

Silicone Breast Implants in America: A Choice of the “Official Breast?”

Linda Coco

Introduction

For those who stubbornly seek freedom, there can be no more urgent task than to come to understand the mechanisms and practices of [insidious] indoctrination (Chomsky 1985:31).

This paper presents the findings of an ethnographic research project exploring the phenomenon of silicone-gel breasts implants in the United States. It describes messages of patriarchy and capitalism internalized by American women, as seen through the beauty-industrial complex. These messages of nominal femininity are made flesh through the institution of organized plastic surgery. The collective psyche conceptualizes the healthy female breast through the rubric of a culture of lack and the medicalized breast. The result is the creation of the “official breast.”

Approximately 2 to 3 million women in the United States have Silicone-gel breast implants.¹ These women average 36 years-of-age and have an average of two children (Travis 1992:35). An estimated 20%² have had implantation as part of reconstruction, due to loss of the breast from cancer or other difficulties, while the remaining 80% have had implantation for the purposes of augmentation, or breast enlargement. Prior to the Food and Drug Administration’s January 6, 1992 moratorium on the sale and implantation of silicone-gel breast implants, 364 women in the United States were getting silicone-gel breast implants per day (Lappe 1991:158), making it the most common cosmetic surgery performed by plastic surgeons (Faludi 1991:218). As a nominally elective surgery, this implantation can cost a woman from \$2,000 to \$7,500. The surgery can last anywhere for one to three hours.³ It takes at least two weeks to recover, with possible health risks including baseball-hard breasts, gel bleed, nipple necrosis and life threatening immune diseases.⁴

Based on these data, the question of why women have chosen silicone-gel breast implants arises. The most popular reason is that women get the implants for psychological reasons.⁵ For two decades, these “psychological benefits,” have become normalized in the popular media; women with high public profiles such as Cher, Jane Fonda, and Jessica Hahn having physical enhancements. Other female public officials, such as Justice Sandra Day O’Conner, have stated publicly that silicone-gel implants were very important to their psychological recovery after cancer surgery.⁶

Since 1989, when the first prime time television programs aired features on the silicone disaster, public debate has surrounded the purpose, risk and availability of silicone-gel breast implants. Few have questioned or deconstructed the socially accepted and systemic connection made between a woman’s breasts and her self-confidence, personal well-being and

social worth. This research reveals a social mandate for women to embody externally imposed cultural norms and values. There has been a furtive colonization of the female mind and body.

In American culture, images of human bodies have come to represent social values. These symbolic representations become normalized to the extent that they appear natural within a specific cultural milieu. As Bruce Knauft (1989:201) writes:

Cultural conceptualizations of the body, being so merged with the reality of bodily perception and experience, "seem" uniquely natural and basic. While the body is eminently "natural," it is just this perception of naturalness that allows culturally variable concepts of the body to be so fundamentally ingrained in the collective psyche. In fact, images of the body everywhere embody social and cultural form.

It is from this perspective that the ethnographer must view the practice of breast implantation in America. When the female body is seen as a reflection of the cultural and social milieu, it is recognized as possessing symbolic status. Thus, it can be argued that American women's bodies, and the treatment thereof, mirror a female social role and cultural identity that is distinctly American.

In other cultures, the female body has similarly come to mediate women's social survival. The Sudanese practice of female circumcision and infibulation presents an example of cultural forces at work; these mold women's bodies to reflect an idealized female body of the collective psyche. In discussing Sudanese female circumcision, Lightfoot-Klein (1989:40) notes that:

Female circumcision and infibulation are...viewed as a way of socializing female [bodies]. Boddy argues that women are not so much preventing their own sexual pleasure as enhancing their own femininity. Women...achieve social recognition by becoming...less like men physically, sexually, and socially....[Their] infibulated vagina will cause [them] to have high value in the eyes of [their] future husbands, and will be a source of pride [to the women].

This physical reconstruction does not compose an inherent reward for women. Rather, it is an act of conforming to a social imperative in exchange for social acceptance; this is seen as providing women with a source of pride, a form of cultural femininity. This pride is a construct of obedience, which has as its genesis the external locus of cultural power.

Similarly, in America, women are taught that their physical appearance must reflect the official and symbolic *beauty feminine* as defined by culture and society, in order that they appear distinct from men. Women's physical embodiment of this ideal offers them social value and acceptance. Like the Sudanese, Amy Fisher, an implant recipient stated, "I now have a body I can be proud of." Ms. Fisher's pride came from the fact that she now embodied the external, the social, and culturally prescribed feminine form.

In response to a social imperative, both Sudanese and American women have been subjected to forms of body mutilation. Sudanese girls undergo this practice just prior to adolescence, at the hands of older women, as part of recognized engendering rites. For

American girls, the body-beautiful imperative begins at birth. In neither cultural group are women entirely free to choose. As Hanny Lightfoot-Klein (1989:70) observed of the Sudanese practice of mutilation, “[women were] entrapped in a [cultural] ritual...unable to free themselves from its centuries-old enmeshment, all of them its prisoners.” In a similar vein, Naomi Wolf writes of the common discourse of breast implants. Breast implantation

is not like real genital mutilation, one could argue, because women choose it. In...Africa, Muslim girls with uncircumcised clitorises can't marry. The tribe's women excise the clitoris with unsterilized broken bottles or rusty knives, leading often to hemorrhage and infection, sometimes to death. Women are the agents there. One could say with as much insight that those women “do it to themselves” (1991:243).

Here it is clear that the argument of free choice is based on a culturally specific perception. In the present case American women stand amidst their own subtle and seductive forces of the cultural milieu, subjected to a process of insidious indoctrination.

Gender Creation as Insidious Indoctrination: The Feminizing Force in “Choosing” Breast Prostheses

From the time we are tiny children we get our identity somehow from them, and a lot of negative feelings come to attach themselves to looks. We make them magical, and therefore neither men nor women can confront them directly (Lakoff 1986:26).

In Victorian culture, women were valued or chastised based on their reproductive success. Over the last 60 years, American culture has judged women's value on how well they recreate the physical standards of “official beauty.” Through alterations of their natural bodies, women have become a physical expression of the social imaginary (Thurber-Cox 1990:2). This cultural re-creation of official beauty is a social mandate personally integrated into and onto women's minds and bodies through socialization, a process of insidious indoctrination, as defined by social contract.

A social contract as used here, implies a tacit understanding among the members of a community which permits societal function. Without this tacit understanding—reinforced here and there by law—disruption would occur. Enforcement of social contract is generally through social mechanisms involving praise, censure, and, at times, even stigmatization (Loewy 1989:46).

To survive in the American psycho-social environment of the social contract, women must internalize and maintain an externally imposed perception of female value. For the young girl, female value is reflected in the faces of models, actresses, and beauty queens. This cultural foundation explains the power of body-beauty. From it, women learn of their socially ascribed power, not just to attract, but to socially survive, based on their beauty performance. Through this perception, the female identifies her body's appearance as the primary locus of

personal success or failure. Such cultural feminization produces, trains, and reproduces a feeling of an unconditional bodily obligation.

Social gender-identity is culturally created and internalized⁷ through a system of reward, that is social acceptance, or punishment, that is social non-acceptance (Freedman 1986:120). For females in America, gender socialization begins at birth with, "It's a girl!" The baby is slipped into the nursery bed wrapped in the pink blanket, and dons a pink arm band. Her motif becomes roses, "Beauty and the Beast," and ruffles and lace. Her inheritance becomes prettiness, cuteness, soft, cuddly, gifts of dolls, stuffed animals with long lashes, lip shade, and Minnie Mouse. Repeatedly, she is given compliments and encouragement based not on internal merit, but on how pretty she looks—validating the myth of body-beauty appearance. Further, the girl also learns the value of appearance from what Joseph Campbell (1985) calls "cultural myths" found in children's stories.

These myths, or fairy tales embody and present the ideals and institutions of gender identity, providing a make-believe world within which a girl sees the role of heroine as one of beauty.⁸ Cinderella, Beauty and the Beast, The Little Mermaid, and Snow White are all constructed around beautiful and ageless females. These cultural expressions show the girl paths for a psycho-social survival through the attractive appearance of her body. Naomi Wolf (1991:61) points out that "...her early education in the [beauty] myth [as in fairy tales] makes her susceptible to the heroines of [the] adult's...mass culture—the models in women's magazines." In describing a woman who has silicone implants Laurie Lucas writes, "...as a child thumbing through Playboy magazine, Michelle Austin would gaze at the Playmate's perfect [body and] breasts and yearn for her own. 'That was the way to look beautiful,' she recalls" (1992:D1). As a young girl grows into her teen years, her perception of herself becomes filtered by the collective representations of female beauty. One breast implant recipient, when interviewed stated that she felt like a "little girl" well into her twenties, because she did not have the breasts of a woman.

When I was getting older, people kept teasing me about looking like a little girl: I was tiny, small breasted, and very thin. My mother used to say that I looked like I had popped balloons on my chest....My aunt use to tell me that my body should look like other women who were walking by in the mall. She was referring to their breast size.

Due to the sex specific demands of official beauty in American society, young women are plagued by the sense that their appearance is inadequate; their bodies are to blame because they are ugly. As Freedman writes:

One of the striking sex differences at [puberty] is a greater self-consciousness in females. Girls find it harder than boys do to measure up against the idealized [cultural] norms for their own sex. In a study of fourth through tenth graders, the oldest girls' self-image...[was determined by the fact that] they frequently felt ugly (1986:130).

As they develop, young women increasingly feel responsible for their appearance, that appearance equals social status. Increasingly, they are exposed to commercially produced beauty images. In reality, these images are designed to create a sense of lack in the young

woman. As she gazes at the cultural mirror of womanhood, an impossible image gazes back. She feels that she is to blame if she is not externally judged attractive. Women tacitly agree with and adhere to a social contract within which their natural bodies become commodities of exchange.

In addition, women face role models of femininity produced by a surgical age. The modern American woman seeks to recreate a literally unreal beauty. The method is violent. As one woman wrote, in *Being Beautiful*:

I felt like a mess. Yet I figured there was still hope for me—not that I could be successful and important without being beautiful, but that I too, could be gorgeous some day.....Never at any time did I believe that a woman's looks were of less than earthshaking importance.

During our adolescent years, my friends and I generally admired women who had one trait in common—beauty. There were no woman doctors or scientists or judges on our “most admired lists....”

As we raced toward the end of our trying teens, our emerging sense of identity depended a great deal, undoubtedly far too much, not only on the way we looked, but on how we felt about the way we looked. As we approached young adulthood we were already firmly caught in the beauty trap (Baker 1986:14).

Nancy Baker (1986) writes about the “beauty trap,” which acts as a siphon to women's autonomy and self determination leaving them empty and insecure. She explains the constant striving to alleviate a sense of lack as a women's “greatest obsession.” Unfortunately, few women realize that they are trapped by internalized fears, whose origin lies far back in a history of insidious indoctrination of a cultural body wrought from traditional myth.

It is understandable that American women spend much of their time preoccupied with beauty. Much of their income is spent on beauty survival products, which often contain carcinogenic ingredients, and on books and other beauty accouterments.⁹ Further, it is not surprising that American women commonly suffer from eating disorders, which can cause serious health problems, and may lead to death through anorexia, smoking as weight control, and other even more dangerous strategies.

The female breast, arguably the strongest cultural symbol of official beauty, becomes yet another fragment of official beauty apparel. However, to attain this symbol, women must engage in more than buying a beauty product Like cosmetics and dieting techniques, plastic surgery has its health risks. Yet, for many women, the promised benefits of social survival outweigh the risks. The FDA's consent form, which women must now sign if they wish to have implants, reveals the potential health risks, but states that the long-term interest of the studies is the “psychological benefits” that may come from having breast implants. As one implant recipient stated: “I am a gambler. I'd rather have *quality of life* than quantity. Not that I think implants will take my life, but I am almost at that point that I'd have them anyway” (Chapman 1991:B4). For some women even those who know the risks, having silicone-gel breasts is even more important than life itself. Thus, the biological drive to survive is strongly influenced, connected, and possibly curtailed by the social contract's beauty imperative.

The Beauty-Industrial Complex: "Weapons of Beauty"

From the turn of the century until this day [the public mind] was the object of a cultural and ideological industry that was as unrelenting as it was diverse: ranging from the school to the press to mass culture in multitudinous dimensions (Chomsky 1985:31).

An operative component of the controlling process of insidious indoctrination is the Beauty-Industrial Complex. The industry co-opts the socially mandated female body-beautiful, and (re)presents and sells it in a consumer-oriented capitalistic framework. The power behind this mandate and these indoctrinated values is realized in the industry's \$654 billion-a-year profits. The industry's advertisements provide women with reminders of the value of the beauty mandate so that it appears natural. Due to its systemic nature, this construction of womanhood goes unnoticed. The molds for thought and feelings about female identity and their bodies is codified by both cultural and capital imperatives.

The industry peels the body away from the woman in segmented form, composing a commodity from and of the body. The vulgarity and lack of perspective within the beauty industry is revealed by Howard Zinn in *The Twentieth Century: A People's History*. Zinn cites a 1930's magazine article concerning beauty and American women which begins with the statement that, "the average American woman has sixteen square feet of skin." The author goes on to say that even though there were 40,000 beauty shops in America, and even though women spent \$2 billion every year on beauty, "American women [were] not spending even one-fifth of the amount necessary to improve their appearance." Following this, he perfunctorily produces an itemized list of the necessary annual beauty needs of every woman: "twelve hot-oil treatments, fifty-two facials, twenty-six eyebrow plucks." Today, as 60 years ago, the industry sells this collection of body parts back to the woman with the sales promise, "this can help change your life" (1984:204).

As a woman steps out into the world, believing that she is taking greater responsibility for her life, the implanted lens of the beauty industry causes her to view her natural body with intense feelings of failure and insecurity. She feels responsible. The woman becomes the ideal "insecure consumer" (Wolf 1991). In an attempt to cover up her inevitable failure, the female reaches for the promise of the beauty products and the beauty experts. This use of socio-industrial official beauty becomes both a psyche-numbing weapon and a mirrored bulwark of fragmented photographic images. This becomes the raw material for women's lives camouflaged as fairy tales of culture. The players in the dominant beauty discourse expand and defend themselves aspiring to economic growth. They engage processes which subvert and transform personal power and autonomy into a constructed failure-driven consumer spending.¹⁰

In her book, *Backlash: The Undeclared War Against Women*, Susan Faludi (1991) shows again and again how political motivation and economic desire create a culture of lack among modern women. This is a culture which they can carry everywhere, a briefcase size beauty neurosis. The industry's operation and management of attack has, as Faludi points out, for many years been aggravating women's low self-esteem and their anxiety about beauty and

feminine appearance. The intent is to increase the industry's profits and decrease the rising power of women in society:

In ad after ad, the beauty industry hammered home its version of the backlash thesis: women's professional progress had downgraded their looks, equality had created worry lines and cellulite. This message was barely updated from a century earlier, when the Victorian beauty press had warned women that their quest for higher education and employment was causing a "general collapse of attractiveness" and "spoiling complexions" (Faludi 1991:202).

The beauty industry (re)presents patriarchal cultural values through the persistent re-creation and dissemination of the official beauty image. The arsenal of beauty weapons are imbued with calculated psychological torment. The first weapon in the beauty industry is an unrealistic expectation of female beauty. The prominent messages in this commercial image are of youth, anorexic thinness, large breasts, European facial features, and passivity. The commercial image, an imaginative lie for female consumers, is presented as easily attainable, but a closer look at the process of image creation will reveal the unreality of this presentation.

A second beauty weapon is censorship in women's magazines: a weapon of misrepresentation. The beauty myth imagery is constructed and edited through airbrushing, computer morphing, and cut-and-paste images. Any natural form of the model which fails to reflect the Iron Maiden is removed. This censorship misrepresents and undermines women's perceptions of their natural bodies; their unique physical appearance and cycles are denied and seen as non-performing and deviating from the beauty image. Censorship helps to create lack within women's psyches, closing the beauty trap around them, causing women to remain thirsty and needy consumers who will "buy more things...[while] they are kept in the self-hating, ever-failing, hungry, and sexually insecure state of being aspiring beauties" (Wolf 1991:66).

A third beauty weapon is the promise of self-improvement presented in the production of official beauty. As Schudson (1984:157) points out, corporate capitalism found a friend in American gendered culture. The beauty industry advertises products as important additions for women to fulfill their social contract and attain official beauty. In return for women's trust, the industry promises happiness, self-esteem, a feeling of well-being, and social worth.

The last beauty weapon is the mass dissemination of the official beauty images. The industry's strategy comes in the form of a saturation bombing of women's psyches, leaving little space for articulating or even remembering, the realities of physical existence. The commercial images of the model female can fill a woman's day with beauty propaganda. They are seen in daily newspapers, on television, on advertising bill boards seen from streets and highways, plastered in and on mass transit, in magazines and in mini-book covers. If a woman shops three times a week, works, reads only the Sunday paper, looks through magazines occasionally, and watches one hour of television a day, a conservative estimate might be that she will see 241 images every week. That is over 12,500 mind numbing messages per year all aimed at controlling how she thinks about the most intimate and vulnerable part of her life, her body. This would be by looking through one paper, watching seven hours of television, seeing

fifty bill boards or poster boards, seeing the thirty-six images at the checkout stand, and thirty images in magazines per week. This does not include the record, video or clothing store displays. It does not include the many women that she will see who are attempting to live up to the beauty myth. It does not include the many times she thinks of how she should look. A study of women's and men's magazines (Travis 1992:32) revealed that in one month there were 96 articles in women's magazines, but only 8 in men's magazines, pertaining to the perfect body shape. These weapons of the beauty industry are effective proponents of a gradual social control. The outcome of this barrage, is that women have searched out beauty experts who know what the women must do to address the failure of their body parts.

Yet the beauty experts have not been able to correct all the maladies of the modern woman. When the woman is "sick with terminal ugliness," and she has tried everything and still can not attain the ideal, she is told, "when all else fails [correct that] horrid shape and awkward size through cosmetic surgery" (Harper's Bazaar 1959:60).

The Discourse of Deformity and the Creation of the "Operative Condition"

Authoritatively, the experts advise women on the cosmetic surgery procedures to meet certain beauty standards: face-lift, eye-lid surgery, collagen injections, chemical peel, nose job (rhinoplasty), stretch marks covered over, liposuction, and various forms of breast surgery. After the litany of the newest beauty body tortures/mutilations has been presented, and the selection made, the experts provide women with information on how and where to find a board certified plastic surgeon. The beauty industry's insecure consumer of beauty is recast as patient, as the deformed beauty invalid. Her socially terminal illness, ugliness, can only be cured with the scalpel.

The discourse of organized plastic surgery is couched in accepted notions of medicine's correlative authority. From this position of power, bio-medicine defines pathology, disease or deformation. It is only after the patient is diagnosed as having a disease, such as hypertrophy (small breasts), that plastic surgeons can perform medical treatment, such as an operation for the implantation of breast prostheses. Under the Hippocratic Oath, the physician can do no harm to a patient, therefore an a priori pathology must exist. In organized surgical medicine, the imperative for surgery is a determined pathology: the health need requiring an operative cure.

Plastic and re-constructive surgeons defend cosmetic surgery procedures primarily on the psychological disposition of those who come to see them, and secondarily on what they call physical deformation. This basis for pathology re-creates the label of "operative condition," thereby problematizing and re-contextualizing social and psychological ills of women. In the 1960's, 64% of all breast prostheses were for augmentation, and by 1980 the percentage had risen to 80%; this suggests that women do not undergo this procedure due to a physical need. The operative condition of the breast, which has arisen from the discourse of organized plastic surgery, is exemplified by the words of a past president of The American Society of Plastic and Reconstructive Surgery (ASPRS):

There is a common misconception that the enlargement of the female breast is not necessary for maintenance of health or treatment for disease. There is substantial and enlarging medical knowledge to the effect that these deformities [small breasts] are really a disease which result in the patient's feelings of inadequacies, lack of self-confidence, distortion of body image, and a total lack of well-being due to a lack of self-perceived femininity. The enlargement of the underdeveloped [or other defined diseases of the] breast is therefore very necessary to ensure the quality of life for the [female] patient.¹¹

Therefore, one role of the plastic surgeon is to diagnose small breasts as diseased and to prescribe treatment or cure, and to ensure the quality of life of the patient. This cure is the re-creation and construction of the official breast.

Plastic Surgeon as Artist

Like many plastic surgeons, I studied art when I was young...[Although] I do the same procedures many times...each case is an aesthetic challenge.
—The "Breast Man" of San Francisco, Robert A. Harvey, MD.¹²

In the 1940's, the ASPRS, the primary organization of board-certified plastic surgeons, began to focus on cosmetic procedures. A study of the Index Medicus from 1880 to 1993 provides a clear history of the interests of those who read, published and wrote medical articles in the West. Beginning in the 1940's there was a marked increase in articles concerning the appearance of the body. This constituted an expansion beyond the traditional concern with functional deformities, such as the club foot and cleft lip. Perhaps more significantly, during the 1940's, plastic surgeons began to consider their work as artistic and their medium the flesh of the human body. Today, it is not uncommon to find plastic surgeons advertising "body sculpting." Plastic surgeons such as Mario Gonzales-Ulloa (1964:242-246) assiduously studied and applied the legacy of official female beauty depicted in Western art which provided a methodological blueprint for recreating and reconstructing the female body.

In the particular area in which we live on the star called Earth, we have been conditioned by a special type of architecture [of the female body] that is related to what is termed the classic ideal of beauty....Our daily labor is to [re]create it, and every effort to understand that everlasting metaphysical ideal will be rewarded with better and more satisfactory results for our patients and ourselves.

The artistic duty of plastic surgeons then was to understand, provide, and recreate the inherited and timeless official beauty, reproducing classic cultural and social values.

In order to recreate the Western aesthetic en masse, plastic surgeons established systems of analysis for the female body. These systems, based in metric-science as applied in Western art, gave the surgeon an outline from which deformity could be conceptualized, along with a framework from which to reconstruct official beauty. Surgeons, like Dr. Gonzales-Ulloa, set out to measure and recreate the harmonious, the well-formed and the officially

beautiful body-form for women. As Dr. Gonzales-Ulloa states (1964:241), the plastic surgeon was to

technically judge the...[body]...structure of a specific individual [in art], to understand why it is beautiful, and in the case of marred or impaired beauty, to have an outline by which to be able to plan for a completely integrated correction.

Dr. Gonzales-Ulloa provided a developed representation of this preconceived approach to aesthetics. By using a series of lines and meridians to determine the correct proportion of the female face (later to be applied to the female breasts), he proposed a mapping technique, inspired by Mercator, the 17th Century cartographer. Dr. Gonzales-Ulloa used as his example the faces of women in Western art. He create a variety of standards, including that of the "well formed" female face. These standards were then applied to the faces of women in America and from this model, corrections were made to nominal deformities.

In 1966, the aesthetics of Western art were applied to the female body, most notably the female breasts, by Paul Regnault. He studied and measured statues in Greek art to determine the appropriate positioning, size and shape of the female breasts.

The ancient Greek sculptures have endured as ideal representations of the beauty of the human [female] body. From observations and measurements of the most appreciated sculptures such as the Venus De Milo, the Aphrodite of Cyrene, or the modern sculptures by Rhodin and Maillol, it appears that the shape of the breast is either hemispherical or conical in shape, but that it always has an elliptical base, the larger axis lying horizontally:

[The ideal breasts] are situated vertically between the 3rd and 7th ribs.... Horizontally, they lie between the line of the sternal border and the anterior axillary line....The location of the nipples at the level of the 4th rib at 9 to 19 cm from the midline, 14 to 16 cm below the lower border of the clavicle and 18 to 20 cm from the sternal notch....The ideal prosthesis [should recreate this] (Reganault 1966:31-37).

Regnault pioneered surgical procedures for the correction of the small ptotic breast, resulting from breast feeding. His procedure included re-situating the nipple and inserting a Dow Corning Silastic® silicone gel implant into the breast. This was designed to recreate a virginal breast, comparable to the accepted aesthetic found in Western art.

An advanced technological form of mapping the female body, Biosteriometry—created in the early 1970's and still being applied—is an even more precise tool used to determine and approximate the aesthetically correct form of the female breast. Biosteriometry provides a three dimensional topographic map of the body's contours through the use of projections, cameras, and computers. A three dimensional topography projection is imaged on the female breasts in order to determine the coordinate points of balance. Pre-operative breasts are categorized as imbalanced based on the mathematical harmony of the line and point markings. Post-operatively, after the insertion of a silicone implant, the breasts are defined as perfectly balanced. Behind the medical creations of these self-proclaimed artists lie the

standards of Western art, and against which the diversity of living women's bodies and breasts are measured and recreated.

It was to women's breasts that the plastic surgeons' technological discourse of official beauty standards was most stringently applied. Unlike the rigid grids, the breasts were seen as out of control. No other part of human anatomy fluctuates in size and density so much as the natural female breast. The discourse and application of the plastic surgeon's techno-art has focused on recreating a particular and static official breast shape, size and density which belongs to the Anglo-American woman and is pert, firm, and of medium size:¹³ the breast of a few sixteen-year-olds.

Though the plastic surgeons concede that there is little physical discomfort to any of these operative conditions. They state that such aesthetic malformations produce marked discomfort to the woman on "psychological grounds." For example, the women studied by Edgerton and McClary (1958:279–305) suffered from what they call a "breast centered orientation." The women's distress over the correct breast size "often made their lives and...the lives of their husbands and families...miserable by the development of such [inner] conflicts." According to Gillies and Marino (1958:1), these women are under such severe stress that they are "entitled to have the deformity corrected." Throughout the discourse, *psychological disease over an impaired sense of femininity* is cited as the basis for the operative condition. Women, according Bromely S. Freeman (1954:149–151) have a "marked emotional response due to loss [or impairment] of an important secondary sex characteristic [i.e. the breast], which warrants the use of plastic subcutaneous breast prostheses."

Thus, nominal deformities of the breast, such as sagging after lactation, have often been cited as an operative condition. Without breasts, women become paralyzingly self-conscious, socially inactive, and insecure. Plastic surgeons claim that women who have had a breast deformity corrected by implants are "helped emotionally;" (Freeman 1954:149–151) and "relieved from this mental suffering" (Bames 1949:449). Cosmetic surgeons state these women have a "heightened morale, happiness, and feminine pride" (Bames 1949:449). Thus, the health need for implants is based in individual psychology as prescribed by psychiatrists with knives.

Psychiatrist with a Knife

Plastic surgeons view one of their roles as that of psychological healer for the person who has a perceived aesthetic deformity. This conception of plastic surgery is inevitable; the perceived suffering is of the mind, not the body. In order to adequately and effectively help an individual confront this deformity, many plastic surgeons say they must first examine the patient's motives. Early and current plastic surgery discourse often states that they must not operate on someone whom they feel is "doing it for the wrong reasons" (Thurber-Cox 1990).¹⁴ The wrong reason for implantation is to express a desire for implants that will possibly result in social acceptance. This is ironic in that the social contract is furtively based on a position of disempowerment of the woman. Thus, the right reasons are an expressed need by the patient, which reveals an internalized belief that she will feel better about herself resulting from the implantation. As exemplified by a California surgeon, Dr. Harry Glassman,

The only justification for doing plastic surgery is to improve the patient's self-esteem, to improve the way the patient feels about herself—in other words, for herself and herself alone (Principle 1984:166).

Additionally, this approach casts the plastic surgeon's diagnosis of an operative condition as one of beneficence, rather than a responsive and collusive part of the controlling process of insidious indoctrination.

In 1958, questions about the proper candidates and the psychological benefits of implantation were asked by a joint project between the Department of Plastic Surgery and the Department of Psychiatry at Johns Hopkins.¹⁵ The study centered on 32 women who were seeking augmentation mammoplasty with the Ivalon® sponge implant. The women were interviewed after the operation to determine if their reasons for choosing implantation were appropriate. The results from these interviews were intended to reveal what sort of candidates would benefit from augmentation in the future. Upon concluding this phase of the study the surgeons believed that they found the acceptable and unacceptable psychological balance for the patient seeking implants:

A patient, who we could not classify as a completely satisfactory result psychiatrically...had...the complaint that we did not make her breasts large enough. On pre-operative psychiatric evaluation she was found to have hysterical character tendencies, developed largely in relation to her father's aggressive interest in women and her husband's tendency to flirt with other women (Edgerton and McClary 1958:279–305).

The woman who asked the researchers to put in another implant so that she could compete with the other women her husband flirted with was turned down and placed into psychological analysis. Simply, this woman was too cognizant, for the plastic surgeons, of the cultural basis upon which American women are judged. Her motivations for implantation were a disturbingly unveiled response to the social hierarchy. Another failed patient was too vocal about the social reality for women in America; she was labeled masochistic:

The woman complained that she was not as black and blue as she had expected to be. She felt that a previous surgeon had used a hammer and chisel on her breasts and that she felt a curious disappointment about this second, less uncomfortable operation (Edgerton and McClary 1958: 279–305).

Again, the response and training of the woman was too honest, too close to revealing the true aspects of power in the American culture. In both of these cases, the researchers felt that the operations were psychological failures. The patient who was a successful choice was described as a woman who experienced "changes in self-image...an increased social ease, loss of self-consciousness, and curiously, a change in the fixating of feeling on the breasts (Edgerton and McClary 1958:279–305).

For these researchers, plastic surgeons and psychiatrists, the choice for implantation was based on the individual woman, and the success or failure of the operation was based on their internal psychological world. The researchers never fully discussed the forces of American culture which provide an external locus of control over women. The women who

were considered a success were subjecting themselves just as much to external forces and forms of masochism as the failed women. Both sets of women consented to the same operation for the same reasons (e.g., to appear more like a "true woman," in society, and to gain social status through physical abuse). The role of the plastic surgeon as psychologist merges in the process of patient choice. As retired plastic surgeon Dr. Henry Jenny states:

A plastic surgeon has to be a somewhat good psychiatrist....to assess the physical is easy, but to get to know that person and find out why the person wants plastic surgery is really difficult. But you have to do this to determine who is a good candidate. If a woman says, I want big boobs because her husband is screwing around, and he looks at every waitress with big boobs I would be very concerned (Thurber-Cox 1990:45).

Taking the role of psychologist further is a San Francisco plastic surgeon/clinical psychologist, Carolyn Cline (1984:106), who states that she is "especially sensitive to the psychological aspects involved with women's motivation for breast augmentation." Dr. Cline explains that the reasons to have breast augmentation are based on a psychological model of a socially created "internal body image" and how it's reflected on to the physical "external body image." She says that when the external body image does not match the internal body image the person feels depressed or feels a lack of self-confidence. In other words, the woman's hopes and desires, behavior and actions, are molded by images of the possible derived from belief, knowledge, and imagination, which is first provided by the social ethos, and its representations found especially in the media. Dr. Cline's proposal is to change the external image to match the internal image through plastic surgery. She argues that "changing that external body image will help them....boost their self-acceptance and self-confidence and it especially true for the woman who has her breast augmented." Dr. Cline goes on to cite American culture as the creator of the internalized body ideal: for her, it is *Playboy* and *Penthouse* who are creating the breasts as a symbol of femininity, which naturally all women must desire for themselves.

In all the above cases, the theme that psychological motivations must be perceived as balanced is repeated but with variations. If the women appear to be "doing it for themselves" and not for a boyfriend or lover then the plastic surgeons/psychiatrists feel that they make a good candidate for the operation. They all recognized that there are social forces influencing the choices that women make but rather than problematizing the issue, they normalized it in popular psychology and watered down feminism by giving women the choice of plastic surgery.

The Big Business of Organized Plastic Surgery

The current surgical age is, like the Victorian medical system, impelled by easy profit. The cosmetic surgery industry grosses 300 million every year, and is growing annually by 10 percent....[and is]depend for their income on warping female self perception and multiplying female self-hatred (Wolf 1991:232).

Thirty years after the shift in focus to cosmetic surgery and the creation of a cosmetic based operative condition, the ASPRS became oriented to the demands and opportunities of market economics. This occurred primarily because of a glut of plastic surgeons. During the 1950's and 1960's, the number of plastic surgeons was less than one-thousand (Rigdon 1992:232). During this time, ASPRS "perceived a shortage in the supply of plastic surgeons" (Zones 1992:232). As a result surgeons were given greater avenues of access by which to join the ranks, including incentives such as increased numbers of residency programs and a growing number of positions. Due to such measures, the numbers of plastic surgeons rose so dramatically that by the late 1970's and early 1980's, there was an oversupply of their services in relation to market demand. Instead of lowering their prices in order to compete, ASPRS organized its members into a unified political and economic force. As Jane Sprague Zones (1992:232) observed, "the ASPRS operated like a commercial enterprise rather than a collegial medical society."

The ASPRS saturated American newspapers, magazines, radio and television air waves offering beauty treatments for signs of aging, fat, small breasts, sagging breasts and face structure deformities (Wolf 1992:A-19). Moreover as a result of the commercialization process, cosmetic surgeons have been able to make formally major surgical procedures to a large extent technically sound, quick, and easy. A Santa Monica cosmetic surgeons' brochure describes this shift; "we treat these [beauty] conditions in much the same way you would 'take in' a blouse or dress that is too large, by removing excess material, re-stitching the garment and ironing out the wrinkles."¹⁶ In light of the above description's familiarity, many women are told nothing of possible complications during or after the operation. Finally, cosmetic surgery was made affordable; it has been democratized. In 1989, in order to make these "resources of well-being" (Faludi 1991:217) more available to the money conscious consumer, ASPRS began to provide low-cost financing to patients. The prospective patient can know in less than 48 hours if her loan, sometimes for several thousands of dollars, has been approved by the suggested household financial institution.

Part of the question of why women choose breast implants has been answered by organized plastic surgery. Plastic surgeons must view the natural female form as diseased, in order to find objectivity and shelter behind a cloak of medical ethics. Organized plastic surgery sees and acts upon the normal female breast as a pathology. The result is the creation of a health need for women based on individual psychology. The plastic surgeons became not only artists and sculptors of the flesh, but also psychiatrists with knives. Not only did they create the physical operative condition, but they developed psychological standards for determining good candidates. Women who placed their trust in the surgeons did not know that what they heard was a created discourse, a sales discourse, produced by patriarchal capitalism.

"Choice" or Experimentation? A Medical-Industrial Discourse within Insidious Indoctrination

One of the most heated debates arising from the present public health crisis surrounding silicone-gel breast implants is whether the implant recipients were informed and freely situated, in order to choose implantation. Did women have adequate access to all pertinent information concerning possible health risks, thus providing for informed choices?

Were women subject to processes—medical-industrial and political in nature—because of which, they were not freely situated making voluntary consent impossible?

Marc Lappe (1991)¹⁷ examined these questions, applying the rules of medical ethics based on the precepts growing out of the “Doctors’ Trial” phase of the Nuremberg Trials after W.W.II (Annas and Grodin 1992). The resultant catalog of ethics, called the “Nuremberg Code,” was primarily a response to medical experiments and research conducted on prisoners. The Code developed a system of medical ethics concerned with human experimentation, as well as the doctor-patient relationships.

The voluntary consent of the human subject is absolutely essential. This means that the person...should be so situated as to be able to exercise free power of choice, without intervention of any element of force, fraud, deceit, duress, over reaching, or other ulterior forms of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable [her] to make an understanding and enlightened decision (Annas and Grodin 1992).

Significantly, the Code states that no agent, device or substance that does not offer or promise a positive risk/benefit ratio must be tested with positive results before it is prescribed and used on humans. Lappe points out that if a woman is not freely situated, consent is vitiated and no medical procedure or experiment may be performed.¹⁸ To secure a true picture of whether or not the recipients of silicone-gel breast implants were freely situated to give voluntary consent three areas have to be reviewed: 1) doctor-patient relations—including written and verbal information provided by ASPRS power structure, 2) the information available to the plastic surgeons and the women from manufacturers, and 3) the role of the FDA.

Coercive Methods and Control of Information

What were women told by organized plastic surgery concerning silicone-gel implants as they contemplated—feeling that they were conscientiously weighing the risks to the benefits—implantation, the surgery, and the post-operative aftermath? What were the power dynamics within the doctor-patient relationship? As this research indicates, in all the areas of possible communication, organized plastic surgery took action to block the free flow of information to women, thus obfuscating their decision making. In their offices of medicine, many plastic surgeons, misused their authority and withheld information pertaining to known and possible health risks surrounding silicone-gel breast prostheses. A relationship of coercion, articulating only benefits and reasons why a woman needed implants—without enumerating the risks—developed.

While undergoing preoperative consultation some women reported a constant pressure not only from plastic surgeons, but also from their medical doctors to consider implants because implants were seen as “the only alternative to cancer, or possible cancer.” Rarely did the consultation discuss lumpectomies or other possible procedures. One woman informant, after numerous visits for the removal of non-cancerous lumps, had doctor suggest that she should have a “prophylactic” double mastectomy to reduce the hereditary chance of breast cancer. He stated that the procedure was easy, and that the breast implant was safe. She

initially rejected the idea, but then considered it, because the doctor said he was getting tired of taking the lumps out. When she asked about her body possibly rejecting the implants he replied, "no way, it has never happened." She then asked about capsular contracture. He claimed the condition was "very, very rare" (literature at the time was reporting its rate of occurrence at 40-75%). Additionally, she was not informed that the procedure required more than one implant. Her surgeon told her that "the implant" he would use was the Meme[®], a textured silicone-gel implant covered with industrial foam.¹⁹

The results of this surgeon's coercive use of his authoritative power was experienced *en vitro* ten days after her surgery; one implant was erupting through her skin below her nipple—a condition called a "fistula," which is caused by the body's rejection of the implant or because the surgeon removed too much tissue to support the weight of the implant. During a post-operative discussion of the woman's implants, the surgeon failed to mention that he had left the implants' outer covering of polyurethane foam and connective glue inside her body. Now inside her body, she has non-excisable granules of polyurethane and glue floating around her body and her "waffle-wasteland chest."²⁰ The kind of coercive pressure and medical misinformation described above poses a systemic barrier to the patient's right to choose. Tragically, the preceding is not a rare report from women interviewed

Another example of professional neglect and abuse concerns a Los Angeles woman's experience with re-constructive surgery in 1989. According to this informant, the surgeon (who thought of himself as a "saint" providing relief to the suffering) prior to a re-constructive operation did not inform the woman (who had recently received a double mastectomy as a result of breast cancer) about possible risks when asked. He too, used the Meme.[®] After the implantation the woman had adverse reactions to the implants even before she left the hospital. After two months the skin around her breasts to develop a burning sensation. Eventually she began to suffer from shooting pains in her arm so severe that she could barely hold a pencil to write. Within three months she was far too ill to leave her bed except to visit her surgeon. When questioned, her no longer saint-like plastic surgeon explained away her agony as a result of the cancer's reappearance.

During the three post-operative months, she was able to obtain Surgitek's (a subsidiary of Bristol-Meyers Squibb at the time) product insert for the Meme[®] implants which explained, among other things, the proper conditions, procedures, and techniques associated the implants. In clear language, the insert stated that the Meme[®] should not be placed in a area which was post-cancerous. Enraged she returned to her surgeon with this information and demanded to know why he had not revealed the manufacturer's warnings. To this, the surgeon replied, "the insert is for the user, not the wearer." With personal dignity, she retorted, "you certainly are the user." Though the FDA has always required package inserts with warnings for the surgeon, it has been left up to the surgeon as to how much information was to be told to the woman. It was not until September 1991, that similar warnings were inserted for women.

Despite the fact that these are only vignettes taken from the histories of women who have received silicone-gel breast implants it is clear and irrefutable that women have experienced and continue to experience coercive and abusive doctor-patient relationships. The women were neither freely situated nor were they informed.

To encourage trust surgeons, silicone-gel breast implants manufacturers, and organized plastic surgery promote selected in-house literature. In order to maintain control of this type of literature, the ASPRS community continues to black ball “unfriendly” members whose work opposes the paradigm that implants are safe. Further maintenance of control is seen in multi-million dollar lobbying concessions orchestrated by surgeon hired lobbying firms in Washington. Thus, along with personal in-office coercion, a woman’s ability to choose is clouded by misleading in-house promotional literature about the medical science of silicone-gel implants. For example, in the ASPRS’ pamphlet “Straight Talk About Breast Implants” the following quote is found:

Breast implants are among the safest surgically implanted devices in use today. For the vast majority of women, the implants will come to feel like part of their bodies, occasionally subject to their own special ‘illnesses’ and “injuries.”

In this passage, women are led to trust and to believe in modern medical technology stating that silicone implants are the “safest” on the market, and that their bodies are to blame for any health complications such those related to gel-bleed.

Further evidence of information control is organized plastic surgery’s attempt to limit the effect of positions taken by unfriendly members on public opinion. Dr. Henry Jenny was one such unfriendly member. Through trade publications, public lectures, mass media, and presentations made before the FDA he attempted to disseminate the results of years of research which proved that there were serious risks surrounding silicone gel implants. Predictably, these attempts were stifled by organized plastic surgery.

In the 1970’s, Dr. Jenny presented his information on the risks of silicone in the body at a annual ASPRS meeting; he was met with extreme hostility. During the same period, his attempts to publish this information in trade journals was met with rejection. In a personal interview with Dr. Jenny, I learned that soon after these attempts, he was approached by ASPRS (of which he was a member) and told that he would be required to pass newly created board tests in order to become “certified.” After he failed these very subjective oral exams, he was approached at a dinner party by a friendly member, and was told that he would never be allowed to pass the exams due to his professional beliefs on Silicone-gel breast implants.

ASPRS also took more public action to frustrate Dr. Jenny’s attempts to inform women of the risks of gel-bleed and other problems associated with implants. In the December 1974 issue of *Cosmopolitan* magazine Dr. Owlsey, Chair of ASPRS Ethics Committee, wrote in a letter to the editor:

I am writing as Chairman of the Ethics Committee of the American Society of Plastic and Reconstructive Surgeons to inquire about an article entitled “I Had A Breast Implant.”...The article contains numerous quotations ascribed to Dr. Henry Jenny, and a number of unfortunate statements which have been distressing to both patients and plastic surgeons around the country alike. I make particular reference to the statement that “Whereas silicone, if it’s ever ‘at large’ in the system cannot be eliminated and behaves like a toxic agent killing tissue.”

This is a small illustration of the concerted effort to discredit unfriendly information and informants. Throughout the 1960's and well into the 1970's control of public and professional perception via information management served as a tool which enabled the lucrative continuance of breast implants. In the mid 1980's, however, wide discussion erupted regarding the withholding of information from pathologists and other non-surgeons, pertaining to gel-bleed and resultant auto immune disorders (U.S. Government 1992:16). It was not until after the mid 1980's that surgeons were regularly provided with product efficacy and health risk information by the manufacturers.²¹ The two decades of silence can be understood, in part, by juxtaposing the paradigmatic perception that silicone—a "high-tech marvel"—was inert, against the character of a capitalistic enterprise, which carved out and wanted to protect a market for the polymer. Moreover, as mentioned earlier, examples of the vigorous control and censure of risk information available to women is exemplified by the capitol hill lobbying campaign of 1991 by ASPRS, as they attempted to counter unfavorable rulings by the FDA and the California courts

As seen, from the most intimate doctor-patient relationships, to the control and management of media and unfriendly members, and to the stultified bureaucracy of Washington due to power-politics, organized plastic surgery has led a successful public relations campaign around the risks of Silicone-gel breast implants. The result is that women's choice is based on industry fabrication. It becomes clear that the controlling discourse of organized plastic surgery has limited the information available to women. Women have been used as human guinea pigs a 1993 government study states (U.S. Government 1992:10). As one doctor wrote to the FDA in 1989, "it has been the custom and practice of manufacturers to modify the implants based on ideas of surgeons, and then provide these custom-made prototypes that would be tried out on patients to see how they worked."

Women and Silicone Breast Implants: The Internalization of the Social Message

It appears that American women are subtly indoctrinated to identify and perceive their bodies through externally imposed social/cultural beliefs. The primary forces at work are patriarchy and capitalism, and the processes most relevant are gender creation, the beauty-industrial complex, and organized plastic surgery. A woman's physical appearance, if constructed through beauty industrial products, becomes a social signal of compliance and adherence to a social contract. Through this institutionalized social economy, this controlling process, women see and behave toward their bodies as forms of tender.

Tender: an unconditional offer of money or service in satisfaction of a debt or obligation made to save a penalty or forfeiture for nonpayment or nonperformance (Mirriam-Webster 1984).

The power and relevance of this truth for women is important to understand. As alluded to before, if the woman fulfills the contract she is told repeatedly by family, media, all forms of social education, the beauty industry and plastic surgery, that she will be valued. However, social and cultural forces are not designed to allow a woman to achieve official beauty. This would provide an unacceptably equal trade within a hierarchy:

Value: a fair return or equivalent in goods, services, money for something exchanged (Mirriam-Webster 1984).

Patriarchy and capitalism are charters for the disempowerment of women. The processes of insidious indoctrination, then, necessarily provide unfair and unequal exchange for women's attempts to manifest the ideal body-beautiful, precisely because it does not have an intrinsic value. It is fiat value; it is defined and symbolic within American culture. Indeed, through the need to recreate bodily beauty, women become engulfed within the present-day Iron Maiden.

The Social Message: Breast Fragments

Women's bodies are sliced apart—fragmented by mirrors in store windows, dressing rooms, and within their own minds as they reflect upon the beauty images they see daily. In these cultural reflections, she is mechanized, medicalized, and merchandised—a sentient machine to be re-calibrated, balanced, cured, and convinced through the promotions and procedures of the quick beauty fix provided by the beauty-industrial complex and organized plastic surgery. The most co-opted and medicalized part of the female body in American patriarchal culture is the breast. As the voice-over on *The Maury Povitch Show* chants to viewers across America,

Most women will admit they'd like to have the perfect [feminine] body...[and] the defining characteristics of that perfect female body are breasts, which means sexy, feminine, a woman....For some, silicone was the answer for that perfect bust line....For 30 years now, silicone has helped nearly 2,000,000 women have the bust line of their dreams.²²

Popular media is joined by professional medicine as they claim to bestow knowledge for the average American; The American Medical Association's new *Encyclopedia of Medicine* adheres to cultural myths surrounding the female breasts. They are even more explicit than the above quote: "the breast is a secondary sex characteristic. It has always been regarded by society as a symbol of femininity, beauty, and eroticism..." (Clayman 1989).²³

It is tempting to ask of *Povitch*, "Whose dream?" and of the AMA, "How long is always?" For the women who inquire about breast implants it is the norm to be advised by a plastic surgeon who supports the myth and offers the radical breast operation as the physical alteration which will feminize the woman. For women, there are powerful external forces which pressure her to take notice of her body, its shapes and sizes, and to seek operations which mutilate her natural body and reshape it in the reflection of a socially collective image.

Internalization: The Personal Message

The following quotes, taken from my interview transcripts, reveal the forces which sold the official breast to consumers; this breast is instilled in our collective psyche.

By the time I was thirty-five, I was very thin and had extra skin on my body. I was able to work-out to get the skin on my body tighter, yet my breasts

remained loose and sagging. They were very droopy. I remember feeling very embarrassed by them around men. I was so embarrassed that at times I would keep my shirt on when intimate. With one boyfriend, I remember, that when I showed him my breasts he gasped when he saw how sagging they were. I was very affected, and I decided not to date for a while.

I had asymmetry (now I have nothing.) When I was younger I was made fun of because my left breast never really developed. But it was not until the failure of my first marriage that I considered implantation. The marriage turned sour, and he called me names like "one sling Sally." This hurt me really bad, and I felt that I needed implants to change the appearance of my breasts, to make them even.

The breasts of these women were no longer their own. The body that was once intimately theirs has been stripped away. The image of the correctly shaped and sized female breast became a driving issue in their relationships and in their own minds. Many of the women felt responsible for their breasts' appearance. The power of insidious indoctrination convinced them that if their body received ridicule, it was deserved. This pattern of identification with ridicule was reinforced through the authority of plastic surgeons, as revealed in the following quotes:

Then he did the exam. I was extremely embarrassed, because when I took off my shirt, the doctor gasped, "god" at the sight of the droopiness of my breasts. He said that I was a good candidate for a textured Silicone-gel implant.

The plastic surgeon said, that I did have a problem. My asymmetrical breasts were a physical deformity.

For these women, the choice to have breast enlargement surgery was determined by American society. Through so much pain, there came a message of promise. The promise said that through breast implants they could take responsibility for their appearance and make it approximate the official beauty. They were told by the media, plastic surgeons, women's magazines, other women, and the business world that they could enhance their lives by enhancing their bust lines. Thus, the social imperative for appearance was personalized, psychologized and normalized.

The plastic surgeons recodify the responsibility of the woman by stating that the best patient for implantation is one who "is doing the operation for herself." In perfect synchronization, women have internalized the social imperative by stating over and over that they had implantation to feel better about themselves. Their choice of implants is explained in the language of feminist self-help, yet, they enact capitalistic-patriarchal values. As seen in the following quotes:

At the time of implantation, I was in a woman's group, and my women friends said that I should just spend the money on myself. I deserved it. The money was the main problem....My final push was how my friends saw it, as something for myself. My mother was not supportive, because she does not like me doing anything good for me. I got them for me and I feel great.

I thought breast implants were a wonderful idea to enhance my shape. They would make me look better in clothes, in bathing suits and in myself. I did it for myself.

I got breast implants because I wanted to remain feminine after my operation....I wanted to continue to feel attractive and social. I felt that this would help me. I did not have to grieve the loss of my breasts.

This internalized imperative was seen in national surveys, indicating that “most women feel they are making the decision [for breast implants] on their own and for themselves, not for the men in their lives. “It’s a self-confidence thing,” says Bonnie. “That’s what it boils down to—feeling like a woman.”

This choice of self-confidence and femininity often can be distilled to economic survival. Many financially rewarding occupations for women involve selling their appearance: as models, actresses, dancers, or strippers. These are the jobs in which women can earn three times as much as men in the same field, a strong incentive when the average American woman earns 66% of what the average male earns. As women strive for economic survival, they encounter the professional beauty qualification.

Interestingly, it was the women who had suffered serious medical complications who were expressive about the cultural pressures on American women. Many women expressed a personal realization that the pressure for implants, although manifested as private, had its genesis in the cultural environment. Many women came to believe that they were individually responsible for the re-creation of the externally imposed beauty imperative. They felt they needed to turn to cosmetic surgery as a beauty resource. All of the women with implants whom I interviewed felt that Silicon-gel breast implants were a personal answer to their social reality. As Laura Shapiro (1992) explains, “those women who locate their self-esteem in their bra are accurately reading their culture.” These women were culturally indoctrinated to believe that the physical appearance of their breasts would improve their social status and give them more control over their lives.

As discussed in the introduction, the practice of circumcision and infibulation of Sudanese women provides a parallel to breast augmentation. In both examples, the female body comes to mediate social relations by re-presenting social values. The Sudanese woman is told as a young girl that circumcision and infibulation are done *for her* and *not to her*. Thus, the oddity of Sudanese body mutilation is only apparent if one stands outside of their culture. In America, the mutilation of natural breasts is also done for the re-creation of the feminine appearance, they too come to believe that breast surgery is done for them.

Most of the women with implants that I interviewed were women that have publicized their stories. These women were interested in speaking, where other women who had not had problems with their implants refused to talk. Their experience explains why so many of the histories I received were informed; they had come to realize the external processes which led them to get implants. What once appeared so normal to them was now problematic, as a personal and national issue for all women. The myth of female vanity and its attendant stupidity, which places blame and responsibility on these women for their bodily failure, was the most apparent issue. The women are blamed by the society and, some, blame

themselves for the failure of the implants. "It is just something about me [my body] which causes the hardening."

Most women I spoke with had feelings characterized by ambiguity, guilt, confusion, sadness, pain, self-blame, and a strong sense that they had been wronged. The myth of vanity and stupidity lashed them as they spoke the truth. The women with whom I spoke who did not have implants often accepted the myth of vanity. One woman said to me on a flight from Oakland to Burbank, "Why don't women just leave their bodies alone, are they just stupid...I mean it's a free country, its not the third world. They have a choice!" She said this to me wearing a face full of carcinogenic make-up, and her feet were pinched into high heels; she was a business woman in a company that protected the environment. The myth of vanity for the female as an American institution prevails as if magical and separate from capitalism and patriarchy.

As these women step out into the world to reveal their experiences, cultural forces lash back against them in perfect synchronization. The forces of culture are separate from these women and judge them as oddities and as stupid. However externally and internally blamed and ridiculed many of these women have bared their physical body parts of non-beauty performance in hopes to reveal a terrible and entrapping lie. Thousands of women with Silicone-gel implants have been able to come together and express their feelings, their pains, their angers, their fears, and their actions. They have started networks, sent newsletters, started support groups across the nation, and have promoted and organized work shops and seminars where present-day ethicists, scientists, surgeons, researchers and attorneys provide women with up to date information on Silicone-gel breast implants. The women have testified before congress and state legislatures, have gone to trial, have given press conferences, and have challenged some of the largest corporations and insurance companies in America. As a result, they have challenged America's most basic, accepted and hidden structures.

There is no doubt that many women who speak up suffer greatly due to feelings of responsibility and obligation. Many of them state they feel a sense of a great loss in their lives and relationships as they began to uncover their own histories. Yet for many their feelings blossomed into a new sense of autonomy and self-worth. One woman who had wanted so much to have breast implants to boost her self-confidence, now feels a stronger self-confidence, one no longer connected to the appearance of her breasts. Others were also starting to see through and beyond the process of indoctrination. It was through such women that I learned how choices for implants were part of a larger dynamic, a dynamic which they felt required them to look a certain way for social survival.

Conclusion

The phenomenon of Silicone-gel breast implants in America occurs within a cultural environment largely created upon a foundation of patriarchy and capitalism. These two cultural forces are primary influences shaping how American institutions conceptualize and represent the female breast. Through the process of socialization, the Beauty-Industrial Complex and organized plastic surgery melded cultural values with the natural female form. These institutions form a matrix of controlling processes to which women are subject.

“Beauty” is a creation of disempowerment on which the dual forces of capitalism and patriarchy depend. Those who do not attempt to reflect beauty are neither praised nor valued, and those who attempt to achieve its standards must relinquish control of their bodies. Patriarchy is hierarchy and capitalism requires insecure-consumers. They both must create a feeling of lack and inferiority to be re-generated, and so their institutions bring their message of *beauty equals femininity* to American women.

In American culture, femininity has become the role-defining characteristic of the female. Through providing women with larger breasts, plastic surgery brings a way for women to, in part, fulfill the social beauty imperative. Not only has the implantation of Silicone-gel breast prostheses come to signify social value in American society, but it has also come to represent a reduction of internalized personal lack.

Although some women are encouraged by family or social peers to engage in breast implantation, the actions involved with breast implantation are often hidden. They become private interactions between the surgeon and the woman. Yet, the slicing open of the women’s breasts, along with the insertion of prostheses and the resultant pushed-out shape of the breasts are rewarded in a social manner. This alteration of the breasts leads to more social and sexual attention from men, greater access to work, and higher social status.

The same is demanded of women in Sudanese culture. For women in America, the surgeon is comparable to the Sudanese midwife. The cultural conceptualization of the female and her body, as well as of the overriding authority of the collective psyche as it is manifested through the operation is a reflection of the cultural hierarchy in both cultures. The operation of the female breast in America holds much of the same social symbolism, and expression of cultural mandate as does infibulation in Sudan. Thus, the question of why women choose breast augmentation becomes moot.

Women in America do not choose implantation. Under the Nuremberg Code, a choice to participate in a medical procedure must be given when the woman is freely situated and informed. The women in this study were neither freely situated nor informed. Thus, Silicone-gel breast implantation is an example of cultural forces overriding medical ethics, but it is also an example of women’s almost subconscious response to the cultural forces and structures in which they live.

Notes

1. See, W. E. Leary. *Breast Implants: A Look at the Record*. *New York Times* Nov. 13, 1988 Pp. E-9. According to Professor Jane Zones of University of California, San Francisco, the number of women in the United States with silicone-gel breast implants is estimated at hundreds of thousands. During a personal interview, Professor Zones indicated that the number of 2 to 3 million was “cooked-up” to spread the risk statistics over a wider range, and to create a public perception that the procedure was safe, effective and more popular than is actually the case.

2. Only 10% of breast cancer patients who undergo mastectomies receive implants. This raises doubts regarding the generally held belief—buttressed by the FDA, manufacturers, and organized plastic surgery along with other advocates of breast implants—that breast implants are a “health need.” See, *The FDA's Regulation of Silicone Breast Implants*. Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operation, Dec. 1992.
3. The hours on the table are for only one operation. Many women who have implants undergo several operations lasting much longer than this. Also, an removal of the implant can last anywhere from a couple of hours to nine hours, depending if there has been a rupture.
4.
 - a) Complications with anesthesia and infection.
 - b) Capsular contracture.
 - c) Calcification of fibrous capsule.
 - d) Implant failure (Spontaneous rupture).
 - e) Micro-leakage (gel-bleed).
 - f) Migration of silicone (transgression) through the tissue planes, into the lymphatic system, lungs, spleen, liver, the smallest of end capillaries, and possibly into the other organs.
 - g) Interference with the accuracy of mammograms, thus decreasing woman's chance for early detection of breast cancer.
 - h) Tumorigenesis.
 - i) Numerous immune disorders: rheumatoid arthritis, scleroderma (potentially fatal), lupus (potentially fatal), mixed connective tissue disease, Raynaud's disease, trigeminal sensory neuropathy, Hashimoto's thyroiditis, myxoedemia, alopecia erythematosa patches, telangectasis, polymyalgia, scleritis, etc.
 - j) Additional operations and procedures in attempt to rectify post-operative complications.
5. See, Mary McGrath, M.D., and Boyd R. Burkhardt. 1984. The Safety and Efficacy of Breast Implants for Augmentation Mammoplasty. In *Plastic And Reconstructive Surgery*, 74:4:550–560.
6. Justice O'Conner told Michigan Representative John Dingell how important reconstructive surgery using silicone-gel implants were for her in her recovery from breast cancer (Rift 1992).
7. Margaret Mead's *Coming Of Age In Samoa & Sex and Temperament in Three Primitive Societies* and Serena Nunda's *Neither Man Nor Woman: The Hijras of India* illustrate how the contents of gender, which Mead calls “temperament,” are socially created rather than biologically determined. Nunda's work with the Hijras in India clearly shows that society, because of this “third sex” questions the boundaries of female and male. The Hijras of India are biologically male, female and male, or neither. In the last case they take on the gender characteristics of a third gender, which according to Indian society, is neither man nor woman.

Edward T. Hall (*The Silent Language*. Greenwich: Premier Books, 1963:10) argues that culture defines the contents of gender. Using Iran as an example, he writes:

In Iran...men are expected to show emotions....If they don't, Iranians suspect they are lacking a vital human trait and are not dependable. Iranian men read poetry; they are sensitive and have well-developed intuition and in many cases are not expected to be too logical. They are often seen embracing and holding hands. Women on the other hand, are considered to be coldly practical. They exhibit many of the characteristics we associate with men in America.

In American patriarchy, males rationalize their social dominance as the natural consequence of innate and gender specific logic, a female paucity of the same, and, female overly emotive characteristic. In Iran, it would seem, that the patriarchal hierarchy would not use this argument, rather its opposite.

8. The origin of the common term "hero" is derived from the name of Hero, a priestess of Aphrodite.
9. As found in *Being Beautiful* (1986:216), common products for appearance that are accepted by the majority in American culture as signifiers of femininity include lipsticks, a variety of make-up, hair dyes, body care products such as shampoos, perfumes, and skin care products. Many of these present serious health risks to the users. Some lipsticks often contain a suspected teratogen butylated hydroxytoluene (BHT), which is used as a preservative, as well as FD & C Blue #1, which is a suspected carcinogen. Additionally they may contain P-hydroxyanisole, which is used as preservative, and has been banned in the countries of the European Economic Community. Mascaras can also contain BHT, as well as Polyvinyl Pyrrolidone (PVP)—a yellowish plastic, which is a suspected carcinogen. Eye shades can contain ethylene diameine tete acetic acid (EDTA), which is a suspected teratogen. The vast majority of hair dyes contain the cancer causing ingredient lead acetate. In products for the nails, toulene, dibutyl phthalate and acetone are found and in perfumes, FD & C Blue #1 and triethanolamine.

An FDA representative, at the 1974 hearings before the Subcommittee on Health, Senate Committee on Labor and Public Welfare:

One thing to keep in mind when discussing cosmetic safety is that cosmetics, unlike food or drugs, are not essential to the health and well-being, regardless of their aesthetic or camouflage value.

In the case of drugs, a benefit-risk judgement can apply in which the expected benefits, may justify the assumption of substantial risk. But since there are few, if any, cosmetics or cosmetic ingrediaents which we could not do without, were we forced to, we should be much less tolerant of any potential for injury from these products.

10. Douglas Kellner writes in "Popular Culture and the Construction of Postmodern Identities" (Lash and Friedman 1992:141-177): "like myths, ads frenquently resolve social contradictions, provide models of identity, and celebrate the existing social order."

Kellner goes on to show how ads provide contemporary mythology and contribute to identity formation.

11. See, Jane Zones of University of California, San Francisco, "The Command Trust National Conference," Tape #1.
12. Susan Faludi. *Backlash* (1991). She notes that this is what he is called in the plastic surgeons circles.
13. This medium size breast has been touted by plastic surgeons as the size preferred since implantable breast prostheses first were introduced. As Cronin and Gerrow—the plastic surgeons attributed with introducing the first Silicone gel-implant with Dow—wrote of their Cronin Implants in 1963 (Cronin, T.D. and Gerrow, F.J. 1963. Third International Congress of Plastic Surgery in Amsterdam, *Augmentation Mammoplasty: A New 'Natural Feel' Prosthesis*, pp.41-49):

At least three sizes of implants will be available (from Dow Corning, Midland Michigan, U.S.A.) a small, medium, and large size. The small one is filled with 210 cc. of gel...while the medium size is filled with 270cc....The large size is not yet in production. Our personal experience indicates that the medium size will be satisfactory for the great majority of women. The small size seems best suited for women of small stature or those who have a fair amount of breast tissue but desire an increase in size. The proposed large size has been nicknamed "The Burlesque" and would probably be used only on very large women or certain burlesque queens or strippers desiring exaggerated augmentation
14. See also, Baker, T.J. The Aging Face. In *Clinics in Plastic Surgery* 1978 vol. 5, pp. 1-2; Baker, T.J. Patient Selection and Psychological Evaluation. In *Clinics in Plastic Surgery* 1978, vol. 5, pp. 3-14.
15. The present studies being conducted by the FDA and some of the manufacturers of breast implants are also designed to reveal and examine psychological benefits of breast implants. Of course, this ignores the deep social motivation for the implantation. The studies are slated to conclude in 1997.
16. From a promotional brochure written for Dr. Steven M. Hoefflin, the celebrity surgeon noted for operating on Joan Rivers' face.
17. Marc Lappe is a toxicologist and professor of ethics at University of Illinois at Chicago Medical school. He has been an expert witness in hearings where women who have had silicone-gel breast implants are bringing suit against the manufacturers, distributors, or the plastic surgeons involved.
18. Paraphrased from Professor Lappe at the November 1992 Command Trust Network Conference held in Chicago.
19. The industrial foam, produced by the Scott Corporation, was to be used only in car parts such as carburetors, oil filters, and seat stuffing. However, in 1987 Scott realized how the foam was being used and immediately sent a letter to the manufacturers of the Meme[®], the Natural-Y[®], and the Repilcon[®], stating that the foam was not to be used in humans. In

1989, Canadian researchers found that the foam broke down in the body releasing a carcinogens.

20. Pierre Blais, the Canadian “junk” scientist who blew the whistle on the Meme® in Canada, attributed this practice to the surgeon’s desire to save time; it takes hours of surgery to dig out the foam from the chest wall and tissue areas. This woman filed suit against the surgeon following the procedure. She lost but has now filed a new suit against the surgeon and the health department where the surgeon practices.
21. There were reports from other manufacturers previous to 1985. For example, the “Dear Doctor” letter written by the president of Heyer-Schulte Corporation in 1976 informed surgeons that their implants might rupture. However, Dow Corning, the world’s largest manufacturer of silicone-gel breast implants—also the first to market the implants—failed to disseminate information to the surgeons until 1985.
22. *The Muray Povich Show*, “Silicone Breast Implants,” April 2, 1992.
23. In descriptions of the penis and the vagina, by comparison, only function are noted.

References

Annas, G. and M. A. Grodin, eds.

1992 *The Nazi Doctors and the Nuremberg Code*. New York: Oxford University Press.

Baker, Nancy

1986 *The Beauty Trap: Exploring Woman’s Greatest Obsession*. In *Being Beautiful*. Washington D.C.: Center for the Study of Responsive Law.

Bames, H. O.

1947 Breast Malformation, A New Approach to the Small Breast. In *Journal of Plastic and Reconstructive Surgery* 2(1):499–531.

1948 Reduction of Massive Breast Hypertrophy. In *Journal of Plastic and Reconstructive Surgery* 3(2):560–569.

Campbell, Joseph.

1986 *The Inner Reaches of Outer Space: Metaphor as Myth and as Religion*. New York: Alfred Van der Marck.

Caplan, Paula.

1985 *The Myth of Women’s Masochism*. New York: Dutton.

Capra, Fritjof.

1983 *The Turning Point: Science, Society, and the Rising Culture*. New York: Simon & Schuster.

Center of the Study of Responsive Law, eds.

1986 *Being Beautiful*. Washington, D.C.: Center of the Study of Responsive Law.

Chapkis, Wendy.

1986 *Beauty Secrets: Women and the Politics of Appearance*. Boston: South End Press.

Chapman, Stephen

1991 The Medical Gamble Women Willing to Bet On. In *The Orange County Register*. November 19. Pp. B4.

Chomsky, Noam

1985 The Bounds of Thinkable Thought. In *The Progressive*. October. Pp.31.

Clayman, Charles, ed.

1989 *The American Medical Association Encyclopedia of Medicine*. New York: Random House.

Cline, Carolyn

1984 What's Available in Breast Surgery. In *Shape Magazine* Sept. 1984, p. 106.

Edgerton, M. T. and McClary, A. R.

1958 Augmentation Mammoplasty: Psychiatric Implications and Surgical Indications. In *Journal of Plastic and Reconstructive Surgery* 21(4):279-305.

Faludi, Susan

1991 *Backlash: The Undeclared War Against Women*. New York: Anchor Books.

Feher, Michael, Ramona Naddaff, and Nadia Tazi, eds.

1989 *Fragments for a History of the Human Body Part 3*. New York: Zone.

Freedman, Rita

1986 *Beauty Bound*. Lexington: Lexington Books.

Freeman, Bromley, S.

1954 Complications Following Subcutaneous Insertion of Plastic Sponge. In *Journal of Plastic and Reconstructive Surgery* 1(5):149-151.

Freeman, Bromley, S.

1962 Subcutaneous Mastectomy for Benign Breast Lesion with Immediate or Delayed Prosthetic Replacement. In *Journal of Plastic and Reconstructive Surgery* 3(6):676-683.

Gillies, H. and Marino, H.

1958 The Periwinkle Principle in the Treatment of the Small Ptotic Breast. In *Journal of Plastic and Reconstructive Surgery*. 21(3):1-24.

Gonzales-Ulloa, Mario

1960 Correction of Hypertrophy of the Breast by Means of Exogenous Material. In *Journal of Plastic and Reconstructive Surgery*. 25(1):15-26.

1964 A Quantum Method For The Appreciation of the Morphology of the Face. In *Journal of Plastic and Reconstructive Surgery*. 34(3)241-246.

Harper's Bazaar

1959 *Harper's Bazaar Beauty Book*. New York: Popular Library.

Knauff, Bruce

- 1989 Bodily Images in Melanesia: Cultural Substances and Natural Metaphors. In *Fragments for a History of The Human Body. Part Three*. M. Feher, R. Naddaff, and N. Tazi, eds. New York: Zone.

Lakoff, Robin.

- 1986 Most Women Lose Playing Beauty Game, Author Says. In *Being Beautiful*. Washington, D.C.: Center for the Study of Responsive Law. Pp. 26.

Lash, Scott and Friedman, Jonathan

- 1992 *Modernity and Identity*. Cambridge: Blackwell.

Lappe, Marc

- 1991 *Chemical Deception: The Toxic threat to Health And The Environment*. San Francisco: Sierra Club.

Lightfoot-Klein, Hanny

- 1989 *Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa*. New York: Haworth Press.

Loewy, Erich

- 1989 *The Textbook Of Medical Ethics*. New York: Plenum Medical Books.

Lucus, Laurie

- 1992 Beauty and the Bust. In *The Press-Enterprise*. Jan. 15. Pp. D2.

Mead, Margaret

- 1946 *Coming of Age in Samoa*. New York: International Universities Press.

Merriam-Webster

- 1984 *Webster's Ninth New Collegiate Dictionary*. Springfield, Massachusetts: G. & C. Merriam Company.

Principle, Victoria

- 1984 *The Beauty Principal*. New York: Simon & Schuster.

Regnault, Paul.

- 1966 The Hypoplastic and Ptotic Breast: A Combined Operation with Prosthetic Augmentation. In *The Journal of Plastic and Reconstructive Surgery* 37(1):31-37.

Regush, Nicholas

- 1992 Toxic Breasts. In *Mother Jones*. Jan./Feb. Pp. 23-30.

Rich, Adrienne

- 1986 *Of Woman Born*. New York: W. W. Norton & Co.

Rift, J.

- 1992 Implant Debate Divides Women Some Want Option, Others Decry Health Risks. In *The Wall Street Journal* Feb. 14.

Rigdon, Joan

- 1992 The Political and Social Context of Silicone Breast Implant Use in the United States. In *Journal of Long-term Effects of Medical Implants*. 1(3):232-254.

Rutlege, Deborah

- 1966 *Natural Beauty Secrets*. New York: Avon Books.

Schudson, Michael

- 1984 *Advertising: The Uneasy Persuasion*. New York: Basic Books.

Shapiro, Laura

- 1992 What is it with Women and Breasts? *Newsweek*. January 20. Pp. 57.

Thurber-Cox, June

- 1990 *Cultural Images of the Body: An Inquiry into the History of Human Engineering*. Unpublished Ph.D. dissertation, Department of Anthropology, University of California, Berkeley.

Travis, Carol

- 1992 *The Mismeasure of Woman*. New York: Simon & Schuster.

Turner, Bryan

- 1987 *Medical Power and Social Knowledge*. Beverly Hills: Sage Publications.

United States Government, Subcommittee of the Committee on Government Operation

- 1992 *The FDA's Regulation of Silicone Breast Implants*. Washington D.C.

Woetzel, Robert

- 1962 *The Nuremberg Trials*. New York: Frederick Praiger, Inc.

Wolf, Naomi

- 1991 *The Beauty Myth: How Images Of Beauty Are Used Against Women*. New York: Anchor Books.

- 1992 Counterpoint. In *The Wall Street Journal*. Jan. 23. Pp. A19.

Zinn, Howard

- 1984 *The Twentieth Century: A People's History*. San Francisco: Harper & Row.

Zones, Jane Sprague

- 1992 The Political and Social Context of Silicone Breast Implant Use in the United States. In *Journal of Long-term Effects of Medical Implants* 1(3):225-241.