

# THE SOCIAL CONSTRUCTION OF “PATIENTS” IN COSMETIC SURGERY

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**Abstract:** This paper seeks to study the way in which the human body is socially constructed, with emphasis on the case of aesthetic surgery. Drawing from semi-structured qualitative interviews with plastic surgeons and individuals who modified their body through aesthetic surgery, it is illustrated a contrast between the medical discourse and the patient’s discourse, in terms of the motives for conducting these surgical procedures. For plastic surgeons, on the one hand, the reasons prompting individuals into aesthetic surgery pertain to their psychological improvement and the enhancement of their inner self, something that legitimize their intervention as “therapeutic”. Persons submitted to these interventions, on the other hand, waive the psychology aspect and give priority to the superficial factor, elevating body appearance to a supreme value and attributing a purely utilitarian character to their decision.

**Keywords:** sociology of the body, embodiment, cosmetic surgery, social constructivism

## INTRODUCTION

Body and its management have acquired a very important meaning among modern western societies (Sarwer and Crerard 2004). The development of medical knowledge and technology, in combination with the prevalence of a new perception, upon which the body is identified with the self, gave significant impetus to the development of the Sociology of the Body (Featherstone and Turner 1995; Shilling 2005; Turner 1997). Body is considered as a complex bio-social entity, which plays an important role in the formation of social identity.

The social subject is determined, henceforth, not as a unidimensional logical being, which mentally processes and communicates messages and meanings, but rather as an embodied

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social perpetrator, a subject, which produces its social substance and behavior, through the dialectic synthesis of its mental state with its body (as a complex and dynamical bio-social entity) (Turner 1995). The “embodied subject” suggests that we cannot comprehend social behavior unless we do include into the analysis the role of the body and the dynamic and permanent relationship that we develop with it (Shilling 2007).

Within this context, body is anticipated as an object, “as a project plan to be implemented” by each individual subject (Shilling 1993). In modern western societies, body is transformed into raw material, which we consider that we can shape over, in order to get closer to the ideal figure that we have formed in our mind (Featherstone 2010). It is socially demanded that we manage successfully our bodies and remove the marks of deterioration, aging and illness.

Cosmetic medicine produces a social and historical model of beauty, structuring uniform, orderly and socially constructed bodies. Botox (Cooke 2008), liposuction, plastic surgical procedures, operations of gender alteration, breast augmentations, hair prosthetics, and so on, constitute examples of body social formation and management in modern western societies.

In this context, it is consequently important to comprehend the reasons for which certain individuals decide to engage in plastic surgery (Gimlin 2007), as well as the way by which medicine, from its own point of view, senses and signifies these procedures. Through a qualitative research based on interviews, this article attempts to comprehend the meaning, which is attributed to these interventions by the plastic surgeons, as well as by the “patients”.

Plastic surgery, provided that it does not “cure” bodily illnesses, legitimizes its existence as a medical action, through the “treatment” of the psychological needs of the healthy “patients”.<sup>1</sup> In cosmetic medicine, the social classification “patient” is produced in order to legitimize the medical intervention.

Therefore, what actually happens is to insert one’s individual wish to shape her body into a medical context. While, initially, it is proposed to conceive the body *as a project concept to be implemented*,

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<sup>1</sup> By using the term “plastic surgery operations”, we only refer to those medical operations undergone for aesthetic reasons and not to interventions of reconstructive surgery, as in cases caused by accidents or malformation.

afterwards, this socially and medically manufactured wish is brought to a medical level, transforming the individual to a “patient”, who requires psychological (medical) help. That is to say, medicine “constructs” the subject of its own intervention, creating a need (of restoring the body, so that it can be beautiful and juvenile) which subsequently comes to fulfill through cosmetic surgery.

#### THE SOCIAL CONSTRUCTION OF THE “PATIENT”

Social constructivism considers that the human body constitutes a continually constructed product of hegemonic discourses, a “social fabrication” that re-produces the dominant way of thinking and acting within specific historical and cultural categories. The way through which we engage, comprehend and manage our body is regarded as the uncertain outcome of complex social processes (Turner 1992). The most central influence here comes from the groundbreaking work of Michel Foucault, who located the human body within a joint process of power/knowledge (see Foucault 1977).

According to Foucault, the modern control of the body co-exists with certain practices of constituting a *productive and useful body*, through hidden mechanisms of monitoring and management (Armstrong 1995). The modern approach to discipline basically aims at the production of biddable bodies that do not simply execute what we wish, but also act in the way that we wish (Foucault 1977). Foucault named the spread of disciplinary power as *bio-politics*, considering it an essential element for the growth of capitalism. Bio-politics, through which mental and bodily control is achieved, constitutes the political mechanism to exercise *bio-power*. Bio-power’s main characteristics are the placement of life at the centre of techniques and technologies of power and management of life, as well as the internalization mechanism of social guilt (Foucault 1979).

Consequently, social constructivism assumes that the human body does not pre-exist; instead of being ontologically prior, it is dynamically negotiated and constructed within a series of performative social processes, which actively contribute to its multiple meanings and functions. The most important element of such an analysis is that the dominant discourse agonistically re-produces the “reality” of the object, in order for the prevailing power relations to be re-crystallized. In the case of cosmetic surgery, the question is whether and how the “patient” is socially constructed. That is to say, whether and how cosmetic surgery comes indeed to fulfill patients’ psychological needs,

or if it actually *creates* these needs, in order to consolidate its social and epistemic authority.

### PSYCHOLOGICAL NEEDS AND AESTHETIC SURGERY

Many theorists have referred to the way through which the modification of the body via aesthetic surgery has positive results to the psychology of the individuals (Sarwer and Crerard 2004; Swami 2009; Park et al. 2009; Henderson-King and Henderson-King 2005).

As Mike Featherstone writes:

“A more beautiful body or face will result in psychological well-being. Yet, this entails a particular view of the body, as bounded and compartmentalized into separate domains, each of which can be renovated or upgraded: a view which encourages people to judge their bodies in terms of social norms” (Featherstone 2010, 205).

According to Gilman (1998, xi), aesthetic surgery is justified as a respectable and essential medical practice, as supplementary to psychoanalysis, provided that it connects exterior appearances to internal happiness. Thus, cosmetic medicine forms the perception that the management and “therapeutic treatment” of the body is also concerning the therapy or “repair” of the mind, as well as the riddance of stress. For Gilman (1998), there exists a reverse relation between aesthetic surgery and psychoanalysis, since the basic precondition for aesthetic surgery is found into the simple inversion of the psychosomatic model undergoing a conventional psychoanalysis.

For a psychoanalyst, mental “infelicity” is pictured on the body in the form of natural symptoms. For a plastic surgeon, the “infelicity” of the client is the result of the material nature of the body (Gilman 1998, 13). In this way, the relation of aesthetic surgery to happiness is reversing “psycho-somatic” to “somatic-mental”. Thus, “restoration” of the body has the meaning of a medical intervention to the mental despair.

Also, Covino (2001, 92) reports that the industry of aesthetic surgery focuses very closely to an improved mental health as the main result of an aesthetic intervention (aesthetic healing). Inasmuch as plastic surgeons intervene to bodies that are functionally healthy, the industry has legitimized its status among medical professions, arguing that it improves the soul of the individuals submitted to an aesthetic procedure.

In other words, when a good exterior appearance is achieved, the inner self is outwardly revealed. The significance for the relation

between spirit and body that is maintained by the industry of aesthetic surgery is, according to Covino (2001, 93), similar to Plato's *Phaedrus*, where the human body appears to be an obstacle to expressing the virtues of our inner self.

In relation to the above, Haiken (1997, 102) perceptively stressed the role played by the "syndrome of inferiority" in the legitimization of aesthetic surgery as a healing art. Aesthetic surgery proposes a specialized use of the term "psycho-surgery" in order to show the final destination of the surgical lancet (Engler 1988, 30-32). In the same line, Pruzinsky and Edgerton (1990, 217) argue that the restoration of the exterior appearance does mean the restoration of the inner self.

According to Heyes (2009), aesthetic surgery, if not aiming to the improvement of mental health, is based on psychological excuses and on its indirect results to the total quality of life of individuals. As supported by plastic surgeons, the advantages of body modification, through aesthetic surgery, include increased self-respect and self-confidence or struggling against shame and stress. In this context, aesthetic surgery eases off infelicity and improves quality of life. The visit to the surgeon and the individual's reporting that she feels a lack of self-respect, or stress pertaining to negative criticisms on a bodily disadvantage, involves an acceptance on her part of a predestinate role in the scenario that the beauty industry has already written.

In this case, however, "as Miller, Howard and Chung stressed, if plastic surgeons really believed that they cure psychological problems, then, they should collaborate with psychologists, something that most of them do not practice. This means that they do not take seriously the statement, that aesthetic surgery is connected directly to psychological problems" (Heyes 2009, 86). Thus, it seems that the psychological problems and the psychological dimension of aesthetic interventions constitute not the developmental base of plastic surgery, but rather a posteriori element, which functions in a legitimizing way for the existence of the profession and the practice of plastic surgeons.

For Featherstone, "cosmetic surgery may not result in being more happy with one's body. The increased expectations arising from surgery can lead to greater scrutiny of the body and face in the mirror and comparisons with others" (2010: 206). The "patient" of plastic cosmetic interventions is socially constructed as a *disadvantageous subject*, who psychologically needs plastic surgeons in order to be able

to socially form her body and realize her individual body project together with a desirable social identity.

## METHODS

The research was conducted between March and December 2008 in the area of Athens. The method used is the qualitative in-depth interview. The semi-structured interviews were conducted with 21 plastic surgeons and with 21 individuals who were submitted into aesthetic interventions and they were performed in various places, person to person, with the use of a voice recorder. The ages of the individuals who were submitted to aesthetic interventions vary between 25 to 65 years, with most of the individuals under research belonging to the age group of 30-40 years old. The individuals subjected to the interviews were women, who were submitted into various types of aesthetic interventions, either surgical or non-surgical.

The research aims at the comprehension of the reasons for which certain individuals decide to undergo cosmetic procedures for the improvement of their body, as well as of extent to which they perceive their bodies as utilizable objects that can materialize their personal will (body project). At the same time, the corresponding attitude of plastic surgeons toward the body is attempted to be recorded. That is to say, the basic case of study is whether both the doctors and the individuals involved into aesthetic interventions have a common perception of the body and its medical management.

The study followed the standards for the conduct of good qualitative research, as described by Elliot et al. (1999). The researchers involved in this study analysed the data separately in order to ensure that the identified themes were in accordance with the interview material. In order to achieve stability and credibility of the data, the text was read multiple times to achieve stability and discussed by the three researchers to strengthen its credibility.

### *The medical discourse on the relation between exterior appearances – inner self*

In one of his interviews, Gilman reported for plastic surgeons: *‘they imported a new term, that one of “mental health” and they warmly supported that they can improve the mental situation of an individual by changing... his body.... Therefore, if one improves the body, also improves the spirit. This perception was very important from an ideological-social viewpoint, since it constituted a pretext even for*

*interventions that were not justified pathologically, but, exclusively mentally*' (Riddle 2008, 61).

Through content analysis, this perception is exactly surfacing, since most of them used the term of "mental health" as a pretext in order to justify the implementation of aesthetic procedures, referring to their selves as "soul healers". The case of R. constitutes a characteristic example: *'We are not therapists with the narrow meaning of the term. We are healers, being psychiatrists with a lancet, isn't it? Our patients feel much better psychologically when they undergo an intervention, which they consider successful'*. X. feels precisely the same about himself: *'I say that we practice psychology with a lancet'*. Also, Y. feels that he is not a healer of the body, but *'a soul healer'*.

The above are in agreement with the opinion of N.Wolf, according to whom plastic surgeons elaborate on the healthy bodies as "patients" in order to invade them (Wolf 1990, 238). The majority of the plastic surgeons answered that cosmetic surgery is not contrary to the oath of Hippocrates, which begins with the words *'firstly, do not cause damage'*, because of the disturbed mental health of those submitted to aesthetic interventions. As S. comments: *'I believe that in case somebody wants simply to correct something, if she has a problem, then there indeed exists a sickness in her soul. And if she actually suffers that and we don't manufacture it as doctors... then I believe that it is not in accordance to what we have been sworn under oath with our other colleagues'*. The same opinion was also expressed by V. and D.: *'I consider it as an improvement of the ... psychosomatic entity, hence under this point of view cosmetic surgery is not contrary to the oath of Hippocrates'*, *'We heal, in some way, we cure the body and at the same time we also heal the soul of the individual'*.

Most plastic surgeons reported that cosmetic surgery improves or restores the mental health of the individuals submitted to it. According to A.: *'I believe that above 60% of the patients, are in need of mental support. That's why they come for an aesthetic intervention'*. Also, F. argues: *'We should reverse the question. What does health means and what does unhealthiness means. From the moment that somebody feels that something doesn't go well with her body, automatically, she is not healthy too. Healthy is the one who thinks and reacts healthily. The one who does not think healthily and is puzzled with her body comes to the doctor. [...] We need then to approach a little into their environment, into their mental health'*.

*Vitiation of the “myth” of psychology*

In contrast to the answers of the plastic surgeons, the ones submitted into aesthetic interventions reported as their main reasons: the nuisance caused by their body image or the effort of perfecting it, the change of clothing style according to the fashion trends, the wish of attracting admiration etc. The characteristic answers of R. and B. were: *‘I had reconciled with the issue, as long as there were certain limits. When after some point I didn’t like this image at all, then I decided to correct it’, ‘I wanted this part to become impressive so that I can show it... to wear these clothes that will show that I have a beautiful breast’.*

Also, it is characteristic that only for few individuals aesthetic interventions led to a positive improvement of their disposition and changed their psychology to the better. The answer of C. is again typical: *‘My picture is what has changed. My disposition has ups and downs, as of all people, I believe’.* But, also, P. reported that the only thing that changed due to the breast augmentation was her exterior appearance and not her inner world: *‘Yes... it changed... in the mirror, let’s say, I like myself better’.* In regards to the non-surgical interventions, into which she continues to be submitted, she told us: *‘I do not do it for a psychology aspect. That is to say... when I go to make these non surgical... I’m doing it, henceforth, on a routine basis’.*

Finally, most individuals used the aesthetic interventions as a means of success in the various sectors of their life (professional life, erotic sector, social sector etc) and not for the improvement of their psychology. They considered that their modified body would provide them with more opportunities. G. constitutes a typical example of such an individual: *‘I feel that my body now provides me with more opportunities, specifically in regards to my relations with the other gender’.*

Z. considers that the otoplasty, into which she was submitted, helped her in her social relations: *‘You become more socially acceptable. In the aspect of making new acquaintances, new friends... getting more contacts in general... it sure helps’.* Also, N. presented her rhinoplasty as the means that facilitated her professional associations, arguing that ever since she is appreciated not so much for her abilities, but for her exterior appearance: *‘Yes, my body provides me with more opportunities. In my professional life. [...] I know that by selling beauty I can make my life a little bit easier. And that certain things, which were not excused before in my work, now are excused’.*

*The demystification and the nefarious circle of aesthetic surgery*

Most of those submitted into aesthetic procedures finally demystified aesthetic surgery. K. and V., who were submitted into blepharoplasty and facelift respectively, are typical cases: *‘I wondered, “what do I feel now”? Ah, nothing, now I got used to it, nothing... nothing; As if I had never done it’*. R. also believes that she overestimated her positive feelings in the period that followed her liposculpture, since she is now not excited by the result: *‘My sentiments, perhaps, were, overestimated. I felt very well and I believe that the first summertime was my most perfect summertime ever. [...] Now I can’t say that I have any particular feelings’*.

E. did not feel great changes in her body or any positive feelings after the implementation of a breast augmentation, liposuction and otoplasty into which she was submitted. On the contrary, from the period of her recovery till today, she is tortured by compunctions and guilt due to the realization of these interventions: *‘I do not believe that a great difference occurred. On the contrary, I was ashamed. [...] When you see around you serious things happening, you get ... a crisis of conscience, since you go ahead to make such types of aesthetic interventions while all kinds of serious problems exist, you come to say “I wish of a good health and nothing more’*.

Besides, although the fact that most individuals demystified aesthetic surgery, they continued the realization of aesthetic procedures, having continuously the sense of the unfulfilled (Featherstone 2010, 206). E. spoke about this feeling: *‘Aesthetic surgery improves things, but... always leaves you something unfulfilled. That is to say, it improved my breast, as I wanted, but did not create the type of breast that I always had wanted to have. Afterwards, you want something better’*. B. feels the same for her new breasts: *‘Ok, I wanted it to get bigger, which of course didn’t happen. [...] After the result was revealed, I asked “doctor, didn’t you do it a little small? I went through all this process and finally, what I got wasn’t what I was looking for’*.

One of the basic conclusions of the research is that the circle of aesthetic surgery never closes. After the surgical improvement of various parts of the body, an individual can only look at the remainder parts of her body, from the aspect of surgical potential, so that aesthetic surgery would lead to more aesthetic surgery. In this line, V.Blum, who used the term “slaves of the lancet”, argues that this

continuous fragmentation and reassembly of the body constitutes the drama of aesthetic surgery (Blum 2005, 106, 125). As it was revealed through the research, the repetition of aesthetic interventions is realized either due to the satisfactory result of the initial one, where the individuals continue getting submitted to more, or due to a failed aesthetic result or complications, thus entering into a process of follow up corrective interventions.

It is remarkable that from the 8 individuals of the research that needed correctional interventions, 4 of them, despite the discomfort that they suffered, continued with new aesthetic procedures into another part of their body. A characteristic example of such an individual is X., who despite failing abdominoplasty and having to undergo into a correctional one, she was also submitted to otoplasty and minor facelift after just a few years: *'I don't like it, because even if this person made enormous efforts to restore me ... instead of becoming better, I became worse. [...] Eh, afterwards... I had my ears fixed, still this one protrudes, and... I also did ... a minor facelift. [...] I have the opinion that what falls should be raised and what can be corrected should be corrected'*.

It becomes incomprehensible when an individual submitted into a cosmetic surgery has a problem with its repetition, but still redoes the repetitive procedure, a process resulting into an increase of medical dangers and a reduction of the probabilities of a satisfactory aesthetic result (Berry 2007). S., who was submitted into a breast augmentation and liposculpture in the legs, precisely pertains to such a case, since her organism reacted to the silicone implants and she was needed to be submitted into two correctional interventions to the breasts: *'I had problem with my breast, because a capsule was developed in one side, and ... I have done surgery two times on my breasts. The redress must take place after a year ... and afterwards, since again had a small side effect, I underwent an operation... without sedation though, under a light numbing medication, a correction. [...] This is a reaction of the organism; a reaction to silicone'*.

G., who was submitted to a breast reduction, after one year, proceeded into a new cosmetic surgery, taking courage from the implementation of the initial: *'After my breast reduction operation and its positive results, it was easier for me to make the decision to also correct the buns I had under my arms. I took courage from the first operation and I felt the need to also correct something else that*

*bothered me and caused me discomfort*'. Also, there are many individuals who, after their submission into certain aesthetic procedures, began to get submitted into non-surgical interventions (most of them continue even today) in order to maintain the aesthetic result achieved (since the duration span of the materials used in these non surgical procedures is rather short).

P. is a typical example confirming the nefarious circle of aesthetic surgery since, after a breast augmentation, she has been submitted into non-surgical interventions to the face over the last 6 years: *'I do botox, as well as mesotherapy. I began 6 years ago. Naturally, afterwards, once you begin, you never go back*'. Precisely the same is also believed by T., who is submitted into repetitive non-surgical interventions, after the initial facelift into which she had been submitted: *'Quit doing it? I don't believe that there is a woman that will quit doing it. That is to say, today some are starving in poverty and they still go and do botox. Eh... it is needed. All right, it needs to be regularly repeated. [...] In case something new has been developed*'.

It is also characteristic that the majority of the submitted to procedures plan to or think of getting submitted into more other aesthetic procedures in the future. B. has already entered into this process of repetitiveness: *'I am in favor of plastic surgery and of the anti-aging methods. I believe that, finally, it is easy to enter the route leading to "I did this, then, I should also do that and the other*'. Still... *I am in favor and constantly get informed*'. V. expressed her wish to have greater economic independence, so that she could be submitted continuously into new aesthetic procedures: *'If I had the money, I would have already done a general overhaul*'.

O. is on a continuous monitoring of herself, in order to maintain the results of the liposuction she underwent in her legs, as well as in order to be submitted in more future aesthetic interventions: *'I have made up my decision. In case of such a need, I will do it again; over and out. Whatever is to be removed, it will be done again. [...] In case I see my buns filling up again, this is the only solution*'.

## CONCLUSIONS

What actually emerges out of our research is the remarkable contrast between the medical discourse and the discourse of the individuals submitted into aesthetic interventions, in regard to the aspect of the psychology of the individuals who select to modify their body through

aesthetic surgery. Through a qualitative analysis of the interview content of the plastic surgeons participated in the research, it is shown their need to justify the aesthetic procedures they perform to individuals who are healthy, using therapeutic excuses in order to integrate the individuals in the classification framework of the non-satisfactorily healthy. The means they use for the justification of their proceeding in performing aesthetic interventions is the psychological status of the individuals who are submitted into them, which at many times is characterized as “unstable”. Thus, they argue that the transformation of the body is performed for the restoration of the spirit (i.e. psychological status), and not of the body.

In contrast to the medical discourse, the individuals participated in the research waive the psychology factor, giving priority to the superficial, with aesthetic procedures interpreted as a concern for the public demonstration of their self and as a need of managing impressions in their daily life. Simultaneously, they feel that, by presenting the improved image of their body, they gain social acceptance and they increase their probabilities of success in modern competitive society. Hence, appearances emerge as of supreme value: the value of one’s self is registered to the figure and appearance of the exterior part of the body for those submitted into aesthetic procedures.

The research revealed the fact that, for most of the individuals submitted into aesthetic surgery, the entire process of an aesthetic intervention had been blown into mythical proportions in their mind, while many have made their success in various sectors of their life, dependent on aesthetic interventions (considering that their body would provide them with more opportunities in the professional, the erotic or the social sector. The individuals, that is to say, transformed their body into a physical asset and an object related to an investment effort. When their expectations were not verified, not only they did not abandon aesthetic surgeries, but they instead entered into a repetitive process, remaining usually with a sense of the unfulfilled. The endless and obsessive pursuit of physical improvement through cosmetic surgery, involves modern individuals in a vicious circle, which never closes and creates a relation of dependency on the services of “experts” and cosmetic surgery, without a saturation point.

The basic conclusion of this research is that there seem to be two different discourses around cosmetic surgery interventions. Firstly, the discourse of “patients”, which gives a utilizing character to their decision, as a means of achieving other pursuits (e.g. erotic

companion). Secondly, the discourse of the “experts”, the doctors who inevitably characterize their “clients” as potentially (psychologically) unstable in order to legitimize their intervention as medical therapy. Clearly, we cannot reach a conclusion on which of the two discourses has a greater validity or importance for the comprehension of the phenomenon.

However, we can assume a broader social context in which the utilization and the commercialization of the body lead to specific phenomena, such as cosmetic surgery, where different groups, motivated by different pursuits and interests, are ultimately led to the same result: the deeper objectification and commercialization of the body. In other words, both groups, albeit beginning from different starting points, point to the “plastic”, immaculate bodies as the dominant bodily form in modern western societies. This acts either as a ticket for conducting more effective social relationships or as a form of “therapy”.

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