

# “The Real Me”: Therapeutic Narrative in Cosmetic Surgery

by Rebecca Huss-Ashmore



At 10:25, Kim gets out of her chair and paces across the examining room for at least the tenth time. She is clearly nervous, frightened. She grabs the ties of the blue-checked bathrobe she is wearing and pulls them tight, then crosses her arms and hugs them to her chest. The room is cold, despite the August day gathering steam outside, but I know that the temperature is not her main concern. She looks at me sitting on my stool in the corner by my tape recorder. “I’m scared,” she says. “Should I be scared?” “Of course,” I say. I know my lines by now. “Everyone’s scared. It’s only sensible to be scared. If you weren’t scared, we’d be worried about you.” Sandy, the nursing supervisor, comes into the room. Kim asks her the same question and gets much the same answer. “But this will help.” She holds out a tiny paper cup containing several tranquilizers, and a larger cup with water. Kim takes them gratefully and sits back down in her chair. “In fifteen minutes,” Sandy says, “this is all going to look a lot better.”

Body modification takes many forms world-wide, from temporary painting and dying of the skin to permanent modification of body shape or surface texture. Many groups in Africa use cicatrization (scarification) to produce permanent patterns on the skin, often starting in childhood and adding new designs throughout adult life. Scars may be produced by medical treatment, when medicinal substances are scratched or incised into the skin. They may also be purely decorative. Although some facial scars, especially around the mouth and above the eyes, are thought to ward off disease or evil eye, they may also be markers of social status, personal traits, political rank, or religious and ritual authority. Among the Yoruba of Nigeria, body incising is a respected specialty, and practitioners owe allegiance to Ogun, the god of iron.

Possibly 19th century standing figure (probably a priest holding a blacksmith’s hammer) with facial scarification from Benin (Nigeria). Brass. UPM AF 5107. H. 63.5 cm

Kim has every right to be nervous. She is about to have a face lift and eyelid surgery (rhytidoplasty and blepharoplasty in the jargon of cosmetic surgeons). It’s not just the surgery that she fears, although that’s scary enough, but the change. It is, after all, her *face*—her self, in a way. How will she look? What will people say? Will she wish she hadn’t done it? It’s so permanent, so drastic! Will she like whom she becomes?

Kim is one of several patients whom I’ve followed through the process of cosmetic surgery. I know her doubts and her fears because I’ve taped the interactions that she’s had with doctors and staff at the cosmetic surgery center where I have been doing research (all names have been

the cosmetic surgery process. They do this to create and enact what I call a “therapeutic narrative,” a story of the patient as a new and better person through the medium of cosmetic surgery. Like any story, these therapeutic narratives have a beginning, a middle, and an end. I expect to see talk about self (“me now and in the past, the me I want to be”) predominate in setting the scene and describing the happy ending, while medical talk is emphasized in the middle, during the “crisis” or “complicating action” of the story.

I think of stories not as fictional accounts, but as creative ways of remembering and interpreting experience. Stories play an important role in medical encounters. Studies of doctor-patient

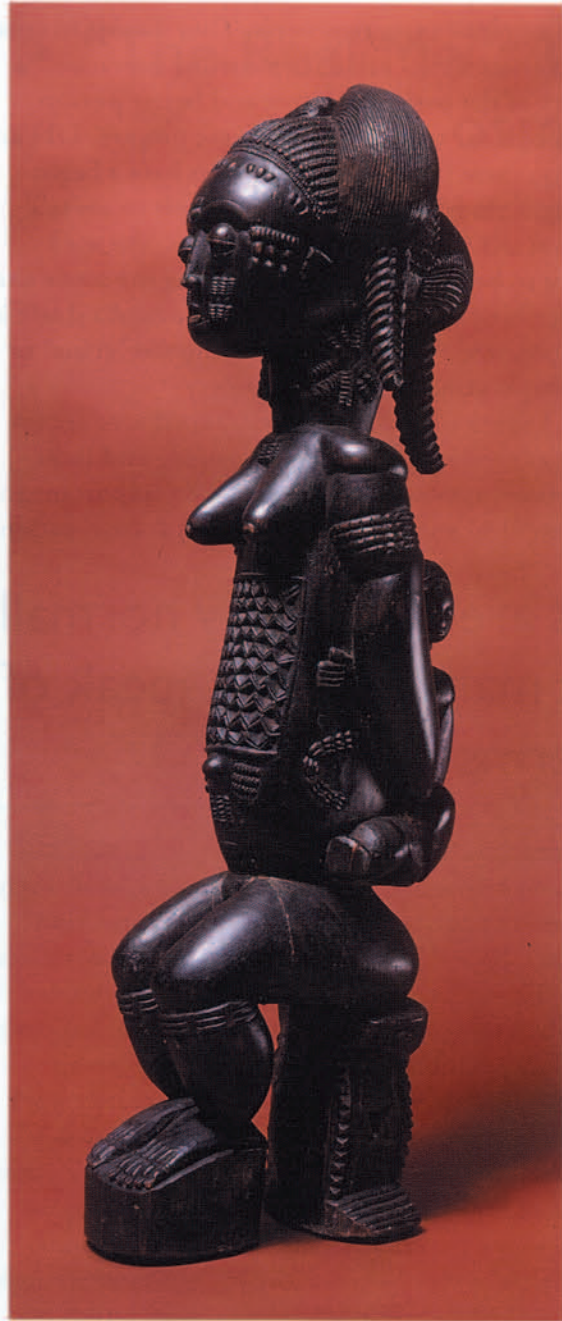
“[cosmetic surgery] patients are not, in any normally accepted sense, sick, and yet many of them speak of their experience in terms of healing.”

changed). Her fears are typical. Staff spend a lot of time dealing with those fears, providing information from which decisions can be made, providing reassurance, providing realistic assessments of what to expect and how to feel about the outcome. But fears are only one side of the equation. Unlike candidates for gallbladder surgery, for example, cosmetic surgery patients come in with strong opinions, fantasies, and idealized images of the product they are about to buy. This consumerist orientation (and the fact that patients pay for the procedures themselves) means that the usual roles of authority and submission in medical encounters do not apply here, at least not in the usual way. Both doctors and patients have authority, one in the realm of medicine, and the other in the realm of what I call “self.”

I am taping these encounters between cosmetic surgery patients and medical staff in order to see how decisions about surgery and expectations of outcome are negotiated through talk about medicine and self. My working hypothesis has been that both medical staff (including doctors) and patients employ both of these discourses strategically and in differing proportions during different phases of

interaction show that being able to tell the story of one’s illness, without interruption, is strongly related to patient satisfaction (Roter and Hall 1992). Some scholars have argued that narratives are the way we make sense of illness, the way we explain to ourselves and others what has happened and why (Good and Good 2000; Kleinman 1988). In addition, clinicians may actually work to help patients see and experience illness as a story. Cheryl Mattingly (1991), for example, shows that occupational therapists take clinical events and shape them into a coherent plot for their patients, a plot in which the patient must struggle but will eventually improve. My work builds on these ideas. For most patients, cosmetic surgery is a positive experience that may change not only how they look but how they feel about themselves. Many describe this change in terms of “transformation” or “healing.” I want to understand how this “healing” comes about (or alternatively how it doesn’t). I am suggesting that change is invoked, at least in part, through *language*—through narratives constructed, reconstructed, and acted out by patients and staff over the course of consultation and treatment.





For African women, scarification is often linked to fertility, with new patterns added at puberty, after the birth of the first child, or when breastfeeding is finished. Often these scars are meant to show bravery, that a woman is prepared to bear the pain and risk of childbearing. Others have erotic connotations, emphasizing both visually and tactually regions of the body with special sensual appeal (especially hips and buttocks). Scarification techniques vary little across the continent: small cuts are made with razors or thorns, and the wounds covered or rubbed with charcoal. Fat and herbs may be used on the wounds to ease the pain.

Early 20th century Baule (Côte d'Ivoire) seated female figure with child on back. The woman's body is extensively scarified, as is her face. Wood.  
UPM 29-12-68. H. 44.5 cm

necessary (tattooing, tooth removal, scarification, circumcision). All cultures have standards of beauty, and while some are arbitrary, some may not be (Lemley 2000). Psychologists have recently shown that even very young infants gaze longer at faces considered attractive by adults. Beauty seems to be equated with features that signal youth, health, and the potential for reproductive success, and may therefore have evolutionary significance. From this perspective, cosmetic surgery is one of a range of cultural practices that alter the body to produce the appearance of youth, health, and fecundity.

In addition, I have a long-standing interest in healing, especially in traditional and alternative medical systems. I am looking at cosmetic surgery through this lens, as a healing system. Prior to this project, I worked primarily in Africa, looking at health-related problems and how people cope with these. One of my earliest studies catalogued the types of healing resources available to rural people in the southern African kingdom of Lesotho. I found that while people used the Western medical care available, they still relied on the traditional system of indigenous healers. Some problems, they said, simply didn't yield to Western medicine. In these cases, healing required more than just treating the disease; it required treating the *cause*, which might be social, psychological, or religious.

I have been particularly impressed with the fact that all medical systems heal. That is, all

#### WHY COSMETIC SURGERY?

As a medical anthropologist, I am interested in how different cultures think about the body, and how they modify it in the name of health or beauty. There is probably no human group that does not practice some form of body decoration and modification. Practices range from the temporary and cosmetic (hair styles, body painting) to the permanent, deeply sacred, and ritually



The Athapaskan-speaking Ingalik borrowed heavily from the Eskimo, including modes of facial decoration. Among the Eskimo, tattoos were thought to enhance female beauty. The most common tattoo was a series of closely drawn parallel lines that ran from the lower lip to the chin. Many girls also had their ears, nose, or lips pierced so they could wear special dangling pendants made of bone, beads, or cloth. An older woman did the tattooing, pulling a needle and thread that had been drawn through lamp soot into and out of the young girl's chin. Full adulthood for males was signified by piercing each corner of the lower lip for labrets, decorative plugs made from shell, ivory, sandstone, wood, and other materials.

Athapaskan, from the village of Anvik, 1917. This mask, used to tell the story of Blueberry Woman, resembles a real woman who wears goggles and is tattooed on her chin. Painted wood, feathers, hide.  
UPM NA5882B. H. 31.9 cm



medical systems manage to relieve illness and to increase well-being, despite dramatically different beliefs about disease, medical technology, and social relations between healers and patients. I find cosmetic surgery an especially interesting case, because the patients are not, in any normally accepted sense, sick, and yet many of them speak of their experience in terms of healing.

My real fascination with cosmetic surgery lies in just these kinds of contradictions. As a surgical specialty, cosmetic surgery is among the most technical and medical of all the branches of biomedicine, with journals written in the most arcane of medical registers. At the same time, materials written for the public emphasize self-enhancement, making the outer appearance match the inner self. Public descriptions of cosmetic surgery are often negative: patients are described as vain and shallow, unable to resist the pressures of rampant "lookism" in American culture, and duped by our consumerist society into seeing the body as a commodity. On the other hand, people who have had cosmetic surgery often report that it has genuinely changed their lives, that they not only look younger or better, but they *are* younger and better, that they are in some sense enhanced, changed, or healed. Some speak of their experience as spiritual, a profound transformation of the self. How are we to understand these dramatic contradictions? What do they say about cosmetic surgery as a medical experience? What do they say about our culture?

And if cosmetic surgery patients see themselves as changed, healed, *better*, how does this happen? The surgeons themselves admit that they don't really know. They have reasonable hunches, that it involves a sense of agency on the part of the patients ("There! I went and did it.") and the feedback that they get from other people ("You look so good. Have you been on vacation?"). But the *how*, the process by which they come to view themselves as better has not been well explained. I think that it occurs through the creation and acting out of a therapeutic narrative, a lived story in which the "me I want to be" or the "me I really am" is brought into being through the linguistic, emotional, and physical experience of surgery and recovery.



Tattooing, widespread in Polynesia until well into the 19th century, reached its most extensive and elaborate form in the Marquesan Islands. Men were tattooed on their faces and over their whole bodies, women mainly on their arms and legs. The number and complexity of motifs far exceeded those found in the other island groups, to the extent that tattooing is considered a major Marquesan art form.

Tattooing of Marquesan men began after puberty, at a ceremony patronized by a chief for his first-born son at which a cohort of other young men also received tattoos. The ceremony was at the same time a puberty rite and a demonstration of the power and authority of the chief. As in the rest of Polynesia, the main significance of Marquesan men's tattooing (*pahu tiki* or "wrapping in images") was as a defense against spiritual and physical dangers.

"Langsdorff's old warrior (1804)." From Karl von den Steinen, *Die Marquesaner und ihre Kunst*, vol. 1, *Tatauierung* (New York: Hacker Art Books, 1969. Reprint of 1925 edition), p. 142, abb. 84.

My research site is a large private cosmetic surgery practice in an affluent East Coast suburb. The single-story building accommodates 4 surgeons and a support staff of 20–30. All surgery is done on an out-patient basis. I have been working with this group for the past two years, full-time during the summers and sporadically during the rest of the year. During the first summer, I did what might be called traditional village ethnography, exploring the culture of cosmetic surgery through "participant observation." I asked to learn what it was like to "do" cosmetic surgery from the point of view of staff members in different aspects of the practice. This meant that I spent the summer of 1998 as a volunteer,

the possibility. She had felt at that time that she wasn't really ready, but now she was back. Cheryl, her aesthetic consultant, settled Kim in a comfortable chair in her homey office, and asked her to explain what brought her in at this time. Kim explained that she had always been a swimmer, spent a lot of time in the sun, and that her face had begun to wrinkle and sag. The fine wrinkles didn't bother her so much, she said, but the incipient jowls had to go. "Look at my jaw line," she said. "It's all downhill, I mean, my face is all running downhill, you see? And my neck—it looks like a turkey. I'm embarrassed. I try to wear high collars so people can't see my profile from the side, you know? But then I just

**“Th[e] disjuncture between the image of the outer self and the true ‘me’ is at the heart of the discourse of self in cosmetic surgery.”**

following different members of the staff, and in some cases, being trained in their jobs. Seeing the practice this way meant that I could, in essence, follow patients through the process, noticing how their experiences and interactions differed from one stage to the next, from their initial phone call to their aesthetic consultations, to surgery and the recovery process. One of the things that struck me was the difference in language, both spoken and written, at different stages, especially the changing salience of medical topics or information. The further investigation of this variance in language formed the basis for my second summer's work, in 1999.

#### KIM'S STORY

I met Kim during the early part of the second summer. She was a slender woman in her late 40s who had been a schoolteacher for almost 20 years. I asked her if she would be willing to have her consultation taped, and she agreed. She had been thinking about cosmetic surgery for several years, and had actually come to the center the previous summer to explore

look in the mirror and I'm...*embarrassed*." Waving at her lower face, "This isn't me."

Cheryl talked to Kim more about her concerns—the eyelids, the wrinkles, the possibility of a chemical peel or just an exfoliant cream. She offered to do computer imaging for Kim, to show her how she might look after surgery, but Kim declined. She already knew what she wanted. When Dr. Wallace came in, he started by referring to their conversation the previous summer. He asked what had changed since then, why she was here now. "Well," Kim's voice was hesitant, and she leaned forward in her chair. "You know, my husband had only been gone about six months at that time, and it was just...well, just...too many changes all at once." "But now you're ready?" "Now I'm ready!" Dr. Wallace hitched his chair forward and patted her knee. "Good girl!" he said. "Don't do anything you don't want. We don't want you to rush into anything." He moved his chair directly in front of her and held up a mirror at the level of her face. "Now, what are we going to do? Talk to me about this face."

Kim's conversations with Cheryl and Dr. Wallace during this meeting show a number of



themes that recur in the initial consultations that potential patients have. At this stage, they are "pre-patients," still deciding their exact course of action. Consultants encourage them to talk about themselves, to explain what bothers them and how they'd like to look. They often talk about their past, their families, who they are, and who they would like to be. This is the beginning stage in the construction of their cosmetic surgery story.

Kim uses vivid metaphors to talk about her concern with her appearance. "Downhill" and "turkey" are negative images that summarize the way she sees her outer self. But, "this isn't me." This disjuncture between the image of the outer self and the true "me" is at the heart of the discourse of self in cosmetic surgery. The surgeon affirms this. She is "good," she has been prudent, independent—she knows her own mind. But this is a complex scene. By making Kim a "good girl," the surgeon also positions himself as a concerned parent who can decide her goodness. Touching her knee reinforces familial (and medical) intimacy, the ability to provide reassurance and reward. What is rewarded here? Prudence, but also the decision to go ahead with the surgery. Kim has made the right decision. At the same time, the surgeon suggests, the decisions are hers to make. She mustn't rush, there is no pressure, and whatever may get done to her face, "we" are going to do it. Her narrative about herself is being recast as a cosmetic surgery story.

Kim scheduled her surgery before she left the building, just the face-neck lift and the eyelids, no chemical peel. When I saw her again it was two weeks before her surgery. This was her "pre-op" visit, where she could ask questions about the surgery or voice any other concerns, but where she would also get a basic medical check and sign consent forms for surgery. Cheryl's tone was different from the first visit—friendly, accepting, but more businesslike. Kim was a patient now. I took her into Cheryl's office while I set up my tape recorder. She was quiet, subdued, sitting forward in her chair. "It's only two weeks now," she said. I asked her if she had butterflies, and she nodded. Cheryl came in a minute later with a stethoscope, a blood-pressure cuff, and a sheaf of papers. Kim



Figurines add to our knowledge of Mesoamerican techniques of personal adornment. The Maya elite prized the effects of dental inlays, crossed eyes, and artificially flattened heads. Throughout Mesoamerica body decoration, including tattooing and scarification, was common practice. Bracelets, pendants, necklaces, nose ornaments, lip plugs, and ear plugs were made of jade, shell, jaguar teeth and claws, and obsidian. Lower classes used simple nose plugs, lip plugs, and earrings of bone, wood, shell, or stone.

A Late Classic (ca. AD 800) seated female figurine from the Yucatan wears ear flares in her lobes and her cheeks are scarified. Hollow painted clay. UPM 62-11-1. Photo by Lucy Fowler-Williams. H. ca. 18 cm

had filled out a health history in the waiting room, and now they talked about her allergies to antibiotics. Kim asked about anesthesia, and Cheryl explained that the center did not use general anesthesia, but rather intravenous sedation, so-called twilight sleep. "You're breathing on your own, and we can talk to you. We can sit you up and ask you questions if we need to." She handed Kim a number of consent forms to read and sign, and Kim read for a while in silence. "Wow," she said, "this stuff would really scare you." Cheryl nodded, fiddling with the blood-pressure cuff. She looked up and smiled at Kim. "Does this stuff really happen?" "Well, sometimes it does," Cheryl agreed. "But it must be really rare?" Kim laughed nervously, seeking reassurance. "Yes," Cheryl told her, "very rare."

The rest of the conversation was one-sided, with Cheryl going through the list of instructions for the week before surgery (no aspirin or aspirin products, nothing that might cause bleeding), the day before surgery (nothing to eat or drink after midnight), the day of surgery (wear loose clothing, nothing that slips over your head, wash your face and hair with surgical soap, no makeup, no contact lenses, bring your support person with you when you come), and the immediate postoperative period. Cheryl took her blood pressure, and then "before" photographs of her face. They discussed the position of face-lift scars along the hairline, with Cheryl showing hers to Kim. "Oh, they're not bad at all." Kim looked relieved. "I could live with that." Laughing, Cheryl said, "Good, 'cause you're gonna!" We all laughed. Kim wrote the check that made the transaction official, and talked about going to the Bahamas with her son once the bruising had faded. She reconfirmed her surgery date, gathered up her prescriptions, and left.

In Kim's case, the contrast between the initial consultation and the pre-op visit is marked. Kim is clearly nervous, and even though Cheryl is reassuring, the tone of the visit is different. The visit has started with a medical history, and the focus of the conversation continues to be medical. Like all medical encounters, this one can be seen as a type of performance, with roles, scripts, and props. As the current representative

of the medical world, Cheryl takes an authoritative role. Even though she has no formal medical training, Cheryl presents herself here as the voice of medicine, initiating topics, answering questions factually, giving instructions. She carries medical props that would identify her to any theater audience as a health care provider. Kim, trained as we all are in how to behave in medical settings, positions herself as a patient. Of course, there are other roles that she might choose (schoolteacher or mother, for example), but patient is the role offered as appropriate at this point in the narrative, and her acceptance of it indexes her cooperation.

And now she is waiting for her next role, the next part of the story. I am waiting with her, while Sandy has gone out to check on Dr. Wallace's schedule. He is finishing another surgery, running a little late. At least the tranquilizers have helped. Kim is sitting in her chair, her hands resting on the arms, her feet stretched out in front of her. She looks vulnerable without makeup, her hair unstyled and frizzy from the surgical soap. The bathrobe and socks add to the effect. I realize that this is part of the ritual. She has been depersonalized, stripped of identifying markers like clothing, makeup, hairstyle, jewelry, even contact lenses. This is a genuinely liminal state and she is being progressively isolated, turned into a medical case. Anesthesia will complete the process, removing her temporarily from social space while her new status is physically inscribed.

Sandy comes back, trailed by Dr. Wallace. He is going to mark Kim's face so that he knows where the incisions are to go. Kim crawls up onto the examining table. She is a little giggly now and laughs when he shows her her face with the clown-like black lines on it. He finishes drawing, touches her arm, and smiles. "See you in the OR." He steps away and then turns back to her, squeezing her shoulder. "We're gonna take good care of you." Sandy helps Kim off the table, scoops up her clothes, and bundles her down the hall to the operating room. I am left tangled in my headphones, but I will join them as soon as I can pack up my recorder. Kim has given me permission to observe her surgery and to follow her through the recovery period.





As in other cultures, surgical modification of the face and body in the U.S. may have significant social and psychological impact for the patient. Both surgeons and patients speak of the process as creating congruence between the inner and outer self, or revealing the true self, the "real me." As one woman said of her surgery result, "I look more like me than I ever did." Here, the surgeon is performing a facial rejuvenation, while the author observes and helps to keep the patient's airway open. The patient's face has been blurred to protect her privacy.

Photo by M. Colonomos, August 1998

By the time I arrive in the OR, Kim is lying on the surgical couch, her body covered with a sheet and a green wool blanket. Julie, the surgical technician, hands me Kim's bathrobe and I put it in the laundry bin. If it was cold in the examination room, it is freezing in the OR. I put on a blue paper surgical gown and rubber gloves, then rub the gloves with alcohol. Julie is talking to Kim as she puts the IV shunt in her arm. "How are you, Kim?" she asks. "Are you okay?" "A little cold," Kim says. Her teeth are chattering. Julie asks me to get another blanket out of the cabinet, so I do, draping it across Kim's lower body. Julie starts the anesthesia. "How are you feeling, Kim?" she asks. "Mmmm?" says Kim in a very small, high voice. "Fi-i-ine." The next time Julie asks, there is no answer. "She's okay," says Julie, and she gets out a comb and a plastic tub of rubber bands to secure Kim's hair away from the incision lines. Now present only in the third person, Kim has become a case.

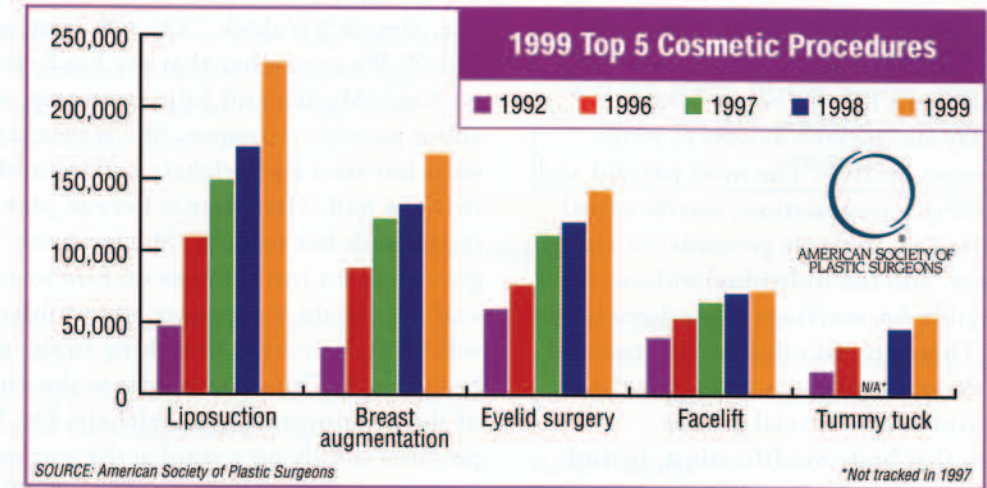
#### THE PURITAN DILEMMA

Each year an increasing number of Americans make this trip, or one like it, to an operating room or surgical suite for cosmetic surgery. Figures vary, depending on the types of surgery included, but the number of procedures per year

now exceeds 1 million, and may be as high as 2 million (Kalb 1999). Eighty percent of the patients are white; as many as 30 percent may be men (Gilman 1999). The modal patient is still a woman like Kim, in her forties or fifties and wanting to look younger. However, patients over 50 make up 29 percent of the cosmetic surgery population, and the number of teens having cosmetic surgery has doubled since 1992 (ASPS 1999). In all age groups and for both sexes, about 40 percent of cosmetic surgery procedures involve modifications of the body, with liposuction the most common (16%) and breast augmentation in women second (13%). These figures make sense in the American cultural context, where a slim body and large breasts define the ideal of female beauty.

Americans have a deep ambivalence about cosmetic surgery. Media coverage reflects the fascination and the unease, with articles in just the past two years in *The Chronicle of Higher Education*, *Newsweek*, *National Geographic*, *Vogue*, and *Parade* magazines, as well as newspapers ranging from *The New York Times* and *The Philadelphia Inquirer* to free neighborhood weeklies and supermarket tabloids. While these articles chronicle the increasing number of surgeries performed, they also counsel caution, including examples of failed or fatal surgery and warning about unqualified practitioners.

In spite of the dangers, cosmetic surgery is



more acceptable than it was a decade ago. A survey conducted by the American Society of Plastic and Reconstructive Surgeons in 1998 showed that about 32 percent of 1000 people surveyed approved of cosmetic surgery for themselves and others, and another 31 percent approved of surgery for others, but not themselves. Not surprisingly, the most favorable attitudes were seen among the respondents aged 45-54, and the least favorable among those 18-24 (ASPRS 1998).

Like the national sample, many of the 18-24-year-olds in my undergraduate medical anthropology classes display strikingly negative attitudes toward cosmetic surgery. I have asked them to list the words they thought of when I said "cosmetic surgery." Almost half give me words like "unnecessary," "artificial," "vain," "grotesque," "insincere," "complications," "superficial," "extravagant," "fake," "Beverly Hills," "rich," "housewife," "excessive," "trite," "frivolous," "insecure," and "a waste of medical training." I would argue that this moralistic tone is not simply a matter of age. While undergraduates may have less perceived need for cosmetic surgery, their answers reflect deeply held cultural beliefs.

A number of scholars have examined factors that may underlie both our desire for and our repugnance toward cosmetic surgery. Mark Nichter and Mimi Nichter (1991) talk about the puritan attitude that makes Americans feel that they need to earn whatever pleasures they enjoy. Although their discussion targets food (the week-long diet

and the weekend binge), the principle can easily be applied to cosmetic surgery. Americans have long held that beauty comes from within, that it is part of character, a moral quality that can only be gained by effort and sacrifice. Ironically, the more easily that beauty may be purchased, the less it is seen to be earned.

Given this ambivalence, why do so many Americans now elect to alter their appearance through surgery? Recent scholars have advanced two major arguments, one more social and economic, the other more psychological. Elizabeth Haiken (1997) traces the growth of cosmetic surgery to an increasingly consumer-oriented economic climate during the 20th century, in which beauty is not only necessary to be successful, but increasingly available as a commodity. Using a more psychological approach, Sander Gilman (1998, 1999) sees the desire for cosmetic surgery as fueled by the conflation of beauty with health and individual happiness. He sees happiness as defined by being part of some valued group, such as a class, race, gender, or age group. Unhappiness is equivalent to being excluded. Thus the surgeon, by altering physical features that mark the patient as different, allows the patient to "pass" as a member of the desired group. This is socially justified, Gilman suggests, by the belief that happiness is a component of health, especially mental health.

As an anthropologist, I see both beauty and body modification in a larger human context. Many forms of body modification, whether tem-



porary or permanent, are culturally defined as necessary for membership in a social group or for identification as a human being (Groening 1998). They may also be seen as ways to evoke the sacred or enact healing. The most painful and dangerous of these (circumcision, scarification) are often justified on hygienic grounds, or as evidence of bravery, and the individual without them may not be eligible for marriage (Nevadomsky and Aisien 1995). These are, in other words, cultural practices that shape the identity and affect the survival of individuals and social groups.

This means that body modification, including cosmetic surgery, is not merely a matter of happiness or of consumer economics. Beauty, however defined, and a body that meets cultural norms affect one's very status as a person. In American culture, the emphasis on individuality and self-definition makes "self" perception especially important. As with Kim, the primary complaint of many cosmetic surgery patients is less "I am not beautiful" than "this is not me." If cosmetic surgery changes self-perception, it has the power to redefine self, and thus personal and social identity or personhood. The American reverence for all things medical makes cosmetic surgery an especially appropriate and powerful vehicle for finding or creating the authentic self. It provides a culturally meaningful ritual setting in which self-transformation can be enacted.


#### A HAPPY ENDING?

Kim is almost ready to leave. Her surgery has been uneventful, Dr. Wallace telling stories as he worked, joking with the technicians, finally leaving to consult with new prospective patients. The technicians have finished the last of the sewing, putting in the fine sutures just below the lower eyelashes. Kim is beginning to wake up. We find her clothes, stuffing her into the loose knit pants and shirt in which she arrived early this morning. I hold up her legs, first one, then the other, as we dress her, and then find her shoes. Julie and Martha have wrapped her head in a large absorbent dressing, with another one across her eyes. She looks a bit like a mummy. Kim is talking now. "What time is it?" she asks. We tell

her, almost 3 o'clock. "Ooooh," she says. "That long?" We assure her that she has finished right on time. Martha and Julie sit her up, warning her about possible dizziness. She is fine, and so they waltz her into a wheelchair and then wheel her into the hall. Her sister is here to pick her up and to stay with her tonight. She has been "speeched," given explicit instructions on how to care for Kim and what to do if there are any problems. She will bring Kim back first thing in the morning to be checked. The sister laughs as she catches sight of the mummy in the wheelchair. Dr. Wallace, perched tiredly on a stool at the nurses' station, turns to the sister and says, "She did fine. We did a really nice job on her." What I can see of Kim smiles, and she holds her hand out, a little groggily, in the direction of the doctor's voice. He takes it and squeezes it. "That's my girl!" he says. "Go home and heal."

I leave Kim's story here, because for me it is still being written. I am now transcribing and analyzing the tapes that I made during 1999, looking for the ways in which the patients' initial stories get told and then retold as cosmetic surgery stories. I am investigating the ways in which both staff and patients use language to create roles and act them out during the process of surgery and recovery. As I do this, I am increasingly convinced that a successful cosmetic surgery experience requires both that the experience be shaped as a story, and that it be acted out in real life. The story is necessary to make sense of the experience, to give it meaning, but the enactment is necessary to make the story true. In this sense, the cosmetic surgery process is like other ritual events, from religious observances to the Fourth of July: we have a special story about who we are (Americans, the Children of God, etc.) and we act it out on these occasions to experience it as true.

But now I need to know if the cosmetic surgery stories really did have happy endings, if the narratives that patients constructed and performed really did create the "me as I want to be." I will look for changes in the story and the sense of "me" in the tapes that I have, in the interactions between patients and staff. Then, as the next step in my research, I will ask these same patients to tell me the story of their cosmetic

surgery as it appears to them now, approximately a year later. I wonder how the narratives will compare. I can hardly wait to hear how Kim thinks her story came out. 

To learn more about body modification in different parts of the world, visit "Bodies of Culture" on our website at [www.upenn.edu/museum](http://www.upenn.edu/museum).

#### BIBLIOGRAPHY

- American Society of Plastic and Reconstructive Surgeons (ASPRS)  
1998. *Cosmetic Surgery Telephone Survey*. Arlington Heights, Ill.: National Clearinghouse of Plastic Surgery Statistics.
- American Society of Plastic Surgeons (ASPS)  
1999. *Plastic Surgery Information Service*=[www.plasticsurgery.org](http://www.plasticsurgery.org) (website). Arlington Heights, Ill.: National Clearinghouse of Plastic Surgery Statistics.
- Gilman, Sander L.  
1998. *Creating Beauty to Cure the Soul: Race and Psychology in the Shaping of Aesthetic Surgery*. Durham: Duke University Press.  
1999. *Making the Body Beautiful: A Cultural History of Aesthetic Surgery*. Princeton, NJ: Princeton University Press.
- Good, Mary Jo Delvecchio, and Byron Good  
2000. "Clinical Narratives and the Study of Contemporary Doctor-Patient Relationships." In *Handbook of Social Studies in Health and Medicine*, ed. Gary Albrecht, Ray Fitzpatrick, and Susan Scrimshaw, pp. 243-58. London: Sage Publications.
- Groning, Karl  
1998. *Body Decoration: A World Survey of Body Art*. New York: The Vendome Press.
- Haiken, Elizabeth  
1997. *Venus Envy: A History of Cosmetic Surgery*. Baltimore: Johns Hopkins University Press.
- Kalb, Claudia  
1999. "Our Quest to Be Perfect." *Newsweek* (August 9): 52-59.
- Kleinman, Arthur  
1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Lemley, Brad  
2000. "Isn't She Lovely?" *Discover* (Feb.): 42-49.
- Mattingly, Cheryl  
1991. "The Narrative Nature of Clinical Reasoning." *American Journal of Occupational Therapy* 45(11): 998-1005.
- Nevadomsky, Joseph, and Ekhaguosa Aisien  
1995. "The Clothing of Political Identity: Costume and Scarification in the Benin Kingdom." *African Arts* (Winter): 62-73, 100.
- Nichter, Mark, and Mimi Nichter  
1991. "Hype and Weight." *Medical Anthropology* 13:249-84.
- Roter, Debra, and Judith Hall  
1992. *Doctors Talking with Patients/Patients Talking with Doctors*. Westport, Conn.: Auburn House.

REBECCA HUSS-ASHMORE is Associate Professor of Anthropology at the University of Pennsylvania. Most of her research has focused on health impacts of agricultural development in Africa, including the countries of Lesotho, Swaziland, and Kenya. She is the co-editor of six books and the author of numerous articles on health and nutrition in populations dealing with environmental and economic change. Her current work on cosmetic surgery comes out of a concern for the nature of healing in widely disparate medical systems. She explains this as a shift in focus from asking how people get sick to asking how people get well. She is currently working on a book on therapeutic narrative and cosmetic surgery.