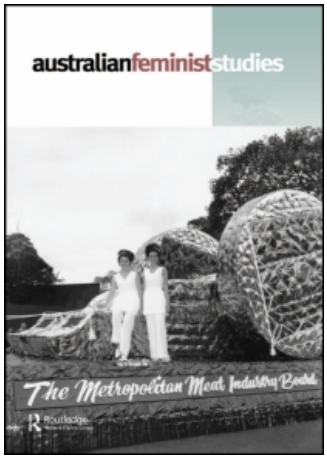

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NORMALISATION AND THE PSYCHIC LIFE OF COSMETIC SURGERY

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Much earlier feminist discussion of cosmetic surgery situates it within the larger frame of a beauty industry that imposes patriarchal norms of heterosexual, youthful feminine appearance.[1] Although this literature is diverse, it shares the assumption that cosmetic surgery represents an attempt by the individual primarily to conform more closely to a cultural standard of beauty (e.g. Morgan 1998; Wolf 1991). More recently, feminist critics have acknowledged that cosmetic surgery is increasingly represented and experienced as an intervention not only in beauty (understood as superficial, transparently culturally dictated, and conformist) but in identity. That is, cosmetic surgery is concomitantly sold through the more resonant contemporary discourse of becoming one's true self, having one's body represent the person one feels one is inside, or being normal (rather than exceptional). To choose cosmetic surgery is to express one's agency, to take control of one's life, or to otherwise intervene in one's lived experience without necessarily being only or even overtly motivated by beauty norms (e.g. Davis 1995, 2003; Gimlin 2006). While to be subservient to beauty norms is most easily parsed as oppression under patriarchy, being invested in self-determination is a subject position with a more ambivalent relationship to feminism. These two emphases in the literature might be understood as successor paradigms, whereby an old interpretive model has been replaced by one that better explains a new lived experience or theorises an emergent political struggle. Instead, I argue that both beauty and identity are always already part of the same phenomenon—namely, that double and contradictory historical process that Foucault calls normalisation, within which developmental standards for populations are deployed to both measure and enforce conformity at the same time as they generate modes of individuality. Normalisation, on this view, both constrains (by compelling compliance with the norm) at the same time as it enables (by making certain forms of subjectivity possible), and, indeed, these two functions cannot be clearly separated. Both compliance and the development of capacities are acted out, in many instances, through the body: we try to make ourselves over to match demanding aesthetic standards, while this process represents itself as externalising an inner authenticity both utterly typical and entirely our own.

The first goal of this essay is to develop this insight by showing how it might move feminist discussion past the impasse in the exemplary debate between Susan Bordo and Kathy Davis. I suggest that the latter misses this double effect of normalisation, while the former struggles (as do many of us influenced by Foucault) fully to theorise what I will call (echoing Judith Butler) the 'psychic life' of cosmetic surgery. Butler's interest in the 'psychic life of power' challenges the Foucauldian rejection of psychoanalysis, as well as the disinterest in Foucault's work on the part of theorists of the psyche, to understand together the mutual constitution of social and psychic in the context of power (1997). This

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work operates at a high level of generality, and might usefully be brought down to a more phenomenological level, particularly with regard to specific case studies. The lived experience of suffering over, or being disappointed with, failed bodies, its distinctively gendered inflections, and the phenomenology of wanting, resisting, having, and having had cosmetic surgery, are by now described in a varied feminist literature (e.g. Blum 2003; Davis 1995; Gagné and McGaughey 2002; Gibson 2006; Gimlin 2000, 2006; Jones 2006). Few commentators, however, bring together this phenomenological level of analysis with a robust theoretical framework for understanding the relation of the choosing individual to the context in which her choices are interpellated (see Blum 2003; Fraser 2003; Gibson 2006), and none does so within an account of normalising judgement. For example, in this paper I argue that Davis mistakenly assumes that normalisation (by which she means simply 'conforming to a cultural standard') relates only to standards of beauty. She thus lacks a theoretical apparatus for theorising *as* normalisation (understood in this Foucauldian sense) the appeals to suffering and ordinariness she recounts. This enables her to represent her conclusions as outside the terms of the Foucauldian model she associates with Bordo, when in fact they deserve to be theorised within it.

If I am right that beauty and identity are mutually implicated in cosmetic surgery's psychic life of power, two positions are untenable: on the one hand, feminists cannot represent the desire for beauty as essentially lying outside the self; as something 'internalised' that can be refused, leaving behind an intact, ontologically prior 'identity'. Indeed, it may be that, as Virginia Blum puts it:

> the bodies of women in a postsurgical culture are all compromised regardless of whether we choose or refuse surgical interventions ... [W]e are inevitably in a relationship to surgery regardless of whether we actually become surgical ... We are hailed by cosmetic surgery as a practice to which we must respond (in one way or another). (2003, 44)

On the other hand, neither can we talk as if having cosmetic surgery to express your true self, become ordinary, or take charge of your life is an expression of an agency unmediated by normalisation (see Fraser 2003, 76–89). These nuances to any account of subjectivity in the context of cosmetic surgery have implications for ethics, where 'ethics' is construed broadly as concerning the art of living and our relationship to ourselves (our *rapport à soi*, as Foucault says). Feminist engagement with cosmetic surgery needs a set of richer ethical strategies—including new grammars and vocabularies—for talking about our own psychic lives in a context of normalisation.[2] The second goal of the essay, therefore, is to pursue this direction beyond Bordo's conclusions to argue that even if feminist thought cannot provide a blueprint for personal conduct, it may be able to elucidate and transform the lived experience (not just the social structures) that motivates the desire for cosmetic surgical change. Although the evidence on whether cosmetic surgery consistently yields positive psychological effects is mixed (and methodologically fraught), I suggest some philosophical reasons why the surgical experience itself may be part of a cycle of suffering and desire that normalisation is capable of endlessly perpetuating. Finally, I point to some alternative ways of engaging lived experience—different ways of working on oneself—that may open feminist discussion.

Normalising Judgement and the Body of Power

As I argue elsewhere, in much theoretical writing (including scholarship that takes itself to be Foucauldian in spirit) the verb 'to normalise' and its cognates are used with relatively little theoretical precision, to imply any process through which homogeneity and conformity are enforced or encouraged (Heyes 2007a,b; and see, for example, Brooks 2004). For Foucault, however, normalisation is a more complex concept. In *Discipline and Punish*, he makes his well-known argument that sovereign power—in which a specific authority has defined rule over others—is increasingly superseded in the latter half of the eighteenth century and beyond by disciplinary power—in which techniques of management that cannot be attributed to any particular individual are used to classify and control populations. This new mechanics of power operated on the individual body to manipulate its movements and gestures, with an eye to shaping their overall economy rather than merely their signification. This coercion was constant, a form of surveillance 'exercised according to a codification that partitions as closely as possible time, space, movement'. 'These methods', Foucault argues, 'which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, might be called ''disciplines''' (1979, 137). Disciplines thus have a double, paradoxical effect: they increase efficiency in their institutional contexts as well as making individual bodies more adept, while at the same time they provide a mechanism for the intensification of power relations. In other words, the very body that develops new capacities and skills also becomes the highly scrutinised subject of the minutest forms of manipulation, or, in some cases, domination (1979, 138). It becomes what Foucault famously called a 'docile body'.

Foucault identifies three defining features of disciplinary power in its early historical formation: hierarchical observation, normalising judgement, and the examination. The second of these, normalising judgement, was enacted through the micro-management of behaviour in areas of social life from which punishment and reward had previously been absent. Instead of rules against particular acts that leave the remainder of the field of action undefined, excellence and mediocrity too can be assessed. 'Through this micro-economy of a perpetual penality operates a differentiation that is not one of acts, but of individuals themselves, of their nature, their potentialities, their level or their value' (Foucault 1979, 181). This process of creating distributions with internally defined systems of meaning is key to normalisation, and it both generates hierarchy and a set of punishments and rewards that can be used to manipulate individuals within the hierarchy to ensure both minute differentiation, and greater homogeneity. The norm can function as a threshold (beyond which lies the abnormal), an average, or a regulatory ideal, and in all these functions it specifies the nature and value of individuals (1979, 182–83).

Normalising judgement is brought into play through the examination, which in ritualised form incorporates the normalising gaze as a mechanism of differentiation and evaluation. Disciplinary power is itself invisible yet renders its subjects hyper-visible in order to tighten its grip: 'it is the fact of being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection' (Foucault 1979, 187). The display of power, Foucault argues, thus moves from overt expression of potency (in which the apparatus of power must be made visible) to the ceremonial presentation of subjects, in which power is only a gaze (1979, 187–88). In this context, the examination is both a mechanism of objectification and—according to Foucault—facilitates the development

of administrative methods in which the individual is constructed as the object of documentation. Disciplinary methods, as Foucault puts it, 'lowered the threshold of describable individuality' (below the lives of the famous men, kings, and heroes previously worthy of biography) and 'made of this description a means of control and a method of domination' (1979, 191). Foucault thus identifies historical shifts in Eurocentric cultures that have generated today's intensified and proliferating forms of surveillance of the body. While sovereign power does not cease to exist alongside disciplinary practices, control of the body has become ever more heavily freighted with symbolic meaning at the level both of the individual psyche and the public discursive order.

Notice two specific aspects of Foucault's position that are especially important in understanding how normalisation has evolved as a distinctively corporeal phenomenon. First, normalising judgement operates on the body of the subject, to create her or him as an individual (rather than existing in relationship with a prior individuality). In the first volume of the *History of Sexuality* (1990), for example, Foucault shows how sexuality as a field of power generates a normal identity from which numerous deviations can be defined. Discovering this identity, which normalisation makes real for every individual, becomes a personal as well as a legislative project. Through one's own desires, the individual must decipher the truth of the self as heterosexual (the norm) or homosexual (a problematised deviation); or, later, as a sufferer of Gender Identity Disorder (a classification that Krafft-Ebing, the great typologist of sexual pathology, would surely have seized upon with glee); or as another taxonomic possibility. The work of normalisation, then, is partly to identify and classify the abnormal, a task for which expert psychiatric opinion would often be required.[3] Foucault's genealogical project aims to reveal the phylogenetic contingency of these labels; far from existing as 'natural kinds' of human beings, these classifications come into being at a certain historical juncture. Critical reflection on history may thus contribute to the effort to think ourselves differently.

The second key feature of normalisation is that a population comes to be defined in relation to the norm, creating an artefactual shared identity. As François Ewald points out, the emergence of norms marks a new system of reference whereby the norm no longer refers to a standard outside itself but rather to the internal 'play of oppositions between the normal and the abnormal or pathological' (1990, 140). On this system, there are no absolute standards of good, perfection, or beauty, only relative measures within a local scale of meaning; yet norms provide excellent intersubjective communicative and organisational strategies in the absence of any transcendental values. And if they prove inadequate to their assigned task, they can be altered without disloyalty to any deeper truth. While Ewald is talking about technical normalisation in the world of insurance about 100 years ago, his analysis helps to establish a framework for understanding normalisation of the twenty-first-century body. This process—unlike those involving, say, risk assessment in insurance (Ewald 1990, 141–48)—relies on a metaphysics in which there is an underlying truth (a 'hidden potential', as Foucault puts it) within each individual. Disciplinary practices that take the somatic individual as their object, then, often have as their overt aim to make visible on the flesh some inner truth, thus obscuring the context relativism of the norms that define that alleged reality.

Normalisation thus works on the body and beyond the formal law, in areas of social life where anxiety about management of populations and adequate self-management prevail. It individualises by creating a necessary relationship between each subject and the norm; and, by refusing transcendental standards, it keeps norms shifting within

populations. One's body becomes, paradoxically, both the marker of a deep, inner truth, and a signifier of one's relationship to a social standard. This can be coded in slippery and contradictory ways as a threshold, an average, and a regulatory ideal; the subjectivities that disciplinary power constructs for us become the fact of who we are—enabling the very grounds of our existence as individuals—and constraints on how our self-identity may be expressed. Normalisation is not, on this view, something that can be sidestepped. There is no subject outside of disciplinary power, and no phenomenology that is not a product of the subjectivities our history has created. There is, however, a sense that as normalisation draws us deeper and deeper into its effects with regard to our embodied identities, it fails ever more regularly to fully integrate any set of experiences. As I argue in detail elsewhere, the remaindered subjectivity that necessarily confounds normalising scripts holds out hope of a kind of freedom (Heyes 2007b). Deploying this freedom will require a keen sense of how normalisation works, and why the teleologies of authenticity and becoming it proffers can never be completed or resolved. I propose, therefore, to show how this Foucauldian framework can be usefully applied to an exemplary theoretical debate between two feminist commentators on cosmetic surgery.

Normalisation: Davis vs Bordo

Kathy Davis, a qualitatively oriented sociologist, famously interviewed a small sample of women in the Netherlands about their decisions to seek state-funded cosmetic surgery. This project became the germinal book *Reshaping the Female Body* (1995). She sought to identify the psychological processes women experience as they contemplate, undergo, and recover from surgical procedures to change their appearance. Davis is hardly uncritical of the larger system that constructs and fosters ideal bodies and makes cosmetic surgery seem to some women like the only solution to intense self-loathing. Her feminist focus, however, is on understanding their narratives on their own terms, partly in the aid of not treating women either as dupes of patriarchy or as empty placeholders in webs of power (Davis 1991). This work led her to contest the then-prevailing feminist wisdom that cosmetic surgery is a beauty practice undertaken only by 'cultural dopes'—'a critique that allowed even well-intentioned feminists to trivialize women's reasons for having surgery or to reduce them to ideological mystification' (Davis 2003, 4). Women's actual accounts, according to Davis, reveal a much more nuanced form of negotiation:

> As a result of my inquiry, cosmetic surgery took on the shape of a dilemma that required nothing less than a balancing act between a critique of the technologies, practices, and discourses that define women's bodies as deficient and in need of change and a sociological understanding of why women might view cosmetic surgery as their best—and, in some cases—only option for alleviating unbearable suffering. (Davis 2003, 4)

Davis is, I think, writing against a real, if now dated, tendency in feminist dialogue to see those who undertake cosmetic surgery as narcissistic strivers after an elusive beauty ideal. As she shows, this is not a typical psychology: most of her interviewees are critical of cosmetic surgery for its implication in corporeal ideals, and seek to become 'ordinary' or 'normal' rather than especially beautiful. Nonetheless, her emphasis on women's own justifications for their choices limits critique of the structures that make cosmetic surgery seem like the only solution to a painful problem. Thus Susan Bordo, in an ongoing textual exchange with Davis, suggests that the latter's rhetoric of agency and autonomy within

her feminist theory mirrors rather than challenges popular, consumerist discourses of taking control and 'doing it for me' (Bordo 1998, 196–98). While the discourse of working on oneself to correct defects has real meaning for many women, this resonance, Bordo argues, should not be mistaken for empowerment. Cosmetic surgery continually ups the ante for individuals: it trickles down to ever more consumers; it is sold to new markets (men, younger consumers, diverse ethnic groups); and it constantly invents new defects and new procedures to correct them. This cultural dynamic, Bordo points out, creates a treadmill effect for the individual. We will never be good enough, no makeover can fix our flaws, and the possibility of backsliding is ever present. Finally, Bordo suggests, a feminism anxious to stress women's agency must take seriously the reality of complicity: 'we are all culture makers as well as culture consumers, and if we wish to be considered 'agents' in our lives ... we need to take responsibility for that role' (Bordo 1998, 208).

Davis rejoins that her notion of agency does not refer to the commodified and simplistic notions of freedom and choice used to sell the beautiful body. Rather, it points 'to the active participation of individuals in the constitution of social life': 'against my own inclination to view women who have cosmetic surgery as ''cultural dopes,'' I positioned them as ''competent actors'' with an ''intimate and subtle knowledge of society'', including the dominant discourses and practices of feminine beauty' (Davis 2003, 12, 13). Individual agency, Davis writes, 'is always situated in relations of power, which provide the conditions of enablement and constraint under which all social action takes place. There is no 'free space' where individuals exercise 'choice' in any absolute sense of the word'. Listening to the attempts of individual women to make sense of their relationship to cosmetic surgery, Davis says, she came to appreciate that women have 'credible and justifiable reasons' for their desires (Davis 2003, 12, 13).

In order to pinpoint the issue that this debate does not resolve, we need to focus on the concept of normalisation. Davis's most important contribution, in my view, is her evidence for the thesis that cosmetic surgery represents not only an attempt to conform to beauty ideals, but also a deeper and more complex attempt to reconcile one's body with one's 'inner' identity, to have one's body express one's lifestyle, moral values, or virtues, or simply to 'fit in', to no longer feel freakish. Davis is at pains to show how the narratives that a woman provides about cosmetic surgery reveal 'the ongoing transformation of her sense of self' (2003, 82):

> Cosmetic surgery does not only represent the constraints and limitations of femininity. It allows some women to renegotiate their relationship to their bodies, and through their bodies, to themselves. In other words, it opens up possibilities for biographical reconstruction and opportunities for women to redefine their sense of self. (Davis 2003, 83)

Davis suggests that by denying the quest for beauty in favour of an identity project, her interviewees have also evaded normalisation. Thus, she writes as if her theory of identity transformation is an alternative to normalisation, which she understands as located in beauty ideals. 'Cosmetic surgery is not simply the expression of the cultural constraints of femininity, nor is it a straightforward expression of women's oppression or of *the normalization of the female body through the beauty system*' (Davis 2003, 85; emphasis added). It is precisely the idea that a certain kind of body expresses an inner identity, however, that is, historically, at the heart of corporeal normalisation. By shifting emphasis from beauty to identity, Davis's subjects mirror rather than challenge the sophisticated

techniques of normalisation in the twenty-first century. This could hardly be clearer than when Davis says (almost as if this were a position that evades feminist critique) 'women who have cosmetic surgery want to be ordinary. They were not primarily concerned with becoming more beautiful; they just wanted to be "like everyone else"' (Davis 2003, 77).

Further, the narratives that Davis recounts are organised around the tropes of self-determination and control that are endemic to disciplinary power, not outside it:

> The women I spoke with viewed themselves as agents who, by remaking their bodies, remade their lives as well. They all rejected the notion that by having cosmetic surgery they had allowed themselves to be coerced, normalized, or ideologically manipulated. On the contrary, cosmetic surgery was a way for them to take control of circumstances over which they previously had no control. (Davis 2003, 110)

Verbal denial of one's own free will, normalised subjectivity, or false consciousness—three rather different things—in an interview is, of course, no guarantee that one is a free agent (although the alternative is not ignoring what women say about having cosmetic surgery). As Suzanne Fraser argues, Davis deploys an 'agency repertoire' in which agency inheres in the individual and is equated simply with action, 'whatever that action might be' (Fraser 2003, 114). Bordo also challenges Davis at this philosophical moment, but she represents Davis's text rather reductively, to charge Davis with arguing that cosmetic surgery is simply empowering, despite the potentially compatible content of Davis's too brief theoretical remarks on agency. There are more complexities in Davis's account than Bordo perhaps acknowledges, although Bordo does correctly hint at Davis's reluctance to acknowledge as normalising the script of ordinariness and of self-transformation that her informants provide.

In fact, Bordo's analysis deserves to be pursued in a direction that exploits the more detailed insights of Foucault's account of normalising judgement. Notice how the key concepts preferred by Davis's informants match his predicted trajectory. First, the population is homogenised (everyone must be ordinary, even when 'ordinary' is a state assiduously cultivated by the very discourse that claims only to represent it). Then, from the uniformity, emerge individuals (everyone wants to realise a unique potential, to make herself over into the person she was always meant to be). Davis drew her initial conclusions (which she continues to defend) based on interviews in the late 1980s with a small sample of women in the Netherlands, whose eligibility for state-funded surgery was assessed on the basis of their mental health and physical deviation from 'normal'. While the women's testimony reflects a complex negotiation of motivations construed as both extrinsic and intrinsic, they are also interpellated into a discourse that creates a powerful incentive to participate (consciously or not) in talk of suffering and normalcy.[4] By contrast, the contemporary North American consumer is interpellated into the (related) language of the inferiority complex (in its modern guises), conformity, and individuality, within which cosmetic surgery can render one ordinary, one's true self, or a distinctive individual (often paradoxically all at the same time).[5] That such models can be traced within both the larger frame of cultural representation of cosmetic surgery and the local frame of personal testimony suggests that feminists need to theorise more carefully the mutually constitutive effects of discourse and subject in this context.[6]

In a longer analysis of the functioning of normalisation in the televisual makeover, for example, I suggested that such shows offer a narrative structure that both mimics and constitutes the more everyday experience of cosmetic surgery (Heyes 2007a). Highly

scripted popular representations and the things that 'ordinary' people say about why they choose cosmetic surgery resonate uncannily with each other. The television show *Extreme Makeover*, the dominant instance of the genre, offers an idealised narrative structure within which cosmetic surgery will not only make us happy by making us more attractive. It also helps us manage a paradox: on the one hand, we want to become 'ordinary' folks, at ease with the bodies we have, who are saved from the unwelcome and disturbing intrusions of the body into consciousness that Drew Leder characterises as 'dys-appearance' (Leder 1990, 96–99). For Leder, 'dys-appearance', which may have organic causes (such as pain) or social causes (such as the male gaze), represents a deviation from 'normal' experience of the body as disappearance—when it recedes from awareness. In a series of interviews, Debra Gimlin found that:

> women sometimes have cosmetic surgery in an attempt to lessen or eliminate their experiences of bodily intrusion ... Because such dys-appearances rarely 'self-correct', they motivate intervention aimed at removing from explicit focus an aspect of the body that causes self-consciousness or discomfort, or draws the attention of the alienating gaze. (2006, 704)

'My fantasy is to be able to walk down the street and I just blend in with everyone else ... to be normal', announces 'before' Lori (on *Extreme Makeover*); and after her large hooked nose has been reduced and streamlined—'I don't have to do anything to hide any more. I'm normal.' The subsequent shot shows her arriving in a school classroom. 'The next day, Lori picked up her children ... Like any normal mom', runs the voiceover.[7] We also want to become the distinctive people we are, on the inside, such that post-surgery our bodies will better represent our 'hidden potential', including our moral character. Dan is looking for 'the me that I see inside that I'd like to see in the mirror', while Amy's surgeon says that she 'is a beautiful person on the inside'. Almost every makeover candidate contrasts the relative superficiality of looking more attractive to others with the real labour of eradicating the internalised self-loathing that has obscured their true personalities (indeed, in a curious inversion of the received wisdom, Dan observes that 'being more comfortable in my skin will make me more attractive').[8]

This is precisely the double effect of normalisation. It exerts a powerful pull in 'new world' cultures such as the United States, Canada, and Australia (all countries where the US edition of *Extreme Makeover* has aired), where historically ideologies of the unhindered development of individuality vie with the pressures on immigrants to fit in and contribute to a unified national character. Clearly, the testimony of the more 'average' recipient of cosmetic surgery exists in a different epistemological frame than does the over-determined narrative of TV makeovers. Yet as many of the same tropes are echoed—self-determination, normalcy, the expression of the inner self—it becomes impossible to separate extrinsic and intrinsic rationales, even as both popular culture and medical literature continue to stress the epistemic gap between choices made 'autonomously' and those forced upon us. Fraser parallels the representation of cosmetic surgery in women's magazines with feminist sociological scholarship, identifying 'a degree of intertextual exchange' that may authorise repertoires of nature, agency, and vanity that do not obviously embody 'oppositional versions of femininity' (Fraser 2003, 120). I am making a similar suggestion here, to the effect that the televisual makeover exemplifies repertoires of normalisation also found in feminist research with less overtly managed subjects.

An Ethics of Cosmetic Surgery?

Of the many implausible aspects of the story that *Extreme Makeover* tells about the possibilities for identity transformation, the belief that women's traumatic bodily dys-appearance will be assuaged by cosmetic surgery is to me the most problematic. The teleological perfectibility of subjects that the show hopes for—this process of surgically facilitated becoming in which we all eventually manifest our essential goodness and live happily ever after—is ethically empty. It is gripping, however, due to its hyperbolic promise that there is a fix out there, a method (albeit a painful, expensive, and risky one) for permanently curing a distinctive form of dissatisfaction with ourselves (and thereafter being beautiful and hence blissfully indifferent to the pressure to be attractive). Blum suggests that the goal of her book is to 'try and make sense of a culture in which surgery presumes to make people feel better about ourselves but often makes us feel worse' (2003, 56). Later she contradicts herself, however, alluding vaguely to empirical evidence (2003, 104) and developing the theoretical position that in fact psychological wounding can rest on the body's surface, and hence be cured by plastic surgery (2003, 109ff.). This contradiction resurfaces repeatedly in critical analysis of cosmetic surgery: the claim that it brings psychological benefits is historically and conceptually central to its survival and flourishing, and is frequently taken for granted as 'common sense'.[9] The literature on the psycho-social impact of cosmetic surgery, however, shows more ambivalence. In review essays, Ted Grossbart and David Sarwer (1999, 104) conclude that the overall (positive) psycho-social impact of cosmetic surgery has yet to be demonstrated by a methodologically convincing study, while Sarwer and Canice Crerand still aver in 2004 that 'it likely remains premature to confidently conclude that cosmetic medical treatments lead to positive psychological benefits in the majority of patients' (103).[10] Furthermore, whatever one can say about cosmetic surgery's psychological effects will be context-relative in numerous ways: patients have different expectations and motivations, undergo vastly different procedures, and have different outcomes, for example.

Nonetheless, the question of whether cosmetic surgery 'works' as a cure for psychological suffering over one's bodily dys-appearance ought to be of great interest to feminists. If cosmetic surgery can be a panacea, under what circumstances can this occur? What is the lived experience of this suffering that makes it susceptible to being assuaged—or not—by cosmetic surgery? How long does one's post-surgical satisfaction last? And—perhaps more to the point—how might one negotiate the body's 'dys-appearance' without surgery? Must the experience of refusing surgery be one of passive resignation to an ugly and unhappy, albeit feminist, fate? I do not have definitive answers to these questions, but I do suspect that cosmetic surgery has produced a phenomenology that makes it less likely—for endemic, structural reasons—to effectively end bodily dys-appearance for any individual. Thus, my ethical objection to cosmetic surgery is based not only on the familiar political ground that women (and men) should not have to endure cost, risk, and physical pain in the name of physical conformity; nor only that cosmetic surgeons divert valuable skills and resources that might be put to better healthcare use; nor only that complicity with aesthetic norms may reinforce those very norms and their political consequences at the expense of those unwilling or unable to conform (e.g. Kaw 1994; Little 2000). While I clearly have some sympathy with all these positions, it seems as though their political moment has passed; they can represent only a kind of ethical wheel-spinning, in which principles supersede practicalities. Instead, I am interested in the

possibilities for negotiating the lived experience of surgical desire, and the promises of ending suffering that it holds out.

Davis's own remarks on the ethics of cosmetic surgery are organised against the backdrop of her desire to balance its 'dangerous, demeaning, or oppressive' aspects against the rationales of the recipients, who 'see it as their best and, in some cases, only option for alleviating suffering that has gone beyond the point of endurance' (2003, 66). She never theorises the origin or dynamics of the 'unbearable suffering' that her participants recount, and their bodies are not, she admits, significantly different from those of other women (and men) who live, more or less happily, with their flaws:

> I did not necessarily share these women's conviction that they were physically abnormal or different. Their dissatisfaction had, in fact, little to do with intersubjective standards for acceptable or 'normal' feminine appearance. For example, when I spoke with women who were contemplating having cosmetic surgery, I rarely noticed the 'offending' body part, let alone understood why it required surgical alteration. (Davis 2003, 77)

There are two critical points here. First, both her interviewees and Davis herself have a particular relationship to the discourse of suffering that goes unremarked. As I have already mentioned, for the interviewees this was the context of the Dutch healthcare system; I also wonder whether Davis herself emphasises suffering in the testimony to bolster the ethical acquiescence she comes close to endorsing. The position that all cosmetic surgery is motivated by extreme psychological torment is clearly unsustainable, especially when we consider the enormous growth in less invasive cosmetic interventions. Botox parties are the *reductio ad absurdum* example here: the image of the woman who saunters over to the syringe-wielding doctor for a quick jab between the eyebrows hardly conforms to the agonised and anguished subject Davis describes. We certainly see more and more images of cosmetic surgery that portray it as 'no big deal'. Anecdotal evidence (the only kind presently available) suggests that some consumers also see minor procedures as a fairly routine kind of body maintenance that belongs more appropriately in the salon than in the hospital. The question of what motivates an individual to seek out cosmetic surgery is thus vexed. Nonetheless, there is evidence—if of a rather tautological kind—that cosmetic surgery is undertaken as a response to dissatisfaction with one's body, which can range from mild to 'unbearable'.[11] For the sake of my argument, therefore, I want to grant Davis her basic point and focus on those who experience psychological suffering of some marked kind that they believe cosmetic surgery will cure.

Second, and more interestingly, Davis assumes that extreme psychological suffering offers a prima facie justification for cosmetic intervention, and indeed it risks seeming unduly callous or punitive to deny desperate women the possibility of some relief, however temporary or risky. Yet there are other cases of first-order desires that are not easily transformed in light of second-order feminist re-evaluation that we are sceptical about accepting. Feminists are accustomed to thinking hard in general about the desire to appear or act appropriately feminine in situations where this might not be to our best advantage, either individually or politically speaking. Several commentators have pointed out that female genital mutilation (FGM) is sometimes sought after by women who see it as their only chance for a 'normal' life. It is interesting to consider, Sally Sheldon and Stephen Wilkinson (1998) submit, that FGM has now been made illegal in many jurisdictions on the grounds that fitting into a cultural milieu by using risky and potentially disabling surgery should not be permitted in the best interests of the individual, whose

first-order desires need to be regulated, effectively, by the second-order values of the state.

Such everyday feminist dilemmas involve both an ethical level (what is the right thing to do, from the perspective of my own integrity and my responsibility to others?) and a related existential level (what kind of self can make this choice against itself? What would it mean for me to be autonomous, and can I recognise it when I am?). Sometimes ethical process involves working to change our first-order desires because we see that a second-order desire has greater legitimacy; this reflection on how we might change our own desires is not just a case of martyring oneself to the feminist cause, as other critics seem implicitly to believe, but of creating better outcomes for the self (including, sometimes, for the self I would like to become). What might other ways of thinking about psychological suffering and identity suggest about the likely *rapport à soi* here? In attempting a foray into this work, I am also distinguishing myself from Bordo, who remarks that:

> [Feminist cultural criticism] is not a blueprint for the conduct of personal life . . . It does not tell us what to do . . . whether to lose weight or not, wear makeup or not, lift weights or not. Its goal is edification and understanding, enhanced consciousness of the power, complexity, and systemic nature of culture, the interconnected webs of its functioning. It is up to the reader to decide how, when, and where (or whether) to put that understanding to further use, in the particular, complicated, and ever-changing context that is his or her life and no one else's. (Bordo 1993, 30)

While I am sympathetic to the tone here, I think Bordo is unnecessarily pessimistic about the possibility of using cultural criticism not only to understand normalisation but also to reorient ourselves as ethical agents without offering lists of commandments. Instead, we might rethink our own interpellation into discourses that depend on certain conceptions of identity, and how that interpellation might invite a particular kind of suffering.[12] This formulation reorients feminist emphasis away from finding reasons to criticise cosmetic surgery's solicitation of our self-hatred, towards the positive project of finding a new *rapport à soi* under normalisation.

Pain, as Ladelle McWhorter argues, 'is a tool that is used extensively in virtually all normalizing disciplines':

> Pain and the threat of pain usually bring compliance with the dictates of a disciplinary regime; they render the subject obedient, docile. The greater and more varied the subject's capacity for pain, the wider the range of disciplinary techniques that can be used on her, and, thus, the greater her potential for directed development. Normalizing discipline uses pain, often carefully measured and graduated, as a tool for increasing the subject's productive capacities while rendering her passive and controllable; furthermore, it not only uses pain but it also develops the capacity for new kinds of pain in the subject, thus multiplying the means for maintaining the subject in near complete docility. (McWhorter 1999, 179)

If McWhorter is right (and I think she is), then normalisation is a significant factor in bodily dys-appearance. Normalising judgement's cultivation of shifting yet disciplinary regulatory ideals, its constant measurement of deviation and conformity, its emphasis on the surveillance of bodies, and its imposition of developmental narratives on the subject, all require and reinforce both complex institutional structures and the appropriate lived

experience. All of this requires the subject's acquiescence and her enablement; it requires her to experience her subjectivity through the mechanisms of normalisation that simultaneously create her conditions of possibility and make that possibility one of cultivated suffering, both physical and psychological. I have already suggested that, following Debra Gimlin's use of Leder (2006), bodily dys-appearance might be a useful way of characterising the pain that normalisation generates. Constant intrusive thoughts of one's own embodied ugliness, or the aesthetic failure of a particular body part or parts, or constant comparative and unfavourable evaluation of one's own body with others, seem quite typical of a lived experience of femininity in Western countries that deserves more sustained ethical attention.

That this lived experience is familiar even to those who have exhaustively researched and reflected on its origins, suggests that it is not caused solely by false consciousness, the cure for which is correcting false beliefs. Instead, it persists even in the face of raised consciousness, indicating that it is, minimally, a dynamic that calls for a different kind of working on the self, a kind of therapy that entails awareness of how suffering and desire are mutually constitutive, and are perpetuated not only by reiterated demands external to the subject but also by her own internalised cyclic self-criticism. To work on oneself against this dynamic (which is, paradoxically, work done by the self against itself), might mean not just providing public feminist critique of cosmetic surgery discourse (an activity I endorse) but also training oneself, contra most feminist advice, to shift one's ethical gaze from a problem outside the self to the inner landscape and experience of facing choices. A process of disidentification from the self that will always strive to be self-improving, and fail, is a process we might describe as both ethical and spiritual, requiring practices of the self that are somatic, meditative, and artistic, as well as communal.

Practices of consciousness-raising, in which personal experiences are externalised and shared in order to be made sense of within larger political contexts, will continue to play an important role. But to take each instance of one's own suffering and attach it to an external cause (especially one that cannot be changed or avoided, such as the reality of ageing or the ubiquity of objectification) is to ignore a whole set of strategies for working on the self under existing conditions. It is also to cultivate a kind of passivity, where one's suffering under normalisation is a given, or, more optimistically, something that only changing the world will affect. More profoundly, to continue to attach our identities to forms of suffering we perceive as sedimented in political conditions, is to risk a politics of *ressentiment*, that Nietzschean quality whereby our 'wounded attachments' become the ways of being we value, even unconsciously. Such a politics 'fixes the identities of the injured and the injuring as social positions, and codifies as well the meanings of their actions against all possibilities of indeterminacy, ambiguity, and struggle for resignification or repositioning' (Brown 1995, 27). Feminists tend to elide working on oneself with blaming oneself, and reflection on one's own psychic life is often seen as depoliticised and individualistic. I am suggesting, however, that working on one's own suffering to end this kind of wounded attachment is a project that should always accompany the political work of joining with others to create new spaces of resistance within which our suffering might lose its rationale and fall away. This general insight echoes the move that Foucault made, at the end of his life, when he famously remarked: 'perhaps I've insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of the self' (1988, 19).[13]

That Davis does not theorise the startling fact that she could not tell what bodily feature her participants wished to change through surgery speaks volumes about the extent to which she has simply accepted that, when it comes to cosmetic surgery, an inner process no longer stands in need of intersubjectively redeemable outward criteria (to put it in Wittgensteinian terms). The desire itself relentlessly individualises ('it's you that needs to change, not society!'), and is internalised in ways that sometimes seem entirely disconnected from reality. This speaks to the doubled structure of the suffering in question. First, the cosmetic surgery industry constantly invents new procedures to fix new flaws, upping the ante for informed consumers, while also working to broaden the pool of consumers itself. The individual is thereby constantly reoriented to novel standards that she has failed to meet. Second, however, this contingent political process is rapidly assimilated to the existing psychic structures that normalisation has established. Just as the diet industry relies on a cycle of success and failure, in direct contradiction of its own rhetoric of permanent, lasting happiness through weight loss, so cosmetic surgery promises a transformation the adequacy of which it will later deny.

What is right about the otherwise vacuous discourse offered by televisual makeover shows is that changing oneself takes hard work. Yet in our present ethical environment the torment of multiple surgeries is a more convincing display of dedication to self-transformation than the less visible labour of becoming happy in one's skin, a project that surely also requires risk, discipline, tactics, and perseverance. As Fraser points out in her critique of Davis, it is possible to reverse the terms of feminist analysis and pose refusal to participate in cosmetic surgery as the active choice (2003, 114). What women living with the dys-appearance of the body lack is not so much agency, as the debate between Bordo and Davis implies, but strategy. Thus, feminists should think through and encourage working on oneself qua working against the suffering induced by bodily dys-appearance, as this work has the potential to effect greater freedom for ourselves and those we influence. Normalisation, I have shown, repeatedly tries to contain our existence within conventional identity schema, and to repress remainders that might complicate its own self-referential system of meaning. As long as we are using disciplinary technologies within their own terms, we are bound to the dynamics of suffering that they induce. We are also enabled, however, by those same terms, in ways we will need to give up, and even to mourn (see Blum 2003, 110–16; Gibson 2006). Electing to have surgery makes one a go-getter, for example, someone who takes charge, not flinching at the prospect of pain, inconvenience, trauma, or risk. Researchers have remarked on the exhilaration and sense of being in control provoked by finally deciding to have cosmetic surgery (e.g. Davis 1995, 132–34). Both real-life medical practitioners and fantasy constructions such as *Extreme Makeover* cultivate this psychology, making cosmetic surgery seem like a courageous choice for the active, self-determining individual. The woman who tries to live with her less-than-perfect body does not have a lot of active options; this choice is often subtly construed as passive or resigned, which is an increasingly uninviting psychology in a world where these qualities are seen as abject, partly because they are associated with traditional femininity and lower class status. Control and self-determination are fetishised in Western cultures at the same time as we lack feminist contexts in which these qualities can find an alternative purchase.

Simply refusing to have cosmetic surgery cannot, therefore, be an adequate form of resistance, since—as Kathryn Morgan points out—'refusal may be akin to a kind of death, to a kind of renunciation of the only kind of life-conferring choices and competencies to

which a woman may have access' (1998, 339). We need to substitute a new solution for the psychic needs that cosmetic surgery both generates and claims to meet. Davis says that the women she interviewed saw cosmetic surgery as 'a very private and personal' project. 'They prefer secrecy to publicity and have no desire to confront others with their decisions . . . They do not care at all about changing the world; they simply want to change themselves' (2003, 111). In this context effective change, I have argued, might not only be surgical, with its dubious and deferred promise of lasting relief from bodily dys-appearance, but also self-transformative, motivated by a deeper understanding of the mutual implication of social and psychic forces in a culture of normalising judgement.

NOTES

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1. In 2005 physicians certified by the American Society of Plastic Surgeons (ASPS) and other US medical specialty licensing agencies performed 1,813,542 million invasive cosmetic surgeries, of which liposuction, nose reshaping (rhinoplasty), breast augmentation (mammoplasty), eyelid surgery (blepharoplasty), and tummy tuck (abdominoplasty) were the most popular, in that order. Since 1992, the number of cosmetic procedures performed by ASPS members (including both surgical interventions and non-surgical procedures such as dermabrasion) has increased 775 per cent. See the American Society of Plastic Surgeons website (2006). As ASPS certifies plastic surgeons in both the United States and Canada, these are rough figures for surgeries performed across North America. They exclude, however, procedures performed by non-certified practitioners, and are thus certainly a significant underestimate of the total number. The ASPS also divides surgeries into 'cosmetic' and 'reconstructive'. The latter category includes procedures in which cosmetic considerations are significantly implicated, including male and female breast reduction, breast reconstruction, and scar revision.
2. I am grateful to Meredith Jones for suggesting this way of making the point.
3. This is made most clear in Foucault's lectures published as *Abnormal* (2003), especially the first lecture, pages 1–26. In the world of cosmetic surgery, this function is exercised through the discourse of excluding from surgery (in theory if not in practice) those would-be patients who are allegedly too mentally disordered to benefit. See the allusion in Blum (2003, 15–16) and Heyes (2006).
4. A similar point is made in Jones (2006, e.g. 41–42), whose own Australian interviewees offer decidedly different rationales for their decisions to have cosmetic surgery.
5. Elizabeth Haiken argues that cosmetic surgery made early use of the concept of the 'inferiority complex' in its psychological self-justifications. The inferiority complex was first mooted by Austrian psychologist Alfred Adler in the 1910s (see Haiken 1997, esp. 108–30; see also Gilman 1997, 263–65). According to Adler, the natural helplessness of the young child must be transformed into feelings of competence and personal adequacy by correct parenting and, hence, a healthy maturation. Continuing failure at the daunting tasks of growing up cultivates a timid and insecure personality, which may in turn be over-compensated for by an aggressive or defensive style. Either way, unless the child can successfully adapt to the challenges of gaining independence and mastery

in the face of an initial and inevitable sense of inferiority, that feeling will be sedimented in the psyche. Most Americans, Haiken implies, did not need to know even this much about the inferiority complex to invoke it as a justification for all manner of technologies of the self, or for it to be a common idiom in media and advertising, and in selling the services of cosmetic surgeons (Haiken 1997, 111–23). The very vagueness and patient-relativity of the concept enabled surgeons to move away from universalising justifications for cosmetic surgery and towards psychological rationales rooted in the psychological needs of the individual prospective patient.

6. The major contributor to this project is Suzanne Fraser, in her 2003 book *Cosmetic Surgery, Gender, and Culture*. Fraser develops a theory of intertextuality, however, rather than pursuing the position indebted to Foucault and to Butler that I am gesturing towards here.
7. Lori Floyd and voiceover on *Extreme Makeover*, Episode 3, season 2, first aired 2 October 2003 on ABC TV.
8. Dan speaking on *Extreme Makeover*, Episode 1, season 2, first aired 18 September 2003, ABC TV.
9. In a recent talk, Alex Edmonds quoted the tongue-in-cheek slogan that 'the cosmetic surgeon knows nothing and changes everything, while the psychoanalyst knows everything but changes nothing', as epistemically central to supporting the vast state-subsidised cosmetic surgery industry in Brazil. When I asked him on what empirical basis the argument had been made, he replied that, to his knowledge, the claim is invoked as 'common sense', without systematic supporting evidence (Edmonds 2006).
10. Also see Honigman, Phillips, and Castle (2004).
11. See, for example, Hasan (2000); Sarwer and Crerand (2004); Sarwer et al. (1998); Schofield et al. (2002) (the latter is an Australian study). The prevailing wisdom in contemporary psycho-social analysis of cosmetic surgery is that someone who is suffering 'unbearably' over the appearance of a particular 'normal' body part likely has Body Dysmorphic Disorder (BDD). BDD is increasingly considered (in theory if not in practice) a contraindication for cosmetic surgery. Thus Davis's interviewees become *poor* candidates for cosmetic surgery—not *good* candidates—within this more recent psychosomatic discourse.
12. Clearly this problem could be approached in a more nuanced way by distinguishing philosophical models that connect suffering, self-identity, and politics, which may be, for example, Buddhist, Nietzschean, Arendtian, or existential.
13. Foucault's ambiguous recommendation that we take care of ourselves is an ethical project I explore elsewhere as a possible antidote to the psychic life of normalisation I describe in this essay. See Heyes (2007b, esp. chap. 5).

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