Selves in Transition: Symbolic Consumption in Personal Rites of Passage and Identity Reconstruction

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The consumption of aesthetic plastic surgery is examined within the broader context of daily life in an investigation of the motives and the self-concept dynamics underlying this symbolic consumer behavior. Data were collected in multiple, in-depth, ethnographic interviews, and analyzed by a constant comparative method revealing insights into both a priori and emergent themes. A priori themes regarding body image, impression management, symbolic self-completion, and possible selves are developed through a literature review and discussed briefly in light of the findings. Emergent themes, including role transitions, sexual selves and romantic fantasies, control and efficacy, and identity play are developed and embedded in a discussion of identity reconstruction and personal rites of passage. It is concluded that consumption activities are important to both the maintenance and the development of a stable, harmonious self-concept. Directions for future research are discussed.

Nature attains perfection, but man never does. There is a perfect ant, a perfect bee, but man is perpetually unfinished... It is this incurable unfinishedness which sets man apart from other living things. For, in the attempt to finish himself, man becomes a creator. [Eric Hoffer 1973, p.3]

One characteristic that makes humans unique among living creatures is our ability to examine ourselves, to find ourselves lacking, and to attempt self-betterment. This sense of incompleteness drives us not merely to create, but also to self-create, and we consume goods and services in the process. This study was undertaken as a way to gain insight into the role of symbolic consumer behaviors in the maintenance or reconstruction of self-concept, an area of recently emerging importance in the field of consumer behavior (Belk 1988; Mehta and Belk 1991; Solomon 1983).

Studying extreme forms of consumption sometimes facilitates the discovery of themes that might be missed in a study of more mundane events (O’Guinn and Faber 1989). A particularly dramatic form of symbolic consumption, aesthetic plastic surgery, was chosen as the domain for this study. Irreversible, expensive, painful, potentially dangerous, and, nevertheless, increasingly popular, cosmetic surgery is at once both highly visible and intimately personal. Once perceived primarily as a vain indulgence of the wealthy, it has become more widely available and acceptable to the American middle class as a potential means of self-improvement (Biggs 1982; Stallings 1977).

This report begins with a discussion of the theoretical foundations and a priori themes that constitute the point of departure for inquiry. The research methods are then described. There follows a discussion of the a priori themes in light of the findings. Several emergent themes are then developed, interpreted, and integrated into a discussion of personal rites of passage and the process of identity reconstruction. The article concludes with suggestions for extending the present research.

THEORETICAL BACKGROUND AND A PRIORI THEMES

Whatever else it may be, elective cosmetic surgery is a means for improving one’s physical attractiveness. An attractive body is a valuable personal attribute, found by researchers to facilitate success in social, romantic, and economic endeavors (Berscheid, Hatfield, and Bohrnstedt 1973; Brislin and Lewis 1968; Hatfield and Sprecher 1986). Opinions about what constitutes attractiveness vary widely across cultures and history (Polhemus 1978), as do methods for becoming more
attractive. For example, in cultures where fatness signified status, women have been placed in fattening houses in preparation for courtship (Talbot 1915); whereas in the modern United States, where slimness is idealized (Garner et al. 1980; Horvath 1979; Wiggins, Wiggins, and Conger 1968), dieting and exercise have become a national preoccupation. People historically have undergone extreme discomfort, pain, and risk in order to conform to culturally prescribed standards of beauty. Examples of such behaviors include the binding and permanent deformation of the bones of the feet or the cranium (Brain 1979; Kunzle 1982; Polhemus 1978), painful constriction of the waist and torso (Cooley 1866), tattooing (Polhemus 1978; Sanders 1989), and ritual body scarification (Polhemus 1978). Each of the preceding means of beautification has been widely accepted in its respective culture (or counterculture); likewise, cosmetic surgery appears to be ascending rapidly to the same level of acceptance in American culture (Hamburger 1988; Morrisroe 1986). Clearly, not all who desire to be more attractive resort to cosmetic surgery. What motivates those who do? Self-concept theory offers some insights.

The self-concept, as the term is understood and applied in this research, is the cognitive and affective understanding of who and what we are. Self-concept is thought, without complete agreement among scholars, to encompass such things as the role identities, personal attributes, relationships, fantasies, possessions, and other symbols that individuals use for the purposes of self-creation and self-understanding (Allport 1943; Belk 1988; Csikszentmihalyi and Rochberg-Halton 1981; James 1890; Markus and Nurius 1986; McCall 1987; Rogers 1951; Turner 1987).

Of the many symbols and expressions of self, the body holds a place of paramount importance both psychically (Belk and Austin 1986; Rook 1985; Secord and Jourard 1953) and culturally (Obevyeskere 1981; Polhemus 1978; Vlahos 1979). Accordingly, an important component of self-concept is body image, the perception and evaluation of one’s own body in terms of such things as size and attractiveness (see Fisher 1986). Dissatisfaction with one’s body image has been demonstrated to differentiate aesthetic plastic surgery patients from nonpatient control groups (Ho 1985; Shipley, O’Donnell, and Bader 1977). Furthermore, Horowitz (1983) found that, following rhinoplasty, patients experienced significant improvements in their overall body images and even in their evaluations of body parts and attributes (e.g., complexion, thighs, voice, and hands) that were unaffected by the surgery. The conclusion that localized improvements in body image may lead to general improvements in self-esteem serves as the basis for a priori theme 1: A poor body image with respect to a specific body part may motivate the consumption of aesthetic plastic surgery.

Social roles also constitute basic components of self-concept (McCall 1987; Turner 1987), acting as symbols of identity with which individuals create self-understanding and communicate self-relevant information to others (Blumer 1969; Firth 1973; Hewitt 1976; Mead 1934). The body and its adornments may be particularly self-relevant as symbols of specific role identities. Extending the metaphor of role performances, Goffman (1959) and Schlenker (1980) discuss the deliberate manipulation of such symbols for purposes of impression management. In a similar vein, Fromm (1947, 1976; see also Hirschman 1987) ascribes the term “marketing character” to people who appear to manage their lives as commodities and perform in such a way as to increase their own socioeconomic exchange value. The importance of physical attractiveness to certain role performances, or to the “market value” of the performer, suggests a priori theme 2: People may elect plastic surgery in order to improve their performance in key social roles.

In their conceptualization of symbolic self-completion, Wicklund and Gollwitzer (1982) indicate that the less complete or secure people feel in roles or statuses to which they are committed, the more likely they are to use stereotypical symbols of role competency to reinforce perceptions of adequate performance (see also Solomon 1983). McAlexander and Schouten (1989) found changes of appearance to be symbolically important in coping with certain role transitions. The observation by some researchers that plastic surgery is often elected before or during major life changes (Horowitz 1983; Hueston, Dennerlein, and Gots 1985) lends support to a priori theme 3: Cosmetic surgery may serve as an act of symbolic self-completion during or following role transitions.

Viewing the self-concept as a cognitive construct formed of systems of symbols called self-schemas, Markus and Nurius (1986) discuss the motivational importance of possible selves: hypothetical self-schemas, either positive or negative, that act as objects of aspiration, hope, fantasy, or fear and that motivate approach or avoidance behaviors (see Lewin 1935). From their work is derived a priori theme 4: Individuals may seek aesthetic plastic surgery as a means of approaching positive or avoiding negative possible selves.

**METHOD**

This study was undertaken with two primary research objectives: (1) to examine the a priori themes in the context of plastic surgery consumption and (2) to identify and analyze emergent themes with the hope of expanding current understanding of the self-concept in consumer behavior. Because the self-concept is complex and highly sensitive to social and situational contexts (Markus and Nurius 1986; Turner 1987), this study required a research method with the ability to delve phenomenologically into the thoughts, feelings, and behaviors of informants, and to capture and ac-
TABLE 1
PERSONAL CHARACTERISTICS OF KEY INFORMANTS

<table>
<thead>
<tr>
<th></th>
<th>Kate</th>
<th>Consuelo</th>
<th>Nan</th>
<th>Tom</th>
<th>Chuck</th>
<th>Jane</th>
<th>Lisa</th>
<th>Leslie</th>
<th>Beth</th>
</tr>
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<tr>
<td>Race/sex</td>
<td>w/f</td>
<td>w/f</td>
<td>w/f</td>
<td>w/m</td>
<td>w/m</td>
<td>w/f</td>
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<tr>
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<td>Rhinoplasty</td>
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<tr>
<td></td>
<td>augmentation</td>
<td></td>
<td></td>
<td></td>
<td>reduction</td>
<td></td>
<td></td>
<td></td>
<td>chin implant</td>
</tr>
<tr>
<td>Surgery under</td>
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<td>Face-lift</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
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<td>Face-lift</td>
<td></td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<td>31</td>
<td>45</td>
<td>30</td>
<td>17</td>
<td>29</td>
<td>31</td>
<td>26</td>
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<tr>
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<td>62</td>
<td>38</td>
<td>32</td>
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<td>26</td>
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<td>Third manage</td>
<td>Single</td>
<td>Married</td>
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<tr>
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<td>Student</td>
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<td>Housewife</td>
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<td>Same</td>
<td>Same</td>
<td>manager</td>
<td>University</td>
<td>Same</td>
<td>Student</td>
<td>Legal secretary</td>
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<tr>
<td>Interventions</td>
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<td></td>
<td>2 (1)</td>
<td>1 (1)</td>
<td>1 (1)</td>
<td>2 (2)</td>
<td>3 (3)</td>
<td>1 (1)</td>
<td>2 (2)</td>
</tr>
<tr>
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<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
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<td>Before and</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>Before and</td>
<td>Before</td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>relative to surgery</td>
<td>after</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>after</td>
<td>before</td>
<td>After</td>
<td></td>
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<td>Daughter</td>
<td>Sister-in-law</td>
<td>None</td>
<td>Friend</td>
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<td>Brother-in-law</td>
<td>Husband</td>
<td>Informant's</td>
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<tr>
<td>relative to surgery</td>
<td>brother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>sister</td>
<td></td>
<td>own journal</td>
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</tbody>
</table>

Note: —n.a. = not applicable.

* Long interviews lasted at least 40 minutes and went as long as three hours. Most lasted about one hour.

b Short interviews were generally not taped. They often were conducted by telephone and had the purpose of probing or clarification during analysis of transcribed data.

...count for the social and situational contexts of those phenomena. Research was conducted using ethnographic interviews (see Bernard 1988; Spradley 1979) in a program of constant comparative method (see Glaser and Strauss 1967).

Two kinds of informants were important to this study: key informants and supplemental informants. The nine key informants all had undergone cosmetic surgery or were currently involved in decisions regarding whether or not to do so. They provided the main body of data. Although a pool of nine key informants may seem small to some readers, it exceeds the number suggested by McCracken (1988, p. 17) as sufficient for generating themes or cultural categories in this type of qualitative research. Supplemental informants, persons who knew the key informants as friends or family members, provided additional perspectives and insights into aspects of key informants' lives that might otherwise have been closed to an outsider; furthermore, they often helped to corroborate, challenge, clarify, or expand on key informants' accounts. Other sources of data included photographs and one informant's journal of her experience with plastic surgery.

Key informants were recruited by networking through friends and casual acquaintances. When potential key informants were identified, the referring persons were asked to act as intermediaries in making contact. Intermediaries frequently turned out to be excellent supplemental informants. Efforts to obtain referrals from plastic surgeons and from signs posted in public areas of a large university campus were unsuccessful. Key informants were both male and female and had experienced or were contemplating one of the two most common categories of cosmetic surgery, that is, facial (nose, chin, eyes, and full face) and breast (augmentation and reduction) operations. Two informants, Kate and Lisa, were interviewed from the time they first began serious consideration of plastic surgery until a few months after they had undergone surgery...
and had had time to adapt. Personal characteristics of the key informants are summarized in table 1.

Interviews with key informants began with “grand-tour” questions (see McCracken 1988; Spradley 1979) pertaining to their biographies and their experiences with plastic surgery. Interviews were kept as loosely structured as possible, allowing informants the freedom to broach topics in their own ways and at their own paces. Under these conditions, rapport developed rapidly, evidenced by the frequently alarming candor with which informants divulged intimate details of their lives, thoughts, and fantasies. As themes emerged, and as rapport with informants increased, it became possible to use more probing questions to test and explore themes across informants. Interviews were audiotaped whenever possible and converted to written narratives including voluminous verbatim quotes and impressions and observations from field notes. When recording was not possible (e.g., in the first interview with Kate, opportunistically conducted over the telephone) notes were taken during the interview and used to produce more complete field notes immediately afterward. Questions and observations jotted during interviews later became the basis for specific probe questions. Informants were interviewed multiple times over as long as 15 months, with interviews ending only when new and relevant information was no longer forthcoming.

Much of the analysis occurred simultaneously with data collection and helped to determine the direction of the study. As new data were collected, they were analyzed in the context of previously gathered data and examined for points of similarity and contrast. This constant comparison of new data to old occurred informally during interviews and more formally and exhaustively between interviews. As themes emerged, they were used to guide but not necessarily restrict the foci of future interviews (cf. Csíkszentmihályi and Rochberg-Halton 1981, p. x).

Analysis was an iterative process of coding, categorizing, and abstracting the data (cf. McCracken 1988, Miles and Huberman 1984). Data of apparent thematic similarity were identified throughout the field notes, highlighted, and coded with key words or phrases. Coded data were compared and contrasted to yield a few broad categories which, through further sorting and clustering, were reduced to the more fundamental patterns that constitute the principal emergent themes. The final analysis integrated the themes into a unified discussion of the identity-reconstruction process.

I gained valuable feedback in the task of analysis by periodically submitting my own interpretations to colleagues of differing backgrounds (cf. Wallendorf and Belk 1989) who often challenged my interpretations or proposed alternatives, exposing my personal biases and leading me to further scrutiny of the data and literature. I also submitted selected conclusions to the informants for their responses. Their reactions ranged from epiphany to skepticism, but more often they responded with some sort of assent to the plausibility of the interpretations. Again, complete agreement was less important than dialogue and a thorough reexamination of questioned conclusions. An unrelated aspect of this study that also helped me keep personal biases at bay was the nature of the phenomenon being studied. Examining extraordinary events (cosmetic surgery initially lay well outside my realm of everyday experience) made it easier to keep a fresh perspective of informants’ realities.

A PRIORI THEMES SUPPORTED

This study gave support to the a priori themes generated from prior research findings; the themes are discussed here and are elaborated more fully in the context of the emergent themes.

Theme 1. With only two exceptions (Nan and Chuck), the informants spoke of their motives for cosmetic surgery in terms of dissatisfaction with a particular body part or feature. Furthermore, as expected from Horowitz’s (1983) findings, some of them (Kate, Beth, Jane, Consuelo, and Lisa) attributed greatly improved self-esteem to their surgery, directly relating feelings of increased attractiveness, self-confidence, or social ease to localized improvements of body image. Negative body images often emerged in adolescence, forged amid growing sexual desires, shifting social expectations, and rapidly changing bodies. Criticism of children’s bodies by parents and peers also contributed to negative body images. Such criticism, however, was not a prerequisite for poor body image; Leslie, for example, evaluated her own appearance much more harshly than would be indicated by social feedback, even to the extent of feeling stigmatized by a feature that peers or other observers found relatively insignificant. For those with highly localized, stigmatizing body images (see Goldman 1963), plastic surgery appeared to be psychically healing, providing more fulfilling public and private lives.

Theme 2. The principle of impression management was strongly reinforced. Consciousness of their self-presentation to particular audiences often played a part in informants’ decisions to have surgery. In Chuck’s case, the deliberate enhancement of occupational role performance constituted a primary motivation for contemplated eyelifts, demonstrating what Fromm (1947, 1976) would call the marketing character. Successful performance in intimate roles were concerns for both Jane and Lisa, who felt sexually inhibited by the sizes of their busts.

Theme 3. Major changes in informants’ roles or statuses often led to feelings of unconvincing role performances and, thence, to behaviors interpretable in terms of symbolic self-completion theory (see Wicklund and Gollwitzer 1982). When particular physical attributes, such as Kate’s flat chest or Consuelo’s tired
and wrinkled face, seemed incongruent with roles they were attempting to cultivate, plastic surgery was seen to offer more appropriate bodily symbols and, consequentially, greater self-confidence and self-acceptance in key role performances.

**Theme 4.** In contemplating and preassessing changes to their physical and social selves due to plastic surgery, informants formulated and elaborated both positive and negative possible selves, and they weighed positive and negative possibilities in a mental balance in order to prejudice the overall outcome of the consumption decision. Those who foresaw the most strongly positive outcomes (e.g., Beth, Consuelo, and Jane) decided in favor of surgery with much less ambivalence and dissonance than those (e.g., Nan and Leslie) who associated both positive and negative possible selves with the same consumption decision.

**PRINCIPAL EMERGENT THEMES**

In the process of data analysis, certain themes emerged anew or took on greater-than-anticipated importance. It became apparent from early in the interviewing that role transitions were much more important than originally expected. Sexual and romantic concerns also surfaced repeatedly in informants' motivations, as did issues of control. Finally, the importance in the decision process of identity play with mirrors, masks, and other media of self-objectification also became noteworthy.

**Role Transitions**

Six informants underwent plastic surgery at times when their lives were in flux or transition, following or anticipating major life events that included childbirth, career changes, divorce, relocation, and deaths in their families. Within the context of role transitions, two subthemes emerged as particularly important with regard to the use of plastic surgery: (1) plastic surgery as a means of reintegrating the self-concept and (2) plastic surgery as a catalyst for further self-change.

**Plastic Surgery in the Reintegration of Self.** Plastic surgery supplied certain informants with physical attributes that helped them to feel more comfortable and complete in social roles they had recently adopted. Kate's motivation for augmentation mammoplasty grew out of a major life transition that brought about the "feminization" of her most important role identities and forced her to confront deep-seated doubts about her own womanhood. From the time of her adolescence Kate had felt shy and self-conscious about her undeveloped bust:

I've been dissatisfied with my shape. I guess, since I was about twelve years old. . . . That was seventh grade. Other girls were starting to develop by then. They were all getting training bras and I was still in undershirts. You think I didn't notice?

She shunned stereotypically feminine pastimes and modes of dress, preferring hiking and other outdoor activities to dating, dancing, or school parties. By high school she had stopped wearing "feminine" clothing such as skirts and dresses almost altogether and limited her wardrobe to jeans and loose-fitting shirts.

Marriage allowed Kate to maintain similar life-style and consumption patterns for several more years. Her husband, Roy, worked in oil exploration, and Kate joined his crew, working outdoors with the men. However, when falling oil prices brought domestic exploration to a halt, Kate and Roy decided to settle down. They traded their motor home for down payment on a suburban house and found regular work, Roy in a factory and Kate in an office. Soon afterwards, Kate became pregnant. The overall change in Kate's life structure was dramatic. She went from being "one of the boys" to being a suburban housewife and working mother; her social circle moved from the campfire to the office, and her working attire from unisex to feminine. For years Kate had cloaked her undeveloped breasts and feelings of nonfemininity in gender nonspecific clothing and activities, but her new social roles made that difficult. The event with the greatest effect on Kate's decision to have cosmetic surgery was motherhood. This most archetypically feminine role provided her with the opportunity for the first time to actually experience having breasts:

The real difference came when I got pregnant. I just naturally went to about a B-size cup and I thought "Gee, this is nice!" Afterward I missed it. It was kind of like I had gone from being a girl to being a woman. But when it was all over I had to go back to being just a girl again, and it really began to bother me. I had to go back to being my same old scrappy self.

Without breasts Kate did not feel complete as a woman. Augmentation mammoplasty allowed her, psychically and physically, to make a complete and irreversible transition to womanhood.

Consuelo's facelift also symbolized a transition to a new set of role identities. Widowed unexpectedly at forty, with eight children and no job skills, she struggled to hold her family together while working her way through nursing school. When at last she had negotiated the difficult transition from dependent housewife to breadwinner, she felt her tired and wrinkled face was incongruous with her new beginning. A face-lift provided an exhilarating symbol of new identity while erasing visible signs of the widow's grief and hardship. In her words, the surgery left her feeling "thrilled . . . excited. It gave me a whole new outlook. I'm young looking anyway, or I was, so taking that tired look out of my face did it. I'd do it again."

**Plastic Surgery as a Catalyst for Further Change.** For Beth, a rhinoplasty and chin implant were part of a large-scale reconstruction of identity. During a prolonged period of marital disharmony and unhappiness
with her life in general, Beth sought various services for the purpose of self-improvement:

I had the plastic surgery at a point in my life when I was, as I like to put it, starting to get my shit together. Starting to figure out what I wanted to do when I got my kids in school and had a little more free time. I wanted to go back to school. I wanted to do some things for me that weren’t going to conflict with my other obligations. So it was part of a general growth.

Along with her return to college, Beth’s plastic surgery contributed to enhanced self-esteem and self-confidence, which, in turn, catalyzed a more encompassing life transition. Within a year of her surgery she had left her husband and began building a new life structure that included single parenthood, her own career, and, later, cohabitation with a long-term lover.

**Summary:** Triggered either by external forces or by changes within individuals, role transitions can be disruptive (see Adams, Hayes, and Hopson 1976) and may lead to a major restructuring of life-styles, relationships, and values (see Levinson 1978, 1986). During such times of identity reconstruction, people may become receptive to goods, services, or ideas that they formerly would have considered unnecessary or undesirable (Andreasen 1984). Space does not permit a full description of even a single informant’s transition experiences, but the data suggest that the surgical alteration of one’s body is a powerful symbolic act that may assist a person in reintegrating a self-concept made ambiguous in the course of a major life transition. This occurs especially when one’s body image has ceased to be congruous with a new set of role identities. While some use plastic surgery adaptively to reintegrate the self-concept, others use it proactively for self-improvement, sometimes to find that postsurgery self-esteem and self-confidence lead them to venture yet other changes in their lives. Other consequences of role transitions also have mediating influences on the surgery decision. Changes in social environment relieve certain normative pressures while bringing others to bear. Transitions can also affect the ability to pay for surgery, through either increased incomes or reordered spending priorities. Lisa, for example, paid for her surgery with money from her deceased father’s life insurance benefit; ironically, while alive, her father had persuasively opposed the plastic surgery.

**Sexual Selves and Romantic Fantasies**

Several female informants experienced negative body images most acutely during intimate relations or social interactions of a sexual nature. Two subthemes emerged as important in the area of sex and romance: (1) body image in the context of the sexual self and (2) ideal self in the context of romantic fantasies.

**Body Image and Sexual Selves.** Breast size was a key focal point of sexual anxiety or self-doubt for some informants. They tended to use clothing as camouflage in public, but covering up was of little value during intimate relations or times of private self-evaluation. Lisa, for example, wore a padded bra and felt self-confident in public, but in her private life with her husband, Doug, she suffered self-consciousness and embarrassment:

As you’re lying there on the bed [your breasts] go even flatter, and it’s like, “Why are you even bothering to . . . ?” And I feel self-conscious like, “Don’t do that [speaking of foreplay with the breasts], you’re just being facetious, or . . . .” It’s like I know this isn’t doing anything for either one of us!

Kate also suffered because of her small bust. Feelings of incompleteness as a woman plagued her in situations she perceived as sexual:

Nowadays just walking someplace, like through a shopping center, I feel good about myself. You might think this is a little weird . . . but before, when men looked at me, like if they thought I was good looking or something, I used to think they must be perverts or something. Like they must like little girls. It was weird. Now when it happens it feels normal, I like that.

Feeling underdeveloped as a woman, Kate attributed pedophilic tendencies to strangers who showed sexual interest in her. Those attributions faded after her surgery.

Jane, like Lisa, felt embarrassed in sexual relations because of her breasts. But unlike Lisa and Kate, Jane’s problem was not too little bust—it was too much:

I was embarrassed about having such big breasts. It makes you feel funny with your husband too, you know? Here you are, you’re layin’ there and you’ve got these big things layin’ all over the top of your chest. It just covers your whole chest up. It’s just embarrassing. I wasn’t relaxed about the whole thing [meaning sex or nudity with her husband].

In a study of patients with conditions and histories similar to Jane’s, Goin, Goin, and Gianini (1977) also found that women with accelerated and excessive breast development often felt stigmatized by their breasts, which they commonly felt were obscene and made them the targets for lewd gazes and remarks. Jane, Lisa, and Kate all underwent breast surgery, and all three reported that they and their husbands were pleased with the results, not only aesthetically, but also in improved intimate relations.

Breasts were not the only foci of sexual or romantic anxiety: Leslie, at 34 years of age, had spent her entire life since adolescence feeling romantically impeded by her prominent nose. She associated her nose temporally with puberty, a time made especially traumatic by two experiences of sexual molestation. As she struggled to come to grips with sexuality, she held her nose responsible for her unfulfilled romantic desires:

Ever since my nose matured—since I was 14 or 15 years old—I was very self-conscious about it. I felt like it made
me ugly. I was always worried about what people were thinking or saying. If there was a boy in a class that I wanted to impress, I would not sit so he could see my profile.

She spoke of her nose as an alien thing that dominated her social relations, especially where members of the opposite sex were concerned. Always painfully aware of how she presented her profile, she controlled her self-presentation by placing her back to a wall or a corner, becoming the archetypal wallflower.

**Romantic Fantasies.** Two informants, Lisa and Leslie, revealed interesting romantic fantasies in explaining their ideal selves. Lisa was bothered that her husband showed less interest in sex than she did (and less than other women's husbands reportedly did). In her fantasies, she taunted her husband to fits of passion in the body of Vanna White, the high-fashion hostess of television's "Wheel of Fortune" and star of the 1988 television movie *The Goddess of Love*. Vanna had become an icon of feminine beauty, a Barbie doll in the flesh. In Lisa's mind, what separated her most from this American ideal was breasts:

I ... umm ... I like to strut around in front of my husband, you know, and I would like to think that I have something that I could tease him with, that other women couldn't ... I mean, you know Vanna White. what do they like? Her boobs. And so I think he would pay more attention, he would be more excited if I had boobs.

Leslie also compared her ideal self with personalities from popular culture. In addition, she drew on the Cinderella myth in framing her romantic fantasies:

L: When I was in high school the girl who had the locker next to me said, "Oh, gee! You look like Barbra Streisand!!" I know she meant it as a compliment, but I remember feeling very hurt for days afterwards. I did not want to look like Barbra Streisand. ... I haven't been able to stand her since.

I: How do you feel when you see her in a movie as a romantic heroine?

L: I'm not convinced by it. I guess I have a hard time with somebody loving somebody that has a nose like that [uneasy laughter]. Which is foolish, I understand. It's foolish. But deep down ... [long pause] I guess Barbra Streisand tends to play a lot of character roles. She doesn't seem to play the romantic lead. And I guess I see myself more in character roles than as a romantic lead too.

I: This is a metaphor I'm not comfortable interpreting ... .

L: Character roles? Well, if I were in *The Wizard of Oz*, instead of playing Glinda, the witch of the north, I would be the wicked witch of the west. Or one of the munchkins rather than Dorothy. Out of the mainstream I guess. Sort of on the sideline. Doing odd things. Does that make sense?

J: But not the romantic lead ... .

L: Not the romantic lead. Oh, I've had fantasies, but that's all they ever were fantasies. I didn't date much in high school. And never with the guys I wanted to date. Only with the guys that were okay for buddies, but not the guys I fantasized being with.

I: So you didn't want to look like Barbra Streisand. Did you have an idea of what you wanted to look like?

L: Sort of. I guess I'd like to look like Leslie Ann Warren. She played Cinderella. Overall, I think my features are fine like hers, except for my nose. She played Cinderella in the musical. Cinderella. I always liked that movie. I saw it several times. It's so romantic.

I: Okay, here you are identifying with a person who in the beginning is sort of not ... well ... respected. Not a romantic lead. She wears dumpy clothes ... just a maid ... and something comes along and makes her beautiful ... .

L: Her fairy godmother offering her a nose job!

Cinderella, magically transformed by her fairy godmother/plastic surgeon to a beautiful princess bride, symbolically bridged the gap between Leslie's real self and her fantasy self. Such romantic fantasies may play an important part in the mental elaboration of ideal selves and may often draw heavily from popular culture and myth for their plots and characters.

**Summary.** Negative body images in the context of sex or romance underlie some consumers' desires for cosmetic surgery. Breasts, probably the most visible and fetishized female secondary sex characteristic, are common foci of stigma. Breasts that are noticeably smaller or larger than "normal" (B or C bra cups, according to informants) sometimes lead to feelings of being judged as either sexually deficient or surfeited. Other body parts may also contribute to insecurity in romance. Correcting romantically disruptive body images appears to be an effective use of plastic surgery in some cases. Other studies have established links between mammoplasty and enhanced sexual relationships (Kilmann, Sattler, and Taylor 1987), and between rhinoplasty and improved social functioning (Horowitz 1983).

Contemplation of more desirable sexual selves may lead to the development of personal romantic fantasies, which often build on or reflect images from popular culture. While fantasies are clearly distinguished from potential reality, just as ideal selves may be distinguished from possible selves, the fantasy and the ideal set the direction for the possible.

**Taking Control.**

The issue of control emerged in the form of two important subthemes: (1) plastic surgery as a perceived means of exercising control over one's body and one's destiny and (2) personal efficacy as the ability to exercise such control.
Plastic Surgery as Control. The theme of control first emerged in the course of interviews with Beth as she described the process of wrestling control over her life away from her authoritarian father. A turning point in her struggle came when she went away to boarding school:

I had been chafing to get away from home. I loved going away to boarding school . . . not feeling so confined. My father’s a very strong, controlling individual. And I think that’s what I was chafing against was that control.

While at boarding school Beth learned that she could take control of aspects of her own life that she had never thought to change before, particularly her appearance:

At boarding school it was natural to experiment with other girls’ clothes and makeup and that sort of thing. I went blond there—blond wasn’t right for me. So when it began to grow out I went red. It’s been red ever since. [Lightening my hair] was a major decision. I was learning that there were things that could be done to improve my appearance and that I could do them!

Beth felt exhilarated by her ability to take control of her appearance, but those feelings were tempered by the limitations of hairstyle and makeup in camouflaging her large, crooked nose and receding chin. At the age of 30, she became acquainted with a plastic surgeon and seized the opportunity to change her face permanently.

Beth’s need to maintain control over all aspects of her self also extended to her love relationships:

B: For years I was frigid. One thing I learned in therapy was that I didn’t want to relinquish control to anyone.

L: Control over . . .

B: Over my body and emotions.

Frigidity was a safeguard against rejection, a means of maintaining tight control over the sexual relationship. It is plausible that plastic surgery allowed her to reassert control symbolically over yet another aspect of her body. Similar motives are observed by Sanders (1989) in women who obtain tattoos to symbolize ownership and control of their own bodies.

Lisa also took a very controlling stance with respect to her body, as evidenced by her enthusiasm for dieting:

It’s always hard to start a diet. But see, I got down and I felt really good. Then slowly I’ve gained about like six or seven pounds over six months. I thought, “Okay . . . I had lost like fifteen and felt really good. Instead of going all the way up fifteen, I’ll lose seven again and . . . It’s a long process that’s taken me . . . I can see where I’m getting control over it and it’s taken a while. Slowly I can see where I have more control over that than I did before.

Lisa felt good when she was in control of her body. She gained psychic rewards from conquering her hun-

ger, and she found the tangible rewards of weight loss intoxicating. She approached her augmentation mammoplasty with similar zeal; it gave her direct control over her bustline and, through it she hoped, indirect control over her husband’s affections.

Chuck tended to control his life like a financial portfolio. Every action, including his aesthetic surgery, was an investment to be considered in terms of risk and return. An old friend of Chuck described him as: “The most frugal and most risk-averse person I’ve ever met. He knows where every penny goes. I tease him sometimes about how everything he does is intended to maximize his net present value.” Chuck spoke of his motives for plastic surgery in strictly utilitarian terms. He claimed, “I just wanted to breathe better.” In consultation, Chuck’s physician offered to make minor aesthetic changes at no extra cost. Chuck felt he was getting more for his investment.

At the time of the interview Chuck was considering plastic surgery on his lower eyelids because, “In this type of business one wants to look, um, alert and excited about the work.” However, further probing with Chuck revealed an additional motivation for his contemplated blepharoplasty—he was attempting to control the aging process:

I think once I start admitting to myself that I’m 44, then I start feeling old. You know, I don’t feel any different than the kids that walk around here on campus. I feel I’m just about the same age, mentally, as any of them. And I don’t have any trouble going out and playing sports. I just think that if I start thinking, “Hey, I’m 44,” and someday “54,” and “64,” I’m going to start acting the way you used to think you were supposed to act when you got that old.

Chuck believed he could will himself to remain mentally young, but will alone could not stave off the physical effects of time. Perhaps plastic surgery could. Just like any other stock or commodity in his portfolio, Chuck could manage his body to increase his overall return from it.

In contrast to Beth, Lisa, and Chuck, for whom plastic surgery symbolized taking control in their lives, Nan interpreted her own rhinoplasty as a loss of control and a concession to her mother’s will:

Mother had always been bugging me. She said, “Some-
day we’re going to get your nose fixed . . . someday we’re going to get your nose fixed.” I never thought it was that bad . . . One Christmas she had some extra cash and she decided to get me the nose job.

This setback in Nan’s struggle (still ongoing at the age of 38) to achieve her own identity within a strong matrilineal family tradition left her feeling ambivalent about the results of her surgery.

Personal Efficacy. Leslie was less willful and controlling than other informants, and her locus of control (see Rotter 1966) appeared to lie largely outside herself.
Leslie was no less motivated than others to have aesthetic surgery; her nose had been painfully stigmatizing to her since adolescence, yet her history as a potential consumer of plastic surgery was characterized above all by tentativeness and indecision. She had had opportunities for surgery and turned them down:

My parents, after hearing me complain about the size of my nose for so long, they said, "If you really want to get it done we'll let you do it. We'll find some way to let you do it." But I felt guilty because I knew they couldn't afford it. And I wasn't sure what people would say.

As long as her parents denied her the surgery, Leslie could wish for it without actually having to go through with it. When her parents put the decision on her, however, she lacked the will to follow through. More than any other informant, Leslie displayed fear of social sanction, and her fear placed her in a terrible paradox. She felt that others looked down on her because of her large nose, but she also feared they would look down on her for having it fixed. The nose was a stigma she knew and had learned to deal with; plastic surgery was a potential source of stigma she was not sure she could handle.

At 34, still hating her nose, Leslie was still incapable of making a decision about plastic surgery and preferred to place the burden of decision outside herself. In one interview she said:

I think I'd really seriously check it out if the opportunity came along. If I could afford it suddenly, or if I could get the insurance to pay for it. So I wouldn't feel I was taking clothing off the children's backs with pure vanity. You know, I've often wondered . . . if it were handed to me . . . in a gift certificate . . . would I do it? Would I really [suspense mounts on this word] do it? And I think I would definitely go at least for a consultation.

In the course of beginning and ending the last sentence she built from tentativeness ("I think . . .") to near resolution ("I would definitely go . . .") and back down to tentativeness (". . . at least for a consultation"). It was a linguistic metaphor for her whole approach to the surgery decision: the constant rise and fall of resolution.

Summary. The desire for aesthetic plastic surgery often reflects a need for increased self-determination (see Deci 1975) and efficacy (see Nuttin 1984) within one's life and environment. Taking control of one's body and its appearance, whether through surgery, dieting, exercise, or other means of body sculpting (see Verba and Camden 1987), is intrinsically rewarding for some and can also be used as a means of increasing control over the emotional responses of other people. Just as the ownership of certain objects allows us to maintain and express power in relationships (see Cikszentmihalyi and Rochberg-Halton 1981; Tuan 1984), so may the ownership and control of one's own body. Similar motives are attributed to the extreme fasting behaviors of some anorexics (see Bell 1985; Muuss 1985).

The extent to which people feel able or inclined to control their lives or destinies appears to affect decisions regarding aesthetic plastic surgery. Those with a strong sense of efficacy (see Bandura 1977; Nuttin 1984; White 1959) seem quicker to act on their desires for surgery, whereas those with less sense of control find it difficult to act, especially in the face of real or perceived social sanction.

Identity Play

In contemplating aesthetic plastic surgery, informants utilized mirror images and other representations of self to help them try on, objectify, and evaluate possible post-surgery selves. Mentally elaborating and, to some extent, making tangible their possible selves allowed them to sort out the difference between fantasy and reality and to reduce the risk of disappointment due to unrealistic expectations. Leslie described an exercise whereby she frequently tried on a new nose:

I'd stand in front of the mirror with another mirror so I could see the side, and I'd hold my finger in front of the bump on my nose to try to see what it would look like if it were straighter. I spent a lot of time doing that! I did it frequently.

On one occasion Leslie even created an aluminum foil mask of her own face, which allowed her to take the role of the plastic surgeon in reshaping the three-dimensional image. Other informants used similar devices to help them visualize more attractive possible selves. Kate, for example, would stuff her brassiere with tissue and examine herself in front of the mirror.

Sometimes such exercises generated images with strong motivating power. Beth wrote in her journal of the effect of viewing retouched preoperative photographs:

First came the initial consultation with [the surgeon], then a series of black and white pre-op photos. They were horrid. Every pore, feecle, and subcutaneous bump was magnified. My skin looked like the surface of the moon. During the second consultation, [the surgeon] used a lead pencil to shade out portions of the nose to give me an idea of what he would accomplish. It looked fine to me. To my surprise, he then took a white pencil and built up the chin area. Grace Kelly I will never be, but that picture was looking better and better. We decided to go for the chin implant as well. Surgery was scheduled for two weeks later.

The retouched photographs not only created a more concrete set of expectations, they also heightened Beth's sense of longing for a more attractive self.

PERSONAL RITES OF PASSAGE AND IDENTITY RECONSTRUCTION

This section discusses a process of identity reconstruction that emerged from the data analysis and has
been informed further by the concepts of rites of passage, liminality, and possible selves. Van Gennep (1960) observed that important life passages generally consist of three phases with their attendant rituals: (1) separation, in which a person disengages from a social role or status, (2) transition, in which the person adapts and changes to fit new roles, and (3) incorporation, in which the person integrates the self with the new role or status. Victor Turner (1969) described the transitional or liminal phase as a limbo between a past state and a coming one, a period of ambiguity, of nonstatus, and of unanchored identity. In van Gennep’s analysis of primal cultures, liminality was a collective experience mediated by culturally prescribed rituals that afforded individuals an experience of communitas or shared psychological support throughout major status passages. In the modern, secular world, however, people often experience an isolated type of liminality (liminoid states) for which there exist few supportive rites of passage or kindred groups (Turner 1974). In such circumstances, people may create personal rites of passage, shaping new identities with such symbols and activities as are made available by our consumer culture (Mehta and Belk 1991).

Cosmetic surgery can be viewed as a self-imposed, personal rite of passage that allows a person to separate from one physical attribute (an act of disposition) and incorporate another (an act of acquisition and consumption). The decision to have cosmetic surgery is often made during a period of liminality. Beth, for example, underwent surgery during a time when she was reevaluating both family and occupational roles; Kate and Lisa both felt ambiguous about their sexuality; Tom was adapting to culture shock; and Consuelo was coming to grips with the new roles of single parent and breadwinner. For most of these informants, plastic surgery helped restore a sense of self-congruity lost in their liminoid states, thus hastening the passage to more stable, postliminal states. The surgery also provided physical symbols of transition. Kate’s augmented breasts symbolized a completed passage to womanhood: the disposition of Jane’s burdensome breasts symbolized separation from a past full of public humiliation and private suffering; Consuelo’s younger face symbolized her embarkation on a new life course.

Failure to make a successful passage results in a prolongation of liminality. Painfully prolonged liminoid states have been observed in conjunction with psychological impediments to normal development (Shorter 1987), permanently debilitating or stigmatizing handicaps (Murphy 1987), and the inability to let go of past roles or statuses (Levinson 1978; Roberts 1988). Nan, who underwent plastic surgery at her mother’s insistence, may have risked a prolonged sense of liminality by subordinating her identity to her mother’s will at a time when she was struggling to form an independent identity; Leslie, on the other hand, may be prolonging her feelings of liminality by not following through with her desires for an altered nose.

An important characteristic of liminoid states is the antistructural element of play, the freedom to experiment with new categories of meaning (Turner 1974). Liminal people appear to be more likely than others to engage in “identity play,” that is, to formulate, elaborate, and evaluate possible selves. Informants often attempted in ludic fashion to visualize their post-surgery possible selves, elaborating their mental images with extensive use of mirrors, photographs, and other props. Similar imaginative exercises also served in the evaluation of possible social responses to contemplated surgery. Lisa fantasized about the quality of sexual response she would receive from her husband after her breast augmentation. Leslie also imagined social responses to her contemplated rhinoplasty, but her mental scenarios often had strongly conflicting dimensions; she imagined herself on one hand as more beautiful and self-confident with others, and on the other hand as the object of scorn and ridicule. As Markus and Nurius (1986) would predict, informants who underwent plastic surgery were those whose surgery-relevant, positive possible selves predominated over the negative.

The Process of Identity Reconstruction

People spend much of their lives with self-concepts that are relatively stable, reflecting established social roles and attention to building and maintaining particular life structures (Levinson 1978). During such nonliminal states, however, the self may harbor a dormant predisposition toward change (e.g., a negative body image). The relative stability of the nonliminal state allows the person to ignore or endure the predisposing condition until such time as a transition is induced by some triggering event.

A transition of identity begins with separation from some role, relationship, or other key component of the extended self. Separation may occur literally in time and space, triggered by some external force or event (see Adams, Hayes, and Hopson 1976; Levinson 1978), or it may be experienced subjectively, triggered by an internal force such as a psychological need for intimacy, security, or control. When a person loses or rejects an important aspect of self, separation occurs and liminality sets in.

Liminal people face the task of reconstructing congruous, integrated self-concepts. If they have experienced unhidden separation from key roles, they must create new roles or emphasize existing roles to fill the gaps. They begin by formulating possible selves. The specific nature of people’s possible selves is affected by many individual and sociocultural factors. Possible self-schemas appear to be composed from aspects of past selves and various role models and assembled according to personal values, fantasies, goals, and per-
ceptions of social expectations. Initially, possible selves may be loosely articulated, but their further elaboration appears to be integral to the process of identity reconstruction.

Sometimes the formulation of a possible self precedes separation and acts as the internal triggering force, especially if the possible self is more appealing to the individual than the actual self. People frequently formulate hypothetical selves and elaborate them in a speculative fashion. Such is the case of the romantic fantasy. Separation need not occur, particularly if the imagined self is perceived as not really “possible,” or as not sufficiently desirable to warrant the disruption of self-change. Because there is no separation, such people are not liminal; they have the luxury of trying on alternative selves from the risk-free vantage of a stable self-concept.

The amount of time and energy people spend elaborating possible selves varies across individuals and situations. Situational factors that lead to increased elaboration include the magnitude (subjectively defined) of the contemplated change and the level of perceived risk it entails. Individual factors include decisiveness (the decision to actualize a possible self tends to cut elaboration short) and the individual’s imaginative tendencies. Extensive elaboration appears to give a possible self greater motivating power. The investment of psychic energy required by the process may lead to cathexis of the possible self, or the contemplated self-schema may simply become more believable as it is made more specific and detailed.

People evaluate possible selves on the basis of their desirability and attainability. One of Markus and Nurius’s (1986) key contentions is that people are motivated to approach desirable possible selves and to avoid undesirable ones. This simple heuristic is complicated, however, when an individual associates both positive and negative aspects with the same self-schema. Such situations engender what Lewin (1935) described as “approach-avoidance conflict,” which makes the decision of whether to actualize the possible self more difficult and may lead to increased elaboration.

The perceived attainability of a possible self also affects its motivating power. If the likelihood of attaining a possible self is perceived as too low, motivation to actualize it is diminished. Perceived attainability depends on such situational characteristics as personal resources, social constraints, and available technology. Attainability may change significantly during role transitions as social and financial conditions also change. A sense of efficacy is also salient. Failure to actualize a desired and otherwise attainable self may owe to a person’s inability to convert will to action.

People can respond to their possible selves in one of three ways: (1) with inaction, (2) with active rejection, or (3) with actualization and the incorporation of the possible self into a revised self-concept. Inaction results when possible selves are not sufficiently desirable to motivate approach, not sufficiently undesirable to motivate avoidance, not sufficiently plausible to motivate either, or when approach-avoidance conflicts result. The short-term consequence of inaction is continued liminality. Rejection occurs when a possible self is deemed unattainable, undesirable, or incongruent with other aspects of the self-concept. Rejection leads to continued liminality and the formulation of yet another possible self. Ultimately, the more well-elaborated, desirable, and plausible a possible self seems to the individual, the more motivating power it wields and the more likely it is to be actualized. Actualization may occur via the consumption of instrumental goods and services as the individual accumulates the appropriate symbols of the new self. Plastic surgery is for some people such a service, providing physical symbols of a revised self.

Incorporation occurs as symbols of self are catherced (Belk 1988) or cultivated (Csikszentmihalyi and Rochberg-Halton 1981) as part of the self. The process may not be immediate, and it may not happen at all. Actualization without incorporation appears to result in extreme feelings of regret and dissatisfaction, such as when a person undergoes plastic surgery but never accepts the new body part. However, successful incorporation leads a person out of the liminal state with an increased sense of completeness and self-congruity.

CONCLUSIONS AND DIRECTIONS FOR FURTHER RESEARCH

This study illustrates the importance of consumption activities in restoring harmony to an ambiguous, incongruous, or unsatisfying self-concept. Furthermore, it explains one process by which individual growth or “damage control” can occur in the course of major role transitions. While the transitions studied here relate to experiences and events surrounding the consumption of aesthetic plastic surgery, the process described does not depend on cosmetic surgery for its meaning or its applicability to consumer experience. Transitions similarly involve goods and services such as clothing styles, homes and furnishings, automobiles, and education, to name only a few. Symbolic and experiential consumer behaviors are important to successful transitions in that they aid the exploration, establishment, and ongoing support of new roles and identities.

Role transitions are crucial times in determining the direction and quality of consumers’ lives, but little is yet known about the consumption behaviors of liminal people. What kinds of products or services are especially relevant to people in transition? How should they be positioned to people whose self-concepts may be particularly ambiguous or mutable?
Possible selves also bear further examination by consumer researchers. To what extent are various purchases evaluated with respect to possible selves? How does advertising influence their formulation and evaluation? What kinds of information or feedback from marketers can help consumers accurately elaborate and evaluate possible selves with respect to high risk, high cost, or innovative products?

Self-doubts and anxiety with regard to sexuality and romance drive some people’s desire for self-transformation through consumption. Such feelings may arise from body images that fail to measure up to the ideals created by popular culture, which prescribe the size, shape, weight, color, and texture of the sexually attractive body and relentlessly promotes the means by which those attributes may be obtained. Further research into media effects on body image would be interesting.

Other people are motivated by the need for greater control over their lives. Plastic surgery and other goods and services, such as clothing, cosmetics, exercise equipment, and weight-loss programs provide some direct control over the physical appearance and, through it, may provide greater power or confidence in social, occupational, or intimate relationships. Such motives may become especially prevalent among people experiencing loss or rejection, or among those raised by controlling, authoritarian parents. Personal efficacy and the need for control may merit further investigation as variables in the consumption of highly symbolic or self-expressive goods.

While the conclusions drawn from this study appear credible within the context of the informants’ experiences, their broad applicability to other persons or other contexts should not be presumed. This report does not present an exhaustive study of people’s motivations for aesthetic surgery, and such was not the intention. A major contribution lies in the synthesis of anthropological and psychological perspectives to arrive at a better understanding of symbolic consumption in the process of self-reconstruction. It should be understood that the interpretation of the data reflects the author’s biases toward social-psychological explanations of behavior. Another researcher with a different theoretical toolbox, such as psychoanalysis, would likely take the same data and compose a very different but equally valuable picture of what they mean.

[Received January 1990. Revised September 1990.]

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