For her fortieth birthday, Marianne, a successful banker in Houston, treated herself to a $15,000 gift. Although she considered herself skinny at 5’3” and 110 pounds, she had, to use her word, “saddlebags.” Regardless of how much tennis she played or how often she worked out, she could not get rid of them. Liposuction, she hoped, would do the trick. And since she was going under the knife, she decided she might as well get her breasts done. Marianne had a clear vision of what she wanted out of cosmetic surgery. With liposuction, she desired a more “curvy,” “symmetrical,” and “proportioned figure.” With the breast augmentation, she told us, “I never wanted to look like tits on a stick. . . . I wanted very natural-looking [breasts].” She joked about scoring 100 percent every time she took the “Fake or Real?” quiz—an internet quiz that presents images of women’s body parts and then asks viewers to determine if that part has undergone cosmetic surgery. She continued, “It was very important that mine did not look fake.”

Marianne is not unique in prioritizing a “natural” outcome. In our interviews with forty-six women who had cosmetic surgery, including Marianne, a concern for natural results emerged as a pervasive
theme. *Under the Knife* examines this theme in light of a cultural paradox. On the one hand, a beauty, makeover, and self-improvement culture encourages women to turn to resources within their means—including cosmetic surgery—to improve their appearance. On the other hand, despite increases in the number of some cosmetic surgical procedures among women, cosmetic surgery can still come with stigma. Women who have cosmetic surgery thus face an inherent contradiction—a double bind. Given cultural beauty and self-improvement logics, they attempt to improve their bodies. Yet they potentially face social condemnation for, among other things, being fake or unnatural. So while women are encouraged to take advantage of surgical innovations, there are also social forces that discourage them from doing so. Faced with this contradiction, how do women who have cosmetic surgery resolve this paradox? How do they make sense of and negotiate their “unnatural” surgically altered body?

**Body Projects in a Makeover Culture**

The pop music icon Madonna purportedly once said, “No matter who you are, no matter what you did, no matter where you’ve come from, you can always change, become a better version of yourself.” These words capture a telling Zeitgeist for women today. There is a cultural imperative for women in America to better themselves. Whether self-help books or reality television programs, a common message emanates from them: Women can improve in all facets of their lives. Whether coordinating the clothes they wear more fashionably or finding their authentic, unique, stable, or true self, they can, as Madonna put it, become a better version of themselves. This is, at least in part, because we live in a makeover culture that rewards people for the work they put into the process of transformation. It is also a culture that exhibits contradictions. For example, despite supposedly being empowered through the process of transformation, one must surrender to experts and authority figures (such as medical doctors and beauty professionals). Additionally, while one wants to be unique, transformation results in looking remarkably like everyone else. This means adopting the appearance of conventional femininity—middle-class, white, ethnically anonymous, and heterosexual.
Because physical attractiveness is inseparable from cultural notions of femininity, for women this self-improvement mandate often centers on appearance. In America, despite subcultural and counter-cultural ideals, women experience pressure to conform to hegemonic beauty ideals—that is, aesthetic forms exalted as the go-to cultural standards at a given time and place. So at the same time that researchers have documented, for example, black beauty norms and appearance norms among lesbians, there is nevertheless an aesthetic ideal pervasive in fashion magazines and blockbuster Hollywood films. Embodied by A-list actresses such as Anna Kendrick, Jennifer Lawrence, and Emma Watson, it spares no body part from rigid expectations. It demands youthfulness; slenderness; symmetry; coiffed hair; taut, depilated, fair, and unblemished skin; and more. Natural embodiment of this ideal is indisputably a statistical anomaly. One study estimates that the probability of having a body shape similar to real-life Barbie is less than one in one hundred thousand. Everyone knows that most women do not have supermodel Gisele Bündchen’s or singer Beyoncé’s body! Although embodying these standards is equivalent to winning a genetic lottery of sorts, women still attempt to embody these ideals, in part because there are social expectations that they do so.

Research shows a “beauty bias,” in that women who meet these aesthetic demands are often rewarded psychologically, socially, and economically in the form of improved self-esteem, increased dating and marriage opportunities, and higher earnings. Meanwhile, as research on women of size confirms, those who do not meet these aesthetic demands are frequently subject to criticism and even discrimination. People who body shame others often feel justified in their admonishments because makeover projects are not only about the transformation of physical appearance. They are, to borrow the term from social theorist Chris Shilling, body projects—“a project which should be worked at and accomplished as part of an individual’s self-identity.” These projects involve a process of becoming that is tied to an individual’s sense of self. They are self-improvement projects that reflect personal expression—who one is and wants to be. The body that fails to meet beauty standards is purportedly representative of some moral deficiency—a lack of desire, effort, will, or
discipline.\textsuperscript{15} Subsequently, these “failures” are supposedly deserving of social derision.

In this demanding cultural context, it is not surprising that women feel inordinate pressure to improve their physical appearance. Cosmetic surgery is one of many tools at their disposal.

**Cosmetic Surgery in the United States**

Cosmetic surgery in the United States is a multibillion-dollar industry, and the latest data indicate that in 2017, Americans spent more than $16.7 billion on cosmetic procedures.\textsuperscript{16} The American Society of Plastic Surgeons (ASPS) reports annual statistics by procedures and not people.\textsuperscript{17} By ASPS calculations, women in the United States underwent about 92 percent of all cosmetic procedures in 2017, with about 1.4 million procedures involving surgery. (As a reference point, there are about 124 million adult women in the United States.\textsuperscript{18}) The most common procedures for women are breast augmentation (augmentation mammoplasty), liposuction, eyelid surgery (blepharoplasty), nose reshaping (rhinoplasty), and tummy tuck (abdominoplasty). Over the last two decades, rates of two of these procedures dramatically increased. Specifically, in 2017, surgeons reported performing 300,378 breast augmentations and 124,869 tummy tucks on women, increases of 41 percent and 107 percent, respectively, since 2000. Table 1.1 presents these data, along with the average surgeon fee associated with each of these procedures.

Cosmetic surgery patients are mostly between the ages of forty and fifty-four.\textsuperscript{19} The limited data on socioeconomic status show that about 60 percent of patients have annual household incomes less than $63,000, suggesting that cosmetic surgery is not just a luxury item for the wealthy.\textsuperscript{20} ASPS data on demographics reveal that the majority of patients are white. This is the case for women undergoing all major procedures. Table 1.2 contains a breakdown of cosmetic surgical procedures by major racial and ethnic groups in the United States. By and large, white women are the primary consumers of cosmetic surgery. This may be because class is de facto correlated with race and ethnicity in the United States\textsuperscript{21} or because researchers have documented more flexible conceptions of beauty among some racial and ethnic minority groups.\textsuperscript{22}
Medicalization, Normalization, and a New Aesthetic?

A driving force behind the growth of these procedures, particularly breast augmentation, is the medicalization of women’s bodies. Scholars have written at length about the gendered nature of medicalization, arguing that women’s bodies and everyday experiences are increasingly subject to medical surveillance.\textsuperscript{23} According to the distinguished Brandeis University medical sociologist Peter Conrad, “Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.”\textsuperscript{24} With the medicalization of appearance, people who are unhappy with their looks and who suffer poor body

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image can use medicine to “correct” and “treat” aesthetic “problems” and “abnormalities.” They can turn to medical experts and technologies to “fix” their bodies. Certainly, a long list of medical advances is now available to combat an array of beauty-related problems. We can have our hair transplanted, skin injected with fillers, and discolored skin tempered by laser treatments. We can freeze our fat cells, excise fat and skin, and manipulate the shape and size of our breasts and buttocks. A number of the aesthetic challenges people use medicine to combat are associated with aging. Thinning hair, liver spots, and wrinkles are all a mainstay of growing old. Yet in a makeover and beauty culture, we view these things as unattractive and therefore problematic. Rather than embracing aging, cultural conventions say we should fight its signs, especially given that we have the medical know-how to do so. A profitable medical market driven by private demand provides an endless array of medical services for those who are willing and able to pay.

Medicalization legitimizes cosmetic surgery as an appropriate response to beauty concerns. Surgeons function like psychoanalysts by relieving psychological suffering and improving self-esteem—only, the former work via alterations of the physical body instead of alterations of the mind. With the medicalization of appearance and body image, cosmetic surgery becomes a reasonable solution to body dissatisfaction. Thus, when women define what they perceive to be an aesthetic flaw as a medical problem, they seek a cure, and they are able to feel legitimated in their decision to turn to a surgeon. Of course, whether women’s body image can be “fixed” with cosmetic surgery is a different matter, and it is unclear if cosmetic surgery in fact results in improved social-psychological outcomes. In their review of extant research, the psychology professors Charlotte Markey and Patrick Markey conclude, “Cosmetic surgery has the potential to improve women’s satisfaction with particular body parts, but it is less likely to improve their overall appearance evaluation and body image.”

Within a medicalization paradigm, as the Dutch medical anthropologist Alexander Edmonds observes, one can think of cosmetic surgery as a self-care health practice despite its elective nature. Beauty effectively becomes an “integral dimension of health,” and the risks of elective procedures are minimized as they “become absorbed into
the medical management of female health.” Within this paradigm, one can even argue that elective cosmetic surgery ought to be subsidized, as it is at the Ivo Pitanguy Institute in Rio de Janeiro. Named after the Brazilian plastic surgeon known for saying, “The poor have the right to be beautiful too,” the institute—a charity and teaching hospital—provides patients with heavily subsidized or free cosmetic surgery. Similarly, the cosmetic surgery procedures examined by the sociologist Kathy Davis in her groundbreaking research in the Netherlands were covered by Dutch national health insurance.

Whether publicly subsidized or not, with “aesthetic medicine,” beauty and health become entangled. Yet this is precisely the concern expressed by critics. Historical and contemporary social intolerance of “abnormal” appearance means that next to everyone falls outside aesthetic norms and needs medicine’s help to correct physical appearance. As a society, we no longer tolerate aesthetic diversity. Instead, as the renowned University of Toronto philosophy professor Kathryn Pauly Morgan argues in her influential ruminations on cosmetic surgery, we pathologize minor deviations from beauty ideals and label “problem areas” as “ugly,” describing them as “deformities” in need of medical correction. Moreover, cosmetic surgery can result in the medicalization of racial features. For example, Eugenia Kaw’s anthropological research involving interviews with physicians and patients shows how Asian American women internalize a racial and gendered ideology constructed by Western media. This ideology, which surgeons promote to increase demand, constructs these women’s natural physical features as undesirable (because it culturally signifies dullness and passivity) and in need of medical correction through, say, eyelid or nose bridge restructuring. Research also shows that medicalization is gendered insofar as surgeons see surgery as “normal” and “natural” for women but not for men. Again, the message remains: The beauty mandate is almost exclusively a woman’s mandate.

Industry growth has led some scholars to argue that cosmetic surgery has been normalized or domesticated. They point out that, over the last three decades, there has been a “mainstreaming of cosmetic surgery techniques and procedures in Westernized societies,” and today “everybody knows about cosmetic surgery.” This normalization is evident in the growing number of procedures, the ubiquity
of surgically altered celebrities, and the emergence and growth of cosmetic-surgery-focused reality television programs since the early 2000s. The internet is now abuzz with gossip about which celebrity had this nipped and that tucked. Notably, this discussion is often rife with judgment and negative assumptions about both motive and character. Morgan even speculates that women who contemplate not having surgery will be subject to stigma, while other scholars maintain that there may be a new coveted aesthetic of artificiality, particularly with breast enhancement, that allows women to conspicuously display upward mobility. She ventures that the pervasiveness of aesthetic technologies will one day mean that the “naturally ‘given’” will increasingly come to be viewed as “technologically ‘primitive’” and that “ordinary” will eventually be perceived as “ugly.”

**Stigma and Cosmetic Surgery**

Despite some procedures becoming more common, medicalization, the claim of a new cosmetic surgery aesthetic, and cosmetic surgery’s pervasiveness in everyday discourses, a veil of stigma still surrounds the cosmetic surgery industry and its patients. Stigma, as the sociologist Erving Goffman has long described it, is an attribute that is discrediting. The stigma of cosmetic surgery has historical roots. At the turn of the twentieth century, those who were conducting invasive medical procedures that would today be labeled cosmetic surgery had quite a spotty reputation. Reputable surgeons accused these practitioners of placing healthy patients at risk and performing medical interventions that contradicted “the traditional American injunction against vanity,” as well as the Hippocratic oath to do no harm. The historian Elizabeth Haiken documents that “‘beauty surgery’ was the province of quacks and charlatans.” In the industry’s initial stages of development, cosmetic surgery earned the unfortunate reputation of being “dirty work.” Practitioners and clients alike were perceived as socially deviant.

Over time, efforts to increase the profession’s legitimacy have been somewhat successful, with professional organizations playing a pivotal role in this transformation. For example, the formation of the American Association of Plastic Surgeons in 1921 helped define
boundaries of acceptable practice, set standards, and regulate practitioners.49 These organizations eventually collected data on their clientele and began marketing extensively to their new consumer base.50 New social norms that emphasized beauty and individuality, along with the medicalization of appearance, further added to the industry’s legitimacy.51 Today, the industry has mostly moved out of the “domain of the sleazy, the suspicious, the secretly deviant, or the pathologically narcissistic.”52

Even with this cleaner reputation, the cosmetic surgery profession still experiences reputational struggles. For example, research in the United States and abroad finds that the public, along with other medical professionals, grossly underestimates the scope of this specialty.53 Specifically, individuals do not typically identify cosmetic surgeons as having broad and extensive technical skills but rather associate them exclusively with procedures used to enhance aesthetic appearance. Narrow media depictions of the profession, such as FX’s Nip/Tuck, have done little to enhance the reputation of cosmetic surgeons. This TV drama graphically depicted surgeries while following the lives of two cosmetic surgeons, including their sexual exploits, sometimes even with patients. After Nip/Tuck’s debut, professional organizations representing board-certified surgeons posted press releases on their websites condemning the show.54 These efforts are worthwhile, as research finds that such shows do in fact negatively affect the public’s perception of the profession.55 Indeed, some cosmetic surgeons recognize that their specialty requires defending. One Seattle-based surgeon goes as far as to include on his surgery center’s website a blurb titled “Clearing Up Stereotypes about Plastic Surgeons.” In it, he insists that it is “not about fancy cars and dating beautiful woman [sic] . . . [or] the money.” Rather, it is about “the positive impact that they can make on their patients’ lives.”56

Stigma surrounds patients, too. Scholars document that cosmetic surgery has been historically associated with a list of undesirable characteristics including immorality, narcissism, and psychological maladjustment.57 Contemporary studies show that the public still holds negative views of cosmetic surgery patients, perceiving them as psychologically maladjusted and associating them with low self-esteem, materialism, self-consciousness, perfectionism, and the unnatural.58 One opinion piece by several plastic surgeons published
in *Plastic and Reconstructive Surgery* opens with “There is, without a question, a stigma in American culture attached to cosmetic surgery and a hidden condescension toward patients undergoing these procedures.” The authors criticize mass media for perpetuating this stigma, speculating that “the stigma in American culture has to do with disrupting antiquated, classicist ideals that beauty is something with which one is born.”59 Until society is rid of the assumption that people are only born beautiful, they maintain, beauty bought will continue to be tainted. These surgeons question why beauty purchased or facilitated by surgery is devalued or loses its luster. Their words, no doubt, are a defense of the medicalization of beauty.

A qualitative study by psychologists in England and Australia sheds light on cosmetic surgery stigma by revealing how public indictment of breast implants operates on two levels.60 First, negative evaluations of surgically enhanced breasts center on their aesthetic unnaturalness and the visibility of augmentation. These researchers observed that people rebuke the results of breast enhancement surgery for looking like “rockhard fake gazongas,” having a “plastic blow up doll look,” and appearing like “robot tits.”61 Yet this aesthetic inferiority, they argue, is just a springboard for a second indictment of “the personalities of women who have breast augmentation . . . [who are construed] as deceptive or deviant.”62 Supposedly, breast implants reveal something about a woman who has them. For example, cosmetic surgery implies that she is a “superficial bimbo,” “trying too hard,” has “confidence issues,” or suffers from “low self-esteem.”63

A 2016 report by the Pew Research Center, a nonpartisan Washington, DC, think tank, further confirms public disapproval of cosmetic surgery. The report maintains that “public opinion [is] mostly negative on [the] use of cosmetic procedures today.”64 Accompanying this claim, the center reports that almost two-thirds of those surveyed say that individuals are too quick to undergo cosmetic procedures and only 16 percent say these procedures have more benefits than downsides.65

It is important to point out that cosmetic surgery in the United States remains uncommon. Yes, more people are turning to it. Everybody seems to know about it. Coverage of it in mainstream media is rampant. Yet in their lifetimes most Americans will not undergo cosmetic surgery. In reality, only 4 percent of adult Americans have ever
had elective cosmetic surgery. It is statistically rare. And because the main consumers are white women, it is even rarer among men and people of color. People who undergo cosmetic surgery, even white women, are not the statistical norm. In fact, they constitute a minority.

So while a makeover culture encourages women to pursue body projects to better themselves, women who turn to cosmetic surgery potentially encounter a conundrum. They attempt to improve their bodies to align with cultural standards but may face social stigma for, among other things, being fake or unnatural. Under the Knife explores how women resolve this paradox, especially within the context of ongoing feminist debates about cosmetic surgery.

**Feminist Perspectives**

*Choice and Empowerment*

Some popular depictions and discussions of cosmetic surgery take a more laudatory approach. They do this by positively framing cosmetic surgery as “scientific progress,” “innovation,” and a tool that provides a “cure for suffering and a route to empowerment.” For example, cosmetic-surgery-focused reality television programs depict women as autonomous self-determining individuals who elect surgery. As rational actors, women choose cosmetic surgery to better themselves.

Such framing is emblematic of postfeminist rhetoric. Although multifaceted, postfeminism suggests an end to feminism as a movement on the premise that women no longer need it. Ostensibly, this is because the postfeminist woman is an empowered and active (including sexually active) subject in both her public and her private life. Epitomized by Kim Kardashian, she chooses her destiny and, if she fancies, even to be objectified. This line of thinking maintains that women can use beauty practices, including cosmetic surgery, to embody sexiness and to gain erotic capital for the sake of advancement. Choice—whether it is the right to choose sexual encounters, make health decisions, or elect cosmetic surgery—is a cherished principle at the heart of neoliberal consumerist and postfeminist culture.
Postfeminist discourses are part of a makeover culture that emphasizes the achieved self, mostly in the pursuit of beauty and body perfection.\textsuperscript{76} Popular cultural references depict the postfeminist woman as educated and successful in the workplace. Yet she is preoccupied with adornment.\textsuperscript{77} Her economic successes enable her to adorn herself with Jimmy Choo heels, Hermès scarves, and Burberry handbags. She is embodied by \textit{Sex and the City’s} Carrie.\textsuperscript{78} At the core of postfeminism is thus consumerism and particularly consumption in the name of beauty and fashion.\textsuperscript{79} Cosmetic surgery is merely one of many tools on the consumer beauty market a woman can purchase to achieve her desired self. In fact, the communication scholars Sarah Banet-Weiser and Laura Portwood-Stacer view the increasing use of cosmetic surgery as the quintessential expression of postfeminism. This is because cosmetic surgery legitimizes idealized feminine beauty and is the quintessential articulation of individual transformation and empowerment. They observe that makeover TV shows stress the “pleasure of transforming the self” and “becoming a better ‘you’ by making better purchases and adopting better lifestyle habits.”\textsuperscript{80}

The first major theoretical lens on cosmetic surgery therefore frames cosmetic surgery as a scientific innovation that empowers women. Rational women elect surgery to open up opportunities and gain various forms of capital.\textsuperscript{81} They are not victims of fashion magazines and Hollywood productions. Rather, they are, according to the sociologist Debra Gimlin, “savvy cultural negotiators.”\textsuperscript{82} They turn to beauty as a means to achieve psychological, social, and material rewards. Women use beauty, for example, to renegotiate their relationship with their bodies and to construct a certain sense of self. The work by one sociologist who has studied cosmetic surgery extensively confirms this. Kathy Davis finds that cosmetic surgery enables women to take control of their lives, to feel normal, and to obtain a body to which they feel entitled.\textsuperscript{83}

\textit{Conformity and Oppression}

In contrast, some scholars point out that this choice and empowerment rhetoric obscures power dynamics.\textsuperscript{84} In reality, what are sup-
posedly freely made choices are constrained. Choices are never made in a vacuum but are made within a social context. A beauty hierarchy, created and reinforced through media discourses, as well as everyday talk, deems some bodies physically attractive and labels others as unattractive. A self-improvement makeover culture and a beauty hierarchy that rewards conformity to hegemonic ideals create compelling social forces. Women feel pressure to conform to beauty ideals, especially in the absence of strong alternative beauty ideals. In this context, women may feel that there is only one choice—to conform.85 In the end, choice looks a lot like conformity and acquiescence.86 From this perspective, cosmetic surgery is not empowering but a form of oppression and discipline to gendered and racialized beauty ideals.87 This oppression works in insidious ways—not through overt coercion but through self-surveillance.88 Women voluntarily comply, participating willingly in their own subjugation.

Critics of the choice and empowerment lens further contend that while cosmetic surgery may result in individual empowerment, these are personal-level gains. These gains do little to challenge social and cultural ideologies.89 One woman’s use of cosmetic surgery may help improve her life circumstances by, say, upping her chances of finding a romantic partner or advancing in the workplace. However, this personal choice fails to challenge sexist ideologies that equate women’s bodies with their identities or reward women’s bodies over their intellects.90 Cosmetic surgery also means the ongoing reification of hegemonic beauty ideals.91 As more women try to embody the ideal, the more tangible and visible it becomes. From this perspective, although women have the free will to opt out of cosmetic surgery, the practice is not empowering to women as a collective.92 It results in the reproduction, not the transformation, of an oppressive beauty culture.93

Victimization is at the heart of this second lens. This lens stresses how beauty ideals support patriarchal and capitalist institutions,94 emphasizing that women who undergo cosmetic surgery have false consciousness.95 They are supposedly complicit in and oblivious to their own oppression. They are not empowered agents but oppressed victims who embody beauty ideals for the male gaze.96 To boot, this lens emphasizes that these ideals are not only unrealistic and unattainable; they can cause physical, psychological, and emotional
They also reinforce racism, ageism, ableism, and classism, because the norms themselves presuppose a white, youthful, and able body. Cosmetic surgery can erase racial and ethnic identifiers. And its embodiment requires financial and time investments—a luxury that favors the socioeconomically privileged. Low-income minority women who are not able to invest in the ideal lose out on economic mobility and other social benefits.

While the empowerment-oppression debate informs contemporary research on cosmetic surgery, some scholars argue for the decentering of the subject. For example, the body scholar Victoria Pitts-Taylor proposes moving past the question of “is she victimized, or empowered?” This is because “the subjectivity of the cosmetic surgery patient is not fixed but rather fluid” and the “personal is implicated in the larger social relations of cosmetic surgery.” Instead, she suggests that researchers examine how these social relations—including medical, popular culture, and interpersonal discourses about cosmetic surgery—continuously shape the way the self is constituted.

**Making Sense of and Negotiating an “Unnatural” Body**

It is in consideration of these competing lenses and the larger social relations that dynamically shape the self that we aim to understand women’s meaning making about their bodies. The pages that follow reveal how women negotiate their “unnatural”—but, they hope, natural looking—surgically altered bodies. Specifically, *Under the Knife* focuses on several interrelated social psychological processes. As we saw in Marianne’s chapter-opening preoperative sentiments, participants desire the “natural fake”—a discreet alteration of the body that appears as if it were achieved without surgical intervention. This natural fake allows them to pass as surgically unaltered. Participants also negotiate their postoperative bodies via their definitions of natural and the natural body. Moreover, they create boundaries between themselves and discredited others who undergo surgery. Finally, when they encounter problems and surgery does not deliver the natural fake, they turn to various management strategies. Ultimately, these strategies—of passing, redefining, boundary work, and physical and psychological management—are essential for identity
management and allow participants to preserve a distinctly gendered, authentic, and moral self.

**Interviews with Women Who Go Under the Knife**

Our findings are based on in-depth interviews with forty-six women who underwent cosmetic surgery. Using the definitions provided by the American Board of Cosmetic Surgery, we recruited participants who were “focused on enhancing appearance” rather than those “repairing defects to reconstruct a normal function and appearance.” 

Study participants must have been, to some degree, motivated to enhance their aesthetic appearance, even if surgery served some functional or health benefit (such as greater mobility or less chaffing). Procedures also had to involve surgery, thereby excluding nonsurgical procedures such as Botox (botulinum toxin) injections, microdermabrasion, and laser hair removal.

Participants’ surgeries were elective in that the procedures they underwent were not immediately lifesaving. Cosmetic surgery is never needed to save someone’s life. However, the concept of elective surgery itself involves contested boundaries, as the sociologist Heather Laine Talley’s work illustrates. Talley argues that the distinction between “optimization and repair, cosmetic and reconstruction, seems to be eroding.” Her research on facial work shows how aesthetic surgery, such as face transplant surgery, can be interpreted as lifesaving work. This is because appearance difference can amount to a form of social death—a cessation of social viability—and facial surgery is considered humanizing in light of the detrimental social consequences of facial disfigurement. Thus, in Chapter 4 we elucidate how participants often define their surgeries as necessary and complicate the notion that cosmetic surgery is elective.

We recruited participants through a wide variety of techniques, including advertisements on cosmetic surgery message boards, at local fitness and athletics establishments, and in surgeon’s offices. Yet it was often through word of mouth that participants found out about the study. While we did not intend to interview only women and we doubled efforts to find men by reaching out to surgeons known to cater to men, our final sample consisted entirely of women, reflecting
the reality that women undergo the vast majority of all cosmetic surgery procedures in the United States.

We conducted interviews in California and Texas between summer 2014 and fall 2015. We each conducted about half the interviews, which took one to two and a half hours each. Our questions covered a broad range of topics related to participants’ surgery experiences and views—from the decision-making processes to adjusting to life after surgery. We digitally recorded all interviews, which were conducted in either an office or a location of the participant’s choosing (such as a coffee shop).

We transcribed about a dozen recordings before turning to a professional transcription service that provided verbatim transcripts. We found the transcripts quite accurate, as interviews did not involve extensive medical terminology and were akin to a casual yet directed conversation. We coded these transcripts using the software program Atlas.ti. Our inductive approach, informed by grounded theory, focused on exploring themes and fleshing out social processes. Because we adapted our interview guide to emergent theoretical developments, not all questions were posed to all participants. Consequently, and because our goal is not statistical representation, we generally do not report numbers, avoiding the misleading implication that these numbers might reflect some statistical pattern in a larger population. Our careful, thorough, and systematic treatment of data, along with our familiarity with social scientific scholarship on the body, make us confident our data, findings, and interpretations reflect empirical processes at work in the social world. We also believe our positionality increased the validity of our data and analysis more than it compromised it. We challenge quantitative researchers to test formal hypotheses derived from our findings and encourage other qualitative researchers to further flesh out our theoretical claims.

Who Are Our Participants?

Of the forty-six women we interviewed, ten resided in California and the rest in Texas. Their ages ranged from twenty to sixty-eight, with an average age of thirty-nine. Similar to national patient demographics, twenty-eight (or 61 percent) identified as white, ten (or 22 per-
cent) as Hispanic, four (or 9 percent) as African American, three (or 7 percent) as East Asian or Pacific Islander, and one (or 2 percent) as Middle Eastern. Thus, eighteen women (or 39 percent) in our sample identified as women of color. While this small number of women of color does not permit elaborate claims about the role race or ethnicity has on cosmetic surgery, we nevertheless point out racialized themes and social processes when the evidence presents itself.

In addition to racial and ethnic diversity, our sample exhibits socioeconomic diversity. Twenty-two (or 48 percent) had some college education or were currently working toward a college degree, while another seventeen (or 37 percent) had completed a baccalaureate degree. Five (or 11 percent) had a master’s or professional degree, while the remaining two (or 4 percent) had a high school degree or its equivalent. Participants had a range of occupations. Some were administrative assistants, sales representatives, and managers (at banks, restaurants, and medical offices). Others worked in professional careers such as teaching, medicine, dentistry, and interior design. Personal annual income data reflect the diversity in participants’ education and occupation. Eight (or 17 percent) earned less than $19,999. Ten (or 22 percent) earned between $20,000 and $39,999, eight (or 17 percent) earned between $40,000 and $59,000, ten (or 22 percent) earned between $60,000 and $79,999, four (or 9 percent) earned between $80,000 and $99,999, and the remaining five (or 11 percent) earned more than $100,000. Notably, all five women with personal annual incomes greater than $100,000 identified as white.

About a quarter of the women were married at the time of their interviews. Two participants were engaged. Just over a third were either single or widowed at the time of their interviews. Sixteen (or 37 percent) had divorced at some time in their lives. Twenty-two (or 48 percent) did not have children, while ten (or 22 percent) had one. The remaining fourteen (or 30 percent) had two or more children. The majority (forty-three, or 94 percent) identified as heterosexual, while the rest identified as bisexual. There is a cisgender bias in our sample, as no participant revealed a lack of correspondence between her gender identity and birth sex.

The age when participants had surgery varied. In an attempt to understand both short- and long-term processes, we placed no study restrictions on when participants underwent surgery. For example,
we interviewed Darla, age twenty-seven, two months after she had rhinoplasty. In contrast, we interviewed Jessica, age sixty-eight, who had had her first surgery—breast augmentation—forty-three years earlier, in 1972.

The type and number of procedures participants had also varied. Similar to national trends, the most common surgery among participants was breast augmentation (twenty-six women, or 57 percent).\textsuperscript{114} This was followed by liposuction and rhinoplasty (both were done by eleven women, or 24 percent) and abdominoplasty (nine women, or 20 percent). Four women (9 percent) had some form of a face-lift.\textsuperscript{115} Participants also had the following procedures alone or in combination with another cosmetic procedure: breast reduction (two women), eyelid surgery (one woman), jaw surgery (one woman), otoplasty (ear surgery) (one woman), and some form of a body lift or tuck (five women).\textsuperscript{116} In the Appendix, we present a table that includes each participant’s pseudonym, key demographics, and the procedures she underwent.

The most common procedure for the women of color in our sample was breast augmentation, which eight of them had. This was followed by abdominoplasty (five), rhinoplasty (four), and liposuction (three). The most common procedure for the white women in our sample was also breast surgery, which eighteen had. This was followed by liposuction (eight), rhinoplasty (seven), abdominoplasty (four), and face-lift (four). Table 1.3 presents a breakdown of procedures by racial and ethnic category.

It is noteworthy that the surgeries participants underwent would not be considered racialized procedures. The sociologist Margaret Hunter describes “racial capital” as a resource drawn from the body related to skin tone, facial features, and body shape within the context.

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<th>TABLE 1.3. NUMBER OF PARTICIPANTS’ PROCEDURES BY RACIAL AND ETHNIC CATEGORY</th>
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<td><strong>Breast augmentation</strong></td>
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<tr>
<td>Women of color ( (n = 18) )</td>
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<tr>
<td>White women ( (n = 28) )</td>
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of existing racial hierarchies. The cosmetic industry sells this capital, she argues, in the form of “Anglo noses, Anglo eyes” while simultaneously maintaining that patients are preserving their racial or ethnic identity. For some patients, then, cosmetic surgery, such as blepharoplasty (eyelid surgery), can have deeper meanings about race and ethnicity. For example, double-eyelid surgery for an East Asian woman may be highly racialized, unlike eyelid surgery for a woman of European descent to remove bags around her eyes. Yet this was not the case with our participants. The only participant in our sample who had eyelid surgery, Penelope, a white woman, said she wanted to preserve a more youthful look, stating she did not like the appearance of these bags. Moreover, when participants discussed an array of issues about cosmetic surgery (including motivations and beauty culture in general), none explicitly framed their desire for noses, breasts, or other body parts in terms of their racial or ethnic identity. Instead, they simply wanted more aesthetically pleasing body parts. By and large, our participants viewed surgery through a gendered lens. As Chapter 2 underscores, motivations for cosmetic surgery are predominantly about living up to aesthetic norms of femininity, while racial and ethnic discourses are secondary at best.

At the time of their interview, just over two-thirds of participants (thirty-two, or 70 percent) had had a single unique procedure, meaning that about one-third had two or more procedures, sometimes three or more. For example, when we met Lena at age forty-four she had had rhinoplasty at age eighteen, followed by breast augmentation at twenty-five, and then a second breast augmentation at thirty-six. The self-reported average age of first surgery was approximately twenty-nine.

Nine women (or 20 percent) had several surgeries of the same type. In the majority of these cases, participants were either dissatisfied with the results or encountered physical problems (such as leakage in a breast implant). All but four participants had surgery in the United States. One participant had surgery in the Middle East because a close relative was an experienced and reputable surgeon whom the participant trusted. The other three participants went to Latin America because they felt they were saving a significant amount of money.
Plan of the Book

To understand how women resolve the cosmetic surgery paradox, we first turn to their decision to go under the knife. The decision is a serious one with, as makeover discourses intimate, supposedly life-altering consequences. Chapter 2 is thus the first of four chapters that set the empirical foundation of the book. In this chapter, we examine women’s motivations for surgery and the stigma surrounding cosmetic surgery. We document why women pursue cosmetic surgery and their concerns about having chosen a form of body modification that comes with social rebuke. These concerns lead them to desire a very specific surgical outcome—the natural fake.

In Chapter 3, we examine participants’ pursuit of this natural fake and their understandings of natural. What exactly are natural surgical results, and after surgery do the women consider their bodies natural? Our interviews revealed that participants associate natural surgical results with what is God-given, with what is not artificially altered, and with inconspicuousness, and that they frame natural surgical results as feminine enhancement and restoration. Moreover, their accounts of their postoperative bodies as still “natural” or “natural looking” constitute a form of passing and one strategy participants use to manage the cosmetic surgery paradox.

Chapter 4 focuses on another strategy. Participants justify their altered bodies and their decision to have cosmetic surgery by creating boundaries between good and bad surgery and between good and bad patients. They construct an image of a good patient as a well-adjusted, psychologically balanced woman who uses surgery to achieve normative femininity and to empower herself. In this way, women who have cosmetic surgery turn the table on the paradox by taking a moral high ground. In a self-improvement makeover culture, they are merely good female citizens seeking to better themselves. Chapter 4 is therefore an in-depth look at boundary work and how this work enables participants to preserve a moral self that also allows them to stay true to themselves.

Does surgery live up to expectations? If women desire the natural fake, are they pleased with the results? Chapter 5 examines what happens after surgery. While the majority of participants were generally content with their decision to have surgery, there were nevertheless
complications and disappointments, including the disappointment that surgery did not deliver the natural fake. Chapter 5 describes some of the psychological and physical strategies participants used to manage these complications and disappointments. It also shines light on the stories of several participants who exhibited a fraught relationship with cosmetic surgery. Their stories illustrate that disappointment with cosmetic surgery can lead to challenges, albeit limited, to the same beauty norms that prompted the initial decision to go under the knife.

Chapter 6 summarizes our main empirical findings within the context of extant research and discusses why all this matters. Ultimately, *Under the Knife* highlights the role of deep-seated yet contradictory gendered meanings about women's bodies. Strategies of passing, redefining, boundary work, and physical and psychological management enable women to preserve an authentic and gendered moral self—a self that, despite the articulation of empowerment rhetoric, comports with traditional notions of femininity and virtue.