influence (Tucker and O'Grady, 1991). Despite the presumed connection between ability and appearance, physical attractiveness was found to have no bearing on grade point average among women at a small college at which students had a significant amount of interaction with professors and grades

were largely based on in-class performance and evaluation of written assignments (Baugh and Parry, 1991). It is possible that in this real-life setting, evaluators were able to use their personal knowledge of students, developed over a long period of interaction, to nullify any assumptions made on the basis of appearance.

It has been proposed that the effect of appearance will become weaker as the research setting moves from structured and unnatural conditions, those in which subjects are invited to stereotype personality and formulate behavioral expectations based on the photographs of others, toward observations of more practical assessments of interpersonal behavior in natural settings (Eagly et al, 1991). This hypothesis certainly deserves attention, but it should be remembered that interactions between persons are often brief and superficial, even when important evaluations may be made. For example, college applicants may be asked to enclose a personal photograph with their application materials, creating an evaluation environment for the admissions committee much like that in the previously mentioned study on men and women job applicants (Heilman and Saruwatari, 1979). At least some of the current evidence suggests that appearance stereotypes do impact on real-life judgments, as in Stewart's (1980) observations that physical attractiveness ratings predicted the severity of judges' sentences of criminal defendants, with more attractive defendants receiving more lenient sentences.

Goldman and Lewis (1977) found that when men and women were rated by opposite sex partners after a telephone conversation, the more physically attractive individuals of both sexes were considered more socially skilled and more likeable, even though the partners never saw each other. Both well-being and achievement, as measured by income, education, and occupational prestige, were positively correlated with attractiveness in a national sample (Umberson and Hughes 1987).

Thus, it seems that at least some elements of the "what is beautiful is good" stereotype have a kernel of truth. It is certainly possible that individuals learn to expect better-looking people to be more successful, happier, and more socially skilled from experiences in which this is the case.

The converse may also be true: physically attractive people may be treated differently because of the stereotype and thus have greater opportunity to develop these favorable characteristics and life circumstances. Children may begin to perceive from a very early age that adults are more attentive to their attractive peers, and may learn to emulate this behavior, particularly when they may receive favorable assessment simply by association with an attractive social partner. They may also receive the implicit message that this preferential treatment of the attractive is warranted; the beautiful must have more appealing traits if they are deserving of such treatment. As these expectations and

behaviors are reinforced throughout the lifetime, the physical attractiveness stereotype may become a sort of self-fulfilling prophecy.

Beauty and Culture

In addition to these social and psychological influences on attractiveness stereotypes, cultural attitudes about beauty may profoundly affect perceptions, expectations, and treatment of attractive and unattractive individuals. Just as children begin learning about the social implications of appearance early in life, they also begin receiving cultural images of beauty and ugliness at young ages. Fairy tales are filled with mean and ugly step-sisters and hideous wicked witches. Their heroes are handsome, powerful princes, their heroines beautiful but kind and humble girls. When an ugly character (usually a male) is portrayed as having positive characteristics, his appearance often turns out to be the result of a witch's spell, from which he is released at the end of the story to be restored to his handsome, princely self (as in Beauty and the Beast). When a beautiful character (usually a female) is portrayed as evil, her evilness is often manifest as vanity (as in the stepmother in Snow White). It is easy to see how similar these messages are to actual physical attractiveness stereotypes.

Television, the movies, and print media are also filled with strong images of beauty. Professionally and socially

successful characters, particularly when they are central characters in a plot, are most often portrayed by attractive actors. Attractiveness stereotypes are especially common in advertisements, which use beautiful models in desirable settings or with desirable possessions. Downs and Harrison (1985) found that over one quarter of all television advertisements contained a reference to attractiveness, and one in 10.8 contained a "direct message that beauty is good, important, valuable, and so on." Even advertisements for products seemingly unrelated to appearance -- advertisements for food and drink, household products, and various businesses -- employed the association of their product with some concept of attractiveness as a marketing tool.

Cultural representations of beauty also reflect the gender differences in society's attractiveness stereotypes. Even in the 19th century, beauty manuals equated femininity and womanhood with beauty (Banner, 1983). In the Downs and Harrison study cited above, female performers were far more likely to be associated with attractiveness stereotypes than male performers. The Miss America Pageant and other beauty contests serve as reminders of how much emphasis is placed on beauty for women in modern American culture. Although other qualities are supposed to be important in these competitions -- talent, social values, compassion, intelligence -- beauty is the central and absolutely essential attribute that determines who will win, or who has a right even to enter. Thus, beauty

is an essential quality of the feminine ideal, not simply a feature which might give the possessor social advantages.

Women's magazines are among the strongest cultural promoters of these images of women. In 1960, Vogue told its readership, "And to anyone who clings relentlessly to the Puritan whimsy that looks don't matter, we wish to say, 'Face facts, they do. If you haven't quite got all you need, go out and buy them.'" (Lakoff and Scherr, 1984, p. 64). Thirty-two years later, in 1992, Cosmopolitan sent its readers the slightly more up-to-date message, "You don't have to look like the woman on the cover of this magazine to have a super life - - just look as good as you can" (Brown, 1992, p. 16). In other words, looks still matter, and although women needn't look like fashion models to be happy and achieve great things, it sure does help. In the end the advice is still the same: be concerned about your appearance and do everything you can to achieve the ideal if you want to get ahead in life. Unfortunately, for most women that ideal is discouragingly far from reality. A study comparing fashion models with college students found that the average female model is 5 feet, 9.5 inches and weighs 122.8 pounds, or 5.5 inches taller and 3.4 pounds lighter than the average female college student (Williams, 1992). The average woman would have to grow nearly half a foot and lose over 10 percent of her per-inch body weight to reach the fashion world's ideal.

This media focus on women's appearance is often

attributed, at least in part, to the efforts of multi-billion dollar beauty industries to maintain and expand their markets. "Women's magazines for over a century...have consistently glamorized whatever the economy, their advertisers, and, during wartime, the government, needed at that moment from women" (Wolf, 1991). As the cosmetics, weight control, skin care, and similar industries have become increasingly more profitable and thus more influential as purchasers of advertising space, magazine editors have responded with images of women that send the message "that women must look a certain way to be loved and admired -- to be worth anything" (Lakoff and Scherr, 1984, p. 114).

The feminist movement was perceived as a real threat to the ability of marketing efforts to convince women of the importance of their appearances, since it gave women a greater sense of independence and self worth and emphasized women's abilities rather than their looks. America's sense of the importance of women's beauty was in fact used as a tool against feminism, both in media coverage which portrayed feminists as ugly, bitter women, and in comments which drew attention to the attractiveness of some feminist leaders. Whether the emphasis is on the beautiful or the homely, "[i]n drawing attention to the physical characteristics of women's leaders, they can be dismissed as either too pretty or too ugly" (Wolf, 1991). Thus,

"...[Gloria] Steinem's birthday smile adorned the covers of magazines precisely because her good looks are so enduring and so exceptional (despite her insistence that this is what fifty really looks like). In contrast to Steinem, Betty Friedan is not exhibited as a wonderful example of how to grow old gracefully" (Freedman, 1986, p. 209).

In addition, while women's magazines have responded to women's desires for substantive articles and a tone which emphasizes women's independence, these articles are still paired with images of women that emphasize appearance. For example, in the same issue of Cosmopolitan quoted above, the cover advertised articles on "25 Ways to Safeguard Your Job," and "How to Prevent Divorce -- Before Marriage," as well as one on "How to Glorify Your Bosom (Even if You Don't Have One)." While the latter article declared that "men will always be fascinated by breasts, so you can't afford to ignore yours," yet another feature in the same magazine listed "Men are Breast Obsessed" as number two among "10 Myths About Modern Men." It should be obvious how this myth, if it is one, is being propagated.

Advertisers are also able to temper the potential of feminism to undermine their efforts to keep women concerned about their appearances by changing the nature of the messages they send about beauty and its relationship to their products and services. Most modern advertisements and articles about beauty and beauty products fall into two main categories: those which emphasize the "naturalness" of their products and the look achieved by them, and those which characterize their

products as "scientific breakthroughs," and create the impression of a "science of beauty."

Advertisements which sell beauty as a "natural" endeavor adopt the pro-woman idea that one needn't look made up to be a worthwhile person. Yet they promote the idea that one can still only achieve the natural look with a certain amount of effort and expense. For example, Clarion's Sheer Illusion blush, promises "a truly lasting bloom that's incredibly **natural**" (their bold) and which will "stay remarkably real."

Also consider Cover Girl's Clean Make-up, whose very name implies that wearing it somehow makes one's skin cleaner, and whose advertisers call it "Natural. Believable. Beautiful.... So good to your skin. So clean." Maybelline recently ran a multiple page series of advertisements for various make-up products with the theme "Maybe she's born with it. Maybe it's Maybelline." Each page pictured a beautiful, made-up model and text suggesting that while "some women" are able to "achieve" certain beauty goals (perfect skin; smooth, supple lips; healthy-looking eyelashes), we should not assume that they are "born lucky," "born blessed," "clever," or that they are the beneficiaries of "natural talent," "heredity," or a "gift of nature." "Oh please," we are told, "Be serious." "Get Real." No one could look so natural naturally; of course these women use Maybelline.

Closely related to this idea that beauty products somehow produce a cleaner, more natural look than a naked face is the

idea that a more beautiful face, even if it doesn't come "naturally," is implicitly more healthy. Coty tells us that "there's a healthy new perspective on beauty," and "eye lashes need a fortifying boost to look healthy." Of course, Coty does not ask women to "fortify" themselves through diet and exercise, but through the application of their mascara. Similarly, St. Ives shampoo and conditioner ads suggest that their products not only make hair more beautiful, but also "have healing properties." Breck shampoos also promise to "nourish your hair" through the use of "vitasomes" containing "moisturizing nourishment."

Advertisements like these which employ health-related arguments for selling their products represent an overlap between the two main forms of beauty product promotion. Health is used as a synonym for "natural" in some contexts, but also symbolizes the final goal of medical science. Thus, Jergens Advanced Therapy Lotion contains a "pure form of your skin's natural lipids." Advertisements for this product, like many others, employ scientific-looking drawings of the microscopic structure of the skin to assist them in explaining how their product works. Other products use charts or graphs as scientific documentation that their products work. That is, they suggest that science has proven that one can be more beautiful by following certain beauty routines. Words such as innovation, patented, formula, and revolutionary, as well as lengthy descriptions of the scientific theory behind certain

products are also used to foster the perceived relationship between beauty and the cutting edge of science. Clinique offers "The System" and "The Clinique Computer" to help you scientifically analyze your own personal needs. Many products, such as Estee Lauder's Advanced Night Repair and the Physicians Formula line of products use the invisible environmental forces of the sun and pollution as reasons why you need their reparative and protective products. In a society which has a great deal of respect for scientific medicine and which believes in the power of science, including beauty in the realm of science makes it a somehow nobler and more important goal.

The physical characteristics of a woman, no matter how successful she is in her chosen field of work, remain important variables in judgments of her social worth. Even the most positive assessments of Eleanor Roosevelt make reference to her well publicized unattractiveness (Wolf, 1991). Freedman (1986) notes that at the time of her selection and induction as the first woman on the U.S. Supreme Court, Sandra Day O'Connor was described in newspaper reports as "good-looking," and representing a "balance of professionalism and femininity." Chief Justice Warren Burger remarked to photographers, "You've never seen me with a better-looking justice, have you?" If this kind of commentary is still considered appropriate in reference to some of our country's most respected and successful women, certainly women

with less revered careers are even more vulnerable to judgments based on appearance. Women anchorpersons continue to be expected to maintain stricter standards of beauty than men. Continental Airlines recently attempted to require their female ticket agents to wear a certain minimum of make-up, which they believed was a necessary element for a woman to look "professional." But for a successful suit by one employee who preferred to leave her face unenhanced by cosmetics, the company would have quietly reinforced the idea that "a woman needed to cover her skin and color her lips in order to work with the public" (Goodman, 1991).

Clearly, especially for women, physical appearance retains an important place in our society and culture. Images of beauty are tied to images of health, success, and happiness, and research indicates that not only do people believe in the connection suggested by these images, but in at least some circumstances they apply it when they assess the social value or desirability of others. Images of beauty and stereotypes about attractiveness act in concert to press women to conform to a specific standard of appearance, and the choice to have cosmetic surgery may simply be one of the many ways in which this behavior is manifest.

Chapter 4

The Possessor of the Aging Face:

Attractiveness and the Middle Aged Woman

The Psychology of Appearance in the Middle Aged Woman

While appearance may be socially and psychologically important to a woman at any stage of life, it may have unique meanings as she enters middle age.¹ No matter how a woman feels about her appearance when she is younger, she may re-evaluate her physical self as she ages and receive different feedback from others as a result of her changing appearance. For both men and women, self-evaluations of attractiveness tend to decline with age (Tiemersma, 1989). Changes in body image generally lag behind changes in actual appearance, and middle-aged and older people often indicate that they feel a discrepancy between the way they look and the way they feel (Hyman, 1986; Whitbourne, 1985). Furthermore, changes in appearance due to aging may be important not only as they relate to attractiveness, but also as reminders of one's advancing years.

The "beauty is good" stereotype has been shown to apply

¹The years which comprise "middle age" or "midlife" are variously considered to fall anywhere between roughly age 30 to age 65. Some theorists further break up the middle years into early, middle, and late stages. For the purposes of this discussion, the terms "middle age" and "midlife" will be used to represent the middle part of this span, or roughly ages 40 to 55. This difficulty with defining middle age serves as a reminder that in fact development does not follow a strict chronology, and is more dependent on individual variables than such definitions will allow.

to middle aged people (Adams and Huston, 1975), and appearance remains important to people as they grow older. A study of adults eighteen to ninety years of age found that older people believed more strongly than younger ones that physical attractiveness is important in selection of marriage partners and friends, marital happiness, and success (Hatfield and Sprecher, 1986). Thus, there are many reasons to believe that as women enter and progress through their middle years, their appearance will be of psychological significance.

There is clearly a double standard of aging in our culture which suggests that women are less socially and sexually desirable than men as they grow older, and that women's desirability begins to decline at an earlier age. In general, older characters and older actors are under-represented in movies, television programs, magazine articles, and advertisements (Powell and Williamson, 1985). Those television programs which contain older characters often cast them in roles of dependence and associate their age with failing health, ugliness, unhappiness, dependence, foolishness, and reduced social opportunities (Powell, and Williamson, 1985; Vernon, et al, 1990). Vernon and her colleagues (1990) found that for every middle-aged female character represented on television programs there were 3.35 male characters in the same age range, the largest ratio of male to female characters for any age group. They also found that while men aged 50 to 64 appeared in leading roles in many

programs, their wives were generally ten to fifteen years younger. This is consistent with the idea that men remain powerful and desirable in middle age, while women must remain relatively youthful to retain social worth.

Advertisers portray aging in an equally unfavorable light, and emphasize the importance of retaining a youthful appearance and preserving youthful characteristics. In an analysis of advertisements in five popular magazines from 1960 to 1979, only 4% of the women characters were estimated to be over 40 years of age, while 57% of women in the actual population are 40 or older (England, 1981). Glassner notes that "middle-aged women violate the myth that everyone can be young until becoming truly old, and that beauty is something available to anyone who will work for it." A 52 year old model he interviewed discussed the dip she was experiencing in her career. She was too old to be portrayed as a young or even "overtly middle-aged" woman, because this would "remind the consumer that, no matter how much she spends on running shoes, cosmetics, clothing, or beauty programs, there's no cure for growing older" (p. 37). Older women are generally considered "bad copy" in a society that fears the loss of youth and the positive things associated with it (health, beauty, sexuality, energy, power, societal purposefulness), and does not want to be reminded of these fears by exposure to aging characters.

The great exception to this rule of limited appearances

of elderly characters is in advertisements which take advantage of and foster these negative stereotypes about aging. For example, advertisements for products designed to minimize the effects of normal aging, such as hair dyes and wrinkle creams, often appear during evening newscasts when a relatively high proportion of older adults are expected to be among the viewing audience (Hess, 1980a). Advertisements directed specifically at the aging population appeal to the "young person within," suggesting that the elderly should attempt to be as much like the young as possible -- that they should try to "stop the clock," to use products designed to eliminate or reduce the biological effects of aging, to remain "young at heart." Advertisers ask women if they can compete with their daughter's looks, and encourage them to protect their girlish complexion and figure (Freedman, 1986; Lakoff and Scherr, 1984). A recent television advertisement for a complexion cream indicates that it is no longer appropriate to "grow old gracefully," but that one should "fight it all the way." The beauty industry has a vested interest in encouraging an intensely age-aware society and making older people, especially women, feel ashamed and inadequate if they look and act "their age."

The media stereotype that age is negatively correlated with attractiveness is supported by several studies. Korthase and Trenholme (1982) found that perceived age was negatively correlated with perceived physical attractiveness for young,

middle-aged, and older adults. Similarly, attractiveness ratings of women aged 20 to 70 years steadily declined with increasing age of the target in a study by Walsh and Locke (1980). The double standard of media stereotypes is also reflected in some studies, which show a significantly greater differential in observer ratings of physical attractiveness between younger and older women than between younger and older men (Deutsch, Clark, and Zalenski, 1983; Milord, 1978).

Other studies, however, have failed to confirm a difference in judgments of attractiveness of middle-aged women and middle-aged men (Cross and Cross, 1971; Adams and Huston, 1975). Berman, O'Nan, and Floyd (1981) suggest that research conditions may influence subjects' ratings in these studies. They found that young men and women rated the physical attractiveness of middle-aged women differently depending on whether they were in same-sex, mixed-sex, or private settings. In particular, they found a striking difference between the ratings given by young men in all-male groups as compared to men making ratings privately; when their same-sex peers were aware of their responses, the young men rated middle-aged women considerably lower than when their ratings were not known to others. This has implications not only for expected results in varying research settings, but also for speculations on how physical attractiveness stereotypes of middle-aged women might operate in real life.

Evidence that individuals, particularly women, in

American society actually experience negative social and psychological effects as a result of aging-related changes in appearance is largely anecdotal (Hyman, 1987; Lakoff and Scherr, 1984; Moss, 1970; Vernon, 1990; Wolf, 1991), but the theory that these physical changes and their cultural association with loss of attractiveness may cause disruption in body image for some women is consistent with Adams' observation that:

"it is during periods of asynchrony between inner and outer progressions that leaps in development are likely to occur....[P]sychological reorganization is most likely to occur when facial or body features become incongruent with social standards or past physical features" (Adams, 1977, p. 232).

Since aging related changes in appearance represent both a shift away from past features and a shift toward the less socially desirable appearance of an older woman, it is understandable that psychological reorganization at this time might involve dissatisfaction with one's appearance and the desire to retain more youthful features.

Women's Development at Midlife

A variety of developmental events other than changes in physical appearance may influence a woman's experience of this time in her life and her satisfaction with her self and her body. Despite the importance of this time of life and the fact that it may be defined as virtually half the lifespan, it is probably the least studied period in development.

Furthermore, research and theories of development over the life course have traditionally been based on male development, and have either attempted to extrapolate concepts directly to women or have altogether ignored female development. More recently, feminist and other researchers and theorists have begun to focus more specifically on women's lives. It is primarily this body of work that forms a basis for thinking about women's development at midlife.

A recurrent finding in studies of female development is the importance of relationships and connectedness with others (Gilligan, 1982a; Chodorow, 1974, 1978; Josselson, 1987; Giele, 1982). In other words, "feminine personality comes to define itself in relation and connection to other people more than masculine personality does" (Chodorow, 1974). Women tend to view others and themselves more in terms of interdependence, and to base their definitions of identity on relationships. Thus, issues of change in relationships and change in social roles that may occur during midlife seem particularly relevant to women's experience of themselves during this period.

Middle age is often described as a time of stocktaking, or evaluation of one's past experiences and accomplishments and one's current roles (Lidz, 1983; Schulz and Ewen, 1988). This concept of stocktaking should be distinguished from the concept of a "midlife crisis," which is frequently discussed in the popular press and to a lesser degree in aging research

and theory. The crisis model proposes an abrupt and dramatic change in personality or outlook on life based on reassessment of one's achievements and goals, and involving concern with time running out for further accomplishments and experiences. While the middle adult years may in fact involve personality change and reassessment, there is no longitudinal evidence which indicates that personality is less stable during this time than any other in adult life; in fact, a "crisis" period may occur at any time in life, and young adulthood seems to involve far more personality change and emotional dilemma than later years (Hunter and Sundel, 1989). For women, when crisis does occur it tends to be in the early thirties to early forties, rather than in the later years (Hunter and Sundel, 1989; Helson, 1992). The issues implicated in the crisis model are probably relevant to stocktaking, but psychological adaptations to midlife typically occur gradually throughout adulthood rather than as a sudden, crisis-like event. Thus, internal conflict and change in midlife are more appropriately viewed in terms of transition than crisis, and emotional tumult of crisis proportions should not be accepted as the norm.

One of the prominent areas in which women in midlife may be expected to take part in stocktaking concerns relationships with their children. Since many women begin childbearing in their twenties or early thirties, this is a time at which children are becoming more independent as they progress

through adolescence and into young adulthood. Much has been written about the transition to the "empty nest," and the implicit task of emotional separation and decline in the nurturant role for women. The belief that this transition will cause significant turmoil and distress for most women has not been supported in the literature (Hunter and Sundel, 1989; Helson, 1992; Mitchell and Helson, 1990). On the contrary, Mitchell and Helson (1992) found that living alone with a partner (that is, with no children in the home) was significantly correlated with self-assessed quality of life for women in their early fifties. Most women seem to focus on their children's newfound independence as an enabling element for their own independent activities. For them, the transition to the empty nest may be seen as a period when they are free to invest more time in their own interests outside the home, for example by more vigorously pursuing a career, seeking higher education, or through other activities. In addition, many women view the empty nest as the culmination of a major purpose in life, to raise and provide a home for their children, and feel an amount of pride and accomplishment in completing this task successfully as well as relief at having this responsibility removed from their shoulders.

It is likely, however, that for at least some women the "myth" of the empty nest is to a certain extent a reality. Clearly, the transition will entail changes in the structure of a woman's daily life and activities, especially if the

traditional roles of wife and mother have been very prominent in her life. Most women probably feel a degree of loss and emptiness, regardless of whatever positive outcomes they experience. Brown and Kerns (1985) note that while in many cultures middle age and the end of the childbearing years bring increased status for women, in most industrialized societies this is not the case. This is in part because in societies like ours there tends to be a greater severing of ties between mother and offspring when the offspring leaves the home and becomes independent. The relative role of negative emotional aspects of the empty nest may increase if a woman has been especially attached to her children and focused an unusually large amount of her emotional energy on them, for example as a result of the death of her spouse. Similarly, if she has regrets or doubts about how successfully she has completed her role in raising her children or if conflict exists in her relationship with a child, the end of this phase of motherhood and the self-reflection it prompts may be sources of dissatisfaction or self-criticism.

A woman's relationship with her husband or other long-term partner may change in a variety of ways in midlife. Research indicates that marital satisfaction declines while children are in the home, presumably as a result of associated life stresses, and then increases again once they are gone (Rollins, 1989). A similar pattern has also been found for the amount of marital communication and amount of marital

companionship in marriages, and it is postulated that the demands of childrearing may interfere with these important aspects of the marital relationship (Rollins, 1989). Thus, for many married women, the empty nest can be seen as an opportunity to become closer to or rediscover their partner. Mitchell and Helson's previously noted finding that living with a partner only was correlated with quality of life in midlife women suggests that continuity of such a relationship, even if it involves some problems, can be an important factor in a woman's happiness. Certainly, this is consistent with the view that relationships and connectedness are central to women's identity processes.

For some women, however, a strong love relationship is not a reality in middle age. High divorce rates and the somewhat greater tendency for individuals to never marry have helped to make single or post-married status common for middle aged women. While divorce rates decline for women and men as they age, the total number of divorced people is much greater in middle age than in earlier years (Rollins, 1989). Divorced women have been shown to have more symptoms of stress than married women (Schulz and Ewen, 1988), and re-establishing a satisfying heterosexual love relationship may be particularly difficult for middle aged women. Chandler (1991) reports that in Great Britain remarriage rates are 58 per 1,000 for men and only 22 per 1,000 for women. This is a reflection of the greater number of single adult women than men that results

both from men's higher mortality rates at younger ages and from differences in social desirability that make it far easier for an older man to establish a relationship with and marry a younger woman than for an older woman with a younger man. Surely, in the cases in which "mid-life brings an end to relationships, to the sense of connection on which she relies, as well as to the activities of care through which she judges her worth" (Gilligan, 1982), a woman's self concept will undergo a more dramatic period of restructuring.

For women who have pursued careers instead of having families or who continued to work while their children were still young, stocktaking in middle age will also involve this aspect of their lives. Have they achieved what they set out to achieve, and if so, are they convinced that the original goals were appropriate? Satisfaction in the workplace, pride in one's abilities and achievements, increased financial success, and the respect of colleagues can add to a woman's self esteem, particularly as she gains experience and prestige. Experience may enable working women to take a more relaxed approach to their work, or it may inspire them to work harder and strive for top positions in their field. For women who are dissatisfied with their work or workplace, stocktaking may result in a decision to change jobs or the course of their career. This can be an exhilarating and gratifying experience, but may also cause a certain amount of anxiety over one's abilities or about the risks involved with making

such a significant change. As women move through middle age, difficulties in the workplace, and especially losing or quitting a job, can be particularly stressful. If she has been very successful or has specialized knowledge or skills, an experienced professional or working woman may have little difficulty finding new employment, but in general it is much more difficult for older individuals to become employed than younger ones (Schulz and Ewen, 1988). Thus, financial and job security may become important issues for middle aged women. This may be especially true for women who are single, divorced, or widowed.

Just as possibilities for relationship status have expanded for middle aged women, so has the range of women's involvement in work outside the home. In general, the percentage of women who are employed during their middle years has continuously increased since the 1950's, so that now over 60% of all middle aged women are in the labor force (Giele, 1982b; Schulz and Ewen, 1988). However, while a little more than a third of women have continuous patterns of work (that is, once they enter the workforce they do not leave it), more women than men experience a broad variety of patterns of work periods interspersed with non-work periods (Corcoron, 1978). These periods of non-work may represent such events as childbearing and greater investment in childrearing, pursuit of further education, or reduced financial incentives to work as a result of changes in a spouse's employment status or pay.

This variability in women's employment patterns suggests how difficult it is to define a "normal" life course for modern women. Giele (1982b) notes that young women attempting to plan their own lifecourses are faced with both the feminine mystique and the feminist mystique; they want both a successful career and a rewarding family life. Some researchers have attempted to define a normal life path or a "social clock" which offers those who adhere to it, who experience life events "on time", advantages in terms of well being (Neugarten, 1979; Rossi, 1980; Elder and Rockwell, 1976; Helson and McCabe, 1991). Much of this work indicates that there can be psychosocial costs for deviating from the normal lifecourse, but some indicates that happiness and satisfaction may also be achieved by following any of a number of different courses (Giele, 1982b).

A rigid concept of the social clock is probably not useful in assessing positive development for women, particularly since their roles inside and outside of the home are becoming increasingly varied. In their study of middle age women, Helson and McCabe (1991) found that the heterogeneity of individuals limits our ability to order developmental tasks, and that in the women they studied personality resources were more important than the ordered completion of tasks in determining adaptation to midlife. Giele (1982b) also suggests that the depth and variety of women's experiences, rather than the order in which they

occur, determines adaptability. While the experience of some events at non-normative times may be disruptive to the life course (for example first pregnancy during teenage years), there is not one path or series of choices which guarantees greater success than all others.

In addition to changes in a woman's social, family and work life, physical changes that take place as women enter and progress through middle age are also important in the assessment of the self. One of the most controversial topics in women's development is the role of the menopause in women's psychology. Cultural stereotypes portray menopause as an event which is upsetting to women both because of the physiological changes which may occur -- including the irregularity of menses, unexpected "hot flashes", sweating, headaches, and emotional lability -- and because of its psychological impact (see for example Sheehy, 1992; Fuchs, 1977). While some scientific literature on menopause indicates that it can be somewhat distressing, much research indicates that in fact menopause is a welcome or neutral event for most women (Dan and Bernhard, 1989; Giele, 1982a; Lennon, 1987; McKinlay and McKinlay, 1986). It seems that menopause is viewed far more negatively by outsiders than by those who actually experience it.

Yet these negative stereotypes probably do affect the way many women approach menopause. As Sheehy (1992) notes, prominent among the fears that women may have about the

consequences of menopause are "I'll lose my looks, I'll lose my sex appeal, I'll get depressed, fade into the woodwork, I'll become invisible." Thus, even though the experience of menopause itself may not result in difficulties for most women, its onset certainly has the potential to evoke thoughts, feelings, and concerns related to identity and social roles. At the very least, menopause serves as a reminder or a marker that one is growing older, and especially if menopause comes earlier than expected, this transition may be seen as the abrupt onset of old age, the loss of one's youth and vitality. This is consistent with our society's tendency throughout history to consider women old at menopause, when they cease to function in their traditional productive role as childbearer (Covey, 1988). The controversial but very common practice in medicine of considering menopause an "estrogen deficiency disease" and treating it with hormone replacement therapy may contribute to this overall sense that menopause represents aging and the failure of the body.

Menopause has also been characterized as a loss of femininity, consistent with the symbolization of menstruation as a "badge of womanhood" (Lidz, 1983). Since menopause often occurs at about the same time in a woman's life that her role as a mother becomes less central, she may feel that she is simultaneously losing her generative capacity and her maternal role, both of which are culturally defined as

important aspects of femininity. At least one study (Giesen, 1989) suggests that women's self assessments of femininity are not adversely affected by menopause, since they tend to increase with age. While numerous theorists have proposed a damaging effect of menopause on women's sense of sexual functioning and feminine worth, there is no conclusive evidence that this occurs.

Menopause and other aspects of aging may also evoke fears or concerns about decreased sexual functioning or changes in sexuality. Among the many myths about aging people are that they are essentially sexless -- that they cease to participate or be interested in sexual relationships. In fact, in a nationwide survey of over 4,000 people aged 50 and older, 93% of women and 98% of men reported that they remained sexually active, and 71% of women and 90% of men reported high enjoyment of sex. While it is true that physiologic and psychosocial factors may change sexual function and the nature of sexual interaction and may interfere with sexuality, most adult men and women find that their sexual selves are perfectly capable of adapting to aging. In fact, for women who are in relationships, interest in sex after menopause has been shown to remain high, and women often actually become more involved in initiating and directing sexual activity in a way that fulfills their own sexual needs (Weg, 1989). Probably the most important factor which contributes to women's decreased sexual activity is the decreasing likelihood

of having an available partner which is correlated with increasing age.

Finally, menopause as well as other changes in a woman's life may make her reflect on her physical health and well-being during middle age. Serious physical illness in herself, her partner, and her friends becomes increasingly likely, and minor physical problems occur with greater frequency. Active or athletic woman may be frustrated to notice that they are unable to perform at the same level as when they were younger, or that their bodies tire or are injured more easily. Women whose partners or close friends are diagnosed with heart disease, hypertension, or diabetes, or who notice that their contemporaries have begun to become seriously ill and even to die may take this as a sign that their peer group is now "old." Caring for elderly parents may become an important part of a woman's life in middle age, and the illness or death of one or both parents can be both an emotionally difficult circumstance and yet another ominous reminder of the aging of one's own body. A woman's attitudes about aging and health as well as her own actual health status will affect how she responds psychologically to these events. While there is little evidence that anxiety about impending death is a common issue for the middle-aged, a sense that time left is limited does seem prominent (Hunter and Sundel, 1989).

Surgery as a Response to Physical Aging

Since the middle years represent a time of physical and physiological change as well as social and psychological transition, it is likely that a portion of the reassessment of self in middle age will involve changes in body image. Procedures which reduce the visible effects of the aging face may be particularly popular forms of cosmetic surgery since they simultaneously enable women to move closer to cultural ideals of beauty, and serve as a response to the psychological reorganization which may occur as a woman experiences this period of change in her body and in her life. However, the choice of surgical "restoration" is not the response of all or even most women, and it is possible that certain social or psychological factors make cosmetic surgery a more appealing and more likely choice for some middle-aged women than for others.

Pertinent psychological characteristics might include excessive dependence on others, narcissistic personality traits² (including hypersensitivity to criticism and need for excessive attention and admiration), borderline personality traits (including instability of self image, moods, and interpersonal relationships), and poor body image. It is significant that most of these characteristics occur with

²It is possible that narcissistic personality disorder and borderline personality disorder are associated with utilization of cosmetic surgical procedures. The majority of cosmetic surgery patients, however, probably do not manifest full-fledged personality disorders, but may be more likely than average persons to have one or a number of the traits associated with these disorders.

greater prevalence in women than men or are more frequently thought of as feminine traits than masculine, and that most fit well with an identity that relies heavily on relationships and connectedness. There may be a risk of instability associated with an identity based on relatedness to others when there is sacrifice or inadequacy of independent identity or the inability to adapt when relationships change. This might also be reflected by a greater tendency toward cosmetic surgery in women who see their primary roles as typically feminine ones, especially if they define femininity in physical terms. Additionally, traits of obsessiveness and the need for control might also contribute to intolerance of physical aging and the desire to actively intervene through cosmetic surgery.

These psychological characteristics might be complexly related with social factors that influence a woman's decision about surgery. The myriad of possible changes in major personal relationships -- divorce, children leaving the home, death of a spouse or parent -- would affect women with strong systems of identity and adaptability much differently than women with less reliable self systems. Changes in marital status might be particularly important in disrupting a woman's sense of her physical self in middle age. Giesen (1989) found that married women compared to single women matched for age were more likely to define attractiveness in terms of physical attributes and less likely to believe that their

attractiveness and sexual appeal had increased over time. In this study, "middle aged and older women specifically mentioned physical age changes such as grey hair, lines and wrinkles, changes in facial contours and weight gain as the cause of their diminished attractiveness and sexual appeal" (p. 90). Single women did not consider these features important. Married women believed that women's peak years of attractiveness occurred in the early twenties to early thirties; single women placed the peak in the thirties to fifties. Thus, women who become single in middle age and wish to establish new love relationships may have a diminished sense of their own physical and sexual desirability relative to women who have been single for many years, and they may see themselves as more "in need" of cosmetic treatments. The precise social situation in which a newly single woman finds herself may also be important. A woman who divorces or is widowed and has a good social support network and many opportunities for positive social interactions will be much more equipped to cope with her loss than a woman who finds herself widowed or divorced and without these other social supports, and may thus experience less disruption in identity.

Yet cosmetic surgery may not only be related with these negative social changes, but possibly with more positive ones as well. It is possible that some women who experience or initiate major changes in midlife and experience a positive transition, a whole new outlook and set of life circumstances,

may consider cosmetic surgery a part of this "second chance." For these women, the act of ending a bad marriage, investing in a new career, and finding new interests and activities may inspire them to also "rejuvenate" their looks. Cosmetic surgery may be seen, in these cases, as a metaphor for actively erasing bad times and experiences of the past in the overall effort to rewrite a personal history.

Other social situations which may increase the likelihood that a woman will choose aging-related cosmetic surgery are employment in careers that emphasize physical attractiveness and youth, a social environment which stresses physical appearance or favors or encourages cosmetic surgery, and previous (and current) high levels of physical attractiveness. Careers for which a young, attractive appearance is overtly beneficial -- for example modeling, acting, broadcast journalism -- may encourage cosmetic surgery for several reasons. The size of a woman's paycheck or the likelihood that she gets and keeps a job in one of these fields may depend on such steps to preserve her appearance. Also, the very nature of these careers might foster a heightened awareness of the body and a tendency to objectify appearance, to see physical features as malleable and detached from the person within. Similarly, women whose social networks encourage concern for appearance or favor cosmetic surgery, (for example, women who have mothers, sisters, friends, daughters, husbands, etc. who have had procedures done in the

past and who openly and strongly support the decision in favor of surgery) may also be more accepting of the concept of physically altering the body. Finally, women who were physically attractive when they were young are on the average more concerned about their physical appearance and have more adjustment problems in middle age (Berscheid and Walster, 1974). They may therefore be more likely to seek to control changes in appearance as they grow older.

This overview is by no means intended to be a complete or detailed discussion of women's psychology in middle age or the psychology of changing the body. It is simply presented as a framework for thinking about middle aged female cosmetic surgery patients and how development, identity, and personality might be related to choosing cosmetic interventions. Research addressing psychological issues pertaining specifically to aging-related cosmetic interventions will be reviewed in the following chapter.

Chapter 5

Surgery as an Intervention in the Visible Aging Process

Just as there is no "typical" middle aged woman, there is probably no such thing as a typical psychological profile of the woman who responds to outward aging by attempting to reverse it surgically. This is probably increasingly true, as the surgical population expands to include an ever growing percentage of the general population. Each woman comes to her decision to have surgery with a unique set of conscious and unconscious motivating and mitigating factors. Yet cosmetic surgery is a medical intervention, and as such it seems appropriate to consider "risk factors" which predispose one person and not another to "need" it. As is the case for most cosmetic procedures, very little research has been done which elucidates psychosocial factors that are related to choosing aging-related plastic surgery.

The Psychology of Aging-Related Cosmetic Surgery: Motivations and Personalities of Patients

Two studies have explored the motivations and personalities of patients requesting facelifts. The first, (Webb, et al, 1965) reported that 48 out of a total of 72 patients in their sample were referred for psychiatric consultation. Of these, 70% were given a psychiatric diagnosis, most commonly emotionally unstable personality,

neurotic depressive reaction, or passive dependent personality. In addition, they found that the original sample fell into three general categories, which corresponded with patient age. The first group was called the "emotionally dependent group," and consisted of 22% of the sample, most of whom were aged 29 to 39 years. These patients had long-standing internal psychological conflicts, were insecure and dependent, and had difficulties assuming adult responsibilities. They had more current and past problems with adjustment and had experienced more significant family disruptions during childhood than the other patients.

The "worker" group contained patients aged 40 to 50 years and comprised about 37% of the total. Patients in this group had professional or semi-professional jobs, were intensely involved in their work, and were motivated for surgery primarily to retain a youthful appearance for their jobs. This group showed the greatest anxiety or ambivalence about aging.

The third group, the "grief" group contained the remaining 40% of the study population, and represented patients who were 50 years of age and older. Ninety percent of this group had experienced the loss of a spouse or other important person in their lives within the last five years, and 60% continued to have signs of grief. Patients in this group were described as extremely independent and likely to reject sympathy, and they sought surgery to enhance self-

confidence and help them make new friends.

The finding that the women in the youngest group tended to have more adjustment problems, to be more dependent and insecure, and to have stronger histories of family disruption during childhood suggests that women with these problems might be "ready" to choose surgery at an earlier age. Perhaps these women had increased difficulty adapting to new roles as they grew older and adjusting to a self concept which included looking (and being) middle aged. Certainly, for these women, the stocktaking phase of midlife might be a difficult process, and traits of insecurity and dependence would likely contribute to psychological distress over separating from increasingly independent children and remaining attractive to a spouse.

In addition, the dependence, lack of security, and histories of childhood family disruption suggest that these women may have poor identity formation with insufficient individuation. Helson (1992) found that women with less adequate ego-identity status reported experiencing their "most difficult times" in life earlier in adulthood when compared to other women. These women may be more vulnerable to identity disruption resulting from changes in their appearances at early ages, despite the fact that the "objective" changes in their appearances may not yet be great.

Webb et al.'s other two groups are centered around common social variables more than psychological ones, although

slightly more than half in the "grief" group shared not only the social reality of a lost loved one, but were also currently involved to some degree in the psychological experience of grieving. As previously discussed (chapter 3), the loss of a loved one, particularly a spouse, might represent a challenge to a woman's sense of identity in a number of ways. It is interesting that the "grief" group was considered to be extremely independent, a finding that is inconsistent with the assumption that women with a stronger sense of connectedness to others would be more likely to seek surgery in response to the ending of an important relationship. It is also interesting that despite this sense of independence, these women sought surgery in order to expand their social connections. The "worker" group in this study supports the idea that a substantial number of women seek surgery because they believe a more youthful appearance will be a benefit in the workplace, and that this motivating factor is more important for women who are especially involved in their work.

The second study of patients requesting facelifts (Goin et al, 1980) employed formal psychological testing (using Minnesota Multiphasic Personality Inventory [MMPI], Beck Depression Scale, and Fundamental Interpersonal Relationship Orientation-Behavior), as well as semistructured interviews with one of two psychiatrists (one of whom was the surgeon's

wife¹) to assess patients pre-operatively. According to MMPI scores, 76% of these 50 women had normal personalities; the remaining subjects had mildly abnormal MMPI scores with a variety of symptomatology, and none were overtly psychotic. The average patient in this study was 56, eight years older than in the Webb et al study. Fifty-four percent were married and living with their spouse; seventy percent of these reported good relationships with their spouses. Eighteen percent were widowed, twenty-four percent divorced, and four percent single. Most of the subjects were employed or retired from full-time employment. Four patients, or eight percent, were in the midst of grieving for a lost loved one.

Unlike the Webb, et al study, this study found very little psychopathology in the patients studied. The majority of these patients were psychologically normal, and when abnormalities in personality were present, they tended to be mild and varied within the population studied. Although the authors state that no diagnostic groupings were evident and do not report having identified specific trends in personality, they report elsewhere in a review article on the psychology of cosmetic surgery (Goin and Goin, 1986) that the women in their 1980 study fell into two groups. One consisted of "aggressive, assertive, and energetic women who often showed

¹Although the authors stated that patients "did not seem to be influenced by the knowledge that (the psychiatrist conducting the interviews) was the surgeon's wife," this is certainly a methodological problem with the study.

poor judgement in social or sexual situations" (Goin and Goin, 1986, p. 91). The other was made up of women who "appeared to be extroverted and socially outgoing but maintained a certain superficiality in their personal relationships" (Goin and Goin, 1986, p. 91). Because this finding was not discussed in the original published report and is not considered in further detail, its implications are difficult to assess.

It is not known how applicable these two studies are to facelift patients in general. Since cosmetic surgery has become much more popular and more affordable than it was twenty five years ago, it is likely that patients who request facelifts today represent a completely different spectrum than the patient population studied in 1965 by Webb, et al. This may, in fact, account for the difference in psychopathology detected by the two studies. Additionally, the clinical setting which is the source of a study population may strongly bias the results. Because the subjects in these studies represented patients from a single clinical institution (Webb, et al, 1965) or, with the exception of two subjects, from one surgeon's patient pool (Goin, et al, 1980), this research has limited generalizability. Since no other evidence is available which duplicates these results, and no research on large, heterogeneous populations has been done, it is hard to know how representative these studies are of "typical" facelift patients. The inclusion of comparisons to the best possibly matched controls available would also have been

useful in ascribing meaning to the two studies under discussion.

Psychological Results of Aging-Related Cosmetic Surgery

Information on postoperative changes in psychosocial characteristics of women who have aging-related cosmetic surgery is also lacking. In the Goin, et al (1980) study, 30 minute psychiatric interviews were performed at 5, 14, 21, 60, and 180 days post-operatively. Twent-seven (54%) of the subjects were depressed at some point postoperatively. In 12, this reaction was transient, lasting less than a week, but in 15, depression lasted for several weeks or more. These negative responses were not found to be associated with the subject's marital status, surgical expectations, bereavement, relationship with spouse or children, whether she had paid for the operation herself, how the surgeon felt about her, feelings about death, or postoperative complications.

Postsurgical psychological improvements were experienced by four groups of patients, although it is not clear whether each group represents a unique subset of subjects, or if some subjects fall into more than one group. Fourteen patients (28%) experienced an increase in self-esteem and self confidence, were less anxious in social situations, reported a new sense of well-being, or felt greater freedom to be self-assertive. Four (8%) felt that they were better able to cope with life in general. Another 4 were more secure, assertive,

or confident in their work. The 4 women who had been involved in grieving all reported diminishment of their grief reactions. The authors do not report whether these changes were consistent over the course of follow-up, or if they increased or diminished. In addition to these four groups, a slight overall decrease in the patients' subjective feelings of depression was detected. Overall change in Beck Depression scores was not reported. In addition, 100% of patients were satisfied with their surgery at 6 month follow-up, but patient satisfaction is an inadequate measure of psychosocial benefit, as discussed previously (chapter 2).

Edgerton, et al (1965) report the results of follow up interviews performed between 6 months and 12 years post-operatively on 55 facelift patients. Although it is not stated in the report, it seems clear that these patients are the same as those studied by Webb, et al (1965). Subjects were asked to assess improvement after surgery in each of the following areas: personal comfort, self-criticism, satisfaction with life, self-consciousness, social ease, self-esteem, and happiness. For each category, over 85% of the patients reported significant improvement. Thirty-five of these patients (64%) were studied for objective changes in life situations which would support these self-assessments of improvement. Fifty-five percent were found to have experienced one or more of the following changes: a new job; a promotion or raise; a merit award; marriage; formation of

other new, close relationships; or termination of an old, detrimental relationship without emotional upset.

This study presents evidence that aging-related cosmetic surgery may be related to psychological benefits, but it is methodologically lacking in several respects. First, the range of time before follow-up (6 months to 12 years) is quite broad, and the authors do not report how the subjects were distributed along this continuum of follow-up time. Such a breakdown might prove meaningful, since there may be significant differences between patients assessed only a few months after surgery compared to those assessed many years later. Additionally, self-report of improvement in psychological characteristics may vary in reliability with the length of time since surgery, and in general more objective evidence of psychological changes, including prospective preoperative data, would be more compelling. The objective measures of improvement in social situations include less than two thirds of the original group, and no control group is offered for comparison of these results, making their statistical relevance indeterminable.

Case Studies: Two Female Facelift Patients

Social and psychological factors related to choosing cosmetic surgery as a response to an aging appearance are not well-researched or understood. In an attempt to better delineate the experience of women who choose such surgery, a

study of middle-aged women seeking facelifts and other types of aging-related surgery was proposed. A guided interview method was designed to assess influences on patients' decisions to undergo cosmetic surgery, and to gain the patients' perspectives on the meanings of their decisions. Subjects were obtained from referral by their cosmetic surgeon, or by word-of-mouth referral from common acquaintances. Interviews of two women, one from each of these sources, were performed post-operatively, and the results are presented here.

The first subject, who I will call Marlene, was a 50 year old Caucasian woman who immigrated to the United States thirty years ago from Germany and currently lives in a large California city. She received nine years of schooling in Germany and was unable to continue her education as a result of World War II. She and her husband have both worked for many years as clerks in a grocery store. They remain married with two children, a son who is 24 and has moved back home after completing college, and a daughter who is 22 and is currently attending college. Marlene was referred to me by her plastic surgeon and I interviewed her in person 3 months after she had had a facelift and eyelift. At that time, she was still undergoing the physical healing process, with some residual sensory loss and clotting under the skin, but without visible evidence of ongoing healing.

When Marlene consulted a plastic surgeon, she did so

resolutely, with a firm commitment to have a facelift and having already decided on the date, which would coincide with her vacation from work. Despite her convictions that she "can't stand pain" and "hate(s) doctors," she denied ever having second thoughts or worries about the procedure. Only fleetingly in the course of describing her first meeting with the surgeon do her concerns surface, but they are quickly replaced by resolve:

"Well, I saw some pictures. And...actually, I get very nervous. I didn't even....I knew I wanted it done, and with him. Somebody I knew had recommended him and I liked him, and I didn't want to shop around, and I just more or less had made up my mind, no matter what."

In fact, Marlene had never met the woman who recommended this surgeon -- she was an acquaintance of Marlene's husband -- and knew little about the doctor or his work before the consultation. Yet her decision was firm, and she actively avoided any thoughts that might challenge her commitment.

But why was this commitment so strong? When I began asking Marlene about what inspired her to have surgery, she described her decision in a removed fashion, explaining that "some friends of mine tell me that I always told them that at 50 I was gonna have it done. But I really can't remember." She said that her friends tell her she began talking about having surgery when she was about 45. With further questioning about what influenced her decision, she offered two types of influences, both based on her physical characteristics. First, she detailed what she perceived her

appearance to be prior to surgery:

"I really didn't have a lot of wrinkles on my skin. What bothered me was the...the hanging of the skin. And I looked in the mirror and I thought, gee, my skin was hanging and I didn't like it."

She then went on to explain that she was particularly troubled by the discrepancy between the appearance of her face and that of her body, saying, "I had a young looking body and an old looking face and I didn't like it."

When I tried to elicit why she found these physical features troubling, Marlene had difficulty describing how she felt about her appearance in terms other than her physical description:

"Well, I never thought, 'That's not me.' It was me getting older, all right! But, I guess...it's not that it wasn't...It was me, but I was getting...I didn't like the hanging."

This tendency to describe why she was motivated to have a facelift in concrete physical terms is consistent with the findings of Dull and West (1990) that cosmetic surgery patients frequently use specific physical characteristics as objective, "self-evident" indicators of the need for surgery. It is also exemplary of Marlene's aversion to exploring ideas about why the surgery was important to her and what it meant for her socially and psychologically.

Several times over the course of the interview, Marlene insisted that her expectations regarding her facelift had only to do with her own feelings about her appearance, not the opinions or actions of others toward her. She also insisted

that since her surgery, she hadn't taken note of whether people treated her differently, saying "I wouldn't really know. And I don't really care about how other people feel." In fact, she stated that her appearance had never been important to her, that she never "paid that much attention to it," and that she "never thought about" whether other people thought she was attractive.

Yet her answers to other questions indicated that the attitudes of other people regarding the surgery were important to her. On several occasions, she said that she thought it was "controversial" that she had chosen to have a facelift, or that people were or would be "shocked" to hear about her decision. Although she insisted that these reactions didn't matter to her and said that she was very open about having had surgery, she clearly had an image of her decision that included a social judgment that it was surprising, unusual, or somehow inappropriate. When I asked her specifically about how her friends and acquaintances had responded to the results of her facelift, she replied:

"Well, you know, that's really amazing. Some say, 'Oh, you really look fantastic,' and others pay no attention or don't say anything. And I tell my husband and he'll say, 'Oh, they must be jealous.' I say, 'Gee, didn't it come out good?' or 'what happened?' But he'll say they must be jealous or....It's really amazing how people react differently."

Despite her insistence that the opinions of others regarding her surgical results didn't matter, she had noted and taken interest in the variety of responses she had received,

expressed very definite concerns about what a "non-response" might mean, and had even discussed these concerns with her husband. Perhaps the most telling exchange we had regarding the importance of other peoples' opinions of her surgery occurred after I thanked her and concluded the interview. Almost immediately after I turned off my tape recorder, she asked me what I thought about her appearance and whether I thought her surgeon had done a good job.

Some of her statements also belied her comments on the insignificance of her appearance in general. She was an avid exerciser, and it was clear that she valued exercise and fitness not only in terms of health-related benefits, but also in terms of the effects on her appearance. She emphasized that she "would absolutely not want to be fat," and she proudly remembers that after she had her first child "I did sit-ups already and people said, 'Oh, you just had a baby?' and I didn't have a stomach." In addition, she described that 35 or 40 is one's best age, because "you're confident, but still good looking. Not too old looking, but you're not 20 anymore. You've found yourself." Although she does not consider attractiveness the only factor in determining quality of life, it certainly does seem important. Finally, her general feelings about how women's looks change as they age also indicate that she considers appearance, including her own, significant:

"I would look at people and say, 'Gee, she was a real good-looking young woman at one time, and look

at her now.' And I would think, how sad that your body does that....I know we're all getting old and getting that way, but yes, I think it's sad."

Although she is concerned about her changing appearance, Marlene states that she is not worried about many other aspects of growing older, as long as she is healthy. She does feel that staying in shape has become more difficult, that as one gets older, one's body goes "faster downhill." She is currently experiencing menopause, and feels quite neutral about it, seeing it simply as "a part of life" which has not affected her "one way or the other." She does state that she is somewhat less confident and less feminine than a few years ago, and thinks that people tend to treat older people with less respect than younger people.

In general, however, she feels positive about this time in her life and the future. She feels a sense of accomplishment with respect to raising her children, and while she is not satisfied with her career, she is looking forward to retirement and sees the future as a time when she will be able to do the things she enjoys doing. Although she thinks of herself as very outgoing, she finds that:

"As I get older, I like to be by myself....I don't want to get close with most people, because that's one part of getting older. The older I get, I see too many people who are, who I don't like, who are not nice. When you are young you don't see it."

She spends most of her social time at home with her husband now, and feels that while they have a close relationship and are becoming closer, she and her husband are very independent

of each other.

There is somewhat of a paradox in Marlene's views of herself and her roles -- she is simultaneously "an old-fashioned woman," whose primary interests center around her family, but not "a real good, old-fashioned wife." She sees herself as different from modern young women, who are more independent, but emphasizes that she too is independent. She had difficulty describing the nature of her own brand of independence and how it differs from that of a career woman, but, particularly in the context of her marriage, she stressed that she was an independent person.

* * * * *

The second patient I interviewed, who I will call Frances, is also a 50 year old Caucasian woman. She is a dental hygienist who is in the final stages of divorce, a process that began two and a half years ago, and she is currently romantically involved with a long-time male friend. She has two daughters, both in college, and lives alone in a suburban area on the outskirts of a large city. She was referred to me by a common acquaintance, and I interviewed her over the telephone more than a year after she had a facelift, which included work on her eyes, chin, and neck.

Like Marlene, Frances had thought about having surgery for many years before she consulted a plastic surgeon. Unlike Marlene, however, Frances actively researched her options

regarding surgery and was frank and comfortable discussing the potential complications. She had previously worked for an oral surgeon, and felt very aware of the technical aspects of the surgery. She had also attended seminars to keep herself informed about cosmetic surgery, so that when she made the decision to have a facelift she felt very aware and confident. Yet in the final stages of decision making, she describes herself as a passive participant in the process:

"My approach was, 'look at my face and tell me what you can do for me.' And he did, and he was a very skilled surgeon, and I just left myself in his hands. I was convinced that he knew what he was doing, and um, just let him do what he wanted to do."

Despite her awareness of "some of the failures" of cosmetic surgery through personal acquaintances, Frances "had no real concerns" about having a facelift. She "felt that it was a risk that was well worth taking," and the only negative factor that affected her decision, "one of the reasons I didn't do it sooner," was the cost of the procedure. When she finally decided to have cosmetic surgery, it was not because the cost itself became less prohibitive, but because of a change in her prioritization of spending her money in this manner:

"My money was going to send my daughters to school, and to keep my husband in his country club and, you know, other priorities. And I just felt it was selfish of me to spend that kind of money on what might be considered a frivolous, selfish, indulgence. I later changed my mind when I became responsible for my own financial welfare. I had always contributed to the family income, but when I then found myself single and decided that I was

worth, you know, I had the money and that it was worth spending the money on myself, that's when I changed my mind."

Frances clearly and consciously relates her decision to changes in her life beyond her aging physical appearance. She depicts this period as a positive "transformation" in many aspects of her life. She describes her transformation on a number of levels: changes in her relationships with others, changes in her responsibilities and activities, and changes in her personality and perspectives. The sum of all these changes was a refocusing of her attention from others to herself, a process which is evident in the quote above and which resulted in a chance for self-discovery that she had previously denied herself. As she sees it, her facelift was only one part the experience of regaining her youth:

"I found myself becoming a single person after 25 years of marriage, and beginning to date again, and beginning to explore options in my life. And, after selling my home, no longer being tied down to a house. My daughters left for college within a year of each other. I found myself alone and really enjoying it a great deal. I got a small apartment and started dating and travelling, and I learned that there were a lot of exciting people in the world that I could enjoy, and I learned to love myself more. The surgery just kind of was the icing on the cake. It just kind of gave me the youthful appearance that I needed."

Frances talks about two different kinds of reasons why she "needed" cosmetic surgery as a part of her transformation. Part of the need, her "objective" indicator that she required surgery, was a perceived incongruence between facial and physical appearance similar to the one Marlene talked about.

In Frances' case, this inconsistency was not apparent until she began to focus on her body as a part of her total transformation:

"Actually, a decade of neglecting myself was culminated in you know, losing weight, and just paying attention to my appearance and just getting myself back in shape in general. And then, when I did, my face looked older than the rest of me. And when I saw the surgeon for a consultation he confirmed that there was a lot he could do to umm, to eliminate the wrinkles and the sags. So I was ready and willing to do it."

The other reasons Frances gave for needing surgery at this point in her life had to do with how others perceived and reacted to her:

"When I lost my looks, I became aware that people didn't respond to me as nicely. And I don't mean, just, you know, men responding to me in a sexual way. I mean, just the way women treated me when I checked out my groceries at the grocery store."

Frances felt that both the desired changes in her physical appearance and the expected social consequences had occurred after her surgery:

"Before my 'transformation,' I drove a station wagon and I was overweight and somewhat frumpy. After my transformation I drove a brand new Lexus, I looked about fifteen years younger, and I dressed younger and had a younger attitude, and people, you know, people started looking at me again like they had twenty five years before. And responding to me in a more positive way."

She believed that these social changes were related both directly to her improved appearance and to the fact that she "felt more positive" as a result of looking younger. For example, she believes that the surgery has improved her current romantic relationship, mainly because she feels better

about herself, but also because she thinks her partner is "a very nice looking person himself, and I know that he likes to be seen with a beautiful woman." She also attributes a pay raise she received after having surgery at least in part to looking better and being more positive as a result.

Frances was very open about her appearance and her awareness of it. She describes herself as someone who was always attractive, and was popular in part because of her looks. She has always liked her appearance, except "when my chin began to sag and my eyes had bags under them and I didn't look like the person I used to be." She considers her ideal appearance to be the one she has now, with the caveat that "as long as I can keep my weight under control, I'm okay."

She also feels that she has achieved her ideal self, both as part of her process of transformation in recent years and as "a result of a lot of life experience, a lot of work that I've done on myself, and people who have influenced my life." Unlike Marlene, who thought that the best time in life was at age 35 or 40, Frances is reaching a pinnacle in her life right now:

"I'm self-actualized. I've achieved most of what I set out to achieve in life. I'm at a point in life where I can enjoy my resources. I have a big beautiful home, a new man in my life who's very important to me, my daughters are successful. And I enjoy my work very much, I'm very successful at it, I'm well known in my field. I love myself, not only for the way I look but for the way I feel. And I have the strength and ability to try new things....I think that I'm very good with people, I have a lot of friends, and I have a great deal of self-confidence."

A major theme of Frances' current experience of self-discovery and her satisfaction with her life has to do with breaking away from stereotypes and rules about "appropriate" behaviors in order to find a true self. For example, she feels that she has established a stronger sense of femininity, is more at ease with her femininity, and feels better about being a woman since she stopped trying to "mold myself to a social model that apparently wasn't necessary." She describes her marriage as "like a Doris Day movie. It wasn't a true relationship, it was more structural. I acted out a role." She feels that in marrying young (at age 23) she had "abdicated" herself, and that she never realized her full potential, in part because she was told early in life that her choices were limited because she was a woman. When she divorced her husband, it was because she was "interested in finding out who I was and being able to live my own life." She abandoned the "religious ethic that you put yourself last," and now feels better than ever before about her roles in life.

This positive outlook also applies to her future:

"The life experiences that I've had have given me a perspective and a self-assurance that leaves me undaunted. I see nothing but positive things ahead. There isn't anything that can bother me anymore, nothing that can get to me, so to speak. I am in control of my life. And I have a lot of fun things that I have planned for myself, so I have a lot to look forward to."

In Frances' view, the only negative aspect of growing older is "that I have to work harder all the time at keeping myself

healthy and in shape."

* * * * *

There are important differences in the life circumstances in which Marlene and Frances chose to have their facelifts, as well as differences in how each characterizes her choice and its meanings for her. To Frances, cosmetic surgery and restoration of her previous appearance was a logical part of the general theme of transformation. She was experiencing a second chance at life, an opportunity to do things in a way that was more true to herself; looking younger and better -- as she had before her years of self-neglect and sacrifice -- was an integral part of this rebirth. The major theme in Marlene's life that corresponded with her decision to have surgery was not change, but constancy. For her, it was difficult to formulate a reason for her decision other than to say that it was for herself, to make the image in her mirror match the image in her mind. Whereas Frances was in the process of achieving her ideal self, Marlene felt that her ideal years had passed. Frances' vision of her roles and relationships was more complex than Marlene's, in that she had many more people who she considered "very important" in her life and many more social roles that she considered central to her self. Both women were optimistic about the future, but Marlene viewed it as a chance to spend more time doing the things she currently enjoys, while to Frances it will be a time to explore herself and find new challenges.

There are also some similarities between how these two women describe their lives and their decision to restore their youthful appearances through surgery. Both Marlene and Frances express overall satisfaction with their lives and their important relationships. They see positive as well as negative aspects to growing older, and for each, the major negative aspects had to do with changes in the body, both related to deteriorating health and to an appearance that is more difficult to control or maintain. They also both stressed that they did not want their appearance changed in any way, that they did not want to look different, but like themselves at a younger age. Both had considered cosmetic surgery for many years before consulting a physician, and when they sought consultation were 100% sure that they wanted surgery and were ready. It seems that to a certain extent, their awareness of the "supply" of surgical techniques for intervention in aging appearance contributed to their "demand" for these services.

It is difficult to determine what impact, if any, the surgery had on their lives and their psychosocial functioning. Although Frances described many positive changes in her life, her outlook, and her social interactions, it is impossible to know how much these changes were influenced by her facelift or whether they would have occurred without this intervention in her appearance. It is probable that many of the changes would have occurred regardless of the surgery, because her

"transformation" was already underway when she decided to have the surgery, and in fact her newfound "permission to be selfish" was influential in her decision.

It is even more difficult to assess the impact of Marlene's facelift on her life. She could not discuss how the surgery had affected her interactions with others, and could describe no internal psychological changes other than that she was "glad she had it done" and "it was worth it." Her inability to recognize or admit that her appearance is important or the reasons why it is important is suggestive of a narcissistic defensiveness, but it is not known whether this represents any change from her previous personality or whether it is influenced by the fact that she is still in the final healing stages of her surgery.

What is clear is that while both Frances or Marlene took for granted that the aging appearances they described were intrinsically undesirable, neither characterized her appearance as abnormal or deformed in any way. Both considered themselves to be physically very healthy. In addition, neither woman described the impact of her appearance on her self image or quality of life as extremely negative, and both women reported being generally satisfied with themselves and most aspects of their lives. Although for each woman the facelift may have had some positive influences, neither of these surgical cases seems to fit with the medical model of treating disease. Again, measures of pre-surgical

psychosocial functioning would be necessary to rule out the possibility of psychopathology which was successfully treated with cosmetic surgery, but the most recent research on facelift patients (Goin, et al, 1980) suggests that, in most patients, psychopathology is absent.

Chapter 6

A Case Study of the Responses of Cosmetic Surgeons to Research on their Patients

One of the key features of allopathic medicine is its basis in scientific thought and method. Indeed, science gives medicine its foundation and credibility, insofar as scientific research provides evidence that clinical interventions are beneficial to patients. In addition to their roles as clinicians who directly provide patient care, physicians are expected to think objectively about the methods they employ and to involve themselves in scientific inquiry. Although this does not necessarily require every physician to design and implement research protocols, it does demand that physicians take an interest in and be aware of research that concerns the techniques that they use, and that doctors think critically about the scientific basis for every intervention they offer or suggest to their patients.

As indicated in previous chapters, there is little good research which objectively shows that many cosmetic surgery procedures have long term benefit for patients. Little is known about who chooses to have cosmetic surgery and why. Cosmetic surgeons have operated for decades without awareness of why their patients seek help or how cosmetic therapy works, if it works at all. Furthermore, there has been no research or dialogue about illness prevention in cosmetic surgery; that

is, no discussion of possible early psychological or social interventions that might help reduce the numbers of people who eventually "need" these invasive procedures. Not only do cosmetic surgeons apply inadequate measures of the psychological effects of cosmetic procedures to assessment of individual patients, it appears that they also have neglected their obligation as a professional subspecialty to objectively examine their work on a larger scale.

The bulk of the research that has been done on the psychology of cosmetic surgery has been by plastic surgeons, sometimes in conjunction with psychiatrists. Very little work has been done by persons external to the field of cosmetic surgery or without reason to be biased regarding the outcome of their research (for example, Marcia Goin, a psychiatrist who has done a number of studies of cosmetic surgery patients, is married to a plastic surgeon). Given that cosmetic surgery is proposed as a form of psychological therapy and is clearly influenced by social and cultural criteria for beauty, researchers from a number of different fields would be equipped to contribute to knowledge about the meanings and value of cosmetic surgery. The field would benefit greatly from a multi-faceted approach, in which the perspectives of psychologists, sociologists, anthropologists, linguists, historians, and ethicists were applied. The potential contributions of these social scientists to research on cosmetic surgery can be estimated by the relatively large body

of informative work they have done in the area of reconstructive surgery.

The absence of a similar body of research related to cosmetic surgery is probably not due to lack of interest on the part of researchers. A number of authors have discussed various social and cultural aspects of cosmetic surgery (Banner, 1983; Carey, 1989; Glassner, 1988; Hatfield and Sprecher, 1986; Hyman, D., 1990; Hyman, J., 1986; Lakoff and Scherr, 1984; Leppa, 1990; MacGregor, 1982; Secunda, 1984; Stafford, La Puma, and Schiedermeier, 1989, Wolf, 1991, Yarborough, 1991), indicating that there is academic interest in the subject, despite the lack of original research. I propose that one of the most important reasons for the dearth of research on cosmetic surgery, and in particular the absence of a large contribution from social scientists, is the threat cosmetic surgeons feel from having their work examined from a critical perspective. I present here my own experience in attempting to work with cosmetic surgeons as evidence for this conclusion.

As part of my master's thesis project, I designed a study of women's motivations for choosing to have aging-related cosmetic facial surgery. I hoped to interview several patients from each of a small number of plastic surgery practices, and contacted a total of 17 surgeons to ask for their assistance in referring patients. I called these physicians based on referral from their colleagues (10), or

from one of two local medical societies (5), or on the recommendation of a medical school's plastic surgery department (2). In no case did I contact a plastic surgeon without referral. All of the surgeons devoted at least some of their practice to cosmetic work. Initially, the responses of the first surgeons I contacted seemed quite positive, and I decided it would be reasonable to proceed with my research. I later encountered a great deal of difficulty in obtaining patient referrals, and it became clear that the physicians who had agreed to put me in touch with patients had either changed their minds or were in fact not interested in helping me. After several months of phone calls and offers to help overcome any intra-office logistical difficulties with the process, I was able to obtain only one subject to interview through these physicians.

It is possible that I was referred only one patient in part because many patients were unwilling or not interested in talking to a stranger about the very personal decision to change their facial appearances. But the nature of my conversations with the plastic surgeons led me to believe that they were not only resistant to having me speak to their patients, but in many cases were also unwilling to express that directly or to address the reasons for their decisions.

Of the doctors I contacted, seven told me directly or via their receptionist that they were not interested in participating in the study without offering a reason and

without asking for substantial information about what I wished to do. One more had cut back on his practice in preparation for retirement and, according to his receptionist, did not think he would have any patients to refer. The receptionist for the plastic surgery department of a medical school informed me that the head surgeon in the department felt that his patients were inappropriate for my study, due to his association with the medical school. Interestingly, I was referred to this doctor by the wife of one of the other plastic surgeons I had contacted (who I will discuss more in later paragraphs), because she thought that a more "clinical" patient population, as one might find in a university hospital setting, would be more appropriate for my research.

A surgeon at another medical school related to me, again via his receptionist, that obtaining permission for research on human subjects from his university would be too difficult and time consuming. The receptionist insisted that the fact that my research proposal had already been accepted by the human subjects committee of the university I was attending was inconsequential in terms of the work required to prepare for review at the medical school. My offer to contact the committee at the medical school myself and complete any extra paper work which was required did not change her opinion. None of my comments regarding human subjects approval were transmitted to the plastic surgeon, leading me to believe that he had told the receptionist in no uncertain terms that he was

not interested in participating in the research.

The remaining seven plastic surgeons all initially expressed an interest in participating in my research, and met with me personally or requested that I fax information about the study to them. One left a message for me on my answering machine that he was not interested in participating after I faxed him an outline of my proposed project and proof of human subjects approval. He did not explain why he did not want to participate. Another surgeon to whom I faxed information agreed to tell his patients about my research, but never found any who were interested. The only female plastic surgeon that I contacted said that she thought my research sounded interesting and very important, that it was a project that needed to be done, but she felt she could not ask her patients to participate due to liability. I asked her if I could change my protocol in any way to make her feel more comfortable with it, and she insisted that the protocol was fine, that it was a well designed project in every respect, but that liability was too great. I asked her what she meant by "liability," and emphasized that the project was human subjects approved and that great lengths would be taken to prevent any breach of privacy or confidentiality. She said she was not just concerned with legal liability, but with "all kinds" of liability. She could not be more specific.

One of the first surgeons that I contacted was very enthusiastic about the project and expressed definite interest

in participating. He indicated that he thought it would not be at all difficult to enlist his patients in the project, and that he would like to see a published paper result from the study. He discussed his practice with me, saying that patients came to him from all over the world to have cosmetic surgery, and that he was very well known for having refined a particular technique. I asked him why he thought aging-related cosmetic surgery was becoming more popular, and he emphasized the trend of an increasing number of women to have facelifts at relatively younger ages, such as the late thirties or early forties. He said that, while this is certainly in part a result of "social factors," it is also related to newer techniques which enable surgeons to take advantage of some of the qualities of younger skin and subcutaneous tissues to produce better, longer lasting results. He strongly encouraged me to consider designing a research project which compare women who have facelifts at earlier ages to women who have them later, in their fifties or sixties.

At our initial meeting, I explained to this surgeon that I was just beginning to design my study, and that I would not be ready to interview subjects for several months. I followed up immediately with a letter thanking him for agreeing to participate, and again six weeks before I wanted to begin my interviews to let him know that I would be calling in the near future to establish a way of contacting patients. When I

called his office, I left repeated messages which were not returned. Finally, I was told that I should speak with the surgeon's wife, who also worked in the office, and that she would contact me. After several weeks and more unreturned phone calls, I spoke with her, and she told me that she was sorry, but her husband's patients would not be appropriate for my study. I attempted to ascertain why this was so, and why the surgeon had changed his mind, but could not get a more clear answer than her suggestion that a more "clinical" patient population would be more appropriate.

It was not clear to me whether the decision not to participate in my research came from the surgeon or from his wife. It is possible that after further consideration, the surgeon decided that he did not feel comfortable having me speak with his patients. This seems odd given his initial enthusiasm regarding the research, and does not explain why he did not convey this at an earlier time point, either directly or through his receptionist. It is also possible that either he or his wife felt personally threatened by the implications of research which forced them to consider the meanings of their own involvement in cosmetic surgery. This would explain why neither of them could give me a reason for not including his patients in the study.

The surgeon may also have changed his mind about assisting me with my research when he realized that I was not interested in pursuing the study he had proposed or in

limiting my subject pool to his patients. In the months after my last conversation with his wife, I discovered two articles in the popular press which mentioned this surgeon. Both described him as a leading proponent of doing facelifts on relatively young women to produce better results, and one described a relatively invasive technique he has developed for a "preventive facelift." Since this surgery requires general rather than local anesthetic and is more invasive and therefore more dangerous than standard techniques, it is somewhat controversial. A published journal article which established that women who had this surgery had more favorable psychological results or greater psychological indications of need for their facelifts would help establish the validity of the procedure. Given his bias for performing the surgery, I assume that he expected results similar to this, and that he would not have sought to publish the research if the results had been different. A favorable article would also serve as a form of free publicity for him, increasing his fame, his patient pool, and requests for his speaking and teaching time.

Another of the physicians I met with regarding my research asked a few cursory questions about the project, and spent most of our meeting discussing his daughter's medical school applications. He was interested in my opinion as a medical student in a combined master's degree and M.D. program on various medical schools and combined degree programs in particular. After our conversation, he said he would be happy

to see if he had any patients interested in participating in the study. When I called his office the next week, as he had suggested I should, his receptionist put me on hold, then told me that the doctor had found no subjects for me. I asked her when I should call again to see if anyone had agreed to be interviewed, and she seemed perplexed. I explained to her that this was an ongoing study and that I had not expected to find all my subjects in the first week, information which should have been obvious to the doctor from our previous discussion and the written materials I had left with him. The receptionist asked the doctor what she should tell me, and reported that he had said not to call again, that his office would call me if anything came up. I never heard from him or his office again. My impression was that the doctor had agreed to meet with me primarily to discuss his daughter's medical school options, had not given my research a second thought or mentioned it to his office staff after our meeting, and never intended to participate.

Yet another of the surgeons I met with greeted me warmly and enthusiastically. While never deviating from his tone of convivial supportiveness, he quickly revealed that he was suspicious of my efforts and my biases. He asked me what I was interested in studying, and I had barely finished a one sentence synopsis of my interests when he asked, "Well, what do you think about it?" I asked him to clarify his question, and he asked me, "Do you think what Gloria Steinem thinks? Do

you think what Naomi Wolf thinks?" I assured him that I was an unbiased researcher and calmly described my proposal in more detail. At one point he interrupted me, pointed to the man's ring I was wearing and said, with almost an accusatory tone, "What's that?" I explained that it was my father's wedding band, and that I wore it because he hated to wear jewelry. This answer seemed to both surprise and satisfy him. After I finished describing my study, he said it sounded interesting, but that he had already done it. He handed me a book he had written which was essentially a consumer's guide to cosmetic surgery, based on interviews with his former patients. It presented these patient's stories: why they wanted to have surgery, what their experience was like, how they felt about the results, and the impact cosmetic surgery had on their lives. The book was clearly intended to encourage individuals considering cosmetic surgery to have it.

This surgeon gave me a copy of his book and agreed to ask patients to be interviewed. When I called on subsequent occasions to ask if he had found any patients, his receptionists told me that he hadn't left any messages about it. After several weeks, I called and spoke with him directly. He asked me when my "deadline" for interviewing my subjects was, and said he thought he would be able to find me some, and that I should continue to call his office occasionally to see if he had found any. Although he did not say so specifically, his comments indicated that he had not

yet asked anyone. He was never able to refer me any subjects.

The only doctor who did find a patient for me to interview had initially offered to ask a series of his recent facelift patients as they came in for follow-up, excluding only those he felt might be psychologically hurt by the interview process. He conveyed a great deal of confidence that many of his patients would be willing to participate. After a few weeks passed, he referred one subject to me and I interviewed her. Some time later, when he had been unable to find any more subjects, I called to ask if there was anything that I could do to make the process easier, or if he knew why he had not had more luck finding patients for me. He responded in an annoyed and sarcastic tone, "Well, if I knew that, I'd be able to plan my income, wouldn't I?" He no longer seemed friendly toward me or my research, and seemed to have forgotten his offer of asking his former patients if they would be interested in being interviewed. Because he was unwilling to discuss any concerns he had about my research or methods, I do not know if he changed his mind after talking to the patient I had interviewed, after reading my proposal more closely, after discussing the research with his colleagues, or because he found the process more tedious or demanding than he had expected it to be.

These physicians may have had a variety of reasons for not wanting to participate in recruitment of subjects for my research or for failing to find patients interested in being

interviewed. Physicians who chose not to participate may have done so based on concerns regarding legal or ethical liability for any harm that came to their patients as a result of participating. However, because the research was conducted under the auspices of a major university and approved by the university's committee for protection of human subjects, and because the protocol and subject consent forms clearly indicated that the physicians who referred patients were in no way responsible for the research or involved in data collection, liability was not a reasonable concern. Furthermore, the one surgeon who raised the issue of liability specifically stated that my protocol appeared to provide adequate protection of subjects rights and interests, and none of the other surgeons expressed concern about the protocol or could offer suggestions for improvements.

Some of the surgeons may have been concerned with the effects of my research on the emotional well-being of their patients who might have participated. All of the physicians who agreed to find patients had expressed apprehension about having patients interviewed prior to their surgery, since this would be a particularly emotional time for them to discuss their decision. Some had also made it clear that not all patients would be psychologically "appropriate" for the study, and that these patients would not be asked to participate. Concern for their patients' emotional and psychological safety is a natural and important attitude for physicians. However,

none of the physicians who reviewed my protocol indicated that they thought the research would pose a risk to subjects, and those who agreed to refer patients presumably did so after reading the protocol and deeming it sufficiently protective. Had these doctors found the protocol to be dangerous to subjects in any way, they would have been morally obliged to discuss these problems with me in order to protect patients -- their own or those of other plastic surgeons -- who participated in the research.

In addition to these possible legal and ethical concerns, some of the plastic surgeons may have chosen not to participate or been unable to find patients due to constraints on their time and energies. In order to reduce the demands of participating in patient recruitment, I prepared a written summary of my research, including my qualifications and contact number, for doctors to give to their patients during an office visit. The actual time demand for a doctor to mention the project and give a patient the information sheet would have been no more than one minute. In addition, several weeks after physicians had agreed to participate but had been unable to refer any patients, I attempted to assess why the physicians were having difficulties and offered to assist in any way they felt would enhance patient participation or ease the burden on their time or their office staff. None of the physicians said that the demands were too great or wanted me to become more directly involved.

It is possible that many of the plastic surgeons I contacted were not interested in participating in the research because they simply felt it was an unimportant or uninteresting project. At least ten of the surgeons I spoke with either made direct statements to the contrary or by their willingness to participate or review additional information conveyed an interest in the topic. Furthermore, in light of the paucity of research on a subject so important to their professional activities, these plastic surgeons should have recognized the value of expanding the body of knowledge about a little understood phenomenon. Several of the plastic surgeons I talked to admitted that they knew little about the subject. One, for example, said he would be very interested in reading the results, that he had never been able to determine what motivates patients to have facelifts, and that as far as he could tell, it was all "some kind of sexual fantasy." I do not intend to suggest that the absence of research on the psychology of aging-related cosmetic surgery should have induced all of these cosmetic surgeons to participate in my project; certainly, any physician could have many reasons for not participating in even the most worthwhile and well-constructed research. I simply wish to refute the argument that the surgeons I talked to decided not to actively participate in my research out of a reasonable conviction that the topic was not important to their professional endeavors.

One of the possible reasons that those physicians who

agreed to recruit subjects were unable to do so is that patients simply were not interested in participating in such a project. It seems unlikely that only one individual out of all the facelift patients of the physicians who agreed to participate was interested. The total time of attempted recruitment varied from about 4 to 8 months, depending on when the physician was initially contacted. It is not known how many appropriate facelift patients were seen by these doctors in this time period, but given the popularity of facelifts as a cosmetic intervention, one would expect the number to be relatively high.

In Goin, et al's (1980) research on facelift patients, the participation rate for the first 64 women asked was 62.5%. These subjects were recruited by distribution to appropriate patients of a letter describing the project. Although their study involved interviews of patients in the doctor's office during follow up, reducing the effort necessary on the patient's part to participate, the total amount of time required for participation was much higher than in my study, since subjects were asked to complete several written psychological tests as well as a one hour presurgical interview and five half-hour postsurgical interviews. Goin, et al's participation rates may also have been elevated by patients' eagerness to please their doctor, who was obviously quite invested in the research since he contributed office space and since both he and his wife were among the primary

researchers involved in the study. Still, it seems unreasonable that so many of these patients were interested in volunteering to be interviewed but only one of the patients of the doctors I contacted was willing to commit an hour to an hour and a half of her time, at a time and place of her convenience, to discussing her surgery.

In the absence of other good reasons why plastic surgeons were not willing or able to contribute to my research efforts, I propose that these physicians did not actively participate as a result of a need to defend their professional activities. At least one of the surgeons I talked to made clear his fear of negative bias on my part, and at least two others expressed concerns about negative, and in their opinion inaccurate, media reports questioning the safety and ethicality of cosmetic surgery. Such media reports, as well as any original research which indicated that cosmetic surgery was not a valuable undertaking for patients or a permissible undertaking for physicians, would threaten cosmetic surgeons on a psychological level and a financial one. Psychologically, cosmetic surgeons would be forced to consider their own involvement in such controversial activities and then justify these activities in light of their ethical responsibilities as physicians. The financial costs might be even more troubling to cosmetic surgeons. Any press which depicts cosmetic surgery as medically unfounded or potentially damaging to patients has the potential to both reduce the number of

individuals who decide to have cosmetic surgery and increase the possibility that other physicians, the public, or government officials seek more stringent regulation of cosmetic surgeons.

If fear of results that have negative implications for the practice of cosmetic surgery does impede physician participation in research, particularly research which is not under their direct supervision and which is performed by persons external to the field of cosmetic surgery, then these physicians are no longer objective about research on the work that they do. Based on my experience, I believe this is the case. Despite the lack of information which delineates the psychological impact of cosmetic surgery of the aging face, cosmetic surgeons were not willing to make strong commitments to a project that could have contributed such information. Not only do these surgeons continue to perform cosmetic surgery without good evidence that it helps their patients, they are also unwilling to participate in or encourage research that might provide them with tools to understand the implications of their work. In medicine, objectivity is required not only in the provision of care to individual patients, but in the pursuit of understanding through medical research. In my experience, cosmetic surgeons do not demonstrate an objective approach to either of these goals.

Chapter 7

Conclusion: The Compromised Role of Cosmetic Surgeons as Healers

Cosmetic surgery, by definition, involves the alteration of physical features which are normal, not deformed. Implicit in this definition of cosmetic surgery is an understanding and acceptance of what the normal range of human appearance is. Cosmetic surgery designed to "correct" changes that result from aging is perhaps the best example of a category of medical interventions designed to alter normal features, since an aging appearance is part of a developmental stage in life, and will be experienced by all individuals who reach this stage. Yet cosmetic surgeons often refer to aging features, as well as many of the other features that they change, as "deformities," implying that they are somehow deviant. A prominent plastic surgeon writes:

"I would like to call attention to another category of deformity, one that many might not consider as such. I am referring to the aging process....Many, maybe most, elderly people feel discarded by a society that idolizes youth, energy, athletics, thinness, and good looks -- 'good' to be synonymous with youthful'" (Goldwyn, 1990).

Accepting that an aging appearance should be treated as a correctable deformity only serves to reinforce society's anti-aging bias and promotes the idea that aging is an illness. Cosmetic surgeons, purportedly with the authority of medical science behind them, reaffirm that there is something

wrong, something medically undesirable, about looking older than a certain age. The cutting edge of cosmetic surgery involves the development of a "preventive facelift," which is already performed by some surgeons and might someday be available to all women and men who would rather risk surgery than confront the certain onset of the disease of a wrinkled face. Rather than prevent the social and psychological circumstances that prompt individuals to seek cosmetic surgery, physicians who are developing these techniques are attempting to prevent visible signs of aging in their patients. Since such a facelift would occur before significant signs of aging were present and able to cause distress to the individual patient, this implies an acceptance that the "diseased" aspect of the patient who requests a facelift -- the condition to be avoided -- is her aging appearance.

Cosmetic surgeons have thus adopted a role in constructing societal attitudes about aging and deformity. While cosmetic procedures performed on the aging face constitute a unique class of cosmetic interventions, the ethical problems related to cosmetic surgery of the aging face which have been defined in this paper should serve as a red flag. They suggest that millions of dollars are being spent, and hundreds of thousands of bodies are being cut open, by physicians who are no longer guided by the principles of good medicine. It is not enough for a physician to have good

intentions; he must also apply serious and critical thought to his actions. Plastic and reconstructive surgeons are some of the most highly trained and hard-working specialists in the American medical community, and they have provided an invaluable service to untold numbers of victims of severe burns, accidents, and congenital defects. The application of plastic techniques to the alteration of normal appearance in accordance with cultural standards of beauty, however, is not only theoretically problematic, but also has resulted in the evolution of a cosmetic surgery business which has the very real capacity to exploit and injure patients.

In a field in which medical need and therapeutic value are so poorly defined, and in which practitioners are unable to be objective about the treatments that they provide, patients are bound to suffer. If physicians are not objective about what interventions will be beneficial to their patients, they are unable to effectively serve as their patients' allies in medical encounters. Under these circumstances, patients must make important decisions about what will be done to their bodies without appropriate guidance. Individuals who request cosmetic surgery are a particularly vulnerable population, since they generally seek consultation having already diagnosed their own disease, and with a belief that the treatment they request will confer some benefit. The surgeon who agrees to perform cosmetic surgery simply because a patient wants it is as irresponsible as the physician who

provides antibiotics on demand for symptoms of a cold. He provides a service which he knows may be harmful to a patient merely because she believes it will be helpful.

This is not intended to imply that cosmetic surgeons themselves don't share their patients beliefs in the value of cosmetic surgery. In most cases, however, they do not require any more proof of the benefit of their work than the patient's satisfaction with the results. A close review of the literature on the psychology of cosmetic surgery suggests that little is known about the motivations of many types of cosmetic surgery patients or about the long-term results of these procedures. My own experience with plastic surgeons in the context of my research suggests that cosmetic surgeons are not willing or able to allow such a study to be conducted by a researcher outside of their field. It appears that they are so protective of their own political and financial interests that they cannot open their practices to objective research which might contribute insight into the meanings of their work.

As physicians, cosmetic surgeons have abandoned their roles as healers of the body and their commitments to objectivity and scientific method. Instead they have become artisans who mold and manipulate the human form. Cosmetic surgeons clearly recognize that they are artists; they frequently compare their work to that of sculptors and painters (Powell and Humphreys, 1984; Stafford, La Puma, and

Schiedermayer, 1989; Morani, 1992; Roach, 1992), and their advertisements and office waiting rooms are often adorned with artistic images of the human form. What these surgeons may not recognize is the impact that their commitment to "aesthetic improvement" of the body has on society's attitudes about deformity and deviance. Rather than deconstructing stereotypes which relate human worth to physical attractiveness, these physicians reaffirm and even play a role in establishing such stereotypes. They objectify human bodies by treating them as lumps of clay which can and should be shaped to conform to a narrow standard of beauty, and they imply that this standard is instead based on parameters of physical normalcy and health. Physicians in all specialties, medical ethicists, and anyone interested in preserving the integrity of the medical profession should be concerned about the consequences of allowing cosmetic surgeons to practice medicine as they currently do.

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