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Saving Face: Women's Experiences with Cosmetic Surgery

by

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DISSERTATION

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For my husband
Allen Guzon Ancheta
for his love and support

and

For our daughter
Sarah Elizabeth Ancheta
for making my heart sing

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When I began graduate school I wore a pin on my book bag, proclaiming proudly, "Behind every successful woman is herself." A feminist play on the idea that successful men are often supported by the unacknowledged work of women, I enjoyed wearing the pin and even believed it was true. Through the course of writing this dissertation I have learned many interesting things, but perhaps the most important is that behind this successful woman are many people. First and foremost, my husband, Allen, has been the most wonderful, most supportive partner any graduate student could ever wish for. He always understood the moral importance of my work, taking seriously any new experience or finding I uncovered. He never thought twice about providing for all of our material needs, giving me complete freedom to spend time as I needed. He used his vacation time to stay home and care for our daughter, so I could write the final draft. And he has always been wonderful company to happily celebrate each accomplishment along the way. Completing this work would not have been possible without his love and support.

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SAVING FACE:
WOMEN'S EXPERIENCES WITH COSMETIC SURGERY

Rebecca Wepsic Ancheta

ABSTRACT

Women's decisions to have cosmetic surgeries are socially situated and experienced. This work explores women's stories of their cosmetic surgery experiences to better understand this growing cultural practice. Data was gathered utilizing in-depth, qualitative interviews with a snowball sample of twenty-one women who have had cosmetic surgery. Transcripts were analyzed using a grounded theory approach (Strauss and Corbin 1990). Utilizing symbolic interactionist theories, this research explores how women's appearances are socially accomplished through the *conversation of gestures* and the *generalized other* (Mead 1934). Key themes developed are women's experiences with aging, decision-making, and social networks. First, the practice of cosmetic surgery can be understood as a response to the "mask of aging" (Featherstone and Hepworth 1991) and the implications of this for the creation of participants' selves. Questions of identity and aging are explored when describing the tension research participants experienced between how they look and how they feel. Cosmetic surgery succeeds in easing the mask of aging, yet surgery may create new types of masks. Second, the importance of social networks in women's decisions to have cosmetic surgery is described. A technique of reflexive accounting is utilized to explore the importance of social relationships in the cosmetic surgery experience. Research participants' friends and doctors suggest cosmetic surgeries and influence participants' decision-making.

Third, participants' beliefs about surgery are reflected in their discourses. The two primary discourses are *minimizing* and *"I did it for myself."* These discourses serve to mediate the highly social and political nature of cosmetic surgery thereby reinforcing social structures and social inequalities. A primary theoretical contribution is to work away from the binary framing in other studies and utilize a more dynamic process-oriented analysis. By examining the importance of appearance and beauty in women's lives, this research unites and expands previous research on cosmetic surgery by focusing on how the social importance of age and gender are culturally constructed in women's bodies through cosmetic surgery practices.

Virginia O. Olesen 3-15-06

Virginia Olesen, Ph.D., Dissertation Committee Chair Date

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CHAPTER I

INTRODUCTION

Why this Topic is Important Today

To some people the study of women's experiences with cosmetic surgery and aging might seem trivial. I learned firsthand about this trivialization several years ago when I attended a small holiday party at the home of a family friend. The father of this family is a tenured professor in a natural science discipline. He is well-respected in his field, established in the academy, and someone I admired. Towards the end of the evening, this man asked me about my graduate work, inquiring about my dissertation topic. I told him, "I'm going to study how women who have cosmetic surgery experience aging." He immediately burst into loud laughter, throwing his head back and almost coughing from his emotional outburst, then blurted out, "You are going to study THAT? Out of all the things you could pick to study, you picked a bunch of old ladies who are trying to look young?" This was followed by more laughter. I stood there stunned and embarrassed. Not only was he questioning the legitimacy of cosmetic surgery as a research topic, but also of the age and gender of my research participants.

This experience made me aware that I might not be taken seriously by "the men of the academy." I felt defeated before I even started. I considered the alternative of choosing a less controversial and more "legitimate" topic, but knew I would be disappointing myself and perhaps other women who might appreciate my research. I later learned that my experience is not unique or isolated. Indeed, research articles on women's use of cosmetics (Dellinger and Williams 1997) and images of business women (Kimle and Damhorst 1997) mention this problem of trivialization.

In their study of the ideal image for business women, Kimle and Damhorst (1997) reveal that,

> [A]t the beginning of several of the interviews, the interviewer initially sensed an attitude on the part of many of the participants that dress was a

> rather trivial subject and not a concern. But as the interviews progressed, the participants often realized and discussed dimensions of dress that could be challenging or problematic for women (p. 51-52).

Similarly, Dellinger and Williams (1997) write that the study of makeup "has been largely ignored by sociologists, including many feminists" (p. 153). The authors note the irony that although women spend a lot of time and money on makeup, and there is an emphasis on 'looking good', the subject has been trivialized and deemed unimportant for sociological study. Dellinger and Williams present three possible reasons for this trivialization of the study of women's beauty practices: (1) Accepted categories of research in sociology reflect the positions and experiences of men, while excluding those experiences that derive principally from the everyday lives of women (Smith 1979); (2) The topic of women's appearances emphasizes women's "difference" and might be feared by feminists to increase the inequality between women and men (Bordo 1993); (3) Some researchers may fear being considered vain and frivolous (Lakoff and Scherr 1984).

The assumed trivial nature of appearance is a part of our cultural discourse which undermines women's experiences and can silence the concerns of women and girls. By deeming appearance a trivial topic this discourse in its academic versions also locates the study of appearance outside an acceptable academic canon. However, this is unfortunate, for cosmetic surgery as a topic for social science investigation, far from being trivial, in fact presents an area in which the intersections of self and society, political economy and personhood, cultural constraints and agency, gender and control all can be examined in a theoretically productive way. As Rosemary Gillespie has argued,

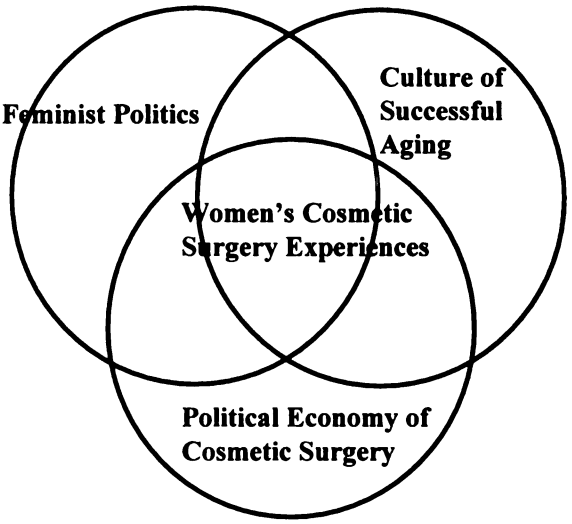
> Cosmetic surgery therefore represents an interesting arena for the examination of women's health and sexual politics, as well as empowerment, agency and resistance (Gillespie 1996; p. 78).

Here I study women's experiences of cosmetic surgery in a theoretically productive way, by examining the subjective experiences of women's aging in light of cultural constraints for youthful appearance and the rhetoric of individual responsibility for healthy aging.

Thus, I examine women's perceptions of their aging bodies and the cultural forces that shape these relationships.

There are three cultural forces that are important in creating the current cultural context for women having cosmetic surgery: (1) feminist politics, (2) a culture of successful aging, and (3) the political economy of cosmetic surgery. These cultural forces can be visualized as three interlinking circles, the center of which contains women's cosmetic surgery experiences.

Diagram of Cultural Forces:



As women's experiences with cosmetic surgeries are culturally situated, it is important to begin this research with a discussion of these influences. In this chapter I offer a brief description of how feminist politics, a culture of successful aging, and the political economy of cosmetic surgery provide the cultural backdrop for understanding women's experiences.

Feminist Politics

This research is informed by feminist theory. Feminist theory on women's experiences conforming to dominant beauty practices, such as makeup use, dieting, and cosmetic surgery, can be divided into two conflicting positions (Dellinger & Williams 1997). These two sides have been referred to as the "paradox of choice" (Gillespie 1996). While each side supports feminist beliefs, and believes it represents the best interests of

women, the conflicts between these positions have divided the work of feminist researchers.

The first side, or "beauty-as-oppression" position (Davis 1995), views women as oppressed victims and cites the restrictive aspects of appearance standards for women, arguing that these requirements are unrealistic and reinforce a subordinate position for women. Women's beauty practices are seen as further propagating their oppression (Faludi 1991; Wolf 1991). Bordo (1997) writes about the oppressive qualities of cosmetic surgery, as situated within a cultural context. The harm to women is that they are wasting money, time and energy to achieve unrealistic standards of attractiveness, rather than working towards matters believed to be of more importance. In the never-ending struggle to be beautiful, women are diverting resources that could be better used to eradicate sexism. Cosmetic surgery, though culturally pressured, is nevertheless an individualistic solution to sexism and ageism. There is no community or group of women having cosmetic surgery that might lead to any collective protest against oppression.[1]

This theoretical standpoint is supported by Foucault's (1979) theory of the "docile body," which maintains that power relationships are expressed and reproduced in the body. Through women's concerns with appearance and control of their bodies, they have internalized the surveillance that society places on them, "transforming their own bodies into 'carriers' or representatives of prevailing relations of domination and subordination" (Dellinger & Williams 1997). An example of this perspective is the work of Susan Bordo (1991, 1993), which examines how women are influenced and shaped by cultural images in ways that reinforce gender hierarchies. Through a detailed analysis of the meanings of slenderness, fatness and control of women's bodies, Bordo examines the female body as a *site of oppression* in Western culture. She finds that the social discourses of mind-body

[1] An exception to the individualized world of cosmetic surgery is when a major error is publicized. The controversy over the safety and efficacy of silicone gel-filled breast implants is one such example. This controversy lead women to form support groups, such as Survivors of Silicone or "SOS."

dualism, control of the body, and femininity all find expression in beauty practices. Furthermore, women exist within culture and therefore cannot escape the beauty system. Women have internalized this system from a dominant patriarchal culture that objectifies and punishes them if they don't meet the cultural standards for attractiveness. Within this discourse, "we do not really choose the appearances we construct" (Gillespie 1996, p. 80).

While this position allows feminists to form a strong critique of oppressive beauty practices, the danger of the "beauty-as-oppression" model is that it can deny women the power of making their own decisions. Kathy Davis (1991, 1995), a strong critic of this position, writes that it is insufficient to explain why women have cosmetic surgery. These models relegate women to the position of "cultural dopes" who have "had the ideological wool pulled over their eyes" (1991, p. 29). Kaw's study of Asian American women and cosmetic surgery (1993), found that women had internalized racial and gender stereotypes, and that their own choices for surgery reinforced racist ideologies. Her study demonstrates the taken-for-granted whiteness that results in privileging Caucasian features, reflecting a racist society where white is the standard. Kaw's analysis fits the "cultural dope" approach by assuming that these women were not aware of the oppressive quality of their actions and were unconsciously further alienating themselves.

Attempts to recognize women's agency in beauty practices compose the other side of the paradox of choice. This "beauty-as-liberation" model has been proposed by several social scientists. Rosemary Gillespie (1996) notes that there is a beauty "caste system" in which more beautiful women have greater social power. Through their relationships with men and in their enhanced employment prospects, these beautiful women have greater opportunities for wealth and more social influence. Thus women's choices to undergo cosmetic surgery can be explained using a rational choice model. Cosmetic surgery can be empowering for women on an individual level in a market economy model where women are valued for conforming to cultural standards of appearance.[2]

[2] However, Gillespie (1996) does recognize that the practice of cosmetic surgery also contributes to women's further oppression, thus creating a "paradox of choice."

In their study of makeup use at work, Dellinger and Williams (1997) search for possible liberatory uses of makeup through reappropriation or subversion of gender norms. They employ the theory of subversion and parody that Judith Butler (1990) sets forth in *Gender Trouble* to examine if women are practicing resistance and subversion to challenge the dominant norms of appearance. In contrast to Butler's theories, Dellinger and Williams "found no evidence of women manipulating their appearance to destabilize sex/gender categories" (p. 172). Rather the women they interviewed discussed the limitations of subversive appearances through dress and makeup.

Because I am a woman who frequently wears makeup and makes some attempts to meet cultural standards of appearance, I am attracted to the idea of women being empowered through beauty practices. I would like my personal actions of appearance work (such as wearing makeup and styling my hair) to be reconciled with my political feminist beliefs. While the "beauty-as-liberation" position is therefore very seductive to me, it has not been adequately supported by research. Although I find this agentic and subversive approach ideologically appetizing, I believe beauty as liberation isn't the only experience that women have regarding appearance and beauty practices. For example, women's decisions to have (or not have) cosmetic surgery are not made outside the cultural forces that shape ideal images of appearance. A study of these decisions, then, cannot ignore the social settings in which they are made.

A primary problem with framing the question of cosmetic surgery as a "paradox of choice" is that it tends to reify the dualistic and competing images of women as either "dopes" or "agents" (Garfinkel 1967; Davis 1991, 1995). The two models oversimplify and polarize women's experiences of cosmetic surgery. By forcing this complex multi-leveled issue of women's relationships to beauty practices into a dualistic model, neither position adequately represents the relationship of women's individual choices to the position of women on a socio-political level. This research is oriented to a more complex model which moves us away from these dualisms.

Culture of Successful Aging

For both men and women, the image of aging is currently undergoing a significant change. No longer treated as a period of relaxation and decline, a new image of aging encourages healthy and active behavior.[3] In his book, *We Live Too Short and Die Too Long* (1991), Bortz addresses the question "What can you do today to age successfully?", and responds by listing eight tasks. Half of the tasks focus on the physical body (exercise, food, sleep and energy), while the other half are emotional and psychological tasks (emotions, goals, mind set, and engaging in activities). As his question implies, each of the tasks is considered an individual responsibility. According to Bortz, if individuals perform each of these tasks well, they may "age successfully."

While Bortz's list does outline specific guidelines for individual behaviors, it also brings up several unanswered and larger questions: What does it mean to age successfully? What measures do we use for determining success? Are there different criteria for successful aging for women and for men? In chapter four, I explore how women's own experiences of their aging interact with their decisions for cosmetic surgery.

The practice of cosmetic surgery reflects, depends upon and shapes the tension between cultural aging and biological aging in the United States. My research is situated between these two processes, attempting to understand how cosmetic surgery influences experiences of aging women in mid-life. Building on Featherstone and Hepworth's (1991) article "The Mask of Ageing and the Postmodern Life Course," in chapter four, I examine if there is tension when one's appearance is aging while one's personal and more subjective identities does not parallel those physical changes. It is this tension between appearance and self-identity that cosmetic surgery promises to resolve. In this way, cosmetic surgery can be seen as a cultural response to this biological decline and tension. It may well be that in a youth-oriented society, where there is less cultural and social

[3] On April 2, 1997, at the tenth anniversary celebration for the University of California, San Francisco's Institute for Health and Aging, a new center was announced, The Center for Healthy and Active Aging.

acceptance of the signs of women's physical aging, that cosmetic surgery is widespread and promoted for middle aged women.

Because appearance is often used to ascertain age in social interactions, cosmetic surgery is a way to influence the aging process on a social level as well as a personal level. Youth becomes a commodity that can be bought with a "younger-looking" face. When a woman looks ten years younger than her biological age, her cultural age is effectively decreased. Through cosmetic surgery, we are able to physically interfere with the signs of biological aging in our bodies and faces in order to make a more youthful person on a social and cultural level. Acknowledging this process effectively disrupts the idea of a progressive, linear life course and invites us to look at women's bodies and age as culturally constructed.

To explore the relationship between biological and cultural aging, I propose that our expectation of what is "normal" aging is influenced by images created within the cosmetic surgery arena. Images of "appropriate," "good" and "graceful" aging are influenced by the practices of cosmetic surgery, often requiring surgical interventions to achieve these results. As the discourse of "successful aging" gains a stronger position in our culture, it could be that the importance of appearance in women's aging will become stronger as well.

Political Economy of Cosmetic Surgery

Cosmetic surgery, uniquely located at the intersection of the institution of biomedicine and cultural emphases on youth and beauty, can be located in the political economy of health care. While cosmetic surgery is practiced within the domain of medicine, there are no clear benefits for physical health - in fact there are significant physical health risks in having surgery. Therefore its location in health care is an interesting achievement, usually explained by the processes of medicalization. Processes of medicalization partially explain why cosmetic surgery can be located in health care, but a further explanation arises from Herzlich and Pierret's formulation of the

"individualization of health" (1987), which demonstrates the relationship between medicine and appearance.

In their study of the meaning of health and illness, Herzlich and Pierret (1987) trace the development of the parallel ideologies "individualization of health" and "socialization of illness." Both of these ideologies are expressed in the health and fitness movement. Individuals are presumed to have more control over their health, and more aspects of social life are viewed as health dangers.

> Secure in its legitimacy and founded upon science and technology, medicine has gradually extended its jurisdiction to other fields than illness alone. It increasingly tends to prescribe a personal hygiene and to dictate the adoption of healthful and rational behavior as a means to remain healthy (Herzlich and Pierret 1987, p. 52).

Because individuals are believed to possess the means for maintaining health, illness becomes viewed as a failure: we have the "duty to be healthy" (Herzlich and Pierret 1987, p. 53). This discourse of individual responsibility for health supports the philosophy of the health and fitness movement in twentieth-century Western culture. Through striving for fitness, we believe we maintain a healthy body and mind, thus ensuring the important life goal of "successful aging."

For women, the meaning of fitness is particularly important, tied as it is to attractiveness and youthfulness. By remaining thin, women are simultaneously achieving the aesthetic of slimness as well as fitness.

> When people talk about health as a goal they are often describing their desire to lose weight. To be healthy is to be thin, literally to be 'in shape' (Crawford 1984, p. 70).

The slim (and therefore fit) physique is the embodiment of health. This physique can be evaluated visually from a woman's appearance and is further synonymous with women's beauty. A thin woman is therefore both healthy and beautiful.

> The innocuousness signified by 'healthy' women manifests itself externally, ideally matching existing cultural standards for female appearance to the bodies of individual women. A socially desirable exterior points to an interior characterized by wellness . . . by simply looking at a woman, in particular her feminine markings, one can make an overall determination of illness and health (Spitzack 1988, p. 8).

Recent research on the meanings of women's use of makeup supports this connection between health and beauty. Researchers report that looking and feeling healthy is one of the primary reasons why women wear makeup to work (Dellinger and Williams 1997). This relationship among women's aging, individual responsibility for health and cultural ideals of beauty and attractiveness is examined through my study of cosmetic surgery.

Why I Chose this Topic

My decision to study cosmetic surgery is both personal and political. After a decade of restrictive dieting, bingeing and purging, I became a college activist in the crusade against unrealistic standards for women's appearance and weight. Through this work I was introduced to feminist politics. Feminism gave my life new meaning by raising my awareness of my position as a woman in this society. For years I had tortured myself in a desperate attempt to fit the ideal image of women's beauty. I wanted feminism and my work on campus to free me from oppressive beauty practices. While my activist work did help to alleviate some of my obsession, the concern with beauty has never completely disappeared. Seeking relief, I would tell myself that "when I got older" I wouldn't care as much about how I looked. I imagined I would "grow out" of this concern. However, ten years later, the relief I imagined would come with time has not. Rather, although I was only twenty-eight years old when I conducted the interviews, I'm now in the throes of a new concern over my aging face and body. I fear for the future day when my feminist beliefs break down and I succumb to the seduction of cosmetic surgery. This investigation, then, is something that I care deeply about. By studying the topic of midlife women's experiences with cosmetic surgery I hope to avoid cosmetic surgery for myself and consequently not have that in my future.

Questions and Specific Aims

Framed by feminist politics, a culture of successful aging and the political economy of cosmetic surgery, my research focuses on the following questions and aims (more detailed interview questions can be found in the appendix):

Questions:

- Under what circumstances do women have cosmetic surgery?
- What is the meaning given by women to cosmetic surgery?

  Is it in any way related to definitions of health, and if so, how?

  Is it related to definitions of aging and attractiveness, and if so, how?

  Is it seen as personally or socially transformative, and if so how?

  Is it empowering for some women, holding the line against mortality?
- How do some women see the altering/ed body within cosmetic surgery?

Specific Aims:

- To explore how cosmetic surgery influences a women's experience of aging, her self-identity, her relationships, and her position in society.
- To identify the important themes/patterns of women's experiences with cosmetic surgery.
- To see if (and if so, how) women perceive marketing practices within cosmetic surgery, specifically as related to aging, fitness and cultural standards of beauty/attractiveness.
- To examine the nature of imagery used by the cosmetic surgery enterprise to construct bodies and produce desires for those bodies.

CHAPTER II

LITERATURE REVIEW

Social Science Theories of the Body

Theories of the body offer very promising prospects for a study of cosmetic surgery. They can help us explore the meanings and social aspects of our bodies, which have often been glossed over as a mundane part of life. This taken-for-grantedness is what theories of the body seek to make apparent. We cannot assume even the existence of our own bodies, as their very existence is socially mediated. Cosmetic surgery is one practice where the social meaning of "the body" as a place for cultural inscription is particularly visible. In short, cosmetic surgery is situated at the intersection between the body and culture. Here I explore some of the problematics and promises of "the body" in social science theory.

The Work of Turner

> "The body is absent in theory, but everywhere is embodiment"
> (Turner 1984, p. 7).

In his book entitled *Regulating Bodies: Essays in Medical Sociology* (1992), Turner asks whether medical sociology as a specialty with definite policy implications also contains the potential to make significant theoretical contributions to the discipline of sociology. He believes that without a theoretical anchor into the parent discipline, the specialty of medical sociology is doomed to fail and will become a set of scattered research agendas with no real sociological significance. There is a risk that medical sociology will be reduced to an administrative science in the service of physicians or

politicians. In the early days of the specialty's history Parsons' *sick role* acted to ground medical sociology firmly within the larger theoretical tradition. Yet with the serious criticisms of Parsons' functionalism and an increasing emphasis on addressing dualisms in theory, the sick role has ceased to theoretically sustain the specialty. It is within this discourse of concern for medical sociology that Turner proposes a theory of the body as important.

Turner states that if medical sociology is to overcome its theoretical crisis and maintain a strong standing in the discipline it must apply itself to the "enduring and central problems of sociological analysis" (1992, p. 159), namely by exploring the question: How is society possible? If medical sociology is successful in addressing this concern it will establish the specialty as one with central theoretical importance within the discipline as a whole. This is the promise of a theory of the body.

> My assumption is that the sociology of the body not only provides an important focus within sociology as a whole in contemporary work, but offers medical sociology, or more specifically the sociology of health and illness, an opportunity to become the leading edge of contemporary sociological theory. This development in medical sociology is therefore part of a much wider critique of the Cartesian assumptions of classical social science by a range of new social movements in contemporary theory (Turner 1992, pp. 162-163).

Thus, Turner is proposing that the challenges in medical sociology are closely connected to the theoretical problems currently facing classical social science. One of these problems is a critique of several dualisms, which a theory of the body is uniquely positioned to address.

Although under attack over the past several years, many dualisms continue to shape the specialty, as well as the wider discipline of sociology. Among these are the

microsociological versus macrosociological levels of analysis. That is, respectively, the interpersonal interactions between individuals and the larger, structural forces which shape society. This dualism is perhaps the most enduring of all, despite some social theorists' attempts to resolve it (for example see Collins 1981, and Fine 1991). Other important dualisms are the Cartesian split between mind and body, the relationship between structure and agency, and the relations between individual and society. Turner believes that addressing these dualisms is important to advance the theory of a sociology of health and illness.

In his efforts to introduce the body to sociology, Bryan Turner relies heavily on the work of Michel Foucault (1973, 1979). Here it is useful to briefly outline Turner's discussion of Foucault. Turner describes how Foucault's genealogies trace the development of knowledge and the ways that medical knowledge is an effort to discipline the social body and control populations (such as in controlling reproduction and sexuality). Medicine is defined as the primary institution for bodily regulation of society. Foucault believes that it was from this standpoint that the discipline of sociology began by studying populations and that sociology is therefore medical in its origins. In place of the current intellectual tradition which asserts that sociology existed prior to the specialty of medical sociology, Foucault argues that all sociological knowledge stems from a social medicine base. Turner writes:

> The implication of Foucault's view of the birth of the clinic (1973) is that medical sociology as the study of the health of populations and of the body of individuals is central to the sociological enterprise as a whole and that sociology cannot be divorced from medicine. This view runs counter to the conventional interpretation of medical sociology which treats the sub-discipline as a late addition to the sociological curriculum. . . The implication of Foucault's perspective is that sociology is applied medicine

and its target is the regulation of bodies (1984, p. 50).

This belief has the potential to significantly strengthen the position of medical sociology within the larger discipline, making its concerns theoretically relevant to the entire field of sociology.

Turner's theory of the body incorporates feminism and acknowledges the importance of controlling women's bodies to maintain a patriarchal system. Sexuality becomes important to continued male dominance involving property ownership. The "feminine body is the main challenge to continuity of property and power" (1984, p. 37). The female body symbolizes desire, while the male embodies reason, effectively demonstrating the cultural representations of mind over body in Cartesian dualism. This analysis offers a unique position from which to study the importance of women's bodies in popular culture. In many of his writings, Turner recognizes feminism for helping to "bring the body back in." He writes that a . . .

> . . . component in the resurrection of the body is the recent history of feminism which has also drawn attention to the negation of emotionality by masculine rationalism in the social science core; but feminism has also drawn attention to the problems surrounding the social constructions of the body, the problematic relationship between nature and culture, and the historical character of the male-female division (1992, p. 164).

Turner notes the rise of consumerism and the influence of "body-beautiful culture on self-preservation and self-maintenance" (p. 165). Although there are recent rises in the number of men participating in the beauty culture (for example, seeking cosmetic surgery), the emphasis on women's physical appearance continues to be much stronger. Within the framework of Turner's theory and model, this emphasis on the external

representation of bodies is interpreted as an increased control of women's bodies.[4] This theoretical stance is particularly important as applied to a study of women's experiences of cosmetic surgery.

One of the most controversial aspects of Turner's writings on the body is his assertion of its absence in sociological theory. In *Body and Society* (1984), Turner asks the question why a sociology of the body has been notably absent from social theory (with a few exceptions, such as Foucault [1973, 1979]). Because the physical object of medicine is the human body, he particularly questions the absence of a theory of the body in medical sociology. He notes that historically sociology was reacting against social Darwinism and sociobiology. Because the intellectual niche that sociology had historically assumed for itself was opposing these intellectual traditions, it was deemed necessary to exclude any sociology of the body. This action further perpetuated the mind/body dualism in sociology.

> Because macro-sociology has . . . been concerned with the relationship between social classes and political parties, between the state and the economic basis of society, and between the family and economic change, the human body cannot be located within this theoretical space. Whereas micro-sociology excludes the body because the self as social actor is socially constituted in action . . . concentrating on the self as a symbolically constituted phenomenon, symbolic interactionism reinforced the more widespread sociological perspective in which the corporeality of social actors was relatively insignificant in social action (1984, pp. 32-33).

In this way Turner argues that the tradition of symbolic interaction has strengthened the dualism between mind and body. He further asserts that this "emphasis in sociology on

[4]A similar argument can be made for the health and fitness movements in the United States. Just as the individual woman is deemed responsible for her physical appearance, this appearance now supposedly also reflects her interior physical health. Increased responsibility for maintaining health is placed upon the individual, which can be see through a rise in preventative health measures and interventions. Turner's

the socially constituted nature of a social being resulted in an implicit position that the body of the social actor is a largely inconsequential feature of the self-in-society perspective" (1984, p. 33). Thus for a variety of reasons Turner argues that sociology has long ignored the body. When he begins to address the sociology of the body he writes about "the resurrection of the body" (1984), as if it had in some sense been crucified.

Symbolic Interactionist Theories

Refusing to accept Turner's critiques of symbolic interactionism and enlivening the debate about a sociology of the body, Virginia Olesen (1994) writes about the history of a theory of the body in sociology, calling attention to the fact that the body has not been absent from sociology, but rather was "snatched." In her review "Problematic Bodies: Past, Present, and Future" of three landmark contributions to a sociology of the body, Olesen (1994) writes:

> All these bodies and more we have glimpsed in sociology's history. Yet, the current proliferation of papers, books, conferences, debates speaks of "the return of the body." Frank's excellent review in *Theory, Culture and Society* (1989) examined 19 recent books; as many or more have been subsequently published. The body, partially theorized by Marx, Weber, Durkheim, and some of their interpreters, has been marginalized thanks to the influence of rationally oriented sociological theorists and measurement-oriented researchers. These theoretical and methodological body snatchers, in thrall to Cartesian dualisms, hived off the messiness of embodied experience, including emotions or symbols of the same. Now, the return is not of the body snatchers, but of the body (p. 232).

Thus Olesen is arguing that while a theory of the body has not been as visible, due to the politics and power in sociological theory, this certainly does not mean that a theory of the body never existed. While Talcott Parsons and his theory of the *sick role* is often credited

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sociology of the body cautions sociologists of health and illness to question "healthy" cultural norms, such as the fitness movement, for the role they have in increasing medical control of the population(s).

with anchoring and helping to establish the specialty of medical sociology within the larger discipline of sociology, this emphasis on the *sick role* has had the effect of overshadowing the work of other important theorists of the body. While Parsons was the most visible theorist in the medical sociology specialty during the middle part of this century, beginning in the 1960's there were many symbolic interactionists working on a sociology of the body, health and illness. They were not, however, as visible as Talcott Parsons.

Given that the body was downplayed in sociological theory for several decades, it is not surprising that upon closer examination the works of many earlier theorists do in fact contain theories of the body. Yet Olesen (1994) is willing to concede that these theories were incomplete compared with recent writings on the body:

> Given the insights of Mead, Cooley, Elias, and Goffman, symbolic interactionism has not explored various bodies, for example, lived as model of social relations, as focus of control, and as potent symbol as fully as might be expected. Nevertheless, the body or some version appears in numerous studies. To name only a few: bodies of polio-stricken children as contested sites of parent-physician interactions and struggles (Davis 1963); the management of lived chronic pain for the existential self (Kortarba 1977); tattoos as self-definition (Saunders 1990); innovative social organizations emergent from women's claims that they are their bodies and that they, not medicine, own their bodies (Ruzek 1978); embodied emotions, genuine and faked (Hochschild 1983); and the exercised or adorned body linked to the economic structures of late capitalist societies (Glassner 1988; Davis 1992) (p. 232).

Olesen is clear to state that the body has not been an ignored topic in sociology, but rather has lent itself to a wide variety of studies in symbolic interactionism. Bluntly put, while mainstream sociology may have been ignoring the body (providing grounds for Turner's opinion that the body has been absent from sociology), symbolic interactionist theory has meanwhile continued to address and develop studies and theories of the body. An

example can be found in Goffman's 1982 Presidential Address to the American Sociological Association, in which he notes the importance of a "body to body starting point" (1983, p. 2) and said,

> Social interaction can be identified narrowly as that which uniquely transpires in social situations, that is, environments in which two or more individuals are physically in one another's response presence (Goffman 1983, p. 2).

One of the founders of symbolic interactionism is George Herbert Mead. Mead's accounts of an individual's relations to the physical world have helped to define a theory of the body. In "Toward a Sociology of the Physical World: George Herbert Mead on Physical Objects," E. Doyle McCarthy (1984) examines four topics from Mead's "broad and varied treatment of the physical object." While the overall thesis is that "the self's relationship to the physical world is a social relation," I am most interested in McCarthy's discussion about "the function of objects in the definitions of the bodily self and its environment" (1984, p. 105).

> For Mead, the minded organism or self is fashioned out of a dynamic process of interaction with physical and human objects. . . Physical things are "defined by their boundaries, and among those things the bodily organism obtains its definition in the same fashion." For example, in the development of the human infant the child reaches her own body as a bounded thing through the discovery of the surfaces of objects which press against her body. In this way the discovery of surfaces -- of "new outsides" -- shows us the outside of our own bodies and these surfaces give to us a sense of our boundedness (Mead, 1932: 119-22; 1938: 327-28). Contact with physical objects constitutes the reality of things within a person's grasps and gives to that body a sense of its orientation in the space it shares with other things (McCarthy 1984, pp. 106-7).

Clearly, then, the early symbolic interactionists such as Mead were interested in a

theory of the body.[5] In fact the body and its boundaries were important in defining the theoretical concept of "self," a concept that continues to be one of the cornerstones of symbolic interactionist theory today. As McCarthy's analysis of Mead details, our physicality, our embodied beingness, is interconnected with and necessary for the development of one's "self." Since symbolic interactionism is based upon the premise that the concept of self is embedded within the boundaries of a physical body, symbolic interactionists therefore have a deep seated tradition in the theory of the body.

The Mindful Body

While theories of the body were often marginalized in the discipline of sociology, they were flourishing in anthropology. Because anthropology did not have to defend itself against Social Darwinism, among other reasons, attention to the body and its significance in various cultures has been historically important in this discipline. A particularly insightful example of anthropological conceptions of the body is an article by Nancy Scheper-Hughes and Margaret Lock (1987) entitled "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." This article is divided into three sections, each encompassing different levels of analysis and different theories for each level.

The first section focuses on "the individual body," a phenomenological sense of the lived experience of the body-self. The authors begin by arguing for a problematizing of the body and questioning Western assumptions such as Cartesian dualisms (mind vs. body, nature vs. society). The origin of mind/body dualism is traced to Rene Descartes

[5] Please note that the words "theory of the body" were not used to identify a set of theoretical concepts and interests until the early 1980's. It is important to recognize that applying this label to Mead's early analysis

and has been used as the model of organic science and medicine. Because this type of thinking is so prevalent and taken-for-granted in our society we have dualisms in our language as well. This results in the difficulty that we have an inadequate vocabulary to express the mind-body-society relationship. One such example is our idea of an autonomous and self-conscious individual identity, which exists and can act apart from society. While this dualism is often believed to be a universal quality of social life and human beings, the authors cite multiple examples from ethnographies where the individual is not a primary unit. In Japanese culture, for instance, family is the primary unit of society, not the individual.

> . . . Japan has been repeatedly described as a culture of "social relativism," in which the person is understood as acting within the context of a social relationship, never simply autonomously (Lebra 1976; Smith 1983). One's self-identity changes with the social context, particularly within the hierarchy of social relations at any given time. . . One fear, however, which haunts many contemporary Japanese is that of losing oneself completely, of becoming totally immersed in social obligations. One protective device is a distinction made between the external self (*tatemae*) -- the persona, the mask, the social self that one presents to others -- versus a more private self (*honne*), the less controlled, hidden self (Scheper-Hughes and Lock 1987, pp. 14-15).

Thus, in Japan the meaning of an individual and his or her role in society is quite different from Western conceptions of self, influenced by Cartesian dualism. Perhaps cosmetic surgery patients in Japan are primarily concerned with *tatemae* in seeking surgery. Women may be actively changing their external and social self. If this is the case, then how is *honne* affected by this change in the external self, if at all? Does the new face make a new person? If the person is primarily *tatemae* then the new self may make perfect sense, since the emphasis is on the external self. Moreover, that is

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of bodily conditions is added after the fact.

culturally legitimate.

Scheper-Hughes and Lock's second focus is on "the social body." This level of analysis is best theorized by symbolic and structuralist anthropological theories and epistemologies. In this section the body is treated as a symbol in culture -- seeing the body as a physical and cultural artifact. The authors make reference to Mary Douglas' *Purity and Danger* (1966), and discuss in depth the example of how "scientific" theories of reproduction actually mirror the patrilineal, matrilineal, and bilateral kinship systems of the cultures in which these theories arise. They write that: "To a great extent, talk about the body and about sexuality tends to be talk about the nature of society" (1987, p. 20). The authors argue that the Western image of the body as machine metaphor contributes to alienation from the body, and aids in turning the body into a commodity, a thing to be sold, changed, and controlled. This is certainly a powerful argument with respect to the practice and sale of cosmetic surgery in the United States. Some cosmetic surgeons have published books that are essentially catalogues for cosmetic surgery procedures (see, for example, Scheibner 1994).

The third section addresses "the body politic." The authors write that social controls are often expanded to control the body of society when there is a threat to social order. One example is the "good social body," defined as a disciplined image of health, in which the individual must work at health. Rather than health being the default setting, health is an achieved status. Furthermore the self-help and fitness movements are resonant with the ideology of Social Darwinism. The slim and fit win, while the fat and

flabby will lose, eventually dropping out of the race for survival.[6] Foucault's (1973) writing traces how the social control of individual bodies is increasingly medicalized. This leads to an overproduction of illness, where a collective dissatisfaction with society is channeled into and understood as an individual illness. It is important to link the "illness" expressions of diseases, such as anorexia and bulimia, with the tensions in society and social expectations for women. Beginning in the 19th century, controlling the human (particularly female) body had become an important aspect of the body politic. This control is noted by Foucault's term "bio-power" which is the regulation of sexuality, gender and reproduction.

Utilizing parts of Scheper-Hughes and Lock's (1987) framework, and utilizing certain features of symbolic interactionism, I explore the relationship among levels of women's experiences with cosmetic surgery -- the individual, the social and the political-economic. By combining the Scheper-Hughes and Lock "three bodies" model with symbolic interactionist theory I am better positioned to overcome the limiting dualism of the "paradox of choice" in feminist politics as discussed in the introduction. For my research the three levels of the body need to be integrated with features of symbolic interaction in order to understand fully women's experiences with aging and cosmetic surgery.

Individual Body-Self

Saltonstall's phenomenological research studies how men and women experience

[6] Examples abound in our own society that the image of a healthy body equals a healthy society and economy. This theme goes back to when Galton coined this term in 1889 and eugenics movements began. One such example is the media coverage of Japanese factory workers exercising together in the morning. This image of hundreds of Japanese men, all in uniforms standing in a field, doing exercises together became a symbol that signified Japan's rising economic power.

and define their health (1993). She finds that the concept of health is located both in the physical body and also in the conscious self (the metaphysical body). Although there are two dimensions of selves that can be identified -- the material/somatic/bodied-self and the immaterial/asomatic/ minded-self -- these two dimensions are represented together in the same self. In this way, both the body and the self are "reflexive aspects of one wholeness, one 'being' " (p. 9). Saltonstall calls this joint representation "the self-soma process." Health is a product of the self-soma process, the relationship between these two dimensions.

Saltonstall's interviewees evaluate healthiness in others by body insignia, certain signs that were believed to demonstrate health. For women, one of the criteria of health is wearing makeup. This finding is supported by recent research which demonstrates that evaluation of health is one reason why women wear makeup in the workplace (Dellinger and Williams 1997) . Women also look for thinness as an insignia of healthiness. Saltonstall points out that although the cultural mandate to be thin can sometimes conflict with physical health, the gendered importance of thinness for health took precedence over eating (1993).

In her research, Saltonstall (1993) finds that the women she interviewed included appearance-related activities for being healthy (such as getting one's hair cut and shaving one's legs), while the men she interviewed did not cite these types of activities. Saltonstall's explanation for the gendered importance of appearance in maintaining health is related to a distinction between the "inner" and "outer" body. Drawing on the work of Iris Marion Young (1979), Saltonstall writes that, "The concepts of the inner and outer body invoke phenomenological conceptualizations of 'my body' as a 'subject' (or 'agent'

body) and as 'object' body" (p. 11). Saltonstall finds that men emphasized the inner body in their discussions of health while women focused equally on the importance of inner and outer body in their discussions.

The concepts of the inner and outer body are explored in Featherstone and Hepworth's (1991) discussion of the changing cultural experience of aging in Western culture. According to Featherstone and Hepworth (1991) the possibility of tension between the inner and outer selves increases as we age, developing into a "masking" experience. Cosmetic surgery may ease the tension between women's inner (subjective) and outer (somatic) selves. Because health is defined by the "self-soma process," a tension between the somatic and subjective aspects of self is a threat to health. Thus, women who seek cosmetic surgery may be doing so for what they perceive as health-related reasons.

Body as Symbol

A substantive area in which theories of the body as symbol have been developed is in the study of consumer culture. In Mike Featherstone's (1991) essay "The Body in Consumer Culture," he explores how advertising helps to develop and create a "self-preservationist conception of the body," where individuals try to maintain the body in the face of aging and physical decay. This attitude towards preserving the body is combined with and reflected in cultural concerns with appearance and beauty. Not only are people sold consumer products and lifestyles based on preserving the body, but this emphasis on health is constantly related to "the cosmetic benefits of body maintenance" (p. 170). Featherstone writes, "The reward for ascetic body work ceases to be spiritual salvation or even improved health, but becomes an enhanced appearance and more marketable self"

(1991, p. 171). This growing emphasis on appearance leads him to differentiate between the two categories of the inner body (such as health) and outer body (such as beauty). While his focus is primarily on the outer body, Featherstone notes that, "Within consumer culture, the inner and the outer body become conjoined: The prime purpose of the maintenance of the inner body becomes the enhancement of the appearance of the outer body" (p. 171).

Featherstone takes up the importance of advertising in creating and stimulating a consumer culture. The largely visual images are powerful, representing a new morality based on consumption, hedonism and luxury. The whole activity of consumption has become a form of entertainment through shopping which, he notes, "encourages voyeuristic consumption. . . The individual is increasingly on display as he/she moves through the field of commodities on display" (p. 173). An important part of advertising is the floating signifier effect, referring to Marx's theory of use value and exchange value to describe how the later comes to dominate.

> The detachment of use leads to a detachment of meaning. . . Advertising in particular takes advantage of and promotes the "floating signifier" effect (Williamson 1978; Lefebvre 1971; Baudrillard 1975) by transvaluing the notion of use so that any particular quality or meaning can become attached to any culture product (Featherstone 1991, p. 174).

In particular, the themes of "youth, beauty, energy, fitness" (p. 174) among others, are infinitely compatible with products and routinely sold. Thus, Featherstone argues, it is within the realm of consumer culture and advertising that individuals are "persuaded to adopt a critical attitude towards their body, self and lifestyle" (p. 174). We learn that even these essential parts of life may always be improved upon with the help of commodities.

Advertising images idealize the female body as a symbol of youth, health, fitness and beauty. The more closely a body fits these images, the higher its exchange value. These images of the body emphasize the importance of display, a new role for the body that has previously been viewed as a "vessel of sin" (p. 177) in Western culture. The importance of display is coupled with the possibility of improving and changing the body. Featherstone writes that, ". . . the tendency within consumer culture is for ascribed bodily qualities to become regarded as plastic -- with effort and 'body work' individuals are persuaded that they can achieve a certain desired appearance" (p. 178). Thus, individuals are believed more able to fully control their appearances and are in effect asked "to assume self-responsibility for the way that they look" (p. 178). Featherstone points out that while the emphasis of an idealized body image is of young, slender women, the responsibility of striving for this image does not disappear with age. In fact to the contrary, "notions of 'natural' bodily deterioration and the bodily betrayals that accompany aging become interpreted as signs of moral laxitude" (p. 178). The graying of the United States provides ample opportunity for the advertising, beauty, fitness and cosmetic industries to expand their consumer base. No one is beyond the reach of cultural expectations of body maintenance and improvement. Compounding this pressure are the vast amounts of electronic images (e.g. photographs, video tapes) which sharpen our awareness of our appearance and invite comparisons.

Particularly relevant to my own thesis is Featherstone's brief discussion of Helena Rubinstein who became a multimillionaire by advocating beauty for the masses:

> [Rubinstein] reassured women that there was nothing wrong with wanting to hold onto youth and formulated the consumer culture equation of youth=beauty=health. "To preserve one's beauty is to preserve health and

prolong life" (Rubinstein 1930) (p. 179).

This equation provides the ultimate justification for why cosmetic surgery is practiced within the medical domain.

An ideal image of beauty and health is coupled by Featherstone with a discussion of the changing relationship between body and self. He argues that a new personality has developed, which emphasizes the performing self. This self is narcissistic and excessively concerned with appearance. The focus in this body and self relationship is directed outward on the importance of appearance, maintaining an image, and making impressions on others. In contrast to an earlier emphasis in Western culture on the importance of good moral character, the current emphasis is one of creating a dynamic personality and a flawless first impression.

> Within consumer culture individuals are asked to become role players and self-consciously monitor their own performance. Appearance, gesture and bodily demeanour become taken as expressions of self, with bodily imperfections and lack of attention carrying penalties in everyday interactions (Featherstone 1991, p. 189).

While individuals may choose to ignore the societal expectations of appearance management, this choice is not without penalties in interpersonal interactions. In particular, he notes the importance of appearance and a "presentational self" in the managerial work force. Taking his analysis of performance and interactions one step further, Featherstone writes that, "Behind the emphasis upon performance, it can be argued, lies a deeper interest in manipulating the feelings of others. Anthropologists and ethnologists have long been interested in developing theories of non-verbal bodily communication" (p. 190). He refers to the studies of Paul Ekman on facial expressions

and the relationship between expressions and feelings.[7] While this topic is not the primary focus of this essay, it does lead into an interesting connection with theories on the accomplishment of genders (West and Zimmerman 1987) and the performance of genders (Butler 1990, 1993). In sum, appearance management and the performing self are similar and important in managing interaction.

Body Politic

The body politic in Scheper-Hughes and Lock's (1987) model refers to the social control of individual bodies and is the most macro oriented of the three conceptual levels. Society produces certain types of bodies through social controls in institutions and cultural discourses. Research utilizing the body politic framework tends to focus on how socio-political and cultural forces shape individual experiences to produce the kinds of bodies a society needs.

An important substantive area in which theories of the body politic have been developed is in the study of health and fitness ideologies. Fitness, according to Glassner (1989), is presented as a way for people to "avert several of the risks to selfhood" in modern society. Fitness promises a "'realm of purity' for the self" against the damaging influences of the modern era. In modernity people suffer a loss of control over nature, leading to increased diseases such as heart disease, cancer, and obesity. Our sense of self is replaced by the race to purchase consumer goods.

There are several important ways fitness ideologies shape selfhood. Building

[7] An interesting debate in cosmetic surgery is how surgery might interfere with the facial expression of emotions. A current procedure to reduce wrinkling on the forehead is to inject a paralyzing agent. This keeps the brow from furrowing. Sometimes facial nerves are affected by facelifts and implants, impairing movement and the expression of certain emotions. In addition, smiles and "twinkling" eyes can be surgically created.

upon Mead's (1934) theory of the relationship between the body and the self, Glassner proposes that because we are more aware of our bodies when we are engaging in fitness activities, the tension between the self and the body is eased. The more a body is shaped by fitness, the more important it is to selfhood. "[T]hrough fitness, selves are truly embodied" (Glassner 1989, p. 184). Fitness, Glassner argues, has become synonymous with all aspects of the self, influencing most aspects of our lives. The fit body is reportedly connected to individual achievements such as marital happiness and professional success.[8] One book states that "in these times of high divorce rates and marital unhappiness, couples who exercise together stay together" (Glassner 1989, p. 183). Another article is titled, "How staying in shape yourself can help keep your relationship in shape, too" (Glassner 1989, p. 184). Thus, fitness is proposed as a key to achieving successful self-hood in our postmodern society.

Expanding this analysis, Edgley and Brissett (1990) examine how American concerns with health and fitness are reflections of the individual responsibility for producing health. Drawing from the work of Crawford (1980, 1984), they identify health maintenance as both an "individual responsibility and a public duty" (Edgley and Brissett 1990, p. 259). Similar to Nazism, in which the social body and the physical body were indistinguishable (p. 260), the authors pronounce American's obsession with fitness to be "Health Fascism" (p. 259) and those who enforce it to be "Health Nazis."

Through an awareness of the costs of illness and disease on society, individuals'

[8] The same ideology is present in discourse used by cosmetic surgeons. At a lecture on cosmetic surgery at the University of California, San Francisco, an assistant professor of surgery in the Division of Plastic and Reconstructive Surgery frequently cited the psychological benefits of surgery. While showing "before and after" pictures of patients, he added his own observations of the patient's improved mood and personality:

health producing behaviors are endorsed and promoted by social institutions. Any individuals who have social, psychological or biological problems are viewed as dangers to society:

> . . . the message of the contemporary Health Nazi to those who do not measure up is clear: "you are the problem and you are creating problems for others." In fact, the damaged others may even be "society at large" when the costs of an unhealthy lifestyle are totaled. Increasingly the bill for work inefficiency, health insurance premiums, and medical care are now being laid at the feet of the unhealthy (Edgley and Brissett 1990, p. 264).

The health and fitness movement in our culture supports a rhetoric of individual responsibility for health. In turn, this ideology of individual responsibility supports a capitalist system by reinforcing the Darwinian philosophy of "survival of the fittest." The body politic, then, encompasses the relationship between social order and individual bodies and practices.

Crawford (1984) presents a detailed examination of how cultural perceptions of "health" are related to the social body. In Western industrialized countries individuals are deemed to have personal control over health, and health is considered an individual responsibility. These beliefs are "in part an internalization of the values of inner directedness and self-creation characteristic of the middle class in industrial, capitalist societies" (Crawford 1984, p. 70). There is a relationship, Crawford argues, between cultural ideology and the political structures in society. The ideology of health and fitness has political consequences for society, because it "mystifies the social production of disease and undermines demands for rights and entitlements to medical care" (p. 75).

"She is happier, more energetic. Gone is that tired and angry look." Therefore, key aspects of the fitness ideology described by Glassner are also found in the ideology supporting cosmetic surgery.

The social body has an investment in maintaining the status quo and is supported by individuals' beliefs about health and fitness. Thus, the rhetoric for healthy bodies supports - and is an internalization of - our capitalist socio-political system.

While this study is not focused exclusively on women's fitness, I do explore the political implications of women's appearance practices. I examine the specific links between the health and fitness movement for women and women's choices for cosmetic surgery. For this reason, an examination of the body politic is an integral part of my research.

Symbolic Interactionist Theories for Studying Appearance

In order to realize the analytic profit from utilizing Scheper-Hughes and Lock's (1987) concepts of the individual body-self and the body politic, it is necessary to draw on theoretical formulations which add the dynamics missing from their formulation and which allow the investigator to link the phenomenological, interactive and societal levels. Such formulations are found in symbolic interaction. Theories of symbolic interactionism are particularly useful for a study of appearance because our bodies are an integral part of our identities. In particular, our faces are a primary symbol for who we are, representing our identities and allowing other people to recognize and interact with us.

Mead's Conversation of Gestures

A basic tenet of symbolic interactionist theory is that the "self" is established, maintained and altered in communication. For Mead, language is social and learned. Mead's discussion of how language is learned begins with an evolutionary discussion of how animals communicate by gestures. Gestures are the first element in a chain of

action, and can be predictive, giving information about an action to come. A growl and baring of teeth can mean that a bite is going to follow. Gestures are only meaningful when they can predict behavior by having the same meaning for the sender and receiver. Communication occurs when significant symbols have similar meanings for all users of the symbols (Baldwin 1986, p. 81 [Mead 1934, pp. 325-328]).

According to Mead, this process of communication is mirrored in our thought processes, as we communicate with words in our heads by mentally "talking" to ourselves. In essence, our thoughts are experienced as words (Baldwin 1986, p. 81 [Mead, 1924-25/1964, p. 288]), and we have internalized the conversation of gestures. Mental communication is particularly important because it allows us to role take. Role taking is "stepping out of one's own role and taking the social position of another person" (Baldwin 1986, p. 94). We do this mentally, by imagining what other people will say and how they will respond. Role taking is important, because through it, we can view our own symbolic behavior from the perspective of others and understand others' social roles better.

Cooley's Looking-Glass Self

Cooley's "looking-glass self" (1956)[9] utilizes the concept of role taking to explain the importance of appearance. There are three elements in the "looking-glass self" experience:

> . . . the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling such as pride or mortification (Cooley 1956, p. 184).

[9] Charles Horton Cooley's book *Human Nature and the Social Order* was reissued in its entirety, possibly with the original page numbers, in *The Two Major Works of Charles H. Cooley* (1956), The Free Press: Glencoe, IL. The citations used here are taken from the 1956 reissued edition.

Even though we cannot see ourselves, we can see others responding to us, which becomes a kind of view of the self. Similar to seeing ourselves in a mirror, we perceive others' responses to us through their reactions. Part of our awareness of ourselves derives from interactions with others and is tied to our physical appearance.

Unlike spoken language, appearance is usually not seen simultaneously by the sender and receiver. The person who is sending the message cannot see what she looks like unless she is looking in a mirror. Through role taking individuals are able to interpret how they look by responding to the actions of others. As I meet a new person, I may watch her responses, gestures, and facial expressions, to interpret if her reactions towards me are positive or negative. Thus, role taking is similar to looking in a mirror.

> Each to each a looking-glass
> Reflects the other that doth pass
> (Cooley 1956, 184).

Instead of using a physical mirror, we are using the reactions of others as a human mirror, giving us feedback about our appearance.

Stone's Theory of Appearance

A key work by a symbolic interactionist on the importance of appearance is Gregory Stone's (1962) "Appearance and the Self." Building upon Mead's theory of social interaction, Stone argues that every social interaction has at least two components: appearance and discourse. Because we cannot see our own appearance (unless looking in a mirror) our awareness of our appearance comes from others' reactions to us. Unlike our vocal discourse, which we can hear and intercept, we usually depend upon interaction for feedback about our appearance. Stone notes that,

> Apparent symbols are often silent and are best intercepted by mirrors, while one's own ear always intercepts one's own vocal gesture about as it is intercepted by others. But mirrors are not always handy; so it happens that the silent appearance, even more than the vocal utterance, comes to require an audience which can serve as a mirror, reflecting one's appearance back upon himself (p. 87, footnote).

Thus, *appearance is a socially situated dimension of human interaction.* It is through interaction that appearance achieves meaning. Stone (1962) believes that appearance is at least as important as discourse for the establishment and maintenance of the self.

In order for communication to occur, the sender and receiver of the message must have a shared basis for meaning. One way that shared meaning is accomplished is by role-taking. In order to engage in role-taking, we must apprehend the other's role, the other's attitude and to some extent the other's self. Thus, to guarantee against non-sense in communication, we use "identification" with the other (Stone 1962, p. 89). There are two processes that must occur in identification. The first is identification of a person and the second is identification with a person (as in sympathy and empathy). Of the prior process, Stone writes, "Above all, identifications of one another are ordinarily facilitated by appearance and are often accomplished silently or non-verbally" (p. 90). As an example he cites gender. The establishment of gender usually takes place through appearance. Thus, when a baby's gender cannot be easily identified by clothing, people will ask, "Is it a boy or a girl?"

> Appearance, then, is that phase of the social transaction which establishes identifications of the participants. . . . It sets the stage for, permits, sustains, and delimits the possibilities of discourse by underwriting the possibilities of meaningful discussion (Stone 1962, p. 90).

Appearance is an active partner with discourse in communication.

To support his thesis, Stone draws from his own research on talk about dress. He

identifies two important concepts which have become important in the study of appearance. These concepts are *review* and *program*. *Review* refers to comments made about the clothing of others. *Program* refers to comments one makes about her own clothes. Stone's concepts of *review* and *program* resurfaced in two articles in Symbolic Interactionism (20:1:1997) addressing women's appearance practices.

Kimle and Damhorst's (1997) research on the social meanings conveyed by an ideal business image for women is an example of how symbolic interactionist theory is useful for a study of appearance from the feminist position of "beauty as liberation." Based on interviews with twenty-four business women, Kimle and Damhorst report that the women showed an awareness of multiple meanings conveyed by dress and appearance, particularly the "reflexive evaluation of appraisals by others" (p. 51). The women were aware of being *reviewed* and reported on others' appearance programs. Using a grounded theory analysis, Kimle and Damhorst identify six core concepts, which they pair into three polar opposites: conservatism and fashion; masculinity and femininity/sexuality; and conformity and creativity. In each of these pairs, the former is linked with traditional male gender roles and the later with feminine roles. The women were aware of the importance of striking a delicate balance between these polar opposites. An extreme position in any category constituted a "danger zone," and could lead to a loss of credibility. For example, extremely masculine attire could lead to gender norm violation.

Between all three dichotomies in the Kimle and Damhorst (1997) framework are continuums of ambivalence. The continuums in the model capture, "The everyday process of integrating multiple 'me's' or meanings of the self (cf. Mead 1934; Stone

1962) in a single appearance . . ." (Kimle and Damhorst 1997, p. 64). Drawing from Goffman's (1959), *The Presentation of Self in Everyday Life*, the authors note that,

> Goffman (1959) contended that identity construction is inherently contextualized within social constructions of time and place. We found that women's business dress in late 20th century American society has a degree of latitude in choice that allows women to embrace multiple roles and contexts in a single appearance (Kimle and Damhorst, p. 60).

Because women in our present society have more choices in terms of work and home roles, the images we construct for these choices carry more significance. As a result of the ambivalence inherent in women's roles -- for example, the tension between caring for a family and pursuing a career -- the choices women make are laden with meaning.

Endorsing the "beauty-as-liberation" position, Kimle and Damhorst (1997) report that their respondents felt proactive in their choices for ideal images of women's business dress and did not feel they were being defined by men's images of women. The women they interviewed accepted the importance of attractiveness and embraced it without complaint. Countering the assertions made by Wolf (1991) and Faludi (1991) that a more traditionally feminine type of business attire is related to keeping women in subordinate positions, Kimle and Damhorst found feminine dress to be a way for women to assert themselves and the importance of the aesthetic in their lives.

> Participants felt that the shift back towards more creative and fashion oriented dress for women's business images was due not only to women asserting themselves, but also valuing themselves . . . The aesthetic nature of appearances are, for women, a productive outlet (Kimle and Damhorst 1997, p. 63).

Shaping their bodies and faces through surgery may be for some women a rewarding aesthetic practice, and begin to define the meaning of cosmetic surgery for women.

Hunt and Miller (1997) further explore Stone's (1962) concept of *review* in their

examination of how discourse about dress and appearance is "identity talk." Stone's (1962) concept of *review* refers to judgments of someone else's appearance. The concept of *review* is divided into three components: (1) moral precepts, (2) program neutralizations, and (3) review neutralizations. The component most relevant to my research is moral precepts. In particular, the moral precept of respecting diverse presentations of self is problematic for a study of cosmetic surgery.

Respect for diverse presentations of self was defined by Hunt and Miller's (1997) respondents as having no absolute standards for an "ideal" appearance. Similar to the motto "you can't judge a book by its cover," interviewees implied that it was "inappropriate" to judge people on the basis of appearance. The appearance of a person isn't a reflection of what they are "inside." When trying to identify an "ideal" appearance, Hunt and Miller "found an unwillingness of respondents to commit to descriptions of an ideal image" (p. 70).

This finding is particularly interesting for a study of cosmetic surgery. How can cosmetic surgery operate in cultures with a strong moral precept against an "ideal image?" Part of what cosmetic surgery does is attempt to mold our faces and bodies to match an ideal image of appearance. In this way, cosmetic surgery homogenizes people by decreasing deviation from the norm. Thus, there is a tension between cosmetic surgery practices and the moral precept that respects diversity of appearance.

Davis on Fashion

In *Fashion, Culture and Identity*, Fred Davis (1992) offers a third and theoretically sophisticated application of symbolic interactionism to the study of fashion and its cultural meanings. His basic thesis is that fashion is representative of cultural

themes, as well as reflecting and influencing individual expressions of identity. For example, changing gender roles are expressed in women's fashions. Davis links women entering the paid work force and having more powerful positions with the emergence of the "power suit" for career women in the 1980's. Fashion serves the purpose of expressing our social identities. As our identities change, so do their expressions in fashion.

Davis' discussion of the importance of ambivalence in creating and understanding fashion is particularly relevant for my study of cosmetic surgery. Fashion has meaning and communicates information about the wearer and the situation. The meanings of fashions are often difficult to interpret, based on the fact that they are wrought with ambiguities. In fact, Davis argues, one of the defining features of fashion is ambiguity.

Describing the importance of ambiguity, Davis turns to semiotics, borrowing the theory of a code for analyzing fashion. This clothing code is not set nor permanent, but rather is built on the qualities of ambivalence and always being in process. The clothing code has three main characteristics. The first quality is context-dependency, in which the meaning of clothing varies depending on the context. Davis notes, "Despite being made of identical material, the black gauze of the funeral veil means something very different from that sewn into the bodice of a nightgown" (p. 8). The second quality is high social variability in the signifier-signified relationship. The meanings of clothes can change dramatically within social relationships: "There is considerable variability in how its constituent symbols are understood and appreciated by different social strata and taste groupings" (p. 8). The third quality of the clothing code is undercoding, which:

occurs when in the absence of reliable interpretative rules persons presume

> or infer, often unwittingly, on the basis of such hard to specify cues as gesture, inflection, pace, facial expression, context, setting, certain molar meanings in the text, score, performance, or other communication (p. 9).

Subtle qualities in clothing communication rely on undercoding to establish that a message is important. In these ways, clothing is expression.

Part of the power of clothing is the unexpressed quality, the quality of ambivalence and divergent meanings depending upon context. Fashion involves the element of change and a shift in the relationship of signifier and signified (what types of clothing carry what types of cultural meanings). In the clothing code this relationship of sign and signified is not as precise as in spoken language, and it is precisely this space for interpretation that is important in Davis' analysis. This space allows for new meanings to develop in fashion.

Since the definition of fashion involves change, Davis asks, "What propels fashion? What underlies the changes in code?" He writes that fashion serves the purpose of expressing our social identity. Our experiences as persons (i.e. yearnings, concerns, sense of self), which are often collective facets of our social identities, are expressed in fashion. As underlying cultural tensions and experiences change, so do their expressions in fashion. For a fashion to be successful it must express these collective facets in our identities and society. Ideally a successful fashion,

> . . . manages through symbolic means to resonate exquisitely with the shifting, highly self-referential collective tensions and moods abroad in the land. Indeed, in so doing it more than lends expression to them; it helps shape and define them as well (p. 18).

This last sentence is particularly interesting. Davis is acknowledging that there is a dialogue between fashion and identity. Not only does our clothing speak about our

selves, but actions of fashion shape collective identity ambivalences. Because Davis is securely grounded in the symbolic interactionist tradition it is clear that this ambivalence of the self stems from diverse inner dialogues involving interactions between mind, self and society (Mead 1934).

In relating this work to my research, I note how cosmetic surgery may be an expression of fashion, however problematic. The facial and physical appearances that cosmetic surgeons attempt to create are clearly influenced by the current fashions and ideals of beauty. Examples are large or small breasts and thin lips versus full, pouting lips. Yet there are significant differences that make this relationship a problematic one. Compared with clothing and hairstyles, cosmetic surgery is much more permanent. Once performed, cosmetic procedures are difficult or impossible to undo. Thus they cannot change as quickly as fashion, making their expression of the constantly changing collective identity ambivalences in our culture more difficult. A second problematic is that many (if not most) cosmetic surgeons would deny this influence of fashion. Instead they tend to articulate that they are subscribing to a higher standard of beauty, an ultimate standard, an ideal image which transcends fashion. Defining the expression of this ideal is a task that some surgeons have attempted as a guideline for other surgeons. A third problem with this comparison of cosmetic surgery and fashion is that the physical act of surgery usually involves women as passive participants. Unlike a woman actively choosing her clothing in a store or her own closet, women having cosmetic surgery are usually sedated or unconscious. Because of these properties, cosmetic surgery will not replace fashion for expressing the quickly changing collective identity in society.

In comparison, fashion has a history of encroaching into the realm of cosmetic

surgery. This is the explicit subject of a New York Times article, "Dressing in Shape for the 90's . . . the No-Sweat Decade" (1995), focusing on the resurgence of body shaping and body controlling undergarments in women's lingerie. The article notes that women are fed up with diets and exercise for achieving a desired body shape, so instead they are turning to shapewear. Shapewear is the new term for modern day girdles, belly belts, and Wonderbras.

Relevant to research on cosmetic surgery is the idea that shapewear may compete with cosmetic surgery. The article points out that many women and models have opted for silicone breast implants. Instead of surgery, and now especially with the dangers of silicone, shapewear is chosen as a viable alternative.

> . . . many an ordinary woman who thought she was cheated when curves were handed out also sought a bigger bra size through silicone. Now that fears have arisen about such implants, however, women have rediscovered the padded bras that helped the small-breasted wear the curvaceous styles of the 1950's. Enter the Wonderbra (p. F-5).

Even more revealing is a new line of pantyhose by Hanes Hosiery called "Smooth Illusions, " promising liposuction without surgery. The president of Hanes Hosiery, Cathy Volker, says: "We call it body contouring and have gone into spot reducing -- whether the woman's problem is her tummy, her hips or her derriere" (p. F-5). The term and language of "body contouring" is identical to that used by plastic surgeons. Thus, these kinds of women's undergarments are now presented as alternatives to cosmetic surgery and the language of cosmetic surgery is borrowed by the fashion industry. This co-optation reveals the popularity of cosmetic surgery and further blurs a distinction between fashion and surgery. Perhaps as Susan Bordo (1991) suggests, cosmetic surgery may be more appropriately named "fashion surgery."

Goffman on Stigma

One of the most important contributions from the symbolic interactionist tradition to studies of appearance is Erving Goffman's (1963) *Stigma: Notes on the Management of Spoiled Identity*. In Goffman's writing the concept of the body immediately becomes a central theme. Indeed, the term "stigma" originated "to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p. 1). While Goffman does point out that stigmas can take non-physical forms (a distinction I return to later), he first attends to visible stigmas. A stigma can therefore refer to a physical, bodily characteristic or marker which marks the individual differentness of the stigmatized person.

For the person disqualified from inclusion in the "normal" group on the basis of a characteristic, this characteristic becomes a stigma.[10] It is important to note that the quality itself is not necessarily a stigma, but that the relationship of this quality to the person can become a stigma. "An attribute that stigmatizes one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing itself" (p. 3). In short, stigmata are socially constructed. A current example would be a tattoo or pierced nose; where in some social interactions this attribute would be stigmatized, in other settings it might confer a degree of belongingness.

Many different attributes can be stigmatized. These qualities can be roughly sectioned into two categories: visible and invisible. Generally the prior is a physical

[10] While Goffman uses the term "normal" without the eroticizing quotation marks, in a footnote (p. 7) he does express concern for using such a blanket term. He questions the criteria for assessing the "normal human being." It is evident from this footnote that Goffman recognized "normal" to be a socially constructed term. For the purpose of this study, the question of physical normalcy in appearance becomes an interesting point for further research.

stigma (such as a facial scar) and the latter is an intangible stigma (such as mental illness or a heart condition). Qualities such as physical birth defects, racial identity, and blindness are often visible on the body and can be readily discerned. Qualities such as dishonesty, mental illness, homosexuality, and genetic predisposition to illnesses may all be judged to have stigmatic potential depending upon the population in which they are being judged.

These two types of stigmata are further defined as discredited and discreditable. The person whose stigma is immediately visible in social interaction is already discredited when interaction begins. On the other hand, the person whose stigma is hidden or intangible is only discreditable. For this person there is the possibility that his or her stigma will not be noticed, and he or she may "pass" as a "normal" individual. It is with these qualities that the process of "passing" becomes important (1963, p. 42). The stigmatized individual has a characteristic that sets her apart and makes her abnormal, but this is not necessarily the case for the individual who "passes" as normal.

Goffman's concept of identity is based at least in part on appearance. He quotes extensively from K.B. Hathaways' (1943) book *The Little Locksmith*,[11] in which the main character is looking at himself after a physical disfigurement. The person in the mirror is perceived as almost an entirely different individual, as if the new, disfigured appearance is forcing a new identity:

> I didn't scream with rage when I saw myself. I just felt numb. That person in the mirror couldn't be me. I felt inside like a healthy, ordinary, lucky person -- oh, not like the one in the mirror! Yet when I turned my face to the mirror there were my own eyes looking back, hot with shame . .

[11] K. B. Hathaways. 1943. *The Little Locksmith.* New York: Coward-McCann. See Goffman (1964, p.41).

> . Over and over I forgot what I had seen in the mirror. It could not penetrate into the interior of my mind and become an integral part of me (Goffman 1963, p. 8).

This quote addresses the importance of appearance in representing and creating identity, while simultaneously testifying to the strength of an identity that is capable (although challenged) of holding a previously formed identity, within a changed and different body or face.

Here Goffman first discusses plastic surgery. How the stigmatized person lives and relates to him or herself depends to a large extent upon how other people accept (or perhaps more often reject) him or her. Sometimes the stigmatized person responds to this situation by trying to correct the attribute and thus remove the stigma. Goffman asks:

> How does the stigmatized person respond to his situation? In some cases it will be possible for him to make a direct attempt to correct what he sees as the objective basis of his failing, as when a physically deformed person undergoes plastic surgery, a blind person eye treatment, an illiterate remedial education, a homosexual psychotherapy. . . Here proneness to "victimization" is to be cited, a result of the stigmatized person's exposure to fraudulent servers selling speech correction, skin lighteners, body stretchers, youth restorers, . . cures through faith, and poise in conversation. Whether a practical technique or fraud is involved, the quest, often secret, that results provides a special indication of the extremes to which the stigmatized can be willing to go, and hence the painfulness of the situation that leads them to these extremes (p. 9).

If I reframe my study of women and cosmetic surgery to identify the surgery, and the accompanying pain, costs and risks as the extent to which a woman is willing to go, then, a la Goffman, this could/would reflect the degree of pain a woman feels by being stigmatized as ugly and/or old. It is painful for many people to be compared to an ideal of youthful beauty, as comparison to any ideal points out our deficiencies. When one's own appearance is judged to deviate sharply from such an ideal, the woman becomes (in

Goffman's terms) "abnormal" and stigmatized. Indeed women's decisions to have surgery were sometimes directly related to difficult experiences of stigmatization. Examples from my interviews include being called an "old bitch" and having a friend verbally remark about one's aging appearance. Thus, for the women who participated in this research study, aging is a stigma.

Feminist Constructions of Gendered and Raced Bodies

Theories of bodies have particular importance in recent feminist theory because this is where issues of essentialism have been raised. Historically the female body has held a prominent place in feminist writing and women's social movements (see Ruzek 1978). Note, for example, the massive political mobilization around reproductive rights. In addition, much research on the female body has focused on women's reproductive capacities and their social meanings.[12] Here I focus on theories where gendered and raced bodies are critically analyzed. First I begin with a discussion of social constructionism, paying particular attention to how such theories can be applied to a study of cosmetic surgery. Then I review how feminist theorists have analyzed the constructed nature of gender and race. While gender and race are simultaneously created and situated, for the purposes of this review I have divided these concepts into two sections. The first section covers literature which theorizes the gendered body, and the second section focuses on the raced body.

The Social Construction of Reality

Although plastic surgeons might argue for an "ideal" or "classic" standard of

[12] For an excellent example of the cultural analysis of women's reproductive bodies see Emily Martin's (1987) *The Woman in the Body.*

beauty against which they measure people's faces, I propose that not only is the standard of beauty socially constructed, but that concerns with a beautiful appearance, and indeed the qualities of that embodied appearance, are socially constructed as well.

The key early work in the history of social constructionism is *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* by Berger and Luckman (1966). This work is important because it developed from a sociology of knowledge tradition and forms a foundation for social constructionist theory in the United States. The title itself has become a significant phrase in sociology. When we say "the social construction of reality" sociologists are referring to a whole set of ideas which this book first discussed in detail. In this way Berger and Luckman's work is pivotal in the history of sociology.

When reading this book, it becomes immediately apparent that the task the authors were attempting was, at the time, quite revolutionary in social thought. It is tempting to lose sight of the novelty of this task, particularly because today social constructionism is accepted as an important part of the sociological canon.[13] Part of its revolutionary quality stems from the task at hand. Because the premise of social constructionism is that we allow all that is believed to be certain and tangible to be opened up for examination, our bases for "reality" and "concrete knowledge" are shaken and destabilized.

In describing the rationale for this line of questioning, the authors trace the origins of social constructionism to a sociology of knowledge:

> Sociological interest in questions of "reality" and "knowledge" is thus initially justified by the fact of their social relativity. What is "real" to a Tibetan monk may not be "real" to an American businessman. The "knowledge" of the criminal differs from the "knowledge" of the criminologist. It follows that specific agglomerations of "reality" and "knowledge" pertain to specific social contexts, and that these relationships will have to be included in an adequate sociological analysis of these contexts. The need for a "sociology of knowledge" is thus already given with the observable differences between societies in terms of what is taken for granted as "knowledge" in them. Beyond this, however, a discipline calling itself by this name will have to concern itself with the general ways by which "realities" are taken as "known" in human societies. In other words, a "sociology of knowledge" will have to deal not only with the empirical variety of "knowledge" in human societies, but also with the processes by which *any* body of "knowledge" comes to be socially established *as* "reality." . . . . we contend that *the sociology of knowledge is concerned with the analysis of the social construction of reality.* (pp. 2-3) (italics in original)

As is evident from this quote, Berger and Luckman were aware of the need to place their argument within a historical framework of social thought. This was probably done for two reasons. First is that the authors were self-consciously aware of the radical nature of their theoretical proposal. A second and more interesting reason is that since the roots of social constructionism itself came from the sociology of knowledge, the authors were already attuned to the importance of tracing the genealogy of their own theories. The authors in effect practice what they preach, and recognize their own historical situations which influence their thought and scholarship. In tracing their intellectual genealogy, Berger and Luckman acknowledge the importance of Karl Mannheim's (1936) work on the sociology of knowledge and the impact that this German scholar had on American sociology. They also point to the contribution of Robert Merton (1957), through whom most American sociologists had, until then, derived their understanding of the sociology of knowledge. Merton emphasized that knowledge is

[13]Beyond the social sciences, however, the revolutionary nature of social constructionism is quite clear to observers. See, for example, Gross and Levitt's attack on constructionist science studies in their *Higher Superstition: The Academic Left and its Quarrels with Science* (1994).

always created from a certain position.[14] Berger and Luckman's treatise on social constructionism is especially important for spreading the sociology of knowledge to a critique of science and nature. This book was a profoundly influential theoretical intervention, because the authors radically extended constructionism to apply to nature and science.

Feminist Constructions of Gendered Bodies

Doing Gender

During the last ten years a revolution has been occurring in feminist theories on the body, stemming from the inadequacies of the sex/gender distinction in feminist social theory. In *Doing Gender*, West and Zimmerman (1987) clearly detailed these distinctions. The terms sex, sex category, and gender are important in showing how gender is socially accomplished. Sex refers to the taken-for-granted, socially agreed upon biological criteria for classification of people as either male or female. West and Zimmerman note that while this category often remains unquestioned, it is nevertheless a socially constituted process with many areas of ambiguity. The term sex category is defined as a "master identity" (Hughes 1945) and refers to assigning individuals to either the male or female category. The authors stress that this assignment is made on the basis of appearance and assumption of conformity. Proof of belonging to a sex category is rarely demanded. "In this sense, one's sex category presumes one's sex and stands as proxy for it in many situations" (p. 127). Therefore, the assignment of sex category is dependent upon "identificatory displays" which actively serve to proclaim our membership. When these displays are ambiguous sex category determination can be

[14] A point much akin to Mead's concept of perspective. See Mead (1934) and Merton (1957). However,

difficult.

In comparison to the terms discussed above, gender is conceived as a more complex production. West and Zimmerman describe how by *doing gender* it is "accomplished" through situated interactions. The term accomplishment here refers to "an achieved property of situated conduct" (p. 126). The authors argue that gender is not an individual property or quality that men and women possess, but rather is constituted through interactional relations and institutional systems.

> Accordingly, virtually any activity can be assessed as to its womanly or manly nature. . . While it is individuals who do gender, the enterprise is fundamentally interactional and institutional in character, for accountability is a feature of social relationship and its idiom is drawn from the institutional arena in which those relationships are enacted. If this be the case, can we ever *not* do gender? (pp. 136-7)

Thus, the authors argue that doing gender is unavoidable, as every action we make is gender accountable. Furthermore, this accountability frames expectations of "essential" differences between men and women, as any social situation allows for the production of difference based on sex category. In particular, conversational style (referred to in Fishman 1978) is discussed as a way of enacting these differences between manliness and womanliness.

Obviously, "doing gender" is part of the action in plastic surgeons' offices.[15] The decision to have surgery, and the social setting which makes such surgery socially sanctioned for women, while problematic for many men, is a gendered arrangement. The entire social setting which makes this kind of treatment of women's bodies socially acceptable is doing gender. It is the very awareness of the pressure on women to be beautiful (whether critiqued or not) that allows cosmetic surgeons to appear compassionate towards women. But these explanations often disguise the fact that plastic

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Merton clearly and thoroughly exempted scientific knowledge itself from social analysis.

[15]Refer to my discussion of Dull and West's (1991) article in the section on studies of cosmetic surgery at the end of this chapter.

surgery itself is helping to create these oppressive conditions. Plastic surgery thus creates new possibilities and expectations for doing gender.

Feminist Theories of Bodies

Nelly Oudshoorn in *Beyond the Natural Body: An Archeology of Sex Hormones* (1994), traces the development in feminist thought of questioning the universal natural body. She writes that feminists "by introducing the sex-gender distinction, reproduced the traditional task division between the social sciences and the biomedical sciences" (1994, p. 2). In contrast, the task of feminist studies on the body today is much more radical, challenging the very basis of a universal natural body:

> The social constructivist approach opened up a whole new line of research exposing the multiple ways in which the biomedical sciences as discursive technologies (re)construct and reflect our understanding of the body. The body, in all its complexities, thus achieved an important position on the feminist research agenda (1994, p. 4).

Oudshoorn is arguing that it is not only the "social" that is constructed but also the "natural." Moreover both are heterogeneously constructed, as Emily Martin's work (1987) also demonstrates. Here I review how the body has been theorized in feminist theory, particularly the control of the female body, slimness, and images of the "normal" female body.

Kim Chernin's (1994 [1981]) *The Obsession: Reflections on the Tyranny of Slenderness*, is an interesting account of one woman's lived experience of attempting to control her weight and minimize her body. Chernin provides both her own reflections and a feminist critique of eating disorders.

The central themes in this book are that women are obsessed with minimizing their bodies and that this obsession is related to patriarchal culture. She writes that girls, especially those on the cusp of adolescence, really fear and dislike their bodies and don't

want them to become womanly. Chernin says that just at the age when girls are developing into women their bodies change. Girls "fill-out" with more soft tissue and fat, develop breasts, fuller thighs and bellies. The idealized image of a thin female body, she argues, is the denial of their womanliness. The curves, softness and fat that girls seek to rid themselves of are the essential qualities of a grown woman. Girls are culturally directed to reject their womanhood and seek bodies like teenage boys.

Chernin believes that all women who are dissatisfied and trying to change their bodies are involved in a struggle of the mind over body:

> The body troubles us. We find that we cannot be at peace in this body that wakes hungering in the morning, filled with urges and appetites we cannot control and are unable to transcend. But it may help us, in our lonely anguish over the body, to realize that the struggle to dominate the body is endemic to this culture, and may well characterize patriarchal culture altogether. The woman who wakes early, and counts over the number of calories she ate the night before, wondering whether her body has added substance to itself at the expense of her will, is standing within an old tradition (p. 56).

In this way Chernin links women's individual experiences to a broader understanding of women's positions in patriarchal culture (i.e. the personal is political). Throughout the book, Chernin appears to be referring primarily to white, middle and upper class women. She does not address race or class issues.

An important point that Chernin makes in *The Obsession* is linking women's personal agony in trying to control their bodies with the political climate of the 1970's. She asks why it is that women's obsession with slenderness, anorexia and bulimia have only recently been acknowledged as problematic. She points out that this increased emphasis on weight happened at the same time as the second wave of the women's movement.

> During the 1960's the Feminist Movement began to emerge, asserting woman's right to authority, development, dignity, liberation and above all, power. What am I driving at here? I am suggesting that the changing awareness among women of our position in this society has divided itself into two divergent movements, one of which is a movement toward feminine power, the other a retreat from it, supported by the fashion and diet industries, which share a fear of women's power (p. 99).

It is interesting to note that Chernin's thesis about eating disorders in American society was written in 1981 and is essentially the same message that Naomi Wolf writes about in the *Beauty Myth* (1991) and Susan Faludi explores in *Backlash* (1991), both a decade later. All three books argue that there is a backlash against women striving for more autonomy and power, and one way the backlash is expressed is in ever more limiting and controlling the female body. All three authors argue that restrictive cultural images of women today are representative of the degree to which women are oppressed in society. This oppression coincides with the degree of changes that women are making to gain autonomous power.

While Chernin focuses primarily on women's obsession to be thin, her analysis can be effectively compared to women's experiences with cosmetic surgery. The participants in this research study did exhibit and discuss signs of obsession with cosmetic surgery. For example, returning for subsequent surgeries was a common experience for these women, with 75% of the sample having two or more surgeries.

The Work of Bordo

Susan Bordo, a postmodern feminist philosopher, has written extensively on the cultural meanings of the slender female body in Western culture (Bordo 1990, 1991, 1993). Her book *Unbearable Weight: Feminism, Western Culture and The Body* (1993), comprehensively explores three substantive topics: discourses and conceptions of the

body, the slender body and other cultural forms, and postmodern bodies. The strength of her analysis is managing to simultaneously address material concerns, individual experiences and cultural influences.

Bordo shows how women's experiences of their bodies are influenced and shaped by cultural images in ways that reinforce gender hierarchies. Through a detailed analysis of the meanings of slenderness, fatness and control of women's bodies, the female body is examined as a site of oppression in Western culture. Studies and writings about eating disorders comprise a major part of Bordo's data and examples. Focusing on anorexia, Bordo describes the experience in terms of power and control, one that supports the mind/body dualism for women in Western culture. This mind/body dualism is gendered in Western thought, where women=body=bad. She argues that attempts to go beyond these dualisms in social theory and philosophy represent a "fantasy of transcendence" (Fisher 1994). In addition, eating disorders are part of our culture and express cultural tensions between the ideals of consumption and restraint. Bulimia is a key example, with the struggle between these two ideals being played out quite literally.

Visual images in popular culture are another source of data for Bordo's analysis. In several interesting passages Bordo deconstructs images in music videos, magazines, and advertisements. Her analysis is particularly strong in "'Material Girl': The Effacements of Postmodern Culture" (1991; 1993). It is here that Bordo examines the postmodern female body, with Madonna as a case example. She contrasts modern and postmodern metaphors of the body. Modern bodies are compared to a machine, like the inner workings of a watch. In contrast, the postmodern body imagines:

> human freedom from bodily determination. Gradually and surely, a

> technology that was first aimed at the replacement of malfunctioning parts has generated an industry and an ideology fueled by fantasies of re-arranging, transforming, and correcting, and ideology of limitless improvement and change, defying the historicity, the mortality, and indeed the very materiality of the body (1991, p. 106).

Bodies have indeed become plastic, with limitless ways physiques can be shaped and controlled in popular culture. Bordo's examples are body building, dieting and exercise, color contact lenses and plastic surgery. While the cultural discourse is one of plastic bodies within a discourse of choice, she notes that the images of ideal bodies are not really plastic but rather rigid images constrained by race, gender and class:

> Of course, the rhetoric of choice and self-determination and the breezy analogies comparing cosmetic surgery to fashion accessorizing are deeply mystifying. They efface not only the inequalities of privilege, money, and time that prohibit most people from indulging in these practices, but the desperation that characterizes the lives of those who do (1991, p. 109).

A cultural discourse of "choice" supports the assessment of all cosmetic changes as equivalent, with no political or cultural differences in meaning. Hair permanents, make-up, color contact lenses and cosmetic surgery are all treated as similar appearance enhancements, choices to be made with no reference to social position or history. In addition, I would add that the varying degree of severity, risk and permanence of appearance enhancements is also ignored.

Within this plastic discourse Bordo examines postmodern conversation in which differences reign. This focus on differences serves to destabilize political critique. By celebrating difference we become powerless to talk about hegemonic cultural patterns identifying the experience of "most" women.

> This spectacle of difference defeats the ability to sustain coherent political critique. Everything is the same in its unvalanced difference. ("I perm my hair. You're wearing makeup. What's the difference?") Particulars reign,

> and generality -- which collects, organizes and prioritizes, suspending attention to particularity in the interests of connection, emphasis and criticism -- is suspect (1991, p. 115).

It is through this discourse of difference and choice that the American Society of Plastic and Reconstructive Surgery can present itself as "the protector of 'difference' against the homogenizing and stifling regime of the feminist dictator" (Bordo 1991, p. 116). What the difference discourse fails to acknowledge is the power of normalizing imagery that is deeply and systematically gendered, raced and classed.

The implication of Bordo's writing for my study of cosmetic surgery is to situate women's experiences within the broader frame of cultural discourses. Bordo critically analyzes these discourses for supporting the postmodern image of the plastic body. While Bordo is clear in identifying the oppressive features of these discourses, she does not present empowering aspects or recognize the possibilities for resistance. Bordo has often been criticized by feminist theorists for not focusing on women's agency (e.g., Davis 1995). "Because she does not dwell on the possibilities of resistance and diversity, she risks reducing women to conforming consumers of their own degradation" (Counihan 1993, p. 20).

The Work of Butler

Another postmodern feminist philosopher of the body is Judith Butler. In *Gender Trouble* (1990) and *Bodies That Matter* (1993) Butler examines cultural constructions and performances of gender. In *Gender Trouble,* the idea of the natural subject is questioned, as Butler deconstructs the premises of identity that support gender constructions. Both gender and sex are acknowledged as cultural constructions whose appearance as "natural" create the means for compulsory heterosexuality. Therefore,

"feminist political strategy must consist of subverting and displacing dominant norms of gender identity and compulsory heterosexuality" (Martin 1991, 421).

Several chapters of *Gender Trouble* are devoted to genealogical critiques of (mainly French) theorists writing on sex, gender and identity. Butler examines the assumptions and heterosexual basis in the theories of Kristeva, Irigaray, Wittig, de Beauvior, Lacan, Freud, Levi-Strauss, and Foucault. She analyzes how the premises of identity in these theories support specific gender constructions. For these reasons, Butler finds fault with identity politics in feminism. Instead we need to subvert/deconstruct identities in order to make "gender trouble."

The strategy Butler proposes is one of parodying and rupturing categories of gender, sex and desire. Examples which parody gender are drag and lesbian butch/femme distinctions. Through the subversion of gender identities Butler argues that we can reveal the culturally constituted nature of these categories. In short, what is "natural" is shown to be artificially created. Through parody the performative nature of gender is expressed. The idea of performance is important in Butler's writing, since that is how gender is expressed and learned. There is an illusion of permanence and consistency in gender when it is not recognized as performance.

In *Bodies that Matter: On the Discursive Limits of "Sex,"* Butler (1993) continues to pursue topics of gender performativity and identity subversion. Here she more fully develops her notion of queer theory, seeking to problematize sexual hierarchies and the power of heterosexuality. Bodies, she writes, are discursively constructed through the identification of sex. The discourse of sex creates the matter (both materialization and signification) of bodies. Sex is therefore a "cultural norm which governs the

materialization of bodies" (1993, p. 3). Sex also forms the subject, being a prerequisite for identity. In this way, "sex" becomes the central focus of Butler's writing:

> the regulatory norms of "sex" work in a performative fashion to constitute the materiality of bodies and, more specifically, to materialize the body's sex, to materialize sexual difference in the service of the consolidation of the heterosexual imperative (1993, p. 2).

Like *Gender Trouble*, Butler suggests subversive performativity reveals the importance of "sex." She provides several illustrations where these complexities are evident, such as Jennie Livingston's (1991) film *Paris is Burning*.

An illustration of subversive performance from the domain of cosmetic surgery which furthers Butler's analysis is the art of Orlan. Parodying the practices of cosmetic surgery, French performance artist Orlan has devoted her body to expose the (literally) constructed nature of women's beauty. As of February 1994, Orlan had "performed" nine facial surgeries in an attempt to blend the facial characteristics of famous beauties in art and mythology (such as Diana, Mona Lisa and Venus) (Rubin 1994; Gerhard 1994). These surgeries were all brought to art galleries through live television coverage, where parts of Orlan's body (skin, tissue, and fat) are framed and sold as pieces of art. How could we get a more authentic piece of artwork than her material flesh and blood? Orlan has become a walking piece of art and in so doing has ruptured our understanding of cosmetic surgery. Her performances expose the constructed nature of female beauty, calling attention to the violent nature of cosmetic operations. This is an excellent example of the power of parody as discussed in Butler's theory, however harrowing.

Feminist Constructions of Raced Bodies

Doing Difference

Taking the analysis from *Doing Gender* (1987) several steps forward, *Doing Difference* (1995) by Candace West and Sarah Fenstermaker is a sequel that incorporates how class and race, like gender, are also accomplished through daily interaction. "'[D]ifference' is an ongoing interactional accomplishment . . . an emergent property of social situations . . ." (p. 8-9), not an individual characteristic.

An analysis of how gender, race and class interact in the "accomplishment" of cosmetic surgery is important for this study. Although the population of women (and men) seeking cosmetic surgery is changing, historically it has been limited to white, upper and upper-middle class women. Therefore, cosmetic surgery is a raced and classed (as well as gendered) phenomenon.

West and Fenstermaker begin by noting that feminist theory has oftentimes tried to correct for an inherrent white and middle-class bias by adding or multiplying the effects of race and class on "women's" degree of oppression. Specifically I found the reference to Elizabeth Spelman's (1988) discussion of the limitations of the term "women" very relevant. They note that "in practice, the term 'women' actually functions as a powerful false generic in white feminists' thinking" (West and Fenstermaker 1995, p. 11):

> First, the description of what we have in common "as women" has almost always been a description of white middle-class women. Second, the "difference" of this group of women -- that is, their being white and middle-class -- has never had to be "brought into" feminist theory. To bring in "difference" is to bring in women who aren't white and middle class (Spelman 1988, p. 11).

There is a tendency in social science research to isolate gender from race and class, which has lead to enormous difficulties and attempts to weigh different oppressions. West and Fenstermaker write that these three "systems" of oppression (racism, sexism and classism) have been discussed as additive, multiplicative, and as intersecting geometric-like planes. Each of these analytic models for studying oppression has major problems. In particular they tend to rank types of oppression (giving preferential treatment to one over another) and fail to express the specific nature of how oppression is experienced.

The last model of oppression West and Fenstermaker review is the most hopeful, they believe, summarizing from the work of Spelman (1988) and Anderson and Collins (1992). This system is described as "interlocking" (p. 13) in which sexism, racism, and classism are represented by interlocking circles. While this picture continues to present the rings as separate parts, the authors propose that we look instead at the experience of all women and men (with the exception of white, upper and middle-class men, who are not represented in the circles) as residing within the space shared between the three rings:

> Here, we face an illuminating possibility and leave arithmetic behind: no person can experience gender without simultaneously experiencing race and class. As Anderson and Collins put it, "While race, class and gender can be seen as different axes of social structure, individual persons experience them simultaneously" (1992, xxi). . . How do forms of inequality, which we now see are more than the periodic collision of categories, operate together? How do we see that all social exchanges, regardless of the participants or the outcome, are simultaneously "gendered," "raced," and "classed" (p. 13)?

The authors seek to answer these questions by building a conceptual model which allows us to think of these three categories as interacting simultaneously.

We become accountable for our activities as conforming or deviating from our gender (as "womanly" or "manly" behaviors), from our race and our class. The authors stress that even this accountability is accomplished through situated social action, and occurs on both interactional and institutional levels, thereby contributing to "the

reproduction of social structure" (p. 21). By extending their earlier analysis of *doing gender* to race and class, the authors note that they:

> are not proposing an equivalence of oppressions. Race is not class, and neither is gender; nevertheless, while race, class, and gender will likely take on different import and will carry vastly different social consequences in any given social situation, we suggest that how they operate may be productively compared (p. 22).

The authors seek to create a way to better understand the interactions among the three as simultaneously experienced and accomplished.

West and Fenstermaker (1995) discuss the social construction and arbitrariness of race as presented by Omi & Winant (1986). While race is not easily assigned (not being scientifically and biologically linked to any physical quality), and its assignment has varied across historical periods, that none the less, we still do assign ourselves and others to racial categories. "As in the case of sex categorization, appearances are treated as if they were indicative of some underlying state" (West and Fenstermaker 1995, p. 23).

Accompanying this categorization is the notion of accountability, where members must act like the racial category. This notion of accountability is central to West and Fenstermaker's theory, and is paralleled in their discussion of both gender and class. Therefore, race is a trait accomplished both in interaction and institutionally. This accomplishment makes racial categorization look "normal" and "natural." Differences are created and then "used to maintain the 'essential' distinctiveness of 'racial identities' and the institutional arrangements that they support" (pp. 25-6). Thus these qualities provide for "racial" behaviors that reinforce positions in society.

In analyzing class, much the same logic is applied to address "the accountability of persons to class categories in everyday life" (p. 26). While class is different than race and gender because we do not believe it is scientifically differentiated physically, we do assume "that a person's economic fortunes derive from qualities of the person" (p. 28). Initiative is a quality reserved for haves, while laziness is ascribed to have-nots.

Strengthening such ideologies which link character to material conditions is the myth of a classless U.S. society.

> We cannot see the system of distribution that structures our unequal access to resources. Because we cannot see this, the accomplishment of class in everyday life rests on the presumption that everyone is endowed with equal opportunity and, therefore, that real differences in the outcomes we observe must result from individual differences in attributes like intelligence and character (p. 28).

Thus, class categories and institutional arrangements seem "normal" and "natural" as individuals are held responsible for their class positions.

In conclusion, West and Fenstermaker present four implications of seeing gender, race and class as ongoing accomplishments. The first implication is that "we cannot determine their relevance to social action apart from the context in which they are accomplished" (p. 30). The impact of these characteristics are socially situated and can only be analyzed within interaction. In fact it is within interaction that each quality of race, gender or class is defined. The second implication is that while social interaction is a prerequisite for studying these means of oppression, "the accomplishment of race, class and gender does not require categorical diversity among the participants" (p. 30). The authors cite the examples of "manly behavior" expressed in all male locker rooms, and "womanly natures" being expressed in beauty salons. While these places are typically reserved for only one gender, the preformance of gender may be exagerated in these settings.[16] The third implication is that what looks like the same activity (such as mothering and childcare) may have different meanings for people differently situated with regards to accomplishing gender, race and class. In effect the situation both creates and *is created by* the accomplishment of these qualities. Accomplishment involves action in both directions, as the situatedness of an individual can define the situation. Lastly, the

[16]This may be a part of what occurs in the practices of plastic surgery, because it tends to be closeted in much of social interaction, but also openly discussed in certain social situations (among close, upper class, white, women friends, for example).

accomplishment of race, gender and class is "constituted in the context of the differential 'doings' of others" (p. 32). Thus, our positions and other's positions will influence the meanings of the situation.[17] In conclusion, the article calls for situated analyses of the study of race, gender and class, and demands that we call "objective" and "natural" differences into question. Only by doing this will the clear accomplished and interactional nature of differences emerge. Clearly, appearance has a lot to do with race, especially the idea of skin color. In addition, previous research posited that women and men are often trying to transform those features that are racialized when they seek cosmetic surgery (Kaw 1993; MacGregor 1967).

Racialized Gender

In writing about the social construction of *racialized gender* Evelyn Nakano Glenn (1993) notes that in the 1980's feminist scholarship was extending from the study of relations between women and men to concerns with studying the relations and differences among women. Glenn writes of the importance of analyzing power in how these relations are created and sustained in institutional arenas. "Incorporating systems of power requires that we conceptualize difference as positioned and therefore relational in nature. We need to recognize that the kinds of lives some women lead depends on the kinds of lives other women lead" (p. 2). Glenn therefore sets out to analyze how white women and women of color are "relationally contructed." To show that gender necessarily has a racial meaning, that the construction of race and gender cannot be separated, she uses the term "racialized gender."

Glenn analyzes several situations where "white gender" and "racial ethnic gender" are relationally constructed. Her analysis is historical, focusing on how racial categories were defined to support existing institutions and social inequalities. An example is

[17] For example, one's perspective on the Senate hearings for Clarence Thomas's Supreme Court nomination and the opposition posed by Anita Hill was influenced by the situatedness of race, class and gender. Similarly, the variety of responses to the O.J. Simpson trial for the murder of his wife was influenced by race, class and gender positions.

Blacks and Whites in the South (p. 21). Glenn traces how a single category of "black" was constructed in order to maintain the "color line" which legitimized slavery. While this process was controlled by non-slaves, it also contributed to the construction of the category "white." Glenn writes, "In the process of creating a specific racial identity for slaves, European settlers created one for themselves" (p. 21). With the shift towards racial slavery in the United States, it became very important to determine who was a slave. This problem became the same as asking "Who is black?":

> Flexible racial designations became less acceptable as slavery came under increasing moral attack by northern and European critics in the ante-bellum years. Slaveowners had to answer questions about inconsistencies in slavery, such as the enslavement of predominately white persons, institutionalized concubinage, and the double standard of morality in miscegenation. Throughout the South pressure was exerted to harden the two-race system by removing in-between positions and resolving all ambiguities. Eventually, the answer to the question of who was black became "anyone with any known black ancestry." By so doing, white southerners could claim "white" as a pure category." (p. 23)

Another important aspect of the distinctions between white and black was institutionalized through Jim Crow laws, forcing segregation in all areas of life. This segregation reinforced the contrasting image that white was exclusive, while black was inclusive. Thus, to be white, meant that one could only be white, but to be black one only needed "one drop" of black blood.

Social Construction of Whiteness

Like Glenn, Frankenberg's book *White Women, Race Matters: The Social Construction of Whiteness* (1993), focuses on how race and gender are socially constructed. Frankenberg's goal in this book is to explore how race shapes white women's lives. She notes that issues of race impact both the lives of white people and people of color, saying that any system of differentiation shapes the lives of both those it oppresses and those it privileges. Those it privileges, however, are usually unstudied while the oppressed are subject to surveillance. Describing and naming the "racialness"

of white experience is Frankenberg's task, for which she interviewed thirty white women. In her description of "whiteness," the author notes that it is a location of race privilege, it is a standpoint from which to interpret one's life, and it is a set of usually unnamed cultural practices. Frankenberg notes that racism is a part of white women's lives, and sets out to reveal the seeming invisibility of whiteness as the norm against which all others are compared.

One of the most interesting themes in this book is Frankenberg's analysis of how race is both grounded in material relations as well as experienced in social-mental constructions. One example, among many, involves the (invisible) presence of domestic workers:

> "Even the presence or absence of people of color seemed to be as much a social-mental construct as a social-physical one: recall the invisible African American and Latina domestic workers in some apparently all-white homes" (p. 69).

Thus, for the women Frankenberg interviewed, their awareness of race sometimes did not coincide with their material lives. The ability to "see" a person of color was influenced more by social-mental perspectives than by their daily material surroundings.

Throughout this book, Frankenberg does an exceptional job of continually linking historical and structural discourses to individual experiences. She does this through her close attention to cultural discourses, especially Western expansion and colonialism, and exploring how these influence and are reflected in the life history interviews she conducted. It is precisely this ongoing analysis of blending micro with macro that makes this book an insightful piece of qualitative methodology. The simulataneous attention to discourses and to women's individual experiences form the strength of this book.

The salience of Frankenberg's work for my research is twofold. Cosmetic surgery frequently operates within a "blind" culture of whiteness. The majority of cosmetic operations in the United States, about 80% (Kaw 1993), are performed on white individuals. It is my contention that cosmetic surgery is very much a racialized activity.

In addition, Frankenberg's analysis of the influence of cultural discourses provides a model for me to study the discourses surrounding women's decisions to have surgery.

Taken together, the writings reviewed here by Glenn, Frankenberg, and West and Fenstermaker, provide ample support for arguing the socially constituted nature of race. I will return to these concerns at the end of this chapter, where I review works on race and cosmetic surgery (e.g. Kaw 1993).

The Mask of Aging

In "The Mask of Ageing," Featherstone and Hepworth (1991) discuss the changing cultural experience of aging, first focusing on the problems of using life course theories as a way to measure aging. In our society there is a distinction between chronological age (actual age) and biological age (defined by the health, fitness and appearance of the body). One important factor which contributes to the distinction between these two is the cultural practice and expectation of body maintenance. These "proper" body maintenance activities, "hold out the promise of turning the clock back and clearly have a strong appeal in the new middle-class markets for middle-aged and older people (Walmsley and Margolis, 1987)" (Featherstone and Hepworth 1991, p. 374). Thus, body maintenance activities (as cosmetic surgery is sometimes characterized) are clearly part of a culture of aging in many Western countries.

An important theme in this piece is reflected in the title, "The Mask of Ageing." It refers to an experiment by Pat Moore, where she, "disguised herself as an elderly women and went out into the streets of 116 cities in the United States to systematically observe the effects (Young, 1989)" (p. 377). "Old Pat" felt like she was trapped in an old body. She reported feeling constrained by the disguise, and was always aware that it was

just a shell which did not match the way she felt inside. "What is more generally significant is that when she let some of the elderly people she met into her secret she discovered that they also felt trapped in a shell: 'young minds trapped behind old faces' (Young, 1989: 17)" (pp. 378-379). This is particularly relevant to the study of cosmetic facial surgery, because such surgery promises to reconcile the disparities between how we feel and how we look. Changing one's outer appearance may then reduce tensions between the mask and the inner personal identity.

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

There is a difference (perhaps even a rupture) which occurs when we age, between our own image of ourselves, and the outer appearance of our aging bodies. Because of ageism in our society, this outer change can be very difficult and painful for many people. Cosmetic surgery is one way of trying to cope with these changes.

Acknowledging the physical and societal effects of aging on the baby boomer generation, journalist Mary Tannen (1994) wrote about cosmetic surgery in a short piece in *The New York Times Magazine* called "The Resistance Movement." Career women now in their 40's and early 50's, she reports, are resisting the physical effects of aging by choosing facial cosmetic surgery. As if this were an advertisement for surgery, Tannen favorably describes some of the new procedures on the market and in plastic surgeons' offices to help women look younger, mainly by removing "excess" skin, and lessening the appearance of deep wrinkles. The piece describes Tannen's own consultation with a

cosmetic surgeon and her feelings and thoughts about facial surgery, concern over her aging face and her need to make more of the "face time" she has left. She speaks about her career and how her face is important in her business relations: "The face was power. And I was losing it" (1994, p.77).

The demographics of the aging baby boomer generation in the United States provides a wider base of eligible cosmetic surgery consumers. While only some people seek surgery while young, many more people may be inclined to do so as they age. Marketing cosmetic surgery operations towards this aging generation is one strategy for increasing the surgeons' potential client base. This is an interesting theme in the domain of cosmetic surgery.

Studies of Cosmetic Surgery

During the 1990's social science research on cosmetic surgery has acquired a small following in academia. Researchers come from a variety of disciplines and theoretical perspectives. Here I focus on the most notable of these studies, beginning with a short discussion of the history of plastic surgery (Haiken 1997). An understanding of the profession's history is important because it informs the contemporary discourse of cosmetic surgeons.

History of Cosmetic Surgery

In *Venus Envy: A History of Cosmetic Surgery* (1997), Haiken traces the history of plastic surgery, paying particular attention to cultural influences on this medical specialty. She discusses the "official" history of plastic surgery as a specialty which was developed after World War I to reconstruct injured soldiers' faces.

However, Haiken is quick to point out that this professional history is not the

whole story:

> Plastic surgery cannot be viewed solely in a medical context because it is more than a medical practice; in the public mind, at least, it was and is inextricably intertwined with the cultural practice of self-presentation. The specialty's early development, then, must be viewed in a cultural, as well as a medical, context -- specifically, that of the American culture of beauty (1997, p. 18).

Cosmetic surgery clearly straddles two cultural domains, medicine and beauty. Part of what Haiken is seeking to explain is the difference (more ideological than actual) between reconstructive and cosmetic surgery. Because this divide is controversial in the history of plastic surgery as well as in current practice, issues of legitimacy are central to any discussion of plastic surgery.

Haiken's chapter on race and ethnicity is particularly interesting. It is here that she discusses how cosmetic operations act to "normalize" body parts, thus creating a narrower range for "normal" appearance. This process is based on underlying prejudices, such as ageism, racism and sexism. An example is the increase in popularity of the "nose job" (rhinoplasty) at a time of increased immigration. Haiken notes that few people wanted to be identifiable with a minority ethnic group. The desire to look more WASPish helped to establish the "nose job" as a mainstay in cosmetic surgery.

A recent addition to the history of cosmetic surgery is Sander Gilman's Making the Body Beautiful (1999b). Gilman presents a European cultural history of aesthetic surgery, drawing primarily from surgical texts at the National Library of Medicine. He also includes a liberal sprinkling of books, film, art, and literature to further illustrate his points. Gilman's central theme is that aesthetic surgery is an expression of our desire to "pass." That is, we want to become a visible person and "pass" as part of the in-group.

His starting point is the history of race and racial science, from which he traces the origins of aesthetic surgery. His chapters on the meaning of short and long noses are the most valuable parts of this book, tracing first the meaning of syphilis caused short noses and second, the creation of long noses as a characteristic of Jews. In all aesthetic surgery, Gilman argues, we are seeking to "pass."

> "Passing" is a means of trying to gain control. It is the means of restoring not "happiness" but a sense of order in the world. We "pass" in order to regain control of ourselves and to efface that which is seen (we believe) as different, which marks us as visible in the world. Relieving the anxiety of being placed into a visible, negative category, aesthetic surgery provides relief from imagining oneself as a stereotype. This is the origin of the happiness generated by aesthetic surgery (Gilman 1999b, p. 331).

One of the central problems with Gilman's book is that his findings are not connected to his data sources. Gilman pulls most of his data from aesthetic surgeons' texts, and does not explore the experiences of individuals actually having surgery. Yet his findings do not address the cultural significance of this growing medical specialty (a task he would be well-suited to undertake), rather he makes statements about the psychological reasons that people choose to have surgery. Because his conclusions are not based on data, in the end Gilman misses the mark, giving us instead psychological explanations not grounded in everyday experiences.

Race and Cosmetic Surgery

In an earlier book *The Jew's Body* (1991), Sander Gilman devotes a chapter to discussing the Jewish nose, subtitled "Are Jews White? Or, The History of the Nose Job." Supporting the claims that Haiken makes, Gilman traces the history of the modern nose job to Jakob Joseph, a "typical acculturated Jew" who "altered his Jewish name when he studied medicine" at the turn of the century (p. 181). Because Joseph was the

father of aesthetic rhinoplasty, he "came to be nicknamed 'Nosef' in the German-Jewish community" (p. 185). Most of Joseph's early patients were Jewish.

> He regularly reduced "Jewish noses" to "gentile contours." Many of his patients underwent the operation "to conceal their origins." In justifying the procedure, Joseph called upon the rationale of the psychological damage done by the nose's shape. He cured the sense of inferiority of his patients through changing the shape of their nose. His primary "cure" was to make them less visible in their world (p. 187).

In an earlier study, Frances C. MacGregor (1967) found that nose jobs were sought by a variety of individuals who desired a more WASPish appearance, including Italians, Jews, and people from the Middle East. She sought to reveal the "Social and Cultural Components in the Motivations of Persons Seeking Plastic Surgery of the Nose" (1967). Similar to Gilman's piece, there is a discussion of patients seeking to disguise their ethnic backgrounds. Their noses are seen as social handicaps consequently causing psychological pain. MacGregor divides motivation for surgery into two categories. In the first category, surgery is viewed as a way to eliminate a physical trait that identified one as part of a minority group, a way to avoid prejudice and discrimination. Individuals in this category were primarily Jewish. The second category is composed of "non-Jewish, of whom almost half were Italian" (p. 132). This group is concerned with removing a facial characteristic that evokes negative reactions and "often led to false social perceptions and distorted images of their personalities and characters" (p. 132).

MacGregor concludes that patients feel stigmatized and seek to become more "acceptable" in American society.

> Requests for cosmetic rhinoplasty as a social phenomenon may be seen as a response to socially and culturally defined deviance, and as a reaction pattern to looking "foreign" or looking "ugly" in a society which values conformity and good looks. . . Plastic surgery was seen as a device by

> which to surmount the barriers society creates for those who fail to meet its physical standards (1967, p. 133).

Although MacGregor does recognize the social importance of appearance norms, she nevertheless holds the individual responsible for psychological problems caused by appearance. In concluding, MacGregor notes that there are few "Old White American" patients in the study and proposes that this is because ethnic immigrants have adjustment problems.

> The hypothesis is suggested that immigrant and minority group members have certain types of adjustment problems that are not shared by Old White Americans. The high visibility of a deviant nose, therefore, is seen as an additional handicap, which reinforces the marginal position in the sociocultural hierarchy (1967, p. 134).

MacGregor's article is an example of an early attempt to understand the racialized nature of cosmetic surgery. In retrospect, it is sorely lacking in its analysis of power relationships, and proposes racist "blame the victim" explanations for a complex phenomena.

More than twenty-five years later, Eugenia Kaw (1993) wrote the "Medicalization of Racial Features: Asian American Women and Cosmetic Surgery." She discusses how gender and racial ideologies influence Asian American women to have cosmetic surgery. She notes that a surprising 20% of cosmetic surgery patients in 1990 were Latinos, African Americans and Asian Americans. This article focuses on the reasons why Asian American women choose "westernization" eyelid surgery and nose surgery (with bridge implants and/or changing the tip shape). Kaw convincingly demonstrates that the choice of surgery is influenced by racial identity:

> Asian American women's decision to undergo cosmetic surgery is an attempt to escape persisting racial prejudice that correlates their

> stereotyped genetic physical features ("small, slanty" eyes and a "flat" nose) with negative behavioral characteristics, such as passivity, dullness, and a lack of sociability (1993, p. 75).

Based on eleven interviews with Asian American women, Kaw discusses their reasons for choosing surgery. These women have internalized racial and gender stereotypes, giving negative descriptions of their pre-surgery facial characteristics which strongly reflect raced and gendered ideologies. The decision to have cosmetic surgery was often justified as giving themselves the opportunity to attain better jobs and improve their socioeconomic status. None of the women Kaw interviewed viewed their own choices for surgery as reinforcing racist ideologies, but rather as a means to enhance their lives. Kaw's own reading of the situation sits in sharp contrast to these women's voices:

> Although the women in my study do not view their cosmetic surgeries as acts of mutilation, an examination of the cultural and institutional forces that influence them to modify their bodies so radically reveals a rejection of their "given" bodies and feelings of marginality (p. 77).

Within this analysis, Kaw argues that:

> rather than celebrations of the body, [cosmetic surgeries] are mutilations of the body, resulting from a devaluation of the self and induced by historically determined relationships among social groups and between the individual and society (p. 78).

A particularly interesting dimension of this analysis is the power that medical institutions have to promote the normalization and legitimacy of these procedures for Asian American women. The medical profession is highly influential because of the prestige it derives from Western scientific knowledge. In addition, through her interviews and study of the clinical literature, Kaw shows that cosmetic surgeons reinforce the relationship between stereotypical Asian features and negative personality traits:

> Such powerful associations of Asian features with negative personality traits by physicians during consultations can become a medical affirmation of Asian American women's sense of disdain toward their own features (p. 82).

In this way, then, Kaw holds the medical profession partly responsible for reproducing this connection between features and personality traits.

What strikes me in this paper is how easily the voices of the women, their own explanations, are pushed aside to make room for larger critiques of cosmetic surgery as a "potent form of self, body, and society alienation" (p. 77). While I do not doubt the racial motivation for seeking these surgeries, this analysis also can be viewed as supporting the "cultural dope" approach to women's actions.[18] It assumes that these women are not aware of the oppressive quality of their actions and are unconsciously further alienating themselves. These questions are central to social science studies of cosmetic surgery and form the divide around which every scholar of cosmetic surgery must position herself.

On the Cutting Edge

Feminist theorist Anne Balsamo (1992) links social studies of science and technology with cosmetic surgery in "On the Cutting Edge: Cosmetic Surgery and the Technological Production of the Gendered Body." Balsamo is concerned with describing "the way in which certain biotechnologies are ideologically 'shaped by the operation of gender interests' (Sumrall 1982) and, consequently, how these serve to reinforce traditional gendered patterns of power and authority" (1992, p. 208). She focuses extensively on visualization technologies that enable physicians to see the internal structure of the body. These computerized techniques, sometimes called morphing, allow

[18] For a detailed critique of this approach, see Kathy Davis (1991, 1995).

the body (particularly face) to be visually examined in fractured and fragmented parts. "The material body comes to embody the characteristics of technological images" (p. 207). While these technologies encourage us to see the body as open for reconstruction, Balsamo questions whether gender identity is also open for reconstruction:

> As is often the case when seemingly stable boundaries (human/artificial, life/death, nature/culture) are displaced by technological innovation, other boundaries are more vigilantly guarded. Indeed, the gendered boundary between male and female is one border that remains heavily guarded despite new technologized ways to rewrite the physical body in the flesh. So that it appears that while the body has been recoded within discourses of biotechnology and medicine as belonging to an order of culture rather than of nature, gender remains a naturalized point of human identity (p. 207-8).

Analyzing the importance of technological innovations, Balsamo relies heavily upon the writing of Carole Spitzack (1988). In her study of cosmetic surgery, Spitzack discusses how the physician's gaze, like Foucault's medical gaze (1973), disciplines and medicalizes the female patient's body. It is within the power of this gaze that the healthy female body is transformed into a sick one, needing the reconstructive fix of cosmetic surgery. Balsamo takes Spitzack's discussion one step further, by arguing that the gaze is now technological as well as clinical.

Balsamo's approach to cosmetic surgery is unique because she focuses on the body as a site where the literal inscription of beauty standards "transforms the material body into a sign of culture" (p. 210). Thus the topic of cosmetic surgery embodies both a discursive and material site for the construction of women. She also offers a very useful analysis of how anthropometry (the science of human body measurement) has become important in cosmetic surgery to identify the "ideal female face." Balsamo notes that, "Not inconsequentially, the 'Ideal Face' depicted . . . is of a white woman whose face is

perfectly symmetrical in line and profile" (p. 211). While cosmetic surgery language appears to be gender and racially "neutral," the images are usually of a white female. These images have the effect, Balsamo writes, of creating a gendered and raced "aesthetic face" as cultural artifact.

Gender and Cosmetic Surgery

In "Accounting for Cosmetic Surgery: The Accomplishment of Gender," Diana Dull and Candace West (1991) explore how gender influences decisions surrounding cosmetic surgery. The authors studied how surgeons account for their activities, and how patients make sense of their decisions to have surgery. Dull and West (1991) discuss the "central dilemmas" of cosmetic surgery:

> The evaluation of patients' complaints, the determination of what should be done about them, and the assessment of postoperative results must be negotiated in relation to what "aesthetic improvement" might consist of, and to whom (p. 54).

Unlike other medical procedures where need is rarely questioned, the need for cosmetic surgery is of dubious legitimacy. Dull and West seek to understand how surgeons can practice medicine in the realm of beauty:

> Our analysis of surgical screening and decision making focuses on how the medical profession comes to enter a terrain that would seem so clearly beyond its mandate -- that is, constructing appearances and performing surgery that, by its own definition, is unnecessary (p. 55).

One of the primary ways in which women discuss their surgery decisions is to provide justifications for choosing surgery. Some women interviewed call cosmetic surgery "normal" and "natural" like using make-up and getting their hair done. Similarly the physicians too provide justifications, often in a defensive tone, calling cosmetic surgery "no vainer than" makeup or hair styles (p. 57). But what is taken for granted in

these descriptions is the gendered nature of cosmetic surgery. It is not argued that cosmetic surgery is normal or natural for men, but only for women. To further justify the "need" for surgery, women are described as citing "objective" indicators in their physical bodies that need correcting, such as sagging eyelids and sagging jowls.

While the focus of this article is primarily on gender, the importance of class and race are also addressed. Dull and West note that facial features are clearly assumed to be already "white." When ethnicity is discussed, the "objective" nature of facial characteristics is even more pronounced. The authors show a clear relationship between ethnicity or race and the surgery which becomes "objectively needed" as demanded by the facial and bodily characteristics associated with different races. Thus, race solidifies the "objective" nature of these decisions, making certain surgeries "normal" and "natural" for certain ethnicities.

In their discussion of the influence of class, Dull and West acknowledge that cost may hinder cosmetic surgery (since it is generally not covered by insurance) but it apparently does not prevent surgery, as women will save or take out loans to pay for the surgery. They also note that surgery can be a status indicator. When cosmetic surgery is common in a woman's social network, this reinforces the acceptance of the practice. It becomes an expected cultural act to look as good as possible, including having cosmetic surgery. Among certain classes and groups, the signs of surgery become status symbols, such as having a face lift or eyelid lift.

In a section on assessing "good candidates" for surgery, Dull and West explore how surgeons make the decisions on whom to operate. One of the qualities that they look for is "realistic expectations." The authors reveal that while these expectations are

discussed in relationship to "objective" qualities, they are actually socially mediated. Similarly, surgeons decide what procedures to perform based on whether or not the patient shows an "appropriate" level of concern for a specific problem. Thus these decisions are interactionally constructed and negotiated between the surgeon and prospective patient. On the other hand, surgeons try to avoid and seek to discover "inappropriate" patients, since they are more likely to bring malpractice suits. Surgeons believe that these qualities are gendered, making men more difficult patients than women. The ideas of "appropriate" concern and "realistic expectations" reinforce the belief in "objective" grounds for assessing surgery needs.

Surgeons claim to judge potential patients to be good candidates by relying on certain indicators. One of these is that they are "doing it for themselves" -- the potential client is seeking surgery for herself, not to please someone else. However, this is revealed by Dull and West to be a myth, since exceptions to this rule are numerous. For example, having surgery for one's job and also having procedures that the surgeon recommends, are ways in which surgery is clearly not "for one's self." Thus in this way also, good patients are "created" (as well as found).

One indicator that permeates both the judgment of surgeons and women is that of "reducing the body into parts." A "good" candidate for surgery sees her body in parts and speaks specifically to the need to change one part or another. Such reductionism helps to problematize and also to (re)construct the "objective" quality of a problematic body part. Reductionism also allows surgeons and patients to conceive of cosmetic surgery as a reconstructive project. The definition of reconstructive is extended to include some cosmetic surgeries, thus defining the "need" for aesthetic alterations. Dull and West note:

> Our data suggest that reductionism is essential to problematizing the part (or parts) in question and establishing their "objective" need for repair. For example, throughout these interviews, surgeons and patients alike alluded to technically normal features as "flaws," "defects," "deformities," and "correctable problems" of appearance. Surgeons referred to patients as "needing" facelifts and breast augmentations, while patients referred to the specific parts (or part of parts) that they had "fixed." Through such terminology, they constitute cosmetic surgery as a reconstructive project. Ultimately, they may even dissolve the distinction between the two categories of plastic surgery . . . Thus, reductionism provides a means of resolving the central dilemma of cosmetic surgery -- defining the nature and treatment of "disease" (1991, p. 63).

Redefining "disease" to include the norms of appearance, solves many tensions for cosmetic surgery participants: the location of cosmetic surgery practices within the medical domain is strengthened, the act of having an invasive surgery for appearance enhancement is legitimized, and the relationship between women's beauty and health is supported.

In discussing the importance of gender in the practice of cosmetic surgery, the authors refer to a theory of gender accomplishment as presented in earlier work by West and Zimmerman (1987). Gender is one of the missing links in explaining the cultural experience of cosmetic surgery. They note that concern with appearance is "normal" and "natural" for women only. A man's desire for plastic surgery must be related to his job or a serious disfigurement. Feeding into this believed difference between men and women, and acknowledged by plastic surgeons, is the double standard of aging. This double standard is commonly expressed by the belief that as men get older they become distinguished looking, while as women get older, they lose their attractive attributes. In this way, women's bodies and faces, particularly those of aging women, are "essentially" in need of repair (Dull and West 1991, p. 66), while men's bodies are not.

When race and ethnicity are advanced as "objective" reasons for "needing" cosmetic surgery, Dull and West describe how these also are gendered accomplishments:

> . . . the descriptions of most surgeons focused on what women in various racial and ethnic groups "have" and "need," not on men. Even while former patients relied on white, Anglo Saxon, Protestant features as the unmarked case, they described their post-operative benefits not only as looking "less exotic," but also, "prettier" and "more attractive to men" (p. 66).

Thus, the process of accomplishing gender occurs simultaneously with the process of selecting "good candidates" for surgery and "[t]he 'normal,' 'natural' character of each process is made sensible in relation to the other" (p. 66). In this way seeking cosmetic surgery is treated as "normal" for a woman and not for a man, and thus becomes a sign of the "essential" nature of sex categorization.

There are three important ways cosmetic surgery operates in the accomplishment of gender, according to Dull and West (1991, p. 68). The first two are that surgeons act as technological facilitators and as cultural gatekeepers in fine tuning gendered presentations of self. The third is that cosmetic surgery is an institutional support for "doing gender." If the constructed appearance of a woman falls outside the socially sanctioned norms for her sex category, plastic surgery provides the means to "correct" that deviation and thus reinforces the accomplishment of gender.

In conclusion, the authors note that studying this topic is important in sociological theory, as it expands the discourse on medicalization to the aesthetic realm and is important in discussions of the body, which is "physically reconstructed in accord with prevailing cultural conceptions" (p. 67).

The Dilemma of Cosmetic Surgery

In *Reshaping the Female Body: The Dilemma of Cosmetic Surgery*, Kathy Davis' (1995) approach is openly feminist. She seeks to understand the positions of women who choose cosmetic surgery, taking women's experiences, their decisions and agency into account. At the same time, Davis discusses her personal feelings of anger at a system that controls and harms women's bodies while she acknowledges those cultural expectations that make such "surgical fixes" possible and popular for women in Western countries.

Davis offers the Netherlands as an interesting case study of women's involvement with cosmetic surgery. Until 1991, the Netherlands was the only country where all cosmetic surgery was covered by national health insurance, as providing for cosmetic surgery was considered important for psychological health and thus was seen as "welfare surgery." With rising health care costs and the need to control state expenditures, this policy recently changed. In an effort to decide which surgeries would continue to be covered by insurance, three criteria of need were initially identified: (1) function is impaired; (2) there is serious psychological suffering; and/or (3) there is "A physical imperfection which falls 'outside a normal degree of variation in appearance'" (Davis 1995, p. 35). Because of the difficulty in defining objective measurements for deviation from a "normal degree of variation" the last of the three criteria was eventually dropped by national health insurance. Thus currently only functional or psychiatric problems caused by appearance are covered by the Dutch health care insurance system. Davis points out that these definitions must fit neatly within the medical discourse and domain. She also notes that the recipient of cosmetic surgery is always missing from these debates.

To better understand how the new regulations regarding national health insurance coverage were implemented, Davis observed consultations for cosmetic surgery applications with a medical inspector for the Dutch health insurance system. The job of this inspector is to make decisions regarding which applications for cosmetic surgery are eligible for insurance coverage (full or partial) under the new regulations. Thus, he had to make decisions about which people had appearance problems varying from the "normal." Davis notes:

> I am intrigued by the opportunity to observe firsthand how the medical profession actually determines which (female) bodies are abnormal enough to merit surgery. In other words, I expect to discover just how beautiful a woman has to be in order to be regarded as "normal" (1995, p. 69).

During consulations Davis was always puzzled by the presenting complaint. She could not tell when the person walked in the door what was the problem body feature. Once inside the office, the patients provided convincing accounts of their suffering and often had to undergo the embarrassment of a physical examination. Davis believes that the willingness to endure this discomfort shows their high desire for surgery. During her fieldwork, 61% of the presenting clients were granted full coverage and 21% were granted partial coverage. Davis notes that there were no objective criteria for assessing the degree of "normalness" in appearance. Instead, the patients' accounts of suffering were the most important factor.

Davis also studied women's justificatory narratives through individual interviews. The women gave a variety of responses that Davis groups together under ten *in vivo* codes. Briefly summarized, each of these codes describes a different psychological reaction and rationale for changing the body part in question. The first example is "I

really hated them . . . ." (p. 73), where the hated body parts were objects, disassociated from the rest of her body and causing pain and suffering. Davis notes that here: "Cosmetic surgery was presented as the final step in a trajectory of suffering -- an attempt to alleviate a problem which had become unbearable" (p. 74). Another code is "You just want something nice to wear . . . ." (p. 78). Here Davis discusses the pain of buying a bra or bathing suit. Shopping for clothes makes a woman's suffering more obvious, showing her as being different from "normal" (e.g. all those clothes on the rack testify to one's own difference). The code "You just can't stop comparing . . ." (p. 80) refers to women comparing their bodies to other women's bodies. This quickly becomes an obsession and is internalized. These women feel critiqued and assessed all the time, so that cosmetic surgery becomes a way to be unnoticed, freed, to become "one of the crowd."

Davis questions whether these reasons for cosmetic surgery are "beauty problems." The women she interviewed routinely separated their own surgery and problem body part from mundane dissatisfaction with one's body. For them, it was not a beauty problem, but an extraordinary problem requiring an extraordinary solution. I like Davis' discussion of why this could be, since all common sense goes against it. She points out that within the Calvinist rhetoric of Dutch society, women cannot admit the power of beauty. Instead the discourse in the Netherlands emphasizes the need to be ordinary. (She speculates that perhaps this would be different in the US, where women may be more likely to talk about their "right" to be beautiful and admit to being vain.) Being ordinary in appearance is not something we can objectively measure, as there are no standards for appearance. Instead, Davis points out that ordinariness is a matter of experience. For all of these women there was a great discrepancy between her public face

(how her body looks to others) and her private suffering (how she feels inside). Davis urges us to listen to the private suffering of women, because the public face is not representative of their experience.

Following her discussion of beauty, Davis reviews social science theories on the topic of women and beauty. For Davis, the most promising theories come from the sociology of the body and present the dualism of "body as bedrock" vs. "body as construct." For the first position she cites Arthur Frank's (1991a) work, where the body is the basis of lived reality. For the second she refers to the work of social constructionists and post-modernists. She also notes the importance of consumer culture and capitalism in a construction of the body as a consumer item to be improved upon. The cultural discourse supporting "body as construct" combines a market model of medicine and consumer culture. The body is a commodity (like a car) and plastic (changeable). The body is also a vehicle for self-expression which can be altered to express one's identity. In particular, the rhetoric that beauty can always be improved upon works to support the meaning of "plastic bodies." Because of this cultural discourse, the use of cosmetic surgery has spread from celebrities to the girl next door.

Feminist attempts to theorize and understand the growing popularity of cosmetic surgery are often, according to Davis, unsuccessful. She cites two positions of feminist thought, summarized as "beauty-as-oppression" and "beauty-as-cultural-discourse" (1995, p. 52). Wendy Chapkis' (1986) *Beauty Secrets* represents the beauty-as-oppression position. Chapkis writes about the politics of appearance and acknowledges that "gender and appearance are mutually sustaining" (Davis 1995, p. 53). Women's involvement is therefore understandable in terms of gender roles and the result of internalized

oppression. This is lived out through secret beauty practices. Susan Bordo's (1991) work is cited for the beauty-as-cultural-discourse position. In Bordo's theories, the female body is a site for gender and power to be expressed. The social discourses of mind-body dualism, control of the body, and femininity all find expression in beauty practices. Bordo acknowledges that women exist within culture and therefore cannot escape the beauty system.

Davis' main critique of these feminist approaches can be summarized as the "cultural dope" approach. These feminist theories do not address questions about women's active (although often ambivalent) involvement in seeking cosmetic surgery.

> The feminist approaches described above do not do justice . . . to questions which concern women's active and knowledgeable involvement in practices which are also detrimental and/or degrading to them. Despite their differences, both oppression and cultural discourse models of beauty account for such ambivalencies by assuming that women who choose to have cosmetic surgery do so because they have had the ideological wool pulled over their eyes. They are cultural dopes. (p. 57)

The problems with these approaches for the study of cosmetic surgery are: (1) they reinforce the mind/body dualism, as women cannot be seen as subjects involved in their own bodies; (2) they ignore agency in women's choices to have surgery, preferring instead to see women as victims; and (3) they ignore the moral contradictions that women face and experience as they choose cosmetic surgery.

In searching for an answer from feminist theory for addressing these concerns, Davis turns to the writings of Iris Young, Dorothy Smith, and Sandra Bartky. She argues that these writings can be used to support a feminist analysis of cosmetic surgery. In the writing of Iris Marian Young, Davis notes that women see their own bodies at a distance. Through Young's (1990) concept of women's participation in "doing femininity," she

acknowledges the female body as both objects and embodied female subjects. These two are not in conflict, but rather can be utilized to explain how women "choose" to be objectified through cosmetic surgeries. In Dorothy Smith's (1990) writings "femininity is discursively mediated through women's practical activities" (Davis 1995, p. 61). Women see female bodies in media images as perfect, and their own bodies by comparison as flawed. In attempting to bridge this gap, women's agency comes into play. Women are agents, fixing and transforming their bodies. Female bodies become experienced as objects of work, not as sex objects. In fact, Smith points out, women's agency is necessary for the texts on feminine beauty to work since women are called upon to fix our own imperfections. Davis notes that, according to Smith, this agency is then transferred to a man, making the woman appear as a "secret agent." Sandra Bartky's (1990) writing is cited particularly for its focus on understanding moral contradictions, or the ontological shocks that occur when a women's values don't match her practical lived reality. In essence, how a woman actually *feels* differs from how she *thinks* she should feel. This is an especially important point for the study of cosmetic surgery:

> I can treat women's ongoing struggles to justify a contradictory practice like cosmetic surgery as a resource for developing a feminist response which speaks to women's experiences rather then simply reiterating the correct line on women's involvement in the beauty system (Davis 1995, p. 64).

This is the goal of Davis' book. Through her analysis of interviews and theory, she develops a feminist understanding of women's involvement in cosmetic surgery. Her focus on ambivalence and the situatedness of women's experiences form the strength for her discussion. What is missing from Davis' writing is an acknowledgment of her own situatedness. She doesn't describe her personal experience, reactions and how she felt as

an embodied subject doing these interviews. Because of the social construction of knowledge, a discussion of Davis' own role in the research would have provided additional insight. Throughout this study, I am careful to avoid this same mistake.

CHAPTER III

DATA COLLECTION AND ANALYSIS

Methods and Sample

Methods of Data Collection

The data for this analysis are drawn from in-depth, qualitative interviews with twenty-one women who have had cosmetic surgeries. All interviews were conducted during the last six months of 1997. I was twenty-eight years old at the time. Participants were recruited through a combination of snowball sampling and referrals from cosmetic surgeons (refer to sample design section below). I provided an initial explanation of the study by telephone. Verbal agreement to participate was obtained by this telephone contact and an interview time and place were established, both at the participants' convenience. Informed, written consent was obtained just prior to the interview (refer to Committee on Human Research approved consent form in appendix). Each participant received her own copy of the consent form. Forms recorded addresses of participants only if they wished to receive a summary report at the completion of the study. Interviews were usually conducted in the participants' homes and lasted from one-half to three hours, with the average length being one and half-hours. Each interview was structured around a set of open-ended questions, which frequently developed into conversations (refer to interview guide in appendix). I encouraged participants to freely discuss anything of interest related to cosmetic surgery, with the belief that this would lead to discussions of their most important experiences. All participants agreed to have the interview audio tape-recorded. In order to maximize the privacy of participants, only small transcribed segments are used in this analysis, without any identification of participants. I have assigned pseudonyms to respondents throughout.

In addition to open-ended questions, I asked participants to complete a brief questionnaire (refer to questionnaire in appendix). The questionnaire consists of

descriptive demographic questions, such as birthdate, religion, household income and occupation. The purpose of the questionnaire is to uniformly compile descriptive characteristics of the sample. Participants were encouraged to provide only information they felt comfortable sharing, and were free to decline answering any questions. [19]

Sample Design

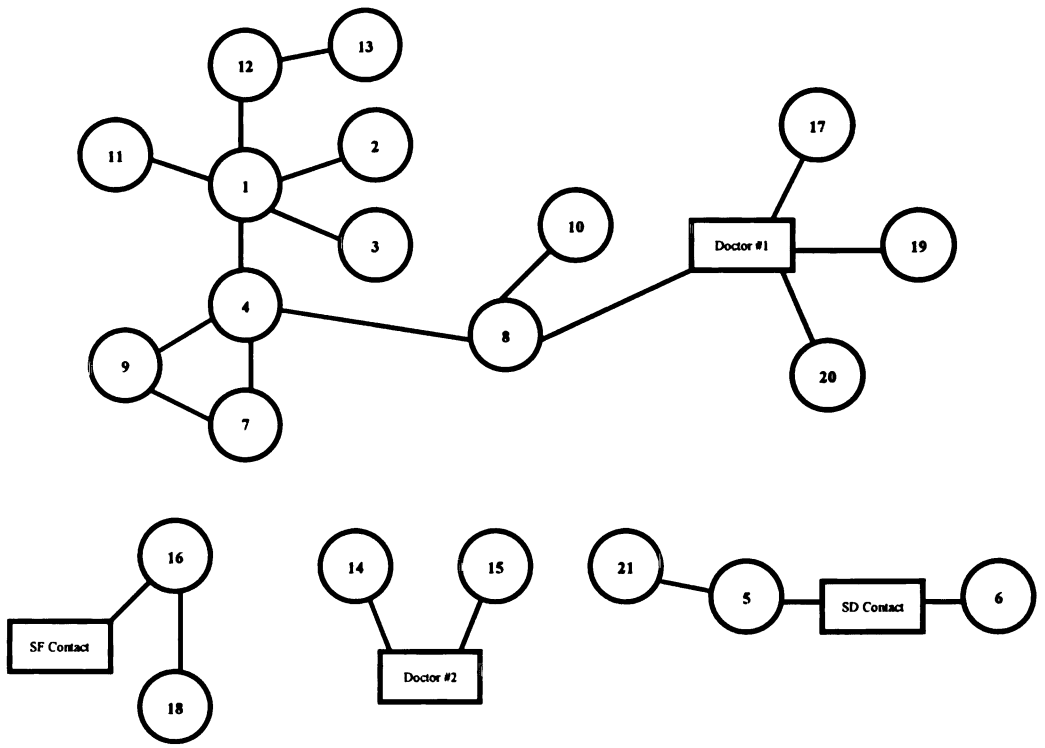
My sample consists of interviews with women who have had cosmetic surgery. While I had planned on utilizing advertisements and flyers for recruitment, I did not need to use these strategies, as my sample came solely from referrals. To begin the sample I contacted a friend who had cosmetic surgery (participant #1), and she referred me to several of her friends. These women, in turn, referred me to their friends. This network of friends yielded a snowball sample in the San Francisco Bay Area. In addition to this primary network, my sample includes three smaller subnetworks, each starting with a key contact. One of these contacts lives in Southern California, and yielded three interviews in the San Diego area, including a mother and daughter pair (participants #5 and #21).

When the pool of new referrals declined, I sought the assistance of two San Francisco cosmetic surgeons, who both agreed to refer me to several patients. Entrée with the first surgeon was aided by our shared institutional affiliation. Participant #8 referred me to the second surgeon. I met with each surgeon, provided a brief description of my study, and was eventually referred to five patients who agreed to participate in the study. These interviews differed from the others because they were professional referrals, their names often being given to prospective cosmetic surgery patients. These women serve as ambassadors between prospective clients and cosmetic surgeons, and therefore constitute a unique subsample of participants. I found these five participants - perhaps not surprisingly - uniformly enthusiastic about their surgery results and the surgeons'

[19] All but one participant completed the questionnaire: When I arrived to interview participant #12, I was surprised to find that she had brought a friend to the interview. Her friend became participant #13, which I named the "surprise" interview. I had only brought one questionnaire to the interview, and thus participant #13 did not complete the questionnaire. After the interview I sent a questionnaire to participant #13, requesting that it be returned, but I never received a response. Fortunately I had brought extra copies of the consent form to the interview.

skills. These participants also appeared very comfortable talking about their experiences and were generally more knowledgeable about cosmetic surgery procedures than the other participants. Because women's networks are important in their decisions to seek cosmetic surgery (a subject I return to in chapter 6), the diagram below is important for visually representing the networks in my sample:

Sample Networks Diagram



Sample Description

I designed the sample to be intentionally inclusive of all women who might be willing to participate. The only requirements were that she be at least 18 years of age, speak English, and have had cosmetic surgery, preferably related to aging concerns. From my previous pilot research of women's experiences with silicone gel-filled breast

implants, I was aware that finding women who are willing to be interviewed about their experiences with cosmetic surgery might be difficult. However, recruitment for this study did not prove difficult. I found that participants were generally eager to be interviewed and often referred me to their friends.

While I welcomed a broad age range, this sample includes a concentration of women in their late 50's and early 60's [refer to Table 1 in appendix]. Participants ranged in age from 34 to 71 years, with half between the ages of 55 and 65 years. As a group, the participants were highly educated, with 1/3 having high school degrees, 1/3 having college degrees, and 1/3 having graduate degrees. All participants were heterosexual, with twelve being married or in long-term relationships. Six of the participants identified themselves as Catholic, five participants listed a variety of Protestant religions, and two are Jewish. Seven participants did not list a religion or wrote "none." Because cosmetic surgery is an expensive elective surgery, generally not covered by health insurance, it is not surprising that my sample is primarily middle and upper-middle class. Seven individuals reported yearly household incomes of $100,000 or higher, and nine participants reported household incomes of $50,000 to $100,000. By contrast, only two participants reported household incomes of below $50,000 per year.[20] Three women declined to report income. While participants may have been from any race, all of the participants in this sample are white. In the United States, 80% of all cosmetic surgeries are performed on white women (Kaw 1993). With the exception of Asian and Asian American women who seek particular kinds of surgeries (such as the creation of a "double eyelid," previously referred to as "westernization" of the eyelid), most cosmetic facial surgeries appear to be marketed towards white women.

My sample's homogeneity in class, race, sexuality and age has undoubtedly created some "blind spots" in the data collected. Similar to the ways heterosexual women treat sexuality as invisible, my sample has "blind spots" related to class and race. Since

[20] The median household income for California in 1997 was $40,623 (from the U.S. Census Bureau, Current Population Survey, March 1998).

these women are in positions of class and race privilege, it was difficult to get personal reflections on how choosing cosmetic surgery is a part of accomplishing their race and class. However, I did not have these same difficulties when discussing age and sexuality. Women who have cosmetic surgery are an excellent population from which to study the experience of aging. Because the discourse surrounding cosmetic surgery practices contains an awareness of age, study participants were very sensitive to discussions of aging and ageism. In addition, participants frequently referred to the importance of their intimate relationships in their decisions to have surgery. These relationships are an important part of how participants accomplish sexuality.

The types of cosmetic surgeries participants had include facelifts, eyelid lifts, breast implants, breast lifts, nose jobs, facial acid peels and laser peels, neck lifts, tummy tucks, and liposuction of the body and neck. It was common for participants to have more than one surgery. Roughly 75% of the sample (16 women) had undergone two or more surgeries. Of these, seven women (1/3 of the sample) had three or more surgeries. I return to a discussion of the reasons why these women have multiple surgeries in chapter five.

Additional Sources of Data

In addition to conducting interviews, my knowledge of cosmetic surgery practices is enhanced by two additional sources of data. Utilizing the technique of *triangulation* to collect data from several different sources provides a more thorough picture of the meanings of cosmetic surgery for women (Lincoln and Guba 1985). While these sources of data are not the focus of my analysis, they do inform and enrich my understanding of the cosmetic surgery experience. The first of these secondary sources of data come from an annual three-day continuing medical education course on aesthetic surgery. This course features live surgery via satellite and is sponsored by The Division of Plastic Surgery in the School of Medicine at the University of California, San Francisco and Davies Medical Center. I attended this course for three consecutive years, in 1996, 1997

and 1998. These courses allowed me to watch surgeries in progress, take notes on surgeons' conversations, and alerted me to questions and concerns arising with each case. This experience is valuable in providing a knowledge of the professional world and practice of cosmetic surgery.

The second source of auxiliary data is composed of a convenience sample of cosmetic surgery advertisements from popular magazines during the past 5 years. I collected and analyzed the advertisements for images of health, age, youth, feminism, cost/social class and other relevant themes. Knowledge of advertisements for cosmetic surgery is important for this research because it allows a study of the body politic. As Crawford (1984) notes, "Individual lives do not readily lend themselves to the analyst's categories of interpretation, perhaps especially those we call 'political implications' " (p. 96). Through this analysis, it is possible to glimpse cultural discourses around women's choices and experiences and see how cosmetic surgery is culturally constructed in popular culture. When (or if) those discourses enter women's decisions (which assumes that the women are reading the magazines) is a more problematic question. It is important to examine advertisements from popular magazines (rather than professional journals) because these may reflect and constitute the everyday world of some women.[21]

Analysis of Data: Layers of Coding

The audiotapes from individual interviews with twenty-one women provide the bulk of my research data. All interviews were first transcribed. I began analysis by open coding directly on the printed transcript, using a grounded theory method, as developed by Anselm Strauss and others (Strauss & Corbin 1990). I used the constant comparative method by comparing each interview with the others, beginning with the first and second interviews (Glaser and Strauss 1967). Thus, data analysis was continuous and occurred

[21]I have already read through some of the recent cosmetic surgery professional journals for *sensitizing concepts* (Blumer 1954). These concepts inform the direction of my research by alerting me to issues that are meaningful in the practice of cosmetic surgery, such as the risk of nerve damage and facial paralysis.

simultaneously with data collection. Coding is the primary way I developed my analytic scheme.

> By providing the pivotal link between the data collection and its conceptual rendering, coding became the fundamental *means* of developing the analysis (Charmaz 1983, p. 112).

My systematic coding of transcripts took place in three steps:

STEP ONE: I open coded on the first seven transcripts (interviews #1 through #7). Open coding consists of physically writing in the right hand margin on each transcript. I made notes about any part of the interview that might be analytically relevant. I coded words, phrases, comments, conversations, and interactions that might be interesting and salient for analysis. While I was coding these first seven interviews, I began a running list of coding topics. I added new topics to this list whenever one was discussed in the interviews. This became my *Coding List* (refer to list in appendix). It consists of 22 codes, ranging from 'after' to 'weight.' Each code is further defined by a brief definition. These definitions are the contents of each code.

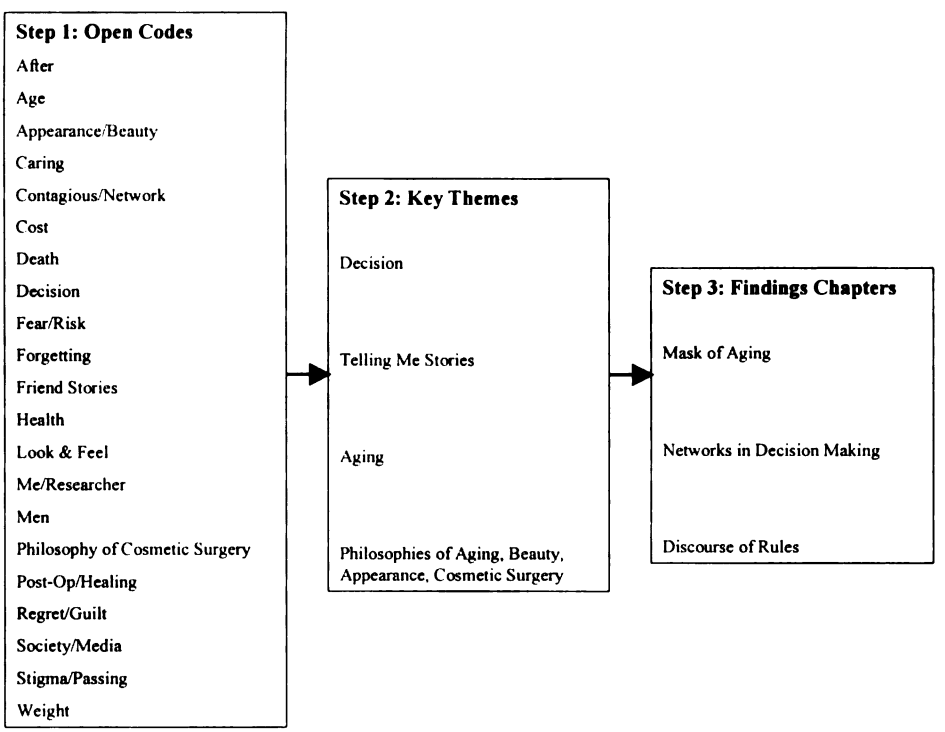
STEP TWO: After the first seven interviews, my open coding list did not continue to grow. Each transcript I read contained topics that were already included on my coding list. Once I had reached this point of saturation in my open coding, I began to focus my attention on those codes that were the most interesting analytically. These codes were (1) *decisions*, (2) *telling me stories*, (3) *aging*, and (4) *philosophies of aging, beauty, appearance and cosmetic surgery*. Using the word processing program on my computer, I cut and pasted pertinent sections of transcripts into folders named for each code. Collected sections of interviews in each folder formed the beginning of memos.

Utilizing aspects of Lofland and Lofland's (1995) technique for writing memos, I began with *elemental memos* on specific points by connecting/relating similar codes. This process resulted in condensing my original twenty-one topics from the open coding list into four key themes (refer to key themes listed in appendix). For the second 1/3 of the interview transcripts (interviews #8 through #14), I selectively coded for the four key

themes. This second stage of memoing consisted of *sorting memos*, during which I focused on identifying processes and core variables within each theme.

STEP THREE: The final stage of coding included all the transcripts, and consisted of writing *integrating* memos, "which are explanations of connections and relationships among sorting memos" (Lofland and Lofland 1995, p. 195). I found the best way to write about code relationships was in the form of chapters. Thus, the three code relationships that are most important in this analysis are represented by my three findings chapters (chapters 4, 5 & 6). In addition to coding transcript text, I also use diagramming whenever possible for visually describing relationships among key process (Strauss and Corbin 1990). The three steps of coding this research data are visually represented in the following diagram:

Coding Diagram



While I have described this process of analysis in a linear fashion, with a consecutive layering of steps, I am aware that the process of my qualitative data analysis is actually more complicated and cyclical. For instance, during the first step of open coding it became immediately apparent that the code of *aging* was a key theme and I began a memo on *aging* by the second interview. During the second step of coding, I found it was very helpful to code deeply within a single transcript, rather than across multiple transcripts. This method of coding gave me detailed and intimate knowledge of several interviews. My previous experiences of coding and analysis of qualitative interview data taught me to fully expect this emergent process of data analysis. To assist this process I paid particular attention to my writing practices and was careful to record any observations, thoughts and ideas I had about the research topic. This writing serves as a journal of my dissertation research, provides an audit trail of my decisions (Lincoln and Guba 1985), and is the origin of the self-reflexive - *italicized* - sections. Because I allowed myself the flexibility to move between the various stages of coding, without sticking to a rigid schedule, I was able to more fully integrate my ideas with the data analysis, thereby yielding a more thorough and rich analysis. In her study of caring for family members with Alzheimer's disease, Orona (1990) writes,

> I believe the beauty and strength of the grounded theory approach is that it is *not* linear. Instead, the approach allows for the emergence of concepts out of the data . . . I was able to use my intuitions and creativity to help me discover and uncover what was conceptually happening in the empirical world (p. 1249).

In the interest of increasing the credibility and trustworthiness of my research analysis (Lincoln and Guba 1985), I made a conscious effort throughout the analysis to acknowledge alternative interpretations of my own emergent findings. One strategy I utilized is what Strauss and Corbin (1990) have called the search for the negative case. When I encountered cases which did not fit my emerging interpretations, I considered these an opportunity for further exploration of the data. The discovery of alternative cases was useful for reformulating my interpretations and stood as an indication of a

pattern not fully discernible in the data. According to Strauss and Corbin (1990), negative or alternative cases

> ...don't necessarily negate our questions or statements, or disprove them, rather they add variation and depth to understanding ... tell[ing] us that something about this instance is different (p. 108-109).

For example, at interview #18 I met Carol, a 41 year old secretary. Carol had extensive body sculpting surgery. After losing 130 pounds she had several surgeries to remove excess skin from her hips, back, arms and stomach. The arm, hip and back surgeries left large purple scars, each about 5 inches long. From earlier interviews, I knew that minimizing scars is an important part of successful surgeries. Minimizing was already an important theme in my *discourse of rules* code. Carol's scars appeared to be extremely obvious and large. When I asked Carol her feelings about the scars, she replied:

> It doesn't bother me. In my clothes. I never even, when I was thinner in high school and we had a pool and I'd wear a two-piece bathing suit, I've never been a person who's gonna wear a bikini. That's not what I'm looking for. The doctor even said, this right here, there's gonna definitely be a scar that shows on my leg, and he said, of course, where we're cutting it is exactly where they cut if you had a hip replacement surgery done. So if you wanted you could tell people you had hip replacement surgery. And I said, I could, but I don't care. If we go on a cruise and I'm in a swimsuit, and someone says, oh my gosh, did you have an accident? I'll tell them. No, I didn't have an accident. And it wouldn't bother me to tell people that, so that part doesn't. But I know a lot of people yeah, they probably are very funny about it.

Because Carol's scars did not bother her, she is an illustration of a negative case for the theme of minimizing in the *discourse of rules* code. At the end of the quote, Carol recognizes this difference about herself, saying other people are "funny about it." This example helped me to more fully understand the meaning of *rules* and provides an instance of *breaking the rules*. Carol's circumstances differ from other research participants because her surgery was (1) not age-related, and (2) was mostly for body sculpting. Thus, this negative case helped to broaden my understanding of minimizing.

Evaluating Research Validity: Reflexive Accounting

In evaluating qualitative research, we face criticisms from outside the field, for not meeting the positivistic criteria for the "truth." From inside our field, we face self-criticism coming partly from the reflexivity that has developed in the field, such as criticisms about representation and legitimation. Examples are: What is the standpoint of the author? Whose voice is the author representing? Qualitative researchers are questioned about the role of the researcher, the basis for the knowledge claims and the difficulty of producing solid findings within a relativistic framework. Because of these criticisms it is important to have criteria for assessing the quality and rigor of qualitative research. Qualitative researchers need to respond to these critiques when conducting, writing, presenting, and publishing research.

In a positivistic tradition, the measure of validity is used to judge the quality of research results. Validity is a term used to describe a measure that accurately reflects the concept that it is intended to measure. Validity is a difficult topic for qualitative researchers. In the qualitative tradition, the contextual nature of data is stressed, including the findings as situational (not universal). Data are usually presented in description (i.e. words). In their article "Criteria for Assessing Interpretive Validity in Qualitative Research" (1994), Althiede and Johnson propose using reflexive accounting to strengthen the validity of qualitative research.

> The process by which the ethnography occurred must be clearly delineated, including accounts of the interactions among context, research, methods, setting, and actors (Althiede and Johnson 1994, p. 489).

Reflexive accounting explores the relationship between the research process and the analysis of data, focusing on the *process* of data collection and production of findings. Through reflexive accounting, the research text will show *how* we claim to know *what* we know. Althiede and Johnson further note that,

> Fieldworkers place themselves in the contexts of experience in order to permit the reflexivity process to work. Experienced ethnographers, then, do not avoid reflexivity, they embrace it (p. 496).

What separates storytellers from researchers isn't the "truth" but rather the processes (or ways) of knowing. We expose these ways of knowing by discussing a variety of relationships in the research field and the decision-making processes regarding which pieces of knowledge to analyze and write about. Part of accounting for ourselves is to leave "tracks" in the research report, to show where we are located, to show our handiwork. In essence, the researcher herself becomes a tool for data collection, as she acknowledges her position in the research and the creation of text. One way to do this is to allow the reader to engage in a symbolic dialogue with the researcher about the problems encountered during research.

There are ten problems researchers routinely encounter that Althiede and Johnson list as important to discuss as part of our reflexive accounting.

1. entree - organizational and individual
2. approach and self-presentation
3. trust and rapport
4. researcher's role, way of fitting in
5. mistakes, misconceptions, surprises
6. types and varieties of data
7. data collection and recording
8. data coding and organization
9. data demonstration and analytic use
10. narrative report

Exploring and writing about research processes make it possible to assess the relationship between what was observed and how it was accomplished. This is one way to establish the quality of a research report.

An example of reflexive accounting is Barbara Myerhoff's *Number Our Days* (1979), an ethnographic study of a Jewish community in Southern California. Myerhoff writes,

> I followed the crowd inside and sat at the bench of the warm, noisy room redolent with odors of fish and chicken soup, wondering how to introduce myself. It was decided for me. A woman sat down next to me who I soon learned was Basha. In a leisurely fashion, she appraised me. Uncomfortable, I smiled and said hello.
>
> 'You are not hungry?' she asked.
>
> 'No, thank you, I'm not,' I answered.
>
> 'So, what brings you here?'

'I'm from the University of Southern California. I'm looking for a place to study how older Jews live in the city.'

At the word *university*, she moved closer and nodded approvingly.

'Are you Jewish?' she asked.

'Yes, I am.'

'Are you married?' she persisted.

'Yes.'

'You got children?'

'Yes, two boys, four and eight,' I answered.

'Are you teaching them to be Jews?'

'I'm trying.'

'So what do you want with us here?' asked Basha.

'Well, I want to understand your life, find out what it's like to be older and Jewish, what makes Jews different from other older people, if anything. I'm an anthropologist and I usually study people's cultures and societies. I think I would like to learn about this culture.'

'And what will you do for us?' she asked me (pp. 14-15).

Myerhoff's status as a Jew is important for her entree. She is letting us in on the research process. Of the previous list of important topics to cover, this passage helps to clarify the first four: entree, approach and self-presentation, trust and rapport, and researcher's role/way of fitting in. This is one example of accounting for oneself in the research.

A second example of reflexive accepting is Dorinne Kondo's writing on Japanese conceptions of race and identity. In *Crafting Selves: Power, Gender, and Discourses of Identity in a Japanese Workplace* (1990), Kondo writes primarily in the first person, often with a reflexive voice. Kondo's voice is one of a Sansei (third generation) Japanese American woman. In describing her own situatedness and its importance in the development of a research problem, Kondo explores her ethnic and national identity as a "conceptual anomaly" embedded within Japanese conceptions of race:

> As a Japanese American, I created a conceptual dilemma for the Japanese I encountered. For them, I was a living oxymoron, someone who was both Japanese and not Japanese. Their puzzlement was all the greater since most Japanese people I knew seemed to adhere to an eminently biological definition of Japaneseness. . . . Japanese Americans and others of Japanese ancestry born overseas are faced with exasperation and disbelief. How can someone who is racially Japanese lack 'cultural competence'? During my first few months in Tokyo, many tried to resolve this paradox by asking which of my parents was 'really' American (p. 11).

In describing her ambiguous position, Kondo reveals the social constructedness of race in Japan and traces how her own identity changed to become "more Japanese." This focus

on the transformation of her own identity eventually led Kondo to study the problem of identity formation (or the crafting of selves) in a Japanese work situation. Thus from her own personal experience and situatedness, the topic of this book was created.

In my own writing and research I have been experimenting with reflexive accounting. Often my writing includes personal reflections and discussions. These sections are *italicized* in each chapter, in order to clearly write my voice into the presentation of findings. I find these reflections to be very important in the development of my analysis. Writing reflexively is one way to acknowledge the important role these personal reflections and experiences had on the development of my research analysis.

CHAPTER IV

MASKS OF AGING

Introduction

In this chapter I explore the relationship between women's experiences with cosmetic surgery and aging. Many cosmetic surgery procedures are designed to create a "young" appearance for women. Surgeries such as facelifts, forehead lifts, eyelid lifts, and face peels are generally performed on mid-life and older women. Through an analysis of in-depth interviews with women who have had cosmetic surgery, I explore the experience of "masking" which may accompany aging and cosmetic surgery.

In "The Body in Consumer Culture," Mike Featherstone (1991) described a cultural philosophy of preserving the body in the face of aging. In consumer culture, individuals are sold products based on preserving the body. Cosmetic surgery is one such product. Featherstone differentiates between the two categories of an *inner body* (such as health) and an *outer body* (such as beauty), noting that, "Within consumer culture, the inner and the outer body become conjoined: The prime purpose of the maintenance of the inner body becomes the enhancement of the appearance of the outer body" (p. 171). By being located within the institution of health care, cosmetic surgery builds upon this relationship by making an explicit connection between beauty and health.

In "The Mask of Ageing," Featherstone and Hepworth (1991) apply concepts of the inner and outer body to a discussion of the changing cultural experience of aging in Western culture. The title of their article refers to an experiment by Pat Moore, who "disguised herself as an elderly woman and went out into the streets of 116 cities in the United States to systematically observe the effects (Young, 1989)" (p. 377). "Old Pat" felt like she was trapped in an old body. She reported feeling constrained by the disguise, and was always aware that it was just a shell that did not match the way she felt inside. The authors write that,

> What is more generally significant is that when she let some of the elderly people she met into her secret she discovered that they also felt trapped in a shell: 'young minds trapped behind old faces' (Young, 1989: 17) .... [T]he image of the mask alerts us to the possibility that a distance or tension exists between the external appearance of the face and body and their functional capacities, and the internal or subjective sense or experience of personal identity which is likely to become more prominent in our consciousness as we grow older. (Featherstone and Hepworth 1991, p. 382).

Thus, there is a difference (perhaps even a rupture) that occurs when we age, between our personal identities and the outer appearance of our aging bodies. This tension between the mind and body is particularly relevant to the study of cosmetic surgery, because such surgery promises to reconcile the disparities between how we feel and how we look. Changing one's outer appearance may then reduce the experience of feeling masked. Because of ageism in our society, this outer change can be very difficult and painful for many people. Cosmetic surgery is one way of trying to cope with these changes and minimize the effects of ageism.

I begin this chapter by exploring the evidence of a tension between participants' outer physical selves and their personal identities. Next I examine if cosmetic surgeries have made a difference in how these women experience that tension. Last, I explore women's feelings about balancing the benefits of cosmetic surgeries with the potential risks of creating new kinds of masks.

Mask of Aging Experiences

The participants in this study shared stories of awareness about a mask of aging that demonstrate the tension between inner selves and outer bodies. The most common ways for participants to describe these tensions were in relation to mirrors (or mirror-like devices, such as window reflections and seeing themselves on television). In addition to actual physical reflections, participants also became aware of aging through their friends' changing appearances. A second way participants experienced "masks of aging" was through other's ageist stereotypes of mid-life and older women. Examples range from concerns with employment, to feeling invisible. A frequently discussed experience that

strongly affected participants was encountering ageist stereotypes when dating. Thus, masking experiences were described both in relation to ones' own physical reflection and in relation to others.

Mirror Reactions

Participants frequently described their feelings of dissatisfaction about their appearance with reference to mirrors. This is not surprising, given that there are a limited number of ways to experience one's appearance. The primary ways individuals experience their physical reflections are by way of mirrors and windows, and less often, representations on television or in video. In addition, we constantly experience ourselves in relation to others reactions. Building on Mead's theory of the conversation of gestures, we experience "mirroring" in social interactions. Recall from chapter two, Charles Horton Cooley's poem on human mirroring sums up this social phenomenon:

> Each to each a looking-glass
> Reflects the other that doth pass
> (Cooley 1956; 184).[22]

Through stories describing their reactions to mirrors, participants told me of the misfit between the ways they look and the ways they feel. These descriptions are evidence of the tension present in the "masking" experience. They report feeling dissatisfied by their own reflections and feeling differently than they look in mirrors.

Heather's decision to have cosmetic surgery is directly related to not wanting to look in the mirror. Her facelift two months before the interview coincided with her fifty-fifth birthday.

> As the years went on, I didn't like the way I looked...I didn't like looking in the mirror anymore. I mean, not that I went to the mirror and said "Oh my God, you look terrific," but I did not want to look in the mirror, and I thought, I can't go through the next 20 years of my life avoiding mirrors.... especially coming onto 55, I just turned 55, I thought, oh, maybe I've just gotta do it [have cosmetic surgery], and my good friend Deborah, of course, you know, she's had everything done. She looks great.

[22]Charles Horton Cooley's book *Human Nature and the Social Order* was reissued in its entirety, possibly with the original page numbers, in *The Two Major Works of Charles H. Cooley* (1956), The Free Press: Glencoe, IL. The citations here are taken from the 1956 reissued edition.

While 57-year-old Cathy does not mention a mirror, her story implies that she did look in the mirror in the morning. Cathy's experience of aging is that she doesn't look the same as she feels. She experiences "masking" because her outer body does not match her inner body.

> The other surgery that I've been considering is related to aging, because you notice that you get the sagginess, you'll get up in the morning, you've had a good night's sleep and you feel peppy but look like you're tired, it's very discouraging... Why can't I look as good as I feel? Why do I have to look so tired all the time when I'm not?

Cathy's inner and outer bodies are not congruent. Her body is expressing physical states that she does not actually feel. Her frustration with this masking experience is evident.

Before her facelift, Diane worried that she began to look like her mother. This was particularly disturbing to her because her inner feelings did not match the "matronly" feelings she ascribed to her mother.

> You look in the mirror, and I noticed that underneath here, on the neck, I was starting to look like my mother, little turkey skin hanging down there, and I thought, I don't want this... If I don't feel like my mother felt like at my age, why should I be looking like her? ...I'm not sure that my mother felt really old at 57 either, but she looked a lot more matronly....

Sometimes women discussed their masking experiences with others. In this quote, both Heather and her friend do not enjoy looking in the mirror anymore. A few years prior, they were able to effectively reconcile their masked appearances by changing their behaviors. As they aged, their ability to change their appearances diminished and they felt they were losing the battle against gravity.

> My friend and I discussed this, that we didn't like looking at ourselves in the mirror anymore. I mean, you'd avoid the mirror. The early 50's, it'd be like - okay, just cut down on the drinking, get a good night's sleep and you can still keep going and look okay and presentable. Then as the years went on, you realized that gravity was overtaking you. And there was nothing you could do about it.

While Heather expresses a feeling of giving up, as there was "nothing" she could do about it, she actually did chose to take action by having a facelift.

Although not as common an experience, some participants also shared experiences of seeing themselves through other media. For Linda, the experience of

viewing herself on television was much more powerful and shocking than looking in a mirror.

> The first time I thought seriously about having cosmetic surgery was when I saw myself on television. When you see yourself on television, you see yourself in the way that you don't usually see yourself. You know, you run by a mirror, you look, but you don't stand back and see yourself... But [on TV] I thought I looked pretty old. I had so many lines there. I thought, Oh God... I looked old... And also sort of unexpectedly passing an image of yourself, be it in a glass window. But unexpectedly to catch a glimpse of yourself, I find I don't look in the mirror as much.

While reflections of one's own appearance were the most common way to describe a mask of aging experience, several participants talked about a tension between their feelings and their ages. Their chronological ages were older than they felt. Thus, their outer bodies - as measured by number of years lived - did not reflect their inner sense of themselves.

Participants compared their changes (both on an outer physical level and on an inner psychological level) to their friends. For Mary, she became aware of her own aging by observing her friends' aging. Her experience of aging is shaped by this reference group of friends. Similar to mirror experiences, Mary uses her friends' faces as mirrors to see her own aging reflected.

> I certainly am aware of aging. A lot of my friends are within a ten-year radius of my own age. I have older friends and some friends that are younger - and I can just see the aging process, I visually can see it, so I'm very aware of things with people, other people. So we can ignore our own sometimes, get really comfortable with our own situation. Once you see something with another person, then you start investigating yourself a little more closely to see whether that's happening to you.

Fifty-seven year old real-estate agent Diane, described a conversation with friends about the distance between how old we feel and how old we are in years. She found the "mask of aging" to be an experience her friends shared.

> This one time we sat around the dinner table and talked about how old we really feel, and it turned out that everyone felt about ten years younger than they actually were. So I would say I feel like I'm about, 40.

Ageist Stereotypes When Dating

Another component of the mask of aging is facing other's stereotypes about aging woman. As women became aware of their age, they developed a sensitivity to the effect this would have on others' treatment of them. This was particularly clear in the arena of heterosexual dating and was a shared experience for several women in my sample. About half of the women in my sample were single, most through divorce. Several were recently divorced and seeking male companions. For these women, a "mask of aging" was heightened. For example, several women reported that their chronological age was used by others to screen out potential dates with men.

This was the case for a young looking, 42 year old recent divorcee. After her facelift, she believed herself to look about 10 years younger than her chronological age. Even with her youthful appearance, she found dating difficult because of stereotypes about age.

> I was competing in the [dating] market, and you know that looks matter when you're 42 years old, a lot of guys are divorced, now they want to marry a younger girl, and when they hear that you're 42 years old they picture an older girl. "How old are you?" "I'm 42." . . .they hadn't seen me first 'cause I ran ads and stuff. And I had to deal with this stereotype of age...

Being labeled as an "older girl" solely on the basis of her chronological age was a frustrating mask of aging experience. Because of stereotypes about age, she tried to avoid the question, "How old are you?"

Similarly, fifty-seven year old Diane believed disclosing her age to friends might limit her dating choices. While she did not keep her age a secret, she was concerned that she would be categorized as being "too old" for some men.

> I don't give a hoot who among my friends know, or if they know I'm in my mid-50's, but if you categorize yourself as being X age, then, if anyone thinks about fixing you up with someone, then they say, "Oh no, she's too old for him."

While not single herself, Shannon was conscious of her single friends' plights and sympathized with their decisions to have cosmetic surgery. This quote expresses her

belief that improving one's appearance is the primary way a woman can increase her chances of having successful dating experiences.

> I think when you're that age and you're single and you don't have anybody on the horizon, then you start thinking to yourself, well, I can't do any more than I'm doing from every standpoint. The only thing I can change is my looks. And maybe, if I look younger, a man will just look at me long enough to ask me out. Because once they get to know me they'll like me...

Clearly, then, women are aware of the mask of aging in relation to dating men. The importance of appearance when dating serves to highlight the experience of masks of aging.

Resolving Masks of Aging

Cosmetic surgery is sought as a way to resolve the tension between how we look and how we feel. It is sought to diminish the experience of a mask of aging. When participants described the effects of cosmetic surgeries, they cited changes in their outer bodies (or physical appearances) and changes in their inner bodies (or self-identities). These two parts were identified by the participants as "looks" and "feelings."

Outer Body Results: Changed Looks

The immediate effect of surgery was a changed appearance. Participants reported looking different post-operatively. Several women showed me photographs of themselves taken before and after the surgery to demonstrate the physical changes. Because women in this study primarily sought surgery to look younger, a successful surgery achieved that result.

Almost ten years after her facelift, Julie reflected on the success of the operation in reducing signs of age. At the time of surgery she was in her early 40's. I asked, "Did it make you look younger?" And she replied,

> The surgery? I think it did, yeah, I think it did....Even though I still looked young before, but when you looked up close, there was some sagging, and when it was done, I really think I looked about 29 years old. No wrinkles and no sagging.... I just know that I look very young for my age and I'm just real glad.

Participants were particularly pleased when surgery recaptured a younger looking version of them. Fifty-five year old Heather had her facelift six weeks before our interview. According to her, the surgery removed about twenty years of aging.

I look more like I looked, as far as facial structure, I think, in my 30's.

Similarly, Mary's results are picture perfect:

> I look very much like I did 15 years ago. I look at some photographs and it looks quite the same.

Before their surgeries, many women expressed a reluctance to look in the mirror. The mirror was avoided because participants' physical appearances did not match how they felt. After surgery, several women reported that they did not avoid mirrors anymore. I asked one woman, "Do you feel differently about looking in the mirror now?" She replied, "Yeah. I don't avoid mirrors." In addition, participants described positive feelings and increased confidence as a result of their improved appearances.

> I think it certainly works on my self-esteem. If you look in the mirror every day - I've looked and thought, well, do I look good today or do I look not good today? And before I had my eyes done and my nose done, I thought, I don't look good. So I had to do something about it....So of course it's gonna affect how you interact with people because you feel good about yourself.

The reasons given for this improvement were the interactive relationship between looks and feelings. Diane describes this relationship as a positive one. According to her beliefs, cosmetic surgery has mental health benefits.

> If you look good, you feel good, and then other people who look at you feel good too because they like physically what they see. So it's all an interactive thing. If it makes you look better, hey, you're gonna get a positive reaction from everybody else... If you're physically looking better it mentally makes you feel better. What could be more positive?

While most of the women cited psychological improvements derived from improving their appearance, a few women also experienced improvements in minimizing the effects of ageism. One such example is the story by Shannon about her friend who regained her visibility through surgery. Prior to surgery, she experienced feeling invisible

and was often ignored and dismissed. After surgery, Shannon explains that her friend was no longer ostracized as an old person.

> And she said, "Now that I look younger, no one really knows how old I am." And it's true, you don't. You can look at her and she could be 30, she could be 50... She said, "The way I look now, I can go up to any group of people and they won't stop talking, they'll just kind of say, oh yeah, she's another one of the gang. But if I go up to them as an old person, they all just stop talking and turn. And they have a different attitude."

Because invisibility is an instance in which the "mask of aging" is experienced, this story suggests a resolution of this "masking" experience.

Inner Body Results: Changed Feelings

In addition to physical changes, participants also expressed changes in their identities. I was initially surprised to hear that some women felt more comfortable about aging after surgery. I had assumed surgery would heighten their awareness and feelings of discomfort about their aging bodies. However, when viewed within the context of easing the "mask of aging," participants' feelings of resolution and satisfaction are understandable.

One fifty-five year old participant described her facelift surgery as a way to make her look age-appropriate, rather than to make her look younger. In this way, the surgery became an integral part of her successful aging, as well as eased the mask of aging.

> And I don't think having cosmetic surgery puts me back psychologically to 45. It just makes me feel better about being 55. ... I don't feel any younger. In fact, in a way I feel much more accepting of where I am in life right now. And I feel good about having the surgery because I can say, yeah, I'm a pretty good 55.

While she did not believe she looked any younger, her surgery made her more comfortable with her age. She felt she looked good for her age.

Other women reported that their appearances were altered to match their values, and this gave them a feeling of peace. At the time of the interview both Linda and Julie were not planning any future cosmetic operations. Sixty-year-old Linda described an acceptance of her appearance:

> I'm reasonably comfortable in terms of the way I look now. I think it's sort of congruent with my values.

Similarly, after struggling with her appearance for many years, Julie told me of her newfound peace:

> But for the first time in my life I don't wear any makeup and - I have less emphasis on my physical appearance. But I also feel paradoxically that I actually look better than I ever have. Just like it's a harmony or something.

Creating New Masks with Cosmetic Surgery

The ability of cosmetic surgery to mend the tension inherent in the mask of aging experience appears to be temporary. Most participants in this study planned to have additional surgeries. Seventy-five percent of the participants had already had two or more cosmetic operations. While participants talked about their relationships to their bodies and described a tension similar to the mask of aging concept, the only times the word "mask" was used by these women was to describe the effects of having too much surgery. Women who had undergone too many cosmetic surgeries were described by others as misguided and failed attempts to maintain a youthful appearance. Stories of these women were told as "horror stories" and as warnings of the dangers of "excessive" cosmetic surgery. These stories reveal the danger of creating a new mask.

Although Heather had previously had a nose job at age 18, she was leery of her first aging-related cosmetic surgery. Through this story she describes her fears about creating a mask through cosmetic surgery:

> I did not want to look like one of those plastic people coming out of L.A. I've seen a lot of that. Real tight around the eyes and mouth. An experience I had, it was in L.A., I had to be in my 30's, and I was at the Saks cosmetic counter, and there was this elegant elegant lady standing there and she had the most beautiful voice. That's what caught me first was her voice. I couldn't see her face. I ended up standing next to her and I turned and looked at her and she was elegantly dressed, and she had a beautiful profile. And then all of a sudden she turned and looked at me, and it was almost scary. I mean, she had to be well - at that point, who knows old. I thought she was well into her 70's, and I looked at her hands, and her face - I mean, she must have been a beautiful young person, 'cause the bone structure was fabulous. But it's like this mask of really tight skin, and you could tell she just wasn't young at all, and I thought oh, never

> never never.. . .I didn't want that. I went in to see [my cosmetic surgeon], and I said, I want to just look better. I don't want to look young.

By telling her cosmetic surgeon that she "didn't want to look young," Heather is expressing some awareness of the limits of intervening in the aging process.

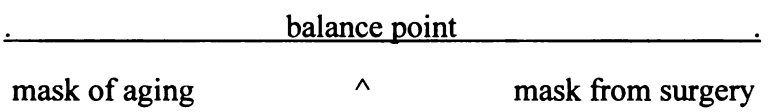
While considering the possibility of having a second face-lift, Diane tells me that the next surgery is a dangerous one, because it is likely to create a mask.

> I think you have to be very careful on the next do. I don't want to look like those women I see walking down the street, who have had not one but two facelifts. And that look - everything looks like a **mask**, and the rest of them look like they're 70 years old. And I don't particularly want that look, but I want to continue looking good.

Shannon, who was 60 years old at the time of the interview and had already had three cosmetic operations, planned to resist future surgeries. She planned to settle for looking o.k. rather than risk looking ridiculous and plastic. Her decision is based on the belief that women older than 70 who have their facial skin pulled tight look silly.

> I've thought, would I ever have any more? I don't think so, because I think there's something almost **plastic** about the way you look at 70 when you have work done... when you know somebody is 75 or 80 and they're just pulled like that. It's silly. To me it's ridiculous. And I don't want to look ridiculous, I just want to look okay.

The dangers of excessive cosmetic surgeries were a cause of concern for many women. Participants talked about the difficulty of knowing when to stop having surgeries. Knowing the point at which one has hit the limit of acceptable surgeries and is in danger of creating a "mask" from the surgery is difficult to identify. This phenomenon can be represented by the image of a seesaw, which visually describes the delicate relationship between the mask of aging and the point at which surgery creates a mask.



Women in this study sought to strike a balance between the two masks, yet the balance is perilous and difficult to achieve. Because our bodies and faces never stop aging, the

point of balance is constantly moving. However, no one admitted to personally going over the balance point and having too much surgery. In other words, no one in the study referred to herself as having the "mask" created by cosmetic surgery. Rather these descriptions were reserved for others. This was particularly interesting for me as the researcher, as several of the women I interviewed had strikingly surgically altered faces, with exceptionally tight skin. Their faces looked "mask-like" to me.

Participant's feelings about the acceptable number of surgeries varied tremendously. On one end of the seesaw is the woman who has collagen injections every six months to keep her skin firm, and had no hesitancy telling me, just as we parted, "I hope to see you in another twenty years and I'll look just the same as I look now - Or even younger!" On the other end is the woman who had only one surgery over ten years ago and has no plans for future surgeries. Some participants conceded, as Diane did, that

> At some point you have to let nature take its course. You have to have a little aging.

Taken to its most extreme form, the mask created by cosmetic surgery would be so complete that the person would completely lose her identity. One participant talked about her fears of losing her identity in this way. Mary had severe complications following her facelift. While in the hospital she was given strong pain medications, such as morphine. In response to the medications she had hallucinations, which prompted the medical staff to have her evaluated by psychiatrists. Mary was greatly concerned about being evaluated, and feared she might be committed to a mental institution. She said,

> I'd think, what are they doing this for, psychiatrists? Now they're gonna put me away in the mental ward. And no one will ever know me, I have this different face.

Because of her cosmetic surgery, Mary feared that her face would be unrecognizable. No one knew she was having the surgery, and thus she might be forever locked away, her true identity never discovered. Although this horrible fantasy did not materialize, Mary did experience the horror of not recognizing her own face. The first time she looked in a mirror she was shocked at the reflection.

> I just thought it was unbelievable. It was incomprehensible that my face would be this huge thing that I saw. It was just unreal.

Much like the older woman who does not readily recognize her own aging face in the mirror, Mary's post-surgical face was unrecognizable in both her nightmare and in real life. Her experience is an example of the extreme possibilities and potential dangers when creating masks with cosmetic surgery.

Conclusion

In conclusion, this analysis reveals that cosmetic surgery does address the mask of aging experience. After surgery and recovery, women reported both looking and feeling better. However, participants also faced the possibility of a second masking experience. Women may now wear masks of another kind: the surgically created masks of old women trying to look young. Similar to masks of aging, surgically crafted masks may also create a distance between one's appearance and one's personal identity.

Thus, while the mask of aging is still a useful concept, it is most useful when utilized in a more fluid, processual manner. Masking represents the tension between one's inner and outer selves. The masking feeling is created when women engage in self assessment in light of cultural norms of aging and sexual attractiveness. These women are assessing their selves by themselves and by imagined others. It is through this ongoing process of self assessment, described by Mead (1934) as an internalized *conversation of gestures*, that the social self is created and recreated. Therefore, the concept of masking is one way to better understand how selves are configured.

In the next chapter I explore how women's decisions to have cosmetic surgery are socially situated. By examining their social networks and the importance of friends' and doctors' comments, I will examine how women cross the line to have surgery, frequently more than once.

CHAPTER V

CROSSING THE LINES: NETWORKS IN DECISION MAKING

Introduction

When I began researching women's experiences with cosmetic surgery I was certain I would never have cosmetic surgery. I believed cosmetic surgery to be oppressive to women, adding to already unrealistic and rigid cultural ideals for women's appearances. In 1992, I conducted a small qualitative study of women's experiences with silicone gel-filled breast implants. Although I worked to establish a good rapport with research participants, I always placed myself in a category separate from them, believing I would never choose cosmetic surgery. After one of these early interviews, I recorded the following interaction with a research participant.

> *I felt connected to this woman, with a relationship akin to friendship during the interview. I found her very beautiful to look at. We "clicked" upon meeting and were similar in many ways. The interview went very well. She revealed a great deal about herself and I sensed that she felt comfortable with me as well.*
>
> *When the interview was over I turned off and put away the tape recorder. We chatted a bit and then she said to me, "Are you thinking of getting implants yourself? Is that why you're doing this study?" I felt like I had been knocked off of my chair. I was aghast. I thought to myself, "Me? Implants? Is she serious?" Trying not to act surprised I explained that I wasn't conducting this research for personal reasons, but rather that I was interested in the FDA controversy over the safety and efficacy of breast implants.*
>
> *For her, the assumption that led to her question melted the difference between us. She was seeing the two of us as the same. Both of us as women who have common goals and ideas about life, our bodies and our actions as women. For me, on the other hand, her question ruptured the sameness between us. I had felt a kinship with this woman, but now I was suddenly aware of our differences.*
>
> *During this interview, my body also became an object that might be subjected to cosmetic operations. My body could be constructed and consumed for the pleasure of others. Just as I enjoyed looking at this woman, she was helping me to create myself as an object for visual consumption.*

Several years have passed since this interaction, and I have since interviewed many more women about their experiences with all types of cosmetic surgeries. I am not surprised anymore when a respondent asks if I am considering surgery, yet I am still

uncomfortable when interactions with participants generate my candidacy for surgery. Indeed, during some interviews participants have offered specific, unsolicited suggestions of what I should have done. These suggestions stick with me long after the interview is over. I find myself paying extra attention to my body and the characteristic in question and fantasizing about the potential changes cosmetic surgery could have on my appearance.

When I chose the topic of cosmetic surgery for my dissertation, I thought I was too young for surgery and therefore safe. Protected by my age, as well as my beliefs, I would not be seduced by the possibilities of surgery. While conducting the interviews for this dissertation, my feeling of safety has slowly been eroded. Rather than becoming increasingly separate from my respondents, I feel I have rapidly aged to become more like them. I have met several reputable cosmetic surgeons and I have seen some surgical results that I find to be quite pleasing. The possibility of transforming my body and face are now closer to concrete actions. Thus, the line separating me from my research participants is breaking down. This chapter is about crossing such a line.

Crossing the Line as Theme

The image of crossing a line emerged in data analysis when I noticed that research participants were likely to have multiple surgeries. Even women who have horrible experiences with botched surgeries and severe complications, report having and planning additional cosmetic surgeries. It appears that once women cross the line to choose cosmetic surgery, they have crossed a one-way threshold. As one research participant explained, once a woman has employed surgical technologies to push the limitations of her body, "Why stop? There are an infinite number of things you can have done, really."

Thus, this image of crossing a line simultaneously holds three meanings. A line separates me from the research participants, women cross a line when they choose cosmetic surgery, and much of cosmetic surgery is done to eradicate or soften lines due to aging. In order to better understand why women cross these lines in favor of cosmetic

surgery, I began to examine the circumstances surrounding women's decisions to have surgery.

Women frequently began the interviews by tracing a history of how they decided to have surgery. In most cases, study participants had a friend who already had surgery. Many women were involved in caring for the friend after surgery, and many selected the same surgeon as their friend. Having some personal connection with a woman who has had surgery is clearly a very important influence in whether or not a woman will pursue cosmetic surgery. I found that decisions to have surgery are made socially by women through their interactions with a network of friends and consultations with cosmetic surgeons. Women do not make the decisions to have cosmetic surgeries in isolation; rather they seek advice from friends and surgeons, and learn from their friends' surgical experiences. Thus, it is through relationships that women come to see themselves as candidates for cosmetic surgeries.

Friends and surgeons suggested, encouraged, and sometimes even "pushed" participants into having cosmetic surgery. I personally experienced the power of this interaction pattern through my changing relationships with research participants. While I began studying this topic feeling an "outsider," I am now treated as a potential candidate for surgery. In this chapter I apply concepts from symbolic interactionist theory to understand the interactive, mirror-like processes that occur when researching bodies, and the changing meanings of the researcher's body as a potential tool for data analysis.

Applying Symbolic Interactionist Theory

Theories of symbolic interaction are particularly useful for a study of appearance. A basic tenet of symbolic interactionist theory is that the "self" is established, maintained and altered in communication. According to Mead, this process of communication occurs in language and is mirrored in our thought processes (Baldwin 1986: 81 [Mead 1934: 325-328]). We experience our thoughts as words, which allow us to mentally role take (Baldwin 1986: 81 [Mead, 1924-25/1964: 288]) by "stepping out of one's own role and

taking the social position of another person" (Baldwin 1986: 94). We role take by imagining what other people will say and how they will respond. Unlike spoken language, appearance is usually not seen simultaneously by the sender and receiver. We rely on others' responses to us, which become a kind of view of the self. Similar to seeing ourselves in a mirror, we perceive others' responses to us through their reactions. Through ongoing interactions with others we internalize and develop a sense of what we "look" like to others. In this way we internalize the gaze of the *generalized other*. Mead (1934) defines the *generalized other* as "The organized community of social group which gives to the individual his unity of self" (p. 154). Individuals converse with themselves from the position of the *generalized other*.

> "The self-conscious human individual, then, takes or assumes the organized social attitudes of the given social group or community (or if some one section thereof) to which he belongs" (Mead 1934, p. 156).

As I meet a new person, I may watch her responses, gestures, and facial expressions, to interpret her reactions towards me. Instead of using a physical mirror, I am using the reactions of another as a human mirror, giving me feedback about my appearance. Thus, appearance is given meaning though social interaction. Therefore it follows that dissatisfaction with one's appearance would be socially mediated and created through interaction as well.

Networks in Decision Making

Suggestions from Friends to Participants

Research participants reported that their interactions with friends are particularly important sources of inspiration for their cosmetic surgery decisions. Julie describes her contact with a social group in which cosmetic surgery was common.

> I was taking dance classes everyday with a lot of upscale income ladies that were worth a lot, so a lot of them had had plastic surgery, it was common to do, in that peer group, and one gal in particular I talked to that had had some and she was supportive...

The first suggestions frequently come from friends who have already had cosmetic surgery. Explaining the reasons for her recent neck lift to eliminate sagging jowls, Shannon says,

> And then when somebody started telling me that they were ugly, I started agreeing with them.

Heather strongly believed her decision to have surgery was influenced by her friend's opinions. Early in the interview she reported that her friends "made her do it" by exerting constant pressure. Her response was to say, "I think you have to trust your friends. . . I mean, I knew I was aging. I didn't realize how rapidly I was aging." In addition, Heather had previously been opposed to surgery, partly because she had seen "so many bad jobs." Her friend's successful results changed her feelings about having cosmetic surgery, particularly because she now knew of a good doctor.

> Dawn really was the force behind me, just kept pushing me, pushing me, pushing me. I don't know if without Dawn - I would have come to it without Dawn. I make my own decisions. I think what Dawn did, it wasn't until I saw her last surgery, and how much better she looked, I thought - but Frank *[her cosmetic surgeon]* is really good. And that was what got me into his office....Because I have seen so many bad jobs, and I just wasn't interested. Even though I didn't like the way I looked, I wasn't yet ready to take that next step. When I saw her results, I thought, I'm ready for the next step.

For Laura, her decision was largely influenced by nursing her friend through the recovery. By her contact with this friend, she learned of the physician.

> And I had a friend who had had surgery recently, and I had nursed her through the process and so I was exposed to the physician .... I was very impressed with the work that she had done and with the physician himself. So then I decided to go ahead and do it.

For Patty, seeing the results of her friend was enough to convince her. This was particularly the case because of the physical resemblance between the two of them.

> I just decided that I wanted to do it, and I didn't do hardly any research on it, I just saw somebody I liked and that was my friend Jenny, she's very much like I am, from the Midwest, same kind of face. We'll look young when other people don't.

Suggestions from Participants to Friends

In addition to being influenced by friends' suggestions and experiences, participants described encouraging their friends to have surgery. The ways in which research participants made suggestions varied. Some women felt it was rude to ever suggest surgery, even when pressed for their opinions. Other women were eager to spread the word about cosmetic surgery. According to Heather, her mother aged overnight following her divorce. The tactics Heather used are particularly direct.

> My mother - I can't tell you how she aged overnight . . . . she's never had any plastic surgery, I dragged her to a plastic surgeon. . . . I drag her in there saying 'Should - you should have it done now.'

While Heather was quite direct towards her mother, most women in this study utilized a specific strategy when suggesting surgeries to their friends. Generally women reported making suggestions only after first being prompted by the friend's own self-criticism. This window of opportunity allows the suggestion to be interpreted as help. Describing this strategy, Diane explained,

> What I do now is if someone says, I'm thinking of doing this, then I say, okay, that's my chance, they need some encouragement, then I say yes, go ahead and do it. It will really make you feel good...

Often women would solicit my advice about appearance matters, providing windows of opportunity for my suggestions. During the interview with Heather, I am prompted to offer advice on whether or not she should color her hair.

> I have gray hair. I go through this every time I go in... we have this discussion with the man who cuts my hair - I'm going this afternoon to get a haircut - as to whether I should start coloring it. And every time we go through this, and everybody in the whole place gets involved in it, some say yes, some say no.

And then I added:

> I would say no.

This brief interchange illustrates how women, including myself, become involved in the decision making process, prompted to offer opinions.

Sharing one's experiences with cosmetic surgery can have the same effect as a suggestion. Because the stigma of having cosmetic surgery has declined in the last decade, participants were often comfortable sharing their experiences with friends. Amy observed that by talking about her surgery with friends, a couple of them,

> . . . who probably would not have had plastic surgery, have had plastic surgery because I did. I think that they feel more comfortable with it. . . And what's amazing is, when you start talking about it, everybody wants to know. And they want to do it. And they do have it done.

Women's experiences with suggestions for surgery support the idea that appearance is inherently social. Participants relied upon others for suggestions and guidance when making cosmetic surgery decisions, and offered their advice when opportunities arose. These interactions are important because they vividly express how norms are socially created and internalized, as women jointly construct the interactions that shape their relationships to themselves.

Suggestions from Physicians

Suggestions made by physicians were reported to be different from friends' suggestions in several important ways: first, physicians' suggestions often occurred at post-operative office visits, and second, physicians often suggested additional surgeries. The initial suggestion for Amy's cosmetic surgery came from an interaction with a physician. Amy was visiting her husband in the hospital when a doctor suggested a surgery,

> A young doctor there said, 'Oh, you're a very attractive woman, but you have an awfully long nose, and when you get older it's going to hook. So why don't you let me nip that off for you?'

Surgeons' suggestions of cosmetic operations were frequently reported to occur during post-operative consultations. Diane reported seeking advice from her cosmetic surgeon on the next appropriate surgery.

> Well, the last time I saw my doctor, I said, 'Do I need to get my upper eyes done now?' He said, 'No, the next thing is, you do this,' *[pointing to her own forehead]* and he said the forehead.

Participants trusted their surgeons' judgments about which surgeries to undergo. Given the vulnerable position of a woman having cosmetic surgery, trust is an important element in this physician-patient relationship. Patty confirmed this point of view when she said, "If you don't have faith in your surgeon, what do you have faith in?"

Three weeks after her surgery, Heather described suggestions during a post-operative visit. Her incisions were still healing when her surgeon suggested keeping the door open for future surgeries.

> When I said this is it, I'm doing it once, I'm never doing it again, he said never say never, I said I know, I know one should never say that, I shouldn't say that. And when I left him last week, he said to me, well, you know, you can come back and we can do a little here and we can do a little there. He didn't say anything in particular. He just said down the road or whatever. No, I wouldn't be against it.

Sometimes cosmetic surgeons' suggestions are unrelated to the originating complaint. Amy reported that,

> I went to see him about my nose, he said that there wasn't a lot he could do for me, because my nose was not good, I did not have a good job before. . . But that what he thought I really needed was a forehead lift. Because I had asked him about getting my eyes done.

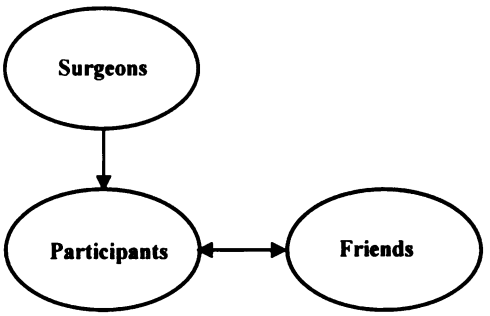
In this case, Amy did get her forehead lifted, and her nose concern was never addressed.

In another instance, Patty described her surgeon as "trying to talk" her into doing a particular surgery. She recalls,

> Patty: He's trying to talk me into doing a laser.
>
> INT: On your face?
>
> Patty: Yeah.
>
> INT: What would that be for?
>
> Patty: Well, it would get rid of all these lines and it would make your face, it would get rid of all the discoloration. I'm just afraid, you know, I think I look okay, and I've never had other stuff done, eyes or anything like that.

Patty's reluctance to have facial laser surgery is an example of how women negotiate with their surgeons. Although suggestions from surgeons are often unsolicited, they are not blindly accepted.

The qualities of suggestions, therefore, are different depending upon who is giving the suggestions. Suggestions by friends are characterized by sharing, learning from each others' experiences, advice after prompting, and encouraging. Suggestions from doctors have more vertical qualities, and are described as being more one-sided and included posing the next surgery. Thus suggestions are characterized by being either vertical or horizontal, and reflect the types of relationships women had with the individuals making suggestions. In this diagram, the direction of the arrows signifies the sender and receiver of suggestions. Note that surgeons' suggestions come from "above" and friends' suggestions are mutually exchanged.



Researcher Enters Network

As I interviewed these women, I became, in some cases, a part of their network. This was particularly true when I was referred to many women within the same network. We often talked about their friends, and their friends' surgeries during the interviews. These women were not acting in isolation, and that became even clearer as the number of interviews increased.

My awareness of the importance of networks is due in part to my becoming a participant in a cosmetic surgery network. Women I interviewed treated me as a potential candidate for surgery. When I sought referrals from a cosmetic surgeon and he initially mistook me as a prospective patient I began to see myself as a prospective patient too. From meeting with over 20 women, I saw the work of each surgeon and learned to identify the differences in their techniques. Through this small survey of the

work of local surgeons, I now have an idea which surgeons would be the best to perform particular surgeries. I am beginning to be a part of the network, to place myself in the network, to pick a surgeon in the network.

The assumption by research participants that I was a candidate for surgery was evidenced by some of their statements. Usually I was given advice about not waiting too long to have surgery. It is believed that having surgery at a younger age results in better outcomes. Diane told me that with younger surgery, "You just look fresher. We had done it soon enough, and you should definitely ..." Patty also encouraged me to have the surgery early, saying,

> The way your mother ages is probably the way you're gonna age. Do it before you get too - before you start to show.

She also provided me with specific suggestions for the types of surgeries I may want to consider and alerted me to the possible problems of having surgery with a high forehead. I got the distinct impression that she did not approve of my high forehead. Here she offers her expert opinion of the future problems I will face.

> You'd be in real trouble. . . it would be a hard thing for you, because I know enough about it that when your eyes, like in here, are pretty low, and some time that will happen with you, but it will be kind of tricky because they can't pull your forehead up any higher...

The first time a research participant treated me as a candidate for surgery, I was shocked. It gradually became something I expected during each interview. While I did not ask for suggestions, by putting myself in the setting of an interview about cosmetic surgery, I entered into a network and became a potential candidate. Knowing this to be the case, I was particularly careful with my choice of clothing, application of make-up and hair styling before the interviews. I felt my appearance was scrutinized during interviews.

This has been a personally difficult research topic because I know I'm treading on a thin line. Although I was not inducted into the club, I was right outside the surgeon's door. When I started this study I thought my relative youth would protect me. Now I

know better. Instead of finding my appearance to be a source of strength, acting to shield me from the promises of surgery, my appearance became a liability. The line separating my body and the women I study became blurred. I used to be quite sure I would not have surgery, yet now I feel increasingly uncomfortable with my "imperfect" appearance as judged by their standards. This discomfort was highlighted during my nineteenth interview when the participant commented that she didn't understand why someone who has something really obvious, like something hanging from their eye, wouldn't get it "taken care of." I had this sinking feeling she was talking about me, and a small skin tag on my eyelid. I felt the sinking partly because I did not like being criticized by my respondent, but also because I knew that I would "take care of it" and would be crossing a line. The distance between us was almost gone, as I too accepted myself as a candidate for surgery. As I sat in the dermatologist's office, waiting for the removal of this skin tag, I thought about the implications of my crossing this line, and wondered what my next step might be.

Conclusions

In conclusion, I want to question the image of a single line. While I had originally experienced my separation from my research participants as one line, I believe that was because I wanted to feel the safety of being on the "other" side of an absolute line. Researching women's experiences with cosmetic surgery has shown me that there are several steps in the cosmetic surgery experience. Learning first to tolerate, then emotionally accept and now to entertain the possibility of surgery is a process occurring through many interactions. While I might have wished for the safety of a clear line, the end product of having cosmetic surgery involves many steps, which could each be characterized as crossing a line. By going through this experience myself, I now have a better understanding of how these women choose cosmetic surgery. These women view their bodies as works in progress and I learned to see myself that way too.

This chapter has implications for Mead's theory of the *generalized other*. Mead writes that abstract concepts are concepts states in terms of the attitudes of the entire social group. The individual converses with herself from the position of the *generalized other*.

> "The organized community or social group which gives to the individual his unity of self may be called "the generalized other." The attitude of the generalized other is the attitude of the whole community (Mead 1934, p. 154).

Surgeons' and friends' suggestions together constitute the *generalized other*. Through their interactions with friends and surgeons, women make decisions to cross the lines and have cosmetic surgery. Accepting the standards of appearance supported by their reference groups shapes these decisions. Norms of appearance are socially communicated through suggestions, which women internalize as the attitudes of the *generalized other*. Thus, women's relationships to their selves and their appearances are created in relationship to others. In the next chapter I explore the discourses women use to discuss their cosmetic surgery experiences, and how these shape the ways women view their surgeries.

CHAPTER VI

DISCOURSE OF RULES

Introduction

Cosmetic surgery, by its very nature, requires some explanation. It is the act of taking a healthy body and causing harm for the sake of surgically altering appearance. The need for explanation increases within a feminist socio-political belief system: How do women, particularly feminist women, choose to have cosmetic surgery? As a feminist studying cosmetic surgery, there is a central paradox I must address: How can I study women who have cosmetic surgery, without undermining the decisions of these very women? In chapter one I reviewed how feminist research on women's experiences conforming to dominant beauty practices has historically been divided into two conflicting positions (Dellinger & Williams 1997). While each side supports feminist beliefs, and believes it represents the best interests of women, they hold opposing views of some appearance practices as either empowering or oppressive. The two sides of this debate can be visually imagined as opposite ends of a continuum.

I----------I

"beauty-as-oppression" "beauty-as-liberation"

At one end is the "beauty-as-oppression" position (Davis 1995), where researchers view women as oppressed victims and women's beauty practices are seen as further propagating their oppression (Faludi 1991; Wolf 1991). This theoretical standpoint is

supported by Foucault's (1979) theory of the "docile body," which maintains that power relationships are expressed and reproduced in the body. The work of Susan Bordo (1991, 1993), is an example of this perspective, in that she examines how women are influenced and shaped by cultural images in ways that reinforce gender hierarchies.

Attempts to recognize women's agency in beauty practices compose the other end of the continuum, constituting the "beauty-as-liberation" position. Women's choices to undergo cosmetic surgery can be explained using a rational choice model (Gillespie 1996), by stating that cosmetic surgery can be empowering for women on an individual level in a market economy model where women are valued for conforming to cultural standards of appearance.[23] In Dellinger and Williams (1997) study of women's makeup use at work, Judith Butler's (1990) theory of subversion and parody outlined in *Gender Trouble* is utilized as an attempt to recognize women's agency in beauty practices. Although Dellinger and Williams looked for ways women might use makeup to resist and subvert dominant norms of appearance, they found no evidence of such use. Their research participants used makeup to conform, rather than rebel.

A primary problem with framing the question of cosmetic surgery as either oppressive or empowering is that it tends to reify the dualistic and competing images of women as either "dopes" or "agents" (Davis 1991, 1995). These two models oversimplify and polarize women's experiences of cosmetic surgery. By forcing this complex multi-leveled issue of women's relationships to beauty practices into a dualistic model, neither position adequately represents the relationship of women's individual choices to the position of women on a socio-political level. In this chapter I present a

[23]However, Gillespie (1996) does recognize that the practice of cosmetic surgery also contributes to women's further oppression, thus creating a "paradox of choice."

third possibility for a feminist analysis of women choosing cosmetic surgery. Through a qualitative analysis of women's discourses of their experiences with cosmetic surgery, I explore how women are able to reframe and redefine the questions of oppression. Women use language – and, more specifically, *a set of rules* – for describing their cosmetic surgery experiences. These rules allow women to reframe questions of oppression and avoid conflict between their beliefs and their cosmetic surgery practices. By focusing on the discursive practices of women engaging in cosmetic surgeries, I am able to develop a feminist criticism, which takes into account women's active participation in their decisions to have cosmetic surgery.

I learn the rules . . .

Women's discourses about their choices and experiences with cosmetic surgery are characterized by a set of rules. Rules are largely unspoken and learned as one enters the domain of cosmetic surgery. I discovered and learned these rules by unknowingly breaking them.

It was my second interview and the research participant was describing for me the reasons she had seven cosmetic surgeries. Using her "before" pictures laid out on the table in front of us, she pointed out various facial flaws. She cited that her earlier nose job had left her nose crooked with cartilage poking out, that she had bags under her eyes, and that she had deep lines in her forehead. Amy said to me,

> *"And I was most concerned about my nose, which is initially why I went to see him."*

I agreed with her, responding,

> *"And you can really see that it's crooked there, and you can see the cartilage poking through, and how you have that line in the middle there."*

Amy, caught off guard, responded with an excuse as to why she looked so poorly in the picture:

> *"Yeah. So anyway, he took these photographs just before surgery, and in fairness to the photographer, they'd already given me Valium, so I probably looked a little more gork than I normally would."*

A few sentences later she cued me in to the rules, by saying

> *"But what the surgeon did was very undrastic, I thought. He just smoothed out the bone of my nose and tried to give me a little more nostril, which I lacked. . . ."*

She minimized the results, calling them "undrastic" and used minimizing language of "smoothed out the bone" and giving her "a little more nostril." I, however, was not yet knowledgeable of the rules of cosmetic surgery discourse, and replied,

> *"That made a very big difference. It's fortunate that you didn't have the upper eyelid done. It did make a really big difference."*

Finally, Amy firmly responded by correcting me:

> *"Well, it wasn't a lot, and as far as I was concerned, I didn't look very different. Nobody ever mentioned it or knew. . ."*

This interchange is an example of how rules of discourse can be taught to new members of the cosmetic surgery community. It was clear I did not know the culturally accepted way to respond to her surgeries and she was doing her best to correct my comments. Amy tried to make my comments rule-appropriate and instruct me on the right ways to judge a cosmetic procedure. I, on the other hand, had no idea that subtle results are a valued quality, and thought a drastic makeover was an optimal result. After all, she spent a lot of money and time, and endured pain to achieve this "subtle" result. While throughout the interview I believed I was validating her experience of the difference

surgery made, instead she experienced my comments as criticism. I had learned my first rule – the rule of minimizing.

The Rule of Minimizing

There are two primary analytic themes in women's discourses about their cosmetic surgery experiences: (1) minimization and (2) self-authorization. The rule Amy taught me was the rule of minimizing. The rule of minimizing can be conceived as a meta-rule, as it is present in each of the three stages of being a good patient. Research participants minimized their motivations, surgeries and results. In my interview with Amy, she minimized the results, calling them "undrastic." Patty used the minimizing rule to describe her friend's laser surgery and her own post-op recovery. Although the friend had a complication, the story is told to minimize her difficulties.

> Patty: My one friend had a very bad experience with Dr. Wolf, even though she loves him, with the laser. And she didn't want to have the laser and then she later said it's the best thing she ever did, but the process was awful. What happened is she went away for the weekend. And it [the oozing skin] stuck to her face, and the truth is, she went too long, and so she tried to take it off, it was just a mess. But now she says it's the best thing that ever happened to her. Everyone has a different post-op tale.
>
> INT: How was your post-op?
>
> Patty: It was a piece of cake.
>
> INT: You didn't have a lot of bruising?
>
> Patty: Down here, the only thing I remember, in fact, all the blood went down and it hung right here in my neck. And it took me a long time for that purple bruise to go away. Then the other day I had a flu shot, and I have a bruise that is two weeks old that is just horrible up here. So I had a great experience. I was very motivated, I was very pleased.

Calling her own recovery a "piece of cake" and stating that laser surgery was "the best thing that ever happened" to her friend, Patty simultaneously minimized the difficult

recoveries they both experienced and exaggerated the positive effects of the surgery. Later in the interview, Patty made an overt reference to the importance of minimizing. She described disclosing her surgery to others, however she doesn't say, "well, I look so great because I've been slashed and diced." While Patty made it clear that she has been "slashed and diced", she was also explaining that she would be breaking the rules if she described it that way. Thus she doesn't tell people about the extent of her surgeries.

Laura minimized the surgery itself, through her use of minimizing words. Describing her surgery, she recalls that the surgeon,

> "just stuck a little sack, and then re-stitched it. . .All I had done was, they took extra skin off my breasts and just kind of tightened underneath. There was no implant or anything."

Describing her surgery in this way, Laura is minimizing her breast reduction. Her words of "just", "little" and "kind of" are minimizing. Even when she talks more specifically about the incisions, she describes these in minimizing ways.

> "They made like a half-moon under the breast, then a T up to the nipple, and they actually did go around the nipple because they had to move the nipple up. And then took off like a pie shape underneath and then just tightened it altogether."

It is striking how Laura is able to downplay the extent of her surgery, even while graphically describing the incisions. Downplaying the invasiveness of surgery is common in the cosmetic surgery community, where surgeries are described as a "nip and a tuck" and often compared with other beauty practices, such as having one's haircut and using makeup. By minimizing the extent of surgery, research participants were able to avoid any discussion of the severity of surgery. The discourse of minimizing thus serves as a tool, allowing women to have cosmetic operations yet not recognize their seriousness. Because cosmetic surgery may appear severe to people who are outside of

the surgery arena, telling minimizing stories is an important way to negotiate the deviance and horror associated with surgery. Communicating their surgery stories as "normal" takes the edges off the deviance and horror of cosmetic surgery, thereby socially placing cosmetic surgery – and the research participants' socially communicated selves - in an acceptable category.

The Rule of Self-Authorization: "I did it for myself."

Women gave a variety of reasons for having cosmetic surgery. Some women cited wanting to look differently in clothing, while others sought to regain a more youthful appearance. While the reasons varied, women consistently pointed out that they did not have surgery to please other people. Versions of the phrase "I did it for myself" were common in interviews. However, this phrase does not mean participants were not referencing a social self or social selves. Rather, "doing it for myself" is a fully social reason related to cultural and sexual norms of attractiveness and youthfulness. Women are certainly aware of the cultural mandates around youthful attractiveness and norms of "successful" aging. While the phrase "doing it for myself" implies solely individual action, my analysis of the networks in decision-making and the social nature of the "mask of aging" shows clearly this is not the case. Rather, their comments sustain a rule of self-authorization.

"Doing it for myself" is a discourse that the women repeat frequently in their stories, claiming autonomy in their decision making. Dull and West (1991) noted that doctors also use the phrase "doing it for themselves" (p. 61) to describe good patients. "Through these means, surgeons located the impetus for aesthetic improvement within patients themselves" (Dull and West 1991, p. 61). However, participants' motivations

are clearly socially situated. Dull and West note their data show a range of outside influences (family, friends, etc.), and that doctors expressed preferences contradicted other reasons patients seek surgery (such as for a job or relationship). Good patients are thus "*created* as well as 'found'" (p. 62). Dull and West point out that the interactions which make a good patient are part of our gender accomplishment. Thus, women are "naturally" good candidates for cosmetic surgery. In *Twilight Zones*, Susan Bordo (1997) writes,

> When people claim to be having surgery "for themselves," they frequently mean that they are not being urged to do so by husbands or boyfriends. But husbands and boyfriends are not the only eyes that survey and evaluate women; the gaze of the doctor, especially with the tremendous authority that doctors have in this culture, may hold a lot of weight. . . (p. 54-55).

From the participants' perspectives, women are trying to be "good patients" by upholding and subscribing to the "doing it for myself" rule. It is a rule that helps them to ignore social influences and minimizes external pressures in their decision-making process. Carol, a forty-one year old secretary, elected to have a tummy tuck and liposuction body contouring after losing over one hundred pounds. Recounting an initial consultation with her surgeon, she describes the importance of having surgery for the "right reasons":

> He interviewed me - "Why do you want to have this done?" - to make sure you're doing it for the right reasons, not because you want to catch a husband or whatever. . . I told him about the weight loss, that I wanted to do that for me, it wasn't for my husband, it wasn't for anybody else but me.

Carol later adds that having surgery is like a gift to herself:

> That's how I view all the surgeries. Like when I get a massage. This is for me. And we all need that, there's nothing wrong with it. So that's how I found him.

Emily, a thirty-four year old hair stylist had breast implants and liposuction. As the youngest participant in this study, she faced an extra burden when describing why she chose to have cosmetic surgery at a young age. Her husband questioned her decision to have surgery, and her response was that she's "doing it for myself."

> Why do you want to do that? You look fine. I'm doing it for myself, you know. I feel better about myself. When you find that perfect dress and you put it on and it just doesn't fit right.

Emily consciously tells me that surgery is for herself, reminding herself to cite the right reason for surgery. By adding "I should say" to her description, the importance of self-authorization as a rule of discourse is highlighted.

> Well, we all can't look like supermodels. But we can try. I think we do it - for myself, *I should say*, it makes me feel better about myself. This is how I see myself. This is who I want to be. This is the way I want other people to see me. That's probably the best way to describe it. But I'm pretty much doing it for myself. When you get out of the shower, you look at yourself in the mirror.

A major exception to the rule of self-authorization was the importance of one's employment in the decision to have cosmetic surgery. Women talked about wanting to look younger for their careers as one reason for having cosmetic surgery. This was the case with Jean, a divorced executive secretary, who told me that she had facial cosmetic surgery at age 67 because of her job.

> I feel in my job situation, I'm 67 as you probably know, but almost everybody where I work is much younger. . . and I just felt that it made me feel like I belonged more. . . And in that situation it kind of behooves you to look as – it's not necessary to look young, but to feel youthful.

She later adds that although her male boss is older, as a woman she is aware that a youthful appearance is important to her career.

> But it's still a man's world when it comes to looks. I think women think more about staying youthful than men do, it's more acceptable for men not

> to, see. ... I felt that as long – and it was a gift to myself, kind of. If I'm gonna be working at this age, and I'm still working and vital and active ... But I felt that it was important to me, and also, it was kind of like a gift to myself. If I'm going to work at this age, past 65, then I've gotta give myself a present. So I did.

Thus, while Jean initially talks about the importance of having surgery to maintain a youthful appearance for her employment, she returns to the rule of self-authorization. In a version of "I did it for myself," she says that having cosmetic surgery was "kind of" a "gift" to herself.

Similarly, Amanda, a fifty-year-old business consultant, describes her facelift, laser face peel, and breast reduction surgeries as both important for her high-profile career and as a way to feel better about herself.

> I wanted it to look natural. I don't want to look 25. I just want to look fresh. And I don't want to look - what's interesting is that, I could see in work doing consulting how your age did start to affect, especially for women, the projects you were given, they didn't see you as able to maybe run and go and chase and hunt down, and it was a little bit easier, I think, looking younger, to get some of the better work. And I could be naive to it, it's just what's out there, what's happening. I also did it for me. What I decided to do is, my decision, why it took so long, I guess, in thinking about it, is, I wanted it to be for me, not for anybody else. And to make me feel better about myself, and I think that that does project. But I wasn't raised from a family that thought this was all okay. I'm sort of cutting edge.

With the exception of their employment relationships, research participants often claimed autonomy in making their cosmetic surgery decisions, thus abiding by the rule of self-authorization. Rarely did research participants question standards of appearance. For example, when Laura, a fifty-four year old public health nurse, talks about her decision to have breast reduction surgery she tells me it is because she was "really drooping."

"I could never wear something like a halter-top or anything without looking like I was really drooping. . ."

She never questions why "really drooping" is a physical state requiring surgery. Similarly, Laura had earlier described how she decided to have surgery as a result of taking care of a friend post-operatively and being exposed to the friend's physician. She tells me,

"I was very impressed with the work that she had done and with the physician himself. So then I decided to go ahead and do it."

By only referencing the physician as a factor in her decision for surgery, Laura is avoiding any discussion of an appearance-related reason. Other research participants described that they were beginning to look old or tired, but not one research participant ever discussed *why* looking old or looking tired warrants having surgery.

Occasionally a research participant would acknowledge the importance of social relationships in her decision for surgery. This was the case with Diane, who reluctantly connected her decision to have breast implants with her recent divorce:

Diane: I probably never would have done that if I were not divorced. But I just figured ...

INT: Was that around when you were divorced?

Diane: Mm hmm. I just thought, well, to attract another man I'd better look good.

INT: So it was related.

Diane: Yes it was. *I hate to say it*, it was.

Diane expresses her reluctance to recognize her divorce as a factor in her decision when she states, "I hate to say it." By admitting to the influence of her intimate relationships in her surgery decisions, she is breaking the rule of self-authorization. Having "surgery for

myself" ensured that women abided by the rule of self-authorization, thereby upholding their claim that cosmetic surgery decisions are made autonomously. By abiding by the rule for self-authorization, women individualized their decisions to have cosmetic surgery, and internalized the motivation for seeking surgery.

Learning the Rules

Although I began my research as an outsider to the social world of cosmetic surgery, I quickly learned to navigate the rules of discourse. The experience of learning the rules is not unique to researchers. Rather, research participants occasionally made overt references to learning the rules themselves. Heather described a story of learning the rule of minimizing when she first entered the domain of cosmetic surgery, by caring for a friend after a face-lift. She recounted the first time she saw her friend post-operatively:

> "That was the first time I had seen her. And I think I hurt her feelings, because I didn't tell her I thought she looked terrific. I just sort of looked at her and she was discolored, she was swollen, and she expected me, I think, to say 'Oh, you look wonderful and beautiful!' and I didn't say that right at the very beginning, and then I realized later on afterwards, I really *should* tell her she looks great."

Heather's use of the word "should" highlights that this is a rule of discourse, not a response she sincerely feels, but one that is expected. Heather is learning a discourse to minimize the severity of cosmetic surgery recoveries. Abiding by rules minimalizes the experiences of cosmetic surgery and avoids the harder questions of what social and cultural themes brought the women to the knife. By ruling these out and emphasizing the individualistic aspects, the women act agentically but without reference to themes which in other literatures have been called oppressive.

Analytic Coda

In closing, I want to acknowledge the interactional context in which the discourses I have described occurred. As Dorothy Smith's theories on femininity explore, discourse is *both* "embedded in economic and social relations, and also constitutes 'a set of relations', which arise in 'local, historical settings' " (Smith 1988: 55). Thus the discourse of rules I have described here is both influenced by and influences social relations and historical settings. The interactional context of my interviews is important for understanding this analysis of cosmetic surgery. I came to each interview wanting to be taught, surrendering myself to their expertise. I presented myself as an inquirer, someone unknowledgeable about cosmetic surgery. A couple of times I was asked point blank, "You don't have much experience with cosmetic surgery, do you?" I felt like the young, naïve researcher, while older, wise women described their experiences to me. Given this relationship it is not surprising that my analysis reveals that I was "taught" rules. I am the student, while research participants are the teachers. A primary responsibility of all students in any discipline is to learn the rules. If my relationship to the research participants had been different, would my analysis be different as well? Of course. I helped to create the interactions that led to these discussions about cosmetic surgery. By being the eager-to-learn, inexperienced, researcher, I helped to create the environment for "teaching" such rules. Does this acknowledgement of my position in creating the research make my analysis any less valid? I think not. This acknowledgement does not undermine my analysis, nor change the stories these women told me. These stories were told, as all stories are, through a process of creation. They were created through the interaction occurring at each

particular interview. My goal in acknowledging the situatedness of these stories is to add a deeper level of analysis, another layer of richness to the text, and a better understanding of how knowledge is socially constructed. In the next chapter I discuss the theoretical implications of this discourse of rules, including the importance of discourse in accomplishing gender inequalities.

CHAPTER VII

CONCLUSIONS AND IMPLICATIONS

This research reflects intriguing issues around the emergence of new empirical areas in the sociology of sociological knowledge. At the holiday party several years ago noted in chapter one, the topic of cosmetic surgery was literally a laughable one. In the past few years this attitude among academics has changed and appearance studies have now garnered a wider audience. Last summer, a piece in the *Chronicle of Higher Education* (Sharlet 1999), reviewed several books on appearance studies (Gilman 1999a; Gilman 1999b; Peiss 1998). While scholars had long neglected this "seemingly superficial subject", several recent books focus on the "culture, economics, and history of physical beauty" (Sharlet 1999; p. A15).[24] This growing interest which detrivializes cosmetic surgery as a topic for research and theoretical concern emerges from the democratization of cosmetic surgeries. This has occurred in part because of an affluent economy at this point in time and surgeon sponsored financing plans. The issue is thus firmly set in a class context. I note in passing the growing popularity of cosmetic surgery among middle class individuals (men increasingly, as well as women). The growing interest also derives from the sharpened scholarly attention to the body which has increased dramatically recently. My study, then, is historically situated at a time when cosmetic surgery is becoming more widespread among the public. In this research I have tried to bring a previously disguised and often trivialized practice into the academic and public discourse through analysis of the experiences and decisions of women who have had cosmetic surgery.

Theoretical Implications

At the most general level, the findings reflect and amplify our understandings of the critical role of the body in articulation of socially and culturally situated selves and identities. This exploration of the cultural construction of women's bodies as related to gender and age goes beyond previous work on cosmetic surgery, to focus on how the social importance of age and gender is culturally constructed through practices of cosmetic surgery and the meanings and interpretations attached to those practices by the women. The findings reveal processes implicated in the multiple articulations of women's bodies, how those bodies are configured with plastic surgery and realized through meanings the women attach to the experience of the surgery and through the social context of their relations with other women undergoing such procedures.

Those processes are best understood via utilization of concepts available in the literature on the body and in symbolic interaction: (1) the mask of aging (Featherstone and Hepworth 1991), (2) the conversation of gestures (Mead) and (3) the generalized other (Mead). But the analysis of the intensely social aspects of the decision to undertake cosmetic surgery and the experience of it also discovered two social processes which flow through and animate the three concepts just mentioned: (1) Women's experiences in networks of other women having or having had such surgery and (2) the discourse of rules. I argue that the intertwining of these concepts and processes lifts our understanding of women opting for cosmetic surgery from the narrow binary views in some feminist literature (oppression vs. liberation) to a more complex grasp of dynamic, not static, social and cultural pressures, women's exercise of choice and agency in the decision, and the experience, choice and agency that are always culturally and materially

[24] For a recent example see Nora Jacobson's *Cleavage* (2000).

situated. This work problematizes that binary and opens new realms with which to interpret this phenomenon much more closely in line with the women's own lived "everyday and everynight experiences," to quote Dorothy Smith (1979).

Mask of Aging

Featherstone and Hepworth's 1991 concept points to the tension research participants experienced between how they look and how they feel, and thus served in Blumer's (1954) terms as a useful sensitizing concept. They felt their exterior appearances aging faster than their interior views of self. They sought cosmetic surgery to relieve the mask of aging feeling, but the analysis showed a more complex picture which amplifies the Featherstone and Hepworth concept. The mask of aging made them uncomfortable, but they also feared acquiring a mask of surgery with too much surgery that would result in a lifted and frozen face. The balance between these two was critical in assessing in light of others' comments and experiences and women's own views of self of how far to go with cosmetic surgery and how often. Analysis of the mask of aging foregrounded the necessity to utilize symbolic interactionist concepts of self.

Conversation of Gestures

The women imagined themselves as viewed by others and talked about themselves as if they were objects. They expressed being conscious of being viewed by others and reacted to their imagined assessment by others. As Mead notes in his framing of this concept, imagined relationship to the self creates a self (1934). It is through the internal dialogue of "real" or imagined interaction that the participants assessed, reviewed and revised their views of their aging bodies, thus creating selves in the process. These were apparent in what I called *the rules of discourse* for describing their experiences.

One discourse, minimizing, decreases awareness of the severity of the surgery and probably insulates self in the internal dialogue from shading into what has elsewhere been conceptualized as the vulnerable self at risk (Olesen 1992). It thus helps to sustain cosmetic surgery as a cultural practice. By utilizing a discourse of minimizing, women's cosmetic surgery experiences are effectively minimized in interactions, becoming through discourse less serious, less dangerous and less painful. This minimization makes cosmetic surgery seem to be a "natural" part of women's everyday worlds, making it an often unquestioned practice by those engaging in it. Similarly, the discourse of "doing it for myself" supports the *rule of self-authorization.* By professing that they are individually motivated for surgery, and minimizing all external social pressures, participants were able to describe their choices for surgery as an act of self-care, thus sustaining the continuing practice of cosmetic surgery. This rule also locates the desire for surgery within each woman, supporting Dull and West's (1991) findings that it is through the accomplishment of gender that cosmetic surgery is practiced.

Mead's formulation of the conversation of gestures, however, is essentially cognitive and leaves little room to understand the emotionally tinged comments women made concerning views of themselves, emotionally tinged comments which were apparent in the rules of discourse for describing experiences with cosmetic surgery. Thus, in this research the conversation of gestures is extended to include these emotional elements, discomfort with aging, fear of too much surgery, etc.. The conversation of gestures, moreover, must be linked to analysis of another Meadian concept, "the generalized other" in order to understand the origins of views self holds about self and the interactive processes in the path to and the experience with cosmetic surgery.

The Generalized Other

The influence of women's social networks in reaching the decision for cosmetic surgery was highly apparent. A wide variety of suggestions from female friends and from physicians provided reasons and rationale for the decision and support afterward. These networks constituted a critical part of what might be called the women's "generalized cosmetic surgery other", there being, of course, many other segments and sectors of the generalized other including cultural aspects around the norms of youthfulness and aging. Mead outlines the link to the emerging self:

> Any thing . . . toward which he acts, or to which he responds, socially, is an element in what for him is the generalized other; by taking the attitudes of which toward himself he becomes conscious of himself as an object or individual, and thus develops a self or personality (Mead 1934, p.154).

In interactions with these others, views of themselves were created, those views eventually becoming part of the conversation of gestures noted above.

These social and phenomenological processes are imbedded in the cultural norms for youthfulness and sexual attractiveness, hence the sculpting of the women's bodies is more than the application of the cosmetic surgeon's knife—it is the sculpting, or construction if you prefer, of social and cultural process in which, it must be clearly understood, the women participate fully. These are not cultural dopes; they are making reasoned decisions within a framework of choices and pressures. More than anything else, this research speaks to the continuing situation of women in a society, where, in spite of economic, social, racial, ethnic and sexual gains, the women are still beholden to antiquated norms and unrealizable ideals—perpetually young, valued more for their appearance than their ideas, and where maintaining a wrinkle-free face and fat-free body are expected signs of good womanhood. Women breaking with these norms risk being

treated as deviant, lose valuable privileges and advantages, and push societal boundaries of gender and age expectations.

Contributions to Various Literatures

My research strengthens theories of social and individual bodies as cultural constructions and is particularly important for feminist research on women's bodies. Deeply rooted in a tradition of women's health research, this study expands both substantive and theoretical literature in the area of cultural beauty practices, by studying women's lived experiences of those practices. I bring symbolic interactionist concepts to bear on a topic that has previously been dominated by dualistic theories. My innovative use of symbolic interactionist theories produces conceptual and theoretical insights of how selves are constituted and explores women's phenomenological assessment of "inner" and "outer" bodies as they age.

By studying the importance of appearance and beauty practices in women's lives, my research extends social science literature into the topic of embodied appearance. I explore how women's identities are relationally constructed through interactions in and around their bodies. I expand social science analysis of the culturally constructed nature of women's bodies and how this is related to age and gender. This research builds on previous research on cosmetic surgery by focusing on how age and gender are culturally constructed on women's bodies through cosmetic surgery decisions. Because I focus on women's experiences as my text, this research is important for adding women's voices to previous research on cultural constructions of bodies.

Methodological positioning is also important in this investigation. I have written from the first person, contributing to a growing body of literature questioning the position

of the researcher and acknowledging the social construction of knowledges, especially the researcher's own shaping of that knowledge. Through introspective sections, noted in the manuscript by italics, I have made explicit connections between my experiences and the resulting data analysis. This is important for pushing traditional, positivistic boundaries in research practice and writing.

Epilogue

During the course of writing this dissertation, I became pregnant and had a baby girl, Sarah. While I had not intended to write about pregnancy, at times I felt the embodied condition of pregnancy so powerfully that it infiltrated my writing. On more than one occasion I found myself writing "baby" instead of "body" and "contractions" instead of "contradictions." For example, "control over one's baby" (I meant body), and "manage the contractions" (I meant contradictions). Each time I would make a typing error, I was reminded of my own embodied condition. While conducting this research I have been constantly reminded of my own embodiment. During the interviews I was aware of my appearance and attempted to control my body in a heightened way. In chapters five and six, I wrote about becoming a part of the cosmetic surgery world, and crossing the lines which I had assumed separated me from the research participants. As I end this project, I would like to believe that I have in some way freed myself from the obsession with appearance. Now I wish the same freedom for my daughter. While writing chapter six, Sarah turned five months old. During that month her eyes changed color from blue to hazel. Her eye color had been a major topic of interest among all of her relatives and our friends, particularly because she had unusually light eyes given the racial heritage of her parents (I am Caucasian and her father is Filipino). When Sarah

was born, many people commented on her beautiful large eyes. People gleefully said, "I love her eyes! They are so light! How's my little blue-eyed baby?!" The importance of these comments was lost on me at first. I knew there was a fascination with her eyes, but I did not grasp the racialized connotations in these comments. Now that her eyes have "turned," the comments have changed and the compliments decreased. Through this experience with my daughter, I learned the importance of eye color for symbolizing racial identity, and have had to examine my own internalized racism and acknowledge the racism in other's comments. As I close this research project, I would like to think that women could be aware of the pressures not only from cultural norms for appearance, but from others in their lives (friends, physicians, families). I would hope that, upon reflection, if they wish, they would resist those pressures and thus in small part undermine those powerful norms and oppressive practices.

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APPENDIX

- Consent Form
- Interview Guide
- Questionnaire
- Table 1: Description of Sample
- Coding List
- Key Themes List

University of California, San Francisco
Consent to Participate in Research

COSMETIC SURGERY AND THE EXPERIENCE OF AGING

A. Purpose and Background

Virginia Olesen, Ph.D., and Rebecca Wepsic, doctoral candidate, in the Department of Social and Behavioral Sciences are conducting a research study entitled "Cosmetic Surgery and the Experience of Aging" to better understand the relationship between aging women and cosmetic surgery practices. I am being asked to participate in this study because I have had cosmetic surgery or I am a cosmetic surgeon.

B. Procedures

If I agree to be in the study, the following will occur:

I will talk with Rebecca for about one-half to two hours in a comfortable, private place such as my own home, my own office, or some other agreeable place. The conversation will be audiotape-recorded if I agree.

The interview will be semi-structured, and will focus on my experiences with having or performing cosmetic surgery.

C. Risks/Discomforts

Talking about my experiences may be difficult or unpleasant. However, I am free to talk only about those aspects of cosmetic surgery that interest me. I may withdraw from the study at any time and I have the right to decline to answer any question.

Confidentiality: Participation in research may involve a loss of privacy; however, my interview materials will be handled as confidentially as possible. For example, when the tapes are transcribed to written form, both tapes and transcriptions are locked in a cabinet at all times. My name is not marked on the transcription; only code numbers are used. Only Rebecca Wepsic and her supervisor, Dr. Olesen, will have access to the tapes, which will be destroyed after two years. I will never be identified with any stories or quotations in any publications that may result from this study.

D. Benefits

There are no direct personal benefits to me. However, the information I provide may help health care providers and policy makers better understand the position and experiences of cosmetic surgery recipients and cosmetic surgeons.

E. Costs/Reimbursement

There will be no cost to me as a result of taking part in this study. There is no reimbursement for the interview.

F. Questions

I have talked with Rebecca Wepsic about the study and have had my questions answered. If I have any further questions about this study, I may contact either Rebecca or her supervisor, Virginia Olesen, Ph.D. at:

Researcher: Rebecca Wepsic, Doctoral Candidate
Department of Social and Behavioral Sciences
Box 0612, School of Nursing, UCSF
San Francisco, CA 94143-0612
Home Telephone (415) 566-7416

Supervisor/
Researcher: Virginia Olesen, Ph.D., Professor Emerita
Department of Social and Behavioral Sciences
Box 0612, School of Nursing, UCSF
San Francisco, CA 94143-0612
Office Telephone (415) 476-2453

If I have any comments or concerns about participation in this study, I should first talk with one of the researchers. If for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00am and 5:00pm, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, San Francisco, CA 94143-0962.

G. Consent

I will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, I may refuse to answer any questions at any time. I may stop the interview at any time. My decision as to whether or not to participate in this study will have no influence on my present or future status as a patient at UCSF.

If I agree to participate I should sign below.

_____ _____
Date Signature of Participant

_____ _____
Date Signature of Researcher Obtaining Consent

Address (only if I wish to receive a copy of the final research report):

_____

_____

The CHR Approval Number for this project is: H971-13496-01.

Interview Questions for Cosmetic Surgery Study

Rebecca Wepsic Ancheta, Doctoral Candidate
Dept. of Social and Behavioral Sciences
University of California, San Francisco

Decision

When did you first start thinking about having cosmetic surgery?

What factors went into your decision to have cosmetic surgery?
Did you discuss your decision with other people?
Where you influenced by other people?

What was the *most important* factor in you decision to have cosmetic surgery?

How did you select your cosmetic surgeon?

Surgery/Recovery

When did you have your surgery?

What kind of surgery(ies) did you have?

What were you thinking before the surgery?
How did you feel?

Did you talk with anyone about those feelings?

Please describe your surgery.

How did you *physically* feel after the surgery?
How did you *emotionally* feel after the surgery?

Please describe for me how you felt the first time you looked in a mirror after surgery.

Please describe your recovery and healing from the surgery.
How long did it take?
How painful was it?

Did anyone assist you during the period after your surgery?
Who and how?

How much did your surgery cost? How did you pay for it?

Results

How do you feel about the surgery and results today?

Are the results what you expected?
(Any particular success aspects or disappointing aspects.)

Would you have the surgery again?

Have you considered any additional cosmetic surgery?
If yes, please describe what types and why.
Would you return to the same doctor?

Would you recommend this doctor to other people?

Relationships

Do you know anyone else who has had cosmetic surgery?

Did other people know about your surgery?
Which people did you choose to tell?
Which people not to tell?

How did people react to your surgery?
Have those reactions changed over time?

Do you have any friends or acquaintances you think could benefit from cosmetic surgery?

Appearance/Beauty

What do you remember learning about appearance as a child?
Who taught you this?

Would you make a distinction between attractiveness and beauty?
If yes, please describe what you mean by each.

What do you think makes an attractive person?
Attractive man? Attractive woman?

What do you think makes a beautiful person?
Beautiful man? Beautiful woman?

Have your opinions/views about your own appearance changed over time?

Age

Have you ever been aware of aging? If so, when?

Have you encountered situations which make you aware of your age?
If yes, please describe.

Has your cosmetic surgery influenced your feelings about your age?
Do you feel younger, older or the same?

Have parts of your appearance/body changed over the years?
If yes, please describe.

Health

What does it mean to you to be healthy?

What do you do to be healthy?

Has your cosmetic surgery influenced your feeling of healthiness?
If yes, please describe.

Interview Number: _____

Short Survey Questionnaire for Cosmetic Surgery Study:

Your answers to these questions will help the researcher to accurately describe the sample of participants in this study and discern possible patterns that may arise when comparing the interviews.

Answering these questions is *voluntary* and you may skip any question you choose not to answer. In order to maintain confidentiality *do not* put your name on the form.

1. Sex: _____ Female _____ Male

2. Date of Birth: _____

3. What is you racial/ethnic background?

_____

4. Please check the category that best reflects your current marital status:

_____ Single (never married) _____ Widowed

_____ Married _____ Domestic Partner

_____ Divorced _____ Long-term Relationship (not married)

_____ Other (please specify: _____)

5. Please check the category that best reflects your sexuality:

_____ Heterosexual _____ Homosexual _____ Other

6. What is your religion, if any? _____

7. What is your occupation?

_____

8. If married/partnered, what is your husband's/partner's occupation?

_____

***** Please continue on the back of this form. *****

9. Please check the highest level of education you have attained:

_____ Some High School

_____ High School Graduate

_____ Some College

_____ Associate or technical degree

_____ Bachelor's/College Graduate

_____ Some Graduate School

_____ Master's Degree (please specify:_____)

_____ Advanced Degree (PhD, JD, MD)(please specify:_____)

10. Please check the category that best represents your gross annual household income:

_____ Less than $25,000

_____ Between $25,001-50,000

_____ Between $50,001-75,000

_____ Between $75,001-100,000

_____ Between $100,001-125,000

_____ Between $125,001-150,000

_____ Between $150,001-175,000

_____ Between $175,001-200,000

_____ Over $200,000

11. What type(s) of cosmetic surgery have you had? Please list type(s) of surgery, date(s) of surgery, and cost(s) of surgery:

Type of surgery	Date of Surgery	Cost of Surgery

***** Thank you! *****

Rebecca Wepsic Ancheta
Masking Mid-life: Cosmetic Surgery and Women's Experiences of Aging
TABLE 1: Characteristics of the Sample

Interview Number	Pseudonym	Age	Marital Status	Religion	Occupation	Highest Degree	Household Income	Cosmetic Surgeries
01	Laura	54	Married	Catholic	Public Health Nurse	PhD	$200k +	upper & lower eyes, breast lift
02	Amy	47	Married	Catholic	Attorney	JD	$200k +	rhinoplasty, facelift, liposuction, eyes
03	Terrie	57	Divorced	none	Furniture Supplier	HS	$50-$75k	breast implants, eyes, lower face
04	Dawn	60	Divorced	missing	Public Relations/Marketing	HS	$50-$75k	facelift, breast lift & implants (excised), acid face peal, necklift
05	Julie	49	Married	Universal	Therapist	MA (2), MFCC	$25-$50k	breast implants (excised), facelift
06	Cathy	57	Married	Catholic	High School Teacher	BA	$50-$75k	rhinoplasty
07	Heather	55	Divorced	Catholic	Retired Private Investigator	BA	$100-$125k	rhinoplasty, facelift, eyes
08	Diane	57	Divorced	missing	Real Estate Sales	BA	missing	facelift, eyes
09	Shannon	60	Married	missing	Homemaker	BA	$175-$200k	rhinoplasty, eyes, neck (lower face)
10	Mary	58	Divorced	Catholic	Real Estate Sales	BA	$50-$75k	facelift
11	Linda	60	Divorced	Jewish	Sociologist	MA	$50-$75k	eyes
12	Rhonda	63	Married	Jewish	Event Coordinator	HS	$100-$125k	facelift, breast implants
13	Gwynne	missing	missing	missing	missing	missing	missing	facelift
14	Amanda	50	Widowed	Episcopalian	Business Consultant	MA	$125-$150k	breast reduction, facelift, laser face peel
15	Jean	67	Divorced	Presbyterian	Executive Assistance	BA	$50-$75k	facelift, eyes, liposuction, laser
16	Emily	34	Married	none	Hair Stylist	HS	$75-$100k	breast implants, liposuction
17	Beth	52	Divorced	missing	AIDS Volunteer	HS	missing	facelift
18	Carol	41	Married	Protestant	Secretary	HS	$75-$100k	tummy tuck, upper arms, eyes, chest & back reduction
19	Patty	59	Divorced	Protestant	Interior Designer	MFA	$50-$75k	liposuction, lower face
20	Christina	missing	Married	missing	Housemanager	BA	$175-$200k	eyes,facelift, laser
21	Teresa	71	Widowed	Catholic	Retired Real Estate Broker	HS	$25-$50k	facelift, liposuction, laser

CODING LIST

AFTER - the results after it has healed; how they look and feel about it afterwards

AGE - menopause; physical changes with age; spiritual changes with age

BEAUTY/APPEARANCE - as a child; importance of now; connection between the two; definitions of these

CARING - caring for others and being cared for afterwards; post-operative arrangements for care

CONTAGIOUS/NETWORK - similar to above; seeing friends' surgeries and going to same surgeon; talk about friends having the surgery

COST - discussion about the cost; how she paid; insurance not covering the surgery

DEATH - thoughts about death; what death looks like; how she wants to die; other's deaths; avoiding death or "She looks like death"

DECISION - reasons why she chose cosmetic surgery; events leading up to the decision; opinions of the right and wrong reasons for surgery

DOCTORS - how they pick the doctor; consultations with doctors; opinions about doctors; suggestions by doctors

FEAR/RISK - fear of complications; knowledge of risk; stories about other's problems; pre-operative fear

FORGETTING - the participant forgets what she looked like before the surgery; difficulty remembering details surrounding which surgeries she has had; forgetting about certain surgeries; suddenly remembering other surgeries

FRIEND STORIES - stories about friend's surgeries; friends' care giving and taking care of friends; friends suggesting, pushing surgery; having surgery as a friendship activity "together"

HEALTH - discussion about health practices; cosmetic surgery and health behaviors

LOOK & FEEL - relationship between looking and feeling; feeling "tired" as reason for surgery; feeling "better" as result of surgery; importance of attractiveness for mental health; the mask of aging (a mismatch between look and feel)

ME/RESEARCHER - any discussion about my appearance or suggestions that I have surgery; awareness of the tape recorder and of being researched

MEN - men's reactions to surgery (supportive or not); relationships with men; men as a reason for the surgery; men and cosmetic surgery

PHILOSOPHY of CS - a stated opinion about cosmetic surgery; derogatory or positive comments about cosmetic surgery

POST-OP/HEALING - complications; recovery and pain; the first time she looks in the mirror

REGRET/GUILT - the post-operative feelings of guilt and regret; feeling punished by God for the surgery; the thoughts of insanity that accompany deep regret; "What have I done?"

SOCIETY/MEDIA - any mention of magazines, movies, or popular culture; acknowledging effect of society and the context of such acknowledgment

STIGMA/PASSING - stigma associated with cosmetic surgery; negative judgments about surgery; lying about the cause of the injury; camouflaging the surgery with other injuries

WEIGHT - wanting to lose weight; being in control of weight; surgery for weight loss (liposuction)

KEY THEMES

1. Decisions
Networks/Cosmetic Surgery as Contagious
Returning for More. The addiction question. (question themselves as addicts)
Socio-political environment when having surgery.
Combining surgeries: reasons for having more than one. (shared recovery time)
Looking tired (comments by others) -> feel tired -> CS -> look awake -> feel awake
Importance of Surgeon: as a friend/person vs. as a technician/surgeon
Experience of surgery vs. particular surgeries sought
Philosophy of self-improvement ("Be the best that I can be")

2. Telling me Stories
Minimizing invasiveness (incisions, pain, recovery, results, complications)
Forgetting past surgeries & the mind doesn't remember a past body.
Stories of friends, others with CS: Bad results, wrong reasons, expectations.
Cosmetic Surgery talk, network of friends talk about surgery.
The Horror Story.
Jokes about CS and jokes about age.

3. Aging
Physical descriptions of aging.
Awareness of age through mirrors, pictures, TV, window reflections
Mask of Aging experience (Look vs. Feel)
Age as a reason for surgery.
Slowing the aging trajectory.
A philosophy about aging.
Plans to die with dignity.

4. Philosophies of Aging, Beauty, Appearance, C.S.
Body Practices visual graph of passive-active continuum and degree of severity (invasiveness) continuum
Inner <--------> Outer beauty relationship
Look <--------> Feel relationship (philosophy about and mask of aging)
Rules for surgery (right and wrong reasons, expectations, results, etc)
Secrecy, stigma, embarrassment vs. pride, encouraging others to have CS