

Feminism & Psychology

<http://fap.sagepub.com/>

Cosmetic surgery and neoliberalisms: Managing risk and responsibility

Michelle Leve, Lisa Rubin and Andrea Pusic

Feminism & Psychology published online 7 November 2011

DOI: 10.1177/0959353511424361

The online version of this article can be found at:

<http://fap.sagepub.com/content/early/2011/11/04/0959353511424361>

Published by:



<http://www.sagepublications.com>

Additional services and information for *Feminism & Psychology* can be found at:

Email Alerts: <http://fap.sagepub.com/cgi/alerts>

Subscriptions: <http://fap.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

>> **Proof** - Nov 7, 2011

[What is This?](#)

Cosmetic surgery and neoliberalisms: Managing risk and responsibility

Michelle Leve and Lisa Rubin

The New School for Social Research, USA

Andrea Pusic

Memorial Sloan Kettering Cancer Center, USA

Feminism & Psychology

0(0) 1–20

© The Author(s) 2011

Reprints and permissions:

sagepub.co.uk/journalsPermissions.nav

DOI: 10.1177/0959335111424361

fap.sagepub.com



Abstract

The practice and culture of cosmetic surgery has proliferated in the past two decades. While much feminist scholarship has investigated women's surgical stories, as well as the gendered sociocultural and sociopolitical contexts surrounding, and promoting, the 'choice' of surgery, very little research has examined material and symbolic risks associated with cosmetic surgery. This study employs a feminist interpretative phenomenological (IPA) approach to investigate cosmetic surgical risk experiences, as narrated by seven women who underwent aesthetic facial surgery. Our analysis focuses on how participants confront, and manage, medical, consumer and self-presentation risks associated with cosmetic surgery, under the political ethos of neoliberalism. The implications of these risk experiences are discussed in relation to the increasing normalization of cosmetic surgery and patriarchal/neoliberal obligations to construct a 'feminine' body through socially sanctioned practices.

Keywords

cosmetic surgery, neoliberalism, normalization, responsibility, risk, risk management

Introduction

This article addresses the relevance of both extant feminist scholarship and neoliberal influences on healthcare to women's narratives of risk in cosmetic surgery. The topic of cosmetic surgery – its practice, culture and patients – is fraught with controversy within feminist scholarship. Much of this debate has been around issues of how feminist scholars should theorize and research cosmetic surgery.

Corresponding author:

Michelle Leve, Department of Psychology, New School for Social Research, 80 Fifth Avenue, 6th Floor, New York, NY 10011, USA

Email: levem469@newschool.edu

Following the feminist tradition of 'giving voice' to women's experiences (Mattuck Trule, 1996), one approach to this topic prioritizes self-narrated surgical stories to access individual women's motivations, feelings and experiences in relation to cosmetic surgery. Other feminist scholars contend that such 'voice-centered' projects can overlook how gendered sociocultural and sociopolitical contexts shape and constrain the choices women make, and the kinds of stories women can tell about these choices (e.g. Bordo, 1997). Recent feminist scholarship attempts to move away from these tensions, to examine how surgery becomes normalized (Banet-Weiser and Portwood-Stacer, 2006; Brooks, 2004; Tait, 2007), the classification of 'good' and 'bad' surgical candidates (Heyes, 2009; Pitts-Taylor, 2007), and the increasing commoditization of surgical experiences (Jones, 2008).

The current study builds on this more recent, integrative feminist scholarship that moves beyond a gaze toward voice *or* culture, with a particular focus on cosmetic surgery risk. Risks to women's health, well-being and identity are at the center of many feminist critiques of cosmetic surgery. Moreover, within a medical context, decision making about surgery (particularly elective surgery) requires the patient to be informed of potential risks before providing autonomous consent (O'Brien et al., 2006). However, the risks, and responsibilities for such 'risk choices,' are always embedded in a cultural context (Tulloch and Lupton, 2003). Thus, our overall aim is to examine how dominant cultural repertoires of risk are reflected, or resisted, in individual narratives of women who have elected to have facial cosmetic surgery and other aesthetic facial procedures. We contend that, when examining risk experiences, it is important to explore both individual and sociopolitical domains because, as Lupton (1999:14) argues, 'those phenomena that we single out and identify as "risks" ... have an important ontological status in our understandings of selfhood and the social and material worlds'. Contemporary conceptualizations and preoccupations of risk in western culture – particularly concerns about medical, interpersonal and economic risk, to name a few – reflect sociocultural, political and economic contexts. Our awareness of these risks, and our choices about how to manage them, impacts our everyday lives, including how we distinguish ourselves from others, and our perception and knowledge of our bodies (Lupton, 1999).

Despite an otherwise large body of feminist scholarship, little attention has been paid to psychological and social risk in relation to cosmetic surgery. One exception to this is Raisborough (2007), who notes that while scholars typically focus on surgical blunders or botched procedures by untrained doctors, the risks associated with cosmetic surgery do not lie solely in the material domain. Rather, becoming a cosmetic surgery patient involves managing multiple physical and symbolic risks en route to, and post surgery. For instance, cosmetic surgery can itself be viewed as a strategy for negotiating risks, specifically aesthetic risks, within sociocultural contexts where physical appearance increasingly marks one's moral worth (Banet-Weiser and Portwood-Stacer, 2006; Raisborough, 2007). We contend that risks associated with cosmetic surgery include, but also go beyond, the physical domain. A key aim of this article is therefore to broaden feminist conceptions of cosmetic surgery risks through an analysis of patients' narratives.

In this article, we enter the tensions arising between voice- and culture-centered approaches, to explore cosmetic surgery risk experiences. Building on extant feminist scholarship and risk research, we explore how cosmetic surgery patients manage medical, consumer, and patient-role risks – paying particular attention to the contexts in which these risks are managed. We employ a feminist interpretative phenomenological analysis (IPA) to examine women’s surgical narratives and experiences from their perspective, while simultaneously situating their narratives within broader sociocultural and sociopolitical frameworks regarding beauty, aging and medicine. In doing so, we first describe our participants’ discussion of risk and risk management in their surgical narratives. Second, we utilize both the participants’ narratives and previous theoretical research as tools to interpret how risks are managed within a neoliberal milieu. Finally, we discuss the functions and consequences of facing and managing surgical risk(s).

Risk and responsibility in neoliberalism

The context that is of special interest in this article is that of a healthcare system shaped by neoliberalism in which individuals are encouraged, even expected, to make ‘lifestyle’ choices to maximize their life chances and simultaneously held responsible for managing and minimizing the risks associated with these decisions (Rose, 2000). Neoliberalism is a political-economic ideology and practice that promotes individualism, consumerism and transferring state power and responsibility to the individual (Galvin, 2002; McGregor, 2001; Newman et al., 2007). Proponents of neoliberalism argue for decreased government funding and power over social services, through deregulation and privatization, in the pursuit of a free market (Kelly, 2001). Further, with government reconfigured in this way, neoliberal citizens are situated as autonomous individuals, independent from society, whose success is measured through continuous work and consumption (McGregor, 2001). This neoliberal paradigm has begun to dramatically (re)shape health‘care’ in the USA (McGregor, 2001); however, neoliberalism permeates many other Anglo/western healthcare systems.

In relation to the body and health, Peterson explains, ‘neoliberalism calls upon the individual to enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement’ (1997: 194). Constructed currently as a form of bodily self-care (Raisborough, 2007), aesthetic surgery is thus a practice befitting the neoliberal ethos; which is perhaps in part why it has proliferated within this healthcare context. Neoliberal citizens are expected to ‘be empowered to take control of their lives’ (Galvin, 2002: 117), and their unruly bodies, with such empowerment usually expressed through consumptive practices. It follows that within this healthcare context, choice, in particular consumer choice, is emphasized (Braun, 2009; Ericson et al., 2000).

Concerning choices such as cosmetic surgery, Braun (2009: 117) for instance argues, ‘choice has been a central mechanism by which consumption, actions or representation otherwise cast as conforming to patriarchal, heterosexist gender relations are reframed as positive and empowered individual choices’.

Moreover, neoliberal citizens are expected to be knowledgeable, educated and reflexive in their risk-benefit calculations and healthcare decisions (Ericson et al., 2000). Underscoring this sort of risk management is the notion that citizens should accept individual responsibility for their health (Newman et al., 2007) and healthcare choices (Galvin, 2002), as the ideology of neoliberalism increasingly shifts responsibility for consumer protection from the state to the individual. Rose (2000: 337) has referred to this moment in 'advanced liberalism' as containing an:

emphasis upon creating active individuals who will take responsibility for their own fates through the exercise of choice, and the organization of sociopolitical concerns around the management and minimization of risks to lifestyles of contentment and consumption.

Thus, in this study, we explore how ideologies of neoliberalism shape women's decisions about cosmetic surgery as a lifestyle choice, their experience of risk and their strategies of risk management.

Feminist perspectives, cosmetic surgery, and risk

As mentioned, earlier feminist perspectives on cosmetic surgery (e.g. Bartky, 1990; Blum, 2003; Bordo, 2003; Morgan, 1991) have been critiqued for prioritizing either individual's narratives of cosmetic surgery or the sociocultural contexts that contribute to, and perpetuate, the practice of cosmetic surgery (see Pitts-Taylor, 2007 for a comprehensive review). These theoretical frameworks have been termed respectively 'agency' and 'structure' perspectives (Pitts-Taylor, 2007). More recent feminist scholarship goes beyond a singular focus on either the cosmetic surgery patient or the culture surrounding surgery. One of these analytic shifts examines the increasing normalization of these practices, positioning both print media (Brooks, 2004) and reality make-over television shows (Banet-Weiser and Portwood-Stacer, 2006; Tait, 2007) as perpetuating American's increasing comfort with cosmetic surgery. With regard to the former, American women's magazines situate cosmetic surgery as a new technology that is 'accessible and healthful, forward-looking and medically legitimate, [which] may become increasingly appealing – even difficult to refuse' (Brooks, 2004: 215). Reality make-over television shows, on the other hand, are considered to contribute to the domestication of cosmetic surgery and to a limited number of subject positions, including the patient as 'expert' (Tait, 2007).

Another analytic shift has converged around the complicated, and often conflictual, expectations of the patient-role in cosmetic surgery, with a particular focus on the 'surgery junkie/addict' (Blum, 2003; Fraser, 2003; Heyes, 2009; Pitts-Taylor, 2007, 2009). Blum (2003: 274) maintains that you 'become surgical' when 'surgery enters your world as a remedy for the body's flaws'. The 'addict', she contends, can be recognized by minimization of one's surgical experience through a comparison with more 'serious' procedures and/or 'someone who is addicted' (Blum, 2003: 280). Yet herein lies the paradox within cosmetic surgery subjectivity: patients

must be sufficiently dissatisfied with their appearance to seek cosmetic surgery, although excessive dissatisfaction may be deemed pathological and a contra-indication (Heyes, 2009; Pitts Taylor, 2007). Although the aforementioned research gives insight into the nuanced classification of surgical candidates, a question remains: how do cosmetic surgery patients manage, and experience, the risks of self-presentation to gain access to surgery?

Typically, risk in modern western cultures, deemed the 'risk-society' (Beck, 1992), is situated as something to be managed, minimized and generally avoided. The body in the risk-society is located in a position of endless safeguarding from external risks such as accidents and infection (Lupton and Tulloch, 1998). One could argue that electing to undergo cosmetic surgery – where risks such as bacterial infections are inevitable for some patients – is in direct conflict to this tendency towards risk-aversion. Raisborough (2007) complicates this taken-for-granted view of risk-avoidance and recontextualizes cosmetic surgery in the risk-society. She presents these procedures as a Foucauldian 'practice of the self', where individuals enhance and manage their bodies to create a self that is in alignment with current notions of morality.

Cosmetic surgery patients, for Raisborough (2007), are an example of Lupton and Tulloch's (2001) 'voluntary risk-takers', who recognize and confront known risks for the purpose of self-development. However, what is experienced as 'voluntary' is shaped by gendered sociopolitical contexts (Chan and Rigakos, 2002). Raisborough explores the everyday 'conditions of choosing' that women negotiate when electing to have surgery. She suggests that cosmetic surgery is currently located, and marketed, on a continuum of women's beauty practices, ranging from make-up and waxing, high-heeled shoes, to corset-wearing. By virtue of joining this continuum of bodily alterations, cosmetic surgery is normalized as yet another practice of 'doing respectable femininity in the everyday' (Raisborough, 2007: 28).

In the current climate of 'self-help' rhetoric, where the body is situated as a reflection of a moral self, what then becomes a 'risk' to women's identity and worth is the 'unattractive body', which signifies 'moral failure' (Raisborough, 2007). Moreover, through 'facing' the known risks of cosmetic surgery, individuals can show their dedication to self-work in the moral economy of neoliberalism that values bodily work for self-transformation. Raisborough (2007: 37) suggests:

as risks of surgery are increasingly known, choices to continue may be articulated through declarations that risks are 'worth' taking for the perceived material and symbolic benefits that a viable feminine body secures (albeit temporarily)... those risks are worth taking if the self has worth.

For Raisborough, then, cosmetic surgery is as much a normalized, understandable, and intelligible 'risk-choice' for women as a legitimate 'practice of the self' in neo-liberalism. The risks to self lie in the decision *not* to utilize cosmetic surgery as a 'normalized vehicle for self-transformation' (Raisborough, 2007: 30).

As a theoretical piece, Raisborough's analysis does not include the voices of actual cosmetic surgery patients. Thus, the question of how this risk-choice is taken up, and managed, by real women remains unexplored. In this article we build on Raisborough's work – incorporating qualitative data from cosmetic surgery patients – to explore the contention that cosmetic surgery is a 'risky-but-rewarding activity' (Larkin and Griffiths, 2004: 215). We suggest that by acknowledging that both agency and choice operate within the neoliberal epistemology, rather than outside it (Nahman, 2008), and situating an analysis within this reality, feminists can further resolve the aforementioned tensions between voice-centered and culture-centered approaches. Thus, following Raisborough, throughout our analysis we locate individual experiences of choice and agency in the conditions of choosing in which they are enmeshed. We hope that by examining both women's personal accounts of surgical risk and the context of neoliberalism in which their surgical stories are embedded, we will begin to understand some of the complexities between the social/political, individual 'choice', and risk.

Method

The current study aims to examine how cosmetic surgery patients discuss, and manage, the material and symbolic risks associated with surgery. Drawing on Smith and colleagues' work (Smith and Osborn, 2008; Smith et al., 1999), we conducted a feminist IPA of seven semi-structured interviews with women who have elected to have facial cosmetic surgery, seeking to both capture and locate their detailed cosmetic surgery narratives within the current healthcare context of neoliberalism. IPA – at once a methodology and an epistemology – enables an analysis of how participants make sense of their experiences while recognizing that these expressions are complicated and multiply determined – thus warranting interpretation. It follows that IPA was useful for this project, as it allowed us to retain our analytic focus on 'person[s]-in-context' (Larkin et al., 2006). This meant attending to the 'key objects of concern' in participants' lived experiences with an interest in how people 'understand and make sense of their experience in terms of their relatedness to, and their engagement with, those phenomena' (Larkin et al., 2006: 109). While this project originally sought to examine decision making in cosmetic surgery, we have chosen to narrow our focus to risk, as it emerged as a key object of concern among participants. Following Gill's (2007) notion of 'critical respect' – considerate and conscientious listening while leaving space for critical questioning – we aimed ultimately to respectfully listen to our participants *and* to critically examine both their stories and the context in which they are embedded.

The seven participants whose experience we analyze here were drawn from a larger project on facial cosmetic procedures. We decided in this study to focus on women, as they had 91 percent of the total cosmetic procedures in 2009 (American Society of Plastic Surgeons, 2010). A sample of seven is in accordance with standards within IPA, where the small sample size speaks to the method's in-depth, idiographic focus (Reid et al., 2005; Smith and Osborn, 2008). In accordance with IPA's idiographic focus (Smith, 2011), we chose to limit our attention to participants who had

at least one facial surgical procedure. Five were selected from the larger sample of 23 transcribed interviews for having undergone a minimum of one facial aesthetic surgery. The remaining two participants, who also experienced at least one facial surgery, were selected to further the ethnic diversity of the sample. Participants had variably undergone a range of surgeries and other facial cosmetic procedures, including: blepharoplasty (eyelid surgery), rhinoplasty (nose surgery), face-lift, neck-lift, forehead-lift, chin-implant, Botox, injectable fillers (Restylane, collagen, etc.), and skin resurfacing

Our participants were between three months and seven years post-operative, and ranged in age from 44 to 64 years old. Three identified as White non-Hispanic, one as White-Hispanic, one as Hispanic, and one as Asian/Pacific Islander. Data on sexual orientation were not collected; all of the women spoke about heterosexual relationships in the interviews. All of the participants had at least some higher education and their reported household incomes suggest a primarily 'middle-' or 'upper-class' group. Two of the participants (Maria and Jan) underwent only one surgery (blepharoplasty), while the remaining five experienced four or more procedures.

All interviews were conducted by a research assistant with prior experience interviewing patients about cosmetic surgeries. Participants were asked the following types of questions: Do you want to start by telling me about the first facial procedure you had? How did you find the doctor? How did you find the recovery process? What were you expecting from the surgery? What did you know about the procedures before the surgery? Are you considering other surgeries? The interviews ended with the interviewer asking the participant if there was anything else about the surgical process that she would like to share. All interviews were audio-recorded and transcribed verbatim by a professional transcription service.

The analysis was conducted using IPA (Smith and Osborn, 2008; Smith et al., 1999). As a qualitative approach that is both idiographic and inductive (Reid et al., 2005), IPA involves two levels of analysis. The first phenomenological phase explores how participants make sense of their lived experiences; the second interpretive phase involves interpreting and contextualizing the participants' experiential claims. The first author began the analysis by recording first-order codes – initial broad notes, potential themes, and anything of interest were noted. Following further examination of the transcript, themes were consolidated, extracted, and recorded to abstractly capture the meaning and context of the first-order codes.

Connections between these themes were then examined to form clusters. During this clustering the transcript was continually referred back to in order to ensure that the connections accurately reflected the participant's narrative. Patterns of convergences and divergences were noted, and multiple family-tree type diagrams were constructed, to further the examination of the relationship between themes. Finally, a directory of excerpts that illustrated the themes was constructed. The thematic directory was reviewed by the second author and an independent auditor to ensure 'transparency' of the results and how well the analysis demonstrates the themes and interpretation process to the reader (Yardley, 2008). A final table of super-ordinate themes and sub-themes was thus constructed, which, along with the directory, was then utilized to guide the write-up of the analysis. In the remainder

of the article we discuss one of the extracted super-ordinate themes – managing risk.

Managing risk

Risk and risk management were ‘key objects of concern’ in the participants’ decision-making narratives. In this section we utilize three identified sub-themes – managing risk as a consumer, managing medical risk(s), and being a ‘good patient’ not a surgery junkie – as frameworks to explore the interaction between individual risk narratives and available sociocultural repertoires of cosmetic surgery risks.

Managing risk as a consumer

In the neoliberal healthcare context of the USA, and particularly in the context of elective surgery, the cosmetic surgery patient is repositioned from patient to consumer (Jones, 2008). This emphasis on the patient as consumer was seen repeatedly in participants’ narratives on doctor selection, which was discussed by participants as a consumer experience or, as Jan referred to it, ‘doctor shopping:’ ‘I mean, you can shop around for doctors, like you can shoe stores or anything else.’ The notion of selecting a doctor is thus positioned as akin to other consumer choices. Moreover, embedded in the participants’ narratives was the repertoire of ‘caveat emptor’ – let the buyer beware – where the onus is on the patient/consumer. Although the means through which the participants found their doctor differed, as ‘responsible’ patients they managed their risk through careful consumer research. Conversely, those who suffered negative outcomes were depicted as generally having only themselves to blame. This sentiment is expressed explicitly by Maria:

Surgery is never easy but you know it’s something that has to be done. Here this is something that you’ve made a choice and if it doesn’t work out then you have only yourself to blame.

Maria’s statement also evokes an increasing imperative for cosmetic surgery (Braun, 2009; Tait, 2007) – cosmetic surgery is discussed here as a *need*, as ‘something that has to be done’. In a similar vein, participants equated cosmetic surgery with other standard, maintenance procedures, drawing parallels between the body and a variety of consumer goods. Valerie compared electing surgery to maintaining the body of a car: ‘It’s trying to keep up a building, you know, a structure together or a car.’ Catherine on the other hand likened surgery to upgrading from a CD player to an iPod, stating:

You can go buy, uh, what’s it called? iPod. You know? . . . Before they don’t have that. Then you don’t have availability, and you, but people totally refused to buy iPod. It’s up to them they still want to carry that big CD.

Catherine's words underscore the expectation of neoliberal citizens to be "enterprising individuals," who make [consumer] "choices" and who, consequently, are responsible for the outcome of these choices' (Galvin, 2002: 117). In contrast, those who refuse such consumption risk being deemed outmoded, or irrelevant.

Part of the management of consumer risk was depicted when participants repeatedly stated that it is the patient's/client's responsibility to find a 'good doctor.' One of the purposes of finding a good doctor was to minimize the chance of surgical mishaps and/or negative surgical outcomes. The relationship between selecting a good doctor and preventing negative surgical outcomes was seen in Jan's discussion of how she finds good doctors:

And usually with doctors, I only go to doctors that are – I – that are referred to me. . . . Because I just like to – I, I don't want to be one of these people that has, uh, whether its whatever the problem is I don't want to have to worry about, um, having a – doctor and have something terribly go, something terribly medically go wrong with me.

The ways in which the participants selected good doctors varied from a single visit with a recommended doctor, visiting multiple doctors (sometimes traveling to do so), and researching doctors on the internet and in articles in beauty magazines. For example, when asked how she found the surgeon who performed her blepharoplasty, Maria explained at length the steps she took to find a good doctor:

What I did is I started with what I didn't want. My mother-in-law had her eyes done and it was a cheap job. It was horrible; she has one eye that looks higher than the other. I don't know what the hell she had done. She said it cost \$2,500 and it was just garbage. The second thing was I started looking around. I guess I've been planning this for ten years because I just started ripping out articles and whatever magazines I saw that had these stories, *Allure*, *Vogue* or something. So I just started ripping out articles and I put them away. Then when I decided I was really going to do it, I pulled out the articles and I started researching the doctors and one of them was Dr. X.

In an attempt to avoid a negative surgical outcome like her mother-in-law experienced (which was seen as a result of going to a bad and cheap doctor), Maria undertook thorough research to find Dr X. However, despite doing so, she ultimately contracted a post-operative infection at the surgical site. She states:

A week after I got an eye infection. They did everything they could, set me up, made several appointments and stuff with doctors to try and clear it up. We finally hit the jackpot with the second doctor who diagnosed the problem. And the eye infection's cleared up. So I was really taken care of every step of the way.

Here we see how Maria's 'doctor shopping,' and her decision to choose a recognized surgeon, shapes her attributions about her own complications. In contrast

to her mother-in-law, neither she nor her surgeon is responsible. Rather, both Maria and her doctors' successful management of the infection underscore her sense of agency, and her successful risk management. Since participants repeatedly placed the responsibility of going to a good doctor on themselves, attributing a negative outcome to the doctor would thereby imply that the patient had done a poor job of managing risk.

Thus, as noted, reflected in the participants' narratives was a conflation of patient and consumer roles. This hybridized subject position echoes rhetoric of the 'postfeminist consumer citizen': a supposedly acultural subject who is empowered by the ability to choose when, how and where she engages with beauty practices (Gill, 2007: 74). At the individual level, the participants expressed feelings of accomplishment through making the decision to elect surgery and shop for a good doctor. However, consumer fulfillment from this choice at the micro-societal level reflects *constrained* choice(s) at the macro-societal level – choices made within a specific, regulated sociocultural system. As Braun (2009) argues, the choice of electing to have cosmetic surgery has become more of a mandate within neoliberalism where choosing to *not* alter one's appearance in accordance with dominant beauty standards means choosing ugliness (or choosing a cumbersome, antiquated CD player over a sleek iPod). The doctor-shopping stories perhaps then indicate feelings of agency, where participants gain a sense of empowerment within a neoliberal healthcare milieu by doing exactly what sustains the system: assuming responsibility for a consumer choice. In this way, managing consumer risk has a somewhat paradoxical effect: the participants experienced feelings of agency through their research skills and their ability to select a good doctor, yet these experiences are simultaneously indicative of a neoliberal ethos that promotes empowerment through consumer choice and responsibility for self-care. Their individual agency, therefore, is embedded in the context in which it is enacted.

Managing medical risk(s)

As noted, risk in cosmetic surgery is typically associated with medical risks such as surgical blunders or botched procedures by untrained doctors (Raisborough, 2007). Although medical risks were not the only forms of risk that the participants attempted to manage, interactions with medical risks did appear repeatedly throughout the participants' narratives. The participants emphasized or described their attempts to manage risks such as pain, bruising, swelling or scarring through various forms of self-care. The participants followed medically recommended strategies of care and also created their own care regimes in efforts to prevent negative physical outcomes such as severe bruising, scarring or infection. Medically endorsed forms of post-operative self-care included but were not limited to: icing the surgical site, sleeping upright, taking or not taking certain vitamins, taking antibiotics and private nurses. The participants explained that by following these recommendations they were able to 'help' the recovery process and avoid potential negative outcomes.

Additionally, some of the women had created their own self-care regimes, which they experienced as aiding in the recovery process. Kelly developed her own form of self-care using herbs and vitamins to manage bruising and bleeding:

The parsley really works. It takes the bruising away . . . Yeah. Just put parsley all over your face. That and, um, you just have to not take vitamin E and your omegas and – 'cause it makes you bleed worse.

We postulate that the participants' emphasis on medically and self-created forms of post-operative self-care reflects both their feelings of electing cosmetic surgery as an agentic decision (Davis, 1995) and the expectation that they act as a good patient/consumer within a neoliberal healthcare milieu, that emphasizes hyper-responsible selves (Braun, 2009) who are liable for the consequences of actions taken on the body. As noted by Galvin (2002: 120), managing risks in health behavior 'has become simultaneously a source of personal power and a tool for blaming those who fail in the face of choice'.

Participants spoke about managing post-operative pain in one of two ways – either as an expected, but necessarily silenced, part of the post-operative recovery process, or by negating and/or minimizing it. This is depicted in the following extract from Kelly:

Yeah. I mean, the first couple of days – you know what I learned as a woman undergoing surgery? You should keep your mouth shut. You know, I don't think it serves anyone to complain about elective surgery. Be a big girl.

Kelly's comment gives insight into why other interviewees may negate the experience of pain. We don't necessarily know how Kelly learned this, but she makes it clear that she learned, perhaps through experience, it is not acceptable to express pain associated with aesthetic surgery. This discomfort with telling others about her bodily suffering could perhaps be explained by Bendelow and Williams's (1995) argument that experiences and expressions of pain are mediated by the sociocultural context. More specifically, Jones (2008:18) argues, 'cultural silences around the actual process of cosmetic surgery mirror the logic of before/after, meaning that the substantial emotional and physical pain, risk and suffering involved in the transformative methods are disavowed'. However, among those who insisted that 'there was no pain', suffering was expressed through various expressions or euphemisms. For example Jan states:

I was surprised because I was given painkillers and I didn't need them . . . But for the, for the, for this, for the, facelift and the eyelid or – there was no pain. There was just, like, fire, discomfort, which was like, no big deal.

Jan's narrative highlights how post-operative physical suffering was indeed experienced by some of the participants. However, what is of analytic interest here is *why* the participants denied and minimized 'pain' – situating these bodily

experiences as ‘no big deal.’ We would like to suggest that these minimizing narratives are a product of the increasing normalization of cosmetic surgery. Articles in women’s magazines highlight cosmetic surgery as casual, unthreatening and accessible – likened to hairdressing or dental work – which contributes to the normalization of this practice (Brooks, 2004). Moreover, cosmetic surgery is located and advertised as a continuation of women’s everyday beauty practices, further normalizing surgery as part of a regime of normative femininity (Jeffereys, 2005; Raisborough, 2007). This minimizing ‘makes cosmetic surgery seem to be a “natural” part of women’s everyday worlds, making it an often unquestioned practice by those engaging in it’ (Ancheta, 2002: 148). The expression of post-operative bodily suffering as ‘no big deal’, like the experience of doctor shopping, illuminates ‘the economic and cultural normalization of cosmetic surgery in the United States over the past decade’ (Banet-Weiser and Portwood-Stacer, 2006: 269). Thus, it could be argued that cosmetic surgery as ‘no big deal’ reflects how in the last 30 years surgery has become just another form of make-up (Haiken, 1997; Jeffereys, 2005).

A ‘good patient’ not a surgery junkie

According to Pitts-Taylor (2009: 125), ‘the sorting of patients into good and bad candidates is now a significant part of the cosmetic surgery process.’ For instance, as part of her participant-observation in a cosmetic surgery clinic in the USA, Gimlin (2002) interviewed a surgeon who discussed the process by which patients are screened and selected. This surgeon had created a typology of potential patients, which included the ‘self-motivated and realistic patient’ and those who are ‘flighty’ and want surgery for ‘bizarre’ reasons, for whom access will likely be denied (Gimlin, 2002). Somewhat similarly, when describing the context of female genital cosmetic surgery, Braun (2009) notes that the ‘ideal’ patient is ‘rational’, ‘reasonable’, and has ‘realistic’ expectations regarding the outcome of surgery. Thus, women interested in cosmetic surgery walk a tightrope, having to maintain sufficient hope, and even fantasy, of how cosmetic surgery will transform their life to make it worthwhile to endure its relative high cost and physical demands, while simultaneously demonstrating to their surgeon their rationality and reasonability in order to gain access to it.

The participants also situated their surgical experience through comparisons with worse, excessive or extreme surgical consumers. Anne for example contrasted her experience as a ‘good patient’ with surgery ‘junkies’ or ‘addicts.’ As the following extract from Maria portrays, a surgery addict or junkie was depicted as someone who radically alters their exterior, while participants’ individual experiences were depicted as rational, common, or normal:

I know certain things there might be limitations. Unless you’re Michael Jackson you’re not really going to be able to change your entire face or the cat lady, what’s her name, Weinstein or whatever her name was. Yeah because this was something

that's very common. It's a very common procedure so this was something that could be done.

Thus, surgery junkies from popular American culture were positioned by these participants as 'Other' to their 'normal' surgical experience. By the Other we refer to a non-self who deviates from social norms (Brooker, 2003), creating anxiety for the self particularly if the boundary between self and Other is blurred (Lupton, 1999). Notions of Otherness are predominant in risk interactions that involve the body (Lupton, 1999). According to Lupton, the body of the 'risky Other' is seen as unregulated and out of control and is frequently positioned as risky to oneself. The narratives in this study illustrate how the participants located their surgical experience within normal boundaries whereas the surgery junkie was positioned as deviating from socially sanctioned surgical experiences. Given that most of the participants compared their decision to elect cosmetic surgery to addicts or junkies from popular culture, we posit that the participants were concerned with what Lupton has called the 'fear of contamination', which occurs in members of the dominant group who have positioned a marginalized group as Other. Extending this concept to the cosmetic surgery patient and the surgery junkie, we postulate that this fear is present in the participants' narratives because gaining access to cosmetic surgery is partially dependent on not being identified as a junkie/addict (Heyes, 2009; Pitts-Taylor, 2007).

Another distinction the participants made was between the procedure(s) the individual elected to have and other cosmetic surgeries. The participants experienced their cosmetic surgery as a *necessary* surgical fix whereas other procedures were situated as too vain, painful or harmful. When asked if she had ever tried any injectables such as Botox or Restylane, Rebecca explains:

I didn't. That's interesting that you said that, because I don't know why I'm against it. Um, and I think because when I see people – when they have it done, they look so – they can't move their face, they can't move their mouth. They look so artificial. And, um, I mean, it's a poison that you're putting into your body.

For some participants, other procedures including fillers/injectables, cheek implants and other forms of face-lifts were discussed as crossing a boundary from reasonable surgical fix to harmful or unnecessary beauty practice. The variety of comparisons between surgeries lead us to postulate that it is not the procedure per se that the participants opposed. Rather, it is the act of drawing a line, demarcating a boundary between one's own cosmetic procedure and Other forms of cosmetic surgery that serves to validate the participants' decisions to elect to have (certain) cosmetic surgery, and to underscore these decisions as bounded and conservative. Larkin and Griffiths (2004) have referred to this form of risk comparison as 'measured risk-taking'. Measured risk-taking involves discursively positioning one's own risk choice as rational and balanced through downward comparisons with other users and activities. Extending this idea to cosmetic surgery, we speculate that the combined comparisons with addicts, extreme surgical

aesthetics and other cosmetic procedures is a form of individual risk management that enables the participants to frame and experience their decision to elect to have cosmetic surgery as rational, reasonable and necessary as opposed to surgery that 'Others' have elected to have, which is seen as irrational, unreasonable and unnecessary.

Such downward comparisons and minimizations of the participant's own practices have both individual and sociocultural functions and consequences. A surgical candidate must present herself as a normal patient, as opposed to a surgery junkie, in order to become a cosmetic surgery patient (Blum, 2003; Gimlin, 2002). If one requests *too* great a change or has had *too* many prior procedures then there is a risk of not being allowed to have surgery (Blum, 2003). However, what is considered 'too much' depends on the subjective decision of a given surgeon. In her interviews with cosmetic surgeons, Pitts-Taylor (2007) found that there was great variability amongst surgeons regarding what constitutes an addict; between five and 25 prior surgeries were cited as indicative of pathology. Thus, what constitutes an addict in interviews with doctors (Pitts-Taylor, 2007), medical texts (Fraser, 2003), and in the participants' narratives, remains vague. Nonetheless, these comparisons with addicts do have a function, they enable those interested in surgery to distinguish themselves as rational, reasonable, good patients who are distinct from the surgery junkie/addicts, and thus these comparisons work as an entry point to a surgical experience where doctors seek good patients. Further, these downward comparisons also reflect the normalization of cosmetic surgery in a larger social context (Blum, 2003). Through discursively positioning their surgical narratives as distinct from surgery junkies, extreme surgical aesthetics and 'unnecessary' cosmetic surgeries the participants located their surgical experiences as normal, which enabled their personal surgical engagement, while simultaneously contributing to the normalization of cosmetic surgery as a practice.

Discussion

The themes that were seen throughout the participants' risk narratives were centered around issues of *normalization* and '*responsibilisation*'. As noted, the participants expressed a responsibility to 'shop' for a good doctor in an attempt to prevent negative surgical outcomes. Although most of the potential negative outcomes were literally out of their control, the participants nonetheless experienced doctor shopping as a safeguard against surgical blunders. This '*responsibilisation*' reflects 'neoliberal imperatives for taking personal responsibility for health' (Newman et al. 2007: 578). Further, participants compared doctor shopping to other consumer choices, which extends Jones's (2008) argument that within the field of cosmetic surgery there has been a shift from patient to consumer. Within the doctor shopping narratives, participants situated themselves as free agents and expert researchers engaging in a consumer activity. We suggest that the theme of doctor shopping – and in particular the casting of cosmetic surgery as an ordinary consumer activity – underscores its normalization. As Brooks argues, readers of American women's magazines are assured that physical risks such as excessive

bleeding or permanent nerve damage can be prevented ‘by choosing an experienced doctor’ (2004: 222). These sentiments contribute to, and perpetuate, Americans’ increasing comfort with cosmetic surgery (Brooks, 2004). Discourses from American media, which normalize cosmetic surgery, were ubiquitous within participants’ narratives. We contend that study participants, situated in this context, experienced cosmetic surgery as a normalized beauty practice and yet another way of ‘doing respectable femininity in the everyday’ (Raisborough, 2007: 28).

The participants’ accounts of *managing medical risks* further illustrate a kind of ‘responsibilisation’ (Kelly, 2001), tied to post-operative self-care. This responsibility for personal health, as we argued in the introduction, is mandated in the healthcare context of neoliberalism (Galvin, 2002). As Novas and Rose (2000: 489) argue, ‘the patient is to become skilled, prudent and active, an ally of the doctor, a proto-professional – and to take their own share of the responsibility for getting themselves better’. The participants’ strategies for managing post-operative pain, and their insistence that pain is (or should be treated as) ‘no big deal,’ are consistent with the growing approval of cosmetic surgery as seen on surgery make-over shows (Banet-Weiser and Portwood-Stacer, 2006; Tait, 2007) and in American women’s magazines (Brooks, 2004). Like participants in the current study, Tait notes the minimizing of physical pain in reality television make-over shows, which she describes as an ‘effacement of carnality’ (2007: 127) that trivializes pain in surgical recovery. Further, the seemingly magical disappearance of physical pain and suffering in surgical make-over shows – the before/after – promotes surgery as unthreatening and inviting, akin to putting on lipstick (Jones, 2008). Thus, it could be argued that the participants’ accounts of managing medical risks both reflect and reproduce discourses surrounding the normalization of cosmetic surgery.

The theme of a *‘good patient’ not a surgery junkie* represents more overt references to both responsabilization and normalization. The participants contrasted their normal surgical needs, expectations, and procedures with surgery junkies or addicts who they deemed over-users of this practice. By Othering the surgery junkie, the participants project their anxieties about the limits of body modification onto the grotesque and stigmatized body of the junkie. This strategy is consistent with Blum (2003) and Gimlin’s (2002) arguments that in order to become a cosmetic surgery patient, a surgical candidate must present herself as normal, as opposed to a surgery junkie who is psychologically ‘disordered’. Women interested in cosmetic surgery ‘must successfully walk the tightrope of assessment’ (Parker, 1995: 196), and endure the burden, and responsibility, of locating their surgical expectations within normal boundaries. The good patient, like the good neoliberal citizen, is a rational individual who accepts responsibility for her healthcare decisions.

Another risk that was more implicitly embedded in the participants’ narratives was the risk of *not* having cosmetic surgery. Women in this study discussed cosmetic surgery as a necessary ‘choice,’ an imperative, and something that *has* to be done. These experiences embody Rose’s (2000) argument that within the neoliberal milieu individuals are required to make ‘lifestyle’ choices, such as cosmetic surgery, to increase their quality of life. Further, this finding broadens previous feminist

research, particularly Tait's argument that television programs such as *Extreme Makeover* normalize cosmetic surgery so that 'facial and bodily features which are culturally reviled become increasingly contingent: [whereby] "ugliness" becomes our choice and responsibility' (2007: 127). Behind participants' adoption of the neoliberal rhetoric of choice were sentiments that cosmetic surgery is an obligation. In contexts where individuals are expected to be self-improving subjects Braun argues that 'choice and obligation are enmeshed' (2009: 244). In addition to experiencing a 'responsibilisation' to manage the aforementioned risks, we suggest that the participants also attempted to manage the 'risk of ugly'. In a gendered social order where women's moral worth is tied to their physical appearance (Raisborough, 2007), women who are deemed 'unattractive' or 'ugly' risk severe social sanctions (Bartky, 1990). Bartky contended that heterosexual women can face a loss of intimacy if their bodies are not plucked, bound, youthful and supple while all women (regardless of sexuality) run the risk of a 'refusal of a decent livelihood' (1990: 104). Given the potential consequences of an unattractive or unfeminine body, in addition to the moral responsibility to construct a feminine appearance, we suggest that the current study provides a qualitative example of cosmetic surgery as a comprehensible risk-choice for women (Raisborough, 2007). However, what remains troubling is the context of neoliberalism and patriarchy that promotes cosmetic surgery as a normalized and understandable choice.

Despite media depictions and 'informed consent' regarding the potential negative outcomes of cosmetic surgery, women continue to elect this practice. At the material level, cosmetic surgery can cause severe pain, scarring, nerve damage, hematoma even death (Morgan, 1991; Moyer and Baker, 2005). Nonetheless, the symbolic risks of *not* having surgery are tied to the obligation to construct a 'feminine' body through socially sanctioned practices, which for many women is essential to constructing an external appearance that corresponds to their embodied sense of self (Bartky, 1990). Flowers, Smith, Sheeran and Beail (1997) have suggested that gay men who engage in unprotected sexual intercourse with other men often do so by privileging certain 'rationalities' (i.e. romantic relationships) over other motivations (i.e. HIV status). We would like to extend Flowers and colleagues' argument to the practice of cosmetic surgery to suggest that the women in this study are privileging the symbolic rewards of a normative feminine body over the potential material risks to the physical body.

Before concluding it is worth noting limitations of the current study that may have implications for the themes that were identified. It is possible that the socio-cultural context in which the participants underwent cosmetic surgery may have exaggerated the participants' feelings of 'responsibilisation'. With respect to this, the extent of transferability of our analysis will depend upon further qualitative studies being conducted with different groups of women in a variety of sociocultural contexts. Gimlin's (2007) comparative analysis of women who elected to have cosmetic surgery in the USA and the UK found some differences between these two groups. Women in the UK made more 'concessions and excuses' when discussing their decision to elect to have cosmetic surgery, whereas American women situated their decisions in terms of individual 'financial sacrifice and physical effort'

(Gimlin, 2007: 55). However, Gimlin's analysis did not specifically address risk and risk management in these two groups. An interesting and fruitful area of research would be to explore experiences of risk management in cosmetic surgery in other non-market-based healthcare contexts such as Canada, Australia or New Zealand.

This article has explored cosmetic surgery risk experiences within the neoliberal healthcare milieu of the USA. Our research extends Raisborough's (2007) argument that cosmetic surgery risks go beyond the material domain, such that women who elect to have this practice must also manage consumer and self-presentation risks. Further, through listening to women's surgical stories we have shed light on how neoliberal rhetoric in popular media that normalizes cosmetic surgery is reflected in individual narratives. We have also drawn attention to the participants' experience of cosmetic surgery as 'something that has to be done'. This imperative for surgery raises questions about the notion of informed consent: If women who elect this practice feel obligated to *do* cosmetic surgery, then how can one autonomously choose whether or not undergo a procedure? Moreover, as Parker argued, 'surgeons' views of and participation in the cultural construction of female beauty are likely to influence their interpretation, and subsequent disclosure of data and information during informed consent' (1995: 189). When both surgeons and patients are embedded in conditions of choosing that morally value normative femininity, risk/benefit discussions – a critical component of informed consent – will likely reflect these values. This is an important issue for women's health advocates and activists, and we would like to suggest that the dialogue surrounding informed consent be expanded to include the cultural and sociopolitical contexts in which this consent is embedded. In sum, research such as ours begins to highlight the importance of examining both individual narratives and the gendered sociopolitical contexts when studying normalized beauty practices. Thus, we suggest that both the structure and agency perspectives *together* are useful analytic tools when exploring cosmetic surgery. Finally, our research provides a further example of women's healthcare experiences where risk, obligation and 'choice' are enmeshed.

Acknowledgements

The authors would like to thank Rachel Liebert and Jessica Henry for their help with earlier editions of the manuscript, and Amie Scott for conducting the patient interviews. Most of all, we extend our gratitude to the women who participated in this research.

References

- American Society of Plastic Surgeons. (2010) *2010 Report of the 2009 Statistics of Plastic Surgery Statistics*, Arlington Heights, IL. Available at: www.plasticsurgery.org/.../statistics/2009-US-cosmeticreconstructiveplasticsurgeryminimally-invasive-statistics.pdf.
- Ancheta RW (2002) Discourse of rules: Women talk about cosmetic surgery. In: Ratcliff KS (ed.) *Women and Health: Power, Technology, Inequality, and Conflict in a Gendered World*. Boston, MA: Allyn and Bacon, 143–149.
- Banet-Weiser S and Portwood-Stacer L (2006) 'I just want to be me again!' Beauty pageants, reality television, and post-feminism. *Feminist Theory* 7(2): 255–272.

- Bartky S (1990) *Femininity and Domination: Studies in the Phenomenology of Oppression*. London: Routledge.
- Beck U (1992) *Risk Society: Towards a New Modernity*. London: Sage.
- Bendelow GA and Williams SJ (1995) Transcending the dualisms: Towards a sociology of pain. *Sociology of Health and Illness* 17(2): 139–165.
- Blum VL (2003) *Flesh Wounds: The Culture of Cosmetic Surgery*. Berkeley: University of California Press.
- Bordo S (1997) Material girl: The effacements of postmodern culture. In: Lancaster R and di Leonardo M (eds) *The Gender/Sexuality Reader: Culture, History, Political Economy*. London: Routledge, 335–358.
- Bordo S (2003) *Unbearable Weight: Feminism, Culture, and the Body*. Berkeley: University of California Press.
- Braun V (2009) The women are doing it for themselves. *Australian Feminist Studies* 24: 233–249.
- Brooker P (2003) *A Glossary of Cultural Theory*, 2nd edn. New York: Oxford.
- Brooks A (2004) ‘Under the knife and proud of it’: An analysis of the normalization of cosmetic surgery. *Critical Sociology* 30(2): 207–239.
- Chan W and Rigakos GS (2002) Risk, crime and gender. *British Journal of Criminology* 42(7): 743–761.
- Davis K (1995) *Reshaping the Female Body: Dilemmas of Cosmetic Surgery*. London: Routledge.
- Ericson R, Barry D and Doyle A (2000) ‘The moral hazards of neo-liberalism: Lessons from the private insurance industry. *Economy and Society* 29(4): 532–558.
- Flowers P, Smith JA, Sheeran P and Beail N (1997) Health and romance: Understanding unprotected sex in relationships between gay men. *British Journal of Health Psychology* 2: 73–86.
- Fraser S (2003) The agent within: Agency repertoires in medical discourse on cosmetic surgery. *Australian Feminist Studies* 18(40): 27–44.
- Galvin R (2002) Disturbing notions of chronic illness and individual responsibility: Towards a genealogy of morals. *Health: An Interdisciplinary Journal for the Social Study of Health Illness and Medicine* 6(2): 101–137.
- Gill RC (2007) Critical respect: The difficulties and dilemmas of agency and ‘choice’ for feminism: A reply to Duits and van Zoonen. *European Journal of Women’s Studies* 14(1): 69–80.
- Gimlin DL (2002) *Body Work: Beauty and Self-image in American Culture*. Berkeley, CA: University of California Press.
- Gimlin D (2007) Accounting for cosmetic surgery in the USA and Great Britain: A cross-cultural analysis of women’s narratives. *Body & Society* 13(1): 41–60.
- Haiken E (1997) *Venus Envy: A History of Cosmetic Surgery*. Baltimore, MD: Johns Hopkins University Press.
- Heyes CJ (2009) Diagnosing culture: Body dysmorphic disorder and cosmetic surgery. *Body & Society* 15(4): 73–93.
- Jeffreys S (2005) *Beauty and Misogyny: Harmful Cultural Practices in the West*. London: Routledge.
- Jones M (2008) *Skintight: An Anatomy of Cosmetic Surgery*. Oxford: Berg.
- Kelly P (2001) Youth at risk: Processes of individualization and responsabilisation in the risk society. *Discourse: Studies in the Cultural Politics of Education* 22(1): 23–33.
- Larkin M and Griffiths MD (2004) Dangerous sports and recreational drug-use: Rationalizing and contextualizing risk. *Journal of Community and Applied Social Psychology* 14: 215–232.

- Larkin M, Watts S and Clifton E (2006) Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology* 3: 102–120.
- Lupton D (1999) *Risk*. New York: Routledge.
- Lupton D and Tulloch J (1998) The adolescent ‘unfinished body’: Reflexivity and HIV/AIDS risk. *Body & Society* 4(19): 19–34.
- Lupton D and Tulloch J (2001) Border crossings: Narratives of movement, ‘home’, and ‘risk’. *Sociological Research Online* 5(4). Available at: www.socresonline.org.uk/5/4/lupton.html.
- Mattuck Trule J (1996) Voices in dialogue: Collaborative ways of knowing. In: Golberger N, Clinchy B and Belenky M (eds) *Knowledge, Difference, and Power*. New York: Basic Books, 274–304.
- McGregor S (2001) Neoliberalism and health care. *International Journal of Consumer Studies* 25(2): 82–89.
- Morgan KP (1991) Women and the knife: Cosmetic surgery and the eclipse of identity. *Body & Society* 8(4): 21–42.
- Moyer JS and Baker SR (2005) Complications of rhytidectomy. *Facial Plastic Surgery Clinics of North America* 13(3): 469–478.
- Nahman M (2008) Nodes of desire: Romanian egg sellers, ‘dignity’ and feminist alliances in transnational ova exchanges. *European Journal of Women’s Studies* 15(65): 65–82.
- Newman CE, Bonar M, Greville HS, Thompson SC, Bessarab D and Kippax SC (2007) ‘Everything is okay’: The influence of neoliberal discourse on the reported experiences of aboriginal people in Western Australia who are HIV-positive. *Culture, Health & Sexuality* 9(6): 571–584.
- Novas C and Rose N (2000) Genetic risk and the birth of the somatic individual. *Economy and Society* 29(4): 485–513.
- O’Brien CM, Thorburn TG, Sibbel-Linz A and McGregor AD (2006) Consent for plastic surgical procedures. *International Journal of Surgical Reconstruction* 59(4): 983–989.
- Parker LS (1995) Beauty and breast Implantation: How candidate selection affects autonomy and informed consent. *Hypatia* 10(1): 183–201.
- Peterson A (1997) Risk, governance and the new public health. In: Peterson A and Bunton R (eds) *Foucault, Health and Medicine*. London: Routledge, 189–206.
- Pitts-Taylor V (2007) *Surgery Junkies: Wellness and Pathology in Cosmetic Culture*. New Brunswick, NJ: Rutgers.
- Pitts-Taylor V (2009) Becoming/being a cosmetic surgery patient: Semantic instability and the intersubjective self. *Studies in Gender and Sexuality* 10: 119–128.
- Raisborough J (2007) Contexts of choice: The risky business of elective cosmetic surgery. In: Jones J and Raisborough J (eds) *Risk, Identities and the Everyday*. Hampshire: Ashgate, 19–35.
- Reid K, Flowers P and Larkin M (2005) Exploring lived experience. *The Psychologist* 18(1): 20–23.
- Rose N (2000) Government and control. *British Journal of Criminology* 40(2): 321–339.
- Smith JA and Osborn M (2008) In: Smith JA (ed.) *Interpretative phenomenological analysis*. London: Sage, 53–80.
- Smith JA (2011) Evaluating the Contribution of Interpretative Phenomenological Analysis. *Health Psychology Review* 5(1): 9–27.
- Smith JA, Jarman M and Osborn M (1999) Doing interpretative phenomenological analysis. In: Murray M and Chamberlain K (eds) *Qualitative Health Psychology: Theories and Methods*. London: Sage, 218–240.

- Tait S (2007) Television and the domestication of cosmetic surgery. *Feminist Media Studies* 7(2): 119–135.
- Tulloch J and Lupton D (2003) *Risk and Everyday Life*. London: Sage.
- Yardley L (2008) Demonstrating validity in qualitative psychology. In: Smith JA (ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage, 235–250.

Michelle Leve is a PhD candidate in Clinical Psychology at The New School for Social Research in New York, USA. Her research explores how gendered neoliberal healthcare contexts interact with, and impact, individual health experiences. This study was based on her master's thesis.

Lisa Rubin is an Assistant Professor of Psychology and Assistant Director of Clinical Training at The New School for Social Research, New York, USA. Her current research explores intersections of gender and biomedicalization, with a focus on reproductive issues and hereditary cancer risk, and decision making regarding elective medical interventions.

Andrea Pusic is an Associate Professor of Plastic and Reconstructive Surgery at Cornell University and Associate Attending Surgeon at Memorial Sloan-Kettering Cancer Center, USA. Her research focus is measurement of patient-reported outcomes in plastic surgery.