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Flat Chests and Crossed Eyes: Scrutinizing Minor Bodily Stigmas through the Lens of Cosmetic Surgery

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FLAT CHESTS AND CROSSED EYES: SCRUTINIZING MINOR BODILY
STIGMAS THROUGH THE LENS OF COSMETIC SURGERY

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
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Cosmetic Surgery

Joan Ann George

ABSTRACT

If cosmetic surgery has become the cultural lens through which Americans look at issues of beauty and ugliness (Haiken 1997), then minor bodily stigma is the personal lens through which we scrutinize our bodies and self-diagnose our own flaws in the first place (Ellis 1998). In this dissertation, I interrogated the stories of eight women who struggled with two specific minor bodily stigmas—strabismus (crossed eyes) and micromastia (small breasts). Cosmetic surgery presents a potential “cure” for both of these conditions, however, as some of my interviewees could testify, the results are unpredictable. While some women reported being grateful that they could try to resculpt their bodies with surgery, others were too afraid to try, or annoyed that the option existed in the first place. Using a Grounded Theory approach, I combined autoethnographic techniques with interactive interviewing to collect and interpret my data about how individuals cope with, and talk about, minor bodily stigma in an age of cosmetic surgery.

The two flaws I chose to examine carry a great deal of cultural significance because in the West, eyes are revered as “windows to the soul,” while breasts are regarded as powerful symbols of sexuality. Consequently, I looked at each woman’s

exposure to culture at three levels—the mass media, the local culture, and the circle of family and friends. First, I wanted to find out how these women identified themselves as flawed in the first place, and what impact their perceived stigma had upon their lives. I wanted to know if, and how, they communicated to others about their minor bodily stigmas. Next, I delineated the eight coping strategies outlined by my interviewees and examined the efficacy of each. Finally, I looked at how each woman made and communicated her decision regarding whether or not to pursue cosmetic surgery as a solution to her minor bodily stigma. I asked those who had surgery to elaborate on their decision and its outcome.

CHAPTER ONE: COSMETIC SURGERY AND STIGMA

When I was a child I used to think I was the only one in the entire world who didn't cross her eyes just to make other people laugh. My eyes were stuck that way—permanently. Many of the kids in my class made fun of me. I remember being asked if it was really true that if you crossed your eyes on purpose that they could get locked into position like that. They wanted to know if that was what happened to me.

As I got older I learned that eyes like mine ran in the family, but there didn't seem to be any predictable pattern. My Great Aunt Ethel had crossed eyes her whole life, and my cousin Shelly used to have them, but she got surgery to fix them. My sister's eyesight was perfect, but I was not so lucky. The medical term for crossed eyes is strabismus. I have a type further defined as alternating esotropia. In layperson's terms, that means crossed eyes that take turns rolling in toward the nose. When the right eye is looking straight ahead, the left eye is pointed toward my nose, and when my left eye is straight, the right eye turns in. Although I wear thick glasses because of a severe astigmatism and I only have eighty percent depth perception, my eyesight is relatively good. My eyes were straight until I was almost six months old and pushing my first tooth. Then one morning I woke up and my parents were shocked to discover my eyes were crossed. As a child, my eyes appeared strikingly crossed, and since my parents chose not to try surgery, my eye doctor used patches and glasses to treat my condition. When I grew older, my muscles developed and grew stronger and the degree of

crookedness evident when I was wearing corrective lenses diminished. When I take my glasses off, however, my eyes still cross sharply.

When I was in elementary school I blamed all of my troubles in life on my eyes. If I had straight eyes I imagined my life would be perfect. I dreamed I would be popular and athletic, instead of picked-on and clumsy. The onset of puberty caused me to re-evaluate my situation. Suddenly, all the girls were developing breasts, and the boys were intrigued. I soon discovered Mother Nature was determined to add insult to injury when it came to my physical appearance. My chest stayed flat, and I wore an AA bra until I went to college and finally graduated to an A cup. In high school I was teased about my flat chest almost as often as I was mocked because of my eyes. Some days it was hard to say which deficiency I resented more.

I am now thirty-one-years-old, and throughout my life, my eyes have caused a wide variety of problems. Because of my lack of depth perception I have functional difficulties doing things like going downhill over uneven terrain, playing sports, and being able to distinguish between the part of the lawn that I've mowed and the part that is still standing. In social situations, I frequently discover that people are unable to tell whether or not I am looking at them. Often they will glance behind their left shoulder to see if I am talking to someone behind them because that is where they thought my eyes were looking. My feelings about my situation and my eyes have run the gamut. I've felt sorry for myself, self-conscious about my appearance, angry that other people can't just overlook my difference, and afraid of rejection. I've felt scared at the thought of trying to straighten my eyes with surgery, lonely because I didn't know anyone else with this problem, and mad about my lousy luck in getting crossed eyes in the first place. I have

entertained the notion that having to deal with my eyes has made me a better person. I have also had days when I felt like my eyes have held me back. Sometimes I have forgotten about my eye problems entirely. But no matter what phase of eye acceptance or rejection I was experiencing, I found one question always lingered. Should I say something about my eyes, or shouldn't I?

I have asked myself this question in countless different social situations. Every time I teach a class, or meet someone new who seems disoriented by my eyes, I wonder if I should say something. When I went to the 3-D, *Honey I Shrunk the Kids* movie at Epcot with my friends, I wondered if I should admit why I wasn't jumping at the special effects like everyone else. I didn't have nerves of steel; I had crossed eyes and everything on the screen looked flat to me. When I date someone new I always agonize over whether I should bring up my eyes. If so, when should I tell him, and how much detail should I reveal?

Although my flat chest has not caused me any physical problems, I also have experienced a significant amount of social stigmatization because of my small breasts. Almost without exception I have discovered that given a choice, men would rather flirt with a woman with larger breasts. I have difficulty finding clothing that fits properly across the chest, and I have been asked many times why I don't pursue augmentation. Over the years, these experiences, feelings, and self-questions about my eyes and my breasts have culminated in a deep curiosity about stigmatization. This dissertation allowed me to pursue that curiosity.

Introduction

Cosmetic surgery has become the lens through which Americans look at issues of beauty and ugliness (Haiken, 1997). How we look matters very deeply in this culture. It matters to others and, simultaneously and consequently, it matters to us. The advent of technologies that allow one to attempt to refashion one's physical traits has led to some difficult decision-making at the personal level. Hope that our physical flaws can be erased by surgery is often accompanied by fear that something might go wrong. The simple act of signing the mandatory waiver form acknowledging the possibility of accidental death or other complications provides a powerful reminder of the dangers of any kind of surgery.

A heightened awareness of bodily imperfection has become such a prominent feature of today's society that a new term, "minor bodily stigma" (Ellis, 1998), has been coined as academics strive to delineate between the study of major bodily stigmas like amputation and blindness, and this new-found focus on less intrusive, yet still socially and emotionally significant, minor bodily stigmas like crossed eyes and flat chests. Nearly everyone can relate to the pain of self-consciousness about appearance on some level, and this dissertation explores the complexities involved in making and communicating decisions about whether or not to pursue cosmetic surgery as a means to resolve this discomfort.

This chapter introduces the reader to the world of minor bodily stigma, beginning by positioning cosmetic surgery within a broader historical and cultural context, proceeding through a review of stigma, and minor bodily stigma, literature, and finally

narrowing the focus to a specific inquiry regarding how individuals make and communicate decisions about whether or not to surgically alter their small breasts and/or crossed eyes.

History and Cultural Critiques of Cosmetic Surgery

There are many versions of the history of plastic surgery (Brumberg, 1997; Gilman, 1999; Haiken, 1997; Schnur and Hait, 2000). Some only tell a specific part, such as the history of breast augmentation (Bruning, 1995; Latteier, 1998; Maine, 2000; Vanderford and Smith, 1996; Washburn, 1996). Some deal primarily with cosmetic surgery, separating this area out from the broader umbrella term—plastic surgery (Davis, 1995; Etoff, 1999; Gimlin, 2000; Gross, 1998; Kaw, 1998; Morgan, 1998; Miya-Jervis, 1999). Each version conducts its investigation from a slightly different angle, but all seem to agree that the history of plastic surgery reveals a radical cultural shift in attitudes.

I have assembled a canonical version of plastic surgery, with an emphasis on breast augmentation. This emphasis mirrors the tendencies of many authors to isolate augmentation surgery and follow its evolution in great detail (Brumberg, 1997; Gilman, 1999; Haiken, 1997). Although my research also involves a close examination of cosmetic surgery performed on the eyes, not much has been written on this area. None of the literature on cosmetic surgery addressed the procedure used to correct crossed eyes. Only the medical journals addressed strabismus (Broniarczyk-Loba, Nowakowska, and Latecka-Krajewska, 1995; Burke, Leach, and Davis, 1997; Coats, Paysse, Towler, and Dipboye, 2000; Katzin, and Wilson, 1961; Okitsky, Sudesh, Granziano, Hamblen, Brooks, and Shaha, 1999; Page, Schneeweiss, Whyte, and Harvey, 1993; Satterfield, Keltner, and Morrison, 1993; Umazume, Ohtsuki, and Hasebe, 1997). Short passages

concerned eyebrow lifts, surgery to correct “bags,” and procedures to smooth out laugh lines around the eyes. The only significant amount of attention centered on the eyes had to do with the ethics of the double-eyelid surgery designed to “correct” Asian eyes (Kaw, 1998). It paled in comparison to the attention centered on the breasts. Perhaps this is an ironic extension of our cultural obsession—even the literature is obsessed with breasts. Maybe the attention is justified by the dramatic nature of the story. After all, the silicone breast implant controversy spawned countless books, articles, and T.V. shows. Or maybe it’s just because plastic surgery is still coded as primarily a feminine activity, and breast augmentation seems to epitomize what most women want. I have indicated interesting points of deviation in various accounts of the history of plastic surgery because I believe that understanding multiple perspectives and explanations gives the reader valuable insight regarding the attribution of meanings that are too often taken for granted. This juxtaposition effectively disrupts the myth that there is any one single “objective” or “true” version of the history of aesthetic surgery.

The roots of plastic surgery can be traced back to A.D. 1000 when Hindu surgeon, Sushruta, reconstructed a patient’s nose by taking a plant leaf the size of the nose, cutting out a patch of adjoining skin, pulling it over the nose and attaching it with sutures (Haiken, 1997, p. 4). However, Sushruta’s role in the development of this field is seldom mentioned, and most researchers skip ahead to 1586 to tell the story of cosmetic surgery. It was then that Gasparo Tagliacozzi of Italy earned the title “father of plastic surgery” by pioneering a method of reconstructing noses by transferring a flap of skin from the arm to the nose (Gilman, 1999; Haiken, 1997, p. 5). This was a long and painful process, and the patient’s arm was literally stuck to his nose for the duration. Scholars debate the

underlying need that drove doctors to discover such an extreme treatment. Haiken (1997) posits these surgeries were prompted by “frequent duels, street brawls, and other clashes of armed men” (p. 5). Gilman (1999), however, offers a much darker, more shameful, explanation for why nose jobs evolved and were performed so frequently. He points out that in the 1500s, outbreaks of syphilis left people with sunken noses—a telltale sign of this unforgiving venereal disease. Because nose jobs were frequently performed to remedy this unfortunate side effect of promiscuity, the surgery itself began to take on negative consequences.

Plastic surgery then stagnated for a long time, losing much of its prestige and becoming the territory of quacks and charlatans. Two powerful social stigmas haunted cosmetic surgery at the turn of the century. It became condemned as a violation of the Hippocratic Oath, which bound physicians to do no harm, and flew in the face of religious prohibitions against vanity (Brumberg, 1997; Haiken, 1997). Then two important events occurred that began to change public opinion regarding cosmetic procedures. World War I started and plastic surgery was needed to reconstruct the faces of soldiers who were injured in battle (Brumberg, 1997; Gilman, 1999; Haiken, 1997; Schnur and Hait, 2000, ¶ 5). The surgeons who remolded shattered soldiers in the war tried to set themselves and their profession apart from the “beauty doctors” whom they looked down upon, but ironically the “beauty doctors” had done much to perfect the techniques and shape the field of plastic surgery in the first place (Haiken, 1997, p. 5).

This debate about the validity of plastic surgery provides a great example of the negotiation of professional authority in the public realm¹.

The second event that helped normalize and popularize plastic surgery was the advent of a cultural shift marked by a rise in consumerism and the emergence of an increasing visual culture (Brumberg, 1997; Gilman, 1999; Haiken, 1997). In the 1920s and 1930s, as America became wrapped up in movie stars, and beauty books told young women that their worth was equated with their outward beauty, Americans also developed a strong interest in psychology. Alfred Adler's concept of the inferiority complex received a particularly enthusiastic welcome in America. It was quickly adopted by plastic surgeons as a powerful justification for their work. This also formed the basis for the broader concept of self-esteem and self-improvement issues that developed later. Inferiority complexes could result from a patient's inability to sustain himself because he could not get hired with a deformity. Or a patient could have a job, but her inferiority complex—caused by a deformity—could erode her confidence to the extent that she found it hard to perform her job well enough to survive in a competitive world. Either way, cosmetic surgery could help by removing the deformity and curing the inferiority complex (Haiken, 1997, p. 94). With this new justification, pursuing

¹This is a debate that continues to be played out today as health professionals squabble over turf issues. Some doctors feel that women who return repeatedly to plastic surgeons to fix body image problems would be better served by pursuing psychotherapy. Others argue over how many “minor” cosmetic procedures, like liposuction, can and should be performed by medical doctors who never received any plastic surgery training (Allison, 2000).

cosmetic surgery—an act formerly coded as denoting weakness—was redefined as a healthy response to the rigors of everyday life (Haiken, 1997, p. 7).

Advertising provided another popular justification for surgery. The “Parable of the First Impression,” identified by Roland Marchand as one of the great parables of modern advertising, attempted to convince viewers that appearance was crucial to success in modern life. A wide variety of advertisements, which ran throughout the late 1920s and early 1930s, persuaded Americans that first impressions could result in certain failure or instantaneous success. Therefore, the savvy consumer had to buy certain products to ensure he left people with a good impression (Haiken, 1997, p. 101). As a natural extension of this rhetoric, consumers inferred that plastic surgery could make them more attractive and also create a good first impression. Focusing on the social and economic significance of appearance allowed surgeons to begin to share the task of diagnosing. Traditionally, physicians jealously guarded the ability to diagnose, because it was the key to their power and prestige. Emphasizing the psychological consequences of appearance ensured the importance of a patient’s input in making a diagnosis. As Haiken (1997) points out, “Not the surgeon’s objective judgment but the patient’s subjective evaluation became the factor that determined whether a deformity existed and whether surgery would take place. The inferiority complex encouraged surgeons to listen to their patients and to allow patients’ self-diagnoses to inform their own” (p. 122).

As the inferiority complex lost its cultural currency, cosmetic surgery was legitimized as another facet of the American passion for self-improvement (Haiken, 1997, p. 3). Notably, the official web site for the American Society of Plastic Surgeons (formerly known as the American Society of Plastic and Reconstructive Surgeons) begins

its own version of the history of plastic surgery with the following tidy justification: “Mankind’s essential nature entails self-improvement...Because human beings have always sought self-fulfillment through self-improvement, plastic surgery—improving and restoring form and function—may be one of the world’s oldest healing arts” (Schnur and Hait, 2000, ¶ 1). While this is certainly an explanation that is congruent with the current rhetoric and thinking about plastic surgery, it ignores that notions like self-improvement are social constructions. We can look back on past actions of others and interpret what they did as an act of self-improvement, but if the concept of self-improvement did not exist yet, can what they did accurately be characterized as self-improvement? (Bochner, 1994) Nevertheless, this type of retroactive nomenclature says something about the attitudes that have prevailed since the beginning of the Twentieth Century.

With the advent of the Miss America pageant in 1921 and an increase in the attention bestowed upon movie stars, beauty became one of the most important criteria for judging the worth of a woman. Surgery offered a way to increase this social worth. Appearance enhancing procedures also were justified economically. Some surgeons took the argument that had been made to justify performing cosmetic surgery on men whose appearance had been marred by war, and extended it to include women wanting surgery to attain greater beauty. They pointed out that while men might need surgery to maintain the confidence that allowed them to hold down a good job, marriage was worthy work for women. In the marketplace of mating, her face was her currency (Haiken, 1997, p. 38-39). Soon this rubric of economic justification covered both genders. Arguably, the distress caused by disfigurement caused the afflicted people to work less, thus lowering their value to society (Haiken, 1997, p. 39).

As plastic surgeons gained credibility, professionals in this specialty mimicked the rest of the medical field and formed a Board and their own Society. Vilray Blair and Jacques Maliniak were important founding figures in their field. Blair made significant contributions to reorganizing the American Board of Plastic Surgery, and Melanic founded the American Society of Plastic and Reconstructive Surgeons (Haiken, 1997, p. 55; Schnur and Hait, 2000, ¶ 11). Still on shaky ground in the eyes of the rest of the medical field, plastic surgeons worked hard to distinguish themselves from quacks, which they argued exhibited four traits. They were profit oriented; they catered to women's vanity and performed risky cosmetic surgeries; they performed their operations in places other than the hospital; and they communicated through non-legitimated mediums like advertising and non-medical journals (Haiken, 1997, p. 54). Two quintessential examples of plastic surgeons who advertised were J. Howard Crum and Henry Junius Schireson. By conducting attention-grabbing stunts, such as Crum's first public face-lift on record, they helped introduce the masses to plastic surgery, and did more to shape the public image of plastic surgery than any other surgeons in their time (Haiken, 1997, p. 76). Although frowned upon by the rest of the medical field, they literally brought cosmetic surgery down to the level of the common people. They presented an appearance-related problem and then showed how it could be remedied—simultaneously instilling faith in the process and an awareness of unacceptable (because they were “fixable”) physical traits.

Of course, board certified “sanctioned” doctors also played a role in determining public perceptions of physical flaws. Beginning as early as the 1930s, doctors expanded their use of the word “deformity” to cover a rapidly increasing list of ailments.

Characteristics, such as a double chin, pendulous breasts, and prominent ears, suddenly became deformities instead of just natural occurrences (Haiken, 1997, p. 122). Soon almost every trait that might trigger feelings of inferiority and threaten someone's social or economic success was deemed a deformity that could be fixed by a plastic surgeon (Haiken, 1997, p. 123). The overwhelming amount of attention focused on women's breast size in America and other Western and Latin American cultures set the stage for the diagnosis of a new deformity called micromastia, or small breasts (Bruning, 1995; Gilman, 1999; Haiken, 1997; Latteier, 1998). Treatment plans were proposed immediately.

The search for the best way to augment breasts has a long and controversial history. In the 1890s, Dr. Robert Gersuny of Vienna used paraffin injections to enlarge breasts. Paraffin turned out to be a bad choice because it caused all kinds of unpleasant physical problems because it tended to break up into misshapen lumpy masses. A technique called autologous fat transplantation was pioneered in the 1920s and 1930s, but since the body tends to reabsorb fat transplanted from elsewhere quickly and in unpredictable ways, this technique also failed (Haiken, 1997, p. 236). Both modes of treatment eventually were abandoned and it was not until after World War II that surgeons began to reexamine the problem of enlarging breasts. When the fashion of the time began to glorify big breasts, a new "beauty problem" emerged (Bruning, 1995; Haiken, 1997, p. 237, 254; Maine, 2000). Los Angeles plastic surgeon, Robert Alan Franklyn, sought to remedy this problem with Surgifoam—a light, durable substance that was resistant to bacteria and fungi, nonallergenic, easily sterilized, and easily molded (Haiken, 1997, p. 237). Self-aggrandizing, "transformation" articles demonstrating how

having bigger breasts could enhance women's lives ran in popular magazines. Many people in the medical field condemned this as shameless self-promotion by plastic surgeons who were always looking for new patients (Haiken, 1997, p. 242). Although physicians experimented with different implantation materials, they found sponges unsuitable because they shrank about twenty-five percent after they were implanted. Sponges also tended to harden as the breast tissue contracted around, and then infiltrated it—making removal difficult (Haiken, 1997, p. 245).

Liquid silicone injections, like the earlier paraffin craze, were popular for a while, but caused an array of problems. Acknowledged from the start to be a purely cosmetic procedure often used by topless dancers and show girls, these injections were pioneered in Japan to enhance the breasts of prostitutes targeting the tastes of American GIs during World War II (Bruning, 1995; Vanderford and Smith, 1996; Haiken, 1997, p. 246). Silicone was known to migrate to lymph nodes or other parts of the body, or to form lumps that disfigured the body and made cancer difficult to detect. At worst, silicon injections could necessitate amputation of the breasts; at best, they were guaranteed to produce pendulous breasts by the age of forty (Haiken, 1997, p. 249). A high rate of cancer also was associated with these shots, and infections (resulting in amputations) could occur (Haiken, 1997, p. 250). Surgeons began to advise against these injections, but women, believing that doctors just did not take their problems seriously, and desperate for bigger breasts, ignored their advice. They began to turn to shady practitioners who often did not even use medical-grade silicone when administering shots (Haiken, 1997, p. 252). After all, this treatment was economical and achieved immediate results.

The first silicone gel filled prosthesis, Silastic, was implanted in March 1962 (Haiken, 1997, p. 256). New models came out on an almost annual basis between 1964 and 1994, but the operation to insert them—an incision made in the crease beneath the breast--remained the same (Haiken, 1997, p. 256). The most common side effect experienced by those who chose augmentation was capsular contracture--the development of a thick fibrous scar tissue that formed around the implant and resulted in hardened breasts, severe discomfort or pain, and a strange “baseball in a sock” appearance (Haiken, 1997, p. 265; Vanderford and Smith, 1996). Loss of nipple sensation is another side effect that proved impossible to predict (Haiken, 1997, p. 267; Vanderford and Smith, 1996). Surgeons knew silicone bled out of the implants in small amounts even when the implant remained intact, and caused all the problems associated with the earlier, unsuccessful silicone injections. Testing on animals also suggested that silicone might not be inert in the body (Haiken, 1997, p. 268). Surgeons, however, preferred not to give too much weight to these clues, since there was no concrete evidence that the silicone implants were harmful (Haiken, 1997, p. 268; Washburn, 1996). These sorts of details only came out when the FDA began to turn its attention to the matter of regulating silicone implants (Bruning, 1995, p. 7; Haiken, 1997, p. 269; Vanderford and Smith, 1996; Washburn, 1996).

In 1976, the FDA passed the Food, Drug, and Cosmetics Act, which required “medical devices” (the rubric under which breast implants fall) to attain FDA approval before being released for use on people. When this law passed, it was applied only to new devices, and not to existing ones already in use. Each new variation of the breast implant was such a slight deviation from the previous model that it was “grandfathered

in” and not classified as a new product. Therefore it was not subject to regulation (Haiken, 1997, p. 278; Vanderford and Smith, 1996, p. 11). Some feeble attempts to take a closer look at these devices occurred. In 1982, the FDA considered the notion that breast implants were potentially harmful (Bruning, 1995, p. 7). Since no convincing evidence existed to assure implants were *not* safe, the FDA never took action on this proposal. In 1985, the FDA set up a program called “Medical Device Reporting,” which required surgeons to file a report if the breast implant devices they installed “failed.” Unfortunately, “failure” was not quantified and surgeons did not keep long-term records on clients, so this approach also was aborted (Haiken, 1997, p. 278).

The controversy did not really begin until June 1988, when *Ms.* magazine published an article about a cancer patient who underwent a double mastectomy and had silicone implants inserted. This woman experienced a wide range of side effects including hardening of the implants, misshapen breasts, the decay of skin grafts, and an autoimmune disease. Five operations later, she investigated further and discovered that the manufacturer’s packaging inserts warned against such potential outcomes, but most physicians did not pass these cautions along to patients. Her article in *Ms.* elicited a flood of letters from women experiencing similar complications with their implants (Haiken, 1997, p. 279). Then, in November 1988, a study showing that silicone gel caused cancer in rats was released by the FDA, thus sparking a national concern. The Public Citizens’ Health Research Group called for an FDA ban of breast implants, but scientists decided the study was not relevant to humans, only to rats, and the FDA voted in December against imposing a ban (Haiken, 1997, p. 279-80).

In December 1990, *Face to Face with Connie Chung* televised a story about women with silicone implants who had serious illnesses they attributed to the devices in their chests (Vanderford and Smith, 1996). A national conflict erupted with patients, plastic surgeons, the FDA, and implant manufacturers all involved. Concern continued to be generated and reflected in the media, and some even began saying that a medical experiment was being performed on millions of women, since appropriate testing was not conducted before the implants were actually implemented (Haiken, 1997, p. 280; Vanderford and Smith, 1996). Finally, in 1991, the FDA gave the manufacturers of implant devices a ninety-day notice and afterward hearings began. In 1992, the FDA banned the use of silicone implants for cosmetic surgery—reserving them for use in cancer patients only (Haiken, 1997; Latteier, 1998). Saline implants—which were assumed to be safe—continued to be available for cosmetic and reconstructive purposes. By 1994, more than 400,000 women had signed up in a class action suit against Dow Corning. In 1995, Dow declared bankruptcy (during a quarter in which its profits were up thirty-three percent), thus effectively freezing all litigation (Vanderford and Smith, 1996; Washburn, 1996, p. 57). In 1996 alone, the FDA received over 100,000 complaints of adverse reactions to silicone implants, and almost 23,000 grievances about saline implants (Latteier, 1998, p. 43). In spite of all this, in 1999, the Institute of Medicine of the National Academy of Sciences released a report finding that women with silicone gel implants were statistically no more prone to cancer, immunologic diseases, or neurological problems than the rest of the general population (Science Dispels, 2000, ¶ 2). This effectively killed the official debate about implants.

The breast implant story has been interpreted in many different ways. Some cite the controversy as yet another example of this nation's lack of interest in women's health issues (Bruning, 1995; Vanderford and Smith, 1996; Washburn, 1996). Others say it's indicative of the power of organized medicine to force would-be legislators to look the other way (Bruning, 1995). Still others envision the hiding of damning evidence about the potential safety risks of implants as an evil plot hatched by the wealthy surgeons and the blood-sucking capitalists at Dow Corning in order to reap huge profits (Haiken, 1997, p. 229). Angry feminists go so far as to say that surgeons and Dow Corning people have colluded with the advertising world as part of a conspiracy to undermine the personal and political gains of feminism, by redirecting women's time and attention toward trying to meet unrealistic physical standards of beauty (Haiken, 1997, p. 229-30). Each of these readings calls for the long overdue imposition of some protective restrictions (Haiken, 1997, p. 230).

Many opposed the idea of restrictions—viewing this as an infringement upon an individual's rights. Some claimed that while implants may have begun as implements of oppression, they have been seized by some women and used in subversive ways. For example, the overwhelming demand for implants coming from women with cancer forced men in the medical field to reevaluate their prior notions that losing a breast to cancer was no big deal as long as the cancer was completely excised (Haiken, 1997, p. 230). Implants allowed small-breasted women to gain access to a kind of cultural power they were previously unable to enjoy because they did not meet the patriarchal standard of beauty and sexiness determined largely by male tastes. But the question remained: did implants signify the power of women to make free choices about their bodies, or

acquiescence to patriarchal authority? (Haiken, 1997, p. 230; Latteier, 1998). For those who read implantation as an act of free will, any attempts to restrict women's access to implants was consequently read as an attempt to limit their power and freedom of choice (Haiken, 1997, p. 230).

Both sides, however, did agree that the FDA was guilty of inconsistency in the manner in which it chose to regulate or not regulate various products. Traditional views decreed implants catered to women's vanity, and those seeking them got what they deserved if they didn't work out. This attitude was cited as one of the main reasons why the health risks of these devices were not taken more seriously (Haiken, 1997, p. 230). Haiken (1997) says the real question is not about whether or not cosmetic surgery reflects feminist, or anti-feminist ideologies, or whether or not breast implants make people sick. She asserts, "The real question is how it happened that so many women became convinced that their lack of mammary endowment constituted a disease in the first place and why implants were so universally heralded—by the companies that manufactured the

implants, by the surgeons who implanted them, by the women who wanted them, and by the men who wanted their women to have them—as a cure” (Haiken, 1997, p. 283).²

Today an ever growing list of physical traits are being redefined as “deformities” (Haiken, 1997) and many of the buzzwords used to justify cosmetic surgery have changed. The once popular “inferiority complex” has given way to the concept of “self-improvement,” which is now an often cited reason given by those who are seeking a surgical solution to a physical “flaw.” However, recipients of surgery still pursue an elusive goal—attempting to boost their worth. To understand how this works, it is important to take a preliminary look³ at the cultural context in which cosmetic surgery is enmeshed.

Cultural Context

The sharp increase in numbers of plastic surgeries performed in recent years provides a telling indication of American’s growing obsession with appearance. Our society is becoming ever more focused on looking good. The number of cosmetic

² Augsberg (1998) has criticized Haiken’s (1997) book, *Venus Envy* for overlooking an “obvious link” between the rise of breast augmentation surgery in the late 1950’s and the origination of surgeries for transsexuals. Augsberg (1998) laments, “I find it disappointing that Haiken does not explore how breast augmentation surgery can also be considered as a gender-corrective surgery for women in a similar vein as gender-corrective surgery is for transsexuals and, for that matter, hermaphrodites” (p. 391). I would argue that based on Haiken’s strong stance against labeling a naturally occurring female body type (women with small breasts) as afflicted with a deformity, that she would not consider breast augmentation as “gender-corrective.” Having small breasts does not make a woman any less of a woman; so making small breasts larger merely alters the body shape, it does not alter gender. Despite her grumblings, Augsberg hails Haiken’s book as a well-balanced good read, and admits that perhaps an inclusion of gender theory was a bit beyond the scope of what *Venus Envy* set out to do.

³ This is a topic that will be fully explored in Chapter 4.

procedures increased a staggering 153 percent from 1992, when the American Society of Plastic Surgeons began tracking these statistics, to 1998, when 1,045,815 aesthetic surgeries were performed. Liposuction procedures increased 264 percent from 1992 to 1998, and topped the list of most commonly performed surgery in 1998 with a total of 172,079. Breast augmentation was close behind with a total of 132,378 women purchasing this surgery in 1998— representing a 306 percent increase from 1992. Eyelid surgery was in third place with 87,704 procedures performed, facelifts were fourth with 70,947, and chemical peels fifth with 66,002 (National Clearinghouse, 2000).⁴

This boom in plastic surgery continues, simultaneously created by and reinforcing and reproducing our narcissistic culture (Haiken, 1997). The increase in plastic surgeries across the board is traced to demographics, advances in medical technology, and health care economics (Balsamo, 1996; Gross, 1998; Haiken, 1997; Stone, 1999). A demographically significant event is happening as the Baby Boomers are hitting their fifties. They have both the financial means to pay for surgical improvements and a strong desire to maintain the appearance of youth—thus providing an ideal pool of potential customers for plastic surgeons. Innovations in technology allow exciting new kinds of

⁴Statistics on cosmetic surgery proliferate on the web, which is a notoriously unreliable source. Numbers tend to be outdated in texts (for example, a book published in 1998 had stats from the 1980s). To complicate the matter, cosmetic surgery is performed by board certified plastic surgeons, uncertified plastic surgeons, and regular doctors. The statistics presented are taken from the official web page of the American Society of Plastic Surgeons—a board certified entity formerly know as the American Society of Plastic and Reconstructive Surgeons. This web page and the Society producing it is cited in other academic sources (see Gimlin, 2000; Kaw, 1998). These numbers do not include procedures performed by regular doctors. No records are kept, but “state health officials figure doctors perform about 100,000 surgeries in their offices each year” (Allison, 2000).

surgeries to be offered, such as laser eye surgery, which eliminates the need for glasses. Meanwhile, the older procedures also gain in popularity as they become safer, quicker, and more socially acceptable. Finally, the dynamics of health care economics have driven many plastic surgeons to aggressively and effectively promote their services since the elective surgeries they perform are usually not covered by state or private insurance. They must convince potential clients that the pursuit of beauty is worth the cost (Balsamo, 1996; Gilman, 1999; Gross, 1998).

In the past, because of the large price tag and the social stigma attached to it, cosmetic surgery was intended primarily for the wealthy and the aging. However, over the course of the last twenty-five years, many changes have occurred. The current rhetoric suggests cosmetic surgery is for everyone, and many people are rethinking previous opinions about it. Recently, newfound attention has been focused on two much smaller categories of plastic surgery recipients—teens and men. In fact, the official web page for the American Society of Plastic Surgeons provides briefing papers concerning both of these topics.

Teenagers and Cosmetic Surgery

As the next generation of potential plastic surgery candidates begins to mature, a new and ethically charged phenomenon is taking place. Adolescents, who are not finished developing and are not yet considered adults, are turning to plastic surgeons to ease their appearance-related anxieties (Gross, 1999). Surgeries that used to be routinely offered to adolescents—such as ear pinnings, and nose jobs—are giving way to the more controversial breast enlargements, liposuctions, and tummy tucks. Teens feel an intense pressure to be perfect and as they watch their parents getting surgically enhanced, they

learn that this is the way to fix body image problems. They know their parents have the money to help them out and they want to emulate the images of perfection the media throws at them.

Doctors differ in their responses to these teens. Some are very reluctant to operate on young adults. Many doctors include psychiatrists and psychologists in their consultations, require the potential patient to come back several times to make sure they are not dealing with a passing whim, and sometimes simply refuse to operate. Other doctors view their position as being similar to that of orthodontists who straighten teens' teeth—they don't view most requests for appearance enhancement as problematic. Almost 14,000 teens had cosmetic surgery performed in the U.S. in 1996 according to data from the American Society of Plastic Surgeons, and the numbers are continuing to grow (Gross, 1999).

Men and Cosmetic Surgery

Although gendered as primarily a female concern by the 1990's, statistics reveal men accounted for thirty-three percent of the patients undergoing facial plastic procedures in 1995 (Gilman, 1999, p. 32). The percentage of people electing to undergo aesthetic procedures is still disproportionately female, but the gender gap is beginning to narrow as male baby boomers also become sensitive about the disadvantages of age. From 1992 to 1997, the number of face-lifts performed on men doubled and the number of men receiving liposuction tripled (Fraser, 1999). Eager to explore another important economic niche, plastic surgeons now mimic the marketing strategies used by sports car companies. They promise surgery will make men more attractive, powerful, and masculine, thus increasing their chances of achieving a desired level of romance in their

lives. Surgery is also presented as a shrewd business tactic. Convinced they are being overlooked for raises and higher paying jobs because they are starting to show the visible signs of aging, men often choose surgery to avoid being labeled as an over-the-hill liability. Surgery that makes a man look younger potentially increases his chance of receiving a promotion or other career enhancement and at the very least promises to allow him to keep his job (Balsamo, 1996).

In 1992 men spent \$88 million on liposuction, face-lifts, nose reshaping, and eyelid surgery. By 1997 that figure stood at \$130 million. Penile enlargements alone cost men \$12 million in 1996 (Fraser, 1999). Despite this new emphasis on men's appearance, feminists, such as Balsamo (1996), speculate that men will never know the same kind of intense pressure to look trim and attractive that women continue to face every day. After all, it is considered "normative" for women to be critical of and obsessed with their weight and appearance (Wolf, 1991). Others, such as Gilman (1999), remain part of a small minority who dispute this prediction. He asserts, "Aesthetic surgery seems to be approaching a time when it will not be gendered at all. The stigmatizing quality of the procedures seems to be diminishing" (Gilman, 1999, p. 33). However, according to the official web site of the American Society of Plastic Surgeons, in 1998 men had only 99,031 cosmetic procedures performed, while women had 946,784 (National Clearinghouse, 2000).

As the pool of candidates for plastic surgery shifts and grows, so too do the reasons for pursuing surgery. Driven by the fickle whims of cultural rhetoric and the fashion industry, different looks pass in and out of vogue. For many years, undergoing rhinoplasty to erase a large nose was standard operating procedure for Jewish girls, who

saw the button nose as the ultimate signifier of acceptability and femininity (Miya-Jervis, 1999). Now thanks to a cultural move toward adopting a rhetoric of ethnic pride, the cookie-cutter, non-Jewish nose that was once so coveted is often negatively interpreted as the sign of a conformist seeking to erase her individuality and ethnic identity. This new read on the situation has even driven some Jewish women back to the doctor's office to try to have their noses changed back to look more ethnic again. This ironically creates a plastic surgery designed to erase the tell tale signs that a woman had plastic surgery (Gross, 1999).

Although appearances that are deemed acceptable may change from season to season, the underlying concept driving people to have surgery in the first place remains constant. People are stigmatized for not meeting physical standards subscribed to by the majority.

Stigma

The decision-making process regarding whether or not to have cosmetic surgery begins with the recognition that there is something wrong; a stigma is discerned and becomes a source of distress, no matter how minor or all-consuming. Goffman's (1963) observations on the rules of interaction in situations in which "normals" and "stigmatized individuals" meet is the starting point for most of the literature on stigma. Goffman splits all interactants in a social situation into these two broad categories; however, he is not suggesting these categories are fixed. He acknowledges that we all occupy both statuses—moving in and out of them in various situations. But, he argues, we need these labels to talk coherently about interactions involving stigma. He points out that normals construct a kind of "stigma-theory", defining why the stigmatized are inferior, describing

the kind of danger the stigmatized presents, and sometimes even rationalizing “an animosity based on other differences, such as those of social class” (Goffman, 1963, p. 5). Normals also decide (rather arbitrarily) that a whole list of faults can be attributed to the stigmatized based on the original, and defining, imperfection. When this happens, and the stigmatized trait becomes viewed as the stigmatized person’s defining characteristic, this undesirable trait assumes what sociologists refer to as a “master status” (Beuf, 1990, Hughes, 1945).

Perhaps the most insidious facet of stigma is that both normals and the people with stigma reinforce its power since both support the same norm, holding the same beliefs about how identity is bound up with the possession of certain favorable characteristics or traits. A person with an undesirable trait takes on the role of the other, stands outside of herself for a moment, and judges herself to be deficient, hence stigmatized. This process, which Beuff (1990) terms self-stigmatization, results in a lowering of self-esteem or, in Goffman’s terminology, a “spoiled identity” (Goffman, 1963, p. 38). Self-stigmatization is easy to recognize in my own story, and I soon discovered that each of my interviewees shared her own unique version of this same process. As Goffman so aptly points out, the stigmatized individual strengthens the status quo even as she internalizes feelings of self-hate and self-derogation. She practices what Foucault (1977) later called self-surveillance, while alone with a mirror as well as in the presence of normals (Lemert, 1997).

Goffman recommends an elaborately orchestrated set of performances when normals and the overtly stigmatized meet. Normals often try to tactfully ignore the stigma, and the stigmatized can help by being at ease with the difference and playing

along. According to Goffman, normals expect the stigmatized to strike a delicate balance. They must act as though their burden is not *too* heavy and does not make them *that* different from normals. At the same time they must maintain a comfortable distance, never making claims to actually *being* normal because most normals like to keep some social distance between themselves and the stigmatized (Beuff, 1990, p. 13; Goffman, 1963, p. 130). If the normal seems to have trouble ignoring the difference, Goffman recommends the stigmatized do something to help ease the tension. This can take the form of anything from joking around or explaining the stigma, to gratefully accepting help offered by a normal.

In order to avoid feelings of shame experienced by the stigmatized and embarrassment and discomfort on the part of the normal, stigmatized individuals who can successfully hide their aberration from normals during everyday interactions often elect to do just that. Goffman refers to this as ‘passing.’ A flat-chested woman, who wears a padded bra that makes her look like she has average sized breasts, is said to “pass” as normal. Those who would probably not be able to pass successfully, or who are in the presence of people who already know about the stigma, may engage in the act of ‘covering’ (Goffman, 1963, p. 102). This is exactly what it sounds like. The man who is missing a digit, but keeps his hand in his pocket when he is around friends who know of his condition is covering. When I wear sunglasses around my friends, I am aware that I am covering, but I typically feel a sense of relief about this respite from scrutiny. Although some of these actions may be identical to those performed when someone is passing (for example, when I have my sunglasses on I may be passing as normal for strangers and covering for friends), there are two key components to covering. First,

others recognize the stigma. Second, the object of covering is to divert attention from the stigma, thus reducing tension and making it easier for all parties involved in the interaction.

While Goffman's investigation lays important groundwork for studies about stigma, as with any early research it leaves gaps to be filled by later investigators. Consequently, I have five main critiques of his work. First, Goffman's concept of stigma has been criticized for being too all encompassing (Ellis, 1998; Cahill & Eggleston, 1995; Susman, 1994). Including physical characteristics, like scars and hairlips, with voluntary activities, like criminal behavior, the category of stigma becomes so large it is rendered virtually meaningless. Second, while Goffman (1963) does a good job of sketching out the stigma rules that most people live by, he concentrates so fully on the "performance" of stigma that he omits many of the "backstage" details (Goffman, 1959). Specifically, I would like to know more about the subjective, lived experience of stigma. What emotions, thoughts, and physical sensations are present for the stigmatized and the normal? Third, his theories tend to come from the point of view of the normal-sketching out what the stigmatized should do to make the normal feel better rather than vice versa. Fourth, Goffman doesn't discuss how interactions may be different between stigmatized and stigmatized; between stigmatized and normals who have some level of exposure and understanding about the stigma; and between stigmatized and unaware normals. Even within each of these categories, many other layers of difference are unconcealed, such as the difference in an interaction between a stigmatized and an unaware, but well-meaning normal, and in one between a stigmatized and an unaware, but hostile, normal. Fifth, Goffman's work is primarily intended to describe what happens when normals are faced

with people with a major bodily stigma—for the most part ignoring the wide range of minor bodily stigmas encountered in everyday life (Ellis, 1998).

Although Goffman's (1963) rules of conduct can be criticized as being incomplete and simplistic, his theories provide a crucial foundation for the study of stigma. As Page (1984) points out, the concept of stigma is elusive and complex. Not only are the rules governing how to react to a stigma in question, but also what counts as a stigma in the first place may change based on culture and time period. It is also possible that the stigma itself may remain, but the justification for assigning a trait or circumstance to the category of stigma may change. For example, centuries ago the unwed mother was stigmatized primarily because she was an affront to the doctrines of the Christian church. Although this religious objection remained in the forefront for some, since the mid-sixteenth century the unwed mother was criticized most frequently in popular venues because she relied upon public aid for support and was seen as a drain on society's financial resources (Page, 1984). Similarly, what we as a society consider to be a stigma that needs to be cosmetically altered, changes over time. The social stigma attached to having plastic surgery also has undergone many transformations.

The Stigma of Having, and Not Having, Surgery

In a world in which physical beauty has come to be equated with social value, and cosmetic surgery has been both commodified and normalized, electing not to have cosmetic surgery can be seen as a naive or outdated failure to deploy readily available resources (Balsamo, 1996; Etcoff, 1999; Haiken, 1997). Ridicule or pity may be heaped upon someone who chooses not to pursue surgery to address a flaw deemed “correctable.” One can easily be stigmatized for such actions; however, the converse is

also true—despite its flourishing popularity, cosmetic surgery can still carry a powerful social stigma. Recently, a number of authors have begun to address the stigma of having plastic surgery, though research on this relatively new area tends to lie scattered throughout existing works on the history and cultural critiques of plastic surgery, rather than within works specifically focused on stigma. Although aesthetic surgery began as a primarily male-oriented specialty,⁵ bodily alteration had become a female project by the twentieth century. In the early days of the twentieth century, people who wanted plastic surgery routinely earned psychiatric diagnoses—ranging from depression to narcissism. By that time, men who wished to be surgically altered were almost always labeled as ill since men were not supposed to be consumed with their appearance like women (Haiken, 1997).⁶ In the last twenty years a more mainstream acceptance of plastic surgery has occurred and the psychiatric assessments of those who pursue plastic surgery also have changed. Gilman (1999) argues that only radical feminists cling to the belief that women who obsess over their appearance and come back for multiple appearance enhancing surgeries are sick. For her, the huge yearly increases in surgeries indicate that the stigma of pathology does not haunt these women (Gilman, 1999, p. 33). In fact, Etcoff (1999)

⁵In the late nineteenth century the majority of patients undergoing aesthetic surgery were men (Gilman, 1999, p. 32). In a patriarchal world, men were the ones who mattered the most. They were the ones with the money and they were the ones who had to go out into the world and look presentable. They were also most often confronted with issues of “passing.” For example, a Jewish man might attempt to mask his ethnic background or simply to meet the classical standards of beauty by having a foreskin reconstitution or a nose job.

⁶Today it is much more socially acceptable for men to get plastic surgery. However, the surgery must be rationalized as a means to enhance marketability. (See Cultural Context section.) “Vanity surgery” is still subject to criticism.

remarks, “psychoanalyst John Gedo recently made the radical suggestion that cosmetic surgery is not so different from altering character traits by means of psychoanalysis: both are attempts at refashioning the self” (Etcoff, 1999).

Despite this new rhetoric of acceptance, to this day there is convincing evidence that plastic surgery still retains a social taint that remains hard to shake (Latteier, 1998; Stone, 1999). Women often are reluctant to admit to having had plastic surgery. Some women who are very pleased with their surgically enhanced bodies will still deny ever having the procedure (Latteier, 1998, p. 56). Claiming that they are naturally beautiful seems to earn women more admiration. They also feel better about themselves and don’t fear people may judge them for pursuing beauty through artificial means. When a cosmetic surgery results in health problems or even tragedy, the woman who elected to have the procedure, also faces the bleak reality that others may think that she got what she deserved for being so vain. This fear often is openly acknowledged in popular magazines featuring personal narratives of people electing to pursue surgery. Stone (1999) writes of her secret terror of being judged by others for deciding to have a face-lift: “What if I die on the table? People will mutter, ‘Live by the mirror, die by the mirror.’” (p. 73). Women who get elective surgery expect, and get, little sympathy if something goes wrong (Haiken, 1997; Latteier, 1998).

Individuals undergoing elective, “vanity” surgery are deemed to deserve what they get. For example, women who received silicone breast implants for sheerly cosmetic reasons and then developed a whole array of complications ranging from cancers to autoimmune diseases were not treated with the same kind of sympathy that such conditions usually merit (Latteier, 1998). Latteier (1998) asserts that having breast

implants “puts women in a subtly contradictory relationship with society. An implanted woman makes herself more acceptable, maybe even more powerful, by augmenting her breasts, and yet the flesh-changing ritual must remain a secret, something apart. If she has problems and wants to talk about them, then she risks becoming a social pariah” (p. 54). Nurses themselves will even tell you that it’s common knowledge that women who are in the hospital recovering from cosmetic surgery, such as a breast augmentation, do not elicit as much sympathy, care, or pain medication from nurses as patients who did not “choose” to be in the hospital (Nurse Kelley, personal communication, October 17, 1999).

Post-Goffman Stigma Research

While Goffman’s work painted with a broad brush, researchers seeking to extend his ideas and break new ground tended to focus on specific categories of stigma-taking types of stigmas that Goffman glosses over and subjecting them to a rigorous scrutiny. Katz (1981), for example, chose to investigate a very narrowly defined dimension of stigma: how normals react to both disabled people and blacks. He found that people in these two categories often were perceived as threats to normals, who tended to avoid or denigrate them. However, he also discovered that when the circumstances are right--for example, when sympathy is aroused and the normal is given an opportunity to do something for the stigmatized--a norm of kindness could replace these negative reactions. Katz’s research bears out Goffman’s prediction that the stigmatized can help make the interaction more positive by allowing the normal to help him or her, and maintains Goffman’s emphasis on the point of view of the normal.

Martel and Biller (1987) and Herman, Zanna, and Higgins (1986) also zero in on a very specific stigmatized population—short males. Martel and Biller (1987) compile an impressive array of materials on body image and psychosocial development from childhood onward into adulthood. They note that childhood cruelty carries over into adulthood, tending to leave teased children significantly less satisfied with their bodies as adults than children who were not routinely picked on. Apparently, males are impacted more powerfully than females. Different gendered cultural expectations help to explain why men are more distressed by the label “short.” Men are expected to be *tall*, dark and handsome, while women are assumed to be smaller and weaker. Martel and Biller (1987) collected data using measures such as tests, questionnaires, and interviews to assess how body image fit into the over-all self-concept; what negative and positive connotations were associated with height; the role height plays in everyday situations; and the subjective, lived experience of feeling stigmatized by height. The conclusions they reached remained consistent across all statistical measures and feedback. Their research revealed short men were much more prone to poor body image and resulting anxiety, depression, and/or hostility. Although having a secure family structure helped to allay some of the disadvantages of being a short male, Martel and Biller (1987) concluded short men in general could expect to be faced with limited dating, marriage, and friendship possibilities.

In her book on the “science of beauty,” Etcoff (1999) points out that tall men also have an advantage in the working world. Taller men attract higher starting and current salaries and are sought after by companies who want employees to fit the stereotypical image of a strong, tall, successful man (p. 173). Furthermore, a preference for greater

height does not seem to be merely a feature of Western society, since being tall was discovered to be advantageous in all known cultures (Etkoff, 1999; Martel and Biller, 1987). Herman et al. (1986) replicate many of these same conclusions about how taller men are considered to be more attractive and competent, but they also point out that height is not, and should not be treated as, an independent variable. Drawing conclusions about height is complicated since this feature interacts with many others such as weight, beauty, and race to form an overall impression. It is this overall impression that largely determines how others will treat an individual.

Minor Bodily Stigma

Ellis's (1998) work on minor bodily stigma also questions society's adulation of beauty and normalcy, addressing the public and private negotiation of minor flaws detectable through the senses. My dissertation builds upon her work—taking two specific minor bodily stigmas and examining how they intersect with discourses concerning cosmetic surgery. Slotting into a category defined by Goffman (1963) as “picayune differences,” minor bodily stigmas are visible, aural, or aromatic traits, which set an individual apart from ideal standards, yet do not significantly impact one's ability to communicate with others (Ellis, 1998, p. 517). To qualify as a minor bodily stigma, a characteristic has to be involuntary and perceived as undesirable by self and/or others (p. 524). Yet, it must also be something that does not really interfere—to the extent that it serves as a block to communication—with social interaction or the living of day-to-day life. A contextually bound concept, according to Ellis (1998), minor bodily stigmas include everything from moles, scars, crooked teeth, and acne, to limps, lisps, scoliosis, and chronic halitosis (p. 524).

Ellis's work addresses each of the five critiques of Goffman's work. Her evocative personal narrative explores the feelings and thoughts experienced by the stigmatized and associated with one's self-construction as a stigmatized person (Ellis, 1998, Perry, 1996). Her opening autoethnographic story (Ellis, 1997) explores an interaction involving two people who both exhibit the same type of aural stigma—a lisp—, and an interaction between two people with different stigmas, one aural and one visual—a lisp and a scarred face. Instead of producing a data driven argument, she uses narrative to show what these experiences are like—inviting the reader into this world (Bochner, 1994; Ellis, 1998).

As evidenced by the boom in plastic surgery, the steady stream of fad diets, and the growth of exercise clubs, Americans seem increasingly preoccupied with physical perfection and imperfections. In spite of the attention focused on minute flaws, ironically we still don't know how to think, act, or talk when it comes to reacting to, or coping with, minor bodily stigmas. Ellis (1998) points out that different rules of tact apply when you are dealing with a minor bodily stigma. Goffman's (1963) rules—designed to address major bodily stigmas—do not suffice. The new rules tend to be more subtle, contextually bound, and frustratingly ambiguous. People easily become caught up in what Ellis (1998) aptly describes as a two-fold Batesonian double bind (Bateson, 1972; Bateson, Jackson, Haley, and Weakland, 1956; Ellis, 1998). If you meet someone who has a trait you consider to be a minor bodily stigma, you may worry about whether or not that person sees it as a flaw as well. Should you talk about it, or remain silent? Conversely, since the impairment is minor, the stigmatized herself may worry about whether or not

others perceive what she has designated as her minor bodily stigma *as* a minor bodily stigma, or even if they have noticed it at all.

My own experiences illuminate this dilemma. I have a recurring problem that typically surfaces when I begin teaching a new class. Before I learn my students' names, I have to rely on eye contact when calling on someone to respond to my questions. I will look at that person, point, and say, "you," and another person will answer. I had a boyfriend once who said, "Just tell them, 'look at my right eye and you will know if I am looking at you or not'." I was mortified at the thought of actually taking his advice. Some of my friends have told me they didn't notice my deviation until I pointed it out. The hope that some of my students won't notice my eyes are crossed is the main reason I don't bring it up in class. If I mention my stigma, I eliminate the possibility of passing as normal.

The second bind the holder of a minor bodily stigma finds herself facing is that of simultaneously experiencing shame and metashame—"feeling ashamed for feeling ashamed about a seemingly trivial blemish" (Ellis, 1998, p. 526). Existing popular narratives are beginning to surface that give voice to this feeling, yet do not term it metashame. For example, I read about a woman who struggled to make a decision about whether or not to have breast augmentation surgery. Britton (2000) reports, "My shame was twofold, for my body and for my desperation to change that body" (p. 58). Often the stigmatized may find herself wondering, "is there something wrong with me for obsessing over such a small defect, or is it really a big deal?" I will never forget the feeling of shame elicited by an off-hand comment by a male friend who didn't seem to understand or appreciate my research interests. Angry because I chose to stay at home

and write rather than take him up on his offer to shoot pool and drink beer, Matt threw his hands in the air in frustration.

“You never want to go do anything. You sit at home night after night writing about stuff that makes you feel bad about yourself. You know, there are people in *wheelchairs* competing in the Olympics and you sit around feeling sorry for yourself and dwelling on something so trivial.”

My face got red when he said that. I felt furious and embarrassed at the same time. Suddenly I started wondering, did I place too much emphasis on my small flaws? Maybe I was making a mountain out of a molehill. Later that evening, as I sat alone and was able to think through Matt’s criticism more calmly, I began to realize that it echoed Goffman’s mandate that the stigmatized should not act as though his burden was too heavy around normals. I also found myself coming up with many reasons why my research amounted to much more than just self-pity. I thought about why the topic was important and what kind of a contribution I could make to people’s lives. I thought about how many times I had sat and listened to Matt’s bitter complaints about the unfairness of dating. He was uncomfortable with the traditional male imperative to ask a girl out because he worried that he was “too skinny and losing his hair” and women wouldn’t be attracted to him. He was lonely and unhappy with himself and seemed to suffer greatly from his own minor bodily stigmas, yet was angered by the notion that I might be drawing attention to and exploring this kind of suffering. There was an implicit assumption that it is nobler to suffer in unacknowledged silence, complaining only to close friends, than to write about and talk to strangers about body image issues. A stigma

was attached to talking about stigma, yet ironically on the cultural level the focus on minor bodily flaws was increasing every year. As a manifestation of this focus, academic and popular narrative accounts of minor bodily stigma have begun to proliferate.

Review of Minor Bodily Stigma Literature

My review of literature began with a book appropriately entitled *Beauty is the Beast*. For her target population, Beuf (1990) selected children who had disorders such as vitiligo, –a pigment disorder that leaves the skin with a mottled appearance--psoriasis, acne, cleft palate, obesity, and myopia—all of which could be classified as minor bodily stigmas. All the children in her study were impaired in appearance only; physically and mentally, they were healthy. This allowed Beuf to isolate the dynamics of coping with sheerly aesthetic handicaps without having to guess how much of the discomfort was caused by accompanying physical pain or dysfunction. Reversing Goffman’s tendency, she sketched out what the *normal* should and shouldn’t do to make the stigmatized feel better. By providing a vivid description of the children’s subjective lived experiences, she hoped to raise the consciousness of parents, physicians, teachers, and the public in general. At the same time, she also examined cultural attitudes about appearance impairment, because they provided the backdrop against which childhood stigmatization was played out (Beuf, 1990, p. 27). Beuf hoped to systematically determine key physiological, social, and psychological factors contributing to the coping abilities exhibited by the children. She found that males, the economically challenged, and members of fundamentalist religious groups tended to be denied access to cosmetics or other technologies designed to disguise their impairment. Consequently, they suffered a greater level of social stigmatization, which typically led to low or impaired self-esteem

(Beuf, 1990, p. 16-17).

Beuf (1990) suggested there were five main factors that determined the level of coping achieved by the children in her study: the socio-cultural system in which the child lived; his or her developmental age; physiological factors (specifically the visibility, severity, and reparability of the impairment); psychological resources such as humor, self-esteem, intelligence, creativity, and enthusiasm; social resources such as a high economic status, well-known, well-respected, educated parents, a supportive ethnic group, and access to political power; and levels of interaction with the social system. This last factor, “levels of interaction with the social system,” referred to the tendency of children to present very different levels of adjustment as they moved from the privacy of their room to a school setting where they were surrounded by their peers (Beuf, 1990, p. 22-24).

Beuf pointed to several encouraging signs of progress in our culture. Foundations like the *International Foundation for Craniofacial Disorders* were formed to educate the public and help people afflicted with these disorders and their families. The success of plays like the *Phantom of the Opera*, and movies like *Mask*, indicated a more accepting attitude being nurtured in the public. Sesame Street included appearance-impaired characters on its show, and commercials started to incorporate images of children who were handicapped in some way (Beuf, 1990, p. 107-108). Beuf, however, saw a need for researchers to make greater efforts. She insisted it was not enough to just compile statistics regarding stigmatized children. It was important also to use qualitative measures. While quantitative measures might reveal that a child had, for example, a low coping score, this still failed to address the child’s specific problems or to find a way to

help the child (Beuf, 1990, p. 108). Professionals, like teachers and doctors, need to be made aware of the profound psychological and social impact that appearance impairment may have on a child, and learn to exercise sensitivity and wisdom in their interactions with these youngsters (p. 110). Finally, in her words:

Concerned people must launch and continue a culture-wide attack on our society's over-concern with and adulation of superficial beauty, at the cost of concern with deeper traits. In raising our children, we must put appearance low on the list, stressing character, intelligence, kindness, and creativity over "prettiness"... (Beuf, 1990, p. 113).

Beuf's strong emphasis on cultural factors peaked my curiosity. I wondered what other types of tales were circulating besides *Phantom of the Opera* and *Mask*.

My search for popular narrative accounts of minor bodily stigmas was frustrating at first. Some of the conditions listed as belonging to the category of minor bodily stigma were not necessarily perceived by all people, in all situations, as being negative characteristics. Having red hair, and being a tall woman, are two classic examples. While both of these traits are considered undesirable by some, I found a beautiful photography book in the bookstore revering red heads, and supermodels are often more than six foot tall. Searches for keywords like "lisp" and "crooked teeth" yielded nothing, but then I began to consider that in some ways a lack of literature also told me something. For example, I could think of several reasons why crooked teeth were unlikely to inspire books or magazine articles. Crooked teeth are typically straightened in childhood, and only remain a problem for poor children whose families cannot afford braces. Poor children are unlikely to publish their writing, and even if they did, crooked teeth are

likely to be the least of their problems. If, when these children grow up they have managed to acquire the education and the desire to write, chances are they also will have accumulated the wealth to get adult braces if their crooked teeth really bother them. Fixing teeth is neither controversial nor associated with undesirable side effects. So the general consensus seems to be, why complain about it if you can fix it?

Lisps, on the other hand, are not so readily fixable, yet stories of lisps are rare⁷.

However, stuttering claims a prominent position amongst the literature on speech impediments. As I paused to consider why this might be so, two answers surfaced immediately. 1.) While lispings may typically⁸ preclude a person from certain professions, such as T.V. commentator or radio DJ, it does not present a barrier to communication in the same way that stuttering does. 2.) Our culture tends to laugh at and about lisps. Although people also laugh about and parody stuttering, it's not politically correct to do so. Stuttering is more commonly seen as a handicap—something to rise above. Lispings is seen as an embarrassing condition—something that elicits shame. At best, society might deem a lisp “cute”—especially when a child has this trait. It seems as though economic and cultural conditions have conspired to produce “worthy” and “unworthy” minor bodily stigmas (Herman and Chomsky, 1988).

⁷ My research uncovered only Ellis's (1998) work on lisps.

⁸ Notable exceptions do exist. For example, Barbara Walters has a lisp. On the local level, 88.5 a Tampa public radio station features Diane Dill—a woman with a pronounced lisp--on Friday mornings. However, public radio stations tend to be more tolerant of difference, and I've never heard a DJ with a lisp on any commercial radio stations.

Crossed eyes are another ignored minor bodily stigma that bears some similarities⁹ to lisping and crooked teeth. The literature reveals a glaring absence of stories about strabismus. Although detected in approximately five percent of the population during early childhood (Page, et al., 1993), a review of literature revealed no existing narratives describing what it is actually like to look at the world through crooked eyes. Perhaps this is because most of the afflicted are operated on when they are very young and the problem is then concealed. My search for narratives about crossed eyes only revealed a Polish, fictional, short, horror story called “Strabismus” (Grabinski, 1993), and a children’s story entitled, *I crossed my eyes and Papa became angry* (Haucke, 1986). Neither explored the lived experience of strabismus. The lack of narratives about crossed eyes may in part be explained by the fact that the majority of strabismus cases occur among children who typically undergo corrective surgery while they are still very young. While I could not find any statistics on the number of adults with crossed eyes, a pubmed search revealed several studies concerning this target group. Most of the existing research on adults with strabismus focuses on two main themes: 1.) Binocularity (Umazume et al., 1997; Broniarczyk et al., 1995) and 2.) negative psychosocial impact (Burke et al., 1997; Coats et al., 2000; Okitsky et al., 1999; Satterfield et al., 1993). It is interesting to note that the similarities between lisping and

⁹ Strabismus is a condition that will bother some normals (see the “Millie Story” in the introduction to Chapter Seven) significantly, while others may not care about the stigma at all. Like crooked teeth, strabismus is a condition that is typically fixed early in life. Like lisping, crossed eyes are clearly recognized as a cultural joke. When someone crosses his eyes in a movie or in real life, most people laugh. They don’t compose narratives exploring the experience.

crooked teeth, and crossed eyes may help to explain why this area has also been ignored.¹⁰

As I continued my quest to discover literature addressing bodily flaws, eventually, I discovered a significant source of first hand accounts of minor bodily stigmas.

Accounts detailing struggles with stigma occurred in three basic forms. First, there are books (both fiction and non-fiction), articles, and short stories entirely devoted to *first hand* accounts of a life bound up with stigma. Second, there are articles in journals or popular magazines that *tell about* individuals struggling with stigma. Often these accounts use extensive quotes from the stigmatized and are meant to raise the consciousness of those who are unaware of what it's like to live with that sigma. Finally, I discovered some interview-derived case studies in handbooks designed to help people with afflictions, such as psoriasis, learn how to cope. All of these narrative accounts of coping with stigma tend to shift the burden of easing interaction from the stigmatized to the normal. They either do it explicitly (Carlisle, 1985; Cram, 2000; Gustafson, 2000), or they do this by getting the reader to identify so completely with the stigmatized person that he is tempted to regard the normal who is reacting unfavorably to the stigma as the insensitive one who needs to change (Jezer, 1997; Lawrence, 1993; Newberry, 2000; Potter, 2000; Turner, 1989; Updike, 1963, 1980, 1989; Weingarten, 1995).

¹⁰There are of course, many definitive differences between lisping and crossed eyes. Lisping remains an issue on the telephone—crossed eyes do not. Crossed eyes are essentially always visible. Lisping is not.

I soon discovered that the majority of the existing literature seemed to revolve around stuttering (Carlisle, 1985; Gustafson, 2000; Jezer, 1997; Lawrence, 1993; Newberry, 2000; Potter, 2000; Turner, 1989) and psoriasis (Cram, 2000; Updike, 1963, 1980, 1989; Weingarten, 1995). Stutterers have trouble expressing themselves, so it seemed natural to assume they might enjoy the chance to do so on paper. However, I wasn't sure what to make of the plethora of works on psoriasis. Maybe since this skin disorder is hard to hide and definitely recognizable as a stigma,¹¹ there is a greater willingness on the part of those who are afflicted to struggle to make people understand and treat them with more compassion so they don't have to hide. Regardless of the reasons these stories exist, they perform an important function—serving as both a catharsis for the author and an eye-opener for the reader who does not know what it's like to live with one of these stigmas.

Approximately one percent of the general population stutters, and both Jezer (1997) and Carlisle (1985) have produced rich autobiographical accounts that take the reader inside the experience of living with this frustrating condition. These replicate a lot of general information, containing well-researched sections detailing speech therapies each author tried, explaining various medical theories posed to account for the possible causes of stuttering, quoting statistics specifying how many people suffer from stuttering,

¹¹While there may be some debate about whether or not some physical traits like red-hair and crooked teeth actually “count” as a minor bodily stigma, someone with a bad case of psoriasis never has to wonder whether or not others consider him or her stigmatized. A compelling example is provided by Susan Weingarten (1995) who reports that both she and her mother (on separate occasions many years apart) were kicked out of public pools because the lifeguards complained their psoriasis was unsightly and disturbing to children and other patrons.

and noting stutterers are usually males. Both books contain detailed accounts of the communicative, relational, and emotional obstacles faced by Jezer and Carlisle as they struggled with stuttering during various phases of their lives. Both authors manage to go back and forth between sounding like they are writing a text book for medical school, and really taking the reader inside the feelings of frustration, fear, embarrassment, and anger that all come together as a stuttering block occurs.

Carlisle (1985) includes a chapter entitled, “Questions people are afraid to ask-- and things they shouldn’t say.” Tactfully, yet firmly, he metes out useful hints such as: don’t complete a stutterer’s word for him unless he has told you he welcomes such help. The donated word often does not express what the stutterer was trying to say in the first place. Carlisle lists unsolicited advice as one of the most common sources of irritants for stutterers. Most importantly, Carlisle (1985) implores, “Don’t look away or leave him as soon as you find a plausible excuse. Just act with normal good manners. Most stutterers dislike it intensely when people switch them off and walk away to spare their own feelings” (p. 8). Although his advice is not consolidated in any one chapter dedicated to schooling normals in the fine art of interacting with stutterers, Jezer (1997) also addresses what it is like to talk to people when he is experiencing a block or stuttering badly. Honestly and eloquently, he sketches out what he would prefer the non-stutterer do and say, or not do and say, while he is experiencing difficulty with his speech. Echoing Carlisle’s advice, Jezer admits to the reader that his anxiety level skyrockets and his stuttering increases if the listener averts his or her eyes, reacts with confusion or irritation, or in any way exhibits a lack of patience or interest (Jezer, 1997, p. 13-14). He

relates that he had people hang up on him and walk away from him in the middle of his conversation because they lost patience with his speech impediment. By paying attention and reacting with compassion, however, some listeners actually gave Jeezer the surge of confidence that he needed to carry him through a bad block (p. 14). He too recommends attentive, compassionate listening.

In a first person account published in *Sports Illustrated*, Sophie Gustafson relates how frustrated she felt when she won the Chick-fil-A Charity Championship golf tournament. She was ecstatic about the win, but without consulting Gustafson, the organizers of the event arranged to have Nancy Lopez give the thank you speech for her. Although she is one of the top golfers in the world, Sophie stutters so she is often considered an undesirable speaker. She admits it bothers her that every article published about her concentrates on her stuttering. She reports that the articles are all nice, but “it’s like making an eagle and having everyone ask about your bogey” (Gustafson, 2000, p. 1). The article titles alone reflect that reporters have decided her speech merits a lot of attention. “Swede’s game speaks for itself: Gustafson no longer afraid to win, works on stutter,” announces USA Today in a story reporting that Sophie used to subconsciously sabotage games she was close to winning so she wouldn’t have to make a victory speech (Potter, 2000, p. 6C). The Ottawa Citizen provides another typical example. “Gustafson addresses her handicap with courage: Swedish golfer fights for words in struggle with stuttering” (Newberry, 2000, p. B7). Furthermore, Sophie complained that she is irritated by the commonly made assumption that she chose golf because her stuttering forced her into reclusive activities that did not require interaction with others. Describing herself as a herd animal who loves company, Sophie concludes her brief article by saying, “What

I'm trying to say is that there's nothing really different about me. I just talk a bit slower than everyone else" (Gustafson, 2000, p. 1).

Her message is loud and clear. Don't assume that a speech impediment is necessarily the most interesting or news-worthy characteristic of someone who stutters, and don't make assumptions about her personality or preferences based on her identity as a stutterer. This article raises a pivotal question. Where do you draw the line between raising awareness among the general population about different types of stigma, and reducing complex individuals to doubly stigmatized "examples of a type of stigma"? Ignoring stigmas can be harmful, but so can focusing too much attention on them.

Another prominent sports star with a stutter who received a lot of attention from the media was Bob Love—an ex basketball player who was the Chicago Bulls all time leading scorer before Michael Jordan. Unlike the press on Gustafson, most of the articles about Bob Love's stuttering emerged many years after he had quit basketball entirely. While he was in the NBA, Love made the all-star team four times and routinely scored over forty points a game. But reporters almost always passed him by after the game and interviewed someone else on the team because it "just took too long" to talk to the stuttering superstar (Turner, 1989). Major publications like *Sports Illustrated* and *People Weekly* finally found him to be a desirable interviewee only after Love had triumphed over his "disability" (Lawrence, 1993; Turner, 1989). After retiring from professional basketball in 1977, he landed a series of dead-end jobs because no one wanted to hire someone who couldn't communicate. Bob Love finally took a job as a bus boy at Nordstrom's and there they insisted he go to speech therapy classes. He complied with their demands and slowly, but surely, attained fluency and newsworthiness as his rags-to-

riches-to-rags-to-riches story ended happily and somewhat ironically. In 1993, Love was hired as Chicago Bull's spokesman (Lawrence, 1993).

Although narratives about psoriasis are not as numerous as those about stuttering, more people are afflicted with this disorder. Approximately two percent of the world population suffers from psoriasis and U.S. estimates range from 2.5 to 7 million (Cram, 2000). It's interesting that even inside the medical realm (Cram, 2000; Meulenberg, 1997; Weingarten, 1995) there is a strong tendency to adopt literary and narrative modes of description to talk about this painful skin condition. Meulenberg (1997) argues that psoriasis seems to have captured the medical imagination in an unprecedented manner. As far back as 1954, J.T. Ingram, in an article in the *British Medical Journal* described the exacerbations caused by psoriasis as having patterns that "may rival the heavens for beauty and design" (Meulenberg, 1997, p. 1709). By 1995, the *British Medical Journal* was actually publishing narratives of psoriasis (Weingarten, 1995), which took their place among other much more technical, medical articles. In her article, Weingarten presents a compelling story of not only her own struggles with psoriasis, but a brief summary of how the disease could be traced through her family tree for four generations. She describes the humiliation that drove her to wear long sleeved garments and thick stockings, even in the summer, to cover her mottled appearance. She also emphasized the relief she felt when she found someone who understood the condition and accepted her anyway. Both she and her mother revealed that one of the main reasons they both married doctors was because these men understood skin disorders and did not react negatively to the psoriasis.

Famous author John Updike (1963, 1980, 1989) penned some of the most well known accounts of psoriasis. He first approached writing about the intimate details of this disorder through fiction. Peter Caldwell, one of the characters in *The Centaur*, had psoriasis and struggled with the question of whether or not to tell his girlfriend about it. Updike (1980) also devotes a chapter called “From the Journal of a Leper” to a detailed description of how psoriasis played a pivotal role in the life of a potter who needed his affliction to produce great art. He uses his understanding of the conflicts of dealing with this stigma to create very believable characters, but his autobiographical writing about psoriasis takes the reader even deeper inside his personal agony. Sparing the reader any kind of long dissertation on the medical mechanics of his skin condition, he writes a very emotionally compelling account of coping with psoriasis—a stigma that is sometimes invisible (usually during the height of summer), and at other times painfully obvious. He even speculates that he may owe his creative genius to the disease, since it often drove him to seek out solitude, thus creating an environment conducive to producing lots of writing. His moral seems to be that the struggle to cope made him stronger in many ways.

Strength gained through learning to cope with looking different was also a theme that was strongly established in the guide to the treatment of psoriasis written by David Cram (2000). In a chapter titled, “The Emotional Side of Psoriasis,” Cram presents four stories derived from in-depth interviews with people afflicted with severe cases of this skin disorder. Fear of discovery, embarrassment, loneliness, and denial were common themes running through each of the tales. Three women and one man each told a three page story, evoking deep feelings of compassion and understanding. One woman

explained that she used to leave her lovers at four o'clock in the morning so they wouldn't be able to see her in the daylight and know her shameful secret. She thinks she married her husband because he told her he had no problem with her skin disorder, and she wanted to avoid the embarrassment of facing another summer alone. The only man in the group lamented that he felt less masculine, and all of the women reported sexuality problems stemming from dissatisfaction with their appearance. Yet, each of these interviewees eventually reached a similar conclusion. "Life is too short to punish yourself for a problem that you had nothing to do with creating," said one woman—summing up the collective feeling derived from all four of the stories (Cram, 2000, p. 25). Not content to wallow in self-pity, and left with no other positive options, since no cure for the condition exists, the psoriasis sufferers in these tales struggled to transcend their concerns about external appearance.

Although I discovered there are many wonderful examples of first-hand accounts of minor bodily stigmas, none of these explored strabismus or conducted a pairing of the breasts and eyes as I proposed.

Breasts and Eyes

Body image issues consume much of our time, energy, and money as we continue to grapple with the awkwardness and pain of looking different. While those who have had plastic surgery remain a minority, the numbers grow by leaps and bounds every year. In 1996 the number of aesthetic surgeries performed exceeded 1.9 million, up from 1.3 million in 1994. That's a yearly average of about one surgery for every 150 people in the United States (Gilman, 1999, p. 6; Hammond, 1999). As the popularity of appearance-enhancing surgeries grows, their price tags shrink—allowing more and more people to

afford them, the question becomes: How do I decide whether or not to have plastic surgery? This is a complex and fascinating decision, located at the matrix of powerful cultural and psychological forces. It is a decision embedded in stories—stories we tell about ourselves, about society, about technology, and about each other. When we speak (or don't speak) about these decisions, we do so by telling stories—even if they are only stories we carry around with us in our heads and whisper to ourselves. This work will present some of those stories being told about why people do, or don't, have surgeries performed to enhance their eyes or breasts.

I have chosen two imperfections—strabismus, or crossed eyes, and small breasts, or micromastia,—of which I have intimate knowledge. I will combine an autoethnographic approach with interactive interviews and participant observation to provide a deeper inquiry into the emotional and cognitive experience of dealing with minor bodily stigmas and making and communicating decisions regarding whether or not to have cosmetic surgery to fix these “flaws.”

My selection of the breasts and eyes as sites of exploration reflects not only my personal interests, but also a broader cultural emphasis. Different cultures place emphasis on different body parts when evaluating appearance (Beuf, 1990; Gilman, 1999). In the U.S. eyes and breasts are revered. The eyes are touted as the “windows to the soul,” while many have argued that women's breasts have become highly sexualized objects of an American cultural obsession (Bruning, 1995; Latteier, 1998; Weitz, 1998). Focusing on these two body parts also allows me to explore a stigma that is always on display (eyes) and one (small breasts) that can to a large extent be hidden. Prominently displayed on our faces, our eyes are part of our “outward identity” (Spadola, 1998, p. 51)

and normally used to establish eye contact during interpersonal interactions. But breasts are our “public and private identity all in one” (Spadola, 1998, p. 51; Young, 1998). Typically hidden from view and considered integral parts of our sexuality, breasts are in many ways very personal. However, Latteier (1998) argues they do not retain this exclusively private status. “They become social—part of what sociologist Raymond Schmitt called ‘the enacted body for the other’” (p. 14). Women often are painfully aware that their breasts are constantly on display and subject to evaluations, judgments, and assessments. Ironically, though few women can meet the cultural standards of ideal female attractiveness, and no women can maintain these standards across the lifespan, they feel compelled to try. Their feelings about their own breasts (and indeed about their overall appearance) are often dictated by others’ reactions (Ancheta, 1998). For example, a woman named Stacy was interviewed by Latteier (1998) about her decision to have implants, and she reported being much more confident now at work. “Because of the ridicule I suffered when I was younger, I would always wonder if people were thinking, gee, she’s flat. That’s too bad...” she said. Although Stacy believed that self-acceptance might be better than surgery, she couldn’t seem to achieve happiness with her natural breasts, and viewed her augmentation as a positive choice. Looking at emotional responses to, and interactional strategies designed to cope with, these two different types of flaws should provide me with a fuller picture of issues that can come into play when dealing with a broad range of minor bodily stigmas.

Emergent Themes

Specifically, I will focus on the following themes that emerged from my research:

- 1.) How did my interviewees come to identify themselves as having a minor bodily

stigma of the eyes or breasts in the first place, and how do they feel, and talk, about this designation? 2.) What are the major complaints my interviewees shared regarding their stigmas? 3.) What impact does the overarching popular culture as well as manifestations of local cultures—such as schools and families—have upon the perceived sense of stigmatization reported by my interviewees? 4.) What coping strategies did my interviewees implement to deal with their minor bodily stigmas? 5.) How did my interviewees make and communicate decisions regarding whether to resculpt their image through surgery or to learn to live with their bodies the way that they are? 6.) What impact did these decisions have upon my interviewees' sense of identity? As I reveal how my participants and I respond to these issues, I invite readers to consider whether or not any of these questions resonate and how they might answer them.

CHAPTER TWO: METHODOLOGY AND REVIEW OF LITERATURE

“He’s got such pretty eyes,” I think as I look shyly down into the glass of sangria I am lifting to my waiting lips. I glance up again and still he is gazing at me with that same warm smile and eyes that make me want to melt. They are greenish-blue, with flecks of molten gold. They are kind eyes, loving eyes, straight eyes. I glance away again, wondering what he thinks of me and why he hasn’t asked me yet about my eyes. Guys always ask. I’ve gone out with Tom more than six times now and still he has never broached the topic. Nervously, I take another large sip of sangria. As a warm delicious feeling diffuses through my body, I worry about what the alcohol may be doing to my muscular coordination. Specifically, I wonder if my eyes are starting to look more crossed, and a cold feeling of dread creeps in. “He’s the one who has been chasing me!” comes the angry mental retort to my last fearful thought.

In a flash, I’m both worrying that Tom won’t think I’m pretty and then chastising myself for worrying about what he thinks of my physical appearance. “Some feminist I am,” I think, but all the theories and knowledge in the world don’t seem to be able to stop the critical voices in my head, especially when I’m with a man to whom I’m attracted. Being intellectually critical of society’s obsession with appearance, and forgiving myself for not looking perfect, are two different things. All the theoretical justification in the world doesn’t make me feel much better when I sit alone in my apartment with only my cat for company. To heck with theory; I want to be attractive.

As we wait for the next tapas dish to arrive, Tom looks around, taking in the restaurant's decor. As his eyes travel over the intricately designed, black, wrought-iron chairs, the elaborately decorated walls covered with paintings and mirrors, and the beautifully painted plates and glasses on all of the tables, he smiles and says, "My mom would love this place." Just the mention of the word "Mom" conjures up a mental image of my own mother with her large, round D cup breasts and full stomach. I glance self-consciously down at myself, noticing how the grey dress stretches taut over my lean frame and modest A sized chest. Our physical differences are only the tip of the iceberg.

Now curious, I ask Tom if he gets along well with his mother. He affirms he has a good relationship with his mother, and I admit I do not. "She's super religious--fundamentalist Christian--and I'm not," I shrug. Then seeing an opportunity to broach the subject of my eyes and end the dread of wondering how he will react, I look at him and smile dismissively. "You know, I got dragged to religious weekend retreats 'cause my mom was hoping God would heal my eyes--the whole nine yards."

Tom smiles sympathetically. Encouraged, I continue. "My mom feels guilty about my eyes. When I was a baby, my eyes crossed. She opted not to get the straightening operation because she said God made me like that for a reason, and if he wanted to cure me he would. A couple of years ago my Mom admitted to me that she still feels guilty, because it's too late to have them fixed now. I've told her it's no big deal, but I don't think she believes me. To be honest, I'm not sure I believe me. She knows that it can't help but impact my interactions with others. I've pointed out that I certainly haven't let it stop me, but I can tell it still bothers her. I think that as long as she suspects that it's still an issue for me, she'll feel bad."

“You don’t seem hung up about it,” observes Tom. “I had a roommate who had what you have. She got the operation as an adult. It seemed to work fine for her. I’ve got an aunt who’s got it too.”

“I was wondering why you didn’t ask about my eyes. Guys always ask.”

“Really?” Tom seems to have lost interest in the conversation as a fish shaped plate featuring an offering of seared tuna and salmon arrives. By now I am satisfied that Tom doesn’t think I am a freak. What a relief. I have never dated anyone who had any kind of experience with crossed eyes at all. For the moment a sense of security and contentment seeps into my brain.

A month and a half later, Tom disappears without an explanation. He won’t respond to e-mail or return phone calls. I take off my glasses, cry, stare into the mirror at bloodshot, puffy, sharply-crossed eyes, and wonder–wishing I was pretty.

Methodology

We gain knowledge of the world through methodology (Denzin and Lincoln, 1994). Conversations about minor bodily stigmas can branch off in a multitude of directions. When I began my research, I wanted a method that would help me to focus my inquiry in a meaningful way, yet was responsive to the situations in which the research was enmeshed. I sought an approach that could make sense of the vast quantity of personal data I had already collected, the mass media accounts I had just begun to explore, and the interviews I planned to do. I turned to a constructivist grounded theory method to meet my research needs. Since much of the data I collected came to me in the form of narratives, and since, similar to MacIntyre (1981), I believe we are “essentially story-telling animals,” I also implemented techniques borrowed from narrative inquiry.

To illustrate the complimentary relationship of these two approaches and to show their role in shaping this dissertation, I will first review the basic tenants of grounded theory; second, explicate my modes of collecting data; third, look at narrative analysis; and finally explain how grounded theory and narrative work together in this dissertation.

Constructivist Grounded Theory

Grounded theory was at the forefront of the qualitative revolution (Denzin and Lincoln, 1994) and it was instrumental in legitimizing qualitative research as a reliable and systematic social scientific inquiry (Charmaz, 2000). However, traditional grounded theory practices have been accused of coming too close to “traditional positivism, with its assumptions of an objective, external reality, a neutral observer who discovers data, reductionist inquiries of manageable research problems, and objectivist rendering of data” (Charmaz, 2000, p. 510). To avoid these types of critiques, I have adopted Charmaz’s (2000) approach to constructivist grounded theory because it acknowledges the relativism of multiple social realities, highlights the co-construction of knowledge by the interviewer and the interviewee, and strives to produce interpretive understandings of subjects’ meanings, while still retaining most of the original methods and goals that distinguished grounded theory in the first place (p. 510).

My research began, as all grounded theory does, with data collection. As I conducted interviews, wrote autoethnographic pieces, engaged in participant observation, and performed a content analysis of two popular magazines, I began to take notes on key issues arising from my investigation. Constant comparison is at the heart of grounded theory, and as I compared interview to interview, and magazine to magazine, and wrote notes about it, conceptual and theoretical notions began to emerge. Next I wrote the

results of this comparison in the margins—engaging in a process of coding. I went into my first interview asking, “What is going on here, and what categories are suggested by the information this woman is giving me?” Furthermore, because I was conducting an interactive interview in which I was sharing my own thoughts, feelings, and stories, I also asked personal and situational questions like, “What cognitive and emotional responses am I having to this conversation?” and, “How are we reacting to each other’s shared experiences?” I coded interviews with different participants, as well as different interviews with the same person—constantly comparing all of my data.

As I coded, I started to write memos, which proposed links between categories or core categories central to the study itself. I continued to add to my sample by interviewing more participants and conducting more than one interview with each participant. Often the contributions of my interviewees emerged in the form of stories that they used to capture the complexities of lived moments of their lives (Coles, 1989). Since they are sense-making accounts, stories reveal important reasons people give to justify the decisions they make regarding whether or not to undergo surgery (Vanderford and Smith, 1996). I continued to examine my transcriptions, and my notes about the interview, looking for recurring themes. I read more from the popular media, I “re-membered” my participant observation through writing, I conducted a review of literature, and I continued to journal autoethnographic accounts.

As the categories I had produced began to saturate, I started sorting—grouping like memos and sequencing them in the order that made my emerging conceptual and theoretical notions clearest. All the while, as these ideas began emerging, I kept testing them to see if they held true. It is crucial that theoretical concepts arise from the data. As

Charmaz (2000) points out, grounded theorists are not allowed to “shop their disciplinary stores for preconceived concepts and dress their data in them” (p. 511). I ended up discarding many of my early ideas that arose shortly after I began interviewing participants. For example, after my first interview with Bea I wrote the following note, “Based on my conversation with Bea, and anecdotal information informally gathered in everyday conversations, I suspect that a person’s exposure and response to feminist thought will predispose them not to want to have cosmetic surgery, or at least will influence the way that they think and talk about this decision.” My first two breast interviews with Bea and Izzy—both self-declared feminists who chose not to have augmentation surgery—supported this hypothesis. However, my next two interviews with Holly and Autumn—women who identified themselves as feminists, yet chose to have augmentation surgery—proved my hypothesis was at least partially flawed. Consequently, I was forced to continue to search for conceptual and theoretical notions that fit the data collected. When I finally began the writing stage of my dissertation, I used the theoretical ideas I had developed from the data to organize my chapters. In each chapter, I examined an idea and showed how that particular idea arose. I returned repeatedly to my data to support and expand these theoretical ideas. Since grounded theory methods specify “analytic strategies,” rather than data collection methods, in this next section I outline how I amassed the vast pool of data I used in this dissertation.

Methods of Data Gathering

All grounded theory is emergent (Glaser, 1998), because the theory is discovered in the data. By extension, qualitative research methods can be emergent too and are not meant to be seen as formulaic procedures, but rather as flexible, heuristic strategies. I

gathered the data for this dissertation using four methodological procedures—autoethnography, interactive interviewing, participant observation, and content analysis. This allowed my work to naturally blossom outward from the personal to the cultural, while at the same time continuously playing back and forth between outside perspectives and voices, and my own experiences.

Autoethnography.

I chose to use autoethnography as a way of situating myself within this project and exploring my own experience with minor bodily stigmas of the breasts and eyes, while simultaneously revealing the way in which culture and the stories and experiences of others have influenced my own tale and my own history influences how I view stigmas. Autoethnography has been described as “an attempt to interpret the public and private dimensions of cultural experience and seek a critical distance and perspective on each” (Neumann, 1996, p. 192). Given my emphasis on how minor bodily stigma have come to be viewed through the lens of cosmetic surgery, this focus on the personal, the private, and the cultural seems well suited for my study.

Autoethnography (Hayano, 1979) is part of what Tedlock (1991) has termed the movement from participant observation to the observation of participation. The observation of participation involves “combining ethnographic information with a dialectic of personal involvement” (Tedlock, 1991, p. 79). Autoethnography starts with the author’s personal life—paying close attention to emotional and embodied experiences as well as cognition. Using sociological introspection and emotional recall (Ellis, 1991) to try to understand an experience, the researcher writes a story. Methodologically speaking, studies of personal experience focus in four directions at once (Clandinin and

Connelly, 1994). They look inward at emotions, morals, and aesthetic reactions, and outward at the external culture in which our lives are embedded. They also look backward and forward, paying attention to the past, present, and future (Clandinin and Connelly, 1994, p. 417).

The significance goes far beyond any personal insights or therapeutic effects it may have upon the individual who writes it. As Reed-Donahay (1997) has suggested, examining an individual's life provides us with insight into a way of life. The specific and vivid details of life provided by autoethnography invite the reader into an important, almost visceral, way of knowing. She is encouraged not just to imagine what it may have been like, but to feel it, and then to reflect critically on her own experiences as they relate to the experiences she has just read about (Ellis, 1998; Ellis, 1993). The layers of consciousness (Ronai, 1995) mediating between the personal and the cultural provide a perfect forum for a topic such as mine. My research emerged initially out of personal experiences that I later recorded in journal entries. I then began to compare notes with other women who bore these same minor bodily stigmas.

Researchers writing about topics they have personal experience with report that while processing the stories told to them by others, they end up also processing their own (Ellis, 1998; Kiesinger, 1995; MacLeod, 2000). In fact, Ellis and Bochner (1996) have pointed out that one of the uses of autoethnography is to "allow another person's world of experience to inspire critical reflection on your own" (p. 22). Thus, autoethnography calls the researcher to recontextualize her experience in terms of the cultural and personal stories told to her by others (Ellis and Bochner, 1996). In her work on bulimia and anorexia, Kiesinger (1995) acknowledges that by merging her story with the tales of her

interviewees, she attempts to understand and recognize the larger issues and deeper meaning of eating disorders and to show “the reflexive qualities of research on lived experience” (p. 3). In her Master’s thesis, Perry (1994) explores, “specifics of the disability experience by using [her] own subjective account of living with hearing loss” (p. 4). Similarly, in my research, I attempted to gain insights into the overarching category of minor bodily stigma by investigating my own story while simultaneously seeking out the stories of others with micromastia and strabismus, and collecting these stories through interviewing. Their stories inspired reflection upon my own narrative, and conversely my story had an impact on theirs. In Chapter Three, I present the stories of each of my interviewees and I make myself a character within the telling of their tales. This allows me to show the reader how new thoughts and feelings about my own minor bodily stigmas are generated spontaneously as I listen to and share with my interviewees.

Interactive interviewing.

I used interactive interviews to collect individual stories and conversations that took place within larger cultural stories that are being told about appearance and plastic surgery. Interactive interviewing represents a break from traditional modes, and its advent was part and parcel of a larger paradigm shift in the social sciences toward interpretive methods (Denzin and Lincoln, 1994). The traditional positivistic interviewer assumes an emotionally neutral position of authority, and does not encourage interviewees to explore their inner-most feelings. Instead the interviewer’s job is to make sure the interviewee does not depart from the scheduled topics. Typically, positivistic researchers also employ a “one-shot interviewing” technique that does not allow the interviewee to rethink his or her original positions, or to develop much rapport with the

interviewer. Because of these kinds of limitations, many qualitative researchers abandoned traditional positivistic approaches in favor of a method highlighting the interview process, stories told, and the understanding gained (Ellis, et.al, 1997). Interactive interviewing provides a format in which both researcher and participant share their feelings, thoughts, and stories.

Interactive interviewing breaks up the standard power hierarchy in traditional interviews in which the researcher does not make herself vulnerable to interviewees, and interviewees seldom share private thoughts and feelings (Ellis et al., 1997; Charmaz, 2000). A strong collaborative relationship can then be fostered (Oakley, 1981; MacLeod, 2000). Charmaz (2000) notes that a constructivist approach to grounded theory “necessitates a relationship with respondents in which they can cast their stories in their terms” (p. 525). Interactive interviewing provides an environment of deep listening and generous sharing of thoughts and feelings, which encourages significant relationships between interviewer and interviewee. Following the premises of interactive interviewing, I required my interviewees to agree to conducting at least two interviews, so that my participants would have a chance to reflect upon what they had said the first time and to amend or elaborate upon their original statements.

My initial interviews spanned from one to two and a half hours in length. Follow-up interviews tended to be shorter, taking only half an hour to an hour to complete. Initially, I hypothesized that feelings about stigma and cosmetic surgery do not remain stagnant across time. My results confirmed this suspicion. The “two interview” format was designed to illustrate the wide range of emotions and cognitive stances that some people go through at various stages of the cosmetic enhancement process, and to record

potential shifts in opinion from those who had not undergone surgery. Interviewees were thus granted time to think about what they said in the first interview and to amend or elaborate upon ideas. For example, one interviewee—Holly—had expressed very negative emotions regarding her augmentation in the first interview. When she got to the second interview she was eager to correct this sharply critical first impression. Holly admitted, “If I really am objective about it, it’s been a very positive experience.” She emphasized that for almost ten years she loved the implants, and the newfound confidence in her appearance. But recently she had experienced so many health problems linked to the implants that she was regretting her decision. She told me, “All those negative things I talked about in the first interview are really bothering me right now. At the moment, if I had to do it over again, I am not sure that I would have the augmentation. But ten years ago—before all the really serious problems started—I would have told you that I was very happy with the result. I was having *some* problems at the time, but it was nothing like what was to come.”

Conducting a second interview also allowed me the luxury of reviewing the transcription so that I could ask follow-up questions and get clarification to illuminate some of my emerging theoretical concepts—a crucial step in grounded theory. Ancheta’s (1998) research on cosmetic surgery patients reveals that her interviewees used other women as mirrors—assessing their appearance and producing corresponding feelings about their bodies based on the reaction of others (p. 4). It stands to reason that the reaction a woman gets after having a cosmetic procedure might be strikingly different than the one she received before she had surgery, so she might experience her body differently and tell new stories about it. My own research also suggested that if a woman

moved to another place and was exposed to a different culture, her feelings about her body might change based on how the people in her new surroundings now evaluated her. This observation made its way into my description of coping strategies outlined in chapter five.

Although I only had two tape-recorded interviews with each woman in my study, I had many other “unofficial” interactions with my interviewees. I maintained e-mail contact with all three of my eye interviewees, and I also occasionally talk on the phone with one of them. I have also maintained contact with all but one of my breast interviewees. I lost track of her when she moved to Japan—although I hear from mutual acquaintances that she is doing well.

My interviewees ranged in age from 23 to 42. All of them completed high school, one had some college experience, one had a Bachelor’s degree, two of them had Master’s Degrees, and one had a Ph.D. Their incomes ranged from lower middle class to upper middle class. All my interviewees knew I have a personal interest in these two minor bodily stigmas, and that I was not a neutral, objective, detached researcher. Conducting these kinds of interviews encouraged a sense of trust, openness, and honesty that provided me with access to thick descriptions (Geertz, 1973) of these particular individual’s lived experiences of stigma.

With the rewards of this kind of interviewing also come ethical responsibilities. While some argue that this type of research method comes too close to psychotherapy with an un-trained professional (Lieblich, Tuval-Mashiach, & Zilber, 1996; Miller, 1998), others expound upon the benefits derived from this format (Parry, 1991; Wiersma, 1992). The benefits available to those who participated in this research included the

opportunity for self-expression and contribution; the chance to explore self and make sense of their experiences; and the opportunity to learn about other's experiences with stigma (Weicke, 1995; Yerby, Buerkele-Rothfuss, & Bochner, 1995). Parry (1991) points to the therapeutic benefits of telling stories, claiming it is empowering for a person to find her voice in the telling of a story that describes her experiences. Wiersma (1992) supports this view, noting that Karen, one of his interviewees, reported feeling empowered when she realized that she could create and change her self-image through words.

The experience of stigma is often one of feeling isolated, alone in one's experiences, and unable to easily broach the topic or talk about the personal issues involving stigma. By sharing my own experience of stigma, as well as many of the facts and stories I uncovered in my research, I made it safe for my interviewees to share their own experiences. Further, I helped them to see how their own unique experiences will add to the body of knowledge regarding minor bodily stigma. Holly, one of my breast interviewees, initially reported feeling somewhat uneasy about the topic of conversation. She admitted, "This is kind of embarrassing. I've never talked about this to anybody." However, after this initial anxiety wore off she became one of my most thoughtful and enthusiastic informants. Our conversations flowed easily, and she wasn't afraid to examine the motives behind her own behaviors. However, we hit another awkward moment when I showed her the transcript of our first interview. "I feel like I sounded like an idiot," she laughed, as we began her second interview by talking about the first interview she had given. "You know, I think of myself in terms of my writing, and I'm just not used to hearing my speaking voice." Later, she softened her stance significantly,

deciding, “It was pretty fun” to read the transcript because it reminded her of a favorite book that was written in what she described as “a colloquial voice.” Holly also pointed out that when she gave it to her husband to read he “absolutely loved it.” She finally concluded, “It was different.”

My breast interviewees were volunteers gathered from a snowball sample. They were either strangers recommended to me by friends, or they were friends or acquaintances that volunteered when they heard about my research. At first I was uncertain how to gather a pool of participants with strabismus because I did not personally know anyone with this condition, and neither did my friends. In the 1960s, Goffman (1963) observed, “Often those with a particular stigma sponsor a publication of some kind which gives voice to shared feelings” (p. 25). Today that tradition continues, but now conversations proliferate on-line as readily as they do in print. There are e-lists for any type of stigma conceivable. Knowing this, I searched for a strabismus e-list and discovered LazyEye. My eye interviewees were gleaned from a pool of volunteers who responded to a long introductory letter that I posted on the LazyEye e-support group list.

I purposely chose to interview both people who had chosen to have cosmetic surgery to enlarge their breasts or straighten their eyes, and those who chose to abstain from surgery. I interviewed seven women in total. Four of these women started out as flat-chested women. For the purposes of this study, I define flat-chested women as those who wear an A cup bra or smaller. Two interviewees had undergone augmentation surgery; one woman had silicone implants originally, but had to have them replaced with saline implants, and the other just had saline implants. Two interviewees chose not to have surgery, but reported feeling stigmatized by their small chests. Three of the

interviewees started out with strabismus. Two of them had corrective surgery. The third woman has not had surgery yet, but is toying with the idea. I am the eighth voice examined in this dissertation. I fall into the categories of a woman with a size A chest who has not had augmentation, and a woman with strabismus who has not had straightening surgery.

For this IRB approved research, pseudonyms were used and I made great efforts to disguise any other distinguishing details. All my participants signed consent forms that explained my study, approximately how much time would be required of them, the procedure followed in my interviewing, any risks involved, any benefits they could look forward to, and their right to request that I omit any of the material they gave me in the interview. They were told they would not be paid for their time and they were given my contact phone number and e-mail address. With their consent I audio-tape recorded, and later transcribed, all of the sessions.

The open-ended format of interactive interviewing allowed my participants to weave their own narratives, describing their physical and psychological experiences. I encouraged my participants to express themselves fully, using probes and inviting them to elaborate on issues that reflected some of the emerging foci of my study. I also pursued unanticipated, but relevant topics that arose during our conversations. I began each interview by asking my interviewee to tell me about her minor bodily stigma.

Throughout the interviewing process I was acutely aware of the myriad ways in which my identity impacted my interactions with my interviewees. The literature suggests, “when researchers’ medical history experiences are similar to their respondents, there is a greater likelihood that they will have greater cooperation and receive more

accurate responses from their participants” (McLeod, 2000). On one level, I had automatic “insider” status with all of my interviewees since I had the two stigmas I was studying. On another level, I was an outsider to those who have chosen surgery, and placed myself in a “different category” than these interviewees (Ancheta, 1998). I was most intensely aware of this difference on two separate occasions when my interviewees asked me why I didn’t pursue cosmetic surgery. Autumn encouraged me to get augmentation, while Hailey told me she thought I should try eye-straightening surgery. During these moments when my interviewees questioned *my* actions I recall feeling vulnerable and defensive. However, these twinges of emotion paled in comparison to what I felt when I decided to try to put myself in the shoes of many of my interviewees. I introduced participant observation into my dissertation by visiting a cosmetic surgeon for an augmentation consultation, and by having an eye exam and conducting an interview with an ophthalmologist who was also a strabismus surgeon.

Participant Observation.

Atkinson (1990) notes that in participant observation, the researcher is “poised between intimacy and distance.” I felt acutely aware of this distinction as I conducted my own participant observations. First I visited Dr. Brown for my free augmentation consultation. Shivering in the air-conditioning that permeated the paper-thin gown I had been given, I waited for what seemed like an eternity for Dr. Brown and his nurse to arrive. Dr. Brown wore a stylish scarf that contrasted sharply with his plain, white lab coat, and he had a thick French accent. My first impression was that of an unattractive man who played up his “French-ness” to gain cultural cache and “snob value.” As I passed this almost unconscious judgment on him, I was sharply aware that he was about

to perform his own judgments of me. I remember he shook my hand before getting right down to business. At his request, I opened my gown and he looked at my breasts with a calculating, appraising eye. He turned to the wall of drawers behind him and quickly retrieved a clear sack of gel. With no further ado he slapped the cold implant up against my right breast and stood back slightly, cocking his head and stroking his beard as though imagining exactly what this intrusive object would look like beneath my skin.

“I think 330 cm would be good,” he concluded.

I didn't know what that meant, and I was slightly shocked that he had not asked me what size I was considering. He was acting like there was a correct size I would obviously want, and apparently that size was 330 cm.

“What size cup is that?” I asked hesitantly.

“It's a C,” he explained. “Your nipples are not centered very well,” he pointed out, using a tone that suggested he was breaking bad news to me. “The left one is more centered than the right, but they both point outward more than they should. It's not that bad, but if you went with D's your breasts would point outward and you wouldn't get the cleavage that you want.” He paused momentarily, once again staring fixedly at my breasts as though they were some sort of problem he was determined to solve. “We would go in through the armpit and put it under the muscle because that would keep them together more. We would also remove some of this sag,” he commented, tweaking the pouch of skin next to my armpit that I had hardly noticed before.

I stared at the flabby little pouches on either side of my armpits with a newfound sense of disgust. “Can I get rid of that with exercise?” I asked, inwardly resolving to exercise every day until it was gone.

“No, nothing will target that area. It’s probably glandular.”

Dr. Brown put the implant away again and began to talk about cost. He took me through credit card options and even mentioned that he’d be willing to remove a couple moles that he clearly also found to be an aesthetic offense for \$150 if I also got an augmentation. Otherwise it would cost me \$250 for the moles.

I left still reeling from the mere suggestion that I might want D sized implants and plagued with a deep sense of self-consciousness about my armpit flab—a trait that I had never thought about before—and my moles. I suddenly realized why women who get one cosmetic surgery are likely to become repeat offenders. It seemed like there was just so much to fix.

My experience with Dr. Mendelblatt also left me feeling vulnerable and self-conscious, but this visit did not fill me with the same feeling of righteous anger that I experienced in Dr Brown’s office. As always, I felt naked without my glasses on, but thanks to yearly eye-exams, the testing and questioning felt routine. Dr. Mendleblatt pressed cold machines against my face, clicked different kinds of lenses into place, asked me which lines looked darker than the rest, told me to read the letters on the wall, and peered into my eyes with bright lights. When he had exhausted his battery of tests, he began to talk to me about strabismus surgery. He readily admitted that most of his patients were children and most were under one year of age. The prognosis for adults is not nearly as good, but Dr. Mendleblatt maintained that cosmetically speaking he still experienced good results with most patients. He explained that double vision is a common outcome of strabismus surgery, but that most of his patients either naturally adapted, or they were able to use prisms in their lenses to overcome this problem. He did

warn me that the eye would eventually drift out of place again and the necessity of repeating the surgery was virtually guaranteed. Still, Dr. Mendleblatt said that many of his patients considered this an acceptable consequence of cosmetically straightened eyes. I left his office still frightened of attempting surgery, but at least considering it.

The notes generated from my participant observation in the offices of Dr. Brown and Dr. Mendleblatt provided me with an “insiders’ viewpoint,” (Jorgensen, 1989, p. 23) and a base of knowledge that I took with me into my interviews. Although I referenced the data I had amassed when I did my writing, I chose not to highlight these experiences. They became important background information, however. The content analysis I performed on magazines also helped me contextualize and make sense of my interviews.

Content analysis.

Richardson (1990) makes a useful distinction between what she calls cultural stories and collective stories. She tells us cultural stories are told from the point of view of the dominant interests and these stories help maintain the status quo. Collective stories, on the other hand, give “voice to those who are silenced or marginalized in the cultural narrative” (p. 212). My pool of stigmatized people fit this later category. Richardson (1990) clarifies that a collective story is not a telling of an individual’s story, but a narration of the experiences of a social group. Although I had collected individual stories from eight women, one of my goals was to discover some broader conclusions that could be drawn about stigmatized people in general. Consequently, in my conclusion I grappled with some of these larger issues affecting all of my interviewees and potentially all people dealing with minor bodily stigma. In so doing, I sought to produce knowledge that meets Bochner’s (1994) standards of worthiness in that it

“widens our sense of community, deepens our capacity to empathize with people who are different than we are, and enlarges our capacity to cope with complicated contingencies of lived interpersonal experience” (p. 24).

However, the category of “collective story” only makes sense in comparison to the “cultural story.” In order to access these cultural stories in a concrete way, I conducted a review of literature spanning ten years worth of two popular women’s magazines—*Ms.* and *Vogue*. *Ms. Magazine* is one of the most widely recognized feminist publications. Although feminists in academia might argue this magazine tends to be more popularized than some of the more obscure and devoutly feminist publications read at the university, they can’t deny that many novice feminists were first introduced to a new ideology through the pages of this publication. *Ms.* is also unique because it no longer accepts advertising.

In sharp contrast, *Vogue* has many advertisements—primarily for beauty products—and its content focuses on popular trends in fashion, the beauty industry, and other appearance-related issues. I studied ten years worth of *Ms. Magazine*—examining issues printed from 1990 through 2000, looking to see what was written about cosmetic surgeries or other appearance enhancing procedures. I began a similar project with *Vogue Magazine*, but I soon discovered that this magazine was so filled with articles about, and ads selling, beauty-enhancing products that it seemed a laborious and meaningless task to look at every single issue printed in the last ten years. Instead, I looked at the years 1990 and 1991, and then 1999 and 2000, and commented upon changes that occurred over this ten-year span. My content analysis of *Vogue* uncovered a lot of cultural stories affirming ideal Western standards of beauty and suggesting that

undergoing cosmetic surgery was an appropriate course of action for those who fell short of these exacting standards. More surprisingly, my content analysis of *Ms.* revealed some similar tendencies to valorize cosmetic surgery. The complete results of this research are explored fully in Chapter Four.

Content analysis has enjoyed some popularity in the field of cultural studies and is frequently used to characterize and compare documents such as popular magazines (Manning and Cullum-Swan, 1994; Berelson, 1952; Kracauer, 1993; Lowenthal, 1962). As a quantitative technique, however, content analysis has been criticized for its inability to “capture the context within which a written text has meaning” (Manning and Cullum-Swan, 1994, p. 464). Nevertheless, I argue that the magazines I chose are representative of the kinds of messages about cosmetic surgery that are disseminated continuously, and the types of materials that all of my interviewees had access to. Therefore, it is important to spend some time examining them. Rather than making claims about the impact of any particular articles or ads, I used these mass-mediated stories to contextualize the stories that my interviewees told. This information then became a part of the cultural backdrop against which these women told their tales. In order to do justice to these emerging stories, I found myself adopting a narrative approach. Next I explore some of the contributions of this important development in qualitative research.

Narrative Approach

In recent years, social science research has made an interpretivist turn (Denzin and Lincoln, 1994). Narrative inquiries combining personal experience methods with more traditional practices such as interviewing and participant observation have experienced a new-found popularity—making significant contributions to contemporary

scholarship (See Bochner, 1994; Ellis, 1993; Ellis & Bochner, 1996; Jago, 1998; Jackson, 1989, 1995; MacLeod, 2000; Neumann, 1992; Perry, 1994; Richardson, 1990; Ronai, 1995; Rosaldo, 1980; Vanderford and Smith, 1996; among others). Recognized as a “valuable tool for exploring the texture and ‘everydayness’ of human life,” narrative privileges subjectivity over objectivity; understanding over explanation or sheer description; the particular voice over the generalized; and personal, lived emotional experiences over universal truths (Kiesinger, 1995, pp. 44-45). Narrative modes of inquiry present a research style that does not alienate non-academic participants the way high theoretical writing does. Fisher (1984) argues convincingly that narrative is a paradigm—a human construction of a set of beliefs that guide action (Denzin & Lincoln, 1994, p. 99). He says it comes closer to capturing the experience of the world than argument because it appeals to the senses, to reason and emotion, to intellect and imagination, and to fact and value. In Fisher’s view, narrative represents an ideal form for researchers and their subjects. We do not need to be taught narrative probability and fidelity since we get these from our cultural experiences (see also Polkinghorne, 1995). Finally, because people are able to reflect upon their lives and create stories from them, they then have the ability to judge narratives for and about themselves. In a world in which post modernism has problematized representation (Hutcheon, 1989), interpretive ethnographers have turned to narrative to portray our individuality and discover how we understand ourselves (Kiesinger, 1995). Narrative inquiry revolves around the view that one’s sense of self and reality is constructed, maintained, and transformed through communication as we tell one another stories (Carey, 1989, Kiesinger, 1995).

The stories that we create and give power to help determine the decisions we make. If a woman tells a story that says, “my body is healthy and functional the way that it is, but society is trying to make me feel inadequate so I’ll waste all my hard-earned money on a cosmetic procedure,” chances are she will chose to forego surgery. If she tells herself a story about how her life would be miraculously transformed and she could attain the relationship and career she wanted by undergoing a routine, safe surgery, that option suddenly looks very attractive. The decisions we make depend largely on the stories we choose. Why we choose certain stories and reject others, or even how the stories we choose change or remain constant over time can be revealed through narrative inquiry (Bruner, 1990, p. 114). After the surgery is over, Gimlin (2000) points out that women must also tell a story about plastic surgery designed to counter the charge of “inauthenticity” (p. 81). Women have to convince others, and perhaps more importantly, they must convince *themselves* that “the new appearance is both deserved and a better indicator of the self than the old appearance—an appearance necessarily repositioned as ‘accidental’” (Gimlin, 2000, p. 81). The twenty women that Gimlin (2000) interviewed about their experiences with cosmetic surgery stressed that they pursued surgery because their physical attributes had kept them from enjoying a “normal” life, not because they had delusions of looking like a supermodel (p. 90). Many of them reported that the most difficult aspect of cosmetic surgery was convincing others to honor this interpretation.

Parry (1991) makes a key observation. He writes, “the recognition that we are characters in each other’s stories reminds us that the only way we have of transcending the limits of our individual vantage points is through imagination and curiosity. These enable us to appreciate through a glass, darkly to be sure, the stories that others are

enacting from their various vantage points” (p. 53). I used these tools of imagination and curiosity to try to better understand the experiences of others and in so doing to better understand my own experiences. I invite my readers to do the same. The full communicative potential of this work lies in my ability to draw the readers into this world with me (Kiesinger, 1995, p. 46).

Combining Grounded and Narrative Theories

Experience is not a given that exists out there in the world. It is mediated through story (Crites, 1971), or, as Polkinghorne (1995) has said, “stories are particularly suited as the linguistic form in which human experience as lived can be expressed” (p. 7).

Consequently, after I collected stories from my interviewees, I presented much of my data in the form of evocative narratives (Ellis, 1997) designed to draw in the reader and encourage her to think and feel with the characters that are being portrayed. The goal of these narratives was expressive and “presentational rather than representational” and points to the importance of “aesthetic” ways of knowing (Schwandt, 1994, p. 129-130). I agree with Richardson (1990), who boldly asserts, “Narrative is the best way to understand the human experience because it is the way humans understand their own lives” (p. 218). Narrative is the way that we address the essential question, “who am I?” Hence narrative studies often turn into studies of identity (Kiesinger, 1995).

In their work with women who received silicone breast implants, Vanderford and Smith (1996) highlight the importance of uncovering identity issues through narrative. “Self-concept plays a major role in women’s decisions to have implants. Narrative is an appropriate method of analysis for women’s stories about their bodies because storytelling reveals keys to self-perception” (Vanderford & Smith, 1996, p. 23). Because

self-concept, or identity emerged from my interview transcriptions and other forms of data as a major theme, narrative was an appropriate way to convey the emphasis that my interviewees placed upon their perceived and imagined identity implications.

When I asked participants to tell me how they came to identify themselves as people with minor bodily stigmas, and how they decided to cope with these stigmas, I invited them to take me back in time to a moment of dissatisfaction that was often buried deeply in the past. I invited them to spin a tale spanning a bridge of time so that I could show how the thoughts and feelings about their bodies evolved and mutated and became bound up with variables such as relationships, cultural shifts, economic status, etc. (Bochner, Ellis, & Tillmann-Healy, 1998). I then took these stories that were told to me and crafted a narrative about each interviewee, using their words and stories, and emphasizing events that they spoke of with great passion. As I struggled to write meaningful and compelling stories (Kiesinger, 1995) of stigma, I was conscious of trying fulfill what Rorty (1982) has pointed to as one of the main duties of a social scientist. I was acting as an interpreter for those toward whom we may feel ill at ease or unsure of how to act around.

As I slipped into this role of interpreter, I was conscious of wanting not only to tell stories, but to suggest some larger theoretical ideas arising from my autoethnographic journalings, content analysis, participant observation, cultural observations, review of literature, and interviews. Consequently, I turned to grounded theory to suggest emergent theoretical ideas. Each idea formed the basis for a chapter. In Chapter Three, I looked at the four main bodily complaints identified by my interviewees. In Chapter Four, I examined the cultural context in which conversations about minor bodily stigmas and

cosmetic surgery take place. Chapter Five presents the coping mechanisms implemented by my interviewees, while Chapter Six examines decision-making and its after-math. Finally, Chapter Seven presents some conclusions.

While grounded theory allowed me to identify emerging theoretical concepts that I used to organize my dissertation, narrative interpretive research allowed me to show how individuals attached meanings to their experiences and how this influenced their lives. Like Jones (1998), I struggle to graft an academic discourse on feminism, gender, sociology, and communication onto a topic that resists such a distancing gaze, and narrative allowed me to keep drawing the reader near, luring her with stories. Often I placed a story at the beginning of a chapter to draw the reader into the experience of minor bodily stigma and introduce, in a narrative fashion, some of the main ideas outlined therein. Little stories were also used to illustrate or clarify main points. Finally, I ended my dissertation with a story that points toward new interpretations, while reinforcing themes introduced earlier.

My research, like that of Carlisle (1985), Jezer (1997), and Perry (1994), adopts a narrative approach, emphasizing subjective lived experience. However, I broadened the scope of my research to include not just an account of my own struggles, but also interviews of others with similar problems. My style is also similar to that of Latteier, (1998) who tells of her own dissatisfaction with her small breasts and presents the stories other women tell about their breasts—small, large, augmented, natural, or amputated. There are moments when her writing assumes a kind of autoethnographic style, giving us a glimpse of her feelings and experiences involving her own breasts:

My discomfort with small breasts was more than just cosmetic. I felt the lack as a poverty of being, as if my very nature was somehow stark and bony. A hollow chest equaled a hollow heart (Latteier, 1998, p. 4)

However, her story focuses more on telling the history of and the cultural meanings attached to the breast. Although I include both of these elements in my dissertation (the history of cosmetic surgery is reviewed in Chapter One, and the cultural context is explored in Chapter Four) they are just two parts of a much larger whole, rather than the focal point of my research. Perhaps the piece that my own work most closely resembles in terms of style, method, and content is Debra Gimlin's (2000) article, in which she describes her attempt to "explore cosmetic surgery as an occasion for autobiographical accounting and a particular kind of account of the self" (p. 77). However, my research remains more narrowly focused than Gimlin's. I am specifically focusing on the decision-making and communication process and only looking at surgeries designed to enhance the eyes and the breasts. One of the most basic concepts that I learned from my study was that all coping mechanisms and cosmetic surgery decision-making strategies are situated within a story about how the stigma was recognized and defined in the first place. Chapter Three introduces these stories, helps to position me within them, and allows each interviewee to give voice to her own unique experience of minor bodily stigma.

CHAPTER THREE: SHARING STORIES OF MINOR BODILY STIGMA

I can't remember the last time I attended a social function and did not talk about breasts. My friends all know about my dissertation topic. When I meet someone new and they ask about my research, I tell them, "I am studying how women make and communicate their decisions regarding whether or not to have cosmetic surgery to fix minor bodily flaws." That's my two-second blurb summarizing the broad scope of my research interests. Then I typically start talking about breast size and implants. It's a wildly popular topic. Guys usually crack some sort of joke regarding their desire to become my research assistant, and women tend to either tell me about friends who got implants, or they share something personal about their own experiences regarding their breasts. I reciprocate by talking about some of my interviewees and their experiences. I seldom talk about myself or divulge the reason I decided to study these two minor bodily stigmas in the first place. I've noticed that I've begun unwittingly to collapse each woman into a stereotype when I talk about her. I choose one key distinguishing marker and develop an easy-to-remember "snapshot identity." I've got Autumn, the lesbian; Holly, the silicone implant recipient; Bea, the raving feminist; and Izzy, the average, flat-chested woman who is sporadically unhappy about her chest size, but can't bring herself to get implants. I've also noticed that midway through my explanation about the breast portion of my research, I become acutely aware of the size of my own breasts, and my presentation of self (Goffman 1959) as a woman who is confident and satisfied with her

own breasts—even if they are small. I am aware that I do not want people to think that I am studying this because I am hung up about any perceived deficiencies in my own appearance.

Perhaps this helps explain why I rarely speak about the strabismus part of my research to anyone who does not have crossed eyes. I am afraid it will make things awkward. My closest friends know about this “hidden half” of my research, but talking about it typically elicits deep feelings of self-consciousness about my own eyes. By choosing to delve into this portion of my research, I am “outing” myself as a person with crossed eyes and inviting people to look closely at my eyes. Because most people know little about strabismus, they frequently stare or ask uncomfortable questions like, “Can’t you get that fixed?” or “How did that happen?” However, even when talking to others who have strabismus, I experience a high level of anxiety.

I “outed” my strabismus-self to my eye interviewees in one of the safest environments, and using the safest mode of communication I could imagine. I have never met any of my strabismus interviewees. I contacted all of them from a list-serve entitled “LazyEye,” using a well-composed letter of introduction inviting them to participate in my study. This way I was able to exercise a great deal of control over my presentation of self. Our ensuing phone and/or e-mail conversations provided a safe environment in which to share personal feelings about our eyes without having to make eye contact or deal with any other “visual-performative” aspects of communication. I never developed strong “snapshot identities” of these women in the same way that I did with my breast interviewees. Perhaps this is because our culture has not produced stereotypes for women with crossed eyes, but there are lots of breast-related stereotypes

to choose from. As I write more and more about my eye interviewees, I have begun to think of Lynn as “the mother,” and more recently, I’ve begun to think of Lori, as “the young mother-to-be.” But, I don’t have a phrase for Hailey. If anything, I have begun to label Hailey as a friend, since she is closer to my age than the others, she was the first to send me a picture of herself, so I know what she looks like, and she corresponds with me the most—including occasional phone calls, and frequent e-mail.

I haven’t been able to visually compare my eyes to those of my eye interviewees in the same way that I’ve been able to make rudimentary assessments regarding how my chest size compared to the women I interviewed about breasts. However, I assume that if I did meet with my eye interviewees I would be quick to compare our degrees of crossing. I was able to scrutinize photographs of Hailey and Lori, but I know from personal experience that photographs often lie. It’s possible to relax your eyes and tilt your head at an angle that makes your eyes look straighter than they actually are in every day life when you are focusing and interacting normally. I also knew that they would be likely to send only their very best pictures to me. I have plenty of photographs of myself that I really like because my eyes look fairly straight, and an equal amount that I would like to destroy because the picture taker caught me at a bad angle and my eyes definitely look abnormal. I would never share these latter pictures with anyone voluntarily. I decided that Hailey’s eyes were straighter than mine, but Lori’s were probably slightly more crossed. However, as I reviewed all the interviews I had conducted, I began to realize that for all of us the most important comparison seemed to lie not in any sort of assessment of our literal, physical characteristics, but in our sharing of stories. Here are some renderings of my experience of those stories.

Portraits of Interviewees

The stories presented below are slices of interactions from the interviews that I conducted. My goal was to present each woman's story of self-stigmatization and to illustrate my interaction and place within each of these stories. In Charmaz's description of constructivist grounded theory she suggests that the product of the type of ethnographic research I performed is "more like a painting than a photograph" (Charmaz, 2000, p. 522). With that distinction in mind I have used these stories to draw portraits of my interviewees.

Autumn

I had to admit they were stunning.

I was staring at the two most perfect breasts I had ever seen in my life and I could feel myself starting to turn a little red as I struggled to find something intelligent to say. Several minutes ago Autumn and I had been discussing the resistance she met when she told the plastic surgeon she only wanted B's. I concurred that this was consistent with my own experience at my augmentation consultation as well as reports from other interviewees. It seemed that doctors typically encouraged women to get C's at least. Autumn was so afraid her doctor wouldn't respect her request that she had her sister write "B's only!" in blue ink across her chest on the day of the surgery. She had always been an athlete and used to rationalize that she was better off being flat. She was also a lesbian, which meant that she didn't need breasts to attract men and she assured me that the women she dated certainly didn't care about chest size. She was a little afraid that her community might accuse her of trying to meet heterosexual standards, but eventually she grew tired of feeling like there was something missing. "I felt like a boy from the waist

up. I mean, I was just that flat,” Autumn confided. However, she had no desire to swing to the opposite extreme. She was adamant about not wanting “dancer breasts.”

I remember asking, “So they ended up being a B?”

She responded, “I think so. I’ll show them to you.” She stood up and peeled off her shirt and sports bra in one smooth motion. As I sat in stunned silence—eye-level to her chest—she asked, “Have you been shown at every interview?”

“Nobody’s shown them,” I stammered. “No. No.”

Part of me definitely felt like I shouldn’t look. Another part just wanted to stare. I didn’t know they could look that beautiful and natural. No wonder Autumn was so happy with them. I knew how flat she had looked before the surgery with clothes on. I couldn’t help myself. I began to wonder what I would look like with a set of those.

“Is it inappropriate?” she asked, no doubt noticing how flustered I was.

Instantly, I began to worry about making her feel uncomfortable. I lifted my eyes to her face. “I just have actually never seen actual...”

“Oh, you’ve never seen?” smiled Autumn. The momentary hesitation had left her voice, and she resumed the conversation in her normal, confident tone, “Oh, well then, you can’t be doing this thing without having seen them.”

Autumn turned at a little bit of an angle. “It seems the only thing you can see sometimes if I stand just right, is a ripple in the bag.”

As she pointed this out, I saw what she was talking about for just an instant and then it was gone. She squeezed both breasts with her hands and said, “You can touch it.”

I laughed nervously. Now I was definitely turning red. “My hands are cold,” I said apologetically, but this weak excuse didn’t get me off the hook.

“That’s okay,” Autumn said reassuringly. “It’s all right. I’ve done this before. It feels kind of hard, like salt water.” She squished them again and stared at me expectantly.

This was ridiculous. I was a researcher. I had to regain my composure. I reached out and tentatively touched the left one. I wasn’t sure what to do, so I gave the bottom of it a small squeeze to see if I could feel the implant itself. It felt firm like a water balloon—only warmer.

I withdrew my hand and Autumn put her bra and shirt back on as I began to question her about the procedure itself.

“It’s called TUBA,” she explained. “Trans-Umbilical Breast Augmentation. And what they do is they make an incision inside your navel and they put this rod thing up beneath the skin under the breast tissue. And they have an expander. I assume it’s very similar to a balloon. And they blow that up, which pulls the breast tissue off the bone, and they deflate that and insert the bag through the same tunnel and then fill the bag inside, and then do it on the other side. The whole surgery takes less than thirty minutes.”

“And the nipple reduction?” I asked, recalling her admission that her oversized nipples were the part that bothered her most of all.

“It took an hour for that surgery. They took the tip of my nipple—just the tip, not the areola—and cut it off at the base. Then they amputated a little part of it in the middle and put the tip back on.”

Concealing my squeamish reaction to these horrible sounding procedures, I asked how she liked her new breasts. Autumn enthusiastically replied that she was very happy

with them. “It’s just a part of me now,” she smiled. “What do I think about it? I think that if you’re in a position where you can afford to do it and it’s something that you wanna do, why not? I mean like I said, it’s an elective thing and it’s not cheap and not everyone can do it, but I think if you have the ability to make a difference for yourself like that, why not? My partner’s step mother said to me, ‘Autumn, you should just be happy with what God gave you.’ And I said, ‘Well, you know what? If that were the case I would have really crooked teeth too, because I had braces as a kid.’ And it’s no different, really, to me than that. I mean that’s just a cosmetic thing that makes a big difference. If you just stuck with what God gave you you wouldn’t wear deodorant, or cut your toenails, or any of that stuff. This made a big difference to me. If you want it and you can afford to do it I say, ‘more power to ya!’”

Holly

I had seen Holly’s breasts too, but my first glance at her curvaceous, nude figure had occurred under very different circumstances, and had elicited a completely different response. I was housesitting for Holly and her husband--tending the plants and taking care of the cat while they were on vacation. I remember discovering the photographs when I walked into their private bathroom to take a shower. There on the wall next to the mirror were two gorgeous black and white pictures of Holly, naked in the woods. Alone in the privacy of Holly’s home, I stared at those photos. A deep feeling of envy began to grow as I glanced from her lean taut body with its perfectly shaped, round, full breasts to my own naked reflection. My body looked much like hers from the chest down, but I had the breasts of a teen-aged schoolgirl, and she looked like some Greek goddess alone in the wilderness.

“Maybe they’re fake,” I thought, leaning closer to look to see if I could detect any scars. It seemed unnatural, and unfair, for someone so thin to have such large, perky breasts, and yet I could not imagine Holly getting implants. I knew Holly to be a feminist of great confidence and intelligence who loved nature and prided herself on being very “earthy” and natural. They just had to be real. Or so I thought.

Her confession took me by surprise. We were having coffee together and Holly had just asked me how the dissertation was going. I began to talk about my latest find—a riveting book about the silicone breast implant controversy (Vanderford and Smith 1996). I had just started talking about the lawsuit filed against Dow when Holly interjected. “I was part of that,” she said with a twinge of bitterness in her voice. “My lawyers still promise they’ll get me some money eventually, but I don’t have much hope anymore.”

I didn’t know how to react to her confession. Her tone implied that she assumed I already knew—that I had guessed her secret. Or was this the only way that she could tell me now without feeling awkward about waiting for more than a year to volunteer this information? Should I act surprised? Should I play it cool? By the time my brain was finished running through all of my options, I realized it was already far too late to convincingly feign surprise. So, I just shut up and listened, and Holly volunteered to be one of my interviewees. Excited to have someone who could share their experience with silicone implants as well as saline ones, I arranged a meeting at her home the following week.

Holly came to our interview wearing a beautiful, blue, clingy, V-necked sweater. She looked stunning and given our topic I found myself trying hard not to look at her well-accented chest.

“I became aware of, and self-conscious about my breasts when I was just ten. I was flat-chested, but I developed very large nipples.” Holly made a distasteful face and her voice got louder when she uttered the words, “very large nipples.”

“Oh, my last interviewee had the same problem,” I quickly interjected, sharply aware of my own pressing need to help normalize her stigma. This was only the second time that I had ever heard of this condition. I wondered if it was more common than I realized, and I was secretly grateful for my own normal-sized nipples.

Holly went on to describe her struggle to deal with her nipples. “When I went to college in 1972 I became aware of burning your bra and all that kind of stuff. I became a feminist and quit wearing a bra. But I was still concerned about my nipples, so I used band-aids to tone them down. It was just a real BOTHER! I always kind of wished I had bigger breasts, but it didn’t become anything I really desired until the 1980s, when I graduated from college and I started getting into fitness and thinking about my body shape. I thought a lot about how I’d look in exercise wear—in tights and leotards. My dream was to be a fitness expert,” she shared.

But Holly didn’t have the made-for-a-leotard body that she needed to realize this ambition. Every muscle was toned, but the breasts were missing. She explained, “It was really about wanting to even out my body and wanting to have this Barbie doll figure that I knew that I could have, because I already had part of it. If I could just have that other part, then I’d have the whole thing. Getting the surgery was just logical to me. Augmentation was getting all this positive publicity. I was in a health care profession and I ended up doing a lot of stuff with plastic surgeons. I knew I would get a professional discount, and I knew the doctors.” Initially, her only serious concern was

about the nipple reduction. She was worried that the procedure might cause her to lose sensitivity.

Sadly, this last minute anxiety proved prophetic. She had the silicone implants put in along the nipple—transforming her bust-line from a 32 A to a 32 C. She told few people, because she was afraid feminist friends who had just sunk their teeth into the newly released *Beauty Myth* by Naomi Wolf would criticize her. Holly lost feeling in her nipples and part of her right breast, and her breasts became encapsulated within a year. She learned scar massage to try to break up the fibrous bands that kept forming, but her breasts soon “got as hard as bricks.” There was also an asymmetry that she noticed right away and that she disliked intensely.

“The right one hangs over to the side, so I have to wear an under-wire bra to keep them in place,” she sighed, pointing to the offending breast. When I’m wearing a bra and a snug top like this one you can’t really tell, but when I wear a swimsuit it’s very noticeable.”

I found myself staring at her breasts for a minute—trying to see if I could detect the asymmetry, and trying to remember if I had ever seen her in a swimsuit.

When Holly complained to her doctors and asked them to fix the asymmetry, they told her she had always had that trait and there was nothing they could do about it. They confirmed this conclusion by showing pictures of her before the surgery. The implants had merely augmented an imbalance she always had, but had never noticed, because her breasts were so small. It was something she would just have to learn to live with. Next, Holly began to experience some joint and connective tissue problems—which were later diagnosed as migrating myalgia—and she had some bouts with chronic fatigue. This is

when she decided to get a lawyer and to become involved in the DOW Corporation lawsuit. She participated in a mandatory mammogram, which revealed that her implants had ruptured. She had to have the silicone implants removed and replaced with saline ones, which she dislikes intensely. “I went under the muscle with the new implants, and that’s always more painful because a lot of the tissue is pulled and stretched,” she explained. “And I had saline, and I hated them. I still hate them. They’re real heavy. Compared to the silicone, they’re heavy. They’re like lead hanging on my chest, and I still have my asymmetry. The saline is much harder and much heavier, and so it slides all over the place. And, I still have the encapsulations.”

She concluded, “If my implants had not given me all these deformity problems I probably would like them, but I’ve had to deal with these contractures and the deformity. My nipples are still numb—that sensitivity never changed. And this last time the doctor made me bigger. He made me bigger than I wanted. You see, I think he thought more volume might help with the asymmetry. But now I’m even bigger than I wanted to be. I just wanted to be normal. I didn’t want to be huge. I don’t regret the nipple reduction. I don’t regret that at all—even though I had side effects. It is wonderful not to ever worry about that. That is wonderful. It is heaven. But the implants? So stupid! I really am mad at myself for doing that now.”

As we ended our interview and I packed up my things, I was aware that my feelings of envy had faded away as I listened to Holly’s story. In their place was a haunting question. What would I do if I were faced with her current dilemma? I thought about those photographs hanging on the wall in Holly’s bathroom and how I might look at them differently now. I would look to see if I could detect some of the details they had

successfully hidden from me before. Could I see the asymmetry? Would her breasts look as beautiful to me? Did Holly's face reveal any of the suffering she had to endure to acquire such beauty?

Bea

The traffic was light as Bea and I zipped along the interstate talking about breasts as we left Tampa, Florida. Bea was a tall, slim, twenty-seven-year-old Florida native with blonde hair, bright blue eyes, a beautiful smile, and a flat chest. We were headed toward South Carolina in a car heavily laden with moving boxes and emotion. Bea was leaving Tampa for good--embracing a new job and a new life in South Carolina.

"One of the reasons I'm on the road right now to leave Tampa is that I think there are other places where whatever you are is valued," Bea began, not even attempting to hide her anger and resentment about the local culture she was leaving behind. "Having big boobs is just not the point of life, you know? I mean god, what if aliens came down and looked at us sticking things in our bodies? But do you know who's setting the standard? It's not like there's a God that's saying, 'Okay, this is what a woman looks like.' You know? I mean we are setting this standard for ourselves and we are mutilating our bodies to meet it. It's ridiculous!"

I nodded vehemently. One of the reasons I had chosen to interview Bea was because of her passionate feelings about augmentation surgery and body image issues.

"Years ago you used to see women who were big busted who also had big butts," Bea pointed out. "Look at Marilyn Monroe. You've got both there, but now it's inconsistent."

“You’ve got to have the body of a teenager with big boobs,” I agreed, feeling my own ire rising as we continued our conversation.

“Yeah, boobs on a stick! It pisses me off that I would be held to that standard!” fumed Bea.

As our conversation evolved I realized that, in many ways, Bea was a woman uniquely and curiously poised to see the breast implant issue from many different vantage points. She was only eight when her own mother got implants, and she explained that cosmetic surgery was a normal practice within her family. “My mom looked like a Barbie doll,” Bea commented, rolling her eyes. “My aunt has implants too, and my grandmother had three face-lifts in her life-time.” However, when Bea went to college she immersed herself in a feminist world where acquiescing to cultural standards of beauty was frowned upon. Then she visited other parts of the world where being small-breasted was the norm. Bea traveled throughout Asia—visiting Hong Kong, Thailand, Malaysia, Indonesia, and China before settling in Korea to teach for a year. “No one had breasts there,” she laughed, explaining that large-chested women were mortified if anyone accidentally ran into what she describes as, “these embarrassing appendages that stood out so far from their bodies.” Upon her return to the United States, Bea settled down in Tampa, Florida, where large breasts or implants seemed to be the norm.

I was intrigued by the fragmented experiences Bea touched upon. “Given your feminist training, it’s not too surprising that you oppose cosmetic surgery, but why do you think your family is so entrenched in these practices?”

“It all started with my grandmother,” began Bea. “She grew up in Detroit and was a beautiful, tall, blonde bombshell. She modeled and was never more than 130

pounds in her life. She was always poised and just a classy, classy woman. She met my grandfather when she was fourteen. He was four years older, so she lied about her age so he would go out with her. It was the late 1930's. My grandfather was working on the floor at the Ford Motor Company and the United States was just coming out of the Depression. He was smart and really good at engineering, so he kept getting promoted. When World War II broke out they made him stay home to design things at the plant because he was more valuable that way. Eventually, he became the director of the European division of Ford, and he got to be really, really high up in that organization. He and my grandmother were very, very, very wealthy. They hung out with very glamorous, wealthy people, like the guy who invented plastic. It was a Hollywood culture and face lifts were just a part of that.”

As I listened to Bea speak reverently about her grandmother, she seemed to condone the face-lifts by saying that it was a common thing to do within her grandmother's peer group and that they had so much money that it wasn't a major expenditure—therefore it wasn't a big deal. Wondering where the ranting feminist I had been talking to a minute ago was, I wondered why Bea seemed so much harsher in her judgment of her mother than in her assessment of her grandmother. As soon as I asked Bea about her mother it became apparent that Bea differentiated sharply between the practice of getting a face-lift and having augmentation.

“My mother and I are very different,” began Bea. “My mom is just more concerned about all that superficial stuff than I have ever been. It's strange. She didn't really teach me to be overly concerned about my appearance. She took me someplace to learn the basics like how to put on make-up, but that was it. I also really didn't read

fashion magazines, and didn't get wrapped up in the cultural obsession with image. I'll give you a great example of how my mother and I differ. On Friday she was helping me pack all day long. She was wearing sandals and a cute little matching shorts and top outfit, and I had on a crappy t-shirt, some ripped shorts, and no bra. I looked bad, but I had to get something for my brother for his birthday. I wanted to go to Nicholson House—which is in a trendy part of town called Hyde Park. All the people down there were dressed up, but I didn't care. I was fine with it. I noticed that I didn't look like other people when I was walking around, but I figured, 'I am buying something, and I am leaving. What's the big deal?' Well, my mother had a cow! She said, 'I don't even go to the grocery store without my make-up completely done!' She was mortified! We were walking around in Hyde Park and she wouldn't look people in the eye. She was just avoiding people altogether because she was embarrassed to be seen with me."

"Did you ever ask her why she got the augmentation?" I interrupted.

"My mom said she did it for herself—after the divorce—so she would feel better about herself. I think that it's disgusting that women in our culture have such low self-esteem that they would succumb to that. We need to teach people better. I feel like I need to wear a billboard saying, 'Look! I'm turning down fake breasts, not because I can't afford them, but because it's a conscious choice.' And it's significant that I feel like it is a choice. Some people might say that since I'm NOT getting surgery I haven't actually made a choice. But I think that because I feel like I would be such a great candidate for augmentation it IS a choice I had to make. Will I do it, or won't I?"

"And?" I prompted.

"I won't!" resolved Bea.

Izzy

When Izzy was twelve she remembers sneaking into her older sister's room and taking her padded bra. "She was a few years older than me," Izzy recalled, "and she had a very nice shape, very well-rounded, very curvy." Izzy pulled on a tight sweater, before covering up her pretend cleavage with a baggy shirt so no one in her family would notice. As soon as she was around other boys and girls her age, she tossed aside her baggy shirt and enjoyed the admiring glances she received. She felt so grown up and she assumed she was just practicing for a role that she would soon fulfill—the role of a young adult with developing breasts. However, she never developed. "I've got a younger sister who's got a really nice shape too," sighed Izzy as she told me she *did* have the distinction of being the tallest of the girls. But, she would have traded her extra inches for some real cleavage.

"Whenever I do find a bra that fits, it's always some flimsy little thing with these skinny straps and they are always white; there's never any choice of colors," Izzy complained.

"What size are you?" I asked, acutely aware that I had been comparing our chests since the moment she had walked in the door. It looked like I was bigger than her, but I wanted to confirm my suspicions.

"I wear AA." Izzy replied before adding, "I used to always think AA was bigger than an A, but then I found out it was 'almost an A.' THAT was disappointing to know."

I nodded in empathy. I had worn AA bras for a long time and I remembered hating the little blue flowers they all seemed to have attached to the front, and feeling embarrassed to walk into the adolescent section of the department store to buy them.

“I tried to order a bra on-line once,” Izzy continued. “I followed all the directions for measuring myself and when I put in my numbers it came back with an error message! The measurements were too small! My cup size didn’t exist. Not too long after that I met a lady that just got her breasts done and it was funny. I was at TJ Maxx. I was in the bra section and this woman said, ‘I never realized how hard it was to find a bra that’s not an under-wire.’ And I shot back a comment, ‘Oh yeah? Well it’s kind of hard to find any kind of bra in my size.’ And she said, ‘Oh, I used to be like that.’ And she pointed out her boobs to me. She said, ‘I just got mine done. That’s why I can’t wear under-wire right now.’ And they actually looked pretty good. They didn’t look real huge. She started talking to me about it and she said, ‘I will never go there again,’ and she pointed disdainfully at the section with the A and smaller cup bras as though it were a bad section of town she did not want to return to. She said, ‘I wish I had done this ten years ago. It’s worth so much more than any kind of therapy.’ She was probably in her late 40’s, maybe her early 50’s. I was happy for her, but then she started hounding me because I told her I had gone to the doctor and I was thinking about it, but my family was really against it. My family’s just appalled that I would even consider doing that. Then that lady said, ‘Well, my *family* doesn’t make my decisions for me. *I* make my own decision.’ So I said, ‘Yeah? Well, I also don’t have the money to do it.’ But that lady kept hounding me all around the store. She was chasing me down saying, ‘Why don’t you do it? Why don’t you do it?’ It got to the point where I almost told her to just get lost.”

I was stunned that someone could be so pushy and rude, but I immediately thought about Autumn’s strong personal recommendation that I get implants if I felt self-conscious about my chest. I also had another close friend who had just gotten implants.

She was so thrilled about her new chest that she actually told me she would help me to pay for it if I decided to get augmented.

“Isn’t it incredible how passionate some women with implants get about trying to convince flat-chested women to follow their lead?” I asked. “It’s like they’ve had some sort of religious conversion and feel the need to give testimonials. They don’t want to see flat-chested women suffering needlessly like they used to suffer, so they try to convince them to join the club and get implants too.”

“Augmented women, and women with big breasts show them off more often too,” added Izzy. “I’d like to find out if there are very many flat-chested women that are willing to rip their clothes off when they’re with a group of people. I remember when I was in Italy we went down to Sicily and everybody just went wild. They tore their shirts off and ran into the water and I held back. I didn’t do that. I’m much more self-conscious. I’m not as likely to let people see my body.”

“I know what you mean,” I commiserated. “The all female camping group I belong to went skinny-dipping one night several summers ago. We were camping that weekend and there was a lovely, alligator-free beach within a short hike of our main camp. When we got there everyone threw off their clothes and went for a swim. There are some really beautiful women in this group—one of them is actually a model—and I was definitely the most flat chested in the group. But I could tell it was going to create a bigger scene if I didn’t join everyone else, so I did it. But believe me, I could not get into that water fast enough! I’m good friends with those women, but I just knew they would be looking and judging.”

“Women can’t help but compare themselves to one another,” agreed Izzy. When I was 35, I decided to take some belly dancing lessons for the first time. I thought it would be really good for me because I thought it would help me to accept my body image,” Izzy explained. Instead she soon discovered that it would stir up even more turmoil. Most of the dancers were large breasted and all of the costumes came with a C or D cup bra. “There are not a whole lot of skinny dancers,” noted Izzy. When she expressed her frustration, her teachers told her that she just had to accept it and pad the bras. She had to pad the bras so much that they were “totally flat inside,” but they made her look like she was big. She felt like a faker, but enjoyed dancing, so she learned to live with it.

“But there was this one move called a torso lift that I could never do,” admitted Izzy. “I didn’t have any breasts to heft up in the air, but this one teacher always used to yell at me. She said, ‘I had a student that was flatter than you and she could do it.’ It used to embarrass me, but she didn’t just leave it at that. This teacher went on to describe just how flat this girl was and said that her nipples looked like cigarette butts. I found that very degrading and demeaning and I never did bond with that teacher. She was also always bragging about her size D boobs and how they kept getting bigger and bigger. She would routinely point out where her bra ended and highlight how her boobs spilled over the edges. I really don’t get much out of those kinds of conversations.”

“Yeah, good for her,” I agreed sarcastically—envisioning some really fat, overbearing woman and deciding that I definitely would not like her.

“It’s frustrating,” said Izzy, sounding more sad than angry. “In some ways I’m still that same twelve year old little girl wearing a costume that makes my boobs look

bigger and pretending to be something I am not. Sometimes I just wish that augmentation surgery didn't exist so that there would be more flat-chested women. Then I could be just another body type—not a woman who is missing something.”

My eye interviewees were all strangers to me, but in many ways our conversations were more intimate than those with some of the breast interviewees I had known for years. Talking about my eyes had always been taboo and I had never spoken to anyone who had strabismus. Although we didn't know each other initially, my eye interviewees and I ended up discussing experiences and feeling that went back as far as we could remember. We quickly developed an intimacy born of empathy.

Lynn

Lynn was the definitive mother figure.

Frequently, when newcomers joined the LazyEye e-list their first tentative pleas for help, information, and reassurance were met with long, encouraging e-mails from Lynn. She never seemed to mind telling her own story over and over again, or discussing topics such as how she had gotten her insurance company to cover vision therapy for her sons by launching a successful letter-writing campaign. When I first wrote to ask if she would consider allowing me to interview her over the phone, she accepted my invitation in the same spirit of cheerful generosity that I had seen her exhibit towards others on the list serve. I could tell she really wanted to make a contribution and to help overcome some of the negative social stigma associated with strabismus. As I talked to her more, I could understand why she was so dedicated to this mission.

“I had a crossed eye from birth,” Lynn began. “I had thick glasses and for a while they tried patching my good eye—my left eye—to see if they could get the right eye to be stronger. I was seven when I had my first surgery. That one was not ‘cosmetic.’ Insurance paid for it and it was supposed to make my eyes work together and make them straight.”

“What happened?” I asked.

“Well it DIDN’T make my eyes straight, and it gave me really bad double vision.”

“Why didn’t the doctors suggest surgery when you were younger?” I asked, thinking about how my own parents were encouraged to get me a surgery when I was just six months old. “I thought that they say that up until nine months of age is the ideal time to try to straighten the eyes?”

“I hear even that age designation is controversial, and now that I have a son with this problem I would hesitate doing it at a young age. I would rather wait until the child is older because my son’s farsightedness has progressively gotten much worse since he was first diagnosed. I’ve heard stories where the child’s eyes completely change, and the surgery is actually working against them then.”

“It’s so hard to know what is the right thing to do,” I commented. I couldn’t help but think about how angry I used to be that my own parents hadn’t gotten surgery for me. Now I was beginning to see that their decision might have been far more complicated than I had ever imagined.

“What happened then?” I asked.

“Sob story,” Lynn said in a light-hearted tone that belied her words. “My mom was a single mom with my brother and me, and she was very poor. After that first operation, the care for me was pretty much put on hold. I mean, I wasn’t neglected, but my eyes were no longer allowed to be an issue. So I had a lot of double vision and problems in sports, and I got picked on a lot. Then, when I was a freshman in high school my mom remarried and I had another surgery. This operation was purely 100% cosmetic and insurance wouldn’t pay for it. But my eye was still obviously crossed right into my nose even with glasses on. So I said, ‘Come on! I don’t want to be a geek my whole life!’”

“Right, and then there are boys...” I added quickly.

“Totally!! It’s not a time when you need to have your eye crossing. So the second surgery was instigated by myself and my parents were very supportive, so we did it.”

“What was it like?”

“I will never forget that when I woke up from the surgery my right eye was pointing out. It was completely pointing out! I was shocked, and so sad, and I could tell that the surgeon was freaked out.”

I gasped—imagining what it must have been like to wake up filled with such high expectations and to find that your eyes were even worse than before.

“It was horrible,” agreed Lynn. “It was so bad. For some reason I’d rather have an eye go in than out. I don’t know why. Luckily, with this surgery they used what is called adjustable sutures, so he went back in. They knocked me out a little bit, so I

wouldn't feel them messing with my eye, but I remained conscious. Then they just adjusted the sutures."

"And?" I demanded. "Are your eyes straight now?"

"My eye looks straight. If you looked at me, you would not know I had a crossed eye. But when I take my son in to have him looked at by an ophthalmologist, they look at me and say, 'Oh, your eye's not straight either.' So a trained professional can definitely tell my eye is not straight."

"Did your right eye get better?" I inquired.

"No, my brain shut off my right eye almost entirely to prevent me from having double vision. My vision in that eye is 20/400, which makes it legally blind. So I tend to tell people about it because it's not something that they can necessarily see. I even told my husband about it on our first date."

"How did you meet him?" I asked, hungry for some details about how someone with vision problems similar to mine had formed a successful relationship.

"My best friend set us up," laughed Lynn. "I was so shy in high school that I never dated."

"Me neither," I admitted.

"My glasses were really ugly, and really thick, and I just never could bring myself to date. Then, I graduated from high school and got a job in town. One day my best girlfriend from high school calls me up out of the blue and tells me she's married. I was stunned, and then totally depressed. I was eighteen and I was just like, 'Oh my gosh. What am I going to do with my life?' College was just not considered an option in my

family, and my best girlfriend then said, ‘Oh, you’ve got to meet this guy.’ I went on a blind date with him and ended up marrying my first date!”

“Wow!” I was surprised, yet slightly envious. I couldn’t quite imagine not ever knowing what it was like to date more than one person, but on the other hand I was pretty tired of the dating game.

“I got married at nineteen and we’re going to have our 14th anniversary in a couple of weeks.” I could hear the smile in her voice.

“Lucky you!” Now I was definitely jealous.

“I know. You’re telling me. I did not want to date anymore. I was nervous enough on my first date.”

“Did he notice your eyes?” I asked, curious about how someone with a hide-able stigma might reveal her secret.

“We actually discussed it on our first date. I’m not very much of an outdoors person, but on our first date we went hiking on Mt. Rainier. I don’t have depth perception and I’m not that sure-footed, so I told him all about it. I also don’t drive at night, so I drove there, but I made him drive us home.”

“I guess he didn’t care about that.” I was smiling now, relieved that this story was going to have a happy ending.

“He was wonderful and supportive. I was the one who cared about it when we started to plan our family. When I was pregnant, I was so scared that I would pass my eyes on to my children. And as luck would have, I did. I have three wonderful boys and they all have varying degrees of crossing. Jake is eight, Buddy is six, and Ben is five. Only the youngest has eyes that are still crossed with his glasses on. The other two are

correctable with glasses. First, I took Ben to an Ophthalmologist and he recommended surgery. But I wanted a second opinion because I wanted somebody to tell me that my son didn't need surgery. Now I take Ben to a vision therapist and I believe it makes a big difference. His vision therapist thinks that having surgery makes it much, much harder to achieve results using her techniques. Ben does eye exercises at home and she checks him regularly and teaches him new ones. He has made so many improvements since he started seeing her. In the beginning he had no 3-D vision whatsoever. Now he does. He does a lot of work with 3-D glasses right now. We found a website on the net that has 3-D pictures on it and Ben can see them all now. I have to double check by asking my oldest son what the pictures look like, since I can't see them. But Ben really can see them now."

"That's wonderful," I reassured her, amazed that she had found a non-surgical plan of treatment for strabismus that seemed viable.

"I'm so grateful that there's an option now. I wasn't given one and now if anything ever happens to my good eye I'll be blind. I don't want that for my sons. I want them to have advantages and options that I didn't. I know that a lot of mothers on the LazyEye list serve think that surgery is the way to go, but I'll continue to respectfully disagree as long as I have hope that my sons can make gains through vision therapy. I'm really grateful that people like you are being more vocal about strabismus now. I think strabismus has lost a lot of the taint it had when I was growing up. Back then it was very hush, hush. Now, more people are aware of a wide variety of eye problems and they are more accepting."

I hoped that she was right, and that things truly were looking up for those of us with strabismus. But deep inside I doubted it. Still, I was glad for the shift in perspective she had provided for me. As I listened to her talk about her own problems, and then about her sons', I found myself siding with her and thinking that surgery should only be used as a last-ditch effort. Maybe it really could do more harm than good. Suddenly, I realized that I had slipped from the perspective of a child who grew up with strabismus, to the point-of-view of a parent having to make an agonizing decision. Choosing whether or not to operate on a child with strabismus didn't sound as simple as I used to think it was. It seemed that even someone who had direct experience with strabismus herself just didn't have all the answers.

Hailey

Hailey and I were chatting like old friends within minutes. We connected in a way that Lynn and I had not. Lynn was older, she no longer had visibly crossed eyes, and she was married with children. When I talked to Lynn I longed for advice, a different perspective, and confirmation that it was okay not to have sought surgical intervention. When I talked to Hailey, I quickly recognized that she was very much like me. She had alternating esotropia and she was young and single. With her, I sought to commiserate with someone who really understood, to discuss coping strategies, and to find out more about her failed surgery. We both knew what it felt like to have crossed eyes, and I enjoyed talking to someone who could relate when I said things like, "Don't you hate it when you are looking at a guy, and talking to him, and he looks over his shoulder to see who you are talking to?"

"Right, right! That always happens," Hailey immediately responded.

We bonded by sharing little moments like that. Still we discovered both similarities and surprising differences in our responses to the experience of strabismus.

“So when did it happen to you?” I asked, after explaining that my eyes crossed when I was six months old.

“I wasn’t born with it, and it didn’t just materialize one day like you describe. I fell and hit my head, and that is when my eye crossed. I was probably two or three years old. After that, they took me to the doctor, and I had surgery right away. That didn’t fix it, and my Mom and I moved to Mexico for five years. We had a lot of relatives there. I was in Mexico from first grade to fifth grade. We had no insurance, so my mother never took me to the doctor, and I didn’t get treated. When I got older and I started to develop an interest in boys, I got very self-conscious and I wanted to find out if my eyes could be fixed. I went to a couple doctors and they were very negative. They said that it had to be done when you are little if you want it to improve your vision. So it came down to cosmetic surgery.”

“That’s what I was always told when I went to visit surgeons for consults,” I confirmed.

Hailey finally decided she was ready to have surgery, so she took off some time from work and had the straightening operation.

“What was it like?” I asked eagerly—uncertain whether I wanted to hear that it was horrible, so I could reassure myself that I had done the right thing by never pursuing surgery, or whether I wanted to hear it was easy, so I could work up the nerve to try it myself.

“It was fine. It was going extremely well for a while. It’s not really painful. After they do the surgery you feel tender. You can actually feel your eyeball. They do something with your muscle, and it sounds weird, but you are very aware of your eyeball and its movements.”

“Does it feel like a strained muscle?” I asked, attempting to clarify the sensation.

“Exactly. And you are bloodshot—it’s full of blood in there for a few days. Then you are fine,” she explained.

“Could you function and see okay right after the surgery?” I asked skeptically, slightly freaked out by the thought of an eye full of blood.

“Yes,” confirmed Hailey. She went on to tell me that gradually, over the course of the next three years, her eye began to cross again. She never returned for any sort of follow-up care and she wonders if this explained why the surgery didn’t hold longer. “I think I was supposed to have used my contact lenses, but I didn’t,” she admitted mournfully.

“Is the crossing worse when you are tired?” I wondered. “Mine always look more crossed when I’m exhausted.”

“Yes it is,” confirmed Hailey. “But what really stinks is that I’ve learned that my eyes can’t really take too many hours because I get bad headaches. This is bad because I like computers, and that is what I chose for my major. Now I’m thinking that I have to find a computer job that will only require me to work eight hours at a time because I can’t take more than that. I am concentrating with only one eye at a time, so it’s just harder on my body. It’s funny. My headaches hurt more on the side where my surgery was done

than on the other side of my brain. But maybe it will get better when I get my next surgery.”

“Aren’t you afraid since the first one didn’t hold that this one might not either?” I asked, voicing one of my biggest fears.

“It will probably take a couple of surgeries,” she said in a matter-of-fact tone. “My doctor was a good surgeon,” Hailey insisted, “and I want to try to look for her again to do a follow-up surgery. I hope she is still at the same clinic.”

“Why do you want to do it now?” I asked, wondering if there had been a trigger for her renewed interest in surgery.

“I guess I want to get the surgery again just for me,” Hailey commented. “Sometimes I think about the future and about giving professional presentations. You have to make eye contact with people. It’s important to ME that I make eye contact with people. Having crossed eyes is a setback in a lot of ways. My self-esteem is low. I evaluate myself negatively because of my eyes. And I notice that it’s harder for me to get OUT of a relationship with a guy—even if I know he’s not right for me.”

I nodded in agreement with her. I had the same tendency. “It’s hard to find someone who...”

“...you are as *comfortable* with.” Hailey finished my sentence for me—using the same word I was about to utter.

“You have to start all over with the explanations. And then there’s the nervousness about whether or not he noticed and thinks your eyes are weird. You have to decide whether or not to mention it, and if you do bring it up, or if he brings it up, you have to figure out what to say about your eyes. It’s hard to explain to someone what it’s

like to only see out of one eye at a time, and to be able to consciously choose which eye to use. You know?” I was overwhelmed just thinking about it.

“Uh huh. I know exactly what you mean,” confirmed Hailey.

“Sometimes it’s just so much easier and less scary to stay with someone who is already broken in and doesn’t seem to care about crossed eyes,” I laughed.

Hailey went on to tell me a story about her current boyfriend that left me puzzled about the inconsistency in the ways in which “normals” often interact with people who struggle with minor bodily stigma.

“Shortly after my eye surgery I met my current boyfriend, Steve, at work,” Hailey began. “Sometimes he can be a jerk about things. There is this computer programmer at my company who has pretty severe strabismus. It is totally noticeable. One day I walked in on Steve and another guy and they were making fun of the computer programmer behind his back. They were picking on his eyes!”

“How did that make you feel?” I asked, instantly angry at Steve’s insensitivity.

“I got so upset I had to walk out of the room. I never talked to him directly about that incident, but when we started dating I told him I had just had surgery. He asked, ‘what for?’ and I told him, ‘I had surgery to correct strabismus.’ He didn’t say anything so I pushed him further and asked, ‘do you know what strabismus is?’ He said he did—but maybe he was lying. I just don’t know. We never talked about it again. It drove me kind of crazy because I kept thinking about him making fun of that guy and wondering if he really knew about me.”

“I doubt he knew what the word meant,” I speculated. “That’s one of the reasons I wanted to write about strabismus. I think that some people make fun of crossed eyes

because they have no idea what it is and they cover their discomfort by going on the attack.”

“Their lack of knowledge makes it hard to talk about,” agreed Hailey. “That’s why I’m sure that I want to have another surgery,” she said, restating her commitment to finding the time and money to undergo surgery. “You don’t sound so sure,” she said, turning the conversation back toward me.

I felt a little embarrassed when she said this. The truth of the matter was that I wasn’t sure about anything, but I didn’t want her to feel like I was negative about surgery, because I didn’t want her to feel invalidated. I quickly told her I was still in school and not in a financial position to consider it right now. I didn’t want to tell her that I was terrified at the thought of having to have an unending series of surgeries, or the thought that something could go wrong and I might lose my vision. Strabismus was a hard thing to talk about, even when I was talking to someone who understood what I was going through.

Lori

My last eye interviewee didn’t want to “talk” about strabismus at all. Lori and I have an e-mail relationship, which began rather tentatively after I asked her if she would allow me to interview her for my dissertation research. She was twenty years old at the time and very wary of connections made over the Internet.

“I’d like to answer any question you would like to ask me,” she wrote, “but I’m quite the wimp when it comes to talking on the phone with, or meeting people off the internet.”

We finally decided to do an e-mail interview. I wrote a letter telling some of my story and stating my questions, and our interaction began. I eagerly awaited her reply, wondering what she might “say” in a self-directed, interruption-free e-interview. When I read her story it resonated deeply with me.

“My strabismus sounds exactly like yours,” wrote Lori. “When I use my right eye, my left one turns in. When I use my left eye, my right one turns in. I think I would have lost function in one of my eyes if I hadn’t noticed when I was little that I was only using one eye most of the time. So, I switched to my other eye. This was hard because my vision was so blurry. But the longer I used my eye the stronger it got. After that, I switched back and forth, between my eyes.”

I paused for a moment in surprise. I did the same thing, and I had never heard anyone talk about it before. I consciously switched back and forth between using my right eye and my left eye because I could remember a long time ago an eye doctor made a gloomy prediction that my dominant eye would take over and the other eye would “go to sleep.” The thought was so terrifying that even though it was more comfortable to use only my stronger eye, I began alternating eyes to make sure that they both remained strong and viable.

“I was on the Internet a few days ago checking out some eye sites again, and the ones I found were actually quite encouraging,” continued Lori. “One of the web pages stated that if the eyes are aligned through surgery, you might have double vision for a week, but your brain would adapt. I hope that’s true. I’m so frustrated with my eyes. Some days I just want to pluck one of my eyes out. Do you get headaches?” asked Lori.

I wrote back to tell her that I rarely got headaches.

“I get them all the time,” continued Lori, “but they go away if I shut one of my eyes. It’s like my brain just never gets used to looking in two directions at one time. I’ve been thinking about using my tax refund for surgery to fix my eyes. I’m kind of nervous I’ll hear bad news when I go to the doctor. My sister had it done, and it made her eyes a LOT better. Now her crossing is hardly noticeable at all. The surgeons couldn’t fix her eyes all the way because (1) she had surgery about 12 years ago, and they didn’t seem to know much then, and (2) she had probably the worst case of strabismus you’ll see. She was literally looking at her nose all the time. So my parents got her surgery when she was young.”

I had a sister too, and I had always felt sorry for myself because her eyes were straight. I wondered why I was so unlucky. But in comparison, Lori’s plight seemed far worse. It would be hard to live with the knowledge that your sister had gotten a surgery and you hadn’t, and at the same time to feel like you couldn’t begrudge your sister her surgery because her eyes had been much worse than your own.

“Boy was I ever teased when I was growing up!” exclaimed Lori, switching topics abruptly. “All through elementary school it was horrible. All the boys picked on me. Some even got hateful and violent. And it was weird because these were kids I used to be friends with. When my school merged with a nearby town in Jr. High, I don’t think the kids from the other school even knew my name. They’d just say, ‘hey, cross-eyed! Come here.’ They’d get my attention, and when I’d look at them, they’d laugh. Cross-eyed was my name in 6th and 7th grade. People notice that I don’t look them in the eyes very much when I talk to them, and I think that makes them want to talk to me less. But

it's a force of habit. When you spend your entire school career looking down or away, it sticks with you.”

I could definitely relate. I actually cringed when I read that Lori had also been called Cross-eyed and laughed at like I had.

“I want to fix it so badly,” insisted Lori. “I’m just scared of how it could turn out. I’ll give you my most recent example of why I want to get my eyes fixed. The summer before 8th grade, I moved to a new town. (Hardly anyone picked on me there; it was weird.) In the 8th and 9th grade, I had a huge crush on a senior—Derrick. He didn’t even notice I existed because I was just a little freshman. But I really liked him. He was so funny, and I noticed all the girls he went out with treated him like crap, and I always thought it was so sad. I used to think, man, if I could ever go out with him, I’d truly appreciate him. Then he graduated and went into the Marines, and I hadn’t seen him in forever. Well, about 3 months ago, I was on the internet and someone instant-messaged me, saying they noticed I was from Belle Plaine, and saying they grew up there. After chatting for a while, I realized it was him. (It’s a small world after all.) He was living in North Carolina.

He thought I was funny, and we e-mailed each other back and forth for about a month. Then he said he was coming to Minnesota in February, and he’d come visit me. That scared me half to death. I didn’t want to see him. But I played along (not thinking he’d actually come) and said ‘well, why don’t you come at the beginning of March for my birthday.’ He did. The first time we met, we were both drunk, and we laughed and talked and danced and danced. We hung out at his house the next two days, talking and

watching movies. (I like sitting side by side and talking with someone because then you don't really have to look at them.)

Anyways, we really hit it off. It was like my dream come true. He was saying he was going to come back to visit his parents and see me more often. Then I hugged him goodbye and he looked at me for a long time and said, 'I didn't know you were cross-eyed.' OUCH! I cried the whole way home. You'd think I'd be used to it by now. But I'm not. People tell me I'm pretty, but I could definitely do without the eye thing."

I was crushed that this story didn't have a happy ending, and my heart went out to her. It was all too easy to imagine something like that happening to me. I quickly began to type a response conveying my utter dismay over how things had turned out and letting her know that I knew EXACTLY how she felt.

Initially our letters were punctuated with smiley faces and frowns to ensure that the tone of our message was not misread. But as time went on, we dispensed with most of these "marginal additions," and we began swapping pictures. We discovered a kind of deep intimacy unfettered by moments of embarrassment or long awkward pauses. Somehow writing rather than talking granted us a license to express our vulnerability and provided a kind of exorcism I had not experienced this fully in any of my other interviews. It was like writing in a journal and having the journal provide loving, supportive, empathic responses.

Four Major Complaints

My interviewees all dealt with their minor bodily stigmas differently, but many of the emergent themes they spoke of were the same. Each of them learned, through a combination of interaction with others and the absorption of cultural messages, that something was wrong with their appearance. Although these “picayune differences” (Goffman, 1963) did not prevent these women from leading productive, normal lives, they each spoke passionately about the significant impact of minor bodily stigma on their lives. As they described why these physical differences caused them such strife, four major complaints emerged. Minor bodily stigma impacted their childhoods, their romantic relationships, their everyday activities in general, and their careers.

Childhoods

Five of my seven interviewees noted that their minor bodily stigma had a significant impact upon their childhood. Of my breast interviewees, only Bea reported having a relatively normal childhood. She told me she didn’t let her chest size bother her too much while she was in high school. She rationalized that it was better to be flat since she was a dancer, and many of the other dancers were also flat and lean. Bea admitted that she used to joke around about her chest size to ease some of the discomfort she felt, but she also assumed that she might get larger breasts later. Her body kept growing and changing in so many other ways that she assumed her breasts might catch onto this trend too. For a long time she was more concerned about having fashionable clothing than she was about breast size. She described her style as “boyish” and notes she was happy in her trendy J Crew outfits, but this bliss didn’t last forever. Bea told me, “One day I remember looking at my body and going, ‘Oh my god! This is my body for the rest of

my life. It's not going to change any more.' And I think that that's when I started to get self-conscious. I realized, 'Okay, this is it,' and I thought, 'Ugh! Still no breasts.'”

My other three breast interviewees first recognized their stigma when they hit puberty. The story sounded very familiar to me. As the girls began developing, the boys began to take an interest in them, and my interviewees began to be teased about their flat chests. Autumn told herself she was lucky that she wasn't overly developed, because big breasts would get in the way of her athletics and interfere with her identity as a tomboy. However, these justifications didn't completely ease the sting of being left out and left behind during this phase of development. Autumn admits to feeling like she was left in limbo when the other girls developed. “I didn't fit in either place. I didn't develop, so I wasn't on the girl's side. But the boys didn't want to hang out with me because I wasn't a boy.” Instead, she became a loner.

Holly didn't experience any social isolation because of her chest-size, but she was very self-conscious about the large nipples that she developed around the age of ten. She remembers the moment she first realized that girls at school were talking about her nipples behind her back. One of Holly's friends told her that a mutual friend had been making wisecracks about her long nipples. She was completely mortified. Holly grew acutely embarrassed about her chest after that and did not want to change in front of anyone else for gym class, because she did not want anyone to see her naked. She was so self-conscious she actually got up the nerve to ask her very “prudish” mother if she could order some bras to help hide her source of embarrassment. Izzy reports that the amount of teasing she received depended on which school she was attending. When she was thirteen, her family moved to a small town out in the country where she immediately

stood out as different. “It’s a terrible thing to say,” Izzy apologized, “but the girls there were all fat, and they hated me because I was skinny.” Not only were the girls mean to her, but she was also picked on mercilessly by the boys who called her Flatsy. “Back then there was this ad for this doll called Flatsy,” she explained. The logo was, “Flatsy, Flatsy. She’s flat and that’s that.” Izzy also confided that the boys would say that she must not have started her period yet because she was so flat, but she assured me that this was not the case. Luckily for her, it wasn’t too long before her family moved close to a city again. As soon as she got back into the suburbs, things got better and she felt more normal. Izzy still recalled feeling “a sense of low self esteem because of it from time to time,” but it paled in comparison to her previous bad experiences.

I spent my entire childhood in the country, and I picked up an equally embarrassing nickname—Plateau. We learned that word in geography class one day, and by lunchtime the boys had drawn a comparison between this large, flat rock formation and my level chest. I got called Plateau for months after that. But the teasing about my breast size didn’t sting nearly as much as the taunts concerning my eyes. I would rather get called Plateau than Cross-eyed any day. There were other flat-chested girls who were also being mocked, but I was the only one at my school with crossed eyes. While I had to wait until the onset of puberty to get teased about my breast size at school, the taunts regarding my eyes started immediately.

I talked with all of my eye interviewees in great detail about the type and frequency of teasing about our eyes that each of us received. Hailey said that she was in Mexico for much of her childhood and she didn’t suffer too much teasing. She

remembers that some of the boys “might have said something,” but it “wasn’t that big a deal.” For both Lynn and Lori, however, school was a nightmare.

Lynn’s coke-bottom thick glasses magnified her eyes and drew even more attention to her strabismus. She said the children would come up to her on the schoolyard and chant, “take your glasses off. Take your glasses off.” When she complied, the children would try her glasses on and exclaim about how bad her eyesight must be. She literally had trouble not bumping into people when she was just walking around. By the time she was thirteen she reports being desperate to look and be normal. This childhood teasing had such a deep impact upon her that she goes to great lengths to make sure that her two boys have the thinnest glasses possible and that they have the best eye care available. Watching them suffer as she had would be the worst torture she could imagine.

Lori outlined a story that sounded all too familiar to me. She was constantly picked on, called Cross-eyed, and laughed at by the other children at school. She became shy and withdrawn and to this day avoids eye contact whenever possible. For a long time, Lori was unable to shake the shameful sense of stigmatization she learned on the schoolyard. As she grew-up, her lack of confidence began to permeate other areas of her life, such as the romantic realm.

Romantic Realm

Because others may notice minor bodily stigmas, and because sexual attraction is such a visually driven phenomenon, it was not surprising to hear that all but two of the women talked about the impact that their physical imperfections had upon their ability to attract and keep a mate. Both Lori and Hailey shared my own impression that of all the

different arenas in our lives, romance was most negatively impacted by the experience of strabismus. Because Lynn has cosmetically straightened eyes, she seemed much more consumed with the impact of strabismus on her children, yet even she agreed that before she got married this was a concern that she too shared. All of my eye interviewees concurred that conversations about romance inevitably involved conversations about whether or not to talk about strabismus.

In this culture, breasts tend to play a crucial role in the attraction process for many people. Often conspicuously displayed when women go out to meet men, or on dates, it is hard to completely deny the lure of breasts. All of my breast interviewees, except for Autumn, acknowledged that how you feel about your breasts plays an important role in the inextricably linked experiences of romance and sexuality.

Lori would have argued that how you feel and how others react to your eyes had an even more profound effect. Her experience with Derrick, the former classmate she reconnected with over e-mail was devastating emotionally. She had spent so much time and effort luring him with her personality and wit, and it was all destroyed when he noticed her eyes. This left her to conclude that she had little or no chance of finding a guy who would overlook her stigma. It was an illogical, but almost irresistible conclusion, and one that I had drawn myself more times than I care to admit. Lori had other equally discouraging stories of routine insensitivity and romantic rejection that also re-enforced this depressing notion. Men at bars would hit on her, and then suggest that she was anti-social because she kept looking away. She also told me she suffered through a two and a half year relationship with a guy who cheated on her and treated her badly. "I stayed because I didn't want to go back into the cruel dating game," she

admitted. Recently, Lori met the man who is now her husband. When I asked her what made this romance work, she told me that her husband is six years older than her and “more mature.” Her eyes don’t seem to bother him and their relationship has flourished.

Hailey also said she found it difficult to find a guy that she was comfortable with, and once she established a relationship she hung onto it, even if it was unhealthy and she knew they were wrong for each other. She laughed and said that maybe if she had straight eyes she would be dating like crazy, but that her insecurity regarding her eyes ensured that she was a “long-term relationship kind of girl.” Six months after our first interview, Hailey and her boyfriend, Steve, terminated their relationship. Since then she has not found anyone new. She told me she tends to avoid eye contact with her boyfriends and she feels like this can impair the intimacy she is able to achieve. She elaborated, “I don’t know. Sometimes I think that because of my eyes I’m really not connecting with my boyfriend. How could you connect with someone? Of course there’s talking, but it’s so much better to be able to look them in the eye and have eye contact so you can see what all of their reactions are. I think that’s why none of my relationships have gone any farther,” she speculated. “It’s hard to get close when you are protecting yourself.” Hailey also admits that she finds it hard to talk about her vision problems with her boyfriends, and she never found the courage to speak to Steve about her eyes. She worries that it might be a while until she meets someone again, because her flirting skills are very limited. It’s hard to flirt when the object of your affections can’t be sure you are even looking at him.

However, Hailey tried to circumvent her flirting difficulties by testing on-line dating and meeting guys in chat rooms. Finally, she met a nice guy on-line. She wrote to

tell me they had been chatting for some time and seemed compatible. Then he sent her a picture of himself. He was very handsome, but the attached e-mail sent tremors of insecurity reverberating through Hailey's mind. He told her what physical type he was attracted to, and in the description he mentioned he wanted a girl with "even eyes." "What does he mean by that?" Hailey asked me. "How could he possibly know? He can't. Can he? Maybe he dated a girl with crossed eyes and he didn't like that." I didn't know what to say. It seemed like an odd criterion to mention. Hailey sent a picture to the guy, but it was a side shot of her head and you could not see both of her eyes. Their flirtation continued and they eventually met face-to-face. She was a nervous wreck going into their first date, but she soon wrote to say she didn't even think he noticed her eyes. Ironically, she quickly decided *he* was a "dud." Although she was the one doing the rejecting this time, Hailey still maintained that the hardest thing about having crossed eyes was trying to overcome her insecurities and have a healthy dating life.

Lynn never dated in high school because of her crossed eyes. Even after her straightening surgery she was still viewed by the other kids and herself as the kid with the really thick glasses who used to have crossed eyes. Although she eventually began to feel more confident about her appearance, she was now forced to cope with the fact that one of her eyes was blind. Her painful shyness was only overcome because a friend finally hooked Lynn up with a "real nice guy" who she soon took as her life-partner.

Izzy acknowledged that she talks to the guys she's dated about her breast size eventually. Sometimes I feel insecure about it," she admitted. She proceeded to tell me a story about a guy that she dated last year. She told me that she felt like she revealed a weakness when she mentioned she was unhappy about her flat chest. Her boyfriend

promptly said, “Well, get a boob job then.” Izzy sadly concluded by saying, “And that was the last time we ever talked about it; and that was the last time that he ever even acted interested in me.” They broke up soon afterward. Later she wondered aloud if her problems attracting and keeping guys were related to her breast size. She quickly posited that she didn’t want the type of shallow man that would care about something like that, but then she went back to her speculation. “I don’t have any problems attracting guys initially. But sometimes I think they’re not turned on because I don’t have boobs.” She also allowed that maybe her low self-esteem was making her imagine this. “A guy’s never really come out and said anything like that to me, Izzy began. “They never say, ‘Too bad you don’t have big boobs’ or anything like that, but sometimes I can sense that and it’s kind of weird. Or maybe that’s just something from inside of me that’s reading that into it.”

Bea acknowledged that many people, especially in Tampa, feel as though their breast size in large part determines their dating options. But she steadfastly vowed that she would not date someone who cared about something like that. If they were bothered by her breast size she declared, “I would want them out of my bed. That would piss me off. They would not be welcomed. They could not touch me anymore.”

Autumn maintained that breast size really didn’t enter into her romantic realm either because she was a lesbian, and wasn’t trying to attract a man. I questioned her about this because I had a lesbian roommate once who was very fixated on breast size, but Autumn staunchly denied that it ever impacted her relationships. Further, she said that since she was in a committed relationship, her augmentation didn’t impact her sex life one way or the other, except it put a damper on it while she was recovering from the

operation and felt very sore. She did feel better about her body afterward and that affected her overall quality of life. In fact, she told me “Before I was always very self-conscious and never wanted to be seen naked. After I was with someone for some length of time, I would be comfortable with her, but if I saw myself nude I would think, ‘Oh, my Gosh!’ I should get these nipples reduced or I should do something just because I found myself unattractive.” Although I pointed out that these comments seemed to indicate her romantic life must have improved, Autumn was still unwilling to attribute any gains in the romantic realm to her larger breast size.

Holly’s experience was just the opposite. “I never had trouble attracting men, and I was never sexually inhibited,” she began, “but having augmentation made me more confident during sex.... It really enhanced my body image,” she explained. “I felt really good about my figure afterwards,” she said enthusiastically, admitting she finally shed her self-consciousness about her breasts and nipples. But there was one instance in which her augmentation negatively impacted her romantic and sexual experience. She and her ex-husband got back together for a little while after she had her surgery and he hated the implants and refused to touch her breasts. He simply claimed, this wasn’t what he married. Ironically, Holly had used the money she got from the divorce with him to get the augmentation in the first place, and he was the only one who hated her new chest. For Holly, the real pain of stigmatization wasn’t centered in the romantic realm; it lay in the everyday experiences that served as constant reminders of her inadequacies.

Stigma In Everyday Life

Everyday experiences ranging from trying on bras to attempting to make eye contact were cited as unpleasant reminders of minor bodily stigma. My breast

interviewees complained that the simple act of shopping for clothing created a strong sense of stigmatization. Winters were the worst according to Bea. “I can’t wear a sweater very well,” Bea complained. “It looks like I have pebbles in my bra. It just looks awful.” To compensate, she sometimes turned again to heavily padded bras. However, she worried that romantic interests might feel misled when they finally discovered she was much smaller than she appeared, and she noted she could no longer feel someone touching her through her clothes because the bras were so dense. Ideally, she expressed a desire to avoid wearing bras altogether. She explained, “I don’t buy them very often. I don’t have big shoulders, so the straps always fall off. I just prefer not to wear a bra at all. In a place where other people don’t wear bras it wouldn’t be that big a deal—and I would just do that. But in Tampa, if you don’t wear a bra with a t-shirt, people notice. You can tell they are judging you, and it’s just not worth it.”

Unfortunately, Bea’s experience of stigmatization was not specific to the Tampa Bay area. Her most unusual experience of physical inadequacy came when she was in Indonesia, traveling in a very rural part on an island called Lombok. She was getting a tour of a Sasak village. That society was very primitive. They were animists and didn’t wear clothing. Bea was with a friend who spoke some Sasak and she described, “They all gathered around me and they sat me down and they gave me a cup of coffee. And I was drinking it and the Matriarch of the village said something to my friend, Bodur, and he said something and everyone laughed. So I asked him, ‘What’s so funny?’ And he said, ‘Nothing, nothing, nothing.’ Then we left. And I said, ‘What did you say back there? What did they say?’ And he says, ‘They thought you were an old man because

you are so tall and you don't have breasts and you have white (blonde) hair. When I told them you were a woman they all laughed.”

Izzy always felt most conflicted about her flat chest when she went shopping for bras. “I remember when they first came out with the Wonder Bra,” she told me. “I thought, ‘Oh. Okay. I’ll try that.’ I went to Victoria’s Secret and I could not find a bra that fit me. Yeah *those* bras are really pretty, but they were too big for me!” It really started getting me mad and I got depressed many times shopping for a bra because we flat-chested women are the ones that would like to have a decent bra just for the proportion. For one thing, a lot of clothing requires that you have a little bit of something up top so you can fit into it.” An even more pressing issue for her was that she had been an avid belly dancer for six years, and the costumes never fit her because the decorative bras started at size C or D. She told me that a boyfriend bought her a beautiful metal-mesh bra and a bikini once, and she couldn’t wear it. “The bra just kind of hung right at the nipple and it was so ugly. I couldn’t figure out how to fix it.” She tried, unsuccessfully, to sew it onto some heavily padded bras. It looked ridiculous. Both she and her boyfriend were disappointed. Her dance teachers always advised her that she just had to pad the costumes as much as possible inside. But she used to get frustrated. “Why?” she asked. “Why can’t we just wear our regular size bra and dance that way? I’ve seen some girls do it, and it’s fine. I think I’d rather see that than see some girl like me padding herself up.” She pointed out, “This is a sensual dance. We’re supposed to be accepting our body image, yet at the same time we’re padding ourselves.”

Izzy felt particularly disenchanted with the idea of padding herself because she worried about breast size inconsistency. She recalled being a young girl with one

stretchy bra and one padded bra and having a boy ask her why she was flat some days and not on others. She was mortified that her chest was being watched that closely and embarrassed to have been caught trying to create the illusion of a bigger chest on certain days. Izzy acknowledged that implants would solve this problem, however, she commented, “I don’t like the really padded bras. I feel uncomfortable in them, even though I think that they do look kind of nice. If I had fake boobs that’s how big they would look, and they might actually look that awkward too—just sticking out like that.” Izzy then added one final gripe, “When you don’t have breasts, everybody thinks you look skinny. If, all of a sudden, you were a size D or C, nobody would tell you were skinny. You know?”

While both breast interviewees who actually chose to have augmentation also remembered clothing complaints from their flat-chested days, their laments lacked the passion and vehemence of Bea and Izzy’s reports. Although Holly and Autumn recalled dissatisfaction when I pushed them to uncover their old pre-surgery feelings, it seemed the sting had eased now that clothing complaints were not a day-to-day reality. Holly listed two major sources of discontent. Because of her career aspirations, Holly’s main concern revolved around how she looked in a leotard. She disliked the way the taut, stretchy material highlighted her flat chest. Secondly, she was worried about her very tall nipples showing through her regular clothing. She wore bras initially, and later, when she and her feminist friends renounced this practice, she used band-aids to “tame” her nipples. “Even when it was kind of cool to show your nipples, mine were just too big,” she laughed in exasperation. “They got too much attention,” Holly admitted.

Autumn also worried about her tall nipples and only wore a size AA bra to flatten them out a bit. Just looking in the mirror was the biggest source of distress for Autumn. She disliked the image that stared back at her. She not only felt like a boy from the waist up, but she was often literally mistaken for a boy when she was out wearing a baseball cap and a t-shirt. As she grew older and began to embrace her femininity more enthusiastically she often grew upset because she lacked the distinctive shape of a woman. Autumn even cited a moment of “clothing envy” when she recalled the instant that she made her final decision to proceed with surgery. One night Autumn went out to dinner with her partner and their friend, Amy. “Amy and I have a very similar build,” explained Autumn. “But she had small breasts, and I of course had no breast tissue at all. Amy had on this dress that was sexy and attractive—with just a little shape. And that’s when I decided,” Autumn smiled. “That’s the moment that I went from ‘the great debate’ to ‘I’m doing it!’” Autumn’s expectations were fulfilled and now she happily reports that she too can “wear a nice little dress and just look great in it.”

One of the subtle notions embedded in these conversations about clothing is that the bras and outfits that do not fit properly serve as unspoken reminders that these women lack normal proportions. In fact, each of my interviewees used the word *proportionate*, or a variation of this word, during our interviews. Bea declared, “I feel like, okay, I would be a great candidate for breasts—big silicone breasts—because I have big hips and I’d definitely look more *proportionate* and all of that. I would look great with bigger boobs.” Izzy optimistically observed that she thinks flat chested girls can get away with wearing a wide variety of styles, before admitting, “But sometimes I feel it’s not *proportionate*. My hips aren’t really that big or anything. But it would be nice if I were

a little bit more *proportionate*.” When Holly reflected on her surgery, she concluded, “It was really just about wanting to have this nice *proportioned* figure.” Autumn even used this word when she was giving instructions to her surgeon. “I told him I wanted to look *proportionate*,” she stated, while also insisting she did not want to look “obvious.” Reporting on the results, Autumn revealed, “They are a little hard, but perfectly *proportioned*.”

This intense focus on proportion is intriguing. Proportion is defined simply as “symmetry,” and symmetry is defined as “exact correspondence of form on opposite sides of a dividing line or plane or central axis” (Etcoff, 1999, p. 16). Both of the minor bodily stigmas I am looking at may be construed as affronts to symmetry. As Etcoff (1999) points out, “One essential human standard of beauty has endured for thousands of years—beauty equals symmetry” (p. 16). This is a thought extending back at least as far as Aristotle. No wonder my interviewees were all so troubled by their inability to meet this mandate.

Symmetry was an elusive goal for my eye interviewees. Even Lynn, whose eyes looked straight to most people, reported that optometrists always noticed her condition immediately. The slight deviation was still apparent to the trained eye. Lynn also was beginning to notice that the pupil of her blind right eye was growing larger and larger over time. This new minor bodily stigma was beginning to bother her, but her motherly instincts also caused her to become increasingly aware of the emotional pain her own children might suffer because they looked different too. Lynn recounted with great sorrow a story about how she unwittingly helped to stigmatize her youngest son. While the brunt of her own stigmatization took place in school, where she was cruelly taunted,

she home-schooled her own boys, thus eliminating the possibility that her boys would encounter similar stigmatizing experiences in an unsupervised school setting. Lynn was quick to point out that her boys had lots of social interaction in 4-H, baseball, soccer, youth groups, and classes at the local home-school allotment program, but that she was always with them to witness any comments about their eyes first hand. She wanted to be there to help her children to process their emotional responses to minor bodily stigma and to decide what actions, if any, to take if they were questioned, or teased, about their eyes. She did not expect that this might mean her children would learn about stigmatization from her.

Lynn was having trouble with her youngest son, Ben. He was five, and the only one with noticeably crossed eyes that were not fully corrected with glasses. Ben was going through a phase when he was completely terrified of a neighbor lady because she was disfigured. This woman had a son who played with Lynn's boys, but when she came to the door to take her child home, Ben would run screaming and hide in his bedroom. "He wouldn't come out until the woman was gone," Lynn explained, embarrassment evident in her voice. "So I did *the talk*. I said, 'Ben, look. Look at your eyes. You have a crossed eye. Would you like someone to run and hide from you because your eye was crossed?' And ever since then I regret doing that. Because now he's really cried about his eyes and he knows his eyes are different and I've caught him several times looking in the mirror at his eyes and I feel so bad that I did that to him. I don't think he really understood before then how serious his eyes are." He was now aware that he did not meet society's standards of symmetry. Ben was now actively engaged in self-stigmatization.

Hailey wanted symmetrical eyes for very pragmatic reasons. She confided that she would like to be able to make eye contact with ease and confidence and never have to worry that the person she is looking at will think she is looking at someone else. She hates it when this happens and usually avoids eye contact so she can prevent that situation.

Finally, Lori bitterly recalled a moment when she was picked on about her asymmetrical eyes. She was hanging out with the man who is now her husband and a bunch of his friends. One of the friends was drinking and got mean. Out of nowhere the drunk man announced, “Your girlfriend is cross-eyed.” Lori remembers her heart leapt into her throat, as she got angry and felt like crying at the same time. Her boyfriend turned to look at his friend and said, “Yeah, so what?” This shut up the drunk friend, and Lori felt there was a palpable sense that everyone understood that her eyes weren’t a big deal and the drunk guy was a jerk to pick on something like that. Lori is now married and very pregnant with her first child. Her sense of stigmatization about her eyes has melted into the background in the face of more immediate concerns like coping with the physical changes she is undergoing, and dealing with her fears that her baby may inherit her eye problems. Nevertheless, she is still adamant that after the baby is born she hopes she can work up the nerve to go to an eye surgeon and discuss her options. She reasons that she may opt to have the surgery after the baby is born because she will be home from work anyway, and will have the necessary time to recover. Still, she fears one of her eyes may shut off if she does have the operation, so she remains tentative.

Lori seemed to feel that her eyes held her back in just about every realm of her life. She wrote, “I’m so frustrated with my eyes, I think I’d still try surgery if it gave me

double vision for the rest of my life. ☹️” Lori voiced a fear shared by many of my interviewees. They felt they could lead better, more productive lives if they could just be “normal.” Many of them specifically noted they envisioned having a more successful, fulfilling career if they weren’t held back by their minor bodily stigma.

Career

For the average adult, work consumes a significant portion of time and energy. Consequently, work related experiences often have a big impact on our lives. Six of my seven interviewees work outside the home, and four of these spoke of the significance of the workplace with regard to their minor bodily stigma. Bea even noted that she first became really conscious about her small breast size and developed a sense that it wasn’t okay to have such small breasts when she graduated from college and started trying to do professional things. In college, she wore loose fitting clothes and she hung out with hippies who didn’t care what size she was. When she began to try on professional clothing in preparation for interviews and a job, she realized that, “in order to look good in these clothes you have to have breasts,” she told me. The tops were always too big, and she hated the way they looked on her. Clothing manufacturers typically left room for C cup breasts in their blouses and jackets and she just couldn’t fill them. Because Bea’s hips were big and her chest was flat, she did not fit the assumed proportions. Consequently, she found herself having to wait until the salesperson wasn’t looking so that she could swap out a smaller top to go with a larger bottom.

Although she didn’t mention fitting more readily into professional clothing, Autumn reports that she feels more confident and persuasive in a business setting with her new breasts. She said that before she used to feel like there was something

“missing,” but now she feels more “sufficient.” Sounding very much like a Goffman (1963) student, she said, “You can’t say that your presentation doesn’t affect everything in your life. I mean you can say it, but that’s not true.”

Holly articulated similar ideas when she explained why she really wanted implants. She also used the word “missing” to describe her experience. She told me, “I always felt like I was missing that element.” She wanted to have bigger breasts so that she could fill out a leotard and work on completing her career dream of becoming a fitness guru. She felt she could only be an inspiration to others if she had a body more closely aligned with conventional standards of beauty. She had the rest of the Barbie doll figure and was just missing the breasts.

When Hailey went to a surgeon to ask for help with her strabismus, she outlined career aspirations of her own. She spoke of wanting to meet conventional standards of normalcy so that she could give presentations and make eye contact with people at work. She speculated this would give her a huge boost in confidence. Hailey also wished that she could sit in front of a computer for more than forty hours a week without developing terrible headaches. Recently she sent me an e-mail describing an embarrassing incident that happened at work. She told me that one morning one of her co-workers just blurted out, “You know, sometimes I look at you and you’re cross-eyed.” Hailey then told her that she is indeed cross-eyed, and the lady went on to talk at great length about glasses and other related topics in front of everyone in the office. Hailey then noticed that her boss was trying to look at her eyes and she suddenly felt very self-conscious and worried that maybe they all thought she was “weird.” To gain promotions and distinction at

work, it is necessary to stand out. Although she knew it was counter productive, Hailey sadly admitted that she spent most of her energy trying to avoid being noticed.

I could relate to the work-related complaints of all of my interviewees. Shopping for a professional wardrobe that doesn't look terrible on a flat-chested woman is difficult at best and good tailors are expensive. I sometimes find myself relying on the little boost of confidence that a heavily padded bra can provide. Being unable to make eye contact at work is even more discouraging than feeling inadequate because of your chest size.

Teaching can be especially challenging when you don't know your students' names yet and when you can't just point at someone and make eye contact so that she knows you are talking to her. Frequently, students look over their shoulder to see who I am talking to.

Minor bodily stigmas present their bearers with many challenging problems. My interviewees and I lamented the way in which our minor bodily stigmas impacted our childhoods, romantic relationships, every day activities, and careers. To really understand how flaws that seem so minor can have such a huge impact on an individual's life, it is necessary to provide a cultural context for the creation of the minor bodily stigma.

CHAPTER FOUR: CULTURAL CONTEXT

In the age of cosmetic surgery it is hard to be at peace with your body.

Sometimes it seems the best one can hope for is a temporary truce until the body once again commits an unforgivable offence, and wrinkles, sags, bulges in the wrong places, or refuses to grow in more desirable spots. We are influenced by the images and ideas our overarching North American culture hurls at us through electronic media, magazines, pageants, advertisements, and so on. We are also impacted, perhaps on a more personal level, by the cultures of all the cities or towns in which we have lived or currently reside. Structured organizations such as schools, which exist inside these “cultures within a culture,” can be the sources of very formative experiences. Universities, for example, provide young adults with access to knowledge that may profoundly impact the way they interpret, experience, and participate in culture. Advertisements may look very different when viewed through a feminist lens and when examined by someone who is studying Mass Communication and specializing in Advertising. Finally, on the most intimate level, our family and friends often profoundly influence us.

This chapter investigates each of these levels, looking at the myriad ways in which culture affects our experience of minor bodily stigmas of the breasts and eyes. In this first section, I scrutinize the overarching culture and the local manifestations of different cultures. I begin by looking at some messages about the body and cosmetic procedures circulated in the popular media. To access this data in a tangible way, I

surveyed two popular magazines and conducted a content analysis. These two periodicals provided a representative sample of the types of publications my interviewees might reasonably expect to be exposed to in their everyday lives. Next, I provided a brief historical overview, revealing how messages about flat chests and strabismus have been communicated in the West. Finally, I reveal the thoughts and opinions of each participant regarding popular culture and their own particular local culture.

Popular Media

Anyone who caught even part of the 2001 Victoria's Secret Fashion Show that aired on prime time television realizes that we are a culture that idolizes a vision of "physical perfection." This vision is lean, long-limbed, and large-breasted, with a face that has symmetrical proportions, beautiful eyes, full lips, high cheekbones, and a thick mane of hair. Since only a minuscule portion of the population naturally meets all these standards, cosmetic surgery is offered as a means to help bring the rest of us closer to an image of ideal beauty. All of my interviewees mentioned that the media played a significant role in determining their thoughts, feelings, and attitudes about their own bodies. To capture some of the diversity of the cultural messages about cosmetic surgery disbursed through the print media, I conducted a survey of two popular, yet very different magazines—*Ms.* and *Vogue*. I chose these magazines because they represent widely read polar opposites in the vast spectrum of publications available for consideration.

Ms. and Vogue

In general, *Ms.* tended to be very critical of cosmetic procedures. Suspicious of the impetus behind the move toward "beauty surgery," and always on the lookout for potential health risks, *Ms.* magazine sought to inform its readers and encourage them to

take appropriate actions when needed. In their column entitled “Our Bodies, Ourselves,” *Ms.* ran three informative pieces on breast implants in September/October of 1991, November/December of 1991 and March/April of 1992 respectively. These pieces warned women of potential risks, pointed out fundamental flaws in the FDA review, which found that implants did not increase a woman’s risk factor for health problems like cancer or immuno-related disorders, and encouraged women who had the silicone implants to consider joining the class-action lawsuit being filed against Dow Chemical Company. Then in March/April 1996, *Ms.* published an expose issue about the silicone implant controversy entitled “Beauty and the Breast.”

In this issue they pointed out that *Ms.* was the first magazine to question the safety of silicone breast implants, and concluded that current evidence proves that these suspicions were well founded. Comparing the breast controversy with the DES and Dalkon Shield scandals, the editors of *Ms.* purported, “It is a tale of inadequate testing and regulation; corporate cover-ups, unbridled greed; women’s bodies, health, and lives ravaged; lawsuits; terrible stories of pain and suffering” (p. 45). The ensuing pages outlined a critical, chronological history of breast augmentation. Personal narratives about the horrifying side effects that some silicone implant recipients experienced were scattered throughout the report. The women featured represented a wide range of categories. The stories included those of ordinary women who wanted to change their appearance, a woman who had had a mastectomy and wished to have a breast again, and the actress who played Erin on *The Waltons*. In each case, their own health and often their appearance was ravaged, and some who breast fed their children also reported unexplained symptoms, like mysterious rashes and high fevers, passed on to their

offspring. Statistics on the continuing growth of the population seeking and receiving implants were balanced with a cold, hard look at design flaws in studies aimed at verifying the safety of these devices. Overall, this issue presented a very convincing case for outright rejection of augmentation practices.

The next (July/August 1996) issue, was filled with praise for this expose issue. The editors printed nine unabashedly complimentary letters, as well as a letter from a disgruntled reader who felt that *Ms.* had gone too far in its strong indictment of silicone implants. The disappointed writer maintained it was essential to allow these implants to be available for women who had had mastectomies and wished to regain a normal shape and a normal life. Two more glowing letters appeared in the September/October 1996 issue. Consensus indicated that this issue represented *Ms.* at its revelatory and revolutionary best.

Then in 1999, *Ms. Magazine* printed an article called “Saving Face” that struck a dissonant chord with many of its readers. In this article, self-declared feminist Laurie Stone wrote unapologetically about her decision to have a face-lift (Stone, 1999). The next two issues sported four angry diatribes in the “letters to the editor” section. The expectations of many loyal readers had been fractured. “I think that the article ‘Saving Face’ by Laurie Stone (April/May 1999) was marred by the author’s unchallenged self-involvement and lack of social conscience,” wrote one angry reader. “Spending \$12,000 on unnecessary cosmetic surgery looks just plain wasteful—not to mention foolish—to me.” Another wrote, “I was very disturbed to see that *Ms.* chose to include Laurie Stone’s article. From the minute they’re born, little girls are taught by society that their worth is based on their looks. For women, one of the most pitiful capitulations to patriarchy is

choosing cosmetic surgery for vanity's sake. This article should have been forwarded to Cosmo." One might argue that they might just have easily suggested that the article should have been forwarded to *Vogue*, because the sentiments I found there were in keeping with the broader cultural acceptance of literally and figuratively paying a high price for beauty.

Even back in 1990, *Vogue* was rife with articles and advertisements highlighting "offensive" physical imperfections and promoting cosmetic surgery as the cure for these problems, without discussing potential consequences. The 1990 January issue featured an article about women who had made it big in the beauty industry, and another informative piece about skin, suggesting chemical peels, liposuction or face-lifts are most appropriate for post-menopausal women (Posnick, 1990, p. 209). In February, an article in their column, "Images," promoted a cosmetic procedure where fat taken from the buttocks is injected into the hands "to cover exposed veins, bones, and tendons and to flatten out surface lines" (McCarthy, 1990, p. 180). An article in that same issue was devoted solely to the neck, promising that liposuction can get rid of a turkey wattle, while a face-lift (which technically lifts the neck too) can correct the sagging of an aging neck (Posnick, 1990, p. 338). In August 1990, "Images" featured an article about cellulite—discussing options ranging from cellulite creams to liposuction, while January 1991's edition of "Images" discussed how the right skin care before and after cosmetic surgery can speed healing. Ads for all of the skin care products listed by the author were placed in the middle of the article so the reader was sure to get the message. Throughout all of the issues in 1990 and 1991, I found an ad for Clarins Cellulite Control Gel reappearing over and over again. The ad featured a shot of a woman in underwear—cropped at the

waist and knees—with her backside to the camera. It promised this wonder gel would banish unsightly cellulite forever.

The cellulite ads were still present in 2000 with a similar rear-view shot of a woman from slightly above the knees to slightly above the waist. However, this time the woman was completely naked, so you could see any potential site for cellulite, and the product was renamed Clarins Body Lift 2000. Joining this ad were others for “100% natural” Breast Enhancer Tablets, Body Sculpture—which promised to reduce fat and the appearance of cellulite—, and Hollywood Celebrity Diet pills.

In 1999, topics of articles had altered to reflect the changing trends in society, and the turn toward even more cosmetic surgery. Longer, narrative-style articles about cosmetic surgery seemed to be taking over. The “Images” column had morphed into the “Vogue Beauty” section. Some of the highlights from these two years include a December 1999 article on a new beauty and health mall that opened in New York’s Soho district. The author promoted it as a place that offered the best of both worlds. At this mall you could address basic medical concerns by seeing a gynecologist, or having a bone scan, and also undergo cosmetic procedures like laser eye surgery, laser vein removal, or botox injections. The unspoken message seemed to be that all these practices were an essential part of health care in the modern world.

In March of 2000, Elizabeth Hayt confessed her secret love for her plastic surgeon in an article which she admitted would sound “screwy” to readers who had not had a cosmetic surgery. She detailed how the amount of attention that her surgeon lavished on her made her feel special, and revealed she was sad when she was finally healed. Looking for the silver lining, she added, “I was consoled by the knowledge that it would

never be entirely over between us. I could always look forward to a future of touch-ups” (Hayt, 2000, p. 422). Women who develop feelings for their plastic surgeons are becoming increasingly common. David Sarwer, a psychiatry professor at the University of Pennsylvania, pointed out that cosmetic surgeons touch us in intimate ways and listen to us discuss our innermost secrets about our bodies. They see us at our most vulnerable, and are gentle and accepting. Gratitude toward someone who has erased the source of dissatisfaction, and positive feelings regarding a new appearance, may be wrongly interpreted as romantic love (Hayt, 2000). Although many claim it is ethically immoral to do so, some doctors inevitably end up dating, or even marrying, former patients. Even for those who don’t end up falling for their doctors, cosmetic surgery holds out the promise of automatically boosting their love life simply because it promises to make them more attractive, thus increasing the odds that they can attract and keep a mate. Over and over again we are told that everyone wants a young, pretty face and body. One 47-year-old plastic surgery enthusiast said she began to alter her body twelve years ago when her former husband informed her that he never dated women over 35 (Hayt, 2000, p. 200).

In July of 2000, *Vogue* ran an article called “Surreality check” that had the potential to be very critical of our cosmetic surgery culture. The header asks, “Is artificiality becoming our new beauty ideal? Elizabeth Hayt reports from the front lines of fake.” The rather disturbing pictures accompanying this article featured a woman in a revealing dress, with a large breast for a head, dancing with a man, with a giant nose for a head. In the text of the article, Hayt points out that, “Nowadays, the quintessential plastic-surgery patient is a waitress who has gotten a bank loan for a boob job.

According to the American Society of Plastic Surgeons, the number of surgeries has risen a dramatic 153 percent since 1992, with a 30 percent increase between 1996 and 1998 alone” (Hayt, 2000, p. 200). A feminist could have taken all the same information and come out with a scathing indictment of this trend. But the same regular *Vogue* writer who had “fallen for her plastic surgeon,” and who again defined herself as a “surgical repeat offender” penned this article. Consequently, her arguments supported the thesis that people get surgery because they just want to match their aging exterior with their youthful, happy interior. Further, this article helped to normalize the idea of cosmetic surgery by pointing out that, “A Newsweek report last year found that many Americans no longer disapprove of cosmetic surgery and feel that there is no stigma attached to it” (Hayt, 2000, p. 200). Instead, it is suggested that surgical intervention may be the smart thing to do whether you are trying to get ahead in a competitive job, or just seek an edge in the singles’ market.

Although I began my content analysis of *Vogue* and *Ms.* with the assumption that these two publications were polar opposites in the on-going debate about cosmetic surgery, I discovered that during the ten-year span from 1990 to 2000, some of the articles in *Ms.* began to sound suspiciously like those printed in *Vogue*. In the early 1990s, the perceived risk of cosmetic surgeries such as breast augmentation substantiated *Ms.*’s claim that surgeons were using females as human guinea pigs for devices that had not been properly tested. But as cosmetic procedures became “safer” and more routine, the debate shifted to the level of the individual. For some, the salient question now became, “Should women have the right to choose to have cosmetic surgery without being criticized for capitulating to patriarchal norms?”

While it may be true that the familiarity cosmetic surgery now enjoys has helped to erase many previous, long-standing fears, different types of surgeries elicit different responses. To understand how the decision-making worlds of my eye interviewees and my breast interviewees differed, it is important to take a step back and take an historical look at Western cultural messages regarding the breasts and the eyes.

A Brief History of Breasts and Eyes

As we have seen in Chapter One, breasts have historically been reduced, enlarged, or reshaped to match the current trends in the West. Both Haiken (1997) and Latteier (1998) point out that the first plastic surgery organization in North America held its inaugural meeting in 1921, just one month before the first Miss America contest. In their view, this proximity was significant because it points to the strong ties between the rise of cosmetic surgery, the rise of the American culture of beauty, and the rise of American consumer culture. All three were interdependent upon and fed one another. As cosmetic surgery became less risky and more acceptable, practitioners began to offer a wider range of procedures designed to resculpt the human body to meet standards promoted by the American culture of beauty. This standard of beauty was disseminating rapidly through society--offered up for public consumption through venues like beauty contests and advertisements. At this time America was becoming a consumer culture. As the public began to eagerly consume images of beauty, this led naturally to increased feelings of body dissatisfaction, the creation of envy and desire, and a corresponding demand to purchase cosmetic surgeries designed to bring patients closer to meeting the ideal (Etkoff, 1999; Haiken, 1997; Latteier, 1998; Wolf, 1991).

To demonstrate the dynamic interplay between cosmetic surgery and popular culture, Latteier (1998) provides a condensed history of the fashion of breast size, showing how surgeries to help the average woman “improve” her appearance and self-image paralleled the style of Miss America contestants. In the 1920's the nearly flat-chested look was in. Miss America contestants averaged thirty-two inches and breast reductions were the most common surgery performed on the average woman who stepped through the door of a plastic surgeon’s office. By the 1940's, Miss America hopefuls were up to thirty-five inches and full-bosomed movie stars set standards to which women aspired. The rule of thumb for women in the general population who sought cosmetic enhancement was that bigger is better. This trend continued in the 1950's and 1960's when thirty-six became the ideal measurement for Miss America contestants. Today the perceived best breast, exhibited in beauty contests and the media as well as in the general population, is an adolescent, perky breast—usually with implants to make it larger (Latteier, 1998). The ideal breast may be very different in thirty years.

Our culture also reveres the eyes, yet society’s adulation of symmetry places someone with crossed eyes in a precarious predicament. Many overarching cultural conversations complicate the way in which people think about, and talk about, strabismus. In the United States, crossed eyes are clearly recognized as a cultural joke. When people see someone cross their eyes in a movie they laugh. When they encounter crossed eyes in real life people tend to either laugh, or assume this is an indication of diminished mental capacities. The man who can look you straight in the eye is strong and trustworthy. One who cannot, or will not, is often considered weak or sneaky. Americans have also become increasingly preoccupied with physical perfection and

willing to undergo cosmetic surgery to achieve this goal. Being beautiful, or at least normal, has become almost a moral imperative, and there is a corresponding guilt associated with reluctance to fix the “fixable.” (Balsamo, 1996; Etcoff, 1999; Haiken, 1997). When it comes to crossed eyes, however, the issues involved in deciding whether or not to have surgery may be much more involved than an uninformed on-looker might assume them to be.

There are many different kinds of strabismus, and a whole host of other related eye problems are often linked to this primary condition. The eyes can go in, out, up, or down. Strabismus causes two conflicting images to be sent to the brain and the child learns to ignore or suppress the image seen by the misaligned eye. This leads to the straight eye taking over and becoming more dominant. About fifty percent of the time, the lack of use of the misaligned eye leads to amblyopia—a diminishing of vision in which the eye is eventually shut off by the brain. Conditions like astigmatism, nearsightedness, and farsightedness also may be present. An adult’s surgical success potential may be determined only after a thorough examination focused on elements such as the strength of each eye, whether or not the client can use both eyes, whether or not one eye is used exclusively, how long the strabismus has been present, what caused the crossing, and whether or not previous surgeries have been attempted. Often more than one surgery is needed to achieve a straight appearance, and the eyes do tend to drift again as the patient ages—thus necessitating future surgeries. Double vision is a common side effect of these surgeries and there is no good way to predict whether or not the brain will adjust and cease to see double after a week or so, or whether the double vision will be permanent. In some cases, the brain may attempt to shut the weaker eye off to avoid

double vision. More surgery can be performed to try to fix the double vision, but each time a new surgery is performed the chances of a successful outcome are dramatically reduced. There is only so much muscle to work with and every new cut reduces it even further.¹² “Fixing” crossed eyes is no simple matter. It’s a potentially costly and risky endeavor. The sense of risk is often exacerbated by the dearth of information about strabismus available to the layperson.

The existing literature is written by and for surgeons. The medical jargon liberally sprinkled throughout these articles is difficult for a layperson to decipher. Functional problems associated with strabismus—such as impaired depth perception, poor hand-eye coordination, a loss of binocularity, and the inability to see 3-D while wearing those funny glasses—are discussed at great length. Because eye-straightening surgery is unable to resolve these physical problems in adults, insurance deems corrective surgery a purely cosmetic procedure after a child has reached the age of seven or eight. Researchers often argue it is unfair to deny adults coverage for these surgeries because of the significant psychosocial impact of strabismus. They point out that adults with strabismus are, statistically speaking, prone to social stigmatization, likely to experience hardships in their interpersonal relationships, inclined to be terrible at sports, and liable to suffer from limited employment opportunities. However, the compelling details are left out. What does it mean to experience “hardships” in your interpersonal life because you have crossed eyes? Why does it matter if you are lousy at sports? How does it feel to go

¹² My information regarding the risks involved in pursuing strabismus surgery come from data gleaned from the “LazyEye” E-list I subscribe to, and from an extensive examination and two in-depth interviews with Dr. Mendleblatt—a local strabismus expert and surgeon.

into a job interview knowing you can't look your interviewer straight in the eyes? In sum, the medical literature fails to address the lived experience of strabismus.

This omission led to an increased feeling of isolation and fear when I compared my eye interviewees with my breast interviewees. Augmentation stories, both good and bad, abound in our culture. They can be seen on T.V., listened to on the radio, read about in magazines or the newspaper, and even heard about first-hand by people we know who had their breasts "done." On the other hand, eye-straightening surgery is something most people never hear about outside of an ophthalmologist's office. Never the less, both my breast, and my eye interviewees reported that they found many cues in both popular and local culture that suggested how they should respond to their stigmas.

Considering the Impact of Popular Culture and Local Culture

All of my interviewees talked about the impact of either their overall culture, or their local culture upon their experience of stigma. Often they blended the two. Their comments point to the overwhelming importance of culture at both of these crucial levels.

Although Hailey lived in Mexico for a while when she was young, she spent most of her life in the L.A. area. Hailey complained that it is hard to be young and single and trying to meet guys when you have crossed eyes. She added that she thought society tended to be a lot more critical of women's appearance than men's. Her self-consciousness was exacerbated by her proximity to Hollywood, CA "where all the beautiful people are." We talked about the social significance of location, and she wasn't surprised when I told her that we were living in the two states—California and Florida—in

which the highest percentages of cosmetic surgeries were performed.¹³ When I talked about my breast research, Hailey pointed out that so many people are getting surgery done to make their breasts look better, but eyes are “way more important than breasts” in her opinion.

Lori agreed that this culture, in general, is very unforgiving when it comes to accepting people with crossed eyes. She wished that it wasn't such a big deal and resented the fact that she felt like a lot of guys would probably reject her the minute they noticed her eyes. Ultimately, however, she felt very grateful that she lived in a small town in Minnesota that still had county fairs. After all, she met her husband at the fair.

Lynn didn't really talk about overarching cultural attitudes toward crossed eyes, and I attributed this omission to the fact that she has not had to deal with this stigma since she was thirteen years old. She was more concerned about the stigma of glasses, and her comments all revolved around a consideration of the local culture in the tiny town in Washington in which she had grown up and still lived. Overall, she was very optimistic about current trends in society, but she said she had been worried when she started to

¹³ Florida's older inhabitants are purchasing the majority of the cosmetic surgeries there, while California has a greater percentage of younger people who elect surgery because they want to look like movie-stars. However, young people in Florida are pursuing breast augmentations, liposuction, collagen shots, and other similar procedures in increasingly large numbers. This trend may be attributed in part to the fact that warm climates tend to encourage less clothing and increased self-consciousness regarding conspicuously displayed body parts.

send her boys to school.¹⁴ When she was young she was the only one in her class with glasses. She got picked on terribly, and did not want to see her boys suffer a similar fate. When she took her oldest boy to school for the first time she was pleased to discover that there were three other kids in the same classroom with glasses. “I think people are so much more aware and accepting of differences these days than they used to be,” she concluded. I was skeptical when she said this, noting that being accepting of glasses and tolerating crossed eyes were two different things. Lynn’s enthusiasm was not to be deterred, however, and she quickly told me she was glad that there were e-lists like LazyEye and that I was writing my dissertation on a topic like this. She continued, “I think talking about it is good, but not only for yourself, or for your children, but so that others can know that there are different ways of seeing.”

Bea pointed out that not only are there different ways of seeing visually, but different cultures promote divergent views on what the body should look like. Of all my interviewees, Bea had lived in, and traveled through, the greatest variety of cultures. She spoke at great length about how her perceptions of her own body changed as she moved around the globe. From 1990 to 1995, she lived in Boulder, Colorado and attended college—majoring in Women’s Studies. She hung out with a lot of feminists and glibly reports, “no one wore bras; no one gave a shit.” At the time, implants were rarely seen in Boulder, and Bea recounted that everyone just stared at women with fake breasts. After graduating, she traveled extensively throughout Asia—visiting Korea, Hong Kong,

¹⁴ As indicated in Chapter 3, Lynn soon decided to withdraw her boys from public school and home school them instead.

Thailand, Malaysia, Indonesia, and China—and she reported that she didn't even take a bra with her on her trip.

When she finished her travels, Bea took a job teaching English in Korea. She lived there for two years and soon discovered her breast size fit the norm, because most of the women were small, and large breasts were viewed as a potential embarrassment. However, Bea's butt was far larger than most, and the kids at school used to playfully call her "teacher big hippy" because hip was their word for butt. She also found herself being pushed out of shops by laughing saleswomen who assured her they had nothing that would fit her. She did not find this distressing, however, because in her words, "It wasn't embarrassing because they were so different, you know? I was a foreigner. I didn't speak Korean very well. I looked completely different. I have completely different standards of beauty." Being in a different culture granted her an exemption. No one expected her to meet cultural norms. After her contract in Korea ended, Bea traveled to England and then Guatemala. In South America she encountered a very different sort of relationship to the breast. The breast was not some highly fetishized object encased in exquisite lingerie from Victoria's Secret. It had a utilitarian function—feeding babies. Bea had a hard time relating to this culture, which offended some deeply held cultural notions about appropriateness. She recalled, "When I was in Guatemala, I was living with a family and for almuerzo, the big dinner they have during the day, all the cousins, and sisters, and aunts would come over. It seemed like there were always a million babies at their family gatherings and they were all breast-feeding. These women were breast-feeding AT the dinner table, which I just found absolutely repulsive because they don't cover it up. They just whipped it out, and there were all these breasts hanging out

at the dinner table. It was disgusting. And there was this sucking noise. Ohhh, god, I couldn't even eat sometimes. And it was just too much mammary. Bleghhh! I don't know. Smaller breasts are great. I don't feel like a dairy cow or anything."

When she left Guatemala, Bea came to Tampa, and there she encountered an entirely different breast-related dilemma. "I just feel like it's breast world in Tampa," she said in an exasperated tone. Surrounded by a myriad of thin, young women with implants, Bea soon developed a profound sense of alienation. She quickly learned that while it was considered fine to show off cleavage, it was considered inappropriate to walk around without a bra on. She attracted stares and rude comments when she did. Describing her culture as "middle-class, suburban, white, and preppie," she was quick to point out that, "there are a lot of different cultures in Tampa that wear tighter clothes than my culture does. If you have big breasts, that's great. People wear clothes that accentuate them--really tight clothes." Although she says she's always been really turned off by the idea of implants and has never received any direct pressure to get them from anyone she knows, Bea asserted that there is an overall cultural feeling of pressure to have large breasts in Tampa just because you *can* have them. "You look more feminine," she conceded, "and there's just a whole bunch of clothes--sexy clothes—I can't wear. I can't wear sexy clothes because I don't look sexy in them."

Izzy boldly declared that society doesn't care about flat-chested people like her. Images of large breasts and sexy lingerie run rampant in this culture, yet when she went to Victoria's Secret to buy some pretty bras to make herself feel better, she couldn't find anything that fit. When she does find a department store bra her size, there are never any choices of colors or styles, she continued. Although she has carried a sense of

inadequacy with her since puberty, it was when she got to Tampa that she became aware of a growing sense of self-consciousness about breast size. Everywhere she looked she saw people with implants. She noted a conspicuous lack of body-type role models at the local level to help normalize her physique. Izzy did admit to being a big fan of the show *Ally McBeal*. “I think those girls are great,” she said enthusiastically. “I think Nelle’s great. Nelle doesn’t have any boobs.” But then she confessed she doesn’t really like *Ally*. “I feel bad, but sometimes I think *Ally* looks ugly without boobs. But maybe that’s my own self image feelings coming out, because I think that’s exactly what I look like.”

When I conducted my last interview with Izzy she was packing to leave the country to accept a job teaching English in Japan. She said she hoped to shed some of this self-consciousness when she went overseas to live in a different culture that might not be so breast-obsessed. She dreamed of finding the same kind of relief that Bea experienced in Asia.

Autumn was very matter-of-fact in her assessment of the overarching culture. “Society is shallow,” she told me, “but either you play the game or you don’t.” For a long time she sat on the sidelines, passively suffering because she was afraid to play the game. Then she decided to take action, and now she counsels others to follow her lead. When I asked her if she watches *Ally McBeal*, she said that she does and that she thinks it’s “cool” and “great” that the girls are flat, attractive, and successful. However, she quickly diverted this line of thinking by telling me that breasts were a big symbol of femininity for her. When I questioned her further about this statement, she admitted that she probably got this idea from the media. However, she pointed out that regardless of how these notions got inside of her head, the fact remains that when she stands in front of

the mirror in the morning she now feels satisfied. Autumn never mentioned the impact of the local Tampa culture at large, but she did admit her fears that the gay community might be upset with her for doing something that is typically coded as a heterosexual practice. However, she was very forthcoming about her surgery, and she was relieved that no one openly disapproved of her decision.

Holly didn't talk about how her local culture impacted her feelings about her breasts either. Instead, she focused on the temporal nature of larger cultural trends and what impact these trends had upon her life. Her decision to have augmentation surgery in the first place was bound up with the overarching trends of the times. Holly was a very active part of the fitness craze in the early 80's, and her career aspirations to become a fitness guru grew out of this emphasis. Also, she explained that "boob jobs were very popular then and there wasn't any negative talk about them." By the time the press began to circulate rumors that silicone might be harmful in the human body, it was way too late for her. Holly observed that she now saw two competing images in the media. She talked about how being flat chested, like Ally McBeal, or Nelle, or some of the other characters on that show, had become almost a trendy, arty statement. This image was then juxtaposed with more blatantly sexual, large-breasted images. She wondered aloud which image would win out in the future, and what another shift in perspective might mean for society.

While my breast interviewees knew their stigmatized status was decreed by society and could be revoked if body fashion standards changed, my eye interviewees also hoped for a positive shift in perspective regarding strabismus, but they would have gladly settled for at least a greater degree of understanding regarding their condition.

Many of the people on the e-list were very vocal about the relief they felt when they finally found a group of people who shared their minor bodily stigma and could talk intelligently about the experience. One of my interviewees, Lori, expressed gratitude for the education and support she was receiving. “I didn’t realize there were other kinds of crossed eyes,” she explained, telling me that both she and her sister had an esotropic turn—eyes that turned in toward the nose. Lori didn’t realize that crossed eyes could also go out, up, or down. She was surprised to hear an estimated five percent of the population starts out with strabismus. Lori always felt so alone in her experience. “My dad has it too,” she continued. “But don’t you feel like we’re one in ten million at times though? I was surprised to even find anything about strabismus on the internet.”

Frequently, members of the LazyEye list-serve spoke of a desire to have their children better educated about issues like strabismus in school. In general, they felt like this was an ideal place to begin to teach children a wider latitude of acceptance toward difference. Although my breast interviewees never specifically proposed that children should learn to be tolerant of different breast sizes in school, I can’t help but surmise that given the amount of teasing they received in school they would have appreciated such an intervention.

Education

In addition to providing us with an education, schools play a crucial role in the socialization process. As we have already seen, six of my seven interviewees identified school as being the place where they first learned the social consequences of looking different. However, looking beyond the high school experience reveals that higher

education actually begins to provide individuals with tools to begin to rethink, or at least question, the ways in which we as a culture judge and assess the body.

Of my eye interviewees, only Hailey is currently pursuing a degree in college. The other two stopped after receiving their high school diplomas. In contrast, all of my breast interviewees went to college and earned Bachelor's degrees. While Autumn stopped here, Bea, and Izzy completed Master's Degrees as well, and Holly attained her Ph.D. It was at their universities that all of them either learned about feminism for the first time, or developed a deeper understanding of it, and this knowledge seemed to color the ways in which they thought about, talked about, and made decisions about their minor bodily stigmas.

Identifying with Feminism

The two women I interviewed with small breasts who chose not to have augmentation surgery both identified as feminists. Bea was a very strident feminist who spoke at length about her beliefs. She got her Bachelor's degree in Women's Studies, and she was very critical of the current trend toward augmentation. "Why the hell do you need big breasts to feel good about yourself?" Bea asked. She then answered her own question by saying that it was because society encouraged this unnatural desire. She said we need to teach young women better, so that they realize there are other options and their worth as a human being isn't determined by physical traits that men find appealing.

Izzy identified herself as a feminist only after I asked her if she had any thoughts or feelings about feminism. She immediately told me that she strongly disliked the look of the "huge, round boobs" that she saw on television all the time and she disapproved of the visual message this sent out to young girls. Then she admitted, "Yeah, I'm probably

somewhat a feminist. I've been independent my whole life. I lived with a guy for three years and that was it in all this time. I don't go around ranting and raving about feminism, or anything, but I know that I am a feminist." It seemed clear that she associated independence from men and disapproval of "unnatural" procedures like breast augmentation with feminism.

It was more surprising to discover that both interviewees who chose augmentation surgery also identified themselves as feminists. During our interviews, Autumn never identified herself as a feminist, even though I spoke of feminism frequently and gave her ample opportunity to respond in kind. Later, when I asked Autumn if she would call herself a feminist, she thought for a moment and then told me that she definitely does consider herself a feminist because she believes that women should have equal rights with men. However, she doesn't "practice" feminism actively out of fear of reprisal if she goes public about something like that. She said feminism has a bad name these days, and as an "out" lesbian she's faced with so many other challenges that she just doesn't want to be part of that battle too.

In contrast, Holly was a staunch believer whose convictions were much stronger than those articulated by Autumn or Izzy. Initially, her participation in what she described as the "feminist culture" in college eased her concerns about her breasts, because in her words, "big breasts weren't a part of that." However, Holly's identity as a feminist became a major source of conflict for her when she decided to have the augmentation surgery. She told me *The Beauty Myth* had just come out, and cosmetic surgery was frowned upon within the feminist sector with which she identified. "I was

afraid I was going to get criticized,” she admitted. “And I didn’t want anybody to know really. Just my very intimate circle knew about it.”

Holly is certainly not the only feminist to have faced such a dilemma and recently several authors have tackled this tricky question. How do you think and talk about a feminist’s decision to have cosmetic surgery? The answer to this question is inextricably bound up with two other complicated inquiries—what is a feminist, and what does a feminist believe?

Defining Feminism

All of my breast interviewees were university educated, but they were not explicit about exactly which theorists they agreed with most strongly. By looking at what each woman said, we can locate her within the dominant feminist discourses she was probably exposed to during the course of her studies. For example, each breast interviewee exhibited awareness that our standards of beauty are socially constructed. They also were aware that while these standards may be arbitrarily determined, and temporally and culturally bound, they carry a great deal of social and economic power. If large breasts are in and you don’t have them naturally, then you can augment what you have, or pay the consequences. This line of thinking can be traced to Foucault and feminists fashioning themselves in his tradition, who theorize an understanding of the body as a discursive construction or a sign-bearing (textual) form that can be read by scholars, and which is situated within established social institutions that regulate and “discipline” its actions (Foucault, 1977). Balsamo (1996) acknowledges that Foucault’s vocabulary is useful for exploring the ways in which certain taken-for-granted “truths”—like women should have large breasts—are actually culturally constructed and later institutionalized (p.

21). Foucault notes that disciplinary power produces a docile body that may be “subjected, used, transformed, and improved” (Morgan, 1998, p. 154). The docile body is clearly a body primed and ready for cosmetic surgery.

Balsamo (1996), however, critiques Foucault for taking gender for granted. This is an arena where feminists have stepped in to expand upon his concepts. Balsamo stresses that there is no a-priori understanding of the body. Our knowledge of the body depends upon representations filtered through interpretive frameworks (Balsamo, 1996, p. 23). Balsamo is quick, however, to warn that this argument—while useful in clarifying how culture colors our perceptions—evolved as part of a reaction against the hegemony of the idea of the body as a biological or “natural” entity. Viewing the body as solely a biological entity can lead to condemnation of any and all “unnatural” practices used to alter it. Ultimately, Balsamo (1996) suggests that this reaction was too extreme, and she cautions against an interpretation of knowledge of the body as exclusively discursive. Instead, she indicates that nature and culture mutually determine understanding. Haraway’s (1985) work on cyborgs also encourages feminists to think about the body as both a material (“natural”) entity and a cultural construction. Cyborgs are, after all, half human and half machine, and Haraway suggest the image of one disrupts a number of dualities—like nature and culture, and male and female—which have been used to oppress women and others in subordinate positions in society. The image of a cyborg also suggests the kind of fusion of technology and the human body demonstrated in plastic surgery. It seems fitting therefore that feminists writing about plastic surgery explore both sides of the nature versus culture divide.

Feminist works on body image issues like plastic surgery maintain an interesting schism that is also evident in my study. Some feminists laud cosmetic procedures, some are adamantly opposed to them, and some fall between these two extremes. As Izzy and Autumn pointed out, it seems that the average person tends to equate “feminism” with those who rail against the patriarchy and look down their noses at those who succumb to the lure of cosmetic surgery. Therefore, it’s important to first take a look at what this “hard-core” strain of feminism actually teaches.

Some feminists see succumbing to the scalpel as an unfortunate reaction to an oppressive, patriarchal system that dupes women into willingly subjecting their bodies to punishment so they can become objects of male desire (Brumberg, 1997; Faludi, 1991; Maine, 2000; Morgan, 1998; Wolf, 1991). These feminist critiques begin with the notion that there is something wrong with society’s push for a stereotypical version of physical “perfection,” and they search for ways to alter the culture. Rather than search for rules to live by inside of a taken-for-granted culture, they interrogate cultural norms and promote a wider latitude of acceptance of differences and advocate change to the existing patriarchal order. Given this view, cosmetic surgery becomes a forbidden activity, signifying acquiescence to patriarchal oppressive norms.

Bea positions herself firmly within this tradition, yet still admits to being tempted by the lure of cosmetic surgery. Bea’s impassioned plea that we must “teach women better” indicates her commitment to begin to change cultural norms through pedagogy. Holly identifies herself as a feminist who “should” believe these ideas, but in reality she has fallen short of the mark and she considers some of these thinkers to be too extreme. She went bra-less and joined NOW for a while, but she believed having larger breasts and

shorter nipples would help her to meet her goals of becoming a fitness guru and easing her self-consciousness, so she decided to flaunt the rules and have augmentation surgery. However, as she got older and began to experience more and more problems with her implants, Holly's position regarding taking an active stance against augmentation began to shift slightly. She told me, "I never felt that I wanted to be this type of person, but I want to take all these young women and say, 'Don't do it! Think about what you are doing before you do it.' I've always been the type that says, 'Oh, go for it! Go for the experience,' but there are a lot of problems that can come out of it, and you never know." Izzy is a tentative member of this "camp" as well. She angrily announces that she is fed-up with clothing that doesn't fit and media images of cheerleaders with large breasts. However, she is not willing to actively do anything to change the culture supporting such norms, and she did seriously consider having augmentation surgery. In her words, she's not the type to "rant" and "rave" about feminism. Her protest is a quiet one lived out at the personal level and symbolized for her by her financial and emotional independence from men.

Both Susan Faludi in *Backlash* (1991) and Naomi Wolf in *The Beauty Myth* (1991) write of a culture that responded to women's liberation by imposing increasingly rigid and impossible beauty standards. Holly specifically mentioned that *The Beauty Myth* had come out right before she had her augmentation, and a quick look at some of the main ideas in this book help to explain why she mentioned it when she revealed that she didn't want anyone to know about her surgery. According to Wolf (1991), "Beauty is a currency system like the gold standard. Like any economy, it is determined by politics, and in the modern age in the West it is the last, best belief system that keeps male

dominance intact” (p. 12). Beauty, in her view, is a fiction created by multi-billion dollar corporations as opium for the female masses. Women are convinced that the way to get ahead is to be beautiful. Wolf (1991) points out that if women suddenly started feeling pretty and satisfied with their bodies the way they are, the fastest-growing medical specialty would be the most rapidly disintegrating one. Rather than “healing,” cosmetic surgeons first create a disease—unattractiveness—and then cure it with unnecessary surgery. Bea made reference to this line of thought when she declared, “It’s disgusting that women in our culture have such low self-esteem that they would succumb to that [augmentation surgery]. We need to teach people better.” While Wolf clearly states that she in no way advocates anyone telling women what they should or should not do with their bodies, or blaming them for their choices, she says that the absence of a public ethical debate about the supply side of the Surgical Age is telling (p. 235). It seems that these sorts of critical debates are only taking place in the feminist sectors.

Bergman (1990) points out that those who privilege external appearance view women who do not take steps to enhance their appearance as disinterested in self-improvement. Since they live in a patriarchal world where they can only attain approval and other rewards through appearance rather than through accomplishments, by buying implants, women can conform to society’s standards, boost their self-esteem, and gain social and economic power (Bergman, 1990). The imperative to surgically correct socially constructed physical flaws such as flat chestedness is so strong that women don’t seem to mind accumulating a ridiculous amount of debt in an attempt to look their best. In 1994, physicians conducted 65% of aesthetic surgeries on people with family incomes

of less than fifty thousand a year—even though these procedures were not covered by state or private health insurance (Bergman,1990).

But it is important to remember that the cost of these surgeries is more than just financial. Faludi (1991) interprets what she describes as the “PR blitzkrieg” (p. 217) promoting plastic surgery in the 1980's as an insidious and pivotal part of the patriarchy's undeclared war against American women. Other prominent feminists, such as Nancy Friday (1996), concur that women become so consumed by envy and competition, and so distracted by the rigors of maintaining their appearance that they have no time or energy to devote to pursuing more broad-reaching goals like attaining equality. As Faludi (1991) points out, we belong to a culture that arms its women with “salves and scalpels to battle their own anatomy” (p. 226). In a world where the body has become women's primary project, dissatisfaction with physical traits begins in girls around age eight or nine, and by the time they are thirteen, fifty-three percent of girls are dissatisfied with their bodies (Brumberg, 1997, p. xxiv).

As more and more women buy into, and, indeed, are raised to unquestioningly accept an ideology that caters to typical male tastes, it becomes a sort of self-fulfilling prophesy. “How can anyone make peace with their bodies when cosmetic surgery is equated with self-improvement?” asks Margo Maine (2000), a feminist who promotes an activist stance in the “body wars” (p. 126). In a chapter entitled “Plastic Surgery: Self Improvement or Self-harm?”, Maine first outlines what she views as the damning evidence against cosmetic surgery and then encourages women to take certain actions to

help fight against the cultural hegemony¹⁵ of conformity. Pointing out that cultural beauty standards change rapidly and that emulating the latest style promises to promote confidence and boost self-esteem, she suggests that plastic surgery might be more aptly named either “fashion surgery” (Balsamo, 1996; Maine, 2000) or “psychiatry with a knife” (Bruning, 1995; Cooke, 1996; Maine, 2000). Maine details the *physical* risks involved in receiving implants and then points out that disempowerment and disconnection from one’s body are two often ignored *psychological* side effects of equating surgical refashioning with self-improvement. She argues that no matter what justifications we might devise to save our egos, altering one’s body to meet society’s standard is necessarily destructive on some psychic level. Furthermore, it’s not enough to just criticize these practices; women should also take action.

Maine (2000) details what women can do on both a personal and a broader political level to help bring about a change in the system. First, she echoes Bea’s comments, imploring women to learn to love themselves the way that they are. Further, she challenges them to fine themselves ten dollars (payable to one of the organizations listed that fights Body Wars) for every relapse into criticism (p. 139). Second, she says women must pressure medical schools to examine the ethics of the boom in plastic

¹⁵ Hegemony is a term used to describe various forms of cultural and political power that are achieved through persuasion rather than brute force or any other sort of overt dominance. Typical models of dominance start with a basic opposition between a dominant ruling class and a subordinate class which have diametrically opposed interests. In today’s late capitalist society things are not that black and white. Hegemony involves the creation of a ruling bloc composed of fragments from the various classes who are given the right to rule by mutual consent from the masses. The agenda of those who rule by hegemonic power is always on the table, so to speak, and they control the way that people think about certain issues by defining the terms of the debate.

surgery and to decrease plastic surgery residencies (p. 139). Finally, Maine (2000) encourages women who have problems with their implants or any other sort of cosmetic surgery to exercise their legal rights¹⁶ (p. 140). Bruning (1995) also presents four alternatives to augmentation surgery. Her list was inspired by a plastic surgeon who laughed at her question about options other than implantation and said, “Alternatives? What alternatives?” (p. 141). In defiance, she penned the following list: 1.) The illusion of a larger bosom can be created with the help of padded bras, falsies, and by choosing a style of dress that compliments flatter chests (Bruning, 1999, p. 141). 2.) A woman can opt for “uplift surgery”—a surgical flap procedure that lifts the breast and makes it look larger and more shapely (p. 141). 3.) Individuals can change their attitudes and break free of society’s emphasis on large breasts. Refuting the plastic surgeon’s diagnosis, Bruning (1995) staunchly maintains, “small breasts are an anatomical variation, not a physical deformity” (p. 141). 4.) Finally, women can attempt “fat transfer”—a procedure in which fat is liposuctioned from a site like the belly or thighs and injected into the breasts. Bruning quickly points out, however, that the effects of this technique do not last and the surgery could cause dangerous infections (p. 141-2).

These feminists frame beauty as a social issue lived out and responded to at the individual and societal level and encourage women to resist pressure to conform to the norm and to strive to change the norm. Their image of a strong feminist hero conforms to the old standard promulgated in the 1970s. In 1977 researchers performed a comparative

¹⁶ It is interesting to note that Holly did attempt to exercise her legal right when she had all her problems with the silicone implants, but the law suit against Dow was a failure, so her pro-active attempt failed.

study of 370 women in the Midwest who were split into three different categories—small-breasted women who wanted to have enlargement surgery, average sized women who were not seeking surgery, and small-breasted women who were not seeking surgery. When the California Psychological Inventory and Attitudes Toward Women Scale were applied, the small-breasted women NOT seeking augmentation scored highest in independence and assertiveness, and had adventurous personalities with a strongly liberated feminist outlook. This suggests the true “feminist hero” actually has no need for surgery at all (Haiken, 1997, p. 276, 278), a view shared by contemporary feminists like Maine (2000).

Although she didn't self-label herself as a feminist in our interviews, Autumn articulated the opposing vein of feminism, which sees plastic surgery as a tool of empowerment that allows women to redesign themselves (Davis, 1995; Haraway, 1985; Stone, 1999). She adamantly stated, “I knew I wasn't pursuing the cultural norm. I wasn't pursuing the men. I was doing it for me, and what I wanted was a B cup.” Regarding her advice to other women considering augmentation Autumn said, “If you want it, and you can afford to do it, I say, more power to ya!” While Holly told me that she had now rejected this type of sentiment in favor of urging young girls to exercise caution rather than rushing into an augmentation they might later regret, she also articulated the empowerment rhetoric when it came to thinking about a cosmetic procedure she might try in the future. “I'm 46 years old, soon to be 47, and I still feel very youthful inside,” Holly began. “So I love the idea of having the opportunity to stay young looking. I'm real optimistic about that. What I'm talking about primarily is the

spider-vein thing. That will be my next step. Probably. And more than likely—I'm not sure I'll need a face lift—but more than likely I'll do that one if I have to."

The vocabulary of choice touted by second wave feminists from the 1970s onward was used by many to frame cosmetic surgeries like breast enlargement as self-empowering and ideologically acceptable practices (Balsamo, 1996; Haiken, 1997; Latteier, 1998). In their view, patriarchal manipulation was not the reason lurking behind a woman's decision to have surgery. Women used technology to exercise their freedom of choice. This hailed back to the strain of feminism that glorified individual self-realization and promoting the value of fulfilling personal desires rather than striving politically to achieve goals like women's liberation (Haiken, 1997). As Gilman sees it, "In a world in which we are judged by how we appear, the belief that we can change our appearance is liberating. We are what we seem to be and we seem to be what we are!" (p. 3). It's interesting that Autumn denied pursuing the cultural norm. She told me that breasts are a big symbol of femininity for her and that is part of the reason why she wanted so badly to augment hers. I would argue that it is culture that teaches us that large breasts are linked to femininity. The media is constantly bombarding viewers with images of women with large breasts. Yet, with increasingly regularity, I find women justifying their decision to have breast augmentation by saying that they are doing it for themselves. By using this particular rhetoric they are able to counter the often-articulated idea that they are weak, insecure women who are altering themselves to win approval from others, especially men.

Roberts (2000) refers to the "I'm doing this for me" rhetoric as the "language of liberation," and questions the true level of choice involved in decisions to have implants.

She reminds us, “‘choice’ is relative. It is tempered by all sorts of considerations...” But in the popular press, the myth of choice lives on and it is used to answer the question, how does a feminist reconcile her beliefs with her decision to have cosmetic surgery? Popular magazines thrive on and promote socially constructed images of the “beautiful body.” Consequently, they easily latched onto this “empowerment” version of feminism, because it allowed them to lay claim to an empowering stance for women while remaining loyal to the fickle dictates of fashion. In 1988 Cher was heralded as a “feminist hero” by the editors of *Ms. Magazine* for showing women how they could take charge of their lives by reinventing themselves surgically (Haiken, 1997, p. 275). This was just a hint of things to come. Today most women writing articles in popular magazines about their experiences with face-lifts, nose jobs, and other plastic surgeries maintain a similar stance, and this attitude has even trickled over into some of the bastions of old school feminism.

Self-declared feminist, Laurie Stone, takes a very personal approach while attempting to interrogate how feminists can justify cosmetic surgery. In 1999 her very controversial article about her face-lift was printed in *Ms. Magazine*. Railing against what she described as the “body police” who would try to tell her what she should and shouldn’t do to herself, Stone (1999) declares, “To hell with the idea that changes over which we have no control, like aging, are acceptable, while changes we can influence—through surgery, bodybuilding, and tattooing—are suspect” (p. 73). She says of face lifts, “I deal with loss and disappointment by mobilizing the flesh—contorting it, training it—finding a way of reversing the passive position” (Stone, 1999, p. 72). She saw her surgery as a way of articulating her desire to be her best and wrote off those who would

judge her decision to be mere acquiescence to social conformity. In her view, it is the old school feminists who assume the role of oppressor.

Still others position themselves somewhere in between these two extremes (Etcoff, 1999; Haiken, 1997; Latteier, 1998; Turner, 1999). Haiken (1997) takes the middle ground, arguing that it is difficult to just point the finger of blame exclusively at men because women have, in her words, “driven, as well as supported, the growth of cosmetic surgery” (p. 9). However, she concedes “women have not always acted freely in the arena of beauty. Consumer culture, in America, has acquired a power that at times approaches coercion, and a variety of other imperatives—such as the post-World War II expansion of the specialty of plastic surgery—have acted in concert with this power” (Haiken, 1997, p. 9-10). Nevertheless, women weren’t just helpless victims; they actively sought medical “fixes” for problems they identified. They poured a lot of money into the pursuit of looking good. Ironically, as women made post-World War II economic gains, they could then use this money to buy surgeries to keep themselves looking great (Haiken, 1997, p. 10).

But it was more than just vanity that impelled this need for cosmetic surgery. Although Americans are reluctant to admit the extent to which beauty can limit or even determine one’s opportunities in life, statistics provide overwhelming proof that it pays to be pretty. Despite the attempts of some feminists to disrupt this trend, in this culture a woman’s self worth is still bound largely to her appearance. Most Americans would like to think that this is a land of equal opportunities where everyone can pull themselves up by their bootstraps and succeed (Etcoff, 1999; Haiken, 1997, p. 9). However, good looking people earn five percent more than average per hour, while ugly people earn

seven percent less (Haiken, 1997, p. 8). As Holly pointed out to me, people won't buy videos or be overly inspired by a fitness leader who does not have a knockout body. Part of the appeal of a workout tape is the notion that one day you might look like the person on the tape. Work on appearance stereotyping has found that even mothers give more attention and love to beautiful babies (Beuf, 1990; Etkoff, 1999). Humans seem innately drawn toward beauty. Experiments reveal infants will look at an attractive face longer, and in general people assume that beautiful people are better, kinder, more intelligent people (Beuf, 1990, p. 11; Etkoff, 1999). This ideology is thought to harken back at least as far as Plato, who believed that outer beauty was a reflection of inner beauty (Etkoff, 1999).

Thus, it should come as no surprise that women spend more than \$20 billion annually on cosmetics alone and additional billions on diets, clothes, hair care, and surgery (Haiken, 1997, p. 9). As long as our society continues to bestow both economic and social rewards upon the beautiful, it will remain difficult to alter existing values regarding attractiveness. Echoing Haiken's point that both men and women are complicit in the creation of the existing plastic surgery dilemma, Latteier (1998) notes, "Combine a scopophilic society with an active advertising industry and the technology to disseminate images, and you get a process that objectifies, judges, and makes commodities of women's bodies, particularly their breasts. There is a gender symmetry to this. While men ogle and judge breasts, women criticize and agonize over their own breasts. While men are hunters of breasts, women consciously work to display their breasts" (Latteier, 1998, p. 125).

Furthermore, Etcoff (1999) maintains that although corporate powers may exploit universal preferences, they did not create them. She believes beauty to be a scientifically verifiable product of evolution, and posits that preferences for certain body types such as lean figures with perky breasts, slim waists, and slightly rounded hips are natural. These physical traits indicate maximum fertility and men's inborn survival instincts ensure they are unconsciously, and irresistibly, drawn toward them. Etcoff acknowledges, "the media channel desire and narrow the bandwidth of our preferences," (p. 4-5) but thinks critics who rail against the current standards of attractiveness have created an unfair "backlash against beauty" (p. 5). She points out that throughout history people "have scarred, painted, pierced, padded, stiffened, plucked, and buffed their bodies in the name of beauty" (p. 5). Yet these practices, which could hardly be termed "natural," do not fall subject to feminist critique. Instead, they are deemed matters of anthropological interest. She argues that beauty is not some recently manufactured notion designed to keep women in line, as Wolf (1991) would have us believe, but rather a concept that stretches back as far as human history and which has some basic evolutionary origins.

Also disputing the idea that "a surgically refashioned face inevitably marks an oppressed subjectivity," Anne Balsamo (1996) puts a different spin on the argument, by challenging what she sees as an oppressive idealization of the "natural"—i.e. untouched by technology—body. She points to what she sees as the hypocrisy of feminists who applaud punk and grunge aesthetics—which often include piercings and/or tattoos—yet condemn the kind of marking of the body achieved through plastic surgery. More recently, writers, such as Turner (1999), have complexified the debate about body modifications still further, pointing out that while these acts signify completely different stances, they are

both born out of the same fundamental need to receive approval from others. Turner (1999) argues:

Plastic surgery is born out of a need to conform (to society's ideas of what one should be) and tattooing/piercing evolves out of a need to announce one's nonconformity to the world...The need to conform and the need to stand out seem to me to stem from the same place. The way we choose to modify our bodies simply depends on whose attention we crave (p. 9)

During my interview with Autumn I talked about Turner's article. Autumn turned to me with an impish smile and said, "I have all three. I pierced my navel first, then I got the augmentation, and finally I got a tattoo. What does that mean?" It was an interesting question to ponder, especially since Autumn not only assumed what Turner describes as two different stances, but she also seemed caught between living a "gay lifestyle" and receiving augmentation, which is strongly coded as a heterosexual practice since it is assumed that large breasts are for men. Autumn's comments point to the need to look at what individuals have to say about their own decisions and to be careful not to make assumptions based on markers like sexuality.

Recently, a move has been made to do just this. Some writers have begun to step away from a more theoretical approach to the debate about feminists and cosmetic surgery, and to look to personal accounts for an explanation. Gimlin (2000) points out that many theorists and social critics view cosmetic surgery as "the ultimate symbol of invasion of the human body for the sake of physical beauty," condemning this practice outright, and ignoring the experience of the women who actually have the surgery (p. 77). She acknowledges one of the reasons that breast augmentation is so open to criticism is

because there are many things that can go wrong physically. Wolf (1991) points out that after the Nuremberg trials, healing doctors adopted a strict code designed to protect patients from irresponsible experimentation or incomplete disclosure of potential risks. A quick glance at the history of plastic surgery certainly provides a compelling reason to suggest that cosmetic surgery has a long history of ignoring this mandate (Gilman, 1997; Haiken, 1997; Wolf, 1991). “Health experts estimate that the chance of serious side effects from breast augmentation are between 30% and 50%” (Gimlin, 2000, p. 79).

Maine (2000) outlines the following comprehensive list of risks associated with breast augmentation. Implants can rupture, deflate, harden, move, be painful, and develop fungal or bacterial infections. Implants may impede mammography and hence the detection of breast cancer. They only have a ten-year life expectancy, and replacement means another surgery, with all its attendant risks. Implants may leak into breast milk. Having breast enlargement can decrease feeling and cause wrinkling of the breast. Silicone implants may cause autoimmune disorders such as lupus. Finally, implants are expensive (Maine, 2000). Gimlin (2000) adds that, women risk being permanently scarred and disfigured if the augmentation is unsuccessful (p. 79).

However, she also reminds readers that the fact remains that cosmetic surgery often works. There are those who suggest the attempt to beautify the human body through cosmetic surgery is an unattainable, never-ending feat because as the body continues to age, there will be more and more things that need fixing. However, Gimlin’s (2000) research suggests that the women who choose surgery often just want to look and feel normal. They don’t desire to achieve “ideal beauty” (p. 80). My research mirrored

this conclusion—my interviewees who chose surgery didn't want to be fashion models, they just wanted to look and feel normal.

Davis (1995) begins her book about breast augmentation by asking, how can an aware feminist come to the conclusion that surgery is the only reasonable course of action for her while remaining fully cognizant that current feminist writings renounce the beauty industry as an oppressive system attempting to discipline or normalize women's bodies? She points out that a woman who gets a divorce because she is suffering and decides to finally do something about it is lauded as a strong woman "taking her life in hand" (Davis, 1995, p. 4). However, a woman deciding to get cosmetic surgery for the same reason is denounced as falling victim to "false consciousness" (Davis, 1995, p. 4). This book is an attempt to construct a meaningful account of how women make their decisions without relegating them to the role of "cultural dope." Women's own explanations are taken as a starting point for this exploration.

There is one last branch of feminism that I wish to discuss because Bea's comments about the various cultures in which she lived indicate she was drawing upon some of these ideas as she articulated her feminist identity. Feminists with an eye toward racial issues raise another objection to surgical alteration. They argue that although discourses on plastic surgery may frame it as an act of individualism, the surgical remolding of the body has led to an oppressive conformity to Caucasian standards (Haiken, 1997). Plastic surgeons have held up the Venus de Milo—the personification of Western, white beauty—as their symbol. Correspondingly, they have reproduced and replicated standards of attractiveness that tend to erase non Anglo-Saxon markers of ethnicity and race, often allowing individuals to "pass" from a less desirable racial

category into a “whiter” or higher ranking category (Gilman, 1999; Haiken, 1997). Michael Jackson is one extreme example of this tendency (Haiken, 1997). Although few, if any, African Americans have ever approached the type of reincarnation attempted by Jackson, lip thinning, skin lightening, and nose reshaping are the top cosmetic surgeries requested by individuals within this racial category. Thanks to a globalization of beauty standards, Caucasian standards still apply to those in other countries. For example, Brazilians tend to request a large number of breast reductions in an attempt to look “less black” (Gilman, 1999, p. 225). Today in Japan and Vietnam, patients also remain fascinated with skin lightening, breast enlargements, nose lengthening, and eye reshaping (usually to create a double eyelid or to widen the eyes) as they try to emulate Western good looks (Gilman, 1999, p. 108). Bea said that her eyes were the envy of many of the women she met in Asia. It is also interesting to note that while some of the Asian women held themselves up to a Western, white standard regarding eyes, Bea felt curiously liberated from conducting physical comparisons in Asia. Ultimately, feminist critiques or affirmations of cosmetic surgery intersect with discourses on nationality, race, and gender.

But feminist critiques do not seem to intersect with discourses regarding eye-straightening surgery. Not only did the word feminist never make its way into my conversations with my eye interviewees, but feminism seems almost an irrelevant term when talking about strabismus. I’ve noticed that I tend to separate out my identity as a feminist from my thinking about eye straightening surgery. Fear of what could go wrong physically if I opted for surgery, and not fear of ramifications within my circle of fellow feminists, takes center stage. I’ve never once thought about strabismus surgery in terms

of acquiescing to cultural norms. While eye-straightening surgery *is* considered “purely cosmetic,” there is more shame involved in NOT getting crossed eyes fixed, than in getting them fixed, and there is no pressure from the feminist sector to resist the temptation to have an operation. Claims of vanity are not leveled at people with crossed eyes who get surgery. Among parents on the LazyEye e-list, outrage is always expressed by at least a few people when a mother writes that she does not want to get her child surgery. Denying someone the normalcy of straight eyes is considered a cruel thing to do. The only people that ever write in to counsel against surgery are those who are speaking from personal experience and cautioning that one of the eyes may go blind if the eyes are straightened for purely cosmetic reasons and the mind is unable to reconcile the resulting double vision in any other way. The preference for straight eyes also seemed universal and unassociated with gender. This may help explain why it does not seem to be a feminist issue. My eye interviewees didn’t learn how to theorize their stigma in school. They never read sophisticated feminist arguments outlining precisely why they should or should not have cosmetic surgery to normalize their appearance. Instead, they often tackled completely different issues as they interacted with their family and friends, which form the next, and most intimate, level of culture that I will explore.

Family and Friends

In this culture, the family plays a pivotal role in a child’s development. The family usually provides our first insights into how to behave and communicate in this world. Ideally, they serve as role models and teach us to cope with our differences. Sometimes, they just help toughen us up by teasing us so we learn to handle what other people say. While theorists might argue about how much or little impact our families

have upon us, it's hard to deny their influence entirely. Therefore, it comes as no surprise that all of my interviewees talked about the importance of family when it came to interpreting and responding to their minor bodily stigma, and making their decisions about whether or not to try and have their flaw eradicated through surgery. One of the first questions my interviewees seemed to ask themselves was, "How did I get this minor bodily stigma?" All of them turned to heredity for an answer. After examining the biological origins of their "flaw," each of them began to explore the complex ways in which both their family of origin and any family or friends that they created for themselves later in life influenced how they thought and talked about their minor bodily stigma and their decisions regarding corrective surgery.

Heredity

Although communication and sociological theory places a lot of emphasis on the socially constructed nature of our worlds (Berger and Luckmann, 1966), biology also plays a pivotal role in a study of minor bodily stigma. Heredity can be both a blessing and a curse, and all but one of my interviewees traced their undesirable traits through their family tree. In general, my breast interviewees searched for examples of more shapely family members and lamented the fact that they didn't get that gene. In sharp contrast, instead of focusing wistfully on the straight-eyed members of their family, the eye interviewees combed the family tree looking for traces of others with the same defect. All of them also were verbal about their fear that their child might inherit their eyes, while none of the breast interviewees said they were afraid their children might inherit small breasts.

Both Holly's mother and her sister were always much heavier than she, and both were well-endowed. In contrast, Holly was thin and pancake-flat—both traits she traced to her father's lean side of the family. She told me she took after her father, because, "his side of the family was all pretty thin, long, and lanky and the women had pretty small breasts." Although she was glad to be fit and slim, Holly wished she had inherited larger breasts. After her augmentation, Holly also discovered that both her mother and her sister had an off-center asymmetry to the alignment of their breasts. She also had inherited this and hadn't noticed it until she got implants and her right breast hung over to the side more than the left one did. This congenital trait later became a huge source of dissatisfaction for her.

Autumn also reported that her mother was shapelier than she. "I mean she wasn't huge, but she definitely had something there," she explained. The silver lining, as she saw it, was that there was no history of breast cancer in her family. Even though she felt short-changed when it came to inheriting nice breasts, for her this clean bill of family health meant that she could pursue augmentation without worrying that the implants might hinder early detection of cancer. Her sister also was flat chested, and had had augmentation six years before Autumn had her breasts done. It was both comforting and incredibly persuasive to see a family member who shared her physique achieve such remarkable results through surgery. This was one of the things that helped tip the scales in favor of surgery when Autumn was struggling to make a decision about what to do about her breasts.

Izzy's envy was aimed at her sisters, rather than her mother. Her mother was shaped just like Izzy; however, she had five children, and after she hit menopause she

was thrilled to discover that she “got some breasts.” On the other hand, Izzy’s sisters were always very curvy. One sister was several years older and the other was younger. Izzy said that when she was young she was anxious to develop breasts like her sister’s, but they never materialized. She was the tallest of the girls by far—and definitely the flattest. Her disappointment was magnified by the expectations of others, such as the boy who wrote in her yearbook, “I can’t wait ‘til you grow boobs like your sister.”

No one in Bea’s immediate family inspired breast envy. She didn’t have any sisters—just one brother—and her mother was naturally as flat as she. While she admitted that she wished she had larger breasts, unlike the others, Bea didn’t point to any one well-endowed family member and say, “I wish I had inherited those.” She saw no point in longing for something she couldn’t attain through natural means.

Like Bea, I had no desire to look like my next of kin. My sister is the same size as me and my mother used to be flat-chested, but after she had two children she put on a lot of weight and her breasts went from an A cup to a D. I’ve never felt any desire to emulate her look. I reserved my envy for un-related people who were tall and thin AND had larger breasts.

Although I never looked to my family for a genetic role model with perfect breasts, I diligently searched for the source of my eye problems. I needed to know why I had been singled out to bear this particular minor bodily stigma. My mother, father, and sister all have straight eyes. Furthermore, my mother’s side of the family displays no tendency toward crossed eyes at all. On my father’s side of the family, however, my great aunt Ethel and my second cousin Shelly both had esotropic strabismus. It was strangely comforting to be able to blame genetics for my dissatisfaction. It seemed I

hadn't been singled out for special punishment by an unfair higher power after all. When I began to interview my participants, I learned I was not alone in my desire to find a scientific reason for my suffering. All of my eye interviewees were also quick to outline the strabismus trail in their families.

Lori's sister had strabismus. Lori told me, "She had probably the worst case of it you'll see." Her eyes were so badly crossed that she was literally looking at her nose all the time, so her parents decided they had to do something. Her sister went through two surgeries. When the doctor performed the second operation he was unable to make the eyes completely straight without causing double vision, so he maintained a slight asymmetry in the alignment. Nevertheless, the results were good, and Lori said that you could hardly tell there was anything wrong. Lori also briefly mentioned that her father was afflicted with strabismus, but she did not comment on him further. During our first e-mail interview, Lori did not mention a fear that her children might have her eyes. She is the only one who didn't bring it up on her own, and I attributed this to her young age. She was only 20 at the time and upset about her inability to attract and keep a boyfriend. We e-mailed one another a few times over the course of the next few months and then our communication trailed off. A year after our first interview I contacted her for an official update. She had some surprising news. Not only did she have a steady boyfriend (who three months later became her husband), but she was three months pregnant. Now the fear of passing on strabismus surfaced. "Hopefully, kiddo doesn't have the same problem as me," she wrote.

Lynn had both a half-sister and an uncle with strabismus and she was on the lookout for eye problems when she began to have children of her own. When she was

pregnant with her first child she prayed every night that he would not inherit her eyes. She said that dealing with crossed eyes was such a “trauma” for her that she did not want her children to have to suffer through that as well. She even went as far as to say, “I mean if he was missing a limb, I wasn’t even concerned about that. It’s just like, ‘he can’t have my eyes’.” She has three sons now, and all of them have eventually developed strabismus, but only Ben, the five-year-old, has noticeably crooked eyes not corrected with glasses. Buddy, the six-year-old, has strabismus completely corrected with his glasses, and Jake, the eight-year-old, has what is known as accommodative esophoria. This is similar to strabismus, but his eye only crosses when he is doing close work.

Hailey was the only one who was unable to find strabismus elsewhere in her family. This seemed to further confirm her suspicion that her crossed eyes were acquired when she fell, and it had nothing to do with genetics. However, interestingly enough she still fears that if she has a child that it might have strabismus too. She said she would be careful to watch her child very closely for any warning signs, and she would be sure to enforce any treatment plans such as patching her child’s eye if she detected problems.

Psycho-Social Influence of Family and Friends

We may have no say when it comes to determining what physical traits we inherit, but we can make decisions about how we deal with the ramification of these traits. Often our attitudes toward our stigma and potential surgical “cures” are influenced initially by our family of origin and then later on by the family we create and/or our friends. For the most part, my interviewees didn’t report any verbal input about their stigma from their families of origin. No one talked about it while they were growing up, and they were left to their own devices when it came to figuring out how to cope with

looking different. Holly and Bea were the exceptions. Holly remembers that her brothers occasionally teased her and her sister constantly picked on her, saying her breasts were nothing more than “mosquito bites.” Bea didn’t get any concrete verbal input regarding what to think about cosmetic surgery, but she was quick to tell me that it was very prevalent in her family, so there was a tacit approval of appearance-enhancing procedures.

But these procedures are all consensual and voluntary. Breast augmentation is also something that is usually performed only on adults. A woman who is dissatisfied with her breast size can choose augmentation, or live with her minor bodily stigma and assume responsibility for her own level of unhappiness. If she pursues surgery and something goes wrong, she may blame the doctor for botching the operation, herself for deciding to get augmentation in the first place, or even society for defining beauty so narrowly and giving it such power, but she cannot blame her parents. Usually parents have no direct influence over this decision. This is not the case with strabismus. Ideally, strabismus surgery is performed when the child is very young so that there is hope that binocularity can still be achieved. Parents assume complete responsibility for the decision. Consequently, I found a distinct pattern of blame finding among the eye interviewees that did not exist with my breast interviewees. I could relate. My eyes crossed when I was six months old, but my parents chose not to have surgery performed because as my mother put it, “If God wanted her eyes to be straight, he would fix them.” They made an unsuccessful attempt at patching, and they got me glasses instead. I can still remember when I first started researching strabismus on my own and I discovered that if I had had surgery right away, I might have straight eyes and binocularity now. At

the time, I definitely felt resentful¹⁷ that my parents chose not to operate. Now the decision is mine to make and the risks are a lot higher and the gains considerably smaller. Sometimes I wish that decision had been made for me.

I sensed that Hailey felt a little resentment toward her mother for not making her wear her prescribed glasses after her first surgery when she was little. She told me that she thinks the surgery might have been more effective if she had followed the doctor's orders. She acknowledges she was a willful child and did not comply easily, but she believes that it is the parents' job to be firm and in her estimation her mother just gave in. Later, she told me that she doesn't think her mother feels guilty about her eyes and that she personally does not blame her mother for her eyes. However, when I told Hailey that my mother said she felt guilty about not getting surgery for me because she knew that my eyes had to have a big impact on my life, Hailey said she thought that was "really nice." She craved the same sort of recognition for her suffering. She said her mother never talked to her about how to deal with the stigma of having crossed eyes, and she still seemed to be searching for some guidance in this arena. She described her mother as a religious woman who didn't show affection often. She was a doer, not a talker and she was very matter-of-fact. She got the initial surgery for Hailey, but when it didn't work she didn't have the money to take her back to a doctor again.

¹⁷ This resentment has dissipated slowly over the years. When I joined the LazyEye list serve and began to read the posts by terrified parents who didn't understand what was wrong with their cross-eyed baby and were afraid the surgery might do more harm than good, I glimpsed a perspective I had not previously had access to. Surgery doesn't always work, and my parents were told that if it was unsuccessful the eyes could go out instead of in, which would compromise my vision terribly. I hope I never have to make this sort of decision if I have children of my own.

“I was nine months, to a year old, when my Mom finally took me to the doctor and got me some glasses,” remembers Lynn. When she was still very small, the doctors tried patching, but Lynn also doubts that her mother tried very hard to enforce this regimen. She remembers she couldn’t see anything out of her bad eye when they covered her good one, and she peeked all the time. After the failure of the first operation, Lynn could still only see well with one eye, and the other one crossed badly. For many years, she just learned to live with the resulting double vision. Although she was still a minor, Lynn was the driving force behind the second operation, so she takes a great deal of responsibility for the outcome. She is grateful that she looks normal now, but she is very unhappy about being blind in one eye. While Lynn never actually said she blamed her parents or questioned their decisions, she is adamant about not having surgery for her five year old who has severely crossed eyes. She is trying every other option—like vision therapy and patching--and says she will wait until her son is old enough to make his own decisions before she will consider cosmetic surgery for him.

Lori didn’t seem to level any blame at her parents, but I wondered if she was just too polite to say anything, and if she ever felt resentful that her sister had corrective surgery and she did not. She reports that her sister’s eyes are almost completely straight now and she readily admits that she wishes her own eyes were too. Lori justifies her parents’ decision to operate on her sister by stressing how severe the crossing was, and their limited amount of money. She has been unable to make the decision to have surgery as an adult because she’s afraid of the outcome, so I can’t help but wonder if she secretly wishes she had been the one chosen to receive surgery so that she didn’t have to

shoulder that burden now. If her child has strabismus, I also wonder what kind of decisions she will make on his behalf.

As we become adults, sometimes we shake free of the influence of our family of origin, no longer seeking their go-ahead as we make our decisions, but sometimes their opinions continue to hold sway. If we create new families of our own, we begin to feel their influence. We also receive input from the friends that we make and sometimes these friends can begin to feel like family. Of course the effect can go both ways. It's important to remember that sometimes we also influence our family and friends.

Izzy is a good example of someone who still values her family's opinion very highly. However, her definition of family includes only her mother and sisters. She told me she no longer speaks to her father. Furthermore she assured me, "I'm sure my father would not have an opinion." When she told her mother and sisters she was thinking about having breast augmentation, they reacted negatively. Her sisters did not comment directly to her. They channeled their opinions through their mother, who told Izzy they were all appalled at the idea. Izzy listed this as one of the main reasons she chose not to augment her breasts. Her friends didn't seem to have any influence over her decision one-way or the other, but since her family disapproved, she would not seriously consider it.

Bea's situation was just the opposite. Her mother had had augmentation surgery and she was very supportive of the idea. An old adage says that women either turn out just like their mothers or exactly the opposite, depending on how strongly they do, or do not, identify with them. Bea was one of the women who wanted to be the opposite of her mother. She identifies with her mother's physique—telling me she had breasts just like

her mothers—and then defines herself in opposition to her. In part, her decision *not* to have implants was borne out of a rejection of her mother's decision *to* have implants. Bea dislikes what she terms her mother's obsessive concern about appearance. Her mother was 5'6" and weighed between 115 and 120 pounds at the time of her surgery. She went from a small A to a C and, in Bea's estimation, her mother suddenly looked like a Barbie doll. Another main reason Bea rejected the idea of augmentation surgery was because in her words, her friends—many of whom were staunch feminists--would think that she “needed counseling” and was “psychotic.”

Both Holly and Hailey fell somewhere between these two extremes. Rather than officially aligning themselves with, or against, any influential figures in their lives, they made their decisions without really consulting others for their opinion. Holly's mother was very religious and Holly knew she would have been strongly opposed to the idea of augmentation surgery, so she just never officially told her. For the first year she wore big clothing in an attempt to hide her breasts, but eventually her family figured it out. She said something about it to some members of her family, but she never talked about it with her mother. Holly also didn't tell many of her friends. She felt a little conflicted because so many of them were feminists and knew her as a feminist and she was worried that they might condemn her actions. She told a few close friends, but for the most part it remained a secret.

When she went in for strabismus surgery as an adult, Hailey told her mother that she was going to have her eyes straightened and she didn't care what anyone thought about it. Her mother seemed fairly neutral about her decision, but Hailey made it clear that even if her mother had objected she would have proceeded with her surgery anyway.

She didn't tell any of her friends before the surgery. Afterward, some of them noticed that her eyes were straight, so she explained that she had had an operation. They told her that was cool, but for the most part Hailey explained that the surgery didn't have any impact on her friendships because they didn't care what she looked like. She also reports that no one said anything when her left eye began to drift back inward again.

Autumn was very positively impacted by her sister's decision to get implants six years before she got hers. She could see that the augmentation boosted her sister's confidence level and enhanced her quality of life. It wasn't long before Autumn began to imagine what implants might do for her. Autumn ended up going to the same doctor her sister had used, because she liked the finished product and she was eager to use the TUBA technique. After her surgery, Autumn actively encouraged her father to address his insecurities about his appearance, telling him that he should NOT save his money to leave it to her and her sister because they would just waste it anyway. Autumn and her sister both had implants and his wife had a face lift 10 or 15 years ago, so that made her father feel okay to have a full face-lift and a gortex chin implant. Autumn proudly reported that he's 63 and looks 52, and he's thrilled with it. "He'll probably live 25 years longer because of it," she predicted. Autumn also encouraged her partner, who had always wanted to get a tummy tuck, to take action. Her partner began to feel a little envious when she saw how perfect Autumn's breasts looked. She eventually went in for a combination tummy tuck and augmentation.

Lori also felt inspired by her sister's successful cosmetic surgery, but she doesn't report receiving any kind of feedback from her family. She wants to have a straightening operation, but she's been too afraid to even visit a doctor to discuss her options until

recently. She's now actively thinking about surgery, and had even gone so far as to arrange to take some time off work to research and possibly have surgery. Then she discovered she was pregnant. Her husband supports her in her decision to try surgery, and she thinks she may do it after the baby is born.

Finally, Lynn's family of origin no longer influences her feelings or decisions about her own eyes, or those of her children. Her husband was very understanding about her eyes from the beginning and remains so. On their first date, Lynn explained that she was blind in one eye because she used to have strabismus and amblyopia. Because her eye condition is not readily apparent, Lynn frequently repeats this speech to explain some of her physical limitations. After she and her husband got married and started their family, they were faced with new decisions regarding whether or not to have surgery for their boys' strabismus. She is adamant about not having her children operated on to fix their crossed eyes unless she gets to a point where there are no other options. Instead, she takes them to an alternative branch of eye treatment called vision therapy. Vision therapy is a young and controversial field and Ophthalmologists feel that no value is derived from this kind of treatment, but Lynn is a firm believer. She'll try just about anything to avoid putting her son through a surgery that she fears might rob him of vision in one of his eyes later in life. Lynn holds out a lot of hope that the culture her children grow up in may be more accepting of difference. This is a hope that all of my interviewees seemed to share.

CHAPTER FIVE: COPING WITH STRABISMUS AND MICROMASTIA

Deciding whether or not to alter the body is never easy. The implications of such a choice are always inextricably enmeshed in a multi-layered web of culture that often disseminates conflicting messages. For example, the mass media pressures individuals to have appearance-enhancing surgical procedures to conform to a certain, fashionable look. Clothing does not fit flat chested women, and movies make fun of crossed eyes. These are all compelling incentives to say, “Yes,” to surgery; however, sometimes the family condemns surgical intervention and the local community frowns upon “unnatural measures.” These are convincing reasons to say “No,” to surgery. To complicate matters further, success stories about cosmetic surgery abound in this culture, but there are also frightening tales of failure. Ultimately, the individual is forced to weigh the pros and cons and arrive at her own decision.

Coping Strategies

The decision-making process is a dynamic one and it often correlates strongly with the perceived amount of stigmatization¹⁸ experienced by the individual and the level and effectiveness of coping skills possessed by the woman making the decision. This chapter presents an in-depth exploration of the coping strategies employed by my

¹⁸ Chapter 3 examines the perceived amounts of stigmatization reported by my interviewees. Our conversations suggested four significant categories. Their minor bodily stigmas impacted their childhoods, romantic relationships, everyday activities, and careers.

interviewees as they combat the self-esteem issues commonly associated with minor bodily stigmas. Some strategies were common to all my interviewees, while others seemed dependent on the stigma type. Perhaps the most instinctive reaction was to hide the difference. Only my breast interviewees tended to rationalize the performance benefits of their body type. However, my eye interviewees highlighted the personality benefits resulting from their experience with minor bodily stigma. All of my interviewees drew “me vs. them” comparisons in which they found themselves to be superior—either physically or morally. Many spent a lot of effort ruling out potential surgical “fixes” to their minor bodily stigma. They cited financial concerns, fears of physical risks, daunting identity implications, and undesirable psychological considerations, like dealing with the specter of unwanted responsibilities and disappointments. Some later overcame these concerns, while others still cling to them. Some talked about their stigma or shared their concerns on a list-serve, others didn’t like to talk about it, and many of them joked about their stigma. Several interviewees referred to the struggle to decide to pursue surgical options or rely on other coping strategies as a great “debate” that was waged internally or with anyone who would listen. Finally, some interviewees managed to eliminate their feelings of inferiority by finding a niche within an alternative culture that supported their decision not to pursue cosmetic surgery, and promoted acceptance of different types of bodies.

Some of these coping strategies worked. Others didn’t. Some worked for one woman, but failed another. The perceived effectiveness of these strategies by those implementing them may help to account for the types of decisions made by my

interviewees. These decisions and their aftermath are the subject of the next chapter. This chapter discusses the context in which those decisions were made. On a regular basis, all of my interviewees faced scenarios too numerous to mention in which their minor bodily stigmas caused them embarrassment, discomfort, or anxiety. In an attempt to avoid the sting of stigmatization, my interviewees admitted they sometimes opted to hide their differences when the opportunity arose.

Hiding

Hiding seemed to be a natural reaction to stigmatization. While it's not a terribly useful strategy in the long run, it often serves as a good short-term fix. Autumn and Holly both reported that before their surgeries they used band-aids and bras to hide their nipples. On the other hand, Bea and Izzy both admitted they sometimes wore heavily padded bras to create the illusion of a larger chest. I nodded in understanding when they shared these tactics. I too use padded bras to enhance my bust line.

I also enjoy hiding behind the security of sunglasses that hide my eyes. At least while I am outside I can pretend to be normal for a little while. I was a little surprised that none of my other eye interviewees mentioned hiding behind sunglasses. In fact, Lynn specifically told me that she cannot wear sunglasses because anytime she puts anything with frames on her face her brain remembers wearing glasses when she was little and tries to force the shut-off, blind eye to see. This results in a double vision so blurry and disorienting that she develops terrible headaches. Lynn would have welcomed the chance to hide when she was young, but there was no practical way to do so. As an adult, hiding has not been something that really concerned Lynn since her eyes look quite

straight. However, now her pupil in the blind eye has begun to enlarge, so soon she may be forced to develop some new hiding rituals to counter this problem.

Lori's favorite hiding tactic was simple, but effective. "I like sitting side by side and talking with some one, because you don't really have to look at them," she shared. Hailey seconded this tactic, adding that she doesn't like to make much eye contact in general. If they don't look her straight in the eyes they can't tell her eyes are crooked.

Often it was not possible, or practical, to hide minor bodily stigmas, and alternative coping mechanisms developed early for most of my interviewees. Knowingly or unknowingly, each began to tell stories about herself or develop rationalizations that helped her to think about her minor bodily stigma in a more positive light.

Highlighting Benefits of Minor bodily Stigmas

Autumn and Bea are good examples of the tendency to "look on the bright side," because they both highlighted performance benefits linked to their chest size. Autumn remembers that despite being "totally flat chested" in high school, she was "pretty happy" with her body. She determined that it was beneficial for her to be flat because she was a tomboy, and an athlete. Employing a similar reasoning pattern, Bea said it was good to be flat in high school because she was a dancer.

While my breast interviewees outlined both physical and personality benefits associated with their body type and even claimed "flatter is better," my eye interviewees focused on ways in which their experience of minor bodily stigma made them more compassionate, understanding human beings. None of my eye interviewees claimed that having strabismus was better than having straight eyes. They just pointed out that they had managed to learn and grow from their struggle with adversity. Because they still had

noticeably crossed eyes, Lori and Hailey both expressed a keen interest in pursuing corrective surgery. However, since the effect of such surgeries is never certain, they were psychologically “hedging their bets” in the event that their eyes were not permanently “fixable.” They hoped to make their eyes look straight, but they drew solace from the fact that even if this was not a realistic goal they could still lay claim to the personality benefits their minor bodily stigma instigated.

Me vs. Them Comparison

One very popular coping mechanism was conducting “me vs. them” comparisons where the role of “them” was assumed by a normal who did not bear the stigmatizing trait of the interviewee; someone who was also stigmatized, but worse off; or someone who also chose cosmetic surgery, but did so for the “wrong reasons.” Those identified as “them” inevitably were shown to be inferior.

Bea contrasted herself with two of her athletic, but large-chested, friends from Colorado—painting a picture clearly depicting large breasts as a liability. “They have considered it at different times to be a problem,” she pointed out, also noting her friends spoke frequently of a desire for reduction surgery. Bea insisted her friend Mary never used her chest as a “physical attractor,” thus rhetorically negating the assumed advantage of large breasts. In vivid detail, Bea described one of Mary’s most dramatic moments of breast dissatisfaction. “I remember one time Mary was running, and they were hurting her so much that she put on two bras and taped them at home with duct tape. Then she went out running and her chest couldn’t expand to breathe and she came back in totally having a heart attack. She had to have someone cut her bras off of her.” In sharp contrast, Bea harkened back to her earlier “performance benefit” rationalization, by

pointing out that she was able to pursue any physical activity she chose without having to worry about her chest at all.

Bea also performed a quick comparison with herself during a time when she had larger breasts, and judged her flat-chest self to be superior. “I got to experiment with bigger breasts once and I didn’t like them,” Bea told me, making a face. “I started taking the pill—it was Ortho-tri-cyclene I think—and my breasts got huge, but they hurt all the time. I was busting out of my bra. I just felt bloated and fat. I didn’t feel like, ‘Oh, look at my voluptuous breasts.’ I felt like, ‘Ohhhh, this is NOT me. I do NOT want implants. I felt like a big mammary factory or something. I didn’t like the feeling so I quit taking the pill.”

Izzy began by comparing herself with someone who had smaller breasts than she. She told me she always thought her cup size—AA—was the smallest one available until a co-worker admitted she wore a size AAA. Suddenly, Izzy didn’t feel as inadequate. During the rest of our interview, Izzy chose a slight variation on the “me vs. them” comparison, establishing instead a collective “we” identity¹⁹ encompassing all fellow flat chested women, and setting up several “us vs. them” contrasts. “We can wear low cut blouses and still look really pretty,” she insisted. “I don’t think you have to have boobs to feel really good about yourself.” Further, Izzy hypothesized that well-endowed women tend to “look their age” more often than their flat chested counterparts. “We look more youthful,” she proudly declared. On a personal level, she pointed out the

¹⁹ It is reasonable to assume that my own identity as a small-breasted woman may have encouraged her to begin to talk in terms of “we,” rather than “I.”

incompatibility of what she saw as the artificiality of breast implants and her own personal philosophy. She said, “I always took pride in being pretty natural.”

It is interesting that Holly also laid claim to taking great pride in being very “natural.” Unwilling to relinquish this claim just because she chose to pursue augmentation, Holly decided to remain quiet about her surgery. She didn’t tell many people and she doesn’t flaunt her chest. It’s not too surprising then that Holly chose to compare herself to someone who had also had augmentation, but for very different reasons. She drew a distinction between someone like herself who chose augmentation to enhance career goals and someone like her co-worker, Lily, who wanted larger breasts so she could show off and boost her self-esteem. Describing Lily as a 35 year old, very exaggerated, out-going woman who asked the doctors to go as big as they could possibly go, Holly confided that Lily’s behavior was an affront to her own modest style. Lily wore push-up bras and revealing tops to work, and brought in pictures of herself in swimsuits, posing suggestively.

While Autumn never focused on a specific example like Holly did, she drew a similar distinction between herself and other women who got implants. One of the primary reasons for her unique sense of difference from other women with implants was her identity as a lesbian. We talked at length about the fact that augmentation is assumed to be a heterosexual pursuit. Somehow it seemed like lesbians were assumed to be raving feminists who would be fundamentally opposed to such “artificial, patriarchal, oppressive practices.” Although Autumn did not fall into this lesbian stereotype, she also preferred to maintain a different kind of distance between herself and heterosexual women with implants—unconsciously reproducing another stereotype about “straight” women who

pursue plastic surgery. Unlike “them,” she did not want to be obvious, or really large, and she didn’t want to show them off all the time. She also pointed out she wasn’t “using her breasts to attract men.”

Hailey chose to conduct a two-fold comparison. First, she compared herself to normals who were quick to judge and assess others based on superficial appearances. “I’m non-judgmental, and I’m not stuck up,” Hailey began in a very sincere tone as she explained that her self-consciousness about her own eyes made her much more forgiving of others’ imperfections. Her closest guy friend readily admitted that he thought this was the best thing about her. I could hear the smile in her voice as she quoted her best friend as saying, “I can take you anywhere and you’ll talk to anyone. You’re not stuck-up. You would never say, ‘Oh, he’s ugly. I’m not talking to him.’” In Los Angeles, a city famed for its obsession with good looks, an open-minded and accepting attitude was rare. Second, she compared her own eyes with those of a former co-worker who also had strabismus. She described him as having a very noticeable crossing and expressed outright disapproval that he did not take action to at least attempt to fix it. “How come he doesn’t care?” Hailey asked in a frustrated tone. In contrast, she cared enough to have surgery, and she assured me that even before she had her surgery her eyes had a much slighter deviation than his.

Lori drew a similar dual comparison. First, she recounted a story about Derrick, a boy that she had a huge crush on in high school. She told me that all the girls who dated Derrick “treated him like crap.” She compared herself to these normals whom she depicted as spoiled, unappreciative, hard-hearted girls who knew they were attractive and treated others badly just because they could. In stark contrast, she told me that she would

have appreciated him and would have been thoughtful, because she knew what it was like to be wronged. This experience had taught her to treat others with the respect and kindness that she wished had been granted to her. Further, Lori characterized these girls as oblivious to their good fortune. “I hate how everyone takes their eyes for granted,” she complained. “If I had straight eyes I’d appreciate it EVERY DAY.” Second, Lori contrasted her own eyes with those of her sister prior to surgery. Lori’s eyes were much straighter than her sister’s eyes used to be, and she drew some comfort from that.

Lynn claimed that because of her eyes she became more “resilient” than the other children in school. Her first unsuccessful eye surgery left her with terrible double vision and periodic accompanying nausea. Yet, she still played sports and did everything a normal child would do. This resilience, combined with the knowledge she gleaned from her personal eye experiences, later made her a strong mother who was very decisive about the plan of vision treatment that she felt was right for her children. In contrast, some of the other indecisive, or uninformed, mothers on the LazyEye list-serve had always had straight eyes themselves and were unaware of the dangers inherent in strabismus surgery. In a “me vs. them” comparison conducted from her vantage point, she was better qualified to be a good mom to children who struggled with strabismus. Some of the pro-surgery mothers on the list-serve may have disagreed with this assessment, because they took issue with Lynn’s reluctance to consider straightening surgery for her son. But Lynn had compelling reasons to resist the thought of surgery and she was not alone in dwelling on these reasons.

Ruling Out Surgery

In fact, another often-employed method of coping is to rule out potential “fixes” for the minor bodily stigma. Financial concerns, fears of physical risk, the implications of changing identity by altering appearance, and psychological considerations, like the possibility that men may not find alterations attractive in the long run, were all cited as viable reasons to reject the notion of cosmetic surgery.

Financial Concerns

One of the most frequently cited obstacles to pursuing cosmetic surgery was the cost. Autumn admitted the biggest reason she resisted the idea of augmentation for so long was money. “I just didn’t want to spend \$5,000.00 on that. It wasn’t that important to me,” she shrugged. Ironically, Autumn ended up spending approximately \$7,000 when she finally had her breasts done, but she thinks it was well worth it.

Autumn speculated that the financial concerns she experienced might not be unique. Her hypothesis assumes one of the main reasons augmentation is frowned upon by the lesbian community might be sheer economics. On average, lesbian couples don’t make as much money as heterosexual couples, so typically they don’t have the disposable income to even consider “a frivolous thing” that fulfills a “want” rather than a “need.” Therefore, many lesbians don’t even see augmentation as an option because of more pressing concerns--like buying things for their kids, or getting that new car--that require their financial attention. Thwarted desire may turn to anger and spawn a rejection of the ideal of augmentation, which helps to minimize the disappointment that would have been experienced if they allowed themselves to want it, even though they couldn’t have it.

Holly was quick to point out that two key financial factors aligned to make her augmentation possible. Since negative publicity about implants had not yet surfaced, money was her most significant inhibiting factor. However, she got a professional discount because she worked with cosmetic surgeons, and she had just received money from her recent divorce with her husband.

Izzy had no such financial resources at her disposal, and money was a huge consideration. She told me, “When I was in my 20s, I thought, ‘Well, I’d rather travel. I’d rather spend my money for something really worthwhile.’” Later in her life Izzy was never able to save enough. “I don’t have the money to do it,” she said, while for the most part insisting that the idea didn’t appeal to her that much in the first place.

Bea didn’t comment on her thoughts about spending money on breast augmentation. She was opposed to it for reasons that had nothing to do with money, and I presume she would not have let money get in the way if she wanted to pursue cosmetic surgery. She did, however, reiterate Autumn’s point by positing that cosmetic surgery is a luxury only enjoyed without some sense of guilt by the wealthy. When Bea told me about her grandmother’s long history of face-lifts, she pointed out, “I think that for her to get a face-lift wouldn’t have been that extravagant because it was such a small part of their [her grandparents’] income. But I think for people who didn’t have that kind of income, that would be just the biggest waste of money.”

Money was a big issue for all of my strabismus interviewees. This isn’t too surprising considering that adult strabismus surgery can be quite costly, and is considered purely cosmetic after the age of about seven, so it is rarely covered by insurance. Both Lynn and Hailey first had surgery on their crossed eyes when they were very young.

Insurance paid for these operations, however, neither procedure worked. Further surgery was now considered cosmetic. Lynn's mother was single at the time and could not afford another operation, so Lynn had to wait until her family's fortune improved. Hailey and her mother moved to Mexico after her failed surgery. They had no insurance and little money, so another operation was out of the question.

Lori's mother didn't have insurance, and she also was in a financial bind. She had two children with crossed eyes, and only enough money to purchase one surgery. Lori has never had surgery and worries she may not have the money to pursue this option even if she can work up the nerve to actually do it.

Initially Hailey shared this fear, and she readily admitted that she was only able to have her surgery as an adult because she found a doctor who did not charge her. She is uncertain about whether the doctor found a way to get her insurance to pay for it, or if the doctor was so moved by her descriptions of the social problems she endured that she decided not to charge for her services. Hailey now plans to attempt another surgery, and again is uncertain about how she will pay for it. She told me she was thinking about putting the fees for the operation on a credit card if she had to.

Hailey seemed to think of money as being one of the only real stumbling blocks to curing strabismus. This was evident in the comments she made as she returned to the example of her former co-worker who also had strabismus. She kept stressing how noticeable his crossing was. "I kinda wanted to ask him—out of curiosity—'how come you don't consider surgery?'" she confessed. "He makes BIG BUCKS." She emphasized these words and then repeated herself in frustration. "I know that he makes big bucks, and I wonder why he doesn't do it!" Her simplification of the decision-

making process to its economic base came as a surprise to me. For me the fear that something could go wrong was much more paralyzing than dealing with financial concerns, and I wondered if her former co-worker harbored similar apprehensions.

Fears of Physical Risk

The specter of what might go wrong haunted all my interviewees. For some, the fears were insurmountable. Others were able to reconcile them. Hailey's fears were not as extensive as my own. I worried about making my vision worse, or losing my sight entirely. I also feared developing an outward or upward turn—a common complication if too much of the weak muscle is severed, or surrounding muscles that stabilize the eye vertically are damaged. Hailey voiced none of these concerns. She still optimistically hoped surgery might help her eyes to work together as a team if she pursued vision therapy also. She fretted about small details like taking time off of work and she worried about dealing with the disappointment if the surgery did not allow her to gain 3-D vision or at least make her eyes look straight. She also was anxious about the longevity of the cosmetic benefit of another surgery. Hailey admitted she hoped she wasn't facing an endless number of corrective surgeries, but seemed pretty confident she could reach a successful surgical resolution to her minor bodily stigma.

Lori was torn between her strong desire to have straight eyes and her terror about having surgery. She confessed she wishes her parents had been able to afford an operation for her when she was little and unafraid, because she was unaware. Now that she is an adult, she fears developing permanent double vision, or that it may be too late to do anything at all. She admitted, "I'm kind of nervous I'll hear bad news when I go to the doctor. That would be horrible." She worries that her prognosis may not be good

because her eyes are “goofy.” Her right eye is nearsighted and her left eye is farsighted with astigmatism, and she gets headaches that are so painful that she told me sometimes she just wants to pluck one of them out. She told me, “When I drive, I use my left eye. When I read, I use my right one. That is why I am so scared to try surgery. If I ended up blind in one eye I would be quite upset.” Still, the success stories Lori reads on the LazyEye list-serve comfort her.

As a teen-ager struggling with overwhelming appearance concerns, Lynn’s desire to have straight eyes far out-weighed any thoughts of physical harm that she may have entertained. However, because of her own unfortunate experience, she is now fearful about letting her own children have their eyes surgically altered. Lynn is adamant about her decision to pursue vision therapy. “I will never have my son operated on as long as his glasses keep his eyes fairly straight,” she vows. “When he takes his glasses off his eyes go right into his nose. When he puts them on, for the most part—not one hundred percent—but for the most part, it’s straight. So I see no reason to do surgery.” Some of the mothers on the LazyEye list-serve disagreed with this philosophy. They posed a difficult question. “Why struggle with glasses, and vision therapy, and tolerate severe crossing of his eyes when he takes his glasses off, when there is a surgical intervention available?” She replied, “There’s a lot more involved than just having the surgery.” Based on her own experience, she fears her own child may lose vision in one of his eyes. If he did and his good eye was ever injured, then he would be blind. She also points out that it takes an average of 2.7 surgeries to get the eyes straight, and even then there is no guarantee. Given these risk factors, Lynn concludes, “If it’s not a bad thing, don’t fix it. If it’s not a horrible, horrible, horrible thing, leave it alone. If he was crossed even with

his glasses on and the doctors were saying, ‘get surgery,’ I think I would feel a lot differently about it; but for now, I don’t want to pursue surgery.” She has total faith that vision therapy is the answer.

While all of my eye interviewees were extensively self-educated about the surgical risks associated with strabismus surgery, my breast interviewees did not exhibit an equivalent knowledge of the dangers specific to augmentation surgery. While my eye interviewees typically started their conversations about stigma by conducting a risk-assessment, I had to bring up the topic with most of my breast interviewees. I shared Holly’s story about the problems she had with her implants with my other breast interviewees as a way of opening up a conversation about their fears of physical risk. Their reactions were predictable. Bea and Izzy used this cautionary tale as justification for their own anti-surgical stances. When I told Izzy about all the problems that Holly had experienced with her implants she listened with great interest, clearly relieved to have her own choices validated. “See, I like hearing stories like that,” she admitted. “Because I think the message is we should just be comfortable with ourselves and happy with who we are. I don’t really think I need fake boobs to make me happy.”

When I told Bea about the encapsulation problems Holly experienced, she asked what that meant. I explained that encapsulation refers to the formation of hard scar tissue around the implant, and that women who suffer from encapsulation have to break up the scarring by squeezing the implant itself until it pops and softens up again. Bea reacted with obvious revulsion, and this new-found fear seemed to cement her sometimes wavering resolve. “I am speechless. Oh my god. Why? Why do women do that to themselves?! God. Uggghhhh. Uggghhhh. No! I will not ever get this.”

On the other hand, Autumn dismissed Holly's problems as unfortunate by-products of much older, unperfected technology. She pointed to her own successful experience as proof that major improvements had occurred since the 1980s. Autumn was, however, quick to sketch out all of her own fears of physical problems and then to reveal how she resolved each concern. First, and foremost, she feared that the doctor would not listen to her and would give her implants that were too big. "I think the doctors tend to want to go bigger," she observed. "I don't know if it's a male thing, or if the doctors find that if they go smaller that the women later say that they wish they had gone bigger." She said she didn't want someone who didn't know her to look at her and say, "Oh, look at her boob job." In spite of all her efforts, Autumn did reveal that the implants were bigger than she would have liked. Autumn describes her current size as a big B, or a small C. She smiled and snapped her jogging bra. "I just wear these sports bras, and I'm a medium." She was quick to add, "I am happy with what they did, even though it was a little bigger than I had envisioned for myself. I am happy with it now. But I think if I hadn't really been adamant, he would have made me bigger yet!"

Autumn also was anxious about the potential that she might be creating health problems—like cancer—for herself in the future. Lingering fears that her athletic lifestyle might adversely affect the longevity of her implants also tugged at her mind. But she quelled these suspicions by talking with doctors who reassured her that the saline implants were durable and safe. Imagining a possible rupture, she informed me, "It's not even an emergency situation. You just have it removed and replaced. It's not toxic." Autumn drew a great deal of comfort from reminding herself that unlike the problematic

silicon implants of the past, the new and improved saline implants were completely benign.

Ironically, Holly described herself as having the least amount of “physical risk” anxiety before her surgery. Her lack of fear may be attributed to her ignorance of the possible side effects of silicone implants. Today most people know about what happened to many of the women who got silicone implants, but back in the 1980’s very few people knew about the risks, and those who did tended to conceal this information. At the time of her first surgery, Holly did express some concern about potentially losing sensitivity in her breasts. This fear turned out to be justified because she lost sensitivity in her nipples and she has a numb area on her right breast. Unfortunately, a whole host of unanticipated complications also assailed her. She suffered asymmetry, encapsulation, rupture, replacement, migrating myalgia, and chronic fatigue. Holly also echoed Autumn’s concerns about getting implants that were too big. The original silicone implants were a little bigger than she wanted, but ultimately within her range of acceptance. However, when she had them replaced with saline implants, her dismay was pronounced: “I’m even bigger than I wanted to be,” she lamented. “I just wanted to be normal; I didn’t want to be huge.”

One of the reasons Holly did not want to be huge was because she feared that people might look at her or interact with her differently. They might realize she had implants and assume certain things about her personality and values. This was a fear held by many of my interviewees. For better, or for worse, changes in appearance often have identity implications.

Perceived Identity Implications

While they were still in their decision-making stage, projected identity implications were all conjecture, yet they had a powerful persuasive presence—sometimes even dictating whether or not an interviewee would seriously consider surgery. While my breast interviewees tended to talk about the identity implications of surgery in terms of how others would perceive them differently if they had augmentation,²⁰ my eye interviewees talked about how surgery would make them feel differently about themselves. Perhaps these are just two different sides of the same coin; nevertheless, these two different approaches may be linked back to the cultural definitions outlined in the previous chapter. We pursue images of ideal beauty that include large, firm breasts to meet a certain cultural aesthetic and by implication to be found pleasing in the eyes of others, and consequently, to ourselves. We pursue images of normalcy—like the mandate to meet standards of symmetry—so that we do not feel stigmatized by ourselves every time we look in the mirror, and only secondarily when others happen to notice and assign negative connotations to our differences.

My eye interviewees all imagined that as long as the straightening surgery was successful it would bring about positive changes in identity. Hailey felt the identity implications of another straightening surgery would primarily impact her work persona and her dating life. She imagined being more confident when delivering presentations or interviewing. She also imagined she might be dating like crazy if the burden of self-

²⁰ Ironically, many of these same interviewees also displayed a tendency to use the “I did it for me” rhetoric without displaying any awareness of the contradictory nature of these two stances. The “I did it for me” rhetoric is explored fully in Ch. 6.

consciousness was lifted. Hailey specifically mentioned that she did not think that a surgery would change who she was to her friends. She was certain that they wouldn't care one way or the other.

Lori imagined eye-straightening surgery might change her personality in general, because she perceived it would make her less shy. "If I had surgery or vision therapy, and it worked, I think I'd be very different than I am now. Much more outgoing," she predicted. She imagined only positive identity implications if the surgery was successful. She even toyed with the idea that she might be better off with straight eyes even if it meant sacrificing acuity, but then felt resentful that she might be forced by social pressure to make this kind of decision. "You know, it's sad. I was actually thinking the other day, 'Would it be worse to have crossed eyes with good vision, or have one shut off and have straight eyes?' I hate the world we live in."

As Lynn reflected on the identity implication her straightening surgery had, she saw a double-edged sword. She was grateful to look normal, and to have the accompanying confidence and ability to make eye contact. However, she was upset about her hidden identity as someone with one blind eye. Thus far, she feels as though her own children have not suffered any sort of negative identity implications, except for Ben's recent realization that he is different. If Ben latches onto this identity as "different and bad" she may be forced to reconsider her choices regarding his eye treatment.

Without exception, my breast interviewees also worried that augmentation surgery would have profound identity implications and some of these were less positive. Autumn worried about feeling like she was "betraying the gay community" by "conforming to heterosexual ideals of beauty." It seemed hard to reconcile her identity as

an out and proud lesbian with the idea of becoming an augmented woman. However, Autumn said she had reached a place in her life where she felt it was important to do what she wanted to, regardless of how others might interpret her actions. She knew that everyone would “have an opinion about it,” but she told all her close friends, and none of them ever said anything negative about her decision.

Holly’s pre-surgery fears revolved primarily around issues of identity. She recalls:

“When the time came, I’ll never forget the morning. I woke up and I was getting ready to go, and all of a sudden I got this huge fear attack. I was just shaking on the drive over there and thinking, ‘Oh my god; what am I doing?’ It was like changing a part of my identity and the reality of it hit me. I got really scared. I mean, I was petrified. And I didn’t stop shaking until they gave me the drugs.”

The fear of changing her identity was new to Holly. She told me that normally she is not afraid of anything, but this was different. People knew her as a feminist, a “natural/hippie type,” and a confident professional. Holly feared that all of these images might now be fractured.

Fears of identity implications kept Bea from even seriously considering augmentation. She was so firmly entrenched in her position as an uncompromising feminist that she wouldn’t have dared to think too seriously about surgery. The ramifications would be too painful. She would face losing her feminist friends, or at the very least, losing their respect. Because she was so outspoken about her opposition to cosmetic surgery, she also could expect a fair amount of teasing from her family if she

changed her mind. She assumed her mother would definitely be supportive in the long run, since she had augmentation herself, but she dreaded losing social power by reversing her long-held position.

Izzy was worried primarily that her mother and sisters would be horrified if she had augmentation surgery. As far as they were concerned, the Izzy they knew would never even consider such a thing. To a lesser extent, she worried that there would be no way to hide it from people who knew her and she dreaded hearing everyone voice an opinion about cosmetic surgery. Augmentation would be especially obvious to her belly-dancing troupe. Izzy also worried about potential negative psychological implications of cosmetic surgery.

Psychological Implications

Rather than imagining that she might now attract men who would treat her wonderfully, Izzy pondered a scenario where she might just now attract a greater volume of equally unsavory men. She worried that augmentation might actually have a negative psychological impact. “It might even make me unhappier, because I’ll find out guys are *still* big assholes. You know?” she asked me. At least now she could cling to the idea that men weren’t good to her in relationships because she could not maintain their interest on a sexual level given she was flat chested. She hypothesized that it would be even more disappointing to think she had just misdiagnosed the problem all these years. Maybe the problem was with men rather than the size of her chest.

Bea followed a similar line of inquiry, questioning what men actually think about implants and the long-term prospects for being in a relationship with someone who has them. “It could be something that is just momentarily sexually stimulating to look at,”

she speculated. “But I wonder if they could have a relationship with someone like that. I mean, I would have the most uncontrollable urge to pop them. You know? Get a pin and see what happens.” Bea also envisioned unwanted obligations and responsibilities that might come with augmentation. “I like to feel comfortable without a bra, with no make-up and my hair unbrushed,” Bea told me. “Just hanging out with people. And if I had fake breasts... I don’t know how you could have fake breasts and ever go anywhere without your make-up. You know? You have to be ON all the time. You would have to live up to your breasts.” She points to her mother’s behavior as living proof that augmented breasts can be experienced as a call to perfection. She rolled her eyes as she told me that her mother wouldn’t even run to the grocery store without her make-up fully done.

Bea and Izzy were the only two interviewees to spell out negative psychological implications of surgery. They also were the two most outspoken participants. They frequently raised the topic of their minor bodily stigma in every day conversation.

Talking, or Not Talking, About Minor Bodily Stigma

Obviously, my interviewees were all willing to talk to me about their minor bodily stigmas—otherwise they would never have agreed to participate in my project in the first place. I found all my eye interviewees on-line on the LazyEye list-serve. Joining this list-serve provided a powerful coping tool for each of them as they struggled to deal with their minor bodily stigma and to stay abreast of medical technologies regarding their eye problems. Although all of them displayed a keen interest in discussing their strabismus on-line, I soon discovered that this did not necessarily translate into a willingness to talk about it in everyday life. In fact, my eye interviewees

represented a wide range of communication styles. Lynn was willing to talk about her eyes all the time in person, on the phone, or on-line. Hailey was willing to talk about it on-line, or on the phone—but only to people who also had strabismus. She said she wished people would talk about her crossed eyes so it wouldn't be such a big deal, but she did not want to be the one to bring it up. Finally, Lori would only talk about it one-on-one on-line. She did not post general messages to everyone on-line and did not wish to talk on the phone.

My breast interviewees also displayed great diversity in their own personal communication styles. Three of them were recommended to me by friends, identified as “someone who would be happy to talk to you about that kind of thing.” These recommendations turned out to be accurate, and all three willingly shared their stories, thoughts, and feelings. The fourth—Holly—was a friend of mine who only “outed” herself as a woman with breast implants and volunteered to be an interviewee after she had known about my dissertation project for over a year and she knew I needed another person who had decided to pursue surgery. She was very articulate and told great stories, but she also admitted to feeling some embarrassment and discomfort about talking about her breasts. I quickly became aware that the willingness to talk that my breast interviewees displayed during our interactive conversations also did not necessarily correlate to their willingness to talk about their minor bodily stigma in their day-to-day lives. Some seemed to draw solace from talking about it casually, while others preferred to avoid it.

Bea was one of my most outspoken interviewees. She had become so sensitized to breast issues that she developed a sort of hyper-awareness that she openly shared with

everyone around her. “If I’m sitting in a café I’ll go—fake, real, fake, fake, fake, real, fake, real. I notice it all the time. The other night I was at Bella’s [a local Italian restaurant] with my brother for dinner, and this woman walked by with the biggest implants I have ever seen. They looked like giant balloons in her chest. And I said, ‘Oh my god!’ And everyone said, ‘What?!’ And I said, ‘Did you see her breasts?!’ I guess some people just think this is really odd, and I think people think I’m obsessed with breasts now, because I just notice it everywhere.” For Bea, talking about breasts had broader-reaching political implications. By constantly drawing attention to “boob jobs,” she encourages others to remain aware (and hopefully critical) of a practice that has become so prevalent that it becomes practically invisible to desensitized observers. By continuing to voice feminists critiques of augmentation surgery, she also hopes to make others aware of what she perceives as the negative impact of these kinds of surgeries and to encourage young women to resist bowing to the pressure to enlarge their own breasts to boost their self-esteem. Continually talking about augmentation in such negative and critical terms reinforced Bea’s own decision not to even consider this type of surgery.

Izzy was very open about discussing breasts and augmentation issues with flat chested women who she believed might hold critical beliefs similar to her own. She was not as likely to enter into a conversation about it if she thought that the other person was very pro-surgery, if they had large breasts and could not by her definition understand her experiences, or if she was speaking to a male. She could not shake the feeling that she was not entitled to complain (especially to men) about being flat chested, because the technology to fix it existed. I listened to her story with great sympathy and admitted to her that sometimes I wished that breast augmentation technology didn’t exist because

then women wouldn't be pressured into pursuing surgery, and stigmatized if they wouldn't consider this option. Izzy agreed that if there were more flat chested people—because they couldn't get augmentation—then the category itself would carry less stigmatization.

Early on, Autumn felt secure in her identity as an athlete, and rarely talked about her breasts. However, she described having an occasional sense that something was “missing.” This feeling recurred periodically, but only became strong and persistent when she hit her thirties. Autumn insisted her partners never cared about her breast size; however, she soon began to talk about her own breast dissatisfaction on a regular basis.

“Did your romantic interests ever get turned off by your lack of confidence about your breasts?” I asked, thinking of Izzy's story about her ex-boyfriend.

Autumn smiled thoughtfully, and admitted that her insecurity about her chest was much more of an issue than her actual chest size. “I would start on the boob job conversation and they would get their fill of it. They would say, ‘Why do you want to do that?’ or ‘You're just fine how you are.’²¹ So, I may have made it an issue for them unknowingly.”

Holly didn't talk about her breast dissatisfaction much before surgery for a whole host of reasons. Her mother was so modest she never encouraged Holly to discuss how she felt about her body. Later in life, Holly constantly received messages from others

²¹ This reaction is an interesting reversal of the response Izzy got from her boyfriend, who told her she should have surgery if it bothered her. This represents the classic contrast between the self-acceptance stance and the “fix it” philosophy.

confirming she was attractive, so she didn't want to complain. She was also a feminist, and therefore felt she wasn't supposed to care about superficial male-oriented concerns.

Hailey insisted that the worst thing about her eyes was that people were afraid to mention them, so no one ever brought up her eye problem. "I just wish people would be more open," she lamented. She described finally asking an ex-boyfriend if he even knew about her eye problems. He said that he had noticed the crossing, but then shrugged dismissively and pointed out, "Everybody is different." "And I just thought, 'How come you never said anything?!'" exploded Hailey. She was laughing as she said this, but her frustration was evident. "Some people don't say anything to me and I don't know if they know. I wish they would bring it up." Ironically, people probably don't "bring it up" because they are dealing with a double bind of their own as they try to decide if Hailey regards her eyes as flawed, or if they would offend her by talking about it (Ellis 1998).

Hailey seemed especially distressed that her boyfriends never talked about her eyes, yet despite her adamant stance that people should talk about crossed eyes, she seemed reluctant to broach the topic herself. She described herself as being "straight out"—"the kind of person who tends to just talk about anything to anyone." She contrasts this with her mother's reluctance to communicate, and yet when she was going to have her strabismus surgery she told me that she didn't really tell anyone about the procedure. She clearly drew a great deal of comfort and strength from her interaction with the LazyEye list-serve, and she seemed very relieved to find someone like me who understood her eye problems and could talk intelligently about them. But talking about her eyes to boyfriends was still a stressful and daunting task that she had never successfully accomplished.

Lori also enjoyed the opportunity to chat with me on-line because she has the same type of strabismus as I do. She liked to “listen” to others telling their stories on the LazyEye list-serve; however, she could not bring herself to talk about her eyes either on the phone with me, or face-to-face with anyone else. Like Hailey, Lori admitted she could not talk to men she was interested in about her eyes—even if they brought it up. She just couldn’t find the words to explain her experiences to those who had no first-hand knowledge of strabismus. In fact, Lori specifically recalled getting very angry with her two and a half year boyfriend for making an insensitive comment about her eyes. She told me he never once broached the topic until she got glasses. Then, she told me, “he nonchalantly said, ‘You know, I heard glasses can make people get more cross-eyed.’ Humph. He wasn’t the brightest bulb,” she observed.

Lynn doesn’t remember ever talking about, or being told about, strabismus prior to her first surgery at age seven. Since then, Lynn has always been very vocal about her minor bodily stigma. Although it is now easy to hide her difference, Lynn continues to talk about it freely.

She fully disclosed the details about her eyes to her husband on their first date. She tells people about it all the time in her day-to-day interactions, and she is one of the most active members of the LazyEye e-list. She gives advice to others, tells her story over and over again, and shares lots of tales about vision problems experienced by her three boys. Because all three of her children have strabismus too, she constantly talks with doctors, vision therapists, and other parents about strabismus and other eye problems. Lynn surmises that people are much more tolerant and informed today than they were when she was young. She thinks it’s good to talk about strabismus and other

eye problems to demystify them as much as possible, yet her experience with accidentally stigmatizing her youngest son Ben made her realize that sometimes talking about it can create negative consequences too.

Inevitably, all of my interviewees ended up communicating a great deal about their thoughts, feelings, and attitudes toward their minor bodily stigmas. Even when they remained silent, or refused to talk about certain aspects of their experiences with certain people, they were still conveying information. Some of my interviewees even chose to joke about their stigmas, thus injecting a light-hearted element into an often-weighty topic.

Joking About Minor Bodily Stigma

For my breast interviewees, humor presented a safe way to express their distress about their minor bodily stigma. Because they were only joking around, they could not be accused of self-pity or be labeled “complainers.” They extended a kind of unspoken declaration that they were comfortable enough about their own deficiencies to make fun of them.

Holly said that while her mother would never talk about breasts or anything related to the body, she dealt with her feelings about her breasts by joking. Izzy admitted to often using the same tactic. “I keep telling people I’m waiting to grow out of my trainer bra,” laughed Izzy, as she declared she jokes about her breast size a lot. Although Autumn didn’t specifically mention using humor as a way to cope with her flat chest, she joked during our interview about how big her nipples used to be. She commented that it’s strange that human beings place so much emphasis on breast size and searched for comparable behavior elsewhere in the animal kingdom. She concluded humans are the

only ones with this obsession. She pointed out that gorillas were closest to humans in terms of evolution and the females of that species don't really have breasts to speak of at all. They just have nipples. Autumn then laughed and observed, "Maybe that's where I got my huge nipples."

Bea also has always made jokes about her breast size. However, when she got to Tampa these jokes became tinged with much more self-consciousness. She said, "Before I definitely joked about the size of my breasts, but it didn't make me feel like I didn't look good." In Tampa, she suddenly felt less attractive because she was flat chested. However, Bea continued to use jokes to allow her to broach the topic of breast size in a less intimidating way. She revealed that she is constantly making breast jokes and that she always brings up breast-size immediately with guys she dates. "I'll definitely make fun of my breasts before he sees them," Bea said. When I asked her why she did this, or what kind of reaction she was looking for, Bea explained that she is irreverent about bodies and humor affords her an avenue to discover whether or not a guy is comfortable with her style of interaction. She described trying her bra on a chubby boyfriend once. She was surprised to discover he could fill out the cup better than she could. She also told me that she joked around with this same young man and his mom one day when the mother was discussing a disturbing new medical problem. Young boys who ate a lot of poultry were getting a high dosage of an estrogen type hormone that was being given to chickens. As a result, they were developing breasts. Bea then jumped into the story and quipped that maybe she should start eating more chicken. Attempting to analyze her own motives, Bea speculated, "I guess I just make jokes like that before someone can say something to me, because I'm afraid that they will."

While each of my breast interviewees learned to crack jokes about their chest size, I did not note a similar pattern among my eye interviewees. I know from personal experience that I'm quick with quips about being flat chested, but I never kid around about my eyes. My reasons for refraining from composing eye jokes are three fold. First, I just don't find it funny that I have to live with a stigma that causes so many interpersonal difficulties. Second, making a joke about my eyes would draw attention to them—a practice I carefully avoid. Third, I've tried making a joke or two, but no one ever laughed. Once a friend told me to wish her luck on an up-coming test. I smiled and said, "I'll keep my eyes crossed for you," creating a playful variation of the familiar practice of "crossing your fingers" for luck. My friend didn't laugh and an uncomfortable silence fell over us. Ironically, although crossed eyes are a cultural joke that always elicits a laugh in movies and on TV shows, my eye interviewees did NOT joke about their condition.

Although some of my interviewees talked about their minor bodily stigma, some preferred to avoid the topic, and some joked about it, three interviewees exhibited a distinct pro-con communication style. Decision-making is a dynamic process. Someone might decide she could never get cosmetic surgery, and then change her mind as the sting of social stigmatization increases. Or she might waffle back and forth, teetering from one position to another. Autumn, Bea, and Izzy were all fairly adept at articulating the pros and cons of cosmetic surgery and often as they sifted through the conflicting data they found themselves trying out opposing viewpoints. They carried out debates with themselves, and often articulated them to me during our interviews, as they struggled with their options.

Self Debate

Autumn described her decision-making process as a “debate with myself.” She explains, “I was completely flat chested, and I was really okay with it, but at the same time I debated about getting that surgery for a long time. Finally, I realized that it was really more of a question of spending the money than whether I wanted to do it or not.” When she had this insight, suddenly it seemed silly to deny herself satisfaction for purely monetary reasons. She still had a few minor concerns to resolve, but the great debate was over. She was tired of feeling unattractive when she saw herself naked in the mirror and she was willing to spend some money to make this feeling go away.

Of my interviewees, Bea seemed to be the most strongly entrenched in her anti-surgical stance. However, even she indulged in brief moments of debate regarding this position. She readily admitted she admired the look of natural large breasts, but she was eager to tell stories about large-breasted friends who considered their chest size to be a liability. At one point in our interview Bea even stopped and considered a scenario that might make her change her mind about breast-enhancing surgery. Bea asked me if I had seen what flat chested women look like after they finish breast-feeding. “There is nothing left in them,” she began with a disgusted look on her face. “It’s like the life was sucked out of them. And they just hang there.” She went on to speculate that if this happened to her, she might consider augmentation. “I really don’t want little flaps. If I had little flappy things, well then...You know? If they were just hanging like pancakes...I think I would really want implants.” She paused for just a second and her resolve seemed to waiver before her adamant feminist self took control again. “But, I still don’t think I would get them. I really don’t,” she finished on a stronger note.

Later in our interview when Bea began to talk about her grandmother's long litany of face-lifts and her certainty that her mother would get a face-lift, I asked her if she would also consider this type of procedure. Apparently my question took her by surprise, because she paused for a bit and then laughed self-consciously. "You know, the thought that came into my head was, 'it depends how I look.'" She laughed again before deciding, "I don't think so. I really don't. I would always think about it. But I don't think I would. I'm also trying really hard to take care of the way I look now. I wear sunscreen almost all the time. I'm careful with my skin. I try to stay physically active. I try to eat reasonably healthy foods and I don't smoke."

Unconvinced, I continued with this line of questioning. "Do you think though, that you would do a face lift quicker than breast implants?" I asked.

"Oh, if I had to choose?" Bea asked. I nodded, and she confirmed my suspicion. "I would get a face-lift first."

"Why do you think that is?" I asked, curious about how a strident feminist might justify a "vanity surgery."

After a long pause Bea admitted, "I don't think it would be as noticeable. I don't think it would be as big of a change. It would be a much bigger statement to get breasts."

Izzy's feelings about her chest also vacillated back and forth—sometimes solid in her anti-surgical position, and sometimes playing devil's advocate. She remembers, "I went braless a lot in high school and wore halter tops and dresses, and I never worried about it. It seems I worry more now. I make sure I have something in there to make it look like I have a little bit of a shape. So it's interesting. I think I go through these periods where sometimes I just don't care, and I think, 'oh well.'" However, she was

quick to consider the other side of the coin, complaining that her shape is not pleasing. In her estimation, her hips aren't too big, but her top is just way too small, so she looks like a triangle. These discontented descriptions had barely passed her lips when her expression changed and she countered her own statement. "But why? Who cares?" she asked, trying to sound like it really didn't concern her.

Of all of my interviewees, Bea, Izzy, and Lori seemed the most haunted by their minor bodily stigmas. Either in person, or on-line they talked about their minor bodily stigmas the most in their everyday life, they tirelessly pondered the psychological implications of their predicament, and they waged great debates about what to do. Ironically both of my breast interviewees settled upon the same effective coping strategy—Bea and Izzy opted to find a niche within a different, non-breast obsessed culture. This was a strategy that was not available for Lori.

Finding a Niche within a Different Culture

When Bea weighed the pros and cons of augmentation she concluded that she could not bring herself to seriously consider surgery. However, just because she chose not to cosmetically alter her body does not mean that she was suddenly free from self-consciousness. Although she implemented a wide variety of effective coping strategies, she was still uncomfortably aware of her stigma in Tampa. Then she hit upon the most effective coping strategy for her—a strategy that helped cement her decision to reject surgery, at least for now. She effectively "erased" her stigma by immersing herself in a culture that did not place value on breast size. When she moved to South Carolina she told me that she hoped that things might be different there. A year after she moved I wrote to her and asked her if she felt differently about her breasts there. Her reply clearly

indicated that she had been freed from the omnipresent sense of stigmatization. She wrote:

“I definitely do not feel the breast pressure here. I am in a very family oriented community that eats a lot of fattening food. So people who have big (sometimes gigantic) breasts are generally overweight. I actually feel thin here, but I am 10 pounds more than I was in Tampa (proving that weight and appearance are relative). I haven’t thought about my breasts in a long time. It would also be shameful here to get breast implants. It’s the Bible belt. I would never be able to live it down with all the public stuff I do. I feel much more stigma for being 30 and single, but find solace in that I am not 30 and divorced.”

When last I interviewed Izzy she was packing all her belongings and moving to Japan.

She was full of hope that this culture would grant her “normal” status when it came to breast size. In a culture filled with flat chested women she hoped to rid herself of the feeling that she was inadequate because she was small-breasted.

Conclusion

My interviewees implemented a wide range of coping mechanisms to help them combat the pervasive sense of stigmatization that they faced in their every day lives. They tried hiding their difference; rationalizing the performance benefits of certain body types; drawing me vs. them comparisons; and ruling out surgical “fixes” by citing financial considerations, emphasizing the risks of surgery, considering identity implications, and citing undesirable psychological implications. They talked about it,

refused to talk about it, joked about it, and indulged in debates about their options. Some of them even tried out life in a non-breast obsessed culture. The perceived effectiveness of these coping strategies by the woman implementing them seemed to be the determining factor when it came to making decisions about whether or not to pursue surgery. Two women could use the same coping strategies and one might decide to have surgery and the other would not. Decision-making is a complex and ever evolving process. The next chapter continues this inquiry, examining how each woman attached meaning to their experience of stigmatization and the effectiveness of coping strategies, and arrived at a decision about how to deal with their minor bodily stigma.

CHAPTER SIX: DECISION-MAKING, IDENTITY AND COMMUNICATION

Minor bodily stigmas are simultaneously very private and inevitably public in nature. They are hard to hide because others typically can see, hear, touch, or smell them, and they are easily recognized since they are socially constructed through consensus (Ellis, 1998). In Chapter Five, I explored the coping mechanisms employed by my interviewees and proposed that the perceived effectiveness of these efforts was a strong indicator of whether or not the interviewee was likely to attempt a surgical fix for their minor bodily stigma. I also hinted in that chapter that identity might be another strong factor influencing the likelihood of choosing surgery. This chapter explores and confirms this suspicion, examining the surgical decisions made by both breast and eye interviewees, and investigating the role of identity and communication in this process.

I begin by looking at the role of identity as an indicator of potential for consideration of surgical intervention. Imagined new post-surgical identities sometimes served as strong incentive to move ahead with surgical intervention. However, allegiances to old ways of thinking and being could also preclude surgery as an option. Next, I narrow my inquiry to an exploration of the actual identity implications experienced by those who chose to have operations. As they began the difficult task of integrating their new bodies into their self-concept, my interviewees discovered that some of their pre-surgery expectations were met; however, other unforeseen issues also cropped up. Shifts in identity almost always necessitate conversations about these

changes. Hence, my next step was to ask those interviewees who chose surgery how they talked about this momentous decision both before and after the procedure was performed. I quickly discovered that their communication styles mimicked those predicted by Goffman (1963). Two chose to be secretive, while the other two demonstrated radical disclosure. Next, I narrowed my focus to a consideration of how my interviewees reacted to very direct responses from others regarding their surgical decisions. I learned that both those who actually had surgery and those who did not reported being called upon to explain their actions, or lack thereof. Those who did not have surgery tended to react with anger to such confrontations, while those who had had surgery often resorted to what I have termed “I did it for me” rhetoric. Despite this ready defense of their decisions, the interviewees who had surgery all engaged in occasional reconsiderations of their choices. They either held onto regret about things in the past, or they were willing to accept the outcome for now. They all also looked to the future with a mixture of hope and anxiety. Those with good results hoped they would last. Those experiencing problems hoped advances in medicine might provide a solution. If there was one universal hope that all of my interviewees—both those who chose surgery, and those who did not—clung to, it was the hope that one day they would craft an identity that would be at peace with their bodies, no matter what they looked like.

Identity and Decisions

Among my breast interviewees, identity seemed a strong indicator of what decisions a woman might consider. Ultimately, each woman had to ask herself, “Can I imagine myself as a woman with breast implants?” Each interviewee answered this question in her own unique way.

Torn between conflicting familial, ideological, and cultural messages, Bea voiced multiple identities as she communicated the struggle between the part of herself that viewed cosmetic surgery as an unenlightened reaction to oppressive patriarchal norms, and the part that was tempted by the lure of social power accessed through appearance-enhancing procedures. Though she admitted she might consider a face-lift one day, Bea's identity as a strident feminist allowed no room to even contemplate something more obvious and inherently political like breast augmentation. Drawing a distinction between wistful "wants" and realistic "options," Bea admitted, "I would definitely want bigger breasts, but that's not really an option for me. The kind of people I want to attract would not appreciate that. Not only men, but friends..."

Ultimately, she decided she was unwilling to trade in her current stigmatized identity in return for an augmented one. While Bea admits she admires the look of natural, large breasts, she defines augmentation as a stumbling block to meeting her self-esteem goals, a turn off to the kind of people she wants to draw into her life, and an impediment to living a life she values. She also discovered an effective coping strategy that eliminated most of the social pressure that had caused her to desire augmentation in the first place—she moved to a small town in South Carolina where augmentation was considered objectionable. As long as the technology to augment breasts exists, Bea will retain the right to change her mind at any time. But, for now, her decision stands firm. She chooses to abstain from surgery.

Izzy told me that in the final analysis her identity as a member of a close-knit family who disapproves of augmentation kept her from seriously considering surgery. However, she admitted to toying with the idea extensively. "I did recently go to the

doctor to find out how much it would cost,” she admitted sheepishly. “First, I just went to talk about my eyes—because I’ve got some bags under my eyes. They’ve been bothering me. But I knew the second I got there I would ask about breast enhancements. So they went ahead and looked at me. They had me look at Playboy pictures to pick boob sizes.”

“Really?!” I interjected. I was surprised that Izzy’s experience didn’t more closely mirror my own, and that the doctor didn’t show what I considered to be more “medically appropriate” pictures. I quickly told her that at my augmentation consultation I had been shown before-and-after photographs of some of Dr. Brown’s patients, as well as photographs from a book on augmentation.

“Yeah,” continued Izzy. “They said, ‘We’re going to be showing you some pictures. What size do you think you’d like to be?’ And I said, ‘Well, I’d just like to be a size B. I wouldn’t want to be really big.’ And so they said, ‘That’s pretty small. You’d probably want to go at least to a C.’ So right there they’re feeding me this information that even a size B is considered too small! They said the biggest complaint they got from women was they wished they had gone larger!²² So when they sat down and showed me the pictures I was really shocked that they were Playboy pictures, because the women are in all these risqué positions, and they’re acting like hot stuff and everything. For one thing, I expected just to see pictures of breasts. I didn’t expect to see all these sexy pictures. For every single picture the nurse pointed out to me, I said, ‘Those are too big. Those are too big. Those are too big.’ It might have been the position of the girl that

²²Dr. Brown also told me that the biggest complaint patients shared with him was that they wished they had gone larger.

made them look too big, but finally I said, ‘Okay. Those are all right.’ And the nurse says, ‘You really DO want small ones—because those are small.’” Izzy shook her head in frustration. “And they did not look small to me!”

Izzy was relatively comfortable with her identity as a small-breasted woman and did not want to trade it in for a new identity as a large-breasted woman. Although she did long to get just enough of a boost to bump her out of the stigmatized category of completely flat-chested and into the “normal” small breast range, ultimately Izzy was not able to resolve her objections to surgery. Instead she too decided to try to escape her self-consciousness by leaving the culture that stigmatized her.

Holly saw herself as a strong feminist, so she felt conflicted by her desire to pursue cosmetic surgery. She readily acknowledged, “I’ve always been given the message by my family and my friends that I’m beautiful. I’ve always had people wanting to date me. I knew I was sexy even with a flat chest. I knew that I was desired. It was really about wanting to even out my body and wanting to have this Barbie doll figure.” She and all of her friends had just read Naomi Wolf’s *The Beauty Myth*, which strongly renounced the entire beauty industry and entreated women not to succumb to the scalpel in pursuit of unrealistic, uncompromising body images. However, there were other influences that also held sway over Holly. She worked at a hospital and not only saw successful cosmetic procedures performed every day, but she also read lots of publications testifying to the safety and efficacy of breast implants. In addition, she knew the surgeons, and this helped to put her mind at ease as she considered the safety of the procedure. She also was offered a significant professional discount on the surgery and the money she had just received from her soon-to-be ex-husband easily covered the

remaining sum. The final enticement was the mental image of what she would look like in a leotard with her new breasts. Ultimately, she was willing to trade in her identity as a “good feminist” for her imagined new identity as a fitness guru.

Similarly, Autumn’s identity as a lesbian (with all of its implied expectations to abstain from activities coded as heterosexual) was overshadowed by her anticipated new identity as someone who is proactive regarding her own happiness and who is pleased with her body. She debated her options for a long time and carefully considered how her choice might alter her social reality. “The gay community kind of has its own stereotypes. More often than not you can tell from someone’s style that they’re gay,” she told me. Large breast implants would certainly fracture these stereotypes, but she began to wonder if someone who didn’t already know her would even notice smaller implants. Autumn also thought about what a boost in confidence her sister had experienced after her own breast enhancement surgery. For many years, Autumn’s sister felt shy and “socially handicapped” because of her figure. Augmentation altered her self-perception radically, and now Autumn was happy to report that her sister was brimming with self-assurance. After witnessing this transformation, Autumn began to wonder if she could reap similar benefits. “I guess everybody has a different perception of what’s important to her,” she explained. Since she had no children, or other pressing financial commitments, Autumn felt free to spend some of her disposable income on herself. She decided she would tell all of her close friends and family, and just hope for a favorable response. She was tired of hating the image that stared back at her from the mirror, and she was ready to do something about it.

The situation was very different for my eye interviewees. Instead of asking themselves, “Can I imagine myself as a woman with straight eyes?” they pondered questions like, “Will this surgery work, and if it does, how long will the results hold?” They wondered, “Can I gather together both the money and the courage to try this, knowing that surgery could negatively impact my vision?” Or they asked, “Am I willing to potentially lose sight in one of my eyes, or suffer from double vision in order to have a chance at straight eyes?” Fear, or financial struggles, rather than an allegiance to an identity viewed as incompatible with surgery, kept them from taking action. They each fervently hoped for a new identity as straight-eyed women, but they were realistic about their chances. After all, they did not want to trade in their stigmatized identities for disabled identities. They also did not have the option of moving to a place where straight eyes were not revered. There were no existing cross-eyed cultures to flee to and they didn’t want to separate themselves out and live with other people with strabismus—they just wanted to be accepted as normal.

Since Lynn made her decision about surgery as a teenager she wasn’t as aware as my other interviewees of all the potential things that could go wrong. At age thirteen she already had double vision and her right eye was already very weak. It was hard for her to imagine she could make anything worse than it already was. She didn’t realize her eye would eventually go blind from disuse because her brain would shut it off to eliminate the double vision. Lynn just knew that she was mocked by the other children and branded a geek. Everyone around her was beginning to pair off as boy friends and girl friends, and she felt she was never going to get chosen if she didn’t do something about her eyes. She figured the easiest way to shed this undesirable identity was to nag her

parents until they got her a surgery. When Lynn's wish finally was granted she had a new identity as a normal looking, but functionally impaired, straight-eyed girl.

Lured by the promise of a new identity as a confident, attractive, young woman with straight eyes, Hailey got her surgery when she was in her early-twenties, and drew strength from the knowledge that she was willing to take action to change her situation. Like Autumn, she felt empowered when she finally decided to address her dissatisfaction. Interviewing surgeons and convincing one to perform the straightening surgery for free reified her pre-existing self-image as someone who is bold and gutsy. While she also saw herself as a little unsure in her career and love life, she hoped surgery might eliminate these insecurities. Unfortunately her gains in these areas were short-lived, since the benefits of surgery did not last. She remains optimistic about her options, hopes to schedule another surgery soon, and encouraged me to try surgery too. She had a glimpse of the new identity she desires and now she wants to get it back and keep it.

Lori admitted that she hasn't been able to overcome her fear of going to the doctor, but that she thinks having straight eyes would completely alter her identity. "I am so chicken shit to actually go see someone about it. I'm afraid of bad news. That would totally crush me. I'm so sick of not being able to really look at people, but I'm too scared to do anything about it. Pathetic, I know....I get so mad sometimes. I think WHY ME?" she complained. Initially, Lori told me she could not even consider surgery because she did not have insurance. Then she landed a job that carried insurance, but she was soon faced with another dilemma. "I still can't figure out how to go about explaining to my boss why I'd need to take time off," she told me. "What do I say, 'um...I'm cross-eyed, and I hate it'?" Further, she confessed, "I'm quite obsessed about this topic. I swear I

think about it at least every 5 minutes of every day--every time some one looks at me, or every time I start to read and get an instant headache.” Lori hopes that some day she will be able to overcome these fears and have surgery. She routinely asks herself if she is willing to deal with the possibility of having double vision or being blind in one eye in order to have the chance to experience straight eyes. Some days she is sure she would be able to make this sacrifice if she had to. Other days she is not so sure.

More recently Lori admitted to me that her impending motherhood has really caused her anxieties about her eyes to melt into the background—replaced by new kinds of maternal fears. The unconditional love that her new husband showers on her also makes her feel more secure. He doesn’t care that her eyes are crooked, so why should she be so upset about it? With her baby due any week now, it remains to be seen how these new roles and identities may impact Lori’s resolve to try surgery.

Although the kinds of pre-surgery questions that my flat-chested women asked themselves were very different from the pre-surgery questions that my strabismus woman posed, both breast and eye interviewees who opted for surgery reported significant identity implications associated with their decisions to alter their bodies cosmetically.

Negotiating a Change in Identity

Before their surgeries, my interviewees all imagined identity implications, but the perceptions did not always match the reality. Gimlin (2000) points out that one of the most difficult tasks for someone who undergoes cosmetic surgery is integrating their changed body into their identity. She writes, “If not in feminist theory, then in popular culture, there lies an implicit notion that the benefits of plastic surgery are somehow inauthentic and, therefore, undeserved. Although the critics of plastic surgery are

insistent that appearance should not be the measure of a woman's worth, the women who have plastic surgery are nonetheless participants in a culture in which appearance is often taken as an expression of an inner state" (Gimlin, 2000, p. 81). The two breast interviewees who received augmentation each approached the task of integrating their changed body into their identity in very different ways, yet both shared a similar identity crisis and voiced similar justification rhetoric. Augmentation was something that violated the expectations of Holly and Autumn's pre-surgery identities. Feminists and lesbians are not expected to bow to social pressures to acquire large breasts.

Holly described herself as someone who is usually not afraid of anything, but she remembers being overcome by an incredible panic attack on the morning of her surgery. It took a while for her to articulate the idea that her surgery might have profound personal identity implications. She was secretive about her surgery because she realized that this decision might change the way others perceived her. However, it wasn't until the day of the surgery itself that Holly began to think about how this decision might alter the way she thought about herself. She had long imagined the positive identification implications—hoping to become a confident role-model and fitness guru—but now she was also wondering if she could still maintain her identity as a feminist after bowing to patriarchal pressure to gain social power by purchasing larger breasts.

Soon Holly found herself assuming an ever changing and often confusing variety of identities associated with her breasts. She was still a staunch feminist, but now—for select audiences—she was also a woman with a secret. Post surgery, she was now an augmented woman, who was initially thrilled with her new breasts, but then dissatisfied with her asymmetry. She eventually settled into an acceptance of this physical defect, but

then she began to suffer from side effects like encapsulation, fibromyalgia, and rupture. She assumed a new collective identity as one of thousands of chronically ill women involved in the silicone breast implant controversy and the lawsuit against Dow Corning. Now she is a woman with saline implants that are larger than she wanted them to be. When I first interviewed Holly, she complained bitterly about her breasts and framed her decision as a terrible mistake. During our second interview she recanted and said it wasn't fair of her to label her actions as a tragic error. She acknowledged that a lot of good had come from her augmentation. "If I really am objective about it, it's been a very positive experience," she began. "Overall, it really enhanced my body image tremendously. I felt really good about my figure afterward. I met my goal of wanting to even out my body and feel like I was put together more proportionally. So that was a great thing. I felt like I looked better in clothes. And really it's been wonderful in many ways."

Holly clarified that currently she is very upset about, and focused on, the asymmetry. "I hate it, and I don't know what to do about it," she summed it up for me. She felt like this caused her to unfairly color the whole experience as a bad one—drawing only upon the negative identity implications. Holly has had her implants for fifteen years and she told me that if I had asked her ten years ago she would have said she was glad she got implants (in spite of never becoming a fitness guru) and she would do it again. "That was before all the serious problems started," she explained. "I was very happy with the results. I mean, although I was having problems at the time, it was nothing like what was to come." The last five years have truly changed the way she thinks about augmentation surgery, and herself.

Although Autumn never used the word identity, she described herself as someone with a multi-faceted personality that seemed in a constant state of flux. She was a tomboy, then a loner, and then she discovered she was a lesbian. Eventually, she began to think of herself as an incomplete woman, who lacked the breasts that would make her truly “feminine.” Autumn maintained she has always been very tolerant of a wide range of body types displayed by others, but she had trouble accepting herself. She feels she was in denial about her femininity until she entered her mid-thirties and decided to take a stand and embrace that side of herself. After deciding to go ahead with surgery, suddenly Autumn was an “augmented woman,” and initially she showed off her new breasts as though they were just another item that she had bought. I experienced this phase of newfound excitement first-hand during an interview in which she pulled off her top and encouraged me to touch her breasts.

Eventually, this attitude shifted and Autumn began the almost unconscious work of incorporating her new breasts into her concept of identity. During a later interview she recounted a story about getting upset with her partner for bringing up that Autumn had had her boobs done and making light of it in mixed company. She told me, “this is who I am.” She explained further, “I don’t think about it now. Before, I would think of it as something that was missing, and now I don’t really think about it.” Her augmentation relieved her of her sense of stigmatization. She now felt normal and she believed that because she had only gone to a large B, no one would look at her and suspect she had implants. Her girlfriend’s comments undermined this desire to fit in as a normal and to accept the implants as part of who she was now. During our final update Autumn reiterated this rhetoric of acceptance when I asked her if the implants felt heavy to her.

She responded that she wore sports bras and didn't even notice a difference from before. "They don't hurt when I run," she told me. "I ran a 10k this weekend, and it's not like I was thinking, 'oh my gosh. They're bouncing again.' They're just a part of me now." The incorporation of her new breasts into her sense of self was complete.

Lynn credits her surgery with a change in her personality. She morphed from a shy, constantly teased girl into a confident, woman who stands up for herself. She told me, "I was made fun of from my earliest memories, since I began wearing very thick glasses at 9 months of age. The glasses did not keep my eye from crossing, so my eyes were both magnified by the glasses for far-sightedness, and one was crossed. I also had to wear a patch at school for a while. My school was very small and in a very small community. I always had lots of close friends, but also endured much teasing. I had my two eye surgeries during the school year. (Great planning Mom!!!) And no one talked to the teachers, or the students, or anything. I was just sent to school to deal with it. I was very shy, so when I was made fun of, instead of slamming the kid back, I would just put my head down and go away, and internalize the pain. Today, I would handle things differently, since my personality is 100% different than it was then. Kids would ask me to take my glasses off, and then comment on how big they made my eyes look. They stepped on my shoes because I had glasses, called me four-eyes, and cross-eye, and they laughed. Kids are cruel; what can I say? It was tough."

But after her second surgery, Lynn's personality began to change as she settled into her new identity as a "normal." Now only ophthalmologists would notice that there was something wrong with her eyes. Although she had always had an optimistic attitude—which she relied upon to get her through the tough times—her confidence

began to flourish when she was finally able to avoid the label “cross-eyed geek.” Even though she did not regain 3-D vision or any other types of acuity, she quickly learned to adapt and mask her difference. She was so skilled at compensating for her visual deficiencies that she proudly announced she became her school’s badminton champion. As she grew older, she married and began to have children who inherited her eye problems. Lynn soon found herself in the new role as the mother of three sons who all had strabismus and other eye problems. She now had to make decisions regarding their vision and their appearance. She has become one of the most out-spoken members of the LazyEye e-list and a tireless champion of vision therapy. Ironically, although she could easily hide her identity as someone who had surgery to correct strabismus, she now talked about it all the time—thus actively retaining her former stigma as part of her identity.

Hailey also experienced a surge in confidence after her first straightening surgery as an adult. She was even able to do something she would never have had the courage to do otherwise—date a co-worker who she had witnessed making fun of a guy with crossed eyes. She and Steve began dating shortly after her straightening surgery and they hit it off immediately. Before too long they moved in together and things were going really well for Hailey for about a year. She was taking computer classes at a near-by college, and doing well at her job and in her relationship. It seemed her insecurities were a thing of the past until things slowly began to unravel again. She was getting bad headaches from looking at computer screens for too long, she lost her job, she had more and more fights with her boyfriend, and her eyes were beginning to drift out of alignment. Finally,

Hailey ended up scaling back on her classes, breaking up with her boyfriend, and finding a new job and place to live.

Soon she was reliving an all too familiar scenario. She was single, shy about her eyes, and worried that they would limit her career aspirations. But at least she now had access to the discussions and information disseminated on the LazyEye e-list. She was very optimistic about many of the things she learned on-line and eager to try another surgery. This time though she was determined to benefit from the conversations and support available through the community she had discovered on-line. She had expanded her communication horizons and wouldn't have to go through it alone this time. This time she imagined she would share her decision and its aftermath with her new cyber-community.

Communicating Decisions

Different interviewees had different communication styles. Chapter 5 examined how my interviewees talked about their minor bodily stigmas, but here I explore how those who chose surgery communicated their decision and talked about their altered bodies afterward. I quickly discovered that communication style was not a constant. For example, while Hailey boldly declared that she wished people would talk about crossed eyes more, she was very close-mouthed about her straightening surgery, both before and after the fact. The need to communicate shifts with time, and to accommodate different circumstances. After their surgeries, my interviewees were initiated into the world of normalcy, but simultaneously they also became discreditable (Goffman, 1963). Someone might guess that Holly had implants, or notice that Lynn's eye was slightly off. Faced with the possibility of being "found out" discreditable people could respond with

techniques ranging from radical disclosure to divulgence to only a small core group. Goffman (1963) notes, “A very widely employed strategy of the discreditable person is to handle his risks by dividing the world into a large group to whom he tells nothing, and a small group to whom he tells all and upon whose help he then relies” (p. 95). Holly was a classic example of this strategy. Feminist concerns kept Holly from talking about her implants both before and after she received them. She had constructed an identity as a strong feminist, a very “natural” woman, and a leader at work and socially. “I’m a real model for a lot of women,” admitted Holly when I questioned her about her involvement in a women’s organization she founded. “I don’t want them knowing that I have this, you know? Sometimes I will reveal it if there’s some therapeutic reason to and I don’t want to mislead anybody.”

However, Holly’s augmentation was only a secret in select circles. She hid it from her family by wearing baggy clothing during her infrequent visits with them. If anyone noticed, they chose not to broach the topic. Despite the fact that she was initially thrilled with the results of her augmentation, in general, Holly did not tell anyone but close friends, and her husband’s friends. Holly recalls that when she married her current husband, Hal, she was adopted into a new circle of friends. She described them as a very artistic and highly intellectual, “well-to-do” group who were doctors and artists and interior designers. “So it’s okay for them to know for some reason,” she shrugged as though it was taken-for-granted knowledge. “They’re okay with that.” Many of them had had cosmetic procedures themselves, so the idea was normalized to them. But in general, Holly was very reluctant to talk about her implants. In fact, she and I had been

friends for years before she even mentioned it. When she did tell me it was only because of my role as a researcher who needed another volunteer for my study.

Holly told me that one reason she was able to successfully hide her implants was that she didn't buy any new clothing afterward—just new bras. Her clothing style was so loose and “hippie-like” that her existing wardrobe could easily accommodate her new chest. Eventually, Holly found that her implanted breasts led to clothing complaints. Although she now looked much better in a leotard, because of her asymmetry she has to wear under-wire bras to keep her breasts in place. “If I'm in a swimsuit (that doesn't have under-wire support), it's real obvious. So it limits me now in what clothes I can wear,” she complained. Because of this problem and the other side effects like encapsulation and fibromyalgia, Holly also became involved in a formal communication of her dissatisfaction and anger concerning the problems associated with silicone implants when she contacted a lawyer and took part in the lawsuit against the Dow Corporation. Although anonymous to a large extent, she was now part of a larger voice of dissent.

Hailey also was secretive about her decision—only telling her mother and one or two close friends that she was going to have straightening surgery. While she didn't prepare most of her friends for the change, many of them noticed the difference immediately. One of her friends even commented, “Hey, your eyes are straight now.” As Hailey suspected, the surgery didn't make any difference to her friends. She explained that they didn't care how she looked. They cared about what kind of a person she was and about practical things like whether or not she could still drive and take turns driving to parties or clubs.

Since Hailey didn't have a boyfriend when she got the surgery she couldn't comment on what she might have said to prepare a partner for this experience. She was quick to tell me that she never really talked about her eyes to her new boyfriend Steve. When they first met and she witnessed him making fun of a co-worker with crossed eyes in private, Hailey told Steve she didn't think that was nice and that she had had strabismus too. She said he acted like he understood what she meant by this, but she secretly wondered if he made the connection. Furthermore, she admitted that when she moved in with Steve she filtered all of her mail from the LazyEye e-list into a special folder so he wouldn't accidentally glance over and see the tag line [LazyEye] and start asking questions. She only viewed these posts when she was alone in the apartment. Ironically, though she repeatedly told me she wished non-stigmatized people would talk about strabismus more, and not place the burden of discussing it only on the shoulders of the one who carried the stigma, she did not feel it safe to talk about her surgery with anyone other than the e-list members.

In sharp contrast, Autumn broadcasted her decision to get augmentation surgery—actively seeking a “discredited status.” Goffman points out that a stigmatized individual who doesn't want to hide “can voluntarily disclose himself, thereby radically transforming his situation from that of an individual with information to manage to that of an individual with uneasy social situations to manage, from that of a discreditable person to that of a discredited one” (Goffman, 1963, p. 100). Autumn felt more in control and better equipped to deal with potential negative reactions if she was upfront about her procedure. Autumn talked about going through definite stages with regard to her communication about her augmentation. After she decided to pursue augmentation,

Autumn recalls that telling others about her decision was often “awkward,” but it made things much easier for her later. When I asked if anyone noticed her augmentation before being told about it, Autumn was quick to admit, “I probably told everyone. They couldn’t have a chance to notice without me telling them.” She went on to explain that she knew that long-time friends would notice. By telling them beforehand, she avoided placing herself and her friends in potentially uncomfortable situations. However, with newer, “post-surgery” friends, she typically chose not to divulge her augmentation status. She figured they probably wouldn’t notice, since the implants were small.

Immediately after her surgery, Autumn recalls, “I was showing everybody my breasts, of course—like everyone does when they have it done.” Providing a testimonial to all who would listen, Autumn was pleased to tell people that she successfully exorcised her dissatisfaction by pursuing augmentation. She remembers being sore for a while after the surgery because she was so flat that the skin was stretched uncomfortably taut. While it was a couple months before Autumn could resume her exercise regime, the procedure didn’t keep her from work for long. She recalls, “I had the surgery on a Friday, flew back home on a Monday or Sunday, and I think I was at work on Tuesday.” After her surgery she was thrilled with the way everything fit and she especially loved the sexy way that dresses accentuated her new curves.

As time passed, Autumn also began to notice that constantly drawing attention to her breasts interfered with the process of incorporating her implants into her self-concept. Although she enjoyed the compliments, she admitted that after a while, “you kind of get over that.” As she moved out of the phase where she showed off her breasts as a new acquisition, Autumn began to incorporate her new breasts into her self-image. She found

herself forgetting about her breasts for the first time. “This is who I am now,” she insisted. She didn’t want to talk about it anymore and suddenly she found herself getting upset when her partner “outed” her in mixed company and “made light” of her surgery. She was quick to put a stop to this behavior by telling her partner that she didn’t like these revelations. These were now her breasts and she didn’t want them pointed out anymore. Her self-consciousness is now gone. “I look just like a normal person rather than a flat-chested woman...I look like a proportionately balanced person.”

While Autumn felt less and less compelled to talk about her surgery as time went on, Lynn felt more and more bound to talk about hers as she grew older. Initially, she informed people on a need-to-know basis.

Lynn didn’t become outspoken about her eyes until she had children who also showed signs of strabismus. Suddenly, she had a strong need to talk about her now hidden stigma. She soon found that talking about crossed eyes and other vision problems on the LazyEye e-list became an every day habit. She told me, “Today, when I read about children going to public school on the LazyEye list, that are patching and all that, I am happy to hear about all the communication between the teachers, principal, and students regarding what the child is going through. It is fantastic. There also seem to be a lot more kids in glasses these days. For kids going through this now, I think it is totally different. We do home school, but my boys went to school for a time, and my Kindergartener had two kids in his class with glasses, and one was patching. My first grader had FOUR kids in his class with glasses. It is a conversation starter between the mothers, but it is just so common to see kids with glasses these days that it is no big deal to their peers.” She went on to explain that talking about strabismus to other mothers was

also easier because of the foot-in-the-door provided by their conversations about glasses. It was easier to jump to conversations about other kinds of visual problems once a broad base of awareness was established. Delivering her own style of testimonial, Lynn was happy to draw attention to a stigma she could probably successfully hide if it meant creating better lines of communication for her children in the future. Having suffered a lot of teasing when she was little, she hoped to be able to shield her sons from these kinds of negative responses from others.

While one might argue that all communication about our decisions to have or abstain from surgery stem from a response to an imagined audience, in the next section I look at how all of my interviewees responded to actual feedback from others. Those who did not have surgery never had to prepare people for the change or justify their choice afterward, but ironically, they also were often called upon by others to explain their lack of action.

Dealing With Other People's Responses

Both the interviewees who pursued surgery, and those who did not, were held accountable for their actions. Perhaps because minor bodily stigmas are socially constructed and agreed upon, people often take the liberty to tell the stigmatized exactly what they think of her decision to either fix, or live with the physical difference. None of my interviewees were immune to this critique—which ranged from complimentary, to insulting.

Autumn experienced both ends of this spectrum of responses. Her partner's stepmother was openly critical of her decision, but Autumn also received many compliments on her new breasts. If imitation is the sincerest form of flattery, then

Autumn soon received the ultimate compliment. Her partner liked the look so much that she decided to have her own breasts done in combination with a tummy tuck. Autumn felt most validated when she got a mammogram and the technician was so impressed with her implants that she asked for the name of the doctor because her daughter was thinking about augmentation. The technician had seen a lot of implants in her life, but she could not believe how perfect Autumn's looked. She was also excited there weren't any scars.

The way in which people responded to Holly's implants was very different because she didn't talk about them very much and she later experienced so many problems with them. She told me, "When I first had them done, I didn't show them off. I hid them. I remember people at work saying, 'God. You did all this. Why do you hide it?' But it wasn't about showing off," she explained. "It was about feeling that my body was proportioned. I really did enjoy having this for the first time." Men also had a varied reaction to her implants. Her ex-husband hated them because he said, "that was not what he married." But later suitors liked the full-breasted look and Holly reported that she felt more uninhibited and confident than ever when it came to intimacy. "The sex was definitely better," she smiled.

The response that Hailey got from others was much more subtle. Some of her friends noticed and commented that they thought it was "cool" she had gotten her eyes straightened. They didn't have an issue with her eyes before, so they didn't have much of a reaction. However, the response that Hailey was most excited about was the interest that her co-worker, Steve, displayed. Though she can't prove a direct correlation, Hailey

believed that he was reacting to her new confidence and appearance. This response was exactly what she had hoped for when she got the surgery.

Lynn also hoped to attract boys with her newly straightened eyes, but her surgery took place so long ago she finds it hard to recall specific responses. She just remembers it was hard to be in school, to take time off for the surgery, and to then come back looking different. No one bothered to explain the situation to her teachers or the other students, so since Lynn was initially shy and didn't broadcast an explanation, others were left to puzzle out the details by themselves. Long term, Lynn got the response she had hoped for. She experienced a huge boost in confidence and managed to attract and marry a wonderful man.

While those who pursued surgery naturally expected some sort of reaction from those around them, even my interviewees who had *not* had surgery felt called upon to account for their lack of action. In my experience, alcohol can easily contribute to an environment ripe for producing these sorts of thoughtless critiques.

One night, after work, I went out for happy hour with my relatively new friend, Fred. At the time I had lived in Tampa only a couple years and he innocently asked how I liked it here. I was in a bad mood about an incident that had happened the night before and I was quick to complain about it to Fred. "Last night I went to the Hydeaway with my boyfriend," I began bitterly. "There were all these beautiful women with their fake boobs pushed up to their necks and my boyfriend didn't so much as glance at me all night long." I was hoping that Fred would side with me—pronouncing my boyfriend an insensitive jerk and renouncing society's unrealistic beauty standards. Instead, without batting an eye, he suggested, "So why don't you get a boob job?" Instantly, I felt insulted

and angry. I wanted sympathy and support, not an “if you can’t beat ‘em, join ‘em,” attitude. For a long time I categorized this sort of attitude under the rubric of “typical male attitude.” Of course it was easy for them to suggest augmentation, I thought to myself. They didn’t have to implant a foreign object in their chests just to get members of the opposite sex to look at them. However, in more recent years I have also had female friends with breast implants ask me why I don’t get them. They would issue a testimonial about how they felt so much more confident and attractive with their new breasts and encourage me to give it a try. It was almost like they couldn’t stand to see someone still suffering the way they used to suffer before they had their surgery.

Izzy’s TJ Max story about the woman who followed her around the store badgering her about getting implants recalls a similar “testimonial to implants” from a complete stranger. She also was insulted and hurt by the guy she was dating, who told her to “get a boob job” if she was unhappy about her breast size. Like me, Izzy had hoped that her complaints might elicit sympathy—not a mandate to fix it with surgery.

Because Bea has such a strong identity as a strident feminist, most people knew better than to ask her why she didn’t pursue augmentation. However, even she was strongly affected by what she described as a palpable feeling that people were looking at her and wondering why she didn’t get a boob job when she went out partying in Tampa. She said everyone would be wearing tight clothing that accentuated curves and showcased cleavage, and she could just feel the unspoken critique.

Lori also experienced this pervasive sense that others were critical of her appearance. This feeling colored her interpretations of situations such that she automatically read arguably ambiguous data as an affront to her eye condition. As I

listened to her examples, I simultaneously understood why she felt offended, and recognized that her reading of these situations might easily sound paranoid to someone who didn't have to live with the daily habit of wondering if someone was going to notice her eyes and make a comment. In an angry e-mail written the morning after one of these incidences, Lori expressed frustration about her eyes. "Last night I went to the bar for St. Patrick's Day and a guy started to hit on me. Then he asked 'how come every time I try to look at you, you look away? Are you antisocial, or what?' Some people are so rude and clueless!" she ranted. Then the tone of her e-mail shifted as she went from mad to sad. "People tell me I have a bad view of myself. I think I'm like this unattractive person not even worthy of dating because one of my eyes is turned in. Why are people born with big noses and that's okay? Some have huge ears; that's fine. Crooked teeth? Not so bad. Crossed eyes? ...We're avoided like the plague."

Lori, Izzy, and Bea were clearly and unapologetically angry about the standards of physical beauty promoted by society, yet they had not decided to pursue a surgical solution to their problems. It is interesting to note that those who did seek surgery seemed far more likely to deny that such cultural, or social pressures had anything to do with their choice. Instead, most of them adopted an "I did it for me" rhetoric.

I Did It For Me!

Despite their acknowledgement of the unrelenting cultural and social pressure to alter their appearance, all but one of my interviewees who pursued surgery adopted an "I did it for me" rhetoric that mirrors the prevailing cultural attitude discussed in Ch. 4²³.

²³ Roberts (2000) referred to this as the "language of liberation," and the prevalence of this rhetoric of justification in the overarching culture is discussed further in Ch. 4.

The responses of others were certainly taken into consideration, but they insisted the primary motivation was personal. Lynn was the only exception to this. She was a teenager when she finally convinced her parents to get her the purely cosmetic, straightening surgery, and she unabashedly admits she wanted it so that others would stop making fun of her. Those who made their decisions as adults seemed curiously compelled to deny that peer pressure might have influenced their decision.

Autumn insisted that her dissatisfaction with her breast size wasn't an "other people thing." She pointed out that none of her partners ever took issue with her breasts, and maintained she was the only one who was bothered. I countered this line of thinking by suggesting one might argue that dissatisfaction with your own appearance is intrinsically an "other people thing." When a girl judges herself, she figuratively steps outside of herself, imagines what she looks like through the eyes of another, and finds herself lacking. Autumn respectfully disagreed. "It wasn't for anyone else. I did it because I wanted to do it, because I've wanted to do it for a long time. Not at anyone else's urging, or pressure, or encouragement, or someone else paying for it for me, or any of that stuff." However, later Autumn said something that suggested that the source of her dissatisfaction was indeed rooted in her assumptions about what other people thought of her body. She said that now if she goes topless at a private outdoor lesbian event during the summer she doesn't have to feel like everyone is thinking, "Oh my gosh! Look at that girl. She has no chest."

Rather than looking to her relationships for justification, Holly framed her "I did it for me" assertions in feminist terms. She adamantly refuted the implicit feminist accusations that she was a cultural dupe to oppressive patriarchal norms that compelled

her to seek surgery. Instead she interpreted her actions as an empowering statement about self-determination. She did it for herself—to enhance the quality of her life and broaden her career options. To prove that she had done it solely for her own benefit, Holly pointed out that after her augmentation, she and her ex-husband experienced a short-lived reunion, and he hated them. She believed he interpreted her decision to do this on her own as taking a step away from him and showing her ability to make decisions without him. She claimed to be okay with this rejection because she certainly hadn't done it for him in the first place.

Hailey also maintains she pursued surgery for herself. “When I was older—just for myself—I wanted to find out if it could be fixed,” she told me. She visited a couple doctors and they told her that she should have had the surgery when she was little if she wanted to regain 3-D and depth perception function. They advised her she was now looking at strictly cosmetic surgery. She decided this was something she really wanted, so she had the straightening surgery. I questioned whether or not Hailey was doing it just for herself, as she claimed, or whether these types of appearance-related surgeries are not always inherently about other people. I pointed out that she and I were living in the top two states with the highest percentage of individuals pursuing cosmetic surgery—California and Florida. Hailey was intrigued by this and said, “Wow. Maybe that’s why we are inquiring so much now,” but then she reverted back to her initial stance, denying the influence of outside sources. “Personally, I would have to say it’s just to improve my self-esteem,” she insisted. “It’s just for my self-improvement. “I don’t think I care what people think. Maybe it’s because I’ve never been picked on. Otherwise I might care. But I care because I want to care—for me, for my self-esteem, so I can feel good.”

Rethinking Choices

All four of my interviewees who chose surgery engaged in speculations about what their lives would have been like if they had made different choices regarding their minor bodily stigmas in the past, and about what surgical decisions may confront them in the future. Because Holly, Autumn, and Hailey spent so much time debating whether or not to have surgery in the first place, and because both Lynn and Holly suffered side-effects, it seems only natural that they all engaged in some form of second-guessing. Also, surgically straightened eyes tend to drift, and implants must eventually be replaced, though they may outlast the ten-year expectation. Thus, the temporal nature of both of these surgeries invites speculation about future procedures.

Autumn was by far the most satisfied with the results of her surgery, yet even she chose to take an occasional look back, to wonder about what might have been, and sometimes looked ahead with trepidation. “Many times I thought about just having my nipples reduced and not bothering with the augmentation,” Autumn acknowledged. “That might have been okay, because I could have gone without a bra, but what I have is great now. They are perfect.” Although she’s extremely pleased with the results, Autumn does still wonder how permanent this feeling will be. “Of course, on occasion I still have that little voice that goes, ‘Gosh, I wonder how long they’re going to last?’ It’s not a nagging thought or anything. But sometimes when I go running, sometimes I think, ‘Wow, I wonder if this is going to make ‘em pop sooner or something’.” Autumn went on to explain that while she understands it would not be an emergency situation if her implants ruptured, she fears that the surgery required to take the old implant out and

insert a new one would not be as “neat and clean” as the virtually no-scar technique used to put them in originally. She was too afraid to ask the doctor exactly what she might expect in such a situation, but she imagines it wouldn’t be pleasant. She did point out that her sister has had implants for more than ten years, and hasn’t had to deal with replacement yet. While Autumn is much more active than her sister is, she is confident that augmentation technology has improved significantly since the time of her sister’s surgery. She told me she has no second thoughts about having surgery, and doesn’t anticipate any unless “something goes awry right now.”

When I asked Holly if she thought she would have reached the same level of confidence at this point in her life if she had not gotten implants, her immediate response was, “It’s hard to say. I don’t know.” But when I pushed her to really think about it she speculated that if she had just had the nipple reduction she thinks she would have been fine. Holly now realizes that when she had the surgery she wasn’t able to distinguish between her feelings about her nipples and her feelings about her breast size. “I was just sort of thinking about my boobs,” she recalls. It never occurred to her to just have her nipples reduced and not have the implants. “But that’s probably what I would do if I could do it over,” she decided. “I’d definitely do the nipple reduction again without a doubt. That was a big problem and would still be a problem today.”

Holly’s post-surgical complications leave her with another decision to make. Should she have her implants completely removed? “You know, I had a friend who had hers removed,” Holly told me during our first interview. “She pretty much had the same history as I did. She had her silicone ones removed. But she just had them taken out, and went back to being flat because she hated them so much. And I know what she means.

I've considered it myself," Holly admitted solemnly. Returning to her story about her friend's experience, Holly concluded, "She's very much happier without the implants. But she admits it looks real bad. So I kind of feel like I'm not ready to do that yet, but I have a feeling I will end up doing that in the long run. When I feel like looking good is not important to me anymore—when I don't look that great in a swimsuit anyway—I might do that." With her voice tinged with regret, Holly acknowledged, "I look at Ally McBeal, and I think, 'look how cute she looks with her little flat chest.' And I could've been like that. I didn't need these things. I feel like now I'm in a trap. Because if I get 'em taken out I'm going to have this ugly deformity. And my friend did tell me that it looks horrible." Later, in our second interview, Holly seemed to have made at least a temporary peace with the decisions she had made. She had decided to quit torturing herself with pointless "what ifs?" "This is what my journey has been," she said simply.

Lynn was driven to question the decisions she made in the past because she suffered a terrible side-effect—her straightening surgery led her to go blind in her right eye. While she is grateful that she has straight eyes now, she still wishes that she could go back in time and try vision therapy instead of surgery. Her regrets have fueled her resolve to ensure she makes the most informed decisions possible with regard to the care of her children's eyes. Her youngest son, Ben, is engaged in vision therapy and is showing marked improvement. He has developed some 3-D vision—something that Lynn doubts she ever had—and the degree of eye crossing with his glasses on is considerably less. Lynn was so pleased with the results her son is experiencing that she has decided to try vision therapy herself. Although it will be several months before she

goes for an evaluation session, she is optimistic that maybe it's not too late for her to experience some benefit.

Meanwhile, Lynn is also experiencing some new problems. The pupil in her blind eye has begun to enlarge. This not only looks kind of strange, because it does not match her other eye, but it also has led her to develop a squint in bright light, because her eye instinctively wants to close to block out some of the light pouring in. Her blind eye has also begun to drift just slightly out of place and doesn't look as straight as it once used to. Lynn believes that eventually she may have to go back in for another corrective surgery.

Hailey's regrets about the past are two-fold. First, she wishes her mother had enforced patching and taken her to the doctor when she was young. If she ever has a child with strabismus she vows to get her proper medical care and to strictly enforce any necessary regimens like patching. However, she has tried hard to accept her reality, rather than dwelling on regrets. "I can't change things," she pointed out, so she's tried to stop questioning her mother's decisions. Ironically, Hailey's second reason for regret is that she herself chose to ignore follow-up treatment prescribed by the doctor who operated on her as an adult. The doctor gave her drops to put in her eyes and glasses to wear and she ignored both of these instructions. She now lives with the nagging suspicion that this may have been the reason why her results did not hold. She thinks she may have put too much strain on her newly adjusted muscles and that may have triggered the regression.

Now Hailey faces another decision regarding whether or not to try a third surgery. She achieved immediate results following the strabismus surgery she had as an adult, and

to her great relief, her eyes were finally straight. However, after a couple years her left eye began to drift inward again. The turn is not quite as noticeable as before, but it gets worse when she is tired and the nagging strain of self-consciousness is back. Since Hailey is once again single and worried about men, and dating, her insecurity is magnified. Not only is it hard to overcome the stigma of looking different, but it's also very difficult to flirt and make eye contact with prospective dates when they can't tell where you are looking. Hailey wants to attempt another corrective surgery, but she has not begun to plot out the details yet. She is, however, certain of one thing. She will follow all of her doctor's post-operative instructions in hopes that this time the improvements will last.

Conclusion

Coping with having minor bodily stigmas like crossed eyes or small breasts is all about the struggle to feel comfortable with yourself. If you can't resolve feelings of self-consciousness within your own self, it's often time to take action. Bea and Izzy found it was helpful to surround themselves with cultures that accept a wider latitude of difference. Lori discovered that finding a partner who is supportive and non-judgmental could help ease the path to self-acceptance. Holly, Autumn, Hailey, and Lynn all chose to pursue a surgical solution.

Decision-making about cosmetic surgery is a process that remains ongoing. Bea could say "no" to surgery now, but decide to say "yes" years later when childbearing and nursing reduced her breasts to an appearance that even she found unacceptable. Choosing surgery is typically not a once-and-done phenomenon. Implants rupture, eyes wander out of alignment or cultural trends change—once again pressuring women to

consider further alteration. Feelings about the effects of cosmetic surgery can also vacillate wildly. Holly provided a good example of this point. I discovered first hand that asking her about her breasts at different times could elicit radically different answers. During our first interview she was completely negative about her experience. Our second interview revealed a change in heart. It seems there is no set-in-stone opinion—“This is how I feel about this experience.” When dealing with human subjects our findings are always contextually situated.

The construction of a sense of identity is also an on-going process. This chapter illustrates that the way in which we talk about and think about ourselves can radically impact our experience of minor bodily stigma. Contrasting Holly and Lynn’s situations provides a nice example of this principle. Both have different stigmas, but both sought surgical intervention to help normalize their appearance. Both suffered terrible side effects. However, Holly has kept her story largely to herself until now. Lynn uses her own experiences to help inform and educate others. They beautifully illustrate the two conflicting sides of minor bodily stigmas. They are both intensely personal, and unavoidably public.

CHAPTER SEVEN: CONCLUSION

I hovered anxiously in the doorway of the kitchen feeling a strange mixture of joyful expectations and uncertainty. There was a social, happy life to this place. I smiled as I watched Pauline's face glow as she embraced her best friend Millie. Pauline and I had moved into this house about two weeks ago and already I loved it. I had the nicest bedroom—the huge one with the fireplace and beautiful view of our shaded backyard. Although I hadn't known Pauline before I moved in, she and I had connected at a deep level almost immediately and I already knew we were going to be best friends.

I surveyed Mille with admiration. Pauline had certainly described her well. I could easily imagine her modeling part time. She was beautiful, with perfect proportions and this incredible, long, silky, auburn hair. I hoped she liked me. I was already imagining that we would become an inseparable trio.

Pauline turned to introduce us and I looked Millie right in the eye, smiled broadly, and said hello. Millie returned the greeting, but her smile had faded. Pauline said something about how I had come to live in Australia. I nervously outlined how I got my Fulbright, and began a brief description of my research on Aboriginal Land Rights.

As soon as I paused, she said it.

Millie stared hard at my face and said, "Your eyes are crooked and I find it really distracting to look at." Then she turned away as though she were dismissing me.

Deeply ashamed, I immediately lowered my eyes as Millie turned back to Pauline and happily began another conversation. I could feel the blood pulsing through my neck, filling my frozen face. A sickly smile that said, “please forgive me and like me anyway” lingered on my lips. For the millionth time I wished I could hide my sad, crossed eyes.

What the hell did she expect me to say in response to that? an angry part of me wondered. *Was I supposed to say I was sorry? Or should I tell her I found her comment to be insensitive and pointless, since there was nothing I could do to “fix” it for her? Should I tell her I thought she was just plain mean? What do you say when someone says something that rips your heart out?*

I stood there on legs wooden with despair, listening to the conversation between Pauline and Millie. I didn’t want to look like a hurt child who was running away. Five minutes crawled by before I decided I could leave without looking too unfriendly. Silently I withdrew, unnoticed. Leaving the friendly chatter and laughter in the kitchen, I walked swiftly down the hall and slipped into the safe confines of my own room.

“OUT!” I shouted angrily as I spotted Pauline’s Staffordshire Terrier, Monty, sprawled on the tiger blanket on my bed. “You know you are not allowed in here!” With an unhappy grunt, Monty hoisted himself off my bed and waddled out into the hall. I shut the door behind him and sank into my bed. Crawling under the covers, I let tears slide down my face and seep into my pillow. *Why did I think it would be any different here?* I thought bitterly.

Introduction

Moments when we are picked on, stared at, or spoken to unkindly because of a minor bodily stigma may be fleeting, but they are typically magnified a million times in

the mind of a stigma bearer. As this dissertation illustrates, some individuals construct an interpretive frame based on these types of memorable negative experiences. They then filter social interactions through this frame, and stories are created that fit this negative interpretation. For example, Lori met someone at a bar who assumed she was anti-social because she would not meet his eyes when he tried to flirt with her. Instead of hearing the hurt and rejection in his tone, she pronounced him an insensitive jerk, who didn't, and couldn't, understand about her eyes. When Millie made an unkind comment about my eyes almost eight years ago I immediately characterized her as an unfeeling, self-centered, bad person. Furthermore, I judged this incident to be "typical" of how I could expect to be treated by strangers, even though I could probably count the number of such incidences I've experienced in my life on one hand. It is telling that although my feelings about this incident have softened over the years, I never forgot it. This memorable scene fit with the larger "story" about my crossed eyes that I often tell myself. It is part of an over-arching interpretive frame that positions crossed eyes as a terrible affront to symmetry, beauty, and normalcy.

In this dissertation, I invited the reader into both the private and public worlds of minor bodily stigma. Traveling back and forth between personal stories and cultural observations, I sought to draw readers in with the immediacy of narratives (Charmaz, 2000), and then to illustrate how these stories are a reflection of the many levels of culture from which they arose. As we have seen, performing self-diagnosis and implementing the resulting treatment plan has become a routine burden for most Americans. If cosmetic surgery has become the cultural lens through which Americans look at issues of beauty and ugliness (Haiken, 1997), then minor bodily stigma is the

personal lens through which we scrutinize our bodies and self-diagnose our own flaws in the first place (Ellis, 1998). My research revealed that once a minor bodily stigma has been identified, the gaze is then often reversed and this troubling flaw is examined through the lens of cosmetic surgery in an attempt to meet overarching cultural standards of beauty and normalcy.

Since everyone can relate to the pain of self-consciousness about appearance at some level, I invited readers to think about their own minor bodily stigmas, even if they did not match up with the two types explored here. I also invited them to think about their interactions with others who bear minor bodily stigmas. I have shown how my interviewees put information about their bodies together in meaningful ways, how they talked about this information, how they formed their own conclusions, and how they acted, or refrained from acting, in accordance with these conclusions. In this final chapter I draw some of my own conclusions about crossed eyes and small breasts in particular, and minor bodily stigma in general.

I begin by focusing on the two flaws that inspired this dissertation—strabismus and micro-mastia. As I compare and contrast these two conditions I review what I learned from my research and tease out broader proposals and questions about the overarching category of minor bodily stigma. First, I look at the ways in which we cope with, make decisions about, and communicate regarding minor bodily stigma. Second, I examine the tendency to want to deconstruct minor bodily stigma—observing that my eye and breast interviewees approached this task very differently, but that both revealed useful strategies for future negotiations. Third, I broach the tricky concept of gender—investigating what role it played in my research and speculating about its function in the

overall phenomenon of minor bodily stigma. There is still much to be learned about how men and women might talk about, think about, and experience physical flaws differently. Finally, I conclude my qualitative research with a story that invites new beginnings and different stories. Standing in stark contrast to the “Millie” story that began this chapter, this tale bears narrative testimony to many of the ideas put forward by this dissertation. The concluding story reinforces the notion that acceptance by others helps pave the path toward self-acceptance and vice versa, it illustrates the hierarchies that exist within the category of minor bodily stigma, demonstrates that communication about stigma is often difficult and emotionally painful, presents an example showing what happens when two different types of minor bodily stigmas interact, and shows how our stories grow and change as we do.

Theorizing Minor Bodily Stigma

Minor bodily stigma is an ever-evolving field. As the categories of people targeted for cosmetic surgery expand to encompass new populations like men and teenagers, new flaws are “discovered” and emphasized. T.V. and radio shows built around the premise of providing a lucky recipient with the money to get the cosmetic surgery he or she has always wanted are cropping up everywhere. Understanding minor bodily stigma is a daunting task. Any overarching theories about minor bodily stigma must be flexible enough to take into account the countless varieties of deviations from the “norm” that would fit under this umbrella category. Anyone seeking to draw larger extrapolations from my particular research has to exercise caution. However, there is still a great deal of useful knowledge to be taken from this dissertation. In order to understand how this knowledge might be most usefully applied, it’s important to revisit

an earlier discussion of how the two separate minor bodily stigmas I examined “fit” together in a larger theoretical sense.

Eyes and Breasts

I decided to study micromastia and strabismus because I wanted to explore a topic that I understood at a deeply personal level and that I thought might have a significant impact on my own life and the lives of others. When I began my research many people thought my investigation represented an odd pairing. Breasts seem to be a hot topic right now, but I was often questioned about why I wanted to look at eyes too. I understood why they challenged my rationale. Arguably there was a significant numerical imbalance in the two stigmatized populations I was examining, and in the interest generated by each type of minor bodily stigma. Women comprise more than half the population. Since they have breasts, consequently, most women are interested in talking about, or learning about, breasts. Many men also have a demonstrated interest in breasts.

In contrast, there is a comparatively small population of people who are afflicted with strabismus. However, the relative uniqueness of strabismus may provide even more of a reason to study it, since there is more opportunity to make a real contribution in this area. Each person with strabismus interacts with many other people—most of whom do not understand her eye condition or know how to talk about it, or act around it. The mass media only conditions people to laugh in response to crossed eyes. No clues are provided about how to have a conversation with someone with strabismus. Research like mine provides answers to some unasked questions and challenges “normals” to reevaluate the way they treat people with crossed eyes, while challenging people with strabismus to rethink their own patterns of self-stigmatization. Furthermore, exploring two minor

bodily stigmas that I have lived with for most of my life provided me with insights into aspects of stigma management that I might not have had access to in any other way. In this conclusion chapter I present a theory on the hierarchies of minor bodily stigma, questioning whether cosmetic surgery itself (rather than the actual physical flaw) has become the source of stigmatization, debunking the notion of surgery as “cure,” and suggesting that it may be time for a new kind of education about stigma.

The uniqueness of this combination of strabismus and micromastia research also allowed me to perform the kinds of comparisons and contrasts that yielded ideas that were useful to both women with small breasts, and women with crossed eyes, and to make larger conclusions about minor bodily stigma in general. Spadola (1998) has pointed out that “our faces are our outward identity—our breasts are our public and private identity all in one” (p. 51). In part, this is what made the pairing of strabismus and micromastia so intriguing and so useful. By comparing and contrasting a feature that is always on display (the eyes) with an element that is sometimes covered—although never permanently—and sometimes prominently displayed (the breasts), I was able to make observations that may apply to a wider variety of minor bodily stigmas that are either hide-able or readily apparent. To understand how these observations might be more widely generalizable, we must look at how breasts and eyes are similar and how they are different.

One important way in which breasts and eyes are similar is that they are both “paired” features that are considered to be crucial markers of beauty in Western culture. The eyes are the “windows to the soul,” while the breasts are symbols of sexuality itself. Both strabismus and micromastia are labeled as deformities because they are affronts to

symmetry and represent proportions that have gone awry. Furthermore, both strabismus and crossed eyes also can be hidden temporarily—with sunglasses and padded bras—but the chance of hiding either permanently is slim.

Although strabismus and micromastia have more in common than one might expect, these minor bodily stigmas are distinguished by five significant differences. First, my breast interviewees described experiencing a sense of “missing” and they all spoke of waiting for something that never showed up—namely larger breasts. Conversely, my eye interviewees spoke of an omnipresent, oppressive sense of their eyes. Hailey said she literally “feels her eyes more” since the surgery, especially if she stares at a computer screen too long and gets a headache. Lori also felt the strain of her eyes pulling in opposite ways since one eye was nearsighted and the other was farsighted. Finally, Lynn talked about her eyes all the time, constantly presence-ing her stigma linguistically. Second, small breasts are only considered to be minor bodily stigmas within certain cultural contexts. Bea’s comments about how the women in Korea considered large breasts to be an embarrassment illustrates this point nicely. Crossed eyes, on the other hand, are stigmatized in every culture. Third, micromastia is a naturally occurring body type with no associated functional impairments, while strabismus is associated with functional impairments including, but not limited to, lack of stereoscopic capacity and impaired depth perception. Fourth, women with micromastia didn’t suffer from stigmatization about their chest size early in life, because this minor bodily stigma appears only at the on-set of puberty. In contrast, strabismus may be present from birth, occur while a child is very young, or be caused by some sort of accident later in life. Frequently, people with strabismus are introduced to stigmatization

when they are barely old enough to understand what is going on. Finally, micromastia is eminently “curable.” While a woman may suffer from any of a wide variety of complications, she is typically able to achieve larger breasts via augmentation. Strabismus surgery has varied results. For some, corrective surgery—while it may also result in complications—holds very well. But the majority of strabismus patients require more than one surgery to get the eyes straight initially, and then follow-up surgeries as the years go by. For many, the dream of straight eyes remains elusive.

As an individual who has both crossed eyes and small breasts, I find it intriguing to consider the myriad of ways in which these two traits are different, yet similar. These comparisons and contrasts allowed me to make larger generalizations about other types of minor bodily stigmas that share some of the same general characteristics outlined here. Talking to my interviewees in each category also helped me to separate out my thoughts and feelings about these two minor bodily stigmas in a way that I had never considered before. As I listened to Holly, Autumn, Bea, Izzy, Lynn, Lori, and Hailey talk about how they coped with, made decisions about, and communicated regarding their minor bodily stigmas, I saw much of my own story in theirs, and I glimpsed positions I had never experienced.

Coping, Deciding, and Communicating

Throughout this dissertation I traced the ways in which my interviewees employed coping strategies, made decisions about whether or not to try cosmetic surgery, and communicated their feelings, thoughts, and decisions. I return to these themes one last time to try to tease out the broader reaching implications of this study for the field of minor bodily stigma research.

Coping

Despite the many obvious differences between strabismus and micro-mastia, I was surprised to observe that my eye interviewees used six of the same eight coping mechanisms reported by my breast interviewees. Future research might reveal whether there are common coping mechanisms used for all minor bodily stigmas. All of my interviewees tried hiding; rationalizing the physical or personality benefits of their minor bodily stigma; conducting comparisons in which normals were found to be inferior; ruling out surgery by citing financial concerns, physical risks, identity implications and psychological considerations; talking or not talking about minor bodily stigma; and debating with themselves.

The type of minor bodily stigma a woman had dictated the type of coping mechanisms that had the most potential to serve as a useful strategy. For example, while the breast interviewees all joked about their flat chests to cope with their emotional pain, none of my eye interviewees joked about their condition. They didn't have to. Crossed eyes are a cultural joke often used to elicit laughter in movies or on TV. The only ones not laughing at this asymmetrical sight are those who can't ever uncross their eyes.

Also, the strabismus interviewees didn't have the option of coping by leaving. Both of my flat-chested interviewees who did not pursue surgery successfully eased the

pain of their minor bodily stigmas by leaving the local Tampa culture,²⁴ seeking dwelling places where less emphasis was placed on breast size. While the mass media would have us believe that everyone yearns for large breasts, pockets of resistance to mainstream norms are still plentiful in the United States. For example, Bea discovered that in places like South Carolina, religious prohibitions against vanity still effectively stymie the temptation to fix minor bodily stigmas with cosmetic surgery. Ironically, Bea objected to augmentations for very different reasons, but she enjoyed the respite from stigmatization regardless of what inspired it. When she moved to Japan, Izzy discovered first-hand what Bea had learned in Korea—not all cultures revere large breasts either. Since crossed eyes are considered an aberration in all cultures, this was not an option for my eye interviewees.

Instead, my eye interviewees found respite from stigma when they experienced acceptance and caring from other human beings. Unconditional love showered upon them by romantic partners relieved them from the dreadful thought that their crossed eyes rendered them undesirable in the eyes of prospective partners, and it seemed to transform their attitudes. Lori's story provides a good example. She used to be preoccupied with the thought of surgery. She regarded the thought of having strabismus surgery with both fear and reverence. Lori feared the surgery might not work, or it might make her eyesight

²⁴ Vanderford and Smith (1996) have noted that Tampa is a culture obsessed with breasts and physical appearance. The high concentration of strip clubs and the proliferation of cosmetic surgery clinics largely devoted to augmentations bear mute witness to this assessment. It should also be noted that Izzy reported that she did not feel the same kind of omnipresent self-consciousness about her chest before she moved to Tampa, and Bea's experiences in Colorado, abroad, and more recently in South Carolina, also support this view.

worse, yet she also hoped surgery might prove to be the magical solution to all of her problems. However, after Lori met her husband she began to “talk” about her eyes less frequently when she e-mailed me. After her son was born she stopped mentioning her strabismus altogether. Instead of obsessing about her own bodily flaws she was now so wrapped up in the loving feeling and the responsible roles of mother and wife that she now sent me pictures of her baby son and her husband, rather than diatribes about how unfair it is that we are judged by our outside appearance. Her love for, and from, her husband and son seems to have banished her all-consuming thoughts about her crossed eyes—at least for now.

My research also indicates that my eye interviewees benefited immensely from other types of social support. Lori, Lynn, Hailey, and I gleaned a great deal of comfort from the support we received on-line from other participants who understood what we were going through. These findings were consistent with conclusions generated by the work on stigma and relationships done by Jones, Farina, Hastorf, Markus, Miller, and Scott (1984), who insisted that people involved in healthy relationships are far more adept at coping with their stigmas.

As I turned to a consideration of my breast interviewees, this observation then begged the question, “does unconditional love help flat-chested women to overcome their minor bodily stigmas?” My research suggested that the answer might be “No,” at least for some women. Izzy’s story about the boyfriend, who bought her the belly-dancing outfit that was too large for her chest, indicates that even when she was involved in a supportive relationship, her minor bodily stigma still haunted her. Bea is now engaged to be married, and my last conversation with her indicates that she still is bothered by her

minor bodily stigma. Holly insisted that even though she was going through a divorce at the time of her surgery, she had no trouble attracting partners. Her augmentation was about career aspirations, not acceptance on the personal level. Finally, Autumn bears the distinction of being the only one of my interviewees (including both breast and eye interviewees) to have a loving, stable, long-term relationship at the time of her surgery, yet it didn't make her any less inclined to alter her body. These observations inspire the question, "What did seem to make one person more predisposed to seek a surgical solution than another?"

Deciding

Depending upon the audience, one can be stigmatized for *having* cosmetic surgery—especially a procedure coded as frivolous, like augmentation—or for *not* having surgery—especially if the stigma is “burdensome” for “normals,” like strabismus. This double-edged sword makes it even harder to decide what to do. I discovered that among my interviewees, it was not the overarching cultural story about their minor bodily stigma, or even their ideological beliefs that determined their proneness to experimenting with cosmetic surgery. Otherwise everyone one with crossed eyes would try surgery, since this aberration is universally condemned, and all feminists would shun surgery as a matter of course. My pool of breast interviewees included two strong feminists (Holly and Bea) and two moderate feminists (Izzy and Autumn). In each of these categories one woman said “no” to surgery, while the other said “yes.” Obviously, their intellectual orientation was not the sole determining factor either. Instead, the way in which a woman made and communicated her decisions about whether or not to have cosmetic surgery seemed dependent upon her own unique personal story, the way in which she

made meaning of the events of her life, and the information she had about a wide variety of factors such as cultural norms and surgical risks. Each of these variables went into the creation of identity, which proved to be a powerful indicator of potential for considering cosmetic surgery. As Vanderford and Smith (1996) pointed out, “self-concept plays a major role in women’s decisions to have implants” (p. 23).

I found this held true for all of my breast interviewees, yet the notion of a unified self-concept proved to be a conflicting and ever-evolving idea. As indicated in the opening story, I sometimes experience my own struggle to make decisions about my minor bodily stigmas as a struggle between two different facets of myself: strong, academic, feminist me thinks I shouldn’t care about what others think and I should love myself exactly as I am, reveling in my differences; vulnerable, non-academic, conformist me wants desperately to be thought of as attractive, to be loved, and to be accepted by others. This results in meta-shame (Ellis 1998), as I experience shame about looking different, and then shame about obsessing over such trivial details. Therefore, I expected to find that others also might report that their decision-making process was complicated by similar incompatible stances embraced by different facets of their own personalities.

Among my breast interviewees I found this assumption that decision-making was a sort of tug-of-war between different factions of the identity to be true. Autumn’s story is a great example, because she was torn between her frugal side, that didn’t want to spend the money, the lesbian side that didn’t want to engage in glaringly heterosexual practices, and the side of her that wanted to feel more feminine and to take charge of her own happiness. My other breast interviewees described similar incompatible elements of their own personality warring to decide whether or not to have surgery. Bea provides a

classic example of a more consistent identity—although even she had moments when she wavered. Most of the time Bea was so firmly entrenched in her identity as a feminist who saw augmentation surgery as an oppressive practice that she would have been ashamed to show her face around her friends and family if she changed her mind and decided to get implants. She feared that others would suddenly see her as weak and ashamed of her body. This assessment fit nicely with the most significant rhetorical difference reported by my interviewees who had surgery. Those with crossed eyes admitted they wanted surgery to help boost their self-esteem, while those with small breasts strongly resisted this notion. My breast interviewees responded to cultural messages suggesting that women who have breast augmentation must say they want to have the surgery to please themselves, or they will be positioned as weak and pathetic individuals who rely on the opinion of others to provide them with self-esteem. Therefore, they all insisted their sense of self-worth was not dependent on their breast size. The women who chose to have surgery proudly declared, “I did it for me.” It struck me as interesting that my interviewees who did not have surgery did not make a similar claim. Not one of them said, “I am choosing to abstain from surgery just for me.” They all cited other self-less reasons for continuing to live with their minor bodily stigmas. Bea couched her refusal to have surgery as an act of resistance carried out on behalf of women who needed to be taught self-acceptance the hard way. Izzy also never said she was choosing not to have surgery because she didn’t want it. She rejected augmentation because her family would have been mortified, and because she didn’t have the money.

In contrast, Autumn’s desire to portray herself as a woman who was responding to her own natural inclinations, rather than a societal mandate was especially strong. To

discover the source of her insistence, it was crucial to look at her self-concept—an idea that I was able to access in the stories she told during our interviews. If I had made a prediction based purely on her identity as a lesbian, I would have guessed she would not want—or at least would not pursue—augmentation.²⁵ As Turner (1999) has pointed out, lesbians belong to an alternative culture that tends toward tattoos and piercings. Lesbians are assumed to take pride in standing out, whereas heterosexual women are assumed to want augmentation so they can conform to dominant cultural standards. Both tendencies, however, stem from the same basic desire to please one group or another. Since Autumn was tattooed, pierced, and augmented, one might infer that she wanted to please both the gay and the straight communities. Instead, she insisted she only wanted to please herself. Although I questioned this interpretation, ultimately I am reluctant to assume the role of the all-knowing interpreter who understands what is “really going on.” I think it’s fair to present an opposing viewpoint, but not to insist my version is right. Autumn’s story points to the need to look at what individuals say about their decisions, and not to make automatic assumptions based on markers like sexual preference.

The situation among my eye interviewees was a little different. None of them cited allegiance to feminist ideology as a source of conflict when they made their decisions. In general, surgery held out the promise of a new identity as a straight-eyed woman. This was an identity they craved, but two of my eye interviewees reported making their decisions not to have surgery as a reaction to a much more primal emotion—fear. This is also my main reason for abstaining from surgery.

²⁵ Similarly, I would have predicted that Holly would have rejected augmentation based on her identification as an ardent feminist.

In general, my experience with the LazyEye list-serve indicated that people with strabismus frequently reported feeling isolated, and fear played a predominate role in their decision-making process. The fear that the mothers of small children on LazyEye felt before their babies underwent surgery was almost palpable. Lori allowed her fear of the potential negative outcomes of strabismus surgery to overwhelm her strong desire to have straight eyes. Lynn's fear that her children might go blind in one eye kept her from considering strabismus surgery for her three little boys.

Holly's horror stories of encapsulation and illness bear testimony to the very real possibility that augmentation surgery can also have terrible consequences, however, none of my breast interviewees mentioned fear as a significant force in their decision-making process. The popularity and familiarity of the augmentation operation seemed to take fear out of the equation for my breast interviewees. My interviewees, however, were quick to reinsert both warnings and accolades as they communicated their feelings about their decisions.

Communicating

Perhaps because their decisions were rooted in their self-concept or their reaction to fear, once my interviewees decided what to do, they often became so entrenched in their stance for or against surgery that they tried to convince me to heed their well-intentioned advice. Autumn wholeheartedly suggested that I should bite the bullet and get implants, while Hailey insisted my life would be better if I got my eyes straightened with surgery. But Bea just flat out insisted that I shouldn't have cosmetic surgery and neither should anyone else. Holly and Lynn—while each undergoing a different type of cosmetic surgery—warned me I could suffer from terrible side effects like they did and I

should exercise extreme caution in my decision. This was a cautionary tale that Lynn broadcast as often as possible because she feared most people who are considering strabismus surgery are probably undereducated about the risks.

My breast interviewees were at a distinct advantage when it came to speculating about what it might be like if they chose to have surgery. Not only did they have the predictions of their surgeon available, but also there is a long list of books and magazine and journal articles that offer insider glimpses into what it is like to have breast augmentation. Those considering breast augmentation could be voyeurs into the culture of cosmetic surgery simply by picking up a book. They could also watch T.V. shows exploring the topic, or talk to friends who had the procedure. My eye interviewees did not have this luxury. Lynn and Hailey both went into their surgeries with absolutely no idea what would, or could, happen except for what their doctors told them. They only discovered the on-going conversation on LazyEye much later. There they were privy to some insights about strabismus surgery, but many of the conversations about this concerned very young children. Adult strabismus surgeries, which are considerably different, were rarely discussed. However, the opportunity to discuss strabismus at all was much welcomed. Without the internet I doubt I could have located enough interviewees to include strabismus as part of my investigation.

The bearers of different types of stigmas showed a natural inclination toward different modes of communication. For example, someone with a stutter might prefer to communicate via e-mail rather than pick up a phone. The medium of e-mail does not betray their stigma at all and allows stutterers the gift of fluency so they can express themselves fully. I located all of my eye interviewees on-line. They were very

comfortable talking about their problems over e-mail because they didn't have to make eye contact or worry about someone staring at their eyes while they were talking.²⁶ It is hard to imagine achieving similar social support structures through any other medium of communication. Because those with strabismus are scattered all over the globe,²⁷ it would be hard to achieve similar results with in-person support groups.

Allocation of blame.

In Chapter Four I discussed the irresistible tendency to look for a hereditary cause of minor bodily stigma. All of my interviewees traced their stigma through their family tree. Many of them, like Bea and Lori, fault society for making it a "crime" to have certain undesirable characteristics. Lori noted that it's okay to have a big nose or huge ears, but having crossed eyes is some unforgivable sin. However, while she may have pointed the finger of blame at society or genetics, each interviewee assumed responsibility for her minor bodily stigma at the individual level and took it on as a cross to bear alone. Looking back at my research I began to notice a subtle, but distinct pattern in their communication. The more an interviewee allocated blame outward at some external entity, the less likely she was to choose cosmetic surgery as a solution to her dilemma.

²⁶ The ability to attach pictures to e-mails has complicated matters slightly for some. Hailey's experience of panic when a guy that she met over the internet wanted her to send him a picture serves as a reminder that extended capacities on existing technologies aren't always welcomed.

²⁷ The majority of the people contributing to LazyEye were Americans, although people from all over the world participated, with the majority of the foreigners coming from England, India, and Japan.

Bea's indignant, feminist outrage kept her from even considering that she could take an action that would ease her affliction. She didn't view her breasts as the true source of her problem. Her distress was caused by unreal, oppressive, patriarchal forces that would not just melt away if she capitulated. Bea's suffering would only end if society stopped oppressing her with unrealistic demands of physical perfection. Autumn took the opposite approach. She accepted responsibility for her own happiness at a personal level. In her own words she finally accepted that "society is shallow, but you either play the game or you don't." Autumn chose to play the game.

Holly actively distanced herself from her feminist tendencies to question society's imposition of unnatural (for most) norms in order to move to a position where she could consider surgery. She chose to focus instead on her goals, and her dreams, and to actively work to correct what she accepted as an undesirable flaw. Izzy took turns blaming society and men for her suffering and considering accepting personal responsibility for her flaws and fixing them. Although she waffled a few times in our interview, she still seemed pretty dedicated to focusing on external sources of blame, so I doubted she would choose surgery. Lynn was so young at the time of her surgery that all of her energy was focused inward. At thirteen she would not have dreamed of blaming society for creating a world in which external appearance has attained such importance. Lynn just knew the kids at school picked on her and she wanted to make them stop. Finally, Lori was always looking outside herself for something to blame for her predicament. While she repeatedly told me that she desperately wanted to work up the courage to have surgery, this intense focus on the external source of her anguish seemed to help reconcile her to her unaltered status.

The intensity of Lori's fury reminded me of Bea's anger, minus the sophisticated feminist rationales. In Chapter Four I pointed out that unlike micromastia, strabismus is not a feminist issue. In fact, even those who study stigma have ignored crossed eyes thus far. Without the full weight of a well-thought-out feminist discipline behind them, strabismus sufferers are left to figure out what role, if any, formal education should play in helping to make the world a better place for those with crossed eyes.

Education

My breast interviewees and my eye interviewees had very different ideas about how, when, and where someone should be educated about their particular kind of minor bodily stigma. My interviewees naturally assumed micromastia was a feminist topic, so women might elect to learn about it in college. Yet, no one but Bea seemed to hold out much hope that feminism would ever succeed in changing the popular notions of how breasts "should" look. Arguing that people shouldn't worry about breast size because those who emphasize augmentation are oppressive, hasn't proven very compelling. None of my interviewees blamed their junior high school education for the spread of negative images of flat-chestedness, despite the fact that this was where and when the teasing began. No one demanded adding a section to the high school or junior high school curriculum explaining that different women have different shapes—and all of them are equally valid. Unanimously, they pointed the finger of blame at the media, and also looked to the media to help fix the problem.

In their struggle to find ways to normalize micromastia, Holly, Bea, and Izzy pointed to popular role models from television who just happened to be flat--naming the three small-breasted beauties on Ally McBeal. Invoking the characters on Ally McBeal,

Holly pointed out that if there had been more positive images of beautiful, flat-chested women back when she had her surgery she might not have felt so much pressure to get the augmentation. Without this pressure, she now speculates she might have just done the nipple reduction and left the rest alone.

While I think that it is very important for the mass media to provide positive examples, I would argue that looking to Ally McBeal to find role models for flat-chested women is problematic. The flattest of the three small-breasted women on the show was Ally herself, played by actress Calista Flockhart. When the show was at its peak of popularity, media fashion analysts commented that Ally McBeal had the potential to make being flat trendy once again. However, women's magazines and entertainment news T.V. reporters were soon hurling allegations that Calista Flockhart must be anorexic because of her tiny frame and lack of body fat. These rumors quickly began to undermine the positive influence of this role model. Coupling an assumption of an eating disorder with a flat chest was adding insult to injury, and doubling the stigma. Personally I felt more encouraged by the images I saw on the popular 2002 summer surfing movie, *Blue Crush*. The three main characters in this movie ran around in their bikinis, flaunting small chests without a hint of self-consciousness, and easily attracting handsome young men. They were young and healthy and were worried about surf competitions and getting up early enough to catch the good waves, not whether or not they should save up for implants. These girls were a refreshing change from the obviously augmented *Baywatch* look-alikes that Hollywood usually offers up as eye candy during beach movies or TV beach shows.

I would also suggest that Debra Messing from the hit comedy *Will and Grace* presents a better model for flat women. Her character, Grace, often pokes fun at her breast size on the show, but she also mocks her own attempts to look larger by using padding and a water-bra. Ultimately at the end of the show she usually has a moment with Will, the show's other main character, when she admits she knows she is sexy and beautiful the way that she is. Recently I read an interview with Debra in which she recounts a story about how she was asked to wear really large inserts in her bra for a role, but she refused, insisting she just wouldn't be funny with big, fake boobs. She went on to say that she was comfortable with her body the way it is.

My eye interviewees were not as quick to hypothesize ways to destigmatize their condition, and they did not suggest the mass media should be involved in this endeavor. They envisioned such an attempt carried out at the more personal level. In part, this may have been caused by the simple fact that functional problems such as astigmatism and poor vision usually accompany strabismus, so strabismus sufferers accept that there is "something wrong" with their eyes in a way that a flat-chested woman never would. Hailey and Lori expressed a strong wish that people were more knowledgeable about strabismus and would accept it as a physical variation like having a big nose, or big ears. They both admitted to being extremely shy when it came to talking about their eyes, however, they did present a few suggestions. First, all of my eye interviewees agreed that the LazyEye e-list was a vitally important step to help educate the public about conditions like strabismus. In the process of demystifying strabismus, list-serves like LazyEye might help to de-stigmatize this condition as well. My eye interviewees were aware that the average person who did not have eye problems, or know someone who did, would

probably never stumble upon, or benefit from, this list-serve, so they also stressed personal responsibility for educating “normals.” Although Lori and Hailey gave lip service to this technique while never actually practicing it, Lynn never missed an opportunity to tell others about her former eye problem or to help enlighten parents and children who noticed her sons’ crooked eyes. In contrast to the thinking of the breast interviewees, Lynn believed that one important way to change the perception of strabismus might be to target the grade schools. The teachers could be educated about strabismus and other eye conditions, and then teach the children not to make fun of or to be afraid of people who had “different eyes.” The emphasis among all the people participating on the LazyEye list was all on education at the lower levels. I agree this is an important place to start, but I think the conversation should continue at the higher levels of education. Although I wouldn’t expect feminism to find an answer to strabismus, I think it is time to add crossed eyes to the conversation, despite the fact that none of my interviewees had envisioned such an inquiry. .

Gender and Minor Bodily Stigma

We are indoctrinated into a culture that teaches us that appearance matters—indeed one’s social and economic value depends upon it. We are bombarded with mass media images of “physical perfection” that we are expected to emulate. However, different messages are constructed for men and for women. A quick glance at just about any “women’s magazine” confirms that pressure for women to meet exacting standards is especially high. The articles are teeming with advice on how to lose weight and tone muscles, how to choose a cosmetic surgeon, how to wear your make-up, how to decide what clothes to wear, and so on. Although the much less popular and significantly

smaller variety of “men’s magazines” set their own standards—projecting chiseled features, flawless, muscular bodies, and full heads of hair—feminists are quick to point out that women are expected to look trimmer and more attractive than men, and research suggests that they are four times more likely to pursue cosmetic surgery than men (Balsamo, 1996, Wolf, 1991, www.plasticsurgery.org).

This gender inequity, concerning both the directive to look “perfect” and the tendency to get surgery in an attempt to comply, points to the need to look more closely at the gendered implications of minor bodily stigmas. Not only do men and women respond differently to different kinds of pressure to conform to different blueprints of physical norms, but some minor bodily stigmas are also gender specific. For example, “micromastia” occurs only among females and a record number of women are responding to this stigma by opting for implants. With a ten percent increase from 2000 to 2001, breast augmentation has become the number one most performed cosmetic surgery with a staggering 206,354 operations performed²⁸. The most frequently performed male cosmetic surgery was nose reshaping and 136,009 men chose this option in 2001. Other minor bodily stigmas like having flabby thighs, or stomachs, may affect men or women, but the response to this physical manifestation of imperfection is strongly gendered. Women are almost five times more likely than men to pursue liposuction. For the nine years from 1992 to 2001, liposuction was the most often performed cosmetic surgery. In 2001, however, the numbers were down by fifteen percent, and only 195,135 procedures

²⁸ These numbers represent only surgeries performed by doctors recognized by the American Society of Plastic Surgeons (ASPS). According to the site itself, the stats are “based on a 95% confidence level with a maximum error range of a +4.5 percent.”

were recorded. Men did have two surgeries more frequently than women, although it must be noted that they did not hold a monopoly in either one of these arenas either²⁹. They led the way in the number of hair transplants performed (27,817 surgeries occurring in 2001) and the amount of ear pinning surgeries (17,555 procedures) elected.

These statistics help to illuminate trends and substantiate hunches regarding the gender differences among by those who seek cosmetic surgery. However, these numbers leave a crucial gap that can only be spanned by qualitative research. Statistics tell only part of the story. They cannot tell us about the different experiences reported by males and females as they communicate about various minor bodily stigmas, and more importantly, the numbers do not reveal why these individuals decided to pursue cosmetic surgery in the first place. The body of qualitative, minor bodily stigma research that addresses gender is minimal, and limited in scope. For example, Martel and Biller (1987) looked at the dilemma of being a short male, and found that males were more negatively impacted by childhood teasing than females. While these authors don't go into great depth, they point out that males tend to take teasing very personally and decide there is something irreparably wrong with them. They then begin to exhibit life-long anti-social behaviors meant to ward off rejection before it happens.

Testing this observation to see if it holds true for any other stigmas might yield interesting results. During the course of my research, I encountered tales of several males

²⁹ Of the surgeries with statistics available on ASPS website, men only held a monopoly in the category "male breast reduction." Penile and pectoral implants are relatively rare and were not recorded on their chart of surgeries performed in 2001, though these procedures would also be exclusive to males.

with strabismus who didn't seem terribly bothered by their condition, and I cannot imagine that they did not suffer at least some teasing in school when they were children. This begs the question, "is being short somehow more unendurable for males than having crossed eyes?" Part of the answer may lie in a quick examination of the cultural significance of height for males. In this culture it is far more acceptable for women to be short (although they are often stereotyped as cute, and not taken as seriously as taller women) than it is for men to be short. Short men are seen as inferior, less capable of inspiring and leading others, less attractive, and prone to suffer from a "Napoleon Complex." These are all unfair projections, but they may help to account for the gendered difference reported by Martel and Biller.

This raises another very specific question. If males are overly sensitive to childhood teasing about a minor bodily stigma that carries a great deal of cultural significance, does the same hold true for females? Responses from my interviewees revealed mixed feedback. Breasts and eyes are clearly endowed with a great deal of cultural significance for women, yet some of my interviewees were strongly affected by teasing and others were not. Two of my female strabismus interviewees—Lori and Lynn—seemed pretty deeply scarred by childhood teasing and two of my breast interviewees—Holly and Izzy—still recall in vivid detail the taunts they endured. However, Hailey only became distraught about her eyes as she got older and dating assumed a central significance in her life, and Bea and Autumn seemed unconcerned about teasing they received about their breast size when they were teens. Perhaps individual personalities and circumstances are more significant than gender when considering what impact a minor bodily stigma will have on a particular person.

Other qualitative researchers don't specifically address the different responses elicited by males and females, but rather give their perspective from the vantage point of one gender or the other. For example, Carlisle (1985) and Jezer (1997) each give a male's perspective on the trials of learning to live with a stutter, while Updike (1985) writes very openly and eloquently about what it feels like to have psoriasis. These are gendered accounts in so far as they give details about the lives of three men, yet they are not necessarily accounts of gender. They do not claim "this is how all, or even most, men suffering from this particular affliction will feel," but rather they announce, "this is how I felt, and I happen to be a man." This male point of view was conspicuously absent from my research and future research might begin to help fill in this gap in perspective.

It seems only natural that my exploration of what it was like to experience the stigma of being flat-chested and to decide whether or not to pursue augmentation necessarily was restricted to the female standpoint; however, it might have been interesting to poll a few men to find out their reactions to and thoughts concerning breast augmentation. The normal assumption seems to be that women enlarge their breasts for men. Izzy admitted that if she chose to get augmentation she would do it in hopes of attracting and keeping a man. However, this theory that women augment themselves just for men is now challenged on a regular basis. Autumn repeatedly emphasized that she did not pursue augmentation for men, and I've begun to read articles in women's magazines³⁰ that suggest that since women are taught from the earliest age to compare themselves to other women, it follows that they may—to a large extent—be dressing for,

³⁰ The August 2002 edition of *O: The Oprah Magazine* provides a wonderful example of this.

and augmenting themselves for, other women. Bea is a good example of this tendency. She told me, “It wasn’t dating that first caused me to be self-conscious about my breast size. I wouldn’t date men who care about that. It was really trying to fit in with women who cared about that kind of stuff.” Dating was also not the impetus for Holly to enlarge her breasts. She wanted to inspire other women with fitness.

Strabismus occurs in both genders; however, despite my efforts to recruit a male with strabismus for my research, only women responded to my call to talk about their eye conditions. I personally invited three men to participate in my study, in addition to posting a general call for volunteers on the LazyEye e-list. One declined, one said there was nothing he had to say about his eyes, and the last one never responded to my request. Their voices were greatly missed. Additionally, about ninety percent of the people writing on the LazyEye e-list were women. In large part this was because they were mothers discussing their children’s newfound vision problems.

But even among the adults who reported having strabismus themselves, the women significantly outnumbered the men. Over the two years during which I monitored the LazyEye e-list, I noticed that the men who did write to this list-serve tended to report that they had already gotten surgery, or they were specifically writing to ask what they might do to remedy their situation. Often their tone was angry or very matter-of-fact and clinical, whereas women tended to be more self-pitying and were more likely to reach out for empathy and encouragement. Unlike the women, the men usually didn’t dwell on details, explore their emotional response to their stigma, or speculate about what impact it had on their lives like the women did. They ignored it, or fixed it and they didn’t hang

out on the e-list forever. They would surface and then disappear, never becoming regular contributors to the cyber conversation.

Hailey's story about her male former co-worker with strabismus confirms this trend. She could not understand why he did not seem bothered by a condition that haunted her. She also could not comprehend why he did not try to fix his eyes since he had the money to do so. Perhaps some of the answers to these questions lie in a closer analysis of how his gender impacts his response to strabismus.

Last year when I presented some of my strabismus research at a national conference, I encountered a male strabismus sufferer illustrating the other end of the spectrum. Before my presentation a young man approached me—staring at my nametag. We began to talk and he quickly revealed that he was looking forward to hearing my paper because he had grown up with strabismus and he never heard anyone talk about it. Acutely embarrassed about his eyes, and scarred from the teasing he received, he finally saved up the money for surgery when he was in college. He was very pleased with the results, because he could finally pass as a normal, but unfortunately the fix was not permanent. He took off his glasses and pointed out the slight inward drift that instantly occurred in his left eye. He said he was soon going to go back for another touch-up surgery. Completely unconcerned about the high probability of a future filled with additional surgeries, he was adamant that getting his eye straightened was the best thing that he had ever done for himself. He gave me the name and number of his surgeon and strongly recommended I look into surgery myself. In his mind it seemed there was no other legitimate option.

The other interesting difference I noted in the tales told by men with strabismus and women with strabismus was that men focused only on their eyes as a problem and when they fixed that problem they essentially closed the book on their dialog about physical flaws. They didn't go on to worry aloud about their thinning hair or beer gut. Some of my female interviewees, however, were quick to introduce secondary flaws into the conversation.

Hierarchies of Minor Bodily Stigma

Much of the research done on cosmetic surgery suggests that once an individual decides to have cosmetic surgery, chances are that person will become a “surgical repeat offender” as secondary and tertiary minor bodily stigmas garner new-found attention (Hayt, 2000, p. 200). Ancheta (1998) refers to the notion of “crossing a line.” She explains that once a woman has crossed the line and chosen to have cosmetic surgery, she is far more likely to have additional cosmetic procedures performed in the future. “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’” (p. 3). One of my interviewees followed this trend. In addition to having follow-up surgery to correct complications resulting from her initial augmentation, Holly has since had an eye-lift surgery to correct her slightly drooping lids and brow. She also speculates that she will have some spider veins erased next, and that she may eventually undergo a face-lift. While it remains to be seen if the interviewees will follow suit as they age, I can say with certainty that this tendency to return repeatedly to surgery to fix flaws merely highlights an important observation. We prioritize our minor bodily stigmas—usually granting one a master status, and pinpointing it as the source of significant amounts of dissatisfaction

in our life. When we take care of that one we tend to move on to obsessing about the next flaw on our list.

Coincidentally, all my interviewees—including my eye interviewees—were small breasted at some point in their lives. Lynn was very flat until giving birth to three children caused her chest to grow two cup sizes. Lori was also an A cup until her pregnancy. Her final chest size is still undetermined since she is now breast-feeding. Finally, Hailey and I are also A's. Yet, all of our early conversations about stigmatization revolved around eyes. It was only after I questioned these participants about their chest-size as I explained the “other half” of my research, that each interviewee identified herself as a small-breasted (or formerly small-breasted) female. While we all admitted to fleeting moments of discontent when we obsessed about this “secondary flaw,” we didn't feel like it limited our options in life the way our eyes did. Small breasts were something we could overcome and didn't spend much time talking about. Hailey's reaction to my inquiry about her unconcerned attitude about her flat chest was representative. “Come on,” she sighed, in exasperation. “Eyes are way more important than that.” It is also significant that Lynn talked about her eyes constantly, but never mentioned her breasts until I brought it up. She also quickly dropped the topic after pointing out that there was a natural “cure” for the A cup dilemma.

“Well, I know how to get larger breasts,” she boasted, with a smile in her voice. “I was very small-chested and my cup size grew two sizes after I had children and breastfed. And after breastfeeding my last child for a year and a half, they're there to stay!”

Later in my interview with Lynn, I was surprised to hear her speak out about a minor bodily stigma that made her feel uncomfortable. Lynn began, “I have a non-blood relative uncle. He has a crossed eye--from an accident. He has never had it corrected, and it wanders all over his eye socket when he is talking to me, and it makes me crazy. I really do not know where to look, until I find his good eye--the one that is looking at me. As an adult, he does not get any harassment concerning his eye; he is a productive and highly respected member of this community. Kids tease, but adults are much more accepting.”

I felt disappointed when Lynn mentioned this. I was hoping that she would be more tolerant of any type of eye aberrations because of her personal experience with strabismus. But as I listened to the description I began to wonder if I too would feel uncomfortable if confronted with that particular type of minor bodily stigma. With a twinge of guilt, I also recalled agreeing with Lynn when she told me that she thought it was a lot worse for crossed eyes to go out, than it was for crossed eyes to turn in. I had shuddered in horror when Lynn told the story about waking up after her second strabismus surgery and seeing that her eyes turned out. I was reminded again of the tendency all of my interviewees had of comparing themselves to someone else who was worse off than they. It seemed quite an irresistible inclination, yet it was this inclination that led to stigmatization in the first place. We were constantly engaged in the process of both self-stigmatizing and othering.

Although Autumn was the most successful at exorcising her minor bodily stigma, even she acknowledged that she just moved on to different kinds of appearance concerns after she got her implants. “You know, the hardest thing for me right now is eating right

and exercising. Just like it's the hardest thing for everybody all the time," she told me—sounding relieved to have what she considered to be fairly standard worries now.

Deconstructing Minor Bodily Stigma

All of my breast interviewees except Autumn were eager to suggest potential ways to deconstruct the stigma of having small breasts at the overarching cultural level. Autumn deftly wrote off this approach by pointing out that she had a choice--she could play the game, or sit on the sidelines. However, she wanted to play the game, not try to change it. In contrast, Holly, Izzy, and Bea wanted to play a different game. They enthusiastically agreed that if there were more flat-chested people and augmentation technology wasn't so readily available, it wouldn't be such a big deal to be small. Citing herself as a leader at an everyday level, Bea made an impassioned speech declaring her position. "But now I also feel like it's my social duty. I feel like, okay, I would be a great candidate for breasts—big silicone breasts—because I have big hips and I'd definitely look more proportionate and all of that. I would look great with bigger boobs. But I'm not doing it, and this is my social contribution to the United States of America to say, 'You should be fine with your breasts, and you don't need to put plastic in you'."

Language is a powerful tool capable of altering and constructing reality. Before the advent of the pathologizing term, micromastia, a woman with small breasts was just a woman with small breasts. She was not "missing" something, and her body did not lack the "proportion" that all of my breast interviewees mentioned. However, knowing this affords only a small comfort. We cannot retreat to an ideological Garden of Eden where society has magically forgotten its pronouncement that large breasts are better than small breasts.

Izzy also revealed that she liked to hear cautionary tales about the potential dangers of implants because they made her decision to abstain from surgery easier and helped to counter the notion that she would live happily ever after if she just got her breasts enlarged. Holly was quick to provide such a tale of warning, counseling, “I want people to really think about it carefully before-hand, because there’s a lot that can go wrong.”

I began this research thinking that people naturally felt stigmatized by the ways in which their bodies differed from the norm. Consequently, the big question for people with a minor bodily stigma became whether or not to pursue cosmetic surgery in order to “fix” their problem, and I proceeded to look at women who said “Yes,” to surgery, and those who said, “No,” to surgery. What I discovered from my research was a much more complicated scenario. My review of literature about cosmetic surgery and stigma highlighted the social construction of minor bodily stigma, which helps to explain why others feel free to comment on women’s decisions to fix or ignore their own flaws. The field of cosmetic surgery and the mass media have done a good job of persuading the public that everyone has a right (and in some cases, an obligation) to pursue ideal beauty. As surgeries to correct an increasing number of bodily dissatisfactions are offered up for public consumption, “Should I have cosmetic surgery?” has been rhetorically positioned as the crucial decision with regard to minor bodily stigma. Other kinds of questions, like, “How can I best cope with my minor bodily stigma?” or “How can I teach others about my stigma?” are never asked in any kind of mainstream venue.

Furthermore, I would argue that stigma can’t be “fixed” at all. Ultimately there is no cure. If we look at Autumn as the most successful interviewee who had surgery, we

can see that even she isn't really "fixed" for good. Although she's thrilled with the results and has taken great strides in incorporating her implants into her new self-image, she still worries from time to time about ruptures, knows that some lesbians might realize she had augmentation and disapprove of her decisions, and is aware that eventually she'll have to have the implants replaced and that procedure will probably result in much more scarring. Autumn's micromastia is still there in a very real sense, it is just covered up in what she hopes is a more or less permanent way.

Lynn situation is similar; her blindness in her right eye and her new problem with the dilated pupil are constant reminders of her strabismus. Lynn's children also remind her of her physical difference because they have inherited her crooked eyes. For all of my interviewees their minor bodily stigmas may also be lurking in their genes, even if they have hidden their own flaws with cosmetic procedures. Therefore, I suggest that minor bodily stigma can be managed or rewritten-but not fixed. When women consciously do something to make themselves feel more accepting of their minor bodily stigmas I would call that managing. For example Bea's feminist critiques help her manage. Izzy clings to a belief that she is a good daughter and sibling because she has chosen to forego cosmetic surgery so her family does not have to deal with disillusionment and disagreement. When their circumstances change so that their pervasive sense of stigma is displaced or minimized, I would say they have rewritten their minor bodily stigma in the sense that they are now telling themselves different stories about how their minor bodily stigmas impact their lives. So when Lori fell in love, got pregnant, got married, and had the baby, her feeling of stigma about her eyes was rewritten and came to assume a much lower place in the grand scheme of things.

When Bea left Tampa for South Carolina she went from actively managing her stigma to rewriting her response to stigma in response to a culture that interpreted small breasts very differently in the first place.

I also propose that the alleged “cure” for minor bodily stigma is out of control. Women have become repeat offenders, going back for surgery after surgery, as they fight a losing battle against both their genetic make-up, and later, the ravages of aging. You hear about women who are trying to make themselves look like Barbie, or to strive to look just like popular movie stars. As I listened to my interviewees who had chosen NOT to have surgery, I heard a new interpretation of the situation being whispered. While reading, and re-reading their transcriptions I suddenly realized that my interviewees were more stigmatized by their decisions NOT to have surgery than they were by their actual physical differences. The lack of surgery, rather than the flaw, had become the stigmatizing element. Some of my interviewees even acknowledged this dilemma, while others seemed unaware of this ironic twist. During our interview, Izzy and I both lamented the existence of augmentation. Without cosmetic surgery, there would be a lot more women with small breasts. Instead of representing a dwindling minority, flat-chested women might actually comprise a significant portion of the population.

They also did not speculate about whether or not they would have to design different educational programs for men and for women since the issues they faced might be different. My findings regarding gender suggest that this may be one of the most significant, yet least investigated, aspects of the study of minor bodily stigma.

Update and Conclusion

My research raises many interesting questions and puts forth useful theories and challenging calls to action. Like all knowledge, the findings here are situational, contextual, and ever evolving. This dissertation is just the beginning of a much larger inquiry about minor bodily stigmas. I've looked at one minor bodily stigma that is usually correctable and one that is sometimes correctable—investigating some of the boundaries between these two categories. Future researchers might also explore minor bodily stigmas for which cosmetic surgery offers no remedy. Such an inquiry might lead to some very different findings, since in many ways it was the “potential fixability” of the minor bodily stigmas I studied that made them so problematic. I conclude this dissertation with a story that not only affirms the importance of social support in coming to terms with a minor bodily stigma, but it questions how stigma bearers with different types of stigmas interact.

The story of this dissertation continues to grow and change even as I write these concluding remarks. E-mails from friends who know Izzy and Bea much better than I do keep me informed about some of their decisions. I recently learned that Izzy has decided to renew her teaching contract and remain in Japan for another year. She is happy there. I also received an e-mail from another friend informing me that Bea has decided to move back to Tampa to be with her former boyfriend, who is now her fiancée. It should be interesting to see how she will re-acclimate to this breast-obsessed culture after her experiences in South Carolina.

Lori gave birth to a beautiful, healthy, ten-pound baby boy with straight eyes, and she sends me e-mail pictures of him on a regular basis. I had a boyfriend once who had

two young daughters. One night he told me, “A baby will stare into your eyes like it’s the most important thing in the whole world just to be looking at you. That child will be completely in love with, and look for and follow, your eyes. I know you are shy about your eyes, but just wait. You’ll probably feel differently about them when you have a child.” Lori already seems more at peace with her eyes because her husband loves and accepts her the way that she is. Now I wonder if Lori’s little boy will allow her to access a different kind of acceptance and love for her own eyes. I also wonder if her child’s eyes will remain straight.

I unexpectedly ran into Autumn in a coffee shop last month, and discovered that she and her long-term partner are no longer together. I was very surprised and curious. I wondered if her implants played any role in the break-up, and how Autumn’s breasts might impact her future dating possibilities. Would she attract more potential partners because of her beautiful proportions, or would lesbians reject her because they disliked what they interpreted as a capitulation to heterosexual standards? What will happen when Autumn has to have her implants replaced?

Although I’ve heard no major news from my other three interviewees, I wonder how life will unfold for each of them. Lynn will have to wait and see what happens with her dilating eye and determine if there is anything she can do about it. She may also face more decisions about whether or not to allow her sons to have cosmetic surgery on their eyes if vision therapy is ineffective, and if they grow more self-conscious about their appearance as they get older.

I wonder if Hailey will try another surgery as soon as she gathers the money, the time, and the courage to try again. Or will she follow Lori's path and meet a guy who changes the way she feels about her condition?

I wonder if Holly will ever get her implants removed. During our second interview she engaged in some interesting speculation of her own, commenting, "You know, I think about what will happen if I don't get these out eventually. When I'm seventy-five years old am I going to have these little perky breasts when everything else is saggy? (Laughing) You know? I wonder how it is gonna all play out in the end."

I'm also curious about the impact this dissertation might have on its readers. Will it cause others to think and talk differently about their own minor bodily stigmas and those that they notice around them? The variables are infinite and the questions innumerable, as we scurry down life's path struggling to make peace with and tell useful stories about our own unruly bodies and those that we see around us. I recently read an article in Oprah Magazine that suggested there are two different kinds of appearance-related suffering and they inhabit two different sections of the brain. Martha Beck (2002) explains, "One part [of the brain] simply registers events, while another creates a continuous stream of thoughts about those events. The vast majority of our unhappiness comes from these secondary responses—not from painful reality, but from painful thoughts about reality" (p. 58). All of my research points to this same conclusion. If the pain lies with the story and not the event, then perhaps it is time that we begin constructing different stories.

The sun shone brightly and a strong ocean breeze cooled my wet, salty skin. Rob and I had just clambered up the rocky Key West beach onto a level, sandy shelf. We were sitting side-by-side staring at the ocean as I launched into an explanation of my less than graceful journey across the rocks. “I only have about eighty percent depth perception,” I began, feeling intensely aware of my need to explain my clumsiness to the athlete I had been dating for three months. Rob had been a single skull rower for thirteen years and made it all the way to the Olympic trials before falling short in his bid to make it to the 2000 Summer Olympics in Sydney. His coordination was nearly flawless, and his eyesight better than 20/20. “It’s because my eyes aren’t completely aligned,” I continued.

Rob looked at me with a mixture of curiosity and surprise. “Oh. I wondered about that.”

“Why didn’t you ask about it?” Now I was curious, and very grateful for the mirrored prescription sunglasses that kept him from staring at my eyes while I finally broached the topic.

“I was going to once,” Rob began, “but then I didn’t, and after that I just kind of stopped noticing it.”

“Oh,” I responded, feeling relieved and pleased.

“Can they fix it?” he asked.

I felt the familiar squeezing sensation in my chest that I always experienced when I worried that people might think I was just too poor, or too ignorant to fix something simple.

“Well, they could try. The problem is if they aligned my eyes now my brain might not be able to figure out how to use them together as a team and I may end up with double vision, or one of my eyes might try to shut off to compensate. And even if they do get them straight, they eventually can be expected to drift again and require more surgery.”

Rob was silent for a moment, thinking.

“That doesn’t sound worth the risk,” he said. “I don’t care,” he shrugged. “I like you the way you are.” He leaned forward and kissed me playfully on the lips. “Come on,” he smiled, jumping to his feet. “Let’s go get something to eat!” I grabbed his hand and he pulled me to my feet. We grabbed our dry clothing and had begun to make our way toward the bathrooms when a young woman broke off from her group of friends and came racing toward us.

“How tall are you!?” She was breathless and giggling. “My friends and I want to know. I guessed six foot five. Am I right?” She stopped finally and just stared at Rob. He had that same frozen, deer-in-the-headlights smile that I had seen so many times in the last three months. He hated being asked that. His minor bodily stigma was his great height. When he hit his head on door jams in buildings or didn’t fit into cars, or in the coach class seats on planes very well his height often felt like a major bodily stigma to him. I knew from my research that height is considered to be a great advantage when it comes to everything from employment to romance, but in Rob’s case it seemed like he had too much of a good thing.

“Six eight,” Rob replied, shaving a half inch off his true stature.

“Wow!” exclaimed the woman, laughing and racing off to tell her friends.

He squeezed my hand tighter and I squeezed right back. Suddenly my stigma was eclipsed by his, unfixable, and hard-to-miss stigma. Oddly enough we were both vulnerable in the same way. We were always on display and open to comment. When we were sitting down and having a conversation with people who were unfamiliar with my eye problem, that seemed to garner all the attention. When we were standing, his height took center stage. We both had little choice but to learn to live with our differences. But then again, as Rob so often asked, “Who wants to be normal?” Wouldn’t life be a lot less interesting if we were all the same?

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