

BREAST IMPLANTS FOR GRADUATION? PARENT
AND ADOLESCENT NARRATIVES

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The purpose of this research is to examine through sociological and psychological theories how women make sense of the desire and attainment of breast implants for graduation.

The study used a qualitative approach and focused on women ages 18-35 in the state of Texas who have received breast implants for graduation. The sample size in this study included 10 high-school graduates receiving implants as a gift and their 10 mothers.

Seven theoretical paradigms provided a better understanding for why the daughters asked for breast implants and why the parent(s) paid for them. Symbolic interaction theory explained why the daughters wished to replace their “fake” cotton padded self with their augmented self, to become the most authentic woman possible. Social construction of reality theory explained why both mothers and daughters wanted to conform to the social construction of gender, and to accomplish their gender well. Conspicuous consumption theory demonstrated how cosmetic surgery practices allow women to appear wealthy, gain status, and “flash” their assets. Feminist theory explained why some women were motivated to capture the attention of men and others altered the body out of empowerment. Reference group and social comparison theories explained how the women in this study were influenced to undergo cosmetic surgery by ranking themselves in attractiveness against real friends and media icons. Lastly, self-discrepancy theory showed how the daughters in this study felt they needed surgery to fix a discrepancy between their real and ideal self.

The majority of respondents expressed complete comfort with their gifting and receiving of breast implants for graduation, claiming it was a great decision. They also agreed surgery was worth any risk to increase their daughter’s confidence. Most of the mothers expressed that they

were comfortable with their decision to gift surgery to their daughters, despite knowing that their gift of augmentation would ultimately result in more surgery in the future.

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TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	iii
Chapter	
1. INTRODUCTION	1
A Cross-Cultural Examination of Beauty	3
Caucasian Beauty	3
African American Beauty	6
Hispanic Beauty	8
Asian Beauty	9
Summary	10
Portrayal of Fashion through Time	11
Cosmetic Surgery	26
Breast Implants	29
Teen Breast Augmentation	40
Implants for Graduation	42
Statement of Research Goal	44
2. THEORETICAL BACKGROUND	45
The Media and Cosmetic Surgery	45
Sociological Framework	49
The Role of Symbolic Interaction in Cosmetic Surgery	49
The Role of Social Construction of Reality in Cosmetic Surgery	55
The Role of Reference Group Theory in Cosmetic Surgery	56

The Role of Conspicuous Consumption in Cosmetic Surgery	57
The Role of Feminist Theory in Cosmetic Surgery	58
Psychological Framework.....	65
The Role of Body Image Discontent in Cosmetic Surgery.....	65
Implications for Research	72
3. METHODOLOGY	73
Why Qualitative Analysis Was Appropriate.....	73
The Narrative Approach	74
Reliability and Validity.....	75
Sources of Data.....	77
Procedures for Data Collection.....	79
Sample Size.....	79
Data Collection Strategies.....	80
Ethical Safeguards	81
Summary	82
4. UNDERSTANDING THROUGH SOCIOLOGICAL PARADIGMS.....	83
Symbolic Interaction Theory	83
Social Construction of Reality Theory	88
Conspicuous Consumption Theory.....	89
Reference Group Theory, Social Comparison Theory, and Self Discrepancy Theory	92
Feminist Theory	99
Summary	104

5. MAKING THE DECISION TO GIFT AND RECEIVE IMPLANTS	106
Critical Events Leading to the Desire for Surgery	106
Decision Making Style.....	107
Reflections	110
Summary	114
6. CONCLUSION.....	115
Overview of Findings	115
Strengths of the Study.....	118
Comparing the Results to Previous Works	119
Limitations	120
Directions for Future Research	120
APPENDIX A: PROPERTY VALUES.....	122
APPENDIX B: INTERVIEW INSTRUMENT	124
APPENDIX C: RECRUITMENT TECHNIQUE.....	133
APPENDIX D: ADS POSTED ONLINE.....	135
APPENDIX E: CONSENT FORM	137
APPENDIX F: ASSIGNMENT OF PSEUDONYMS	141
APPENDIX G: DEPICTIONS OF SOCIAL CLASS	143
REFERENCES	147

CHAPTER 1

INTRODUCTION

Beauty may be defined as a combination of qualities that delight the senses (Boone, 1986). Recent research suggests that people's standards of beauty are remarkably consistent regardless of race, ethnicity, nationality, gender, or age (Fink & Neave, 2005). Those of different ethnic or racial backgrounds often share common standards of beauty (Cunningham, Roberts, Barbee, Druen, & Wu, 1995). In fact, what one considers beautiful may be explained in terms of mathematics, evolution, and homogenization.

The ancient Greek writings of the mathematician Pythagoras noted that objects and humans symmetrically proportioned seemed more attractive to onlookers (Burkert, 1972). Symmetry is thought to reflect an ability to resist the harmful affects of mutations, parasites, and/or toxins (Thornhill & Gangestad, 1993). Symmetrical people are reported to have greater emotional and psychological health than their asymmetrical counterparts (Shackelford & Larsen, 1997). Preferences for symmetrical faces may have some adaptive value.

Charles Darwin's evolutionary theory reveals that the ultimate goal of all species is successful adaptation. Many human physical characteristics that have evolved in specific ways have done so in order to make individuals attractive to one another and further promote reproduction (Darwin, 1872). Physical characteristics typically associated with beauty have often played a role in the selection of human sexual partners (Buss et al., 1990).

Certain physical characteristics judged as attractive in any given culture may have been judged so because they served an evolutionary purpose (Darwin, 1872; Sarwer, Magee, & Clark, 2004).

The following are examples of such adaptive attraction. Among 37 cultures in Asia, Africa, Western Europe, North and South America, researchers examined those traits that men and women found attractive (Buss et al., 1990). They discovered that in all studied cultures females were attracted to economic stability, whereas males were attracted to beauty (Singh, 1993; Sarwer et al., 2004).

Also, 2 month old infants have been shown to prefer the same women's faces already deemed attractive by other young adults (Bower, 1987). It seems infants are able to discern attractive faces from unattractive ones. Sixty-four infants who were shown photos of adult Caucasian women looked significantly longer at those faces that were deemed attractive. The data suggest that a universal definition of beauty may exist (Bower, 1987).

Further, Dr. Stephen Marquardt insists that facial beauty can be reduced to a geometric equation based on the Golden Ratio – the recurring measurement in nature of 1.618 to 1 that shows up on everything living (Marquardt Beauty Analysis, 2006). For example, Marquardt claims that the ratio between the height and width of the two upper front teeth, and the widths of certain front teeth when viewed in a full frontal smile, are always the same when we look at any person's smile (Marquardt Beauty Analysis, 2006).

Dr. Marquardt has invented technology that scans a person's face and then graphically morphs it to conform to this ideal mathematical equation. Cosmetic surgeons can now use this end result as a guide to transform any face into the mathematical ideal. The Advanced Aesthetics Institute has plans to use this program in Tokyo, London, Paris, Rio, and 40 markets in the United States and Canada (Guterl et al., 2003).

Perhaps what many Americans view as beautiful – clear skin, bright eyes, and lustrous hair – in essence have served as biological markers for fertility (Sarwer et al., 2004; Symons,

1979). For example, cosmetic medical treatments designed to improve an individual's appearance may increase desirability in a biological sense. Breast augmentation procedures alter waist-hip ratios, women with larger breasts seen as more attractive than women with smaller breasts (Singh & Young, 1995). Thus, spending money on cosmetic procedures may be motivated by adaptive and reproductive desires. This study aims to explain the reasons why today's youth have undergone breast augmentation surgery after receiving the procedure as a high-school graduation gift from their parent(s).

In affluent Western culture, women have been altering their natural bodies through extreme measures for centuries in an effort to better their appearances and increase rates of reproduction (Schofield, Hussain, Loxton, & Miller, 2002). The examination of the concept of beauty among Caucasians, African Americans, Hispanics and Asians along with the portrayal of fashion over time will lend much insight into the current trend of gifting surgery to young women.

A Cross-Cultural Examination of Beauty

Caucasian Beauty

Our bodies are deeply affected by our social experiences, as well as by the norms and values of the groups to which we belong. Brumberg claims that cultural pressure has made coming of age in a female body a more difficult experience today than it was a century ago (1998). A girl's experience of these inevitable biological events is shaped by the culture in which she lives (Brumberg, 1998; Patton, 2006). What is considered beautiful varies among cultures, but what remains consistent is that many standards of beauty are rooted in hegemonically defined expectations (Patton, 2006). With the process of globalization, adherence to White definitions of beauty may occur with harmful consequences. One such example occurred after the export of

American television programming to Fiji. When Fijians began to watch American television shows, the rates of anorexia and bulimia increased (Lazarus, Wunderlich, & Cengage Learning, 2003; Patton, 2006).

The Western definition and model of beauty has been exported around the world and often accepted as the ideal. *Vogue* and *Cosmopolitan* fashion magazines portray images strikingly white, Western and wealthy (Jaggar, 1994). Haiken (2000) claims that today, our acceptance of cosmetic surgery has been based on a series of assumptions: that inside every person who looks “other” is an “American” struggling to get out; that inside every homely girl a confident girl is trying to emerge; that inside every middle-aged woman a younger woman remains intact.

Since the emergence of cosmetic surgery at the turn of the twentieth century, individuals in the United States and Europe have looked to cosmetic surgery not only as a way to enhance their appearance, but also as a way to minimize or eradicate physical signs that – they believe – mark them as ‘different,’ that is, other than the dominant, or another, more desirable, ‘racial’ or ‘ethnic’ group. (K. Davis, 2003, p. 73)

Throughout America’s history, beauty surgeons have linked individual identity with American identity. Nineteenth-century America was filled with racism and the notion that all traits, positive or negative, were genetically transmitted. When the United States passed restrictive immigration laws, those immigrants struggling to find work and make a better life for themselves needed to “fit in,” to appear as American as possible (Haiken, 2000). In an effort to help immigrants assimilate, plastic surgeons lengthened Irish immigrant “pug” noses hailing largely from the British Isles (Schute, 2004) and chiseled down larger “Jewish” noses of Eastern Europe (Roberts, 1892).

One example of such a chiseling occurred when the Jewish comedienne Fanny Brice explained that she got a nose job to earn a role in a famous play, Henrik Ibsen's *A Doll's House*.

The quote that Brice had “cut off her nose to spite her race” has since been widely recited (“Review,” 1923, p. 4; Katkov, 1953). Other research suggests more Jews sought surgery because they believed Americans “read” their faces in order to make assumptions about identity and character. As Arthur Steelman told sociologist Frances Cooke Macgregor around mid-century, "I wanted a Jew to know I was a Jew...At the same time I didn't want others to know I was a Jew" (Macgregor, 1975, p. 231).

With the processes of industrialization, urbanization, and immigration in the 20th century, the United States moved from a primarily rural nation to an urban one (Kraut, 1994). Identity that was once grounded in religion and family life moved toward one of self-presentation in which beauty took precedence (Susman, 1984). In most premodern societies, thinness was not regarded as desirable at all – partly because it was associated with lack of food and therefore poverty (Giddens, 2007). In Europe in the 1600s and 1700s, the ideal female shape was well proportioned. The notion of slimness as the desirable feminine shape first appeared among middle-class groups in the late 19th century. Then the proponents of aesthetic surgery emphasized the social and economic importance of external appearance (Haiken, 2000), and the need to look like a beautiful, thin “American.”

Today, a beautiful woman in America may be defined as very slim, weighing 110-130 pounds, 5’7” tall, with light skin, straight hair, and light colored eyes. She has large breasts, a small waist, and wide hips. Her lips are full, and her eyes are round. Only 5% of women in the United States actually look like the ideal (Y. Jones, 2004). This construct alienates women of color and may drive some to take drastic measures in order to fit in.

Cosmetic surgery often is about blending in, assimilating, diminishing ethnic traits in order to melt into the masses (Epstein, 2000), and wanting a face or body that closely conforms

to the prevailing American standard of beauty. Some people state they hope to escape the appearance of their ethnic or racial heritage through cosmetic surgery. A study conducted by *American Demographics* found that 87% of minority adults would change a part of their body if given the opportunity (Fetto, 2003).

African American Beauty

Throughout history African American women have challenged white definitions of beauty (Patton, 2006). Researcher Patton argues that the continuance of white standards of beauty not only perpetuates European standards in the United States, but also marginalizes beauty that deviates from the norm. Due to our racist history within the United States, there are identity and beauty issues that minority women face. The unrealistic expectations of beauty and hairstyle reify the divisions that exist between African Americans and whites (Patton, 2006).

Since 1619, African American women and their beauty have been juxtaposed against White beauty standards, particularly pertaining to their skin color and hair (Patton, 2006). During slavery, African American women who were lighter-skinned and had features that were associated with mixed lineage tended to be house slaves and those with darker skin and kinky hair tended to be field slaves (Patton, 2006). This racist legacy brought about the “Lily Complex.” This complex defined as altering, disguising, and covering up one’s physical self in order to assimilate, to be accepted as attractive (C. Jones & Shorter-Gooden, 2003). As African American women deal with pressure to meet a beauty standard that is inauthentic and often unattainable, the result may be a loathing of one’s body and a belief that “Black is not beautiful” (C. Jones & Shorter-Gooden, 2003).

Jennifer Hochschild (2004) believes that skin color, rather than race, may be a better indicator of how attractive one appears in the United States. Across the races, the darker a

woman's skin color, the lower she is likely to rank on any scale of beauty in the United States (Hochschild, 2004; Ogle, 2007). Her research states that lighter skinned minority women report feeling more attractive than darker skinned women. Black females are judged less often on the basis of how much they weigh and more often on the basis of factors such as skin shade, the "right" kind of lips, and "good" hair (Ogle, 2007, para. 3).

In the 2005 documentary *A Girl Like Me*, Kiri Davis interviewed young African-American girls about white standards of beauty. She also conducted the "doll test", originally performed by Dr. Kenneth Clark. This doll test showed that 15 out of 21 children preferred a white doll over a Black doll (Henry, 2007).

For many black women, white America's ideal standard of beauty has kept African Americans somewhat enslaved even in modern society (Ogle, 2007). As a result, an increasing number of African American females are conforming to many whites' unhealthy attitudes about thinness and they are developing eating disorders (Nielsen, 2006). What appears to be happening is that the more a black female identifies with white middle class culture, the more likely she is to adopt whites' attitudes about thinness and unattainable standards of beauty (Edut & Walker, 1998).

To achieve the "white" look, many black Americans have resorted to bleaching their skin, straightening their hair, and having cosmetic surgery. It is estimated that skin bleaching products account for 40% of profits earned by the entire cosmetic industry (Hochschild, 2004). According to the American Society for Aesthetic Plastic Surgery (American Society for Aesthetic Plastic Surgery Inc. [ASAPS], 2006a), cosmetic and reconstructive surgery quadrupled among African Americans. This reflects an increase in disposable income and a gradual acceptance of cosmetic surgery within the African American community. African Americans

accounted for more than 760,000 cosmetic procedures performed. The report states that the most commonly requested cosmetic procedures by African-Americans are rhinoplasty (nose reshaping), liposuction, and breast reduction, which raises the question of patients attempting to erase the broader noses and curvier silhouettes associated with their ethnicities (Henry, 2007).

Dr. Julia Hare, psychologist and founder of the Black Think Tank, claims that cosmetic surgery is the alternative to skin bleaching creams and hair straightening products that plagued African-American women throughout the 1960s who were desperate for a more Nordic look. "Black women who are very successful are sending another message out to a younger sister that 'I may have achieved, but I still don't look acceptable'," Hare said (Henry, 2007, para. 2).

In the past, fewer African Americans had cosmetic surgery procedures, perhaps for fear of being accused of trying to conform to the European ideal of beauty. Dr. Few, an African American plastic surgeon, claims that cosmetic surgery has risen among the black population because its perception has changed in the African American community (Simon, 2006). The antique notion that surgery would transform a black into a white has been replaced with available and affordable options (Simon, 2006). An ideal of beauty which specifies one color of skin and one type of hair blatantly discriminates against women who possess a range of skin colors and hair textures.

Hispanic Beauty

Hispanics are a population drawn from 25 countries around the globe (Genuario, 2007). The U.S. Government Census definition of Hispanic states "a person is of Spanish/Hispanic origin if the person's origin is Mexican, Mexican-American, Chicano, Puerto Rican, Dominican, Ecuadoran, Guatemalen, Honduran, Nicaraguan, Peruvian, Salvadoran; from other Spanish-speaking countries of The Caribbean or Central or South America; or from Spain (Everett, 2000).

According to cosmetic surgery data, Hispanics account for 8.5% of all cosmetic procedures, a 1% decline over the previous year (ASAPS, 2006a). New research released by Dove beauty brand demonstrates that Hispanic women are dissatisfied with the divide that exists between their definition of beauty and American society's. The Dove Report finds that 60% of Hispanic women are happy with the way they look. They are comfortable with their appearance and do not feel compelled to change their appearance (Dove Report, 2005). Nearly 70% of Hispanic women agree that beauty can be achieved through attitude, spirit, and attributes that have nothing to do with physical traits. Forty-six percent said that they feel beautiful when they achieve success, help others (54%), or do something artistic (39%). The majority of Hispanic women (81%) report they feel most beautiful when they feel loved, compared with 75% of African Americans and 70% of Caucasians (Dove Report, 2005). The Hispanic concept of beauty rests less on external beauty than on internal beauty, perhaps influencing their lower rates of cosmetic surgery.

Asian Beauty

In Asia, Western notions of beauty have been overtaking classical ones, from China and India to Korea and Japan (Guterl et al., 2003). The classical voluptuous Indian goddess and the round-shaped face of the Chinese beauty are yielding to large eyes, oblong faces, and lean figures popular among Western women (Guterl et al., 2003). Asian women are now pursuing surgery at an increasing rate. As prices continue to plunge, more and more women are electing to undergo cosmetic surgery in order to meet an emerging global standard of beauty. A growing number of Asian women are now augmenting their breasts, rounding their eyes, or shaving their cheekbones (Guterl et al., 2003).

For many years an Asian beauty has been defined as a fair skinned, straight nosed, shiny black haired, small mouthed woman (Guterl et al., 2003). Today, Asian women wish for their faces to be lengthened and their cheeks to be more angular. Surgeons heighten Asian noses with silicone implants, shave jaw bones, and perform multiple eyelid surgeries—changing their most distinct genetic features (Epstein, 2000; Haiken, 2000; Hall, 1982).

In China, the practice of surgery has become so popular that the government has issued regulations to try to control and minimize industry practices. In 2004, 3.5 million plastic surgeries were performed (Haworth, 2005). The country held its first ever Miss Plastic Surgery Pageant for 19 Chinese women who had undergone cosmetic surgery. The world's first pageant for plastic surgery contestants demonstrated a shift in cultural ideology. Just decades earlier Maoist officials condemned any form of personal grooming or beautification. They regularly beat women for owning hairbrushes, wearing blush, or painting their fingernails (Haiken, 2000).

Today, in South Korea, more than 1200 cosmetic surgeons are at work, the highest per capita in the world, performing roughly 500,000 procedures per year (Guterl et al., 2003). In the business directory of the California *Nguoi Viet Daily News*, where one of the largest Vietnamese populations reside, there are more than 50 local listing for nose and eye surgery (Lam, 2007):

Vietnamese children of mixed parentage born of American GIs during the war have been perceived throughout history as a permanent underclass. Perceived as children of the enemy, they were often derided, chastised, and beaten. But these days those mixed children's features are coveted by many wealthy people in Saigon and Hanoi. They want their noses, eyes, lips, and would save a fortune to go under the knife to look like them. (para. 2)

Summary

The greater the acceptance of the homogenizing of beauty may be demonstrated through the increasing surgery rates among minority groups in America (ASAPS, 1997–2007; Maine, 2000). In 1998, 14% of surgery patients were Non-White, the remaining 86% were Caucasian. In

2004, racial and ethnic minorities had 20% of all cosmetic procedures: Hispanics, 8.5%; African-Americans, 6.2%; Asians, 4.6%; and other non-Caucasians, 1.1%. In 2005, Asian Americans had 437,000 cosmetic surgeries, up 58% from 2004. The number of African Americans undergoing cosmetic procedures increased 67% in just 1 year, from 460,531 to 768,512 surgeries (ASAPS, 2005a). It is believed that cosmetic surgery among non-whites in the United States is likely to increase beyond the current 20% of cosmetic surgery clientele in the near future (Jesitus, 2006).

The reasons for the increase in plastic surgery among African Americans and Asians are varied. Bruce Cunningham, president of the American Society of Plastic Surgeons, attributes it to greater exposure to the benefits of plastic surgery, a growing acceptance of the specialty, and increased economic power within these ethnic groups (Haynes, 2006). Cosmetic surgery services have become one of the fastest growing medical practices in the world, with those bought and sold in North America the most popular (ASAPS, 2007). The extension of a Western standard of beauty around the world has increased the desire for cosmetic surgery globally.

In the past, surgeons based their operations on a white definition of beauty, with medical schools and textbooks giving only Caucasian examples (ASAPS, 2005b). Now, driven by the demand from minority clientele, a new generation of plastic surgeons may need to implement techniques allowing patients to address cosmetic desires while retaining their ethnic or racial identity.

Portrayal of Fashion through Time

Why do people wear what they wear? Clothes have traditionally served four basic functions: to protect the body, to exalt the ego, to arouse emotions, and to communicate by means of symbols. Fashion may be defined as the financial ability of a large number of people to exchange old clothes for new with some regularity and a general style that invites change and

evolution (Batterberry & Batterberry, 1977). A fashion is birthed from situation, time, and place. By manner of fashion a culture reveals its conception of beauty at a particular time. This research will examine the evolution of fashion from 5000 BC to the present.

In the Ancient Near East, 5000 BC, sheep were the earliest source of thread and cloth for primitive farmers. Lapis lazuli (the most brilliant blue stones) and gold from nearby streams were available. Therefore it is likely to assume these earliest farmers wore dyed skins, jewels, and gold (Racinet, 1888). Luxury came to be identified with color, and to be “dressed in purple” meant more than wearing the finest jewels.

Color also designated royalty among the Assyrians. Kings wore heavy make-up, perfume, and wigs. The Tower of Babel was known to be plated in gold as were the women of the courts clothed in purple, scarlet, gold, and precious stones. The Assyrians were known to be inordinately cruel to women (Batterberry & Batterberry, 1977). A woman could be impaled on a stake or have her ears cut off for an infraction. According to 1200 BC Assyrian Law - wives, daughters, and widows of gentlemen were forbidden to go unveiled.

The Egyptians abhorred the Assyrians because they viewed them as inferior nomadic shepherds. Everything Assyrian was viewed with distaste. Egyptian priests were forbidden from wearing wool into the temple and instead adorned themselves with linens. In 600 BC, women’s dress was simple, clean, and white. Both men and women wore their hair thick, blunt, and of “pyramidal” shape. Women used pumice stones to remove body hair, face creams, hair dyes, and perfumes. An obsession with cleanliness reflected the disapproval of their nomadic Assyrian neighbors.

In 2500 BC Greece, Cretan men wore kilts of many layers while women wore bell shaped skirts. Royalty was distinguished by feather headdress. Minoan women on the isle of Crete began

wearing a bra that pushed the breasts above clothing, exposing them in all of their nakedness (P. Thomas & Thomas, 2004). Both men and women wore metal waist cinchers so tight that they often dieted to fit into them (Racinet, 1888).

With the Fall of Italy in 1500 BC, social disorder, a breakdown in trade, and a loss of wealth plummeted much of Greece into a Dark Age. The people of Greece now had a moral objection to luxury after the wealthy Persians defeated them. Their concept of beauty was absolute simplicity. Feathers, jewels, and bright colors were replaced by loose, draped, and totally unsewn garments. The Dorian *peplos* worn by women, and the *chiton* worn by men were merely two rectangles of white wool folded at the top and draped over the body. Skill at draping fabric became a symbol of education and social standing.

The earliest Roman Etruscan men wore tunics and cloaks. These white *tebennas* were fitted, draped, and worn with a belt. As these early Romans were influenced by the Oriental tastes of Asia Minor and Greece, they began to wear purple *tebennas* and colored shoes. Gold breastplates birthed during Gladiator warfare came to symbolize rank and authority.

The general Roman population in 450 BC did not have the wealth of the Etruscans, and they despised the gold owned by the Etruscan rulers. Average citizens wore wool shawls cut into the shape of a circle, *togas*. The toga was always white and woven at home. Only footwear and borders of color indicated rank. For example, Senators wore red shoes beneath their white togas. The togas were hot, heavy, and limited physical activity. As one Roman put it, "He should never lose his poise by becoming out of breath" (Batterberry & Batterberry, 1977, p. 53).

Imperial Rome expanded, and in AD 25 it stretched from Spain to the Sahara. Never before had private individuals had so much wealth. Women now wore bright colors to denote rank, and silk was a new indulgence. Diamonds, opals, emeralds, and pearls graced the bodies of

those with status. Sanitation was plentiful, and the taking of baths occurred every day before dinner at home and in public baths. These public baths led to a general acceptance of public nudity. Face packs made of sheep fat, bread crumbs, and crocodile urine were applied to women's faces to make them pale. A beautiful woman in Imperial Rome had a white complexion, a low forehead, long eyebrows, detachable hair, silk gowns, many jewels, red lips, and a hairless body. A handsome man was tan with a spotless white toga. He had clean teeth, was well shaven, and his sandal straps were laid straight on his ankles.

The Byzantine Jews rebelled against Rome and their nude bathing. Immodesty was grounds for divorce, and all make-up was seen as adulterous (Batterberry & Batterberry, 1977; Racinet, 1888). Efforts of beauty were seen as vain because they could not lead to salvation. The Byzantines of 100 AD wore long robes, shawls, and veils because modesty was beautiful.

During the Middle Ages in 1095 AD, godliness was represented through chastity. The *cassock* garment worn by men of the church was floor length and had 33 buttons – each representing 1 year of Christ's life. Knights were dressed in layers of robes.

In the 12th century, the Gothic elite began to demonstrate superiority through impeccable taste and minute attention to detail. Women wore corsets around the waist with bodices surrounding their breasts. These corsets were made of harsh whale bone that flattened the breasts and accented very thin waistlines. Advertisements for these read, "Supports the weak, gathers the floppy" (Holland, 2007, para. 6). Gothic trains indicated rank and were worn by all important women. The church steeple hoisted in communities was reflected in pointed toe shoes, pointed sleeves, and tall hats. The amount of fabric and length of toe on a shoe was dictated by law. The higher the status, the more fabric allowed. The higher the rank, the longer the toe – a

prince was allowed a 24 inch toe, while a gentleman only 12 inches (Batterberry & Batterberry, 1977).

Many fashion editors claim that exaggerated fashions follow in the wake of a disaster (Coutie, 2004). After the Black Plague wreaked havoc upon Europe, one could describe the beauty concept as exaggeration post devastation. Women bought wigs, powdered their faces, and wore sleeves so tight they had to be sewn on at each wearing. Women knew their breasts were girded high enough when they could balance objects upon them (Racinet, 1888). Men wore sleeves so long they had to be tied in knots to prevent them from dragging on the floor.

In all of Europe the hat of a craftsman signaled his trade and rank during the Renaissance: doctors wore bird masks filled with medicines, gentlemen wore wide brimmed straw hats, and peasants wore wool. The widened necklines of the Renaissance mimicked their mass forms of architecture. In 11th- and 12th-century Europe, dress indicated social rank. Women carried silk kerchiefs with heritage brandings, tight-laced bodices, and layered skirts. Men wore white shirts signaling a separation from manual labor. Peasants wore brown smocks and cloaks.

In the 15th and 16th centuries, Europeans began to change clothes when it was fashionable to, not when it was necessary. The textile industry was booming. Trade with the East brought the Medici family to the height of textile power, producing enough to commission a temple.

Catherine de Medici designed a steel corset that permanently reduced waist size to only 10 inches. She banned “thick waists” at her court attendances. The edict of Strasbourg read, “No woman will support the bust by the disposition of a blouse or by tightened dress” (Holland, 2007, para. 12).

In an effort to follow these guidelines, women went through “corset training” which required them to work their way into smaller and smaller corsets until their ribs cracked under the pressure of unforgiving steel (P. Thomas & Thomas, 2004). Women were considered “trained” when their waist size was reduced to the desired 10 inches. This proved to be costly, as they suffered from cracked ribs and bruised internal organs (Coutie, 2004). These corsets required the assistance of corset servants to put on because all fasteners were located in the back of the garment, and a woman could not place herself into the garment alone.

The overall theme of the High Renaissance Period was visible hierarchy, “Men had been put by God under Princes (Batterberry & Batterberry, 1977). The visible rank of women was demonstrated through blonde hair, bleached complexions, bleached teeth, false hair, garters, velvet shoes, and stockings. Their bright gowns of every color bared their pale breasts. The High Renaissance man wore a silk shirt beneath a black coat and tights. He was considered handsome if he had curled hair and plucked eyebrows. Henry III, son of Catherine de Medici, was an extravagant dresser. He wore superb costumes, gold, perfumes, and many earrings (P. Thomas & Thomas, 2004).

The 16th century was an era of costume, or dressing up. In Spain, men wore trunk hose, skirts, high shoes, stiff hats, silk stockings, and earrings. The man’s *ruff*, white ruffle around the collar, signaled that he did not work and was above those who did. Women began wearing metal hoops under their heavy gowns with corsets and gloves.

In order to better their complexions, women swallowed arsenic and dabbed bats’ blood on their faces. Some used boys’ urine to erase the marks of freckles on their brows (“Pots of Promise,” 2003). Queen Elizabeth applied lead paste over her face, neck, and breasts to appear fair skinned and of a leisure status (P. Thomas & Thomas, 2004). Poisonous plants were used to

cause hallucinations and widening of the pupils in an effort to appear more sexually attractive (Brumberg, 1998).

The Thirty Year War caused a breakdown in the textile industry, and the importing of goods into France was forbidden. With this came the decline of gaudy costume. Having depleted their own forests of natural resources, Europeans began penetrating North America. Between 1699 and 1715, 54,000 deerskins were sent to England from South Carolina alone (P. Thomas & Thomas, 2004).

With the Protestant Ethic and a value placed on work, work clothes became sacred. Dark colors, wool, and minimum lace replaced the excessiveness of Henri IV. To Henri, a man was respected if he owned 25 suits he could change everyday (P. Thomas & Thomas, 2004).

During the Counter Reformation in Italy, fashion was again becoming big business under the influence of yet another King. Louis XIV modeled the wearing of hundreds of yards of ribbon, lace, wigs, buckles, silk stockings, high heeled shoes, skirts, pantaloons, and jewelry. To his credit the Hope Diamond was acquired. Women wore stiff boned corsets, lace, bows, ribbons, brocaded shoes, long trains, and carried parasols. It is claimed that the expense of keeping up crippled even the wealthy under Louis XIV (P. Thomas & Thomas, 2004).

The preoccupation with dress was both a cause and a symptom of the Industrial Revolution. American colonies needed England's exports, India supplied England with Cotton, and Louis XIV's silk mills in Britain all created a cycle that would change industry forever. Mass production was aided by Britain's flying shuttle, Hargreave's spinning Jenny, Arkwright's water-twist frame; Cartwright's weaving loom, and Watt's steam engine. England's cotton ships exchanged fabric for slaves in Africa which then took the slaves to North America for raw cotton

that would then be processed back in England. This triangle trade birthed ready to wear clothing available to the masses.

With the Industrial Revolution came the growth of the bourgeoisie. Class distinction among the higher classes was blending as evidenced by the fact that the great balls or dances of the Court of Versailles were open to the public. In the 1700s, women wore brocaded gowns that were so stiff they could stand by themselves. The hoop petticoat made of whale bone was 5 feet wide. The enormous skirts opened at the front to reveal silken petticoats of every design and color. Their shoes were so fragile they were not meant for walking. The man's *justaucorps* or outer coat covered an inner jacket, knee breeches, and collarless shirt. Lace scarves, silk stockings, buckled shoes, and wigs made of sausage curls were worn by all men other than the peasantry.

With Louis XV, religion was out of fashion and everything else was in fashion. He states, "Where a group of men and women see each other daily, having much in their pockets and little on their minds, fashion is inevitable" (Batterberry & Batterberry, 1977, p. 166). Getting dressed, the "morning toilet," took half of the day. Men and women wore make-up, wigs, and nail-polish. Patches of animals and plants were glued to the face to cover pimples and wrinkles. The first fashion magazine, "The Mercure Galant," was published in 1670.

With the Enlightenment came a love of freedom in dress and manner. For the first time, were children dressed in more practical clothing, not that of adults. Their clothing changed with a concern for their education. Much of the fashion of this period was influenced by Marie Antoinette. Women who were considered beautiful had transparent skin, china blue eyes, long necks, and blonde hair. Hair grew to 2.5 feet tall boasting feathers, wooden objects, and glue. Bugs and mice were common in women's up-dos, and hair was considered rancid when varmint

ran out. This fashion changed when Marie Antoinette started losing her hair after childbirth and could no longer pile it high.

Everything fancy was linked to aristocracy and during the French Revolution in 1789, ostentation was done away with. The new beautiful was understatement. Bonnets, caps, and turbans covered heads. Pantaloon replaced silk stockings. Men wore wool frocks, short waistcoats, stiff collars, and black robes. Women wore narrow, dull colored skirts with no corsets or petticoats underneath.

During the 1800s, progress was synonymous with industry. In 1838, the first department store, “Galeries du Commerce,” sold ready made clothing. The “little dressmaker,” Maison Worth, was the first to present a collection of dresses that could be ordered. The sewing machine was invented in 1846, and those clothes that were practical in factories flourished for many men. Simple blue or brown tailored fits replaced the silk shirts of the earlier decades. They wore no ruffles and no stockings. The modern day suit was designed in 1868.

Women wore clothing that advertised man’s material success. They continued to wear petticoats of horsehair, bustles made of bone, and tight corsets. Their corsets were so tight they had to be laced by servants, and their skirts were so large they had to be lowered on by servants. A much needed technological advance appeared in 1820, allowing women to dress themselves for the first time (P. Thomas & Thomas, 2004). This patented invention, called the “corset mecanique,” enabled a woman to put her corset on with the help of pulleys instead of servants (Shuttleworth, 2003).

Forty-seven years later in America, the Thompson Patent Glove-Fitting Corset was the first to appear with snaps and hooks at the front. A woman could now reach her corset fasteners at her chest and do away with all pulley devices. The Union Under-Flannel Corset, created by

Susan Taylor Converse in 1875, had no bones, eyelets, or steel and was comfortable, flexible, and also front-fastening.

Now that women were able to dress themselves in their breathable underwear, modifications were being made to various design elements. In 1889, Hermione Cadolle created the Victorian bikini, “Bien-etre,” which, for the first time, supported a woman’s breasts by the shoulders rather than the waist. Marie Tucek modified this design in 1893 by adding separate pockets for each breast and calling it the “Breast Supporter.”

Liberation from the corset fell in line with the evolution of many labor saving devices. The telephone, the electric light, and the automobile all represented freedom and revolt against suppressive Victorian attitudes (Batterberry & Batterberry, 1977). Designer Paul Poiret crafted free flowing tunics of soft gauze and chiffon in pastel colors. In 1907 the “brassiere” was introduced in Paris by *Vogue* magazine, and then modified by Mary Phelps Jacob of New York in 1913. She had a party to attend and a sheer dress to wear. She and her servant, Marie, quickly threw together a backless bra using handkerchiefs and pink ribbon. Friends and family attending the same party demanded to know where she purchased her new backless bra. Soon Mary applied for a patent under another name, Caresse Crosby, and on November 3 was granted the patent for the “Backless Brassiere.” She later sold her patent for \$1,500 to the Warner Brothers Corset Company, which, in turn, collected \$15 million from consumers over the next 30 years (Coutie, 2004).

With WWI came a loss of interest in fashion. The life of the comfortable bourgeoisie woman changed as most husbands and servants entered the military. Women in Europe joined their husbands’ businesses to work, and leisure was now seen as unpatriotic. Gabrielle Chanel opened her own clothing shop in 1915 and designed clothing for the working girl. Her jersey

dresses, twin sweater sets, and sailor pants supported the troops abroad while allowing women to perform their duties at home.

During 1914-1918, the United States War Industries Board demanded that women stop buying corsets in order to reduce the production and of steel, resulting in the conservation of 28,000 tons of steel, enough to build two battleships (Coutie, 2004). Men who didn't join the armed forces wore trousers without cuffs, pleats, or pockets to save cloth.

The 1920s brought a mood of dissatisfaction with the past. Prohibition, radio broadcasting, and women's ability to vote was reflected through emancipation in fashion. Women could now wear free-fitting, casual clothing at sporting events, formals, or work. Waistlines dropped to the hip, silver replaced gold, and *cloche* hats covered foreheads. The *eton crop* hairdo was paired with long earrings and long necklaces. In 1926 the skirt became the shortest in history, landing just below the knee. Flesh colored stockings replaced black, and the suntan was brought into vogue after Chanel returned from a vacation aboard a yacht. The "flappers" of the day smoked, drank, drove without chauffeurs, and flattened their breasts.

Ida Rosenthal, a Russian immigrant, and her husband, William founded the Maidenform Company in 1928 to protest the flat-chested flapper girls of the Roaring-20s. They created bra cup sizes and training bras for pubescent young girls. Maidenform training bras were popularized for American girls who wanted to be "mature," and doctors usually recommended them (Coutie, 2004). One such doctor, physician Frank Crowell, thought a dropped breast was "not attractive," and believed an adolescent girl needed a bra in order to prevent sagging breasts, stretched blood vessels, and poor circulation. He suggested that mothers closely inspect their daughter's breasts regularly to ensure proper development, meaning the nipple would rest halfway between the armpit and elbow (Brumberg, 1998).

The Rosenthal's weren't the only to revolt against the boyish look of the 1920s. As a whole in 1930, women returned to femininity by dropping their waistlines and exposing their foreheads. With the fall of the stock market came the lowering of hemlines (Milbank, 1989). During the Great Depression, the first synthetic fabrics nylon and rayon replaced hard to find cotton, rubber, silk, and steel. The entertainment industry influenced fashion as well. Katherine Hepburn's trousers, Marlene Dietrich's style, and Lana Turners sweater-girl look were all copied. Turner's sweater girl look preceded the wearing of "falsies" or pads worn inside bras that enhanced fullness.

During WWII, England and the United States were drawn closer and British styles replaced French ones as Paris was occupied. Four years of isolation from Paris gave American designers the chance to create an "American look." Easy fitting dresses, sarongs, and tight sweaters were part of this new look. Voluptuous stars such as Jayne Mansfield, Jane Russell, and Marilyn Monroe wore strapless bras and pointed cup shapes beneath their tight sweaters (Brumberg, 1998). In fashion, Americans were patriotic. American women proudly wore uniforms or coveralls to signify they were pitching in. "The woman who could change instantly into service clothes and look charming is the smart woman of today" (Batterberry & Batterberry, 1977, p. 330). Women wore pants without stockings, snoods to keep the hair out of their eyes, and carried purses large enough to hold emergency supplies. Square suits for women were commissioned by the government. The tall, broad shouldered zoot-suit worn by men exuded machismo. There were no vests, cuffs, pleats, pockets, or belts due to regulations put forth by the War Board.

Following the war, 1950s America yearned for the romance of the pre-war period. As many men returned from the war, women abandoned their workplace responsibilities and

returned to the home. The beautiful American woman of this decade had bright teeth, shiny hair, and a tall frame (Milbank, 1989). The ballet became popular in America, and so too the ballet look. Women wore their hair in pony tails with heavy eye make-up and ballet slippers. Flatter chests were worn beneath cashmere sweaters and tweed skirts. Men wore grey flannel suits with white shirts, narrow ties, and buckskin shoes. With the booming mass textile industry in America, everyone could now afford clothing. Lockers provided inside the factories allowed workers to leave their uniforms inside the workplace. For the first time in America, work clothes were not visible on the street.

In the 1960s, teenagers represented a powerful class. One third of France was under the age of 20, and one half of America was under the age of 25 (Batterberry & Batterberry, 1977). Teens spent \$3.5 billion on clothing alone in 1965. American pride in landing a man on the moon was tempered by the assassination of John F. Kennedy, Martin Luther King, and Robert Kennedy. Race riots had shaken the country, and the Vietnam War was worsening (Milbank, 1989). The young marched for peace, demonstrated for equality, and united to rebel against their parents generation. The fashion of this era represented a total breakdown of tradition and blending of cultures. One could wear whatever one wished.

Hot pants and tight-fitting garments served to express pride in oneself. Unisex clothing further emancipated the youth from traditions. Both men and women wore denim fashioned from tent canvas by Levi Strauss. They wore unkempt hair, shirts with deep collars, bright colors, and no undergarments.

The bra-burning movement of the 1960's encouraged women to go bra-less. Those with aging or sagging breasts had difficulty competing with the new fashion models that emerged

during this era. With the popularity of models flaunting the newly designed bikini, diets and breast augmentation were born.

Although the bra-burning movement of the 1960's encouraged women to go bra-less, the bra's popularity re-emerged with a vengeance in the 1970's as seen in the creation of Victoria's Secret in San Francisco. Roy Raymond's cozy Victorian boudoir successfully marketed the lingerie lines: "Angels," "Body by Victoria," "Glamour," and "The Miracle Bra" (White, 2005). Victoria's Secret has become the leading retailer of lingerie, with more than 1,000 stores now available across the United States. Victoria's Secret, perhaps more than any other brand, has helped to attract attention to the lingerie industry (White, 2005).

With the wider use and acceptance of birth control, many women began postponing marriage and children in favor of starting careers. Whereas 1960s women of all ages tried to look like little girls, 1970s women aimed to look serious (Milbank, 1989). The 1970s woman was intent on proving that her appearance didn't concern her, since admitting she cared for her looks was similar to confessing that she was frivolous. Hair looked as if nothing had been done to it, fashions became simpler, and the wearing of pants even more popular. Easier travel and central heating meant both men and women could wear lighter weight clothing.

In the 1980s, the dominant market was older and financially secure. The USSR opened up to private enterprise and the Berlin wall came down, allowing western clothes to be exported to eastern bloc countries. Both men and women were shopping in large malls wearing shoulder pads and tailored suits. Big hair, bangles, and heavy make-up were popular among women. To express affluence in the 1980s, one would likely wear designer labels purchased with a credit card.

In the 1990s, less became more and rules for dressing relaxed. Working from home became more common, and the term “business casual” was coined. With the British handover of Hong Kong, the colony was given back to the Chinese in 1997. The opening up of China brought a new availability of goods to the United States, and the influx of Mandarin animal print and silk fabric was evident. Women wore stirrup pants, oversized sweaters, long jackets, and blazers. The beautiful woman of 1990 was casual, wearing little make-up, natural hair, and nothing with a brand label showing.

Under it all, the Wonderbra was described as "one of the most heralded episodes in underwear history" (Moberg, Siskin, Stern, & Wu, 1999, para. 1). After creating a fashion sensation in Europe, the Wonderbra Brand made its United States debut with the Push-Up Plunge Bra, selling at the amazing rate of one bra every 15 seconds and becoming the nation's number one selling bra (Bellis, 2005).

The 21st-century fashion market may best be described as a global one. Dubai, Romania, and Hungary are among the latest countries to export fashion goods to the United States. Mail order and home shopping has become increasingly popular with the expansion of the Internet. Dress has become less formal and casual brand names signify status: Abercrombie & Fitch, Polo, Tommy Hilfiger, Aeropostale, American Eagle, and LaCoste. Cotton and linen pleated skirts, drop waists, baby doll dresses, hooded tops, and retro styles are popular among women. Stripes, pastels, and tropical print sportswear are popular among men. Perhaps the greatest accessory today among men and women is the mobile phone.

A beautiful 21st-century woman may be described as weighing 110-130 pounds, 5'7" tall, with light skin, hair, and eyes. She has large breasts, a small waist, and wide hips. Her lips are full, and her eyes are round. She wears clothing sizes 0-6, and has a D cup breast size (Milne,

1998). As the beauty ideal has shifted to a thin woman with a large bust, the tight lacing of an external corset has been replaced by the stitches of a cosmetic surgeon (P. Thomas & Thomas, 2004).

Cosmetic Surgery

Plastic surgery, from the Greek word *plastikos*, means “fit for molding” (Epstein, 2000). Cosmetic surgery involves reshaping normal structures of the body in an effort to improve a patient’s appearance or self-esteem. Deemed medically un-necessary and elective, it is usually not covered by health insurance (ASAPS, 2006b).

Reconstructive surgery, on the other hand, is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease and is generally performed to improve function, but may also be done to approximate a normal appearance (Haworth, 2005). It was not until WWI that reconstructive surgery became a part of American medicine. Trench warfare maimed a generation of young men and American surgeons worked as pioneers in what was then called maxillofacial surgery (Barsky, 1978). The earliest documented cases of plastic surgery were all reconstructive, performed to restore health to an individual. Cosmetic surgery, on the other hand, done only for appearance sake, developed with American surgeons (ASAPS, 2008b). This research examines elective, cosmetic procedures only.

More and more Americans are choosing elective plastic surgery. Data from the American Society for Aesthetic Plastic Surgeons (ASAPS) demonstrate the enormous growth of cosmetic surgery in the United States over the last several years. Americans spent just under \$12.5 billion on cosmetic procedures in 2004 (Rauste-von Wright, 1989), with 11.9 million surgical and non-invasive cosmetic procedures performed, a 44% increase in the total number of cosmetic

procedures in 2003. Since 1997, there has been a 465% increase in the total number of cosmetic procedures. The top five surgical cosmetic procedures in 2004 were: liposuction (478,251, up 24% from 2003); breast augmentation (334,052, up 19%); eyelid surgery (290,343, up 8%); rhinoplasty (166,187, down 4%); and facelift (157,061, up 25%). Women had nearly 10.7 million cosmetic procedures, 90% of total procedures in 2004 (ASAPS, 2004), a 49% increase over 2003.

It is important to note that these figures illustrating the widespread use of cosmetic surgery include only procedures conducted by certified cosmetic surgeons who choose to self-report their procedures to data collection agencies. These data exclude cosmetic procedures performed by doctors in combination with other medically necessary procedures. For example, if a patient has a real medical concern and undergoes surgery for that need, he or she may opt to have a cosmetic “fix” while under that general anesthesia. This cosmetic procedure would not be “counted” among purely cosmetic surgeries. Hence, the above data may be an under-estimate of the true prevalence of cosmetic surgery rates in the United States.

Available data under-represent patients having multiple procedures or seeking care as repeat customers. It is common for women to have repeat surgeries. Blum argues that after body parts have been surgically altered, a woman cannot help but look at the rest of her body in terms of surgical possibilities (Blum, 2005). Once a body part is “corrected,” a woman often views the rest of the body as needing work. Also, it is easier for a woman to have multiple surgeries at one time. In the past, a woman may have had a tummy tuck and nothing else for a year. Frequently surgeons will do liposuction and tummy tuck one day and the next day a facelift, upper and lower lids, rhinoplasty, and other procedures. The recovery time is generally about 2 weeks whether a person has one procedure or many (“Changing Faces,” 1989).

The cosmetic surgery industry is booming for several reasons. Surgery is less expensive, more available to the masses, and doctors who prefer all cash business are moving away from hospitals into convenient retail surgical centers.

What used to be the preserve of actresses and celebrities has become safer and more affordable. For example, one of America's leading cosmetic surgeons says: "Ten years ago a surgeon could reconstruct a woman's breasts for \$12,000.00—now it can be done for \$600.00" ("Beyond Botox," 2003, p. 61). Dropping prices have helped those who traditionally couldn't have afforded to undergo cosmetic surgery now attain it, with more than 70% earning less than \$50,000.00 a year (ASAPS, 2006a).

Advances in technology result in less trauma, quicker recovery, and better results. There were 8.4 million minimally invasive cosmetic procedures performed in 2005, an increase of 13% from the previous year and 53% since 2000, according to the American Society of Plastic Surgeons (ASAPS, 2006b, p. 1). Minimally-invasive cosmetic procedures are mostly performed in an outpatient setting, do not call for general anesthesia, require little to no downtime, and usually cost less than the more invasive cosmetic surgeries. As minimally invasive procedures grow, it is believed that new products will be developed to advance the science and lower costs even further (Jesitus, 2006).

Furthermore, doctors who have seen their income reduced as a result of restrictive managed care view cosmetic surgery as a possible solution to greater earnings. It is more lucrative for today's physicians to move away from hospital managed care to retail cash business (Stires, 2003). In cosmetic surgery practices, fees are paid up front, in-full, which does away with bill collecting and prevents unsatisfied customers from withholding payment (Epstein, 2000). Cosmetic procedures often occur away from the traditional hospital setting. For example,

in 2004, 46% of cosmetic procedures were done in a surgeon's office facility (ASAPS, 2006a). In California, Rodeo Drive Plastic Surgery Center is located between retail shops such as Chanel and Hugo Boss. In this new wave of retail medicine, a patient can literally shop for a custom fitted bra before her breast augmentation procedure in the same retail shopping center. These retail centers are now present in Florida, New York, and Texas (Stires, 2003). The treatment of a cosmetic ill can now take place in a resort-like setting. If one combines this new convenience with advances in technology, a surge in industry will be witnessed (Layton, 1999).

Breast Implants

In the 18th century, large breasts were so coveted that women underwent painful and disfiguring procedures in which such materials as ivory, glass, metal, and rubber were implanted into their breasts (Sarwer, Nordmann, & Herbert, 2000). In 1890 an Austrian doctor used paraffin injections to swell the breasts. During WWII, 1942-1945, barrels of industrial grade silicone mysteriously disappeared off the docks of Japan. It was discovered that Japanese prostitutes were injecting their breasts with industrial grade silicone to appeal to U.S. soldiers (Breast Implant Info, 2006, para. 1). In the 1950s, the first implants appeared on the American market front when doctors implanted Ivalon polyvinyl sponges into the chests of young women. Eleven years later, the first silicone implant was developed by two Houston surgeons, and then Dow Corning took it to the mass market industry in 1963. The first saline implant was invented in France in 1965 (Didie & Sarwer, 2003).

Today's ideal body image in relation to breast size is more unrealistic than ever before. The average Victoria's Secret model advertising lingerie on television is 5 feet, 11 inches tall, weighing 110 pounds, with a D cup breast size (Milne, 1998). Compare that to the average American woman who is 5 feet, 5 inches tall and weighing 145 pounds. The thin, large-busted

American ideal beauty portrayed on television and in magazines today is highly impractical, creating over the past several years a body type for women that many cannot attain (Hamburg, 1998). Over the past several decades, the average breast size of women considered the ideal in Western cultures has increased relative to trimmer waist and hip dimensions (Sarwer et al., 2000).

The mammoplasty or breast enlargement procedure places a bag of saline solution under the breast to correct or enhance breast size through an incision. It will not improve nipple asymmetry, move breasts closer together, or lift droopy breasts. Silicone shells filled with saline solution are used in 90% of enlargement procedures, while all-silicone implants are used in 10% of enlargement procedures (ASAPS, 2008a).

Breast augmentation costs approximately \$3000 to \$6000 and is not covered by health insurance (ASAPS, 2006a); requiring women who seek surgery to use personal savings or reallocate finances from other areas to pay for the procedure (Didie & Sarwer, 2003). Many women often make challenging financial decisions in order to undergo breast augmentation surgery.

When a woman decides to have breast augmentation, she must choose the shape and texture of her implants, whether they will rest above or beneath the muscle tissue, and consult with her doctor on the type of incision that will be made.

Implants may be round or teardrop shapes, and may come in a smooth or textured surface. Round implants are the most common choice because they are not affected by rotation. If the implant moves after surgery, the round shape will not distort the appearance of the breast. Teardrop implants provide a more natural look, but cost more than round implants. If a teardrop shaped implant shifts after surgery, the distortion becomes apparent.

Implants that are filled with less than 350 ml of fluid have a lower risk of displacement, movement within the chest wall, but may not provide the desired size. Implants that are filled with more than 400 ml of fluid have a higher risk of displacement, but often provide the desired size. According to surgeons, a 400 ml implant placed on a woman with an A cup will produce a C cup. The same implant placed on a woman with a B cup will produce a D cup (ASAPS, 2002).

Textured implants have an increased risk of rippling, but a decreased risk of movement. They also cost about \$1000 more. A recent study showed that textured implants are more likely to deflate than smooth implants (ASAPS, 2006b). While smooth implants have a lower risk of rippling, they are less firm than textured implants. With smooth implants, any circular rotation will not be noticeable in the chest wall.

Implant position refers to whether the breast implant is placed above or below the pectoralis muscle. Placement under the pectoralis muscle is the approach most commonly used. It does require general anesthetic, but has a lower risk of capsular contracture, hardening of tissue, interferes less with a mammogram, and offers a better cosmetic result in women with small breasts. Implants that are placed above the pectoralis muscle and below the breast tissue have a greater risk of capsular contraction, interfere more with mammograms, and are worse cosmetically for women with small breasts (Smart Plastic Surgery, 2007).

A woman often consults with her doctor at length regarding incision placement. Incisions can be made under the breast flap, around the nipple, in the armpit, or in the belly button (ASAPS, n.d.; Seaberg, 2006). Inframammary incisions, the most common type, are made on the lower portion of the breast, in the crease where the breast meets the chest, so that any scar should remain hidden. Periareolar incisions are made in the areola. The incision is usually a small semi-circle, and the scar is camouflaged by the nipple. However, if there are any imperfections in the

scar, it will be highly visible, and this type of incision has an increased risk for diminished nipple sensation (Smart Plastic Surgery, 2007). Auxiliary incisions are made in the armpit and may require the use of an endoscope. The scar is well-hidden, but provides poor visibility for the surgeon. Umbilical incisions are made in the belly button and usually require the use of an endoscope. It is very difficult to place the implants below the muscle utilizing this method (Smart Plastic Surgery, 2007). Therefore, the scarring is less but the risk that the implant may rupture is high (ASAPS, n.d.; Food and Drug Administration [FDA], 2004).

In any breast augmentation procedure, the possible risks are numerous and include: anesthesia reaction, asymmetry, bleeding, breast droop, capsular contracture (hardening of scar tissue around the implant), deflation, displacement, hematoma (pooling of clotted blood), implant leak, infection, interference with mammography, keloid (heavy scarring), nerve damage, nipple numbness, permanent numbness, reactions to medications, rippling, rupture of the implant (often due to injury), seroma (pooling of watery blood), skin irregularities, sloshing, slow healing, swelling, symmastia (breasts merging into one mass), and visible scarring (ASAPS, 2006a; Smart Plastic Surgery, 2007).

Capsular contracture is one of the most common complications associated with breast augmentation, occurring when the scar tissue hardens around the implant. It may be more common following infection, hematoma (a collection of blood inside a body cavity), and seroma (a collection of watery blood around the implant or around the incisions). If a hematoma occurs, it is usually soon after surgery; it can also occur after an injury to the breast. While the body absorbs small hematomas and seromas, large ones will require the placement of surgical drains for proper healing, resulting in a small scar. Capsular contracture is much less common and less

severe with saline implants than with silicone implants (FDA, 2004; Smart Plastic Surgery, 2007).

Three studies demonstrate the prevalence of capsular contracture among implant patients. In a clinical study of saline-filled breast implant patients, 9% (113.76) of 1264 women experienced capsular contracture after 3 years, requiring additional surgery (FDA, 2004). The Food and Drug Administration studied 901 implant patients and found that 9% (81.09) of them experienced capsular contracture (FDA, 2004). Another FDA study of 749 women found that 17.5% of them had at least one additional surgical procedure over an average of 7.8 years because of capsular contracture (FDA, 2004). This study included women who had implants for cosmetic and reconstruction purposes, most of whom had silicone gel-filled breast implants (Smart Plastic Surgery, 2007).

Implants can move out of position at anytime after surgery, and this is referred to as displacement. If an implant moves only a little, it may not be noticeable enough to require correction. If an implant moves enough to cause discomfort, one may need surgery to put it back into position. The larger the implant, the greater the risk of displacement.

Necrosis, or dead tissue surrounding an implant, prevents healing. Necrosis may be severe enough to require surgical correction and/or implant removal, and may lead to a permanent scar and/or deformity. Factors associated with increased necrosis include infection, smoking, chemotherapy/radiation, and excessive heat or cold therapy (Smart Plastic Surgery, 2007).

Sometimes after breast implant surgery, a woman may begin to involuntarily produce breast milk (more likely if she has previously lactated). At times the milk production stops

spontaneously or medication may be given to suppress the milk production. In other cases, removal of the implant(s) may be needed (Smart Plastic Surgery, 2007).

Saline and silicone implants always hinder mammogram readings (Wyatt, 2005). When implants are below the muscle, 90% of breast tissue is visible. If implants are above the muscle, 75% of breast tissue is visible (FDA, 2004; Smart Plastic Surgery, 2007; Wyatt, 2005).

Rippling occurs when a woman's implant creates the appearance of indentations or waviness on the surface of the breast. It is less likely to occur with implants that have a smooth surface, and it can be prevented by overfilling of the implant. It is more common in implants that are placed above the muscle, especially in women who have very little breast tissue to begin with.

After surgery, a patient may have temporary or permanent numbness along with a possibility of diminished sensation or increased sensitivity. The risk of having permanently numb nipples is roughly 15%. Implants placed above the muscle may have a greater risk for this as the surgery may interfere with breast tissue near the skin. One can also expect sensation change if the incision is in the areola. If the surgeon injures the nerves which lead to the nipple area it can lead to temporary or permanent numbness. All incisions come with risk of diminished sensation (ASAPS, 2006a; Surgical Services International, 2007).

A woman should be aware that implants do not last forever, and they are bound to break. All breast implants wear out over time and deflate and additional surgery is needed to remove deflated implants (FDA, 2004). Some implants deflate or rupture in the first few months after being implanted and some deflate after several years. When a saline implant breaks, the salt water is absorbed by the body. While saline implants leak only salt water, silicone implants leak harmful substances (FDA, 2004; Zuckerman, 2006). "Silent ruptures" occur when the skin of an

implant leaks and the shape remains, leaving the woman unaware that her implant has ruptured (FDA, 2004).

Three FDA studies demonstrate rates of deflation among saline implant patients. In one study (1997), 3% of 1264 patients suffered deflation of one breast after 3 years. In a second study (1997) a deflation rate of 5% among 901 women was discovered after 3 years. A third study found that 10.1% of women followed for an average of 6 years had at least one implant deflate (FDA, 2004; Smart Plastic Surgery, 2007).

When silicone gel implants rupture, women may notice decreased breast size, hard knots, uneven appearance of the breasts, pain or tenderness, tingling, swelling, numbness, burning, or changes in sensation. The U.S. Food and Drug Administration researchers asked 344 women with ruptured silicone gel implants if they had ever experienced any of the following: persistent joint pain, swelling or stiffness; a rash on their breasts; fatigue; or whether a physician had diagnosed them with fibromyalgia – a chronic condition marked by fatigue, musculoskeletal aches and sleep disturbances (Breast Implant Info, 2007; FDA, 2004). The women were all given magnetic resonance imaging (MRI) examinations to detect whether silicone gel had leaked outside of the scar tissue immediately surrounding their implants. It was discovered in the study that women with silicone gel outside the fibrous scar around the implant were nearly 3 times more likely to report that they had been diagnosed with fibromyalgia than women without silicone gel rupture (Breast Implant Info, 2007; FDA, 2004). Factors that were associated with rupture included increasing age of the implant, the implant manufacturer, and submuscular rather than subglandular location of the implant (FDA, 2004; Smart Plastic Surgery, 2007).

Additionally, Fairfield Hospital in Cleveland, OH, recorded spontaneous deflation rates in 305 saline solution-filled breast implants and discovered that if implants are filled with greater

than the recommended volume during surgery they are less likely to deflate (Wojtanowski, 1999). Deflation is more likely to occur in under-filled breast implants because they tend to fold with physical movement and eventually rupture and deflate.

If a woman encounters a problem with an implant, additional surgery may be needed to replace or remove the implant(s) due to problems such as deflation, capsular contracture, infection, shifting, or rupture. Women who do not have their implants replaced may have cosmetically undesirable dimpling, puckering of the breast following removal of the implant, or other unsatisfactory cosmetic outcomes (Surgical Services International, 2007).

Repeat surgeries are fairly common, as demonstrated by Mentor and McGhan. Mentor studied women who received saline-filled breast implants and found that 13% of the 1264 patients needed additional surgery after 3 years. In a similar study, McGhan found that after 3 years, 21% of 901 patients needed additional surgery (ASAPS, 2006b; FDA, 2004).

How quickly a woman will experience a problem with her implant(s) is unknown, but the following research sheds useful insight. A study of both saline and silicone-filled implants concluded that 24% of women with breast implants experience adverse events resulting in surgery during the first 5 years after initial surgery (ASAPS, 1997–2007; Wojtanowski, 1999). About 1 in 3 women getting breast implants for reconstruction may need a second surgery within 5 years, and about 1 in 8 women getting breast implants for cosmetic augmentation may need a second surgery within 5 years (ASAPS, 1997–2007; Smart Plastic Surgery, 2007; Wojtanowski, 1999). These additional surgeries often result in the loss of breast tissue. Regardless of the type of implant initially chosen, a woman will need to have additional surgeries to repair, replace, or remove her implants (FDA, 2004).

Studies of saline-filled breast implants in May 2000 showed implant removal rates of 8% at 3 years and 12-14% at 5 years for augmentation patients (FDA, 2004). The same studies showed implant removal rates of 23-27% at 3 years and 28-30% at 5 years for reconstruction patients (FDA, 2004). In a retrospective study of augmentation patients with silicone gel-filled breast implants, 303 of 907 (33%) women reported that they had at least one additional surgery in which their implant(s) were removed or replaced. The average time to removal, as reported by those who remembered the date of their surgery, was 11.5 years (FDA, 2004).

Due to additional surgery needs and complications, three court cases have ensued in an effort to completely remove silicone breast implants from the industry. For instance, in 1984, Maria Stern blamed her systemic autoimmune disease on her silicone breast implants. After a month long trial, the jury awarded Maria Stern \$211,000 in compensatory damages and \$1.5 million in punitive damages (FDA, 2004).

In July of 1991, an Alabama jury decided against breast implant manufacturers and awarded \$5.4 million to Brenda Toole, who demonstrated preliminary symptoms of systemic autoimmune problems and thus an increased risk of developing an autoimmune disease (FDA, 2004).

In December of 1991, \$7.3 million was awarded to Mariann Hopkins, whose connective-tissue disease was linked to her ruptured silicone breast implants. The lawyer for the case, Dan Bolton, won the suit with the help of previous transcripts from Maria Stern's lawsuit. After winning the suit, Mr. Bolton gave several of the internal documents acquired in the trial to the FDA commissioner, David Kessler (FDA, 2004). In January 1992, David Kessler called for a voluntary moratorium on the distribution or implantation of silicone breast implants until the

FDA and the advisory panel had the opportunity to consider the newly acquired information. The implant manufacturers agreed (FDA, 2004).

In February 1992 the General and Plastic Surgery Devices Panel reconvened to review information regarding the safety and market of silicone breast implants. The panel recommended that silicone implants be limited to reconstructive breast surgery only and that women receiving the implants participate in experimental studies to assess the risk of autoimmune disease. The panel later concluded that no causal link could be found between autoimmune disease and silicone breast implants (FDA, 2004).

To date, all saline-filled breast implants are considered investigational while the FDA continues the ban on silicone implants. In January, 2004, the FDA determined that the silicone gel implant was “not approvable,” allowing women to receive them by participating in clinical trials only (FDA, 2004).

A woman who electively chooses to undergo breast augmentation can prevent some potential hazards by researching the surgeon’s credentials. The credentials that signal significant cosmetic surgery training and skill are those of the American Board of Plastic Surgery, the only board recognized by the American Board of Medical Specialties for certification of Plastic Surgeons in the United States. This certification requires surgeons to attend rigorous training sessions and provide safe medical and surgical care. Board certification training lowers risk, as it requires at least 5 to 7 years of residency experience after medical school. However, surgeons who receive fewer years of training for their specialty may legally advertise that they perform "cosmetic surgery" because legislators in most states allow any licensed physician to perform cosmetic surgery.

Although the risk may be great, many women are undergoing breast implant procedures, and there are numerous doctors willing to accommodate them. According to ASAPS, there were 334,052 breast augmentation procedures performed in 2004 alone. Breast augmentation procedures have increased 177% between 1997 and 2003.

Cosmetic surgery patients report discontent with the specific feature for which they seek surgery, but not necessarily dissatisfaction with overall body image (Didie & Sarwer, 2003). Research shows that women who have breast augmentation surgeries do so because they are unhappy with their breasts, not necessarily with their overall appearance. Prior to having surgery, women who get breast augmentation report avoidance of being seen undressed by others, camouflaging the appearance of their breasts and checking the appearance of their breasts more than half the days of the month (Didie & Sarwer, 2003). Forty percent reported comparing the appearance of their breasts to those of women around them or to women in television and magazine ads (Didie & Sarwer, 2003).

Didie and Sarwer examined factors that motivate women to seek cosmetic breast augmentation surgery. Twenty-five breast augmentation surgery candidates completed surveys measuring body image, marital, and sexual satisfaction. Thirty physically similar women who were not interested in breast augmentation also completed the measures. Breast augmentation candidates, compared with controls, reported greater dissatisfaction with their breasts (Didie & Sarwer, 2003). Another study compared breast augmentation candidates with small chested women not seeking surgery. Women who wanted surgery reported significantly greater dissatisfaction with their breasts and more frequent negative emotions in situations where they were aware of their physical appearance: wearing a bathing suit, trying on clothes, or during sexual relations (Sarwer et al., 2000).

Patients who choose to have breast augmentation surgery share several demographic characteristics in common. The typical female patient is Caucasian, of middle to upper class, aged 20s–30s, married with children, usually lower than average body weight, and discontent with her breasts (Edgerton & McClary, 1958).

One surgeon reports that augmentation patients usually come in two groups: younger women aged 19-20 who have never been happy with their breasts and older women who have finished breastfeeding their children and want a pick-me-up (Milne, 1998). Another surgeon states that his typical implant patient is a 30-something year old mother whose breasts deflated after nursing, or a young professional who can finally afford to do something about the flat chest that has soured her beach vacations for years (Sommerfeld, 2004).

Women who do have augmentation surgery often experience psychological benefits such as: increased body satisfaction, increased self-esteem, and a reduction in negative emotions related to appearance (Hilton, 2005; Schofield et al., 2002). A recent study conducted at the University of Minnesota in consultation with the Food and Drug Administration followed 450 women for a decade that had undergone breast augmentation (FDA, 2004). Ninety-six percent of the women with saline-filled breast implants stated they would make the same choice again. Ninety-three percent were satisfied or very satisfied with their breast implants and 71% rated their breast implants as soft and natural (ASAPS, 2006b).

Teen Breast Augmentation

Research has shown that of all age groups, teenagers are the most likely to be dissatisfied with their appearance. Rauste-von Wright (1989) examined 90 girls and boys in a longitudinal study at the ages of 11, 13, 15, and 18. Their satisfaction with the various parts of their bodies was discovered through a questionnaire. Satisfaction was reported highest at age 18, with males

more satisfied than females at all age levels. Those who developed secondary sex characteristics after their peers were more satisfied with their bodies than early maturers who developed secondary sex characteristics before their peers.

Under pressure to look good and gain admiration from peers, teens are now seeking breast enlargements. Popular, well-endowed teen idols like Britney Spears and Lindsay Lohan have made some girls dislike their own bodies (“More Girls Getting Implants,” 2004). The age at which women are seeking breast augmentation is lowering (Sarwer, 2001). As costs go down and technology speeds up, these procedures become more viable to teens (Austin, 2000). The message is that kids can, with enough money, change their bodies for the better (Austin, 2000).

Teenage cosmetic surgeries in general nearly doubled between 1996 and 1998, from 13,699 to 24,623 (Austin, 2000). In 2003, almost 331,886 teens 18 or younger had some kind of cosmetic surgery procedure, a 48% increase over 2002 (Kelley, 2003). In 2004, 3,841 teens under the age of 18 underwent breast augmentation (“More Girls Getting Implants,” 2004). In America, the number of teenage breast implants and liposuctions rose by 562% between 1994 and 2001 (“Beyond Botox,” 2003).

In just 1 year (2003), the number of girls 18 and younger getting breast implants jumped nearly threefold, from 3,841 to 11,326 (Sarwer, 2001). In 2005, those aged 19-34 had nearly 2 million cosmetic procedures, and the most common of all procedures was breast augmentation (54% of the breast augmentation total). Breast augmentation has become the third most frequent plastic surgery procedure for girls 18 and under, just after nose jobs and ear pinnings (Beasley, 2006).

Breast augmentation surgery is not legally approved for anyone under 18, and the FDA advises against it (FDA, 2004), but a doctor can perform the surgery with parental consent. The

FDA strongly discourages augmentation among teens because the surgery has a very high complication rate that often requires additional surgery within 5–10 years (FDA, 2004). Breast pain, hardness, and numbness last a lifetime and often result from the procedure. Furthermore, it is reported that for a young girl of 18-21, if she has augmentation surgery, she will likely need another surgery while she is in her 30s, 40s, 50s, and each decade following (FDA, 2004; Sarwer, 2001).

Some surgeons turn away patients under the age of 18 for a variety of reasons, but primarily because their bodies are still changing (Olding & Zuckerman, 2004). Teens that have not grown into their bodies physically or emotionally are setting themselves up for disappointment and a lifetime of surgery. They may not appreciate the permanence of the change. If a teenager changes her mind and chooses to have her implants removed a few years later, she will be left with breasts that are stretched-out and saggy (Institute of Medicine, 1999; FDA, 2004). Many women who have breast surgery will be unable to breastfeed their offspring because they will not produce enough milk. Others will find nursing painful because their nipples are sensitive or numb after surgery (Olding & Zuckerman, 2004). Several doctors have warned teens and their parents against having major surgery as a quick fix for popularity or self-esteem (Olding & Zuckerman, 2004).

Implants for Graduation

Plastic surgeons say that thanks to the success of shows like ABC's *Extreme Makeover* and *The Swan*, more people are asking for—and getting—cosmetic surgery as gifts (Springen, 2004). Teens are ignoring the health risks associated with implants and surgery, and are requesting breast implants as graduation, birthday, or holiday gifts and apparently more parents are paying for the procedure (Sommerfeld, 2004). For some women, possible risks and future

complications involved in augmentation surgery are worth having larger breasts. To the teens, appearance trumps caution. “If I have 1 to 3 years of my life where I feel great about myself, you can’t take that back” (“Why Are Parents Buying,” 2005, p. 3).

Some believe that teens view augmentation surgery as a quick fix. One surgeon states, “They regard it as having their hair done or getting a new watch” (Kreimer, 2006, para. 2). For some girls augmentation may be considered a rite of passage or a link to a new identity. The young girls receiving the implants for graduation claim they ask for them because they are about to embark on a lifestyle change – leaving high-school and entering the college atmosphere (“More Girls Getting Implants,” 2004). The implants allow some to feel more confident, more adult, and happy (“Why Are Parents Buying,” 2005).

Parents sometimes believe that helping daughters get breast augmentation helps their psychological well-being. Mothers claim they are paying for breast implants in order to boost their daughter’s self-esteem and make them happy (McKenzie, 2006). The parents who have the money to afford the implants cannot bear for their children to be unhappy (“Why Are Parents Buying,” 2005). Dr. Senderoff, a cosmetic surgeon in New York, states that when parents pay for breast enlargement, they do so because it is “important for their child’s well-being” (Sommerfeld, 2004, para. 2).

Mothers who’ve had breast surgery themselves seem more likely to allow their daughters to undergo such procedures. The reported boost to their own self-esteem becomes a gift they can then pass on to their next of kin. Another plastic surgeon in Miami states, “I’ve definitely seen a steep increase in 18 and 17 year-olds coming in. When the mother has had it, she knows what it did for her, so these women are quite fine with their daughters doing it. It’s a big boost to some girls’ self-esteem” (Farrell, 2004, para. 2). Sometimes mothers and daughters have the procedure

done together. It has been found that 25% of surgeons surveyed by the American Academy of Facial Plastic and Reconstructive Surgery had mothers and daughters undergo surgery at the same time (DeNoon, 2003). The phenomenon of giving implants for graduation is taking off across the country, but doctors say it is especially popular in Texas and California (“More Girls Getting Implants,” 2004). “It’s becoming quite the graduation gift: it’s cheaper than a car and better than a fountain pen” (Farrell, 2004, para. 2).

Statement of Research Goal

This research, like most body image research, focuses on women alone for several reasons. There is general agreement that the pressure to appear attractive is more pronounced for women than for men (Bulik & Kendler, 2000; Holzgang, 2000; LaVoie, 2000). In addition, their self-concepts are highly affected by television and print media (Rabak-Wagener, Eickhoff, & Vance, 1998). Research shows they are less satisfied with their bodies than men (Harrison, 2003). Additionally, women encounter more prejudice when they are considered overweight, they are more likely to diet, have plastic surgery, and have problematic relationships with food (Orbach, 1993).

The purpose of this research is to investigate reasons why some young women ask for breast implants for graduation, and why parent(s) pay for such procedures. It is important to discover if young women know that having breast surgery at a young age will result in multiple breast surgeries later in life. If they do know, how do they feel about having multiple surgeries? What might their parent(s) think about creating the need for more surgery? Breast augmentation surgery is increasing at such a fantastic rate among young girls despite safety concerns. It is important to uncover the truth surrounding a parent(s) willingness to change a daughter’s body.

CHAPTER 2

THEORETICAL BACKGROUND

Cosmetic surgery has proliferated, yet, despite the surge of interest, why are all women not visiting cosmetic surgeons? In order to better understand the current state of American feminine culture, this chapter will examine how the media has fostered low self-esteem and distorted perceptions of body image among women. Exploring each of these facets will allow for a more holistic view of the development, acceptance, and surge of cosmetic surgery in modern society. Additionally, symbolic interactionist theory, social construction of reality theory, reference group theory, conspicuous consumption theory, feminist theory, and psychological research throughout this paper intend to explain why some women have internalized Western beauty ideals enough so they resort to surgically altering their bodies.

The Media and Cosmetic Surgery

The fashion industry for decades has intentionally fostered body insecurity. In 19th-century America, one promotion of the corset in Victorian times suggested that if one wanted a girl to grow up feminine, she would need to be tightly laced (Faludi, 1991). In the 1920s, when ready-to-wear clothing was first manufactured, a new era emerged. Previously, dressmakers designed articles of clothing for individual women. With the onset of manufacturing, women now had to fit standard sizes. This shift brought a significant increase in anxiety about shape, weight, and dimensions. Women began to notice that if clothing did not fit properly, their body was to blame. To add insult to injury, they had to pay for alterations to ready-made clothes while men of any proportion did not have to pay for their alterations (Brumberg, 1998).

By the mid-20th century, the commercialization of female beauty fueled the explosion of the fashion industry. This was largely due to the evolution of modern advertising and its

accompanying weapon, fashion photography. In earlier eras, women's decisions about appearance were a personal rather than a media driven pursuit. The onset of fashion photography bred body dissatisfaction. Slimmer models became the chosen ones in order to make up for the camera's distortion and to promote the belief that clothes look best on thin frames. This helped to fuel the comparisons between the self and the ideal.

In the 1960s, mothers were advised in the *Ladies Home Journal* that appearance played too important a role in a young girl's life not to have her grow up beauty conscious (Brumberg, 1998). Body shape shifted to a more thin type, and well-known model icons like Twiggy came to represent self-control and strict dieting. The slim and flawless cover girl became the American icon, with millions of women paying it homage ("Boomers Are a Lucrative Market," 1996; Hesse-Biber, 1996).

Today, the average woman sees 400 to 600 advertisements per day (Dittrich, 2002), and by the time she is 17 years old, she has received over 250,000 commercial messages through the media (LaVoie, 2000). Only 9% of these commercials have a direct statement about beauty, but implicitly emphasize the importance of beauty through product appeal (Dittrich, 2002). Many of these messages teach women to quest for body success like men quest for professional success (Henderson, 2006). One study analyzed 4,294 television commercials and concluded that over one fourth of the commercials carried a message that told its viewers what was and was not attractive (Jones, 2004).

The ads in magazines and on television present abnormally thin bodies as if they were the standard (Maine, 2000). Mainstream magazines rarely feature photos of full-bodied or even average-sized women (Holzgang, 2000); in fact, women are commonly seen on television

wearing children's clothing sizes in order to cover their starvation-induced small frames (Harrison, 2003).

Such marketing has been influential in the promotion of Western cultural standards and beauty ideals. These icons of beauty have inspired women to pursue cosmetic medical treatments for decades (Sarwer et al., 2004). The mass media industry contributes to the increasing popularity of cosmetic procedures, portraying to the world that which is considered "attractive." The media constantly offer and advertise the latest 'body' as a consumable and attainable asset and this has subsequently led to the mass expansion of the cosmetic surgery industry. Television programs, magazine articles, the film industry, and other forms of media continually reinforce the notion of the 'ideal' body; a body which is slim, fit, and beautiful. Society places a great deal of pressure on women to conform to this culturally constructed body type. As a result, some women feel they must undergo cosmetic surgery to achieve the ideal (Jaggar, 1994).

Half of advertisements in women's magazines and over half of television commercials aimed at female viewers use unattainable beauty as product appeal. This constant exposure to female-oriented advertisements may influence girls to obsess over their physical appearance as a measure of their worth (Dittrich, 2002). Researchers now report that the more women watch television, the more likely they are to engage in intentional vomiting in an effort to lose weight, have distorted perceptions of their own bodies (Thomsen, Weber, & Brown, 2002), and lower self esteem (Rabak-Wagener et al., 1998).

Researchers have studied the effects of advertising on young people and have come to the general conclusion that women are more critical of their bodies than are men (Rabak-Wagener et al., 1998). Harrison (2003) discovered that immediately after showing images on television to college men and women, the women were more personally and emotionally affected by the

images than the men. A recent study explored the factors influencing young women to undergo cosmetic breast augmentation surgery. According to the researchers, 40% of the surgery candidates reported comparing the appearance of their breasts to those of women around them or to television or magazine images (Didie & Sarwer, 2003).

The mass marketing of such ideal tall, thin, toned women (Kilbourne, 1994) has normalized unrealistic bodies and created an unattainable desire among many women (Hamburg, 1998). Shows like ABC's *Extreme Makeover*, MTV's *I Want a Famous Face*, and Fox's *The Swan* glorify cosmetic procedures and break down social stigmas (George, 2004). When *Extreme Makeover* was launched in September 2003, it was marketed as an opportunity for contestants to change not only their looks, but also their lives (Heyes, 2007). MTV's *I Want a Famous Face* uses a soap opera format to follow patients through the process of becoming a Xerox copy of a famous American. Fox's *The Swan* puts its numerous contestants through a total body overhaul before having them compete in a beauty pageant.

At their core, extreme-makeover shows are entertainment, but their ultimate effect is the normalization of plastic surgery and the elimination of the stigma that used to surround the procedures. In the end, this ensures the enhancement of the cosmetic surgery industry as beautifully as the bodies they service (Lawton, 2004; "Pots of Promise," 2003).

There are some social benefits that come with good looks. For example, studies show that being pretty confers enormous genetic and social advantages. Attractive people are judged to be more intelligent and better in bed, they earn more, and they are more likely to marry ("Pots of Promise," 2003). Persons who are considered physically attractive have been shown to receive preferential treatment in both professional and personal situations (Bull & Rumsey, 1988). The most conclusive evidence of socio-economic significance of beauty and ugliness is presented by

Kaczorowski (1989), in his study of the Canadian Quality of Life panel survey of 4000 full-time workers. He found that good looks and high-incomes are highly correlated. Furthermore, he found that good looks also determine wealth. Many may believe that wealthy people are good looking because they have the resources to purchase beauty items that can allow them to become so. Scientifically it has been proven otherwise – those who are good looking to begin with become wealthy, not the reverse (Kaczorowski, 1989).

If the feminine condition is to be beautiful, the innovations in cosmetic surgery promise appeasement of this impossible desire by allowing women to alter anything they choose. Cosmetic surgery then becomes a temporary solution to the never ending struggle for perfection (Blum, 2005; Layton, 1999). Emulation of media icons, friends, and even strangers becomes an unattainable goal for those with poor self-image (Etcoff, 2000; Swan, 2004). Blum (2005) demonstrates how cosmetic surgery is elusive and constantly changing, moving the ideal further from reach:

No matter how close we come to imitating the Other Woman—through the products we buy or how we wear our hair, and most dramatically through surgery—once it is we who are in that position, she instantly jumps to another place on the map for us to trail after. Cosmetic surgery seduces us with the possibility of literally becoming our rival. One can only rise above this jealousy through emulation. (p. 125)

Sociological Framework

The Role of Symbolic Interaction in Cosmetic Surgery

The symbolic interaction perspective is a valuable tool in analyzing human behavior at the microlevel (Blumer, 1969). Symbolic interaction theorists purport that behavior originates within the constructs of the mind. The world humans inhabit is seen as a social construction, a product of our ability to think and express our thoughts symbolically. Things we recognize as being part of our society may simply be products of our own mind. Society is therefore an

elaborate fiction we create in order to help make sense of our relationships and the world around us.

This perspective is concerned not only with the individual or society, but with the response and adjustment of the actor and his or her audience. The self then becomes a being that emerges from a sense of how others view him or her. Symbolic interaction theory may serve as a basis for understanding how women interpret their own beauty and respond to the environments in which they live. The internalization of media images and a woman's perception of her own beauty may influence whether she chooses or refuses cosmetic surgery.

The meaning of one's own body image may be determined by media internalization. Internalization is a process through which people come to identify parts of the culture as themselves, especially in relation to norms that guide decisions about appearances and behavior. Internalization is a crucial element that may lead some people to regulate their own appearance in accordance with accepted forms, i.e., those displayed in the media. Charles Horton Cooley, George Herbert Mead, W.I. Thomas, and Erving Goffman all described thought processes that might motivate women to create good impressions, to put on good performances, and to reflect upon their own body image.

Charles Horton Cooley (1902/1964) described the self-concept as an entity formed through social interaction. His concept of the looking-glass self is one derived from the outside world. As he put it in the following:

Each to each a looking-glass, reflects the other that doth pass. As we see our face, figure, and dress in the glass, and are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we should like them to be; so in imagination we perceive in another's mind some thought of our appearance, manners, aims, deeds, character, friends, and so on, and are variously affected by the internalization of such. (p. 183)

According to Cooley, one's body image reflection may involve three principal elements: the imagination of our appearance to the other person; the imagination of his or her judgment of that appearance; and some sort of self-feeling, such as pride or mortification in return. The imagined judgment is quite essential. The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon another's mind. We often imagine, and in imagining, share the judgments of the other mind (Cooley, 1902/1964).

Cooley states that the social self is simply an idea, drawn from society. The person looks to others for a sense of how he or she is perceived and comes to judge the self according to the way others perceive the responses. The self-concept, once formed, explains motivations for behavior. Cooley determined that internal thinking involves imaginary conversation carried on silently within one's mind. According to Cooley, other people are real to us only because we imagine an inner life that we do not directly observe, but which we project onto them. Interaction involves the process that takes place when people act in relation to one another in a social context. These processes are both mental and physical, and include others' responses and interpretations. Someone's physical body provides a way to interpret our ideas of what we think they must be like. According to Cooley, someone's physical body does not represent her true personality, but something based upon our imaginations.

The assumption may then be made that one's own level of attractiveness is based on the interpretation of other's perceptions. One who feels unattractive to others or to oneself and has the financial means to change her appearance may have private mental conversations leading to cosmetic surgery (Didie & Sarwer, 2003).

Before a woman undergoes such surgery, she is likely to play out in her mind what her life will be like when she gains the “perfect body part” that she believes she is currently lacking (Sarwer et al., 2004). George Herbert Mead (1934) discussed this imaginative role-playing, this new “me” that one tries out in different social settings. A woman who intends to undergo surgery can only imagine what the new younger, more beautiful woman will be like following elective cosmetic surgery. Cooley’s looking glass allows for a woman to think about cosmetic surgery; Mead’s role-playing practices explain how she pretends in her new body.

Expanding on Cooley’s notion of the “looking-glass self,” Mead examined the parts of oneself that emerge in different social situations. According to Mead, after one has interacted with other people over time, a “me” emerges. This “me” is how a person would imagine and describe her own behavior if she were to role-play in various situations (Mead, 1934). According to Mead, our concept of “self” is derived from social experience. Thought is conversation carried out, once again, with oneself. The “me,” or self-image, emerges after interaction with others. The “me” can become the imaginary person that we act out in various social settings in our minds to role-play, and to try out certain things before we actually do them in real life. In a way, this “me” might represent the voice that talks to women in the mirror, ‘If I only had breasts that were up here, then I’d be happy,’ or, ‘If my thighs were only this thin, then I would be...’

The ways in which women define a situation is as important as any objective reality because such beliefs may guide their actions (Stryker & Statham, 1985). W.I. Thomas stated this as well when he postulated that within everyday life any definition of the situation will not only influence the present, but the entire personality of the individual (W. I. Thomas, 1923). If a certain behavior becomes defined as prestigious, and is internalized, then this behavior may be what people desire. Behaviors that become identified as prestigious are used as tools to gain

status and to create specific impressions in the minds of others (Goffman, 1959). In today's society, the beautiful woman and her behavior have become a prestigious status symbol (Synnott, 1989).

Advertising and media icons strive to pressure consumers, especially women, to reconsider their appearances. If a "look" is portrayed as the ideal in society, women often choose that prestigious, beautiful image even when it comes at a costly price (Kilbourne, 1994). Women who internalize media images as real may be more likely to choose cosmetic surgery in order to attain prestige, whereas women who view media icons as unattainable, false representations may be less likely to undergo elective procedures (Harrison, 2003).

Choosing to adopt the "ideal look" would be a natural thing, according to Erving Goffman, if one wishes to impress audience members. A woman may manipulate her physical appearance in an effort to give off her best impression to an audience of observers (Goffman, 1959).

Every social setting determines which scripts are to be read, and these are further determined by factors in which the social setting is situated. These factors include, but are not limited to, race relations, gender relations, and class relations. How people may relate to one another in specific social settings is determined by their race, gender, social class, and other pertinent statuses. According to Goffman, we not only rehearse these gender scripts and visions within our minds, but we perform both for ourselves and for our audiences as well.

Appearances can tell us of performer's youth, vibrancy, and social status. Our public expects that our appearances match our real beings, that there is consistency between our façades and our true manner. While persons are usually what they appear to be, such appearances could

still have been managed. Those who have undergone plastic surgery are managing an audience; they are maintaining their youthfulness perhaps 'better' than others.

Impression management involves the way in which individuals guide and control the impressions others form of them; the body and face are parts of this process. The goal may be to make the audience believe one is youthful, vibrant, attractive, and valuable to society. Those individuals trying to appear more youthful or more beautiful in society may begin a dramatic costume change, a transformation process through the implementation of cosmetic surgery.

Impression management involves the way in which individuals guide and control the impressions others form of them; the face and body are important parts of this process. The goal is to change perceptions; to have women perceive, in their own minds, that their audience believes they are youthful, vibrant, attractive, and valuable to society.

Keeping up appearances according to modern societal standards requires effort and youthful maintenance. Rewards for hard work may come in the form of physical compliments, the wearing of smaller dress sizes, and/or positive attention; both from audience members and from a woman's reflection in the mirror (Didie & Sarwer, 2003).

The American socialization process is influenced by the media, thus our meanings and interpretations of beauty are influenced as well (Harrison, 2003). We have been socialized to know what is considered "beautiful" or "ideal" (Kilbourne, 1994). When we cross paths with either the beautiful or the unattractive, interpretations of physical symbols may drive the way in which we view the people we see, and ourselves. Western culture, media influence, and symbolic interaction may result in body dissatisfaction, thus motivating some women to undergo cosmetic surgery procedures (Didie & Sarwer, 2003).

The Role of Social Construction of Reality in Cosmetic Surgery

The social construction of reality represents the social processes by which humans collectively construct, interpret and assign meaning to their actions, institutions, roles, and events (Berger & Luckmann, 1966). The human body itself may be seen as a social construct, a means of social expression or performance by which our identity and value is created, tested, and validated (Sile, 1981).

Simone de Beauvoir (1953) stated: “One is not born, but rather becomes, a woman...; it is civilization as a whole that produces this creature which is described as feminine” (p. 267). Gender is constantly created and re-created out of human interaction and depends on everyone constantly “doing gender”:

For the individual, gender construction starts with assignment into a sex category on the basis of genitalia. These babies are dressed and adorned in a way that displays the category because parents don't want to be constantly asked whether their baby is a girl or a boy. A sex category develops into a gender status through the use of gender markers. Once a child's gender is evident, others treat those in one gender differently from those in the other, and the children respond to the different treatment by feeling different and behaving differently. As soon as they can talk, they start to refer to themselves as members of their gender. The gender work adults do shape women's and men's life experiences, and these experiences produce different feelings, consciousness, relationships, skills – ways of being feminine or masculine. All of these processes constitute the social construction of reality. (Lorber, 1994, p. 2)

As a process, gender construction creates the social differences that define “woman” and “man.” In social interaction throughout life, humans learn what is expected and act and react in accordance, maintaining the gender order (Lorber, 1994). In daily encounters, humans produce gender, behaving in ways they learned were appropriate.

In *The Politics of Women's Bodies: Sexuality, Appearance, and Behavior*, Rose Weitz (1999) demonstrates how ideas regarding the female body in turn affect women's lives. Social constructions often are powerful enough that women augment their breast size with silicone and

reconstruct their faces with cosmetic surgery to conform to cultural ideals of feminine beauty. When this behavior is done consistently, these gender constructs are rendered legitimate (West & Zimmerman, 1987).

The Role of Reference Group Theory in Cosmetic Surgery

The basic premise of reference group theory is that much of human behavior is driven by reference groups, or those groups that influence the attitudes and behavior of individuals (Dawson & Chatman, 2001). People often take the standards of significant others as a basis for making self-appraisals and comparisons (Hyman & Singer, 1968). Reference groups give individuals a basis for comparing themselves to others and are often used as a sort of yardstick allowing one to measure how they “stack up” relevant to some standard.

According to research, how people stack up against the group with which they most often compare themselves has an enormous impact on their behavior. Schor (1998) analyzed consumerism and television, and found that the more TV a person watches, the more he or she spends. Researchers Shrum, Burroughs, and Rindfleisch (2005) found that the more people watch dramatic TV shows, the more they think American households have tennis courts, private planes, convertibles, cell phones, maids, and swimming pools. These same viewers overestimate the portion of the population who are millionaires, have had cosmetic surgery, and belong to private gyms.

Individuals seek membership into certain groups because of the groups’ perceived status and the benefits gained from belonging to such groups (Dawson & Chatman, 2001). Reference groups possess power through their ability to influence individuals who desire to become members. A woman’s perception of her own appearance may be driven by comparisons with women in the media, or women others view as “beautiful.” Women may seek affiliation with

women viewed as beautiful because they are depicted as having desirable social status. Some women may choose beautiful women as a reference group and ultimately undergo surgery in an effort to feel part of a more favored group.

The Role of Conspicuous Consumption in Cosmetic Surgery

In Veblen's (1899) classic work, *The Theory of the Leisure Class*, he states that status is determined by displaying wealth through acts of conspicuous consumption. Conspicuous consumption involves the acquisition and display of those items that attract attention to one's wealth or suggest that one is wealthy. It is an economic, cultural, and social process that reflects the opportunities and constraints within a society (Zukin & Maguire, 2004). Consumer goods are often used by socio-economic classes to differentiate their status from others. These goods serve as symbolic cues that signal levels of prestige.

The Veblen thesis proposes that the rich set standards that the rest follow. For example, the middle class may emulate the upper class by purchasing fine articles of clothing, and the lower class may emulate the middle class by driving a fine automobile in an effort to elevate perceived status. Americans are engaged in an intensifying "national shopping spree" rooted in competitive emulation – keeping up with the Joneses on a manic scale (Schor, 1998). The wealthy have set spending precedents for everyone else.

The eccentricities of the rich have a purpose, to reaffirm their status as members of the leisure class and to display power (Veblen, 1899). According to Veblen, the display of power was external in pre-industrial society. It was easy to "see" who the powerful were in feudal society because they commanded large armies and ruled over segments of society while living in castles (Carolan, 2005). There was no need to speak of conspicuous consumption because all consumption was a display of power. Individuals today, however, no longer rule over peasant

classes. Consumption is now something done by all. As such, status is displayed in other ways. We are no longer content with merely surrounding ourselves with “nice things.” Instead, we now strive to become the “nice thing” itself – to literally embody conspicuous consumption (Carolan, 2005).

Within American consumer society, the youthful and attractive body has become a status cue. Beauty has come to represent the good life – viewed as a display of high social status and prestige (Sile, 1981). A fit, firm, exercised, and well-regulated body has come to symbolize personal triumph over impulse. A body in control over itself has come to represent a body in control of the world around it (Carolan, 2005).

The opportunity for one to control the world around them is marketed heavily in the West. It is control for sale. Cosmetic surgery is a form of consumption, and a very conspicuous one at that (Carolan, 2005). What could be more conspicuous than something which alters your body, the very thing you take with you everywhere?

The Role of Feminist Theory in Cosmetic Surgery

Dissatisfaction with personal appearance is widespread, particularly among women. Although patients are disproportionately female and cosmetic surgery is used to intensify the gendered appearance of bodies, it is not an exclusively a gender custom. Nevertheless, cosmetic surgery inscribes our gendered beliefs about appearance (Sullivan, 2006) and personifies the social, psychological, and economic value we place on an attractive appearance.

The gender power differential extends to the surgeons office as well. Research continues to demonstrate that what is considered “normal” or “natural” (insofar as appearances are concerned) for a woman is not “normal” or “natural” for a man. The American Society for Aesthetic Plastic Surgery (ASAPS) reports that surgeons are united in the view that women’s

concern for physical appearance is of greater concern than men's. Surgeon's report women come into their offices for surgery solely for appearance sake, while men have surgery in an effort to enhance their career (ASAPS, 1997–2007). By emphasizing the competitive advantage in the workplace, surgeons promise to help male potential clients meet their career goals (Maine, 2000).

Throughout the 1960s, when surgeons meditated on the question of aging and its effects on identity, they were clearly concerned only with women. When they did mention men, it was only in the context of comparison: whereas aging was widely perceived to alter female identity in a negative way, it brought benefits to men, who were perceived to become more powerful, not less, as they aged (Davis, 1995). Surgeons were influenced as well by the homophobic culture of American masculinity, which held that "real men" did not care about their looks (I. Davis & Davis, 1975, p. 103). As one surgeon put it, any man considering a facelift was "an aging actor, a homosexual, or both" (Curtin, as quoted in Haiken, 2000, p. 84).

Surgeons characterize men's concerns for their appearance as extrinsic to their nature as men (K. Davis, 2003). Research has shown that men are more accepting of defects in body image (Rabak-Wagener et al., 1998). Therefore, men often do not have the psychological investment in maintaining outward appearances that many women do. Men are more apt to attend to their appearance in an instrumental fashion, for example, to attain a more prestigious job (Dull & West, 1998). Cosmetic surgery is not as popular among men, within our culture, for several reasons: (1) Where age makes women ugly, it makes men mature and distinguished; (2) Techniques for treating the cosmetic problems that most bother men, such as balding, are ineffective. (3) The culture of masculinity is homophobic. "Real" men should not pay too much attention to their bodies; therefore, men who do are suspect (Clatterbaugh, 1997).

In society, the desire for beauty becomes a double-edged sword: a kind of oppression in one sense, and also a way to feel good about oneself when taking the opportunity to appear the way one wishes (Hamburg, 1998). Two competing feminist views pose arguments within cosmetic surgery literature. One sees women who elect to undergo cosmetic surgery do so because they are objects of the “male gaze” (Canavan, 2003), and the other argues women who elect to have surgery are merely exercising choice in controlling their own bodies (Gagne & McGaughy, 2002).

The first feminist view that women change their appearance for men’s sake is based upon three assumptions. (1) Women who believe they are creating their own identity through surgery are simply conforming to male dominated norms of femininity (Canavan, 2003). (2) Women who have surgery are in a state of “false consciousness.” They may believe they are free to make their own choices regarding their bodies, but, in fact, the choices have already been made. The choices have already been made by those displaying unrealistic body images in the media, and by those surgeons molding bodies behind closed doors. Hence cosmetic surgery is a form of domination, not liberation. (3) Cosmetic surgery can never be regarded as a positive and acceptable course of action, even though women believe it is, since the technologies associated with the industry are fundamentally oppressive (Davis, 1995).

More often than not, what appear at first glance to be instances of choice turn out to be instances of conformity. Women who undergo cosmetic surgery in order to compete in various beauty pageants are clearly choosing to conform (Canavan, 2003). So too are women who undergo facelifts, tummy tucks, and liposuction in order to win approval from men in mass without knowing what one man’s individual preference may be. In some ways, it does not matter who the particular judges are, actual men: brothers, fathers, male lovers, male beauty experts,

other women; or hypothetical experts living in the aesthetic imaginations of women (D. Davis & Vernon, 2002; Morgan, 1991).

Women are lead to believe that by constantly altering the body, they are able to take control of their lives, but in fact, they are being controlled by powerful institutions. This sense of oppression is extremely difficult to avoid, as society places a great deal of pressure on women to conform to various beauty norms. Women are surrounded by homogenizing images of the female form, all of which suggest the ideal body is attainable (Maine, 2000). Consequently, women are prepared to conform to such images, as it allows them to 'fit' the cultural ideal: a beauty myth that patriarchal society promotes and perpetuates (Wolf, 1991).

Even further, these feminists claim that by undergoing cosmetic surgery, women are actively contributing to their own oppression. As this quote from Davis shows, 'women who choose to have cosmetic surgery do so because they have had the ideological wool pulled over their eyes' (Davis, 1995, p. 57). Wolf, for example, believes that 'cosmetic surgery processes the bodies of women, who make up the vast majority of its pool, into man-made women' (Wolf, 1991, p. 220). Women who undergo cosmetic surgery are conforming to men's notion of beauty and femininity. Since breasts are linked to cultural notions about femininity, the rationale for breast surgery is translated into sexual desire (Wolf, 1991).

Feminists such as Wolf believe women are culturally constructed objects of masculine desire. By conforming to the beauty norms of patriarchal society, women present themselves for the "male gaze" (Wolf, 1991, p. 220). Women are not simply electing to change their appearance, but are fulfilling an obligation to express an ultimate sense of "femininity" (Wepsic, 1996). Gender is not simply something one is, rather, it is something one does in ongoing interaction with others (Morgan, 1991). To the extent that members of society know their actions

are accountable, they may design their actions (and appearances) with an eye to how others might see and characterize them.

This beauty myth has come to be used as a political weapon and form of social control, preventing women's advancement in society. Women have been made to believe the beauty myth is associated with the celebration of women, but, in fact, it is connected to men's institutions and institutional power. "Women are mere 'beauties' in men's culture, so that culture can be kept male" (Wolf, 1991, p. 59). Women invest in clothing, make-up, endless beauty rituals, dieting, cosmetic surgery, and other activities in order to garner status, acceptance, and feelings of worth (Adams, 2002).

Those who adhere to this first feminist view translate such behaviors into sexual objectification used to dehumanize women (Wolf, 1991). Rather than women aspiring to be self-determined, they aspire to capture the all encompassing "male-gaze" (Jaggard, 1994).

The cosmetic surgery industry constantly promotes the notion of ugliness as a disease which can be cured by going under the knife. Women accept cosmetic surgery as the correct diagnosis, because it is portrayed with a great deal of authority - the medical profession. The surgeons market is imaginary, since there is nothing wrong with women's faces or bodies (Wolf, 1991); so the surgeons depend on warping female self-perception for their income.

The institutions within the beauty system, in particular the cosmetic surgery industry, have a homogenizing effect. This Western ideal of beauty has become so pervasive that not only are women under pressure to conform to beauty norms, but now ethnic features are becoming treatable diseases which need to be cured by cosmetic surgery (Davis, 1995). Women are being instructed that their bodies are unacceptable: too fat, too thin, too wrinkled, and now, too ethnic (Davis, 1995).

Cosmetic surgery has become a form of Eurocentrism, promoting European Western notions of beauty as the ideal form of beauty, and by doing so, labeling all other standards as different, as “other.” What is being created in all of these instances is not simply beautiful bodies and faces but white, Western, Anglo-Saxon bodies (Jaggar, 1994). Cosmetic surgery may result in the homogenization of female beauty, as difference is transformed into sameness.

Many feminists fear that the standardization of female beauty will result in global cultural homogenization which will not only result in the world being a very boring place, but simultaneously confirm women's subordinate position in society. These feminists argue that women are unable to recognize that by partaking in the beauty system, they are actively contributing to their own subordination.

Our culture socializes women to internalize an observer’s perspective on their bodies, and therefore to experience more shame and distress over bodies that do not fit the cultural ideal (D. Davis & Vernon, 2002). Cosmetic surgery promises every woman an attractive, youthful and socially acceptable body; hence it comes as no surprise that an increasing number of women undergo surgery. As a consequence, more and more women will be labeled "ugly" and "old" in relation to this more select population of surgically created beautiful faces and bodies that have been contoured and augmented, lifted and tucked into a state of achieved female excellence (Jaggar, 1994). Women who cannot afford, or do not wish to have, cosmetic surgery will be stigmatized for not attempting to achieve the ideal beauty standard.

Cosmetic surgery assumes that the human body has flaws which can and should be fixed (Blum, 2005). Women often view themselves as the problem and their own body parts as obstacles to happiness (Schofield et al., 2002). Ironically, in all of this, the cultural values that

are impressed upon us everyday through the media are not seen as changeable; it is the body that is considered changeable (Harrison, 2003).

The medicalization of a woman's appearance through cosmetic surgery reinforces limited and restrictive models of femininity (Dull & West, 1998). Cosmetic surgery has become a form of psychiatry with a knife (Blum, 2005). "We are coming to know the knives and needles of cosmetic surgeons - the knives that promise to sculpt our bodies, to restore our youth, to create beauty out of what was ugly and ordinary. What kind of knives are these? Magic knives. Magic knives in a patriarchal context. Magic knives in a Euro-centric context. Magic knives in a supremacist context" (Morgan, 1991, p. 32).

The second feminist view, in contrast, argues that women are not being controlled by the beauty system. This perspective argues the modification and improvement of women's bodies is vital to their sense of identity. By investing in the body as a "project," women are able to express their sense of identity and increase the control they have over their bodies. In this sense, women are not being oppressed by the beauty system; they are simply taking control.

Women who have cosmetic surgery may do so because it enables them to become embodied female subjects. Cosmetic surgery therefore may serve as an act of liberation, achievement, and power. Sometimes, it allows women to gain a higher social and economic status (Kaczorowski, 1989). Cosmetic surgery enhances women's self-esteem and confidence. In this sense, cosmetic surgery does not act as a form of oppression but empowerment. These women take their experiences with their bodies seriously, they acknowledge suffering, and believe surgery is the best course of action under the circumstances (K. Davis, 2003).

Cosmetic surgery is the ultimate culmination of the female body as a project. Women now have the ability to alter and perfect their bodies, as part of their self-identity. Cosmetic surgery is the cultural product of modernity and of a consumer which treats the body as a vehicle for self-expression (Davis, 1995).

Women are socialized to look good and to disguise real or imagined defects (Bulik & Kendler, 2000). A woman, as a product of society and Western media, may want to primp and look as pretty as she can. Her conscious effort to disguise defects may become an intrinsic part of her self-concept as a woman. The fact is that neither moral censure nor fears about safety will stop women from wanting to look better. The desire is too entrenched (“Pots of Promise,” 2003).

Not all women are blinded by cultural beauty norms. Many do not believe cosmetic surgery is the perfect solution to their problems, but simultaneously they understand that we live in a society where beauty is offered at a price, albeit a dangerous and painful one.

Psychological Framework

The Role of Body Image Discontent in Cosmetic Surgery

Cosmetic surgery is mainly about treating someone’s sense of self, so it becomes important to know why some women may choose to undergo elective surgery being aware of the risks they may face. Overall, a majority of patients seeking cosmetic surgery do not suffer from serious psychological disturbance such as split personality or suicidal tendencies. Rather, those seeking surgery report low self-esteem and poor body image (Hilton, 2005; Thorpe, Ahmed, & Steer, 2004). Women relate cosmetic surgery desires to identity issues – to the desire to feel comfortable with their bodies, to look ‘normal,’ to look younger, or to ‘feel better’ (Tackla, 2006). These issues are confidence, self-esteem, and happiness matters. Women seeking surgery report that they seek procedures to cure these self-esteem maladies (Harrison, 2003). Patients are

motivated to have surgery because they are unhappy with their appearance, often resulting from a perceived physical problem – a mismatch between how they feel they ought to be and how they perceive themselves (Thorpe et al., 2004).

One theory that may explain this phenomenon is Duval and Wickland's (1972) self-discrepancy theory. This theory postulates that some people look at themselves more as objects than as human beings. When this occurs, unhealthy comparisons are made between the actual self and an ideal self image. Duval and Wickland report that individuals become increasingly dissatisfied with body image as they focus on the ideal self. Such discrepancy may motivate some to act in an effort to reduce perceived discrepancy (Thorpe et al., 2004).

This discrepancy can be so strong that the perception of the actual self in relation to the ideal one may result in a sense of failure, as if the individual does not belong with the rest of society (Thorpe et al., 2004). American society being a beauty focused society can make ordinary women consider themselves ugly and deficient (K. Davis, 2003). If there is a discrepancy between the way women feel they actually look and how they ideally ought to look, there may exist the drive to reduce this discrepancy through surgery. Research demonstrates that women, as a consequence of feeling under pressure to appear beautiful, go to great lengths to achieve this (Young, 1990). Before surgery, women consider themselves imperfect, striving for perfection (Thorpe et al., 2004).

Another theory that is often used to explain why women may seek surgery as an alternative is Festinger's Social Comparison theory. It proposes that comparison with others is often undertaken in order to fulfill the basic human drive for self-evaluation (Festinger, 1954). In his original study he thought people would compare themselves to those who looked similar to them. However, he found that people compare themselves with those who are more beautiful

than themselves (Engeln-Maddox, 2005). This is done in an effort to gain valuable information in order to improve oneself. In other words, if one compares their own attractiveness to that of a magazine icon, one can gain valuable information such as beauty tips, fashion sense, tricks on losing or maintaining weight, etc. For those who have internalized the societal ideal, comparison processes are likely to be ongoing (Engeln-Maddox, 2005).

Often women compare themselves to idealized media images and to images of other women (Martin & Kennedy, 1994) and that comparison may result in body dissatisfaction. Some women may find themselves inspired by such comparisons, or even evaluate themselves more favorably than their models. Researchers report that social comparisons are much more likely to result in negative feelings than positive ones (Engeln-Maddox, 2005) and can lead to cosmetic surgery (K. Davis, 2003).

Women construct their ideal body image as one revolving around a particular age or image, a standard not subject to universal aging and deterioration processes (Thorpe et al., 2004). Women motivated to have surgery construct their body image as if there is such a thing as an objectively normal body image, and determine that their bodies, pre-surgery, do not conform to this standard (Thorpe et al., 2004). The drive becomes a wish to fit in with some national idea of normality, or how “everybody else” looks (Tackla, 2006).

However, many of those who seek cosmetic surgery are already very attractive by societal standards (Neimark, 1994), but their perception of their own attractiveness is unfavorable. Some women may have a distorted perception of what their bodies look like. They may look in the mirror and see a larger body than the one they have. Large thighs, large buttocks, and a round abdomen may lead to distress for some women (Harrison, 2003).

“Normative discontent” reflects the notion that body image dissatisfaction has become so common for American women that it is the norm for women to feel poorly about their physical selves (Engeln-Maddox, 2005; Rodin, 1993). Body dissatisfaction among women is a concern because it can engender excessive focus on the appearance of one’s body, and can steal resources (time, attention, monetary resources) from other activities that might empower women, rather than making them feel adequate (Engeln-Maddox, 2005).

Research demonstrates that American women are not satisfied with their physical appearance. For instance, a study of 803 American women indicated that nearly half of the sample reported a negative global body image, and 25% expressed additional dissatisfaction with their upper torso (Cash & Henry, 1995). American Demographics, in an exclusive survey using a national sample of 2510 adults, found that when adults were asked to rank how happy they are with their physical appearance on a scale of 1 to 10, (1 being the least happy), 47% gave themselves a score of 5 or lower (Fetto, 2003). Fewer than 1 in 7 Americans are happy enough with their bodies they wouldn’t change a thing. This issue of unsatisfactory physical appearance is not limited to the United States. Similar findings have been documented in studies spanning 10 other developed countries: Australia, Canada, China, England, Germany, Greece, Holland, Ireland, Italy, and Japan (Harter, 2000; Realo & Allik, 2002) in which poor self esteem appears to be meaningfully related to a high employment rate.

Today’s fashion models weigh 23% less than the average female (Brown & Dittmar, 2005; Holzgang, 2000), and a young woman between the ages of 18-34 has only a 7% chance of being as slim as a catwalk model and a 1% chance of being as thin as a supermodel (Olds, 1999). Although young girls feel insecure about these “very thin” models (Maynard, 1998), they still use them for comparison purposes (Holzgang, 2000).

There also exists a relationship between body image discontent and disordered eating habits (Muehlenkamp & Saris-Baglama, 2002). A study of 502 adolescents revealed positive associations between the frequency with which females read women's beauty and fashion magazines and the use of appetite suppressant/weight control pills, skipping two meals a day, intentional vomiting, and restricting calories (Thomsen et al., 2002).

According to the United States Food and Drug Administration (2004), more than 90% of those with eating disorders are women. Further, the number of American women affected by these illnesses has doubled to 5 million in the past three decades. Recent data reported by the American Psychiatric Association suggests that of all psychiatric disorders, the greatest patient mortality due to natural causes is associated with eating disorders (Bulik & Kendler, 2000). In fact, many women suffer from body image discontent and assiduous dieting. The relentless pursuit of thinness has become normative behavior among women in Western society (Dittrich, 2002).

In one study, the most significant variable associated with cosmetic surgery was self-reported frequency of dieting to lose weight in the past year (Schofield et al., 2002). Women who have cosmetic surgery appear to take a more active role in dieting and maintaining their perceived ideal body weight, so much so that friends and family members know they are actively dieting.

In addition, a study (Fetto, 2003) found that a troubling 24% of American women said they would give up 3 years of their life to achieve their weight goals. Furthermore, following memory loss, weight is the second largest concern of older women (Furman, 1997). Research suggests that mothers who are food-and-weight preoccupied tend to have daughters who are the same (Milne, 1998). A study involving 12,000 children between 9 and 14 examined the influence

of parents, peers, and the media on girls' body image concerns and found that girls who perceived that thinness was important to their mothers were more likely to become constantly worried about body perception than those without this concern (Field, Camargo, & Taylor, 2001).

Girls aged 7 to 12 years rate their ideal figure as significantly smaller than their current figure, indicating some degree of body image discontent (Tiggemann & Wilson-Barrett, 1996). In contrast, there is no significant difference for boys' ratings. Some researchers found that societal standards of beauty have reached not only mothers, but their female children as well (Tiggemann & Wilson-Barrett, 1996).

While social interactions with mothers can certainly play a role in the development of body dissatisfaction, the role of the media and its contribution to women's relationships with their bodies cannot be overlooked. Exposure to images of attractive thin female models can increase depression, guilt, shame, stress, anger, and body dissatisfaction in women (Fister & Smith, 2005). Correlational studies have also linked exposure to media that contain ultra-thin ideals to increased body-dissatisfaction (Brown & Dittmar, 2005).

The internalization of media images affects women of all age groups (Lokken, Ferraro, Kirchner, & Bowling, 2003; McCabe & Ricciardelli, 2003), as body dissatisfaction among women is found to be constant across the lifespan (Tiggemann, 2003). Physical signs of advanced age are more harshly judged in women than men (Sontag, 1972). Aging involves an inevitable, undesirable, and uncontrollable status passage in which the true self becomes less visible in the aged shell of the body (Glaser & Strauss, 1971).

When women enter mid-life, their social value diminishes earlier and at a more rapid rate compared to men (Freedman, 1988). Advertising consistently uses teens and young adults to

promote products designed for older cohorts. In television ads, only 2% of the actors appear to be over age 60 (Friedan, 1993). After age 40, men receive 3 times as many acting roles as women (Kilbourne, 1994), and women who are portrayed over age 40 are likely to be cast in negative roles (Gerbner, 1998). On television, women's career opportunities peak at age 30 (Friedan, 1993).

Without a youthful appearance, women report that they are rarely considered beautiful (Clarke, 2001). Older women state that mirrors and reflected images are a particular source of anxiety, shock, and disappointment in that they challenge their concepts of themselves as youthful individuals (Clarke, 2001). Women struggle against the implications of having to appear young in order to avoid disrespectful, if not discriminatory behavior, in our youth oriented society (Clarke, 2001). Women mask chronological age with make-up, hair dye, and in some cases, cosmetic surgery.

Dissatisfaction with body image has been the predominant psychosocial factor linked with demand for cosmetic surgery (Schofield et al., 2002). Although cosmetic surgery patients are commonly thought to have poor body image and self-esteem (Sarwer et al., 2000), a study of 100 cosmetic surgery patients found that they did not demonstrate greater dissatisfaction with their overall appearance compared with the norm on two body image scales (Sarwer et al., 2000). However, when asked about the specific body part receiving cosmetic surgery, they reported greater dissatisfaction than the normative sample. Thus, cosmetic surgery patients appear to have a specific preoccupation with a particular body part, rather than more generalized body image dissatisfaction (Schofield et al., 2002).

In an in depth study, Kathy Davis (2003) interviewed women pre and post-surgery. The women expressed a wealth of self-loathing comments about their bodies when interviewed

before surgery. Some comments made by surgery candidates included: “I was just a beanpole with two meatballs.” “A pair of sagging knockers.” “Mountains of fat.” “Just two flaps of skin.” Others spoke of shame and cruel remarks from others. Many prefaced their comments with the phrase, “I’m just a housewife” (K. Davis, 2003, p. 159). Cosmetic surgery was seen as a form of oppression at the outset of this research, but Davis could not argue the fact that the women who had procedures done felt a sense of freedom after their surgery was completed.

Implications for Research

Research on cosmetic surgery is a fascinating topic of study encompassing media influence, body image discontent, sociological theory, and humans who are willing to put themselves at risk for the sake of appearing more beautiful to society.

Prior research has demonstrated how advertisers normalize unrealistic body images (Dittrich, 2002; Kilbourne, 1994; Morgan, 1991; Wolf, 1991), and how exposure to these body types lowers self-esteem (Rabak-Wagener et al., 1998). Such studies have become the launching pad for exploration used in the current study, a basis for the formulation of interview questions.

The current research is distinctly different from all other cosmetic surgery inquiry in that parent and adolescent narratives are used to understand the experiences of both parties. No research was found that gathered data from both high-school graduates receiving implants and the mother(s) who paid for the procedure. Interviewing young women and their parents about the gifting of breast implants helps us discover why parents are willing to allow their children to undergo pain and possible complications in order to change perceptions, even if only their own. Since little is known about the social phenomenon, quantitative measures could not be gathered. Therefore, narrative analysis was used to uncover the whole experience of subjects, as they wished the experience to be known.

CHAPTER 3

METHODOLOGY

The human tendency to create narratives or stories about everyday experiences allows for the preservation of events in the past. Significant, memorable, and emotional events often retold make sense of an ever changing world (Murray, 2003). Such storytelling in research gives subjects the ability to articulate their own story the way they wish for it to be heard. Adolescents and mothers narratives in this study aim not to reveal what they ‘really’ think, but how they bring to life a version of their own surgical experience, why they chose breast implants, and why their parent(s) paid for them. The purpose of this research is to demonstrate through sociological theory how the interviewees made sense of the desire and attainment of breast implants for graduation.

This chapter addresses the appropriateness of qualitative analysis and why the study necessitates the narrative approach. Reliability and validity within narrative research will be examined. Sources of data, data collection strategies, and sample size will be outlined. Lastly, ethical safeguards and the method of analysis will be presented.

Why Qualitative Analysis Was Appropriate

The current research employed a qualitative design in order to capture the experiences and decision making processes of those giving and receiving breast implants for graduation. The purpose of this qualitative approach was to explore new terrain where variables were not easily identifiable and to offer a comprehensive summary of the event in everyday terms. A literature search conducted using EBSCOhost, ProQuest, SIRS Knowledge Source, and Lexi Nexis Academic with the keywords “teen breast implants” revealed most entries focus on marketing surgery to young patients, weight concerns among youth, reconstructive surgical procedures

available, and the Barbie Doll. The literature surrounding the gifting of breast implants for graduation is absent from major sociological journals and texts.

Following the guidelines presented by Creswell (1998), a qualitative method was appropriate for this study because: (1) the topic of gifting breast implants needed to be explored, (2) available theories were applied in a new fashion to explain the behavior of both parents who made the gift of breast augmentation and the young women who received it, and (3) there existed a need to present a detailed view of the topic.

In summary, because the literature was limited regarding the gifting of implants for graduation and no existing measures were available for cosmetic surgery among teens, qualitative research was used to illuminate the world of cosmetic surgery among youth and help us understand this new trend of gifting surgery.

The Narrative Approach

A narrative of personal experience reports a sequence of events entering the biography of the speaker (Labov, 1997). They are privileged forms of discourse that play a role in almost every conversation. Narratives in the social sciences may be defined as discourse with clear sequential order that connect events in a meaningful way for a definite audience often used to analyze causal understanding (Hinchman & Hinchman, 1997). The chronology of events distinguishes it from mere description by linking a prior choice or event to a subsequent one.

Narratives empower research participants and allow them to determine the most important themes in an area of research. The telling of a personal narrative aids in the development of one's sense of self (Mishler, 1995). The theoretical basis for using narrative analysis in sociological research is two decades strong. In *Research Interviewing: Context and Narrative*, Mishler (1986) argues that paying attention to the stories that respondents tell

potentially leads to a radical re-examination of the standard practices typically followed in qualitative interview research. He emphasizes the need to understand that the subject and the researcher jointly construct the interview. The whole conversation remains key not the tendency to suppress stories in the analysis phase of research.

Holstein and Gubrium (1995), in *The Active Interview*, also focus on the interaction between the interviewer and interviewee as central to in-depth interviewing. They discuss how conventional interviewing techniques often treat respondents as passive and argue that the aim of an interview should be to stimulate the subjects' interpretive capacities.

Ferber (2000) asserts that narratives do not merely reflect experience, they give meaning to it. In the re-telling of a life experience in the form of a narrative, an individual is forced to reflect on those experiences most readily remembered. It is this process of making sense out of experience that makes narratives different from and better than structured interviews. Thus to gain a better understanding of the world of women (youth and mothers) who underwent or paid for breast augmentation surgery, using narrative will shift responsibility to the subjects (Chase, 1995).

Reliability and Validity

Qualitative research often struggles with issues of reliability and validity (Heppner, Kivlighan, & Wampold, 1999; Hill, Thompson, & Williams, 1997; Lincoln & Denzin, 1998; Merriam, 2001). While reliability is generally defined as stability of research findings, validity refers to the ability of research to measure the concepts of interest (Elliott, 2005). Becker (1996) argues that because these terms originate in quantitative methods, they are less appropriate for evaluating qualitative research. Measuring is not the main aim of the narrative, but the providing of a detailed descriptive account of the experiences of respondents in a study is.

In an effort to overcome reliability concerns, the narratives in this study were tape recorded, analyzed and then analyzed again by another sociologist experienced in narrative analysis. Between consecutive interviews the two researchers discussed the materials to ensure that all possible questions were addressed. The comments by the sociologist not conducting the interviews were valuable in providing a more detached and objective view of the conversation.

Validity is often epitomized by the question, “Are we measuring what we think we are measuring?” (Kerlinger, 1973). While internal validity refers to the ability to produce results that are not simply a product of the research design but a measurement of truth, external validity is a measure of how far the findings relating to a particular sample are generalized to the broad population. Since this study used convenience sampling, generalization is done with caution.

Heppner et al. (1999) adds that validity can be discovered by viewing how participants are changed by the study. The nature of discussing a topic in depth can alter perspectives, offer opportunities for growth, and spur action. It is the intention of this investigator to culminate this deeper critical thought and perhaps alter perceptions related to the gifting of breast implants not only from the storytellers, but from future audience members.

Numerous ways of ensuring the verification of this study’s results included the use of multiple theories, member checks, and peer examination. Multiple theories helped to check the verifiability of this research. Also, the transcripts were viewed by the subjects, and all of them approved the accuracy of the information. In addition, I had several meetings with the sociologist experienced in narrative analysis, and through these we compared the results of the findings and ultimately arrived at consensus through much debate. Truthfulness and authenticity in this study further emerged when the details of the daughter’s stories were compared with those of the

mother's, and again when government tax appraisal data was used to verify portions of the stories related to social class (see Appendix A).

Other methods of ensuring validity included the guidance from key individuals who contributed to this study. After drafting the questions for the interviews, four key individuals assessed the questions (see Appendix B) to ensure that they were representative of all theoretical paradigms in this study. Three of the reviewers held Ph.D. degrees in Sociology, and one a Ph.D. in Psychology. All provided feedback was used to alter questions into their final state. This included adding questions about social class, place of residence, types of activities in which participants engaged, toys played with as a child, and definitions of beauty.

In addition, another sociologist and a psychologist read the transcripts and provided their feedback in the form of a discussion group after all data were collected. The psychologist had an M.A. in Sociology and a Ph.D. in Psychology, and the other his M.A. in Sociology. After individual readings of the transcripts, all parties compared findings and debated differences until reaching agreement.

Sources of Data

In this qualitative study, participants were selected by means of purposeful sampling, for their ability to provide information about breast implants. Trends within the ASPS data that were most striking provided a basis for interview sample selection. For example, data revealed that most breast augmentation surgeries had been performed on Caucasian women, upper-middle class, ages 19 to 34 (ASAPS, 1997–2007), and the majority of breast implant gifting occurred in Texas and Florida (Springen, 2004). Those who had been declared information rich for the purposes of this study were women ages 18-35 in the state of Texas who have received breast implants for graduation. Only mothers were asked to participate in the study because they too

may have undergone breast augmentation. For mothers who had not undergone breast augmentation surgery themselves, perhaps the gift was motivated by their own unmet desires.

Recruitment was a tedious and time-consuming task. Recruitment efforts included posting of an IRB approved flier (see Appendix C) on Implants for Graduation.com, on Facebook.com, in the *Community News*, *The Fort Worth Star Telegram*, Craig's List, a Sorority website, the UNT Psych Research Pool, and at Tarrant County Community College Northeast campus. The flier was also hand delivered to a surgeon's office in Fort Worth, and numerous classroom announcements were made (see Appendix D).

Six subjects were recruited through classroom announcements, two through Facebook.com, and two through Tarrant County College fliers. None were recruited through snowball sampling techniques or any of the other postings. Eleven days after initial recruitment, the first mother-daughter pair were interviewed. Twenty-two days after recruitment began two other pairs were interviewed as well. The other subjects were not recruited for another 45 days, and total recruitment time was 72 days.

Each participant who answered a recruitment ad was asked if they indeed had received implants for graduation, if they lived in Texas, and if their mothers would also be willing to be interviewed. For consistency purposes, only those subjects who could be paired as mother/daughter and who both resided in Texas were included in this study. Seven interview subjects were identified as "problem" subjects, either non-paired or not qualified for the study. For example, one daughter revealed half-way through an interview that she paid for her own implants after graduating from nursing school.

Each subject was contacted by phone or through email to determine participation ability and to discuss the estimated time commitment, the use of audio taping, and the purpose of the

research. The women were all asked to participate on a voluntary basis and were told they would receive no monetary compensation.

A total of 20 interviews were conducted; 10 daughters who had already had breast augmentation surgery and their 10 mothers. The daughters were all Texas residents who had received breast implants as a graduation gift from their parent(s) or in two instances, from their grandmother(s). The participants lived in nine cities in North Central Texas. Several of the daughters were living away on college campuses and were interviewed while home visiting family members.

Procedures for Data Collection

I had planned to conduct all interviews in the subjects' homes but quickly realized they were not comfortable with a complete stranger coming into their residence. I then conducted all interviews wherever it was most convenient for the subject, asking them to select the location. Five interviews were conducted at coffee-houses, one in a vehicle, five in my faculty office, seven in homes, and two at a day spa center. Of those homes that I did not visit, I collected their primary residence address so that I could then look up the property value of the residence within the Tax Appraisal District database (see Appendix A). This reference aided the verification of social class.

Sample Size

One goal of qualitative research is to increase understanding of a phenomenon as opposed to generalizing data extrapolated from the sample to the population at large (Byrne, 2001). In this narrative analysis, a minimum number of subjects who offered a maximum amount of information was considered ideal. The important point was to describe the meaning of a small

number of individuals who have experienced the phenomenon of implant surgery (Creswell, 1998).

The sample size in this study included 10 high-school graduates receiving implants as a gift and their 10 mothers. This small sample size was critical for several reasons:

- (1) The topic is so new that it was very difficult to locate participants.
- (2) The topic is of a sensitive nature, and therefore participation was limited.
- (3) It was difficult to find paired daughters and mothers willing to participate.
- (4) Limited narratives allowed for similarities and differences to be discovered among the participants without generating an overwhelming amount of data.

Data Collection Strategies

I conducted semi-structured interviews, encouraging as much narrative response as possible (see Appendix B). The instrument was used as a flexible guide for the researcher. When a subject's response fit a question that was located anywhere on the instrument the researcher then asked that relevant question next. This allowed for a comfortable conversation to emerge, one that would encourage narrative. The researcher could respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic (Merriam, 2001).

A semi-structured interview approach was the method used for questioning all research participants (see Appendix B). While the subjects were responsible for producing the narrative, I demonstrated that the story had been understood, that I had listened. This was done through non-verbal cues, short responses like "Yes, I see," or back channel utterances such as 'sure', or 'hmm', and by asking additional questions (Mishler, 1986).

Participants ranged in age from 19 to 61, with a mean age for mothers of 50 and a mean age for daughters of 21. Of the 10 mothers, 6 were married and 4 were divorced. Of the 10

daughters, only one was married, all others were single. Only one of the daughters had children, but all others planned to in the future. Sixteen of the participants self-identified as Caucasian, and four as Hispanic. The most predominant religions identified in the study were Non-Denominational Christian and Baptist, with one mother-daughter pair identifying as Jewish. Mothers education included high school graduate ($n = 6$), Technical Degree ($n = 1$), Bachelor's Degree ($n = 2$), and Master's Degree ($n = 1$). Daughters education included Technical Degree ($n = 2$), Sophomore in College ($n = 3$), Junior in College ($n = 4$), and Master's Degree ($n = 1$). Mothers employment included not currently employed ($n = 2$) and currently employed ($n = 8$). Daughters employment included not currently employed ($n = 2$) and currently employed ($n = 8$) with incomes ranging from \$100 to \$3600 per month. Daughters self-reported socioeconomic status as follows: Upper ($n = 2$), Upper-Middle ($n = 3$), and Middle ($n = 5$). Mothers self-reported socioeconomic status as follows: Upper ($n = 1$), Upper-Middle ($n = 5$), and Middle ($n = 4$). Using the tax appraisal database, primary residence property values ranged in value from \$91,900 to \$235,400 (see Appendix A).

Ethical Safeguards

Although participants reflected upon the experience of undergoing breast augmentation in a manner they may have not been required to do before this study, none of them really showed any distress. Subjects were prompted to reflect on areas of their lives that they may not have thought about before. Once interviewees were given the space to provide stories about their surgical experience, unexpected distress did not emerge.

On the contrary, some subjects reported to have benefited from being given the opportunity to reflect on and talk about their lives with a good listener. Narrative analysis in this research may have facilitated empathy since it provided a form of communication in which

individuals externalized their feelings and indicated which elements of those experiences were most significant (Elliott, 2005).

All interviews were conducted in accordance with the University of North Texas Institutional Review Board, (IRB) policies. All subjects signed a consent form with stamped IRB approval (see Appendix E). Anonymity was ensured through the assignment of a pseudonym for each respondent (see Appendix F). Confidentiality of research records was achieved as names were not used at any time during the interview process. The interviews of all daughters were conducted in private, away from the mothers, and vice versa. Audio tapes were securely stored in a separate location, apart from the research documents. All data will be used for the purposes of research only.

Summary

In the end, by allowing daughters and their mothers an opportunity to tell their own stories and by creating a context in which they felt comfortable exploring their feelings and experiences, I was able to learn more about those factors influencing the gifting of breast implant surgery. The aim has been to listen to the stories of young women who felt such cultural pressure that they and their mother(s) were willing to undergo surgery in order to conform to the cultural ideals of beauty.

CHAPTER 4

UNDERSTANDING THROUGH SOCIOLOGICAL PARADIGMS

Seven theoretical paradigms illuminate why some women ask for breast implants for graduation, and why parents pay for them. Symbolic interactionist theory, social construction of reality theory, conspicuous consumption theory, reference group theory, social comparison theory, self-discrepancy theory, and feminist theory attempt to explain why some women have internalized Western beauty ideals enough to surgically alter their bodies.

Symbolic Interaction Theory

Full breasts are a powerful symbol in American culture. They have developed into a representation of sexuality, femininity, maturity, and worth. Choosing to adopt the “ideal look” in society would be natural, according to Erving Goffman, if one wishes to impress his or her audience members (Goffman, 1959). Symbolic interaction theory as a tool allows a view into how women metaphorically change costumes backstage in an effort to alter perceptions when they arrive in the front stage. Cotton padding, filled water bras, and implant surgery occurs in the backstage area. Efforts made backstage allow for women to believe, in their own minds, that they are perceived as beautiful, well-endowed, and valuable to society.

Symbolic interaction theory allows a contrast of backstage practices to front stage behaviors found in the interview narratives. First, the daughters padding practices will be explored. Then, moving to the front stage area, the women will describe how their audience couldn't even tell they had surgery. Their efforts to move from external cotton padding to internal surgical padding seamlessly and convincingly occurred.

Most of the daughters in the narratives told stories of “faking” the appearance of large breasts prior to implant surgery. To achieve the desired look, they used heavy cotton padding,

water bras, or multiple bras. Some sewed shoulder pads into their bra cups; others sewed darts into their shirts. These secret efforts to manage impressions were hidden in some cases from friends and boyfriends.

Evidence of this metaphorical backstage to front stage transition was exemplified in Annie's¹ description of her costume change:

I mean people would see me, and they would think I had boobs just cuz of the bra; but, I really didn't.

In accordance with Goffman's theory, Sheryl's efforts made backstage allowed her to believe she was perceived as well-endowed:

All through high-school I wore padded bras, and I made it look realistic, and then they're like, 'Oh, I didn't even know you needed surgery.'

From removable external padding to surgical internal padding, the transition was undetectable according to some women. One of the participants mother's stated:

Traci covered her issue that she did not have babushkas (breasts) well. She dressed, she fixed, you would never know.

Further evidence of faking out the audience is seen in Sandy's statement regarding her daughter, Jane:

You know I think a lot of people don't know, just because we did it in between high-school and college. So unless you knew her when you went to high-school, there's really not a change.

Additional support for Goffman's claim that one wishes to convince their audience that they are valuable to society, i.e., well-endowed, is found in Sheila's description of how Stephanie has convinced her audience that she has always been well-endowed:

The people she is dealing with now, unless she came right out and told them, they have no clue she had her boobs enlarged.

¹ Names in this study are not real names of subjects; rather, they are pseudonyms.

All of these women made extreme efforts to conceal their true appearance in the backstage to manage how they appeared on the front stage and to create the desired impression. With the growing availability of breast augmentation surgery, more and more women now have the option to permanently alter their breast sizes to change the body they display to audience members.

Another Symbolic interactionist theory, Cooley's looking-glass self, can also explain some of the behaviors in this study. According to Cooley, one's body image reflection may involve three principal elements: the imagination of one's appearance to the other person; the imagination of his or her judgment of that appearance; and some sort of self-feeling, such as pride or mortification in return. The imagined judgment is quite essential. We often imagine, and in imagining, share the judgments of the other mind (Cooley, 1902/1964). Cooley determined that internal thinking involves silent imaginary conversation within one's mind. The assumption arises that one's own level of attractiveness depends on the interpretation of others' perceptions. One who feels unattractive to others or to herself and has the financial means to change her appearance may have private mental conversations leading to cosmetic surgery (Didie & Sarwer, 2003). The daughters' narratives support this practice of reflective judgment. They used imaginary perceptions to critique their own appearance.

The first of the elements in Cooley's looking glass self asks, "How do I think you see me?" Amber answers this by saying:

I know that I'm better than the average person you see shopping at Wal-Mart, but not as good as the girl shopping at Abercrombie. You know, it's all relative. I think I'm real cute for a mom, but if I had to go on a date or something, I'd be real worried.

Carol explains what she thinks others think of her appearance:

I'm thinking they are probably thinking I still have a really flat chest....

The second stage of Cooley's self reflection involves the imagination of the onlooker's judgment of one's appearance. Kim's imagination comes to life in the following excerpt:

I would just think, oh gosh, next to somebody else I would say, 'Wow – it'd be nice to have my body look like that in a bathing suit.' Just like, 'That sucks! That's not fair! I got the short end of the stick genetically!' You think people don't like the way you look or they look at you and say stuff about you...

Amber, on the other hand, imagines others judgments of her appearance as ambivalent:

Well, you know, like when you go out with a zit on your face or something, you think everyone else notices. Really they don't. Even if they do, they don't care. It's like boobs. I don't think anyone else really notices, unless they're huge or hanging out or something.

As a result of these imaginary judgments, according to Cooley, in the end one experiences some sort of self-feeling, such as pride or mortification. One can sense the pride in Susan's comment:

...The way I feel when I look at myself. Like look at myself in a mirror. Like my figure. Like you know, if you feel good about yourself when you go out in public, it makes you feel good around others and have a good time.

Jennifer feels proud now that she has had augmentation surgery:

I'm confident in what I wear. I don't lack confidence because of my chest anymore. I don't let my lack of confidence hold me back anymore.

Traci's comment illustrates the other aspect, mortification:

Um, there are times I look at myself and I'm like uh, I look like crap!

We see in the previous comments Cooley's three elements of the looking glass self – imagining one's appearance from another person's perspective, imaging his or her judgment of that appearance, and feeling something in return.

The last symbolic interactionist theory, George Herbert Mead's imaginative role-play, helps us understand how the daughters "me" emerged and then engaged in role-play practices.

Annie's behavior reflects Mead's theory of identifying her "me" through social interaction:

I guess seeing pictures of other girls who have boobs in magazines, I just wanted them. The way they look right here (she touches her breast bone), cleavage, I like that.

Annie, after she had interacted with people over time (pictures of other girls in magazines) saw herself as less than those women depicted. Some of the daughters then went through a rehearsal process that can be called role-play. They had this imaginary self that they created having the perfect breasts. This role-play was illustrated by Jane in the comment below when talking about her surgery:

I went in and showed them pictures of what I wanted, what I didn't want, you know. I did not want to be too big, that was my biggest thing. I wanted to look natural. And so I took pictures in and he (the surgeon) gave me some implants to wear underneath my shirt to see how I liked the size. He gave me a 375cc, which is like 375 tablespoons and that, was pretty much the equivalent to a full C cup. And I liked that one, I thought it was great, so we were gonna go with that.

Another woman went through great lengths to ensure the imaginary self corresponded to the imaginary "me" by doing certain things. Annie talked about the way the "me" felt disguising her small breasts:

When we had bathing suits, mom used to put stuff in 'em, and then sew it. Yeah shoulder pads. She put those in once. And then that worked, extra padding.

All of the women above illustrated George Herbert Mead's imaginative role-playing techniques. The women altered their real self that they learned not to like through social interaction, and through role-play they imagined having larger breasts in various situations and ultimately liked that better. Their role-playing techniques allowed them to transition smoothly from practicing with breasts to actually having them.

In conclusion, symbolic interaction theory allows an understanding of why the daughters reported they felt better after surgery when they no longer had to "fake" the appearance of large breasts. They no longer needed to use the original routine of backstage padding before their front stage appearances. The augmented self then became the version of the self they always tried to

present. Interestingly, padded bras made of cotton were replaced with saline implants. Although both are false, to each woman the implant made her more authentic in her own mind.

Social Construction of Reality Theory

The social construction of reality paradigm allows an analysis of the efforts taken to construct gender by examining the behavior of mothers and daughters prior to surgery itself. Gender construction creates the social differences that define “woman” and “man.” In social interaction throughout life, humans learn others’ expectations and act and react in accordance, maintaining the gender order (Lorber, 1994). As eloquently stated by Simone de Beauvoir (1953), “One is not born, but rather becomes, a woman” (p. 267). The mothers in this study often referred to their daughters in a pre-surgery state as though they had something physically wrong with them. They were not whole, missing something, immature, not feminine, and they looked like “boys.” Sammie explained why she thought her daughter’s flat breasts kept her from dating:

Susan wasn’t dating; the guys were all her friends, just her friends. So at some point you have to wonder if they just stay friends all the time because she was flat chested like one of them. At some point does she get to become a young lady? Which is sad to say but it’s almost like if she doesn’t have boobs then the guys would never see her as more than just a buddy which is what she was.

Not only were the mothers influenced by the social construction of gender, but the daughters as well. The daughters willingly underwent elective surgery in order to obtain larger breasts, those that would be clearly identified as womanly, separate and distinct from manly. Since these women lacked genetic endowment, they used surgical tools available in their social environment to construct large breasts. Through the portrayal of the daughter’s surgical narratives, one can see how the young women actively took part in “doing gender.” As illustrated in the following comments, many of the subjects talked about altering their boyish image, becoming more beautiful and feminine.

Jennifer, describing how she asked her parents for augmentation for graduation, stated:

It came down like I told him (her father). I was flat like an 8 year old boy. And it's not something that bothered him, it bothered me. To the point that I was wearing two padded bras when I was in middle school.

Although another respondent, Jane, didn't specifically say she looked like a boy, the social construction of what a woman should look like taught her she was deficient:

I was not happy with how I looked. I wasn't comfortable. I didn't feel like a woman. I felt like a 13 year old girl and they (breasts) weren't gonna get any bigger. And I was not in a comfortable, I was not comfortable at all. I dunno, I just wasn't comfortable. When you are so small, it doesn't make you feel like a woman.

Sheryl described how she didn't feel beautiful prior to surgery, but talking about her post-surgery image stated:

I am able now to look in the mirror and say you know, I am a pretty girl! I am a beautiful girl. I can say that. I used to not be able to say that.

Social construction of reality theory clearly weaves through the comments above. The women underwent augmentation surgery to appear as feminine, grown women. The daughters, maintaining the gender order, became society's constructed definition of "woman" after surgery.

Conspicuous Consumption Theory

Conspicuous consumption may be defined as people wasting resources just to display status. The fact that individuals can waste time or money demonstrates that they have moved beyond mere survival. According to Thorstein Veblen's (1899) theory of conspicuous consumption, the earliest stages of societal economic development were marked by members who survived by consuming all of the goods they produced. With the development of the industrial system and private ownership, members of society established class through the accumulation of wealth. As wealth continued to accumulate, a leisure class emerged with more

and more differentiation. Leisure class members not only consumed more than needed for survival, but they consumed discriminately, with fine taste and affection for quality.

This conspicuous leisure class exists in the present time, with upper class members displaying status through tastes for fine art and high fashion – those objects that have no inherent economic value. With the emergence of the middle class in the 20th century, the term “conspicuous consumption” can be applied to those with expendable income whose spending was prompted by status rather than survival.

All of the women in this study belonged to what may be defined as a modern day leisure class, based on Veblen’s definition. The average value of the homes among all subjects in this study was \$159,321. Some drove luxury vehicles such as Lexus, BMW, and Mercedes; others drove SUVs and Sedans. The parents paid an average of \$1441.00 per month towards the daughters living expenses (see Appendix G). This leisure status afforded the parents to pay for not only their daughters living expenses, but their breast augmentation surgery as well.

As the level of consumption necessary to be conspicuous becomes more readily available, people may want to demonstrate that they have a high quality of life and a personal style through the purchase of cosmetic surgery. With the production of not only goods, but now image, consumers can purchase representations of those body parts of others who are iconic. The breast shape and size of the rich and famous can now be bought and sold as a consumer good. Some of the women talked about how their decision to get breast augmentation surgery was influenced by media icons, models, and revered groups in society.

Kim describes why women feel large breasts give them desired status:

I would think the media, I mean it’s just so, so like stereotypical of what a perfect woman is. You know, big boobs, really skinny, looks like specific celebrities, models and everything. It’s about diets, no carbs, no this and that. You know, everything in a magazine, everything on TV, you know everyone is beautiful. I mean if everybody was

fat and had no boobs then I probably wouldn't have wanted them, but if that's the way we grew up, the society you grow up in, you want to look a specific way. Like you would like to have a small waist with a bigger chest. I mean I'm sure that's our American culture in general.

Amber's description of Angelina Jolie brings to focus a description of this American standard of beauty:

I like Angelina because I think she is the most beautiful woman. She's Amazon tall, gorgeous hair, and big lips. Looks like she just crawled out of bed and had every hair fall perfectly into this mess of dreaminess. And she has kids hanging all over her. She lets the rest of us know how bad we suck.

Jessica Biel, to Annie, represents the model image she would like to emulate:

I like Jessica Biel. She's pretty, and I just like how she is.

The word "perfect" is used by Jennifer in her description of Jessica Simpson:

She's perfect...she stand out. She doesn't look trashy.

As Veblen described in his theory, rich people who display their wealth often receive acknowledgement. When something is valued, those who can afford it often purchase it. These women who value revered or beautiful women may not be rich, but they can enhance their status through the acquisition of large breasts. Further, those women who augment their breasts may "flash" them to others as the ultimate display of conspicuous consumption.

Linda describes how the attainment of larger breasts has brought her daughter, Kim, esteem and admiration by men especially:

She has on occasion gone places with me, with like the little spaghetti strap top that she really shouldn't have been wearing. We were in a restaurant once and men just kept ogling her. We were in the grocery store once and the same thing. There were these firefighters that were trying to see over the aisle and look at her...

It is important to note here that Kim isn't wearing the spaghetti strap innocently, she wants to make sure her breasts are visible, admired, and can enhance her status. The flashing of breasts demonstrates that their chests are augmented, they can afford to buy them, and they have

moved far beyond survival needs to purchase them. However, in other cases, loved ones may be worried about the effects of flashing.

Kim's boyfriend didn't want her to have breast augmentation because he feared she would flash them for attention:

I don't think he liked the idea of me going off to college and have what he thought were going to be like giant fake boobs. To show them off, he thought I was doing it to attract other people.

The American leisure class no longer seems content with hoarding quality goods; they now strive to become the good itself. With the basic survival needs cared for and the time and money to spend on status symbols - conspicuous consumption makes sense. Having large breasts can be considered conspicuous consumption in America because American society gives people with large breasts high status. Cosmetic surgery is a form of consumption, and what could be more conspicuous than flashing breast implants?

Reference Group Theory, Social Comparison Theory, and Self-Discrepancy Theory

In both sociological and psychological disciplines several theories relate to how groups influence the attitudes and behavior of individuals: reference group theory, social comparison theory, and self-discrepancy theory. Reference group theory provides a way to understand how women may be influenced through comparisons with significant others, and social comparison theory provides a way to understand how women often compare themselves to media icons. Self-discrepancy theory notes that when women compare themselves with idealized media images, this may result in body image dissatisfaction. Women in this research study use others as yardsticks to evaluate their own beauty. In each of the narratives, the women made realistic comparisons using relatives or friends and idealistic comparisons using media icons. This portion of the chapter portrays women's comparisons with significant others, and then delineates those

comparisons made to media icons. Lastly this portion illuminates the subjects' own definitions of beauty, and whether or not they felt they measured up to those standards.

The first theory to be addressed, reference group theory, explains how reference groups give individuals a basis for comparing themselves to others and provides a sort of yardstick allowing one to measure how they “stack up” relevant to some standard. According to research, how people stack up against the group with which they most often compare themselves enormously impacts their behavior. Using reference group theory allows a better understanding of how women may be influenced by comparisons with significant others.

In this research study, each of the daughters described the reference groups they felt played a role in their decision to undergo breast augmentation. These reference groups included coworkers, close friends, and fellow sorority sisters. Sheryl used her coworkers as a “yard-stick,” comparing her breasts to those of the women she worked with:

A couple of girls I've worked with, actually there were 2 girls there that had boob jobs. And then my boss did. They talked about how I would like it (breast augmentation) and I would be happy. They gave me advice.

More than co-workers, peers and friends seemed to represent the most common reference group among the women in this study. The article “More Girls Getting Implants” (2004) supports the notion that some youth feel pressure to keep up with their peers. The peers of the daughters in this research included those friends they had known for at least 1 year that they regularly socialize with. The participants created a mental image of what their friends look like physically. For instance, Annie describing her experiences with her peers since junior high commented:

Uh, well it's been going on like, since I was in junior-high. When am I gonna get boobs? ...Oh, like, how the girls have been developing and I haven't. Like when you wear a sports bra and go and change, I didn't have anything.

Susan reveres her sorority sisters and feels she has to compete with them:

...Like so many sorority girls, like the ones I hang out with. They are like really thin and like pretty. So, I feel like I have to compete with that.

In other cases, the respondents described their sorority sisters and how breast augmentation was popular within the sorority house. The respondents recognized that breast augmentation was common within this reference group, something one has done if “needed.”

Jane described how augmentation seemed common among all the girls she was around:

All the people that I was around, I felt like it (breast augmentation) was socially acceptable. It wasn't really like, ‘Oh my God – you're gonna get that done?’ I think everybody who had to get it done would have done it.

Reference group theory allows for an understanding of how the women in this study took note of their close friend's body structure, weight, and breast size. Using friends as a tool for comparing how they themselves ranked, many girls acknowledged that their bodies were not as attractive as their friend's. Those in the study who belonged to sororities came to view breast augmentation as common, regular, and “no big deal.”

The second paradigm, Festinger's social comparison theory, proposes that comparison with others often occurs in order to fulfill the basic human drive for self-evaluation (Festinger, 1954). People compare themselves to those who are more beautiful than themselves (Engeln-Maddox, 2005) in an effort to gain valuable information in order to improve themselves. In other words, if one compares her own attractiveness to that of a magazine icon, she can gain valuable information about becoming more beautiful. Icons of beauty have inspired women to pursue cosmetic medical treatments for decades (Sarwer et al., 2004). The mass media industry contributes to the increasing popularity of cosmetic procedures, portraying to the world that which is considered “attractive.” The media constantly offer and advertise the latest “body” as a consumable and attainable asset, which has subsequently led to the mass expansion of the

cosmetic surgery industry. All of the women in this study described how they compared themselves to their favorite celebrities, magazines, favorite television stars, and toys they played with as children.

Social comparison theory explains how women compare themselves to those who they think are more beautiful than themselves in the media in an effort to improve their own attractiveness. Some daughters in this study compared their own beauty to Eva Longoria and Angelina Jolie. Susan said she admired Eva Longoria because she resembled her:

My favorite one (celebrity) would be Eva Longoria because I resemble her, but like she's perfect. She is umm just physically fit. She's not too curvy, yet not thin. Her beautiful complexion that is just, healthy, big full hair. Her face structure and lips, very pretty.

Amber, talking about how she feels comparing herself to Angelina Jolie reported:

I like Angelina because I think she is the most beautiful woman. She's Amazon tall, gorgeous hair, and big lips. Looks like she just crawled out of bed and had every hair fall perfectly into this mess of dreaminess. And she has kids hanging all over her. She lets the rest of us know how bad we suck.

Like they did with celebrities, the women in this study used magazines to evaluate their own appearance and gain information that would allow them to improve themselves. The daughters talked about their favorite magazines, and how these subscriptions offered useful advice and beauty tips.

In some cases, the daughters had to convince their parents about their 'abnormal' chests by showing them magazines. By showing them magazines, they illustrated what 'normal' breasts looked like to them. A mother talking about how a daughter convinced her to have surgery reported:

Well she started talking about it when she was 16. She brought it to my attention a lot. She would bring me magazines and show me pictures in magazines. Stuff like that.

In other cases, the daughters talked about their favorite magazines and how these subscriptions offered them advice and beauty tips. For instance, Annie reads *Cosmo* for beauty advice:

Cosmo. I like to read all the stuff that they have, the advice and what to do. I dunno I just like that magazine (giggle).

Also, television programs continually reinforce the notion of the 'ideal' body; a body that is slim, fit, and beautiful. Breast augmentation depicted on television in reality shows on MTV and ABC normalize plastic surgery and eliminate the stigma that used to surround procedures. All of the daughters in this research were asked to discuss their favorite shows. Many of them described “reality” TV shows and others known to be filled with ideal beauty types.

Sheryl’s favorite TV shows on MTV normalize cosmetic surgery:

I usually just watch reality tv shows, I watch pretty much every single reality TV show you can think of, *The Hills*, *America’s Next Top Model*, *Beauty and the Geek*, everything. I love ‘em all.

Traci described her favorite reality shows as well:

Um, yeah, stupid shows like *The Hills*, *One Tree Hill*, um, what else do I like? *Life of Ryan*.

Not only were the women questioned about celebrities, magazines and television, but about favorite toys they had as children. Festinger’s social comparison theory revolves around iconic comparison. The Barbie Doll in America represents the most iconic toy figure available to young women (Lord, 2004). The daughters all remembered playing with Barbie. Robin explained why her Barbie was “cool:”

My favorite Barbie was the one that had long blonde hair, she was tan, her hair was down to her ankles, ya know, cool Barbie.

Amber clearly remembered her experiences with Barbie as a child:

I can remember playing with Barbies, their clothes and that super huge cool yellow camper. (Laughter). I was an only child, so I had to be pretty imaginative. My Barbies had an awesome time!

It is clear that the daughters in this research have been immersed in American culture, comparing themselves to beautiful women they find in magazines, television, and in the toy store. The breast augmentation normalized in the media did in fact influence the women who compared themselves to those they considered more beautiful.

The final theory to be addressed in this section of the chapter, Duval and Wickland's self-discrepancy theory, postulates that such unhealthy comparisons made between the actual self and the ideal self found in the media can lead one to become increasingly dissatisfied with their appearance. Researchers report that social comparisons are likely to result in negative feelings (Engeln-Maddox, 2005) that can lead to cosmetic surgery (K. Davis, 2003).

All women in this research explained what beautiful meant to them, and then described why they thought they were or were not beautiful themselves. Using their own definitions of beauty, they described their imperfections, how they had "good days" and "bad days," they were too tall or too heavy, how they planned to have more surgery in the future, or how they were just not beautiful. When Annie was asked to describe a beautiful woman, she outlined her concept of beauty and then described why she felt she did not match that definition:

Athletic looking or built. Just athletic looking. Brown or blonde hair. Like Jessica Biel, she has brown hair. I think she has like blue eyes, pretty lips, and a little nose, and she is athletic built. (Do you think you are beautiful?) No. Because, like the way my clothes fit, I know I need to lose weight you know? That doesn't make anything better. You always want to wear baggy clothes kinda, like the ones with a drawstring on it. I don't look like a person I would say was beautiful. They're really like beautiful ya know? I don't know. I think Jessica Biel is beautiful, she's pretty. I'm not anything like her. The way she looks. I dunno, like the way she looks and everything. I mean, she's built, ya know? She can go wear a little tube top and feel confident, comfortable in it and stuff.

Carol's self-discrepancy is evident in her comparison to Jessica Simpson:

A beautiful woman would look like, not athletic where they're overly built, but not really skinny. I don't like skinny girls, and I don't like fat girls. Sandra Bullock or Jessica Simpson minus the boobs. They're huge. Too big, they need to go smaller. Somebody that has nice abs and toned legs toned arms and shoulders. (Do you think you are beautiful?) Looks wise there is a lot of things I still would change. My stomach. I don't like it. It hangs over my jeans. Even though I'm not heavy or fat, it's just not, and I have bird legs and I don't like that.

Susan doesn't compare herself with any one particular person in the media, but is dissatisfied with her body:

(How would you describe a beautiful woman?) Good complexion, doesn't have to be tan but not broke out. Acne isn't very attractive. A pretty smile. Good teeth have a lot to do with a person's smile so, good teeth, whiter teeth. Normally a physically fit person is more attractive than one that is overweight. The hair - whatever looks goods on that person, just healthy, not damaged. No caked on makeup, messy hair. Just someone who is nice to look at. (Do you think you are beautiful?) I don't have a perfect body but like I don't have a like really disgusting like misshaped, like I have all my limbs...I know I have my flaws like I think my nose is too big, my hips are too fat...

In some ways it is surprising that these women, although they have undergone breast augmentation, still did not feel pretty. They still see a mismatch between how they feel and how they ought to feel as stated in Duval and Wickland's (1972) self-discrepancy theory. Also, in some cases they look at themselves as objects more than as human beings - "stomach hangs over jeans" and "having bird legs," or "nose too big." Undergoing breast augmentation they have tried to reduce the discrepancy between their real self and their ideal self. Now will they still continue reducing this discrepancy in the future with their other body parts since they still don't like their real selves?

It was important to discover just how many other women these participants thought had undergone breast augmentation. Perhaps this would also aid in understanding how they were comparing themselves to the rest of the population. If they felt a large number of women were having surgery, then they might be influenced to have it as well, to reduce discrepancy. Only one underestimated the actual number, all others guessed much higher than the actual number. They

were never told the correct answer during the interview. Since ASPS has been collecting data there have been 1,019,558 breast augmentation surgeries on women aged 18-34 (ASAPS, 1997–2007).

Feminist Theory

In society, the desire for beauty becomes a double-edged sword: a kind of oppression in one sense, and also a way to feel good about oneself when taking the opportunity to appear the way one wishes (Hamburg, 1998). Two competing feminist views pose arguments within cosmetic surgery literature. One sees women who elect to undergo cosmetic surgery as those seeking to become objects of the “male gaze” (Canavan, 2003), and the other argues women who elect to have surgery are merely exercising choice in controlling their own bodies (Gagne & McGaughy, 2002).

The foundation for the first feminist view, that women change their appearance for men’s sake, presents cosmetic surgery as a form of domination exercised by those displaying unrealistic body images in the media, and by those surgeons molding bodies behind closed doors. By undergoing cosmetic surgery, women actively contribute to their own oppression. Women who undergo cosmetic surgery, then, conform to men's notion of beauty and femininity, and those who have breast augmentation specifically unduly tax their bodies in an effort to increase sexual desire (Wolf, 1991).

Breast augmentation may be seen as contributing to the oppression of women in this research in three ways. First, this oppression is evident among those that chose implant surgery in an effort to gain positive attention from men. Second, the women described how their male surgeons chose large implants for them. Third, the daughters said they would gift breast

augmentation surgery to their own daughters in the future. This, in a way, perpetuates the notion of further oppression.

Some of the mothers in this research ambiguously described how they viewed their daughter's implant surgery. Barbara described how the gifting of implants changed her daughter's encounters with men:

I see men when we go places look at Jennifer. Even guys that I work with, when she's been there, kind of flirty, I don't really like that.

However, describing how she feels about her daughter post-surgery she stated:

I wish I had her body. I think that she's fit...I think she's beautiful. I think she's perfect.

Another mother, Vivian, describes how her ex-husband reacted to her daughter's augmented breasts:

...My ex-husband. Oh, he was a pervert anyway so you can image what he thought about them. (Laugh) Well, I can tell you almost verbatim that uh he would talk to his sons about my daughter and he would say oh until you see her she is so hot and he would put his hands up by where boobs would be and he would go (making a nasty sound).

This mother also thought her daughter had become really beautiful. She stated the following when she described her post-surgery:

I think she is really blessed because she has that physical beauty well above average and she also has the inner beauty that I was talking about before and so she's got it all.

It is important to report that only two daughters overtly stated that they did the surgery to attract male attention. Jennifer, for instance, had to be probed several times before admitting the following:

It's a good feeling when someone looks at you and notices you. And I expected that. But I didn't want it in a dirty way. I wanted someone to be, you know, hey she's pretty. It sounds different whenever you're saying she's pretty and she's got huge boobs. That sounds different. But to get more attention but not in a bad way. Positive attention, I don't know how I can say it...To get positive attention from guys. I want girls looking at me and saying I want to look like her.

The notion that men influence women to change their appearance is again evident through the actions of the surgeons performing the surgery. Several of the women in this study described how the input from their plastic surgeons, all male, played a role in choosing the size of their breast implants. Jennifer's surgeon demonstrated excitement when he stretched her skin from an A cup to a D cup:

He went as far as my skin would allow it to stretch. So I think I have 425cc in my left and 415cc or 412cc in my right. He was like, 'What size do you think you are?' I said I don't know am I a B? He said, 'No, no, no you are going to be a C, borderline D!'

Gabrielle described how her daughter's surgeon felt breast augmentation would increase her confidence:

He mentioned to me that Robin had, for her age, even though her breasts were very small, they were a bit saggy. That was probably what was making her self-conscious. So he said that sometimes when you have what are called pendulum type breasts that happens. So he felt that having this procedure would help lift and make her feel more confident about her appearance.

The notion that women actively contribute to oppression is evident through the participants planning to gift implants to their own children in the future. Most of the participants who had undergone breast augmentation said they would gift the surgery to their own daughters in the future. Nine of the 10 said they would gift implants if their daughters needed them. The word "need" was found in almost all of the narratives, and they were sure to explain that if their daughters were an A cup, then they would "need" them and they would gift implants. Annie explains if her daughter were a B or C cup, then she wouldn't consider implants a need and, therefore, would not gift them:

Possibly, it just depends on how she is. How she develops. Why would I say yes? Because I know how I felt after, I would want her to feel the same way if she wanted them. I would say no if she didn't need them. If she was already big enough, ya know, a C or something like that.

Sheryl describes how an A cup would illicit such a gift, but a B cup would not:

Yes if she needed it. If she was a B cup, probably not. I wouldn't condone it if it wasn't necessary or if it wasn't needed I guess. I mean, when I say I felt like I needed it I just felt un-proportioned.

Kim compared breast augmentation to rhinoplasty (nose reshaping) in her explanation of why she would gift implants to a future daughter:

I think it's just like if your kid has like a really big nose or something, like if you're just really self-conscious about it, and you just wanna fix it, not try to over correct anything, to make your self-confidence higher and not make you any different of a person then, yes. If it makes you feel better about yourself than I think it's alright. If they prove to me they deserved it, I mean good grades and everything. I wouldn't just like randomly get it, you know, they have to graduate college or have done something. I wouldn't just do it like when you turn 16 or something.

The daughters described breast augmentation surgery as if it were reconstructive and not cosmetic surgery. The definitions of femininity seem deeply entrenched within the minds of these young women who feel that flat-chested women are defective, needing correction.

The second feminist view, in contrast, argues that women are not being oppressed by the beauty system; they are simply taking control. By investing in the body as an improvement project, women are able to express their sense of identity and increase their control over their bodies. In this sense, women who have cosmetic surgery may do so because it enables them to experience greater self-esteem and confidence.

In this research, many of the daughters viewed augmentation surgery as an act of empowerment. This can be heard in the narratives when the women described how they chose to have implant surgery for themselves, not for any other person. A few of them explained that their boyfriends didn't want them to have surgery, and that they thought their girlfriends were beautiful just the way they were. Three of the daughter's fathers still are unaware that they had augmentation surgery, an obvious indication that the women were not feeling pressure from their

boyfriends or fathers. Some of the women may have undergone breast augmentation just to be empowered, like Traci, who reported the following about why she had breast implants:

I don't know if anything influenced me. Honestly I think it was just something I wanted to do personally for myself. It wasn't necessarily that I wanted other people to look at me, I wanted to feel better about myself.

She also said the following:

I know a ton of strippers who have gotten their boobs done...They said after they got theirs done they were making \$300 or \$400 more.

In other cases, the women went against their boyfriend's advice for not getting implants.

They did it anyway because they wanted to elevate their self-esteem or just wanted to have them done. Kim wanted breast augmentation surgery despite the fact that her friends and boyfriend thought it was unnecessary:

...None of my friends, my boyfriend, nobody was like 'Oh you'd look so much better with bigger boobs.' I just felt like I would be happier with it. My boyfriend didn't want me to get it done. We had talked about it before and he said, 'Well after we get married and you have kids and everything like that, then well, then you get 'em.' I was like no, I want 'em now.

Traci did it for her own self-esteem despite her boyfriend's objection, as an act of empowerment as well:

I think it was just something I wanted to do personally for myself. It wasn't necessarily that I wanted other people to look at me, I wanted to feel better about myself. You know, I mean it's more of a self-esteem thing, if you don't feel good about yourself, you know, then who else would? My boyfriend was not for it really, he didn't understand why I wanted to change myself. He thought I looked fine the way I was. He didn't understand why I needed it. I just kind of explained that's the way, it's not for you or anyone else, it's for me. You know its not, I'm not getting it to get attention. I'm doing it because I don't feel comfortable.

Three mother/daughter pairs kept the surgery hidden from their fathers. Each daughter described how the father was left out of the decision making process because they felt he either

wouldn't want to be concerned with it, or that he wouldn't approve of it. Robin laughed at the fact that her father has no idea she spent his money on her breast augmentation surgery:

Um ha ha! Actually he doesn't know! My dad's kind of in the, doesn't want to know about things mode. He wouldn't want to be a part of it, ya know? This was just a thing between me and my mom.

Sheryl considered herself daddy's little girl, an innocence she'd rather perpetuate:

He (father) doesn't know. I'm daddy's little girl and oh my gosh, he would die! I don't really picture myself telling my dad that I've got implants so I can have bigger boobs. I never thought that that was a conversation that needed to happen.

It became evident in this research rather quickly that the decision to undergo breast augmentation surgery resulted from dissatisfaction with one's personal appearance. Whether motivated to capture the "male gaze" or to alter the body out of empowerment, these women did conform to norms of femininity.

Summary

In this chapter seven theoretical paradigms provided a better understanding for why these daughters asked for breast implants and why these parent(s) paid for them. Symbolic interaction theory explained why the daughters wished to replace their "fake" cotton padded self with their augmented self, to become the most authentic woman possible.

Social construction of reality theory explained, at least in part, why both mothers and daughters desired breast implants for graduation. Both wanted to conform to the social construction of gender, and to accomplish their gender well. They wanted to look feminine, beautiful, and not like "boys."

Conspicuous consumption theory demonstrated how cosmetic surgery practices, once common only among the wealthy, now appeal to the new middle class. The demonstration of

personal style and status through breast augmentation allows women to appear wealthy, gain status, and “flash” their assets.

Reference group and social comparison theories explained how the women in this study may have been influenced to undergo cosmetic surgery by ranking themselves in attractiveness against real friends and media icons. Self-discrepancy theory demonstrated how the daughters in this study felt they needed surgery to fix a discrepancy between their real and ideal self.

Lastly, whether motivated to capture the “male gaze” or to alter the body out of empowerment, these women were conforming to norms of femininity. The male influence on women changing their appearances – through breast augmentation – was also perpetuated by their surgeons. These women will further continue the oppression by gifting implants to their daughters in the future.

CHAPTER 5

MAKING THE DECISION TO GIFT AND RECEIVE IMPLANTS

The current segment of this chapter examines critical events, decision making processes, and reflections within the narratives of those gifting and receiving implant surgery. First, the critical events leading to the desire to seek augmentation surgery will be examined. Second, the process of those who claimed to have made the decision early will be contrasted with those who may have vacillated in their decision making. Finally, the participants' current reflection on their decision will illuminate both concerns and comforts regarding their choice. It is important to discover if young women know that having breast surgery at a young age will result in multiple breast surgeries later in life. If they do know, how do they feel about having multiple surgeries? What might their parents think about creating the need for more surgery?

Critical Events Leading to the Desire for Surgery

The daughters who received breast implants for graduation often presented key events that led to their initial desire to ask for the gift. Most of the girls described how encounters with ill-fitting clothing, swimsuits, and water-bras led them to ask for implants for graduation. Others had already received most everything for graduation, and implants were the only reasonable alternative.

Not fitting into swimsuits and fashionable shirts was a recurring theme in each of the narratives. Carol described how she had difficulty finding clothing:

...I couldn't wear a top, even like an extra small in the juniors department, I couldn't do it. To buy a top in the little girl's department, I couldn't wear the bottoms. I was on drill team and I had to wear skin tight leotards. I never wore a bra and I was like flat all the way down. So I got really frustrated and uncomfortable.

Robin explained how she had never been comfortable in clothes because of her small chest:

I have never been real comfortable in clothes...I could never find anything to fit.

In comparison to discomfort, it seems that some of the girls received breasts as graduation gifts because they had already received cars. Some mothers described a sense of loss surrounding what to get their daughters. They wanted to gift them something large, meaningful, expensive, nice, and memorable. The daughters knew to expect something generous, and knew breast implants were an option. Kim explained how breast augmentation surgery became an option for graduation:

They had asked what I wanted or asked what I expected for graduation. If you would like to get me my boobs done and I would love for you to pay because you know I want to get it done anyway.

Bonnie described how her daughter's grandmother ultimately paid for her augmentation:

It was getting close to graduation time, and grandma says, "Now precious, what do you want for graduation? Your mom and dad already bought you a car, so grandmother can't buy you a car. What do you want?" My daughter said, "Grandma I want a boob job." I had just had mine like a year, year and a half earlier. My sister-in-law, who is my mother-in-laws daughter, she had one as well, so it was kind of already in the air.

Key events leading up to the request for augmentation surgery therefore included clothing struggles and the need to present the daughters with a worthy gift for graduation.

Decision Making Style

Most of the daughters and mothers clearly explained that the decision to undergo breast implant surgery occurred at a young age. The gifting of breast implants for high-school graduation often took place because the daughter finally reached age 18, the age at which most surgeons first allow the surgery. Barbara stated she would have gifted the surgery to her daughter earlier had the surgeon allowed it:

Well Jennifer started talking about it when she was 16...When she turned 18, which was the youngest that we could find a doctor that would do it to her, she got pretty serious about it. I would say probably 3 or 4 months where there was pretty hard core pestering. That's when I said ok.

Annie also wanted to have her implant surgery at a young age, and had to wait longer than she wished because her doctor was booked:

Well it's been going on like, since I was in junior-high. When am I gonna get boobs? I went to the doctor in February and I wanted to have them done in March, like during Spring Break, but I couldn't cuz he was all booked. So I had to wait to the end of the year, to get out of school.

The actual process of asking for implants differed for each respondent, but most daughters described how they “convinced” their parents to pay for them. They knew they were going to receive graduation gifts, so they wanted their expensive augmentation procedures to be paid by their parents; hence, implants became a graduation present. Timing presented as a key ingredient. The daughters wanted to enter the new world of college as larger busted women, so the summer after high-school seemed like the “perfect” time. Many of the narratives contained similar plots: the daughter approached her mother to ask for implants; mother was hesitant but listened to her daughter’s plea, and then ultimately agreed. Linda illustrated how her daughter Kim convinced her to buy her implants for graduation:

Well, I was very against the whole thing from the very beginning... I was against it because I think when I see those 90210 kinds of shows where you know they're talking about people getting their 15 year olds breast surgery for their 16th birthday, I think that's kind of ridiculous. I never saw myself doing that. My daughter told me that she was going to see the doctor and that she would like me to go with her to the consultation, and that she knew I was against it, but she would rather have me there supporting her than not. So she left it up to me. I went to the consultation with her because of the way she put it, you know, that she wanted my support, and my, I guess somebody to give her another opinion of what the doctor said. As we got closer to that point I knew she was going to do it one way or another so I knew she would need help with it, and we wanted her focusing on school, and I kind of started to see her perspective on it. I started to see it less as just a girl who wanted to look like a stripper and more that she actually rationally thought through it and even wanted to wait until she was at the maximum point of growth. That she wasn't going to get any larger, and he (surgeon) felt like she had her head on straight about it. I guess that was when we decided that if we were gonna give her money, she could choose to use it for that.

Gabrielle explained how her daughter, Robin, convinced her it was enough of a psychological issue that it needed to be addressed. She stated:

She just kind of approached me one day and said, “Mom, you know, I’m not happy with my, you know the way my breasts look. Um, I wish you know, that they would fit my total appearance better and whatever.” So we discussed this and I didn’t realize how big of a psychological issue it was for her, because she always appeared to be very content with who she was. I told her to wait until she was 21, and maybe she would be a little more mature, and maybe have a different opinion. Because I think she was being influenced by a lot of the girls at the school. She kind of backed off for about 30 days, and she came back and said, “No mom, I really want to do this.”... I said first I would like for us to go have a consultation with a surgeon, and get his opinion on this whole thing. I had heard a lot of things, ya know, what about breastfeeding? What about if she gets breast cancer? What are the implications later on in life because she has implants? I wanted to for both of us, make an informed decision. So we did. We went and we saw a surgeon and he kinda took a look at her, and he had individual sessions with the both of us. He said he typically doesn’t recommend it for young girls unless he really feels that they really and truly have some sort of a psychological issue with their appearance...So with that input I decided to go ahead...

Most of the daughters convinced their mothers; however, of all 20 cases, only one daughter vacillated with the decision to undergo surgery. Her mother was the one pushing the idea and quite sure that this surgery was the best thing for her daughter. Ultimately, Sarah, the mother, convinced the daughter to have the surgery after a visit to a gynecologist’s office, as shown in the excerpt below:

I don't remember wanting it. I remember my mom saying something in the car on the way home about what would you think if you had surgery, would that even be something you wanted? So then it kind of put that little idea into my head, more so than the doctor saying it. So then I kind of thought about it from then on. Initially I didn't like it, I didn't want to have it, I thought it was kind of scary. Because I was comfortable with who I was and what I looked like. I just thought, number one I thought they were going to be like, I didn't know you could get like natural, I didn't know they could give me natural looking ones. And I thought that they would be like, really hard. Or that they would look like a ripply or whatever. And then I thought that they would deflate like the first time you slept on your stomach. So I was afraid of them. And then I got over that and I was like maybe. That's when we started talking about seeing doctors for consultations and things. [They discussed this for 6 months]. Although I didn't want it like really bad, I thought later on down the road I might wish that I had. So I just thought maybe for like the future. Well I figured, I still don't know, but I figured the older I got, that I would want to have even just a little something. So that wasn't wearing little kids clothes. Padded bras things like

that. There was always that thing in the back of my mind where, like I said I might want it one day down the road. Or some days it would be nice. But, I don't know, I still don't know completely.

The indecision shown here was rare among all the cases in the study. Most of the daughters ardently requested breasts from their parent(s) for graduation.

Reflections

All respondents were asked to reflect upon their decision to gift or receive implant surgery. Nine of the daughters and nine of the mothers were entirely comfortable with their gifting and receiving of breast implants for graduation, claiming it was a great decision. Most said they had never experienced such comfort in clothing, self-confidence, and they would do it again if necessary. All of the mothers and daughters reported that they knew that having breast surgery at a young age would result in multiple breast surgeries later in life. All but one daughter felt that having multiple surgeries was worth it, that "feeling good" for awhile was all that mattered. All of the mothers agreed that creating the need for more surgery was just a "risk" involved in the surgery, a price that one pays when having augmentation surgery.

Nine of the 10 daughters said they felt better, looked better, and loved having larger breasts. Robin even claims she makes better decisions now that she's had implant surgery.

I feel I make better decisions because I feel, well I don't feel like something is holding me back. I am not holding back when I'm living in society, I don't feel stupid now. Before when I thought I didn't look good I would hold myself back. Now that I feel that confidence I feel like I can choose and do anything I want.

She also added:

I like that I'm confident. I like that I don't have to hide things about myself. I think I've become a lot more open. I'm more social now.

On the contrary, Amber's reflection seemed to express concern over the decision to undergo surgery. She expressed regret and wished she had never had it done as shown in the following comment:

Now that I've had two operations, I wish I would have never done it. It's so not worth it! They have so many cute bras that add padding and stuff, and they're so much cheaper and safer than implants. I just wish I would have tried other things first. I know that if I do have to have surgery again, I won't put implants back in. I'll just have them take off as much skin as possible and be super flat. They have really cute clothes out there that I can't wear because I can't do the buttons now. And with boobs you look heavier than without. I think flat chested women are real attractive, but I probably wouldn't have come to that realization without having gone through what I've been through. It is still surgery, and it's still serious...I have had two surgeries and will no doubt have a third. The only place left to enter is through my armpit, and that's a whole different set of scars. It's real scary when you think about it!

All of the mothers expressed pleasure over the gifting of implants, that they believed their gift had brought happiness to their daughters. Tamara describes how her daughter is happier with implants:

I see Annie smiling and she says, "Look mom." Ya know? "Look, I have shape." She's happy. I think she is happy with the results. Yeah. Best money we ever spent. I know it was the best money I ever spent. Your clothes fit, everything fits. No more padded bras.

Bonnie described how her gift made her daughter more content:

I could see that it has made Sheryl happier and more confident. She just seems to be, you know, she's not complaining all the time about herself. You know that's gone. And that was a constant horrible feeling about herself that she had. She just felt like she was so inadequate. She just constantly complained about it, and she doesn't do that anymore.

Jane emotionally expressed how her gift has given her daughter a new lease on life:

Sandy has told me on numerous occasions that she feels more confident. That in a group, like at the sorority house or the fraternity house, if she's in a group of girls, now it wouldn't be anything for her to come up and tell me, "Mom I was the prettiest girl in the room." She has never in her life ever wanted to be in a pageant, and a year and a half ago she entered one, and she got in the top 10. First International pageant ever! So yeah, I definitely think she feels more confident.

Although happy, the participants were aware that breast augmentation came with risk. Each of the daughters and mothers were asked if they had signed liability waivers. All of the daughters claimed they had, and few could remember anything about what the liability waivers said. Often mothers didn't read the waivers at all because their daughters were of age (18) and could sign for themselves. During the interview, each heard a list of possible complications found on liability waivers associated with breast augmentation surgery. The list contained the following items: anesthesia reaction, asymmetry, bleeding, breast droop, capsular contracture, deflation, displacement, hematoma, implant leak, infection, interference with mammography, keloids, nerve damage, nipple numbness, permanent numbness, reactions to medication, rippling, rupture of the implant, seroma, skin irregularities, sloshing, slow healing, swelling, symmastia, visible scarring, difficulty breast-feeding, and the need for further surgery. During a few of the interviews, the participants became² agitated during the reading of the complications. As demonstrated in the following statement, Bonnie defensively explained how Sheryl's surgery was different from most that the possible complications didn't really apply:

Her surgery was a little different than some implants because she had a nipple area that was more pronounced, and that's the way he put them in. So he made some corrections on her breasts.

Each participant answered whether or not hearing the list would have changed their desire to have implant surgery. Eight of the daughters and nine of the mothers said the surgery was well worth any risks. Reflecting on pre-surgery, all of the daughters agreed that nothing could have stood in the way of them seeking out and ultimately having augmentation. They told stories of other women they knew who traded cars for implants, sold sex for implants, and one sold her eggs for implant surgery. As demonstrated in the following excerpts, the daughters

² I think they were defensive about the list of the risks that they didn't consider prior to surgery.

believed they needed the surgery, would find a way to pay for it, and risks were the least of their distractions. Jennifer broke up with her boyfriend following her mother's promise to pay for surgery if she no longer dated him:

I wanted it so bad that nothing mattered. I didn't care about anything. Obviously, I broke up with someone that I was supposedly serious with. I didn't care about anything. I did everything I could, it didn't matter what it was. I walked all over my parents to do it.

Some women, such as Kim, minimized the associated risks of augmentation surgery. She stated:

The likelihood of all of those are really really low, I mean other than like scarring, there was nothing, like he had never had a patient that died.

For these women, hearing the risks apparently caused little concern. The only one who said it was not worth the risk had already undergone two augmentation surgeries and was facing a third procedure. One other concerned daughter, Sarah, became upset during the interview when she realized she may have difficulty breastfeeding in the future. She revealed in the following comment that she was aggravated that her mother, Carol, allowed her to undergo surgery without making her aware:

I didn't know breastfeeding had anything to do with it. Well if I ever do have kids I would want to breast feed them you know, initially. If it causes problems, I dunno, I didn't know it did that. It might change my mind on how I do things when I have kids.

However, her mother Carol stated she was aware of the breastfeeding concerns, and her response was:

There's not anything that doesn't come with risk. I think you just have to be informed of any possibilities.

Finally, the greatest measure of reflection within the narratives occurred when the mothers answered whether or not they would do it all over again if given the opportunity. What did the mothers think about creating the need for future surgery? Nine of the mothers agreed it was worth the risk to make their daughters feel more confident, and their comments below

demonstrate their lack of regret. Bonnie argued that her daughter's desire mitigated any possible dangers:

Well I think with any surgery, I realize that there are complications, there is a risk with anything, and it can happen. Her desire was so strong the doctor gave us a lot of confidence. We just felt like things would go real well, we just felt real comfortable with him, and he was real thorough with everything. He was very good.

Amy stated that life itself comes with risks, so one should enjoy the time allotted:

There is risk with a lot of things in life to begin with anyway.

Such comments imply that breast augmentation surgery may be viewed as a routine procedure well worth the risk, since hazard is a part of routine daily living. Only Vivian said, upon reflection, she would not gift implants to her daughter if given the opportunity again:

Amber knows that I'm not real happy about it (the surgery), that I still worry about the complications whatever they might be. And she's old enough that if she wants any more she can pay for it. I just think she learned through experience that it's not necessarily all that's it cracked up to be.

Summary

This chapter explored the decision-making process that resulted in the eventual choice to gift or receive breast implants for graduation. The participants rarely experienced moments of questioning as they realized discrepancy existed between their bodies and their peers.

Augmentation was a route the participants wanted to pursue, regardless of any possible risk involved. The reflections revealed that only one subject worried about her augmented breasts, with reservations about impending surgery. The women overwhelmingly felt pleased about the decision, nine expressing comfort with their decision to have breast implants. Almost all of the mothers expressed comfort with their decision to gift surgery to their daughters, despite knowing that their gift of augmentation would ultimately result in more surgery in the future.

CHAPTER 6

CONCLUSION

This research has explored the lives of 20 women who participated in the gifting of breast implants in order to examine how they felt their decisions evolved over time and how their decision to give or receive implants had affected their lives. The questions were designed to evoke awareness and reflection so that the respondents would reveal private thoughts. Blending the narratives with sociological paradigms provided a means to better understand the phenomenon of the gifting of implants.

This final chapter has five central aims. First, the overview of findings will be outlined. Second, the strengths of the study will be discussed. Third, the findings of the investigation will be compared with those discussed in the literature review. Fourth, this current investigation's limitations will be revealed. Last, future directives for research will be explored.

Overview of Findings

In this qualitative study, participants were selected by means of purposeful sampling, for their ability to provide information about the research topic. Trends within the ASPS data that were most striking provided a basis for interview sample selection. Those participants who had been deemed information rich for the purposes of this study were women ages 18-35 in the state of Texas who had received breast implants for graduation. The interview sample was deliberately created to contain 10 women who had received implants as a graduation gift ($N = 10$) and 10 mothers who gifted the surgery ($N = 10$). Those who had received breast implants for reasons other than graduation were excluded from this research. Also, those daughters who could not be paired with mothers were excluded from the study.

Narrative analysis empowered research participants and allowed them to determine the most important themes in the area of breast augmentation research. The use of personal narratives allowed for the whole surgical experience to enlighten the researcher, not any particular aspect of the conversation. The narratives were all read with the sociological paradigms in mind. These theories were used to provide insight into motivations behind the asking for and gifting of breast implants.

First, symbolic interaction illuminated why most of the daughters in the narratives “faked” the appearance of large breasts prior to implant surgery through the use of heavy cotton padding, water bras, or multiple bras. Some sewed shoulder pads into their bra cups, others sewed darts into their shirts. All of these women made extreme efforts in the backstage to conceal what they really were and manage how they appeared in the front stage, in order to create the feminine impression desired. The daughter’s narratives supported both Cooley’s practice of reflective judgment and Mead’s role-playing techniques. All of the daughters in this study practiced having larger breasts before undergoing surgery, and considered the procedure a success when audience members couldn’t tell they had surgery.

The social construction of reality paradigm offered a means to analyze the efforts taken to construct gender by examining how both mothers and daughters actively engaged in the perpetuation of the construction of gender. The mothers often referred to their flat-chested daughters in a pre-surgery state as though they were physically marred. They were not whole, missing something, immature, not feminine, and they looked like “boys.” The daughters also wanted to undergo breast augmentation surgery in order to obtain larger breasts, those that would be clearly identified as womanly, separate and distinct from manly.

As conspicuous consumption theory explained, when the level of consumption necessary to be conspicuous becomes more readily available, people want to demonstrate that they have a high quality life. All of the women in this study belonged to the middle class or what may be defined as a modern day leisure class. This leisure status afforded them the ability to pay for not only their daughter's living expenses, but their breast augmentation as well.

Reference group theory and social comparison theory provided a means to explain ways in which women compared themselves to friends and often to those they consider more beautiful than themselves. When the daughters in this research compared themselves with media icons found among celebrities, in magazines, and on television they were dissatisfied. This research supports self-discrepancy theory in that the perception of the actual self in relation to the ideal one resulted in a sense of failure. Using their own definitions of beauty, they described their imperfections, how they had "good days" and "bad days," or were too tall or too heavy, how they planned to have more surgery in the future, or how they just were not beautiful.

Two competing feminist views were used to understand the daughters' motivations for wanting surgery. One theory argues that women who elect to undergo cosmetic surgery are seeking to become objects of the "male gaze" (Canavan, 2003). The other theory argues that women who elect to have surgery are merely exercising choice in controlling their own bodies (Gagne & McGaughy, 2002). In this research, some of the daughters viewed augmentation surgery as a means to gain positive attention from men. Others viewed their augmentation as an expression of empowerment. In some instances, this research supports the notion that cosmetic surgery represents the ultimate oppression of women in America. The women eager to gain positive attention from men surgically altered their bodies, and said they would do the same for their own future daughters.

Most of the daughters and mothers were very clear that the decision to undergo breast implant surgery occurred at a young age. Critical events leading to surgery included encounters with ill-fitting clothing and the wish to be supplied with a generous gift for graduating from high-school. The gifting of breast implants for high-school graduation often took place because the daughter finally reached age 18, the age at which most surgeons first allow the surgery.

All mothers and daughters were asked to reflect back on their decision to gift or receive implant surgery. The majority of respondents expressed complete comfort with their gifting and receiving of breast implants for graduation, claiming it was a great decision. Most said they had never experienced such comfort in clothing, self-confidence, and that they would do it again if necessary. Most of the mothers agreed surgery was worth any risk to increase their daughter's confidence.

Almost all of the women in this research felt their choices were empowering ones that they were pleased about having made. Most of the mothers expressed that they were comfortable with their decision to gift surgery to their daughters, despite knowing that their gift of augmentation would ultimately result in more surgery in the future.

Strengths of the Study

The current study explored new terrain in an effort to understand the phenomenon of the gifting and receiving of breast implants. A cross cultural examination of definitions of beauty and the portrayal of fashion through time made this study literature rich. Using seven theories within the disciplines of sociology and psychology allowed for a broad understanding of women's issues that will contribute to the discipline of sociology and body image research. Narrative analysis allowed mothers and daughters to tell their stories surrounding such personal choices, helping to illuminate the private thoughts of women. This research exposed private

struggles with body dissatisfaction in hopes that dangerous surgical trends would be revealed and that others would become aware of this phenomenon.

Comparing the Results to Previous Works

Although unique, this research shares similarities with existing research on breast augmentation. Just as Epstein (2000) purports, cosmetic surgery involves wanting a face or body that closely conforms to the American standard of beauty. Society places a great deal of pressure on women to conform to this culturally constructed body type. As a result, some women feel inadequate (Patel, 1996).

Didie and Sarwer (2003) collected survey data from 25 women who wanted breast augmentation and 25 women who weren't interested in the procedure. They found that cosmetic surgery patients reported discontent with a specific feature of their body, not necessarily dissatisfaction with their overall body image. Similarly, some women in this current research reported discontent with their breasts, not necessarily overall body image. Didie and Sarwer (2003) found that women who underwent breast augmentation did so after hiding their small breasts from others. The women in this research behaved similarly.

Sarwer et al. (2000) reported that the average size of breasts women consider ideal is now a size C or D cup. All women in this research considered large breasts (size C/D cup) attractive, and small breasts (size A/B cup) unattractive and "boyish."

The claim made by McKenzie (2006) that mothers pay for breast augmentation to boost their daughter's self-esteem correlates with findings in this research.

Like the finding in the article "More Girls Getting Implants" (2004), girls in this research also seemed to request and receive implants when they were about to embark on a lifestyle change: going off to college after high-school.

This research also supports Sommerfeld's (2004) claim that teens are ignoring health risks associated with implants.

In the end, the current research findings parallel research demonstrating that women who do have augmentation surgery often experience psychological benefits such as: increased body satisfaction, increased self-esteem, and a reduction in negative emotions related to appearance (Hilton, 2005; Schofield et al., 2002).

Limitations

This research was somewhat limited in scope because all of the respondents were Texas residents, and their fathers were not interviewed. Therefore, the ability to generalize from the current study could be challenged on two fronts: (1) the sample size of N=20 was fairly small and (2) the women were all from the same sub-region of Texas. The sample was not randomly drawn from the population. Participants were selected who were similar to the criterion built upon in the ASPS data set. The trends shown to have been the strongest over the last 6 years were used to create a criterion for sample selection. Data gathering methods were limited by complicated issues surrounding confidentiality outside the doctor/patient relationship. Furthermore, this cross-sectional study limits the findings in terms of long-term changes that the respondents may have regarding their breast augmentation experiences.

Directions for Future Research

Future studies should include women from all regions of the country as well as fathers. The topic should expand to include not only those implants given and received by parents to daughters, but by husbands to wives. The topic should be expanded to include the gifting of implants for any and all occasions, not just graduation. Many women who asked to be included

in this research did not qualify because their implants were given for reasons other than graduation. Their narratives should be captured as well.

There is ample room for much growth in the area of breast augmentation research. This is a booming industry, evidenced by growing rates of surgery (ASAPS, 1997–2007). The unbiased collection of surgical data in the United States would lend valuable information to the field of cosmetic surgery research.

APPENDIX A
PROPERTY VALUES

	Code Number	TAD Value
1	001	Apartment
2	002	\$136,900
3	003	\$91,900
4	004	\$91,900
5	005	\$235,400
6	006	\$235,400
7	008	Sorority House
8	013	\$222,200
9	009	Dorm
10	010	\$155,300
11	011	\$116,930
12	012	\$116,930
13	014	Sorority House
14	017	\$133,700
15	015	\$130,366
16	016	\$130,366
17	019	Apartment
18	018	N/A - PO Box
19	020	\$211,200
20	021	\$211,200

APPENDIX B
INTERVIEW INSTRUMENT

Questions that will be asked of Ten (10) high-school graduates who have received implants for graduation:

1. What is your current age?
2. What is your current marital status?
3. Do you have any children?
4. Do you plan to have children in the future?
5. How many years of formal education do you have?
If college education:
Major?
Degree?
Date of Graduation?
6. How many years of formal education does your mother have?
If college education:
Major?
Degree?
Date of Graduation?
7. How many years of formal education does your father have?
If college education:
Major?
Degree?
Date of Graduation?
8. Do you practice any particular religion?
What kind?
How often do you attend (church, mosque, temple, gathering, etc)?
What kinds of people are there (physical appearance, social class, race, etc)?
9. What race or ethnicity would you say you are a member of?
10. Where were you born?
11. Are you currently employed?
What do you do?
What kind of people do you interact with (age, sex, social class, physical appearance)?
Do you work full-time; part-time; other _____?
What is your monthly income?
12. Is your mother currently employed?
Yes: Where?
What is her profession?
What does she do?
No: Has she ever been employed? If yes, what did she do?
13. Is your father currently employed?
Yes: Where?
What is his profession?
What does he do?

- No: Has he ever been employed? If yes, what did he do?
14. How would you describe your social class?
15. Is this your only family residence?
 Yes: How long have you lived here?
 Do you move often?
 No: Where else does your family own/rent?
16. Do you own a car?
 Yes: What kind of car?
 How many cars have you owned?
 No: Have you ever driven or owned a car?
17. Does your mother own a car?
 Yes: What kind of car?
 How many cars has she owned in the last ten years?
 No: Has she ever driven or owned a car?
18. Does your father own a car?
 Yes: What kind of car?
 How many cars has he owned in the last ten years?
 No: Has he ever driven or owned a car?
19. Do you travel outside of the immediate area?
 Yes: Where and with whom?
 How often?
 No: Have you ever traveled?
20. What types of recreational activities do you engage in?
21. What are your hobbies?
22. Do you belong to any organizations?
 Yes: Which?
 What do they do?
 How often do you meet?
23. Did you play with toys as a child?
 Yes: Do you remember your favorite childhood toys?
 No: What did you do?
24. Do you watch television?
 Yes: How often?
 What are your favorite television shows?
 Do you remember your favorite television shows as a child?
 No: Why not?
25. Do you subscribe to any magazines?
 Yes: Which ones?
 Why those?
 No: Have you ever?
26. Do you have any favorite celebrities?
 Yes: Who?
 Why?
27. Do you live independently, paying for all of your necessities and recreational activities?
 Yes: What do you pay for?
 How much does that amount to per month, on average?

- Does your income cover that comfortably?
 No: Who pays?
 What do they pay for?
 How much does that amount to per month?
28. Do you have friends that you socialize with?
 Yes: How many do you regularly visit with?
 How often?
 How long have you known them?
 What do you usually do with them?
 How would you describe them in terms of their physical appearance (age, sex, social class, race, etc.)?
29. What year did you have breast augmentation surgery?
 30. How old were you when you had the surgery?
 31. How did this gifting of surgery come about?
 32. Please tell me how your parent(s) ended up paying for your breast augmentation?
 33. Do you know how they paid for the procedure?
 34. Where did you have the procedure done?
 35. How did you locate your surgeon?
 36. Did you receive silicone or saline implants?
 37. Was this the first cosmetic procedure you've had?
 No: What other procedures have you had done?
38. Why did you have breast implant surgery?
 39. What influenced your decision to have breast augmentation surgery?
 40. Describe your self-esteem prior to implant surgery.
 41. How many people do you think have had breast augmentation surgery in the United States?
42. Did any of your friends ever talk about having surgery before you had it done?
 Yes: How many?
 What did they say?
43. Did any of your relatives ever talk about having surgery before you had it done?
 Yes: How many?
 What did they say?
44. Prior to your surgery, did you know others who had breast implant surgery?
 Yes: How many?
 Who were they?
 How often did you interact with them?
 What is your relationship with these people?
45. Did these people influence your decision to have breast augmentation surgery?
 Yes: How?
 No: Why not?
46. Tell me about your surgical procedure in detail – from beginning to end.
 47. Did you suffer any complications from the surgery?
 Yes: What kind?
48. Did you sign a liability waiver before you had the surgery done?
 Yes: What did it say?
 No: Did you know there was a liability waiver?

49. Were you aware of the following risks before surgery?
 Anesthesia reaction, asymmetry, bleeding, breast droop, capsular contracture, deflation, displacement, hematomas, implant leak, infection, interference with mammography, keloids, nerve damage, nipple numbness, permanent numbness, reactions to medications, rippling, rupture of the implant, seroma, skin irregularities, sloshing, slow healing, swelling, symmastia, visible scarring, difficulty breastfeeding, and the need for further surgery.
 Yes: Which ones?
 No: Would this knowledge have changed your desire to have implant surgery?
50. What results did you expect to achieve with the surgery?
51. Are you satisfied with the results?
52. Are you who you thought you would become after surgery?
 Yes: How so?
 No: Why not?
53. Do you see yourself differently now that you've had surgery?
 Yes: How so?
 No: Why not?
54. Imagine you are looking at your body in a mirror. How would you describe it?
55. How would you describe a beautiful woman?
56. Do you think you are beautiful?
 Yes: Why?
 No: Why not?
 What would you change?
57. Do you like who you have become after surgery?
 Yes: What do you like?
 No: What don't you like?
58. How do people interact with you now that you've had implant surgery?
59. Have you changed who you socialize with now that you've had surgery?
 Yes: How so?
 No: Why not?
60. Have you changed the types of activities you engage in since you've had surgery?
 Yes: How so?
 No: Why not?
61. If you have a daughter in the future, will you allow her to have breast augmentation?
 Yes: Why?
 No: Why not?
62. Would you pay for your daughter's augmentation?
 Yes: Why?
 No: Why not?
63. Do you know anyone else who has received breast implants for graduation?
 Yes: Who?
 How old are they?
 Did they receive their implants as a gift?
 May I contact them for this study?

Questions that will be asked of Ten (10) mothers who have gifted implants to their daughters for graduation:

1. What is your current age?
2. What is your current marital status?
3. How many children do you have?
4. Do you plan to have any more children in the future?
5. How many years of formal education do you have?
If college education:
Major?
Degree?
Date of Graduation?
6. Do you practice any particular religion?
What kind?
How often do you attend (church, mosque, temple, gatherings, etc)?
What kinds of people are there (physical appearance, social class, race, etc)?
7. What race or ethnicity would you say you are a member of?
8. Where were you born?
9. Are you currently employed?
What do you do?
What kind of people do you interact with?
How often do you work?
10. How would you describe your social class?
11. Is this your only family residence?
Yes: How long have you lived here?
Do you move often?
No: Where else does your family own/rent?
12. Do you own a car?
Yes: What kind of car?
How many cars have you owned?
No: Have you ever driven or owned a car?
13. Do you travel outside of the immediate area?
Yes: Where and with whom?
How often?
No: Have you ever traveled?
14. What types of recreational activities do you engage in?
15. What are your hobbies?
16. Do you belong to any organizations?
Yes: Which?
What do they do?
How often do you meet?
No: Why not?
17. Do you have friends that you socialize with?
Yes: How many do you regularly visit with?
How often?

- How long have you known them?
 What do you usually do with them?
 How would you describe them in terms of their physical appearance (age, sex, social class, race, etc.)?
 No: Why not?
18. Did you play with toys as a child?
 Yes: Do you remember your favorite childhood toys?
 No: What did you do?
19. Do you remember what toys your daughter played with as a child?
 Yes: Which ones?
20. Do you watch television?
 Yes: How often?
 What are your favorite television shows?
 Do you remember your favorite television shows as a child?
 No: Why not?
21. Do you subscribe to any magazines?
 Yes: Which ones?
 Why those?
 No: Have you ever?
22. Does your daughter live independently, paying for all of her necessities and recreational activities?
 Yes: What does she pay for?
 How much does that amount to per month, on average?
 Does her income cover that comfortably?
 No: Who pays?
 What do they pay for?
 How much does that amount to per month?
23. What year did your daughter have breast augmentation surgery?
 24. How old was she when she had the surgery?
 25. Please tell me about how this gifting of surgery came about.
 26. How did you pay for the procedure?
 27. Where was the procedure done?
 28. How did you locate the surgeon?
 29. Did she receive silicone or saline implants?
 30. Was this the first cosmetic procedure she's had?
 No: What other procedures has she had?
31. Describe her self-esteem prior to implant surgery.
 32. How many people do you think have had breast augmentation surgery in the United States?
 33. Did any of your daughter's friends ever talk about having surgery before she had it done?
 Yes: How many?
 What did they talk about?
34. Did any of your relatives ever talk about having surgery before your daughter had it done?
 Yes: How many?

- What did they talk say?
35. Have you told anyone about your daughter's surgery?
 Yes: Who?
 What were the reactions?
 What did they say?
 No: Why not?
36. Did you know others who had other cosmetic procedures?
 Yes: How many?
 What is your relation to these people?
37. Did you know others who had breast implant surgery?
 Yes: How many?
 What is your relation to these people?
38. Tell me about her surgical procedure in detail – from beginning to end.
39. Did she suffer any complications from the surgery?
 Yes: What kind?
40. Did you sign a liability waiver before she had the surgery done?
 Yes: What did it say?
 No: Did you know there was a liability waiver?
41. Were you aware of the following risks before surgery?
 Anesthesia reaction, asymmetry, bleeding, breast droop, capsular contracture, deflation, displacement, hematomas, implant leak, infection, interference with mammography, keloids, nerve damage, nipple numbness, permanent numbness, reactions to medications, rippling, rupture of the implant, seroma, skin irregularities, sloshing, slow healing, swelling, symmastia, visible scarring, complications with breastfeeding, and the need for further surgery.
 Yes: Which ones?
 No: Would this knowledge have changed your desire to give your daughter implant surgery?
42. What results did you expect to achieve with the surgery?
43. What results do you think she expected to achieve from the surgery?
44. Do you think she is satisfied with the results?
45. Is she who you thought she would become after surgery?
 Yes: How so?
 No: Why not?
46. Do you think she sees herself differently now that she'd had surgery?
 Yes: How so?
 No: Why not?
47. Imagine she is looking at her body in a mirror. How do you think she would describe it?
 How would you describe it?
48. How would you describe a beautiful woman?
49. How do you think your daughter would describe a beautiful woman?
50. Do you think your daughter is beautiful?
 Yes: Why?
 No: Why not?

- What would you change?
51. Do you think you are beautiful?
Yes: Why?
No: Why not?
What would you change?
52. Do you like who your daughter has become after surgery?
Yes: What do you like?
No: What don't you like?
53. How do people interact with her now that she's had implant surgery?
54. Has she changed who she socializes with now that she's had surgery?
Yes: How so?
No: Why not?
55. Has she changed the types of activities she engages in since she's had surgery?
Yes: How so?
No: Why not?
56. Would you pay for your daughter's augmentation if you had to do it over again?
Yes: Why?
No: Why not?
57. Do you know anyone else who has gifted breast implants for graduation?
Yes: Who?
May I contact them for this study?

APPENDIX C
RECRUITMENT TECHNIQUE

My name is Lori Fowler, and I am conducting a study for my Doctoral Thesis on Breast Implants for Graduation.

If you are a Texas resident between the ages of 18-35, and have had augmentation surgery after receiving the procedure as a gift from your parents, I would love to interview you! I would also need to interview your mother and ask her questions as well.

Please contact me right away! lori.fowler@tccd.edu

Thank you for your help. You will remain anonymous.

APPENDIX D
ADS POSTED ONLINE

www.implantsforgraduation.com

My name is Lori Fowler, and I am conducting a study for my Doctoral Thesis on Breast Implants for Graduation. If you are a Texas resident between the ages of 18-35, and have had augmentation surgery after receiving the procedure as a gift from your parents, I would love to interview you! I would also need to interview your mother and ask her questions as well.

Surgeon Request:

Dr. Strock - 800 Eighth Ave.
Suite 606
Fort Worth, Texas 76104
Phone: (817) 335-1616

Craig's List Online:

My name is Lori Fowler, and I am conducting a study for my Doctoral Thesis on Breast Implants for Graduation.

If you are a Texas resident between the ages of 18-35, and have had augmentation surgery after receiving the procedure as a gift from your parents, I would love to interview you!

I would also need to interview your mother and ask her questions as well.
Please contact me right away! lori.fowler@tccd.edu

Thank you for your help. You will remain anonymous.

APPENDIX E
CONSENT FORM

Subject Code Number: _____

University of North Texas Institutional Review Board

Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

Title of Study: "Breast Implants for Graduation?" Parent and Adolescent Narratives

Principal Investigator: Lori Ann Fowler, a graduate student in the University of North Texas (UNT) Department of Sociology.

Purpose of the Study: You are being asked to participate in a research study which involves reasons why today's youth have undergone breast augmentation surgery after receiving the procedure as a high-school graduation gift from their parent(s). The narratives told by adolescents and parents in this study aim not to reveal what they 'really' think, but how they bring to life a version of their surgical experience, why they chose breast implants, and why their parent(s) paid for them.

Study Procedures: You will be asked to participate in a face-to-face interview about breast augmentation surgery experience and/or the gifting of breast implants. This should take about 3 hours of your time.

Foreseeable Risks: (1) Taking time out of your schedule for a lengthy interview may cause some irritation. (2) Talking while being audio taped may cause some discomfort and uneasiness. (3) Discussing your personal feelings regarding body image, breasts, and surgery may cause some anxiety if you or your daughter did not have a positive surgery experience.

Benefits to the Subjects or Others: (1) We expect the project to benefit you by giving you the opportunity to reflect on and talk about your life with a good listener. Narrative analysis can facilitate empathy since it provides forms of communication in which an individual can externalize her feelings and

indicate which elements of those experiences are most significant. (2) You will contribute significantly to the discipline of sociology, feminist theory, and body image research.

Procedures for Maintaining Confidentiality of Research Records: Anonymity will be ensured through the assignment of a code number in lieu of your name. Confidentiality of research records will be ensured in that your name will not be used at any time during the interview process. Your interview will be conducted in private, away from the other party involved. Audio tapes will be securely stored in a separate location, apart from the research documents. All data will be used for the purposes of research only. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact Lori Ann Fowler or the faculty advisor, Dr. Ami Moore, UNT Department of Sociology.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Lori Ann Fowler has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.

- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

_____ Printed
Name of Participant

_____ _____
Signature of Participant Date

For the Principal Investigator or Designee: I certify that I have reviewed the contents of this form with the participant signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

_____ _____
Signature of Principal Investigator or Designee Date

APPENDIX F
ASSIGNMENT OF PSEUDONYMS

	Pseudonym	Relationship	Date	Age	Race
1	Jennifer	daughter	7/24/2007	21	Caucasian
2	Barbara	mother	7/24/2007	42	Caucasian
3	Annie	daughter	8/3/2007	20	Hispanic
4	Tamara	mother	8/3/2007	50	Caucasian
5	Carol	daughter	8/4/2007	19	Caucasian
6	Sarah	mother	8/4/2007	50	Caucasian
7	Robin	daughter	9/6/2007	19	Hispanic
8	Gabrielle	mother	9/18/2007	52	Hispanic
9	Kim	daughter	9/11/2007	20	Caucasian
10	Linda	mother	9/12/2007	48	Caucasian
11	Sheryl	daughter	9/13/2007	22	Caucasian
12	Bonnie	mother	9/13/2007	61	Caucasian
13	Jane	daughter	9/20/2007	20	Caucasian
14	Sandy	mother	9/20/2007	40	Caucasian
15	Traci	daughter	9/20/2007	22	Caucasian
16	Amy	mother	9/20/2007	49	Caucasian
17	Susan	daughter	9/22/2007	19	Hispanic
18	Sammie	mother	9/22/2007	49	Caucasian
19	Vivian	mother	9/23/2007	61	Caucasian
20	Amber	daughter	9/23/2007	35	Caucasian

*Conducted 21 Interviews: Stacey paid for her own surgery so she was thrown out.

Recruitment Process	
My Online Website	0
Surgeon Request	0
Facebook Ad Online	2
Community News Online	0
Fort Worth Star Online	0
Craig's List Online	0
Class Announcements	7
UNT Research Pool	0
TCC Co-Workers	2
Sorority Website	0
Snowball Sampling	1

**10.5 Pairs/72
days**

APPENDIX G
DEPICTIONS OF SOCIAL CLASS

[Mother Barbara and Daughter Jennifer]

The value of their primary residence is appraised at \$136,900. The mother, Barbara, describes herself as middle-class. Jennifer said, "I would consider my parents pretty wealthy." The daughter drives a Chevy Tahoe SUV currently, but has had a Miata, a Ford Explorer, and a street bike. The mother drives a corvette, and has owned four other cars in the past ten years. Both of the subjects work full-time, the daughter as a personal trainer and waitress, and the mother as a treatment coordinator at an orthodontics office. The daughter earns \$3100.00 each month, and the mother pays an additional \$450.00 toward the daughter's expenses each month.

[Mother Tamara and Daughter Annie]

The value of their primary residence is appraised at \$91,900. The mother, Tamara, describes herself as middle-class. Annie said, "We're not poor, (laughter), and we're not rich. So we're somewhere in the middle." The daughter drives a Honda Prelude and has had an Acura Integra. She bought the new car when: "That car, um, I didn't realize you had to change the oil and stuff. So, I was being a girl I guess. I just burnt the motor out. I know we tried to get it fixed, and it was just like, my grandparents said it wasn't good for me so they wanted to get me a new car. And that car was a POS (piece of shit). But I loved it (laughter)." The mother drives a BMW purchased by her boyfriend. Both of the subjects work full-time as frontline managers or tellers for the same bank. The daughter earns \$1200.00 each month, and the mother pays an additional \$175.00 toward her daughter's expenses each month.

[Mother Sarah and Daughter Carol]

The value of their primary residence is appraised at \$235,400. The mother, Sarah, describes herself as upper-middle. Carol said, "In between middle and upper if that's an option." The daughter drives a Lexus and has had three other cars. "I got a bug when I turned 16. But it was a standard and I didn't like it so I got rid of it. Then I bought a 4-runner that was an automatic and then I got rid of that in like 5 months." The mother drives a Lexus and has owned three cars in the last ten years. Both of the subjects work full-time. The daughter works as a receptionist and the mother as a surgical assistant. The daughter earns \$1000.00 each month, and the mother pays an additional \$200.00 toward her daughter's expenses each month.

[Mother Gabrielle and Daughter Robin]

The value of their primary residence is appraised at \$22,200. The mother, Gabrielle, describes herself as upper class. "I would say with the price of things today I'm middle, but everybody says that I'm really upper, because of my income. I mean I make 6 figures a year, so I guess that puts me in the upper-middle class." Robin said upper-middle class also. The daughter drives a TransAm and has not had any other cars. The mother drives a Chevy Jimmy and has owned three cars in the last ten years. The daughter is a full-time student, and the mother works as a director of financial reporting at Verizon. The mother pays \$400.00 toward her daughter's expenses each month.

[Mother Linda and Daughter Kim]

The value of their primary residence is appraised at \$155,300. The mother, Linda, describes herself as upper-middle class. "Can I say upper middle? Yeah upper middle I think." The daughter, Kim, said upper-middle class also. The daughter drives a Mazda Tribute and has not had any other cars. The mother owns four cars: A Ford 500, a Ford F150, and a Ford Expedition. The daughter is a full-time student, and the mother is unemployed. The parents pay \$4000.00 - \$5000.00 toward their daughter's expenses each month: "Oh gosh, the kicker is that she goes to a private school so, I mean tuition is about \$15,000 a semester so, I mean if you broke it down monthly, I would say at least \$4000 a month. That's including tuition and everything, somewhere between \$4000 and \$5000."

[Mother Bonnie and Daughter Sheryl]

The value of their primary residence is appraised at \$116,930. The mother and daughter both describe themselves as middle class. The daughter drives a Chevrolet Silverado and has had two other cars: "My car in high-school was a '94 Silverado, and after that I had a '95 Mustang, and now I have a Silverado." The mother drives a Chevy Tracker and has owned two cars in the last ten years. The daughter works full-time in a dental office, and the mother is an independent insurance agent. The daughter earns \$1000.00 per month, and the parents pay \$100.00 toward their daughter's expenses each month.

[Mother Sandy and Daughter Jane]

The value of their primary residence is appraised at \$133,700. The mother, Sandy, describes her social class as middle. "I don't know there's a lot to choose from. I'm like the middle of the road, middle class." The daughter also describes herself as middle class. The daughter drives a Honda Civic and has not had any other cars. The mother drives a Toyota Corolla and has owned three cars in the last ten years. The daughter works part-time in a deli, and the mother is a full-time patient advisor for Fig Lipo Dissolve. The daughter earns \$100.00 per month, and the parents pay \$2000.00 toward their daughter's expenses each month.

[Mother Amy and Daughter Traci]

The value of their primary residence is appraised at \$130,366. The mother describes her social class as upper-middle. The daughter also describes herself as middle class. The daughter currently drives a VW Jetta. Traci said, "This will be my second, and before that I had a Nissan Maxima. And in December I am about to get another new car, an IS 250." The mother drives a 1969 convertible Camaro and has not owned any other cars in the last ten years. The mother and daughter both work full-time in a beauty salon. The daughter earns \$1300.00 per month, and the parents pay \$1550 for a shared mortgage each month.

[Mother Sammie and Daughter Susan]

The value of their primary residence was not available. They would not release their primary residence address. The mother describes her social class as moderate, medium. The daughter also describes herself as middle class. The daughter drives a Sebring Chrysler convertible currently and has had two other cars. Susan said, "I had a 2001 Cougar Sports car, and then I got new 2007 Camry. My mom has the Camry, 2007 Toyota Camry." The daughter works part-time as a beverage cart girl at a golf course, and the mother is a full-time property manager. The daughter earns \$1100.00 per month, and the parents pay \$0.00 toward their daughter's expenses each month.

[Mother Vivian and Daughter Amber]

The value of their primary residence is appraised at \$211,200. The mother describes her social class as upper-middle. The daughter describes her own social class as upper class. The daughter, Amber, drives a Chevy Tahoe and has had many other cars. "I've had a Jeep, a Z, a Sequoia, a BMW, all within like 4 or 5 years. My husband's hobby is buying and selling cars." The mother drives a Toyota Avalon and has had six other cars within the last ten years. The daughter is a full-time coordinator for a children's services organization and the mother is un-employed. The daughter earns \$3600.00 per month, and the mother pays \$0.00 toward her daughter's expenses each month.

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