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Qual Health Res published online 30 November 2012
DOI: 10.1177/1049732312468335

Qualitative Health Research
XX(X) 1–10

DOI: 10.1177/1049732312468335
http://qhr.sagepub.com
SAGE

Embodying Racism: Race, Rhinoplasty, and Self-Esteem in Venezuela

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Abstract

In this article, I examine how race motivates women's decisions to undergo aesthetic rhinoplasty in Caracas, Venezuela. Through a combination of cultural domain analysis and thematic analysis of qualitative interviews, I explore how the preference for whiteness and associated facial features dovetail with the aesthetic ideals promoted by cosmetic surgeons. Rhinoplasty is offered by physicians and interpreted by patients as a resolution to body dissatisfaction and low self-esteem. The clinical ethos of objectivity established by cosmetic surgeons fails to acknowledge how perceptions of the self and body are strongly tied to racial marginalization: patients' efforts to alter the nose reveal attempts to change not only how the body looks, but how it is lived. As a result, cosmetic surgery only acts as a stop-gap measure to heighten one's self-esteem and body image.

Keywords

embodiment / bodily experiences; ethnography; Latino / Hispanic people; race; racism; self; surgical enhancement

In the United States, cosmetic surgery is a thriving industry aimed at the transformation of physical appearance. A growing scholarship addresses patients' motivations for submitting their bodies to the knife, although relatively few researchers consider the global implications of aesthetic surgical procedures. In this article, I examine how aesthetic ideals promoted by the cosmetic surgery industry interact with local ideas about race in Caracas, Venezuela, focusing on one cosmetic procedure, rhinoplasty, more commonly known as a "nose job." Using a methodological approach that combines cultural domain analysis with thematic analysis of qualitative interviews, I explore the complex interactions among (a) local ideologies about race and physical appearance, (b) patients' decisions to have rhinoplasty, and (c) clinical assessments of nasal anatomy. Ultimately, by pointing to the ways that selfhood is embodied, I aim to complicate claims that cosmetic surgery improves self-esteem. Because many women are motivated to alter the shapes of their nose to alleviate experiences of racial marginalization, rhinoplasty acts only as a stop-gap measure.

Many analyses of cosmetic surgery have emphasized the question of agency (Negrin, 2002). Often, cosmetic surgery is viewed as a form of embodied submission to forms of regulation based on social conceptions of the ideal feminine body (Bordo, 1993). For example, Bourdieu argued that women's bodies are objects of a social gaze "that constitutes women as symbolic objects whose being is a being-perceived, [having] the effect of keeping them in a permanent state of bodily insecurity" (2001, p. 66). Subjected to this social gaze, women often find themselves caught between a real body in which they live and an ideal body to which they aspire. To reduce feelings of inadequacy caused by the disjunction between the real and ideal, women look to "the fashion-beauty complex . . . to fulfill [the] function of reassurance" (Bourdieu, p. 68).

The poststructural framework emphasizes the role of power structures in motivating women's decisions to undergo cosmetic surgery. Other scholars have cautioned that this emphasis overlooks women's subjectivity and their own reflections on the choices they have made (Davis, 1995; Huss-Ashmore, 2001). An understanding of cosmetic surgery that incorporates the patient's point of view might offer a more constructive analysis of women's narratives (Askegaard, Cardel, & Langer, 2002). In my attempt to balance these two approaches, I frame my analysis of rhinoplasty as a transformative endeavor aimed at altering not only how the body looks, but how it is lived (Davis, 2003).

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From this perspective, cosmetic surgery holds the potential to operate as a liberating act, providing women with a space to recraft their bodies. Nevertheless, it is also acknowledged that women usually modify their bodies according to specific aesthetic ideals. Ideas about appearance are governed by cultural discourses that label certain physical characteristics as desirable. For example, women generally do not request surgical procedures to add fat deposits to the stomach or wrinkles to the face. Women might be active consumers in their endeavors to recraft the body, but we must recognize that only certain bodies are available for that consumption. Just as these constraints reveal underlying cultural assumptions about feminine appearance, we must also consider the racial implications of such practices. The case of rhinoplasty provides a particularly illustrative example of the intersection of race and medicine, revealing the subtle interplay between notions of ideal appearance and the universality of an aesthetic preference for whiteness.

Technologies of Whiteness

The surgical techniques that form the basis of modern-day aesthetic rhinoplasty emerged in Central Europe and the United States during the 19th Century (Whitaker, Karoo, Spyrou, & Fenton, 2007), in conjunction with cultural and scientific discourses that regarded perceived racial features as an outward reflection of a person's morality, work ethic, and intellectual capacity (Davis, 2003; Gilman, 1991; Haiken, 1997). The nose, for example, was viewed as a physical marker of race, and rhinoplasty allowed patients to disguise their perceived racial identity and access privileges associated with being White (Gilman, 1999). Because what counts as a physical marker of whiteness has varied across time and space, different groups of people have been perceived as either White or non-White depending on the political and economic agenda of the state (Frankenberg, 1993). Shifting definitions of whiteness have corresponded with the development of surgical techniques to minimize perceived non-White features on specific populations, including rhinoplasty for Jewish "nostrility" in Germany and Central Europe (Gilman, 1991) and the Irish "pug" nose in the United States (Haiken).

Today, the racial undercurrent in the practice of rhinoplasty continues to play a significant, albeit more subtle, role. Assumptions about normal nose shape are governed by a discourse that privileges the aesthetics of whiteness: surgeons endeavor to bring harmony to the face and body based on assessments of form and proportion that take an ideal White body as its starting point (Davis, 2003; Gilman 1998, 1999; Kaw, 1993). For example, the presumed "gold standard in rhinoplasty" is a nose that is associated with being "Caucasian" (meaning White): a tall, slender nose with a narrow nasal base (Cobo, 2003; see also Grimes, 2007). This is not to say that surgeons seek to inscribe "White noses" on all patients regardless of their presumed race, but rather that the White ideal guides the mitigation of unwanted—and therefore, racial—phenotypes to the degree that physicians and patients feel is warranted. Surgeons often advocate surgical interventions, such as rhinoplasty, that improve facial harmony, thereby explaining away the racial implications of aesthetic facial surgery by emphasizing physical balance of the face. This disguises the fact that balance, harmony, and symmetry are achieved most often by making perceived racial features look more, rather than less, White (Davis, 2003).

In Venezuela, the practice of rhinoplasty shares a cultural history with Europe and the United States. Before residency programs were established in Venezuela in the early 1960s, Venezuelan physicians traveled abroad to finish their medical training. On returning to their native country, surgeons were optimistic that the knowledge they had gained would modernize Venezuelan medicine (Cisneros, 1978). With the establishment of domestic residency programs, cosmetic surgeons received the majority of their medical instruction in Venezuela, but their training continued to be influenced by North American standards through the use of medical texts published in the United States. Beginning in the 1980s, a great deal of the American medical literature on rhinoplasty was dedicated to understanding the aesthetic implications of racial mixture, forging the development of techniques aimed at correcting the so-called *mestizo* (racially mixed) nose (Daniel, 2002). The exportation of these techniques to Venezuela carried with it judgments about physical appearance and perceived racial features.

Although the symbolic valuation of whiteness in cosmetic surgery has been globally distributed, the ways biomedical practices intersect with local ideas about race require careful consideration. The cultural employment of race and racial categories operates in complex and nuanced ways. Race can be invoked to provide individuals with ways to describe themselves and perceive and interact with others, but it can also serve as a cultural and political script with which to justify the symbolic or structural domination of certain groups by others (Harrison, 1995). The analysis of racial categorization is by no means a straightforward matter: it requires recognition of the historical and structural dimensions of race, while appreciating how difference and power are played out in particular contexts.

With the right methodological tools, it is possible to reconstruct race as it is conceptualized in a particular society, while also considering the ways individuals interpret and negotiate such categories in their daily lives. To understand the extent to which race motivates

individuals' decisions to have aesthetic rhinoplasty, and how such decisions are interpreted by cosmetic surgeons, it is instructive to develop an empirical model of Venezuelan racial categories and the ways they are linked to cultural values. This requires an integrative and holistic methodological approach to explore how perceptions of the body are constituted within ideologies of race and how such perceptions shape decisions to alter perceived racial attributes. Cultural domain analysis can be used to develop a cultural model for racial classification to display how individuals conceptualize racial categories, whereas in-depth qualitative interviews provide an avenue to explore how a person interprets, incorporates, and navigates such categories in different social arenas, including clinical encounters with cosmetic surgeons.

Method

Data presented in this article were drawn from a larger, multiphased ethnographic study that took place in Caracas, Venezuela between 2005 and 2007. Caracas is home to over half of the cosmetic surgeons in Venezuela (Gulbas, 2008). Although national data are not collected to document the prevalence of cosmetic operations, it is difficult to deny its social and economic significance. The beauty industry is the second largest industry in Venezuela, and a major component of its success is the business of cosmetic surgery (Alvarez & Serrano, 2002). Moreover, media reports claim that the prevalence of cosmetic surgery in Venezuela is one of the highest in the world (Durán & Davies, 2005). Although many cosmetic surgeons charge prices that are unaffordable to most Venezuelans, banks and private clinics offer special credit options to help patients finance their surgical procedures. Coincidentally, a major reorganization of the Venezuelan public health care system has only intensified the popularity of cosmetic surgery. Based on a decree issued by President Hugo Chávez in 1999, public institutions may not charge a fee for services rendered (Pan American Health Organization, 2006). Effectively, this made all surgical procedures, including those for aesthetic reasons, free in all public hospitals.

Sample

Participants in the overall study included 499 women and men, with and without cosmetic surgery, between the ages of 18 and 65 years, stratified by race and class. Race was self-identified by the participants, whereas class was documented according to household income, type of housing structure, and neighborhood of residence. Following a site-based sampling approach (Arcury & Quandt, 1999), I recruited participants from a number of locations, including three private clinics, a private practice in a large private hospital, and plastic surgery departments in two public teaching hospitals, in addition to recruiting individuals from salons, clinics specializing in cosmetology or weight loss, and modeling and beauty pageant schools. Research was approved by the Institutional Review Board at Southern Methodist University and the Committee on Research Ethics at the public hospitals. In the private clinics, permission to conduct research was granted by clinic directors. For purposes of anonymity, I have not specified the names of participating individuals or institutions, and I use pseudonyms instead.

Cultural Domain Analysis

Cultural domain analysis offers one way to understand local constructions of race (Gravlee, 2005). I used pile-sorting activities (Borgatti, 1996; Weller & Romney, 1988) with 40 individuals (20 men, 20 women), stratified by race and class, to explore Venezuelan conceptualizations of race. For coherent domains, samples of 20 to 30 informants are generally adequate (Borgatti). I conducted pile sorts using Marvin Harris' facial illustrations (1970) to explore links between phenotypic features and racial classification (see Gravlee). Harris created 36 male and 36 female faces to represent all possible phenotypic combinations given three different skin tones (light, medium, dark), three hair types (straight, wavy, curly), two nose widths (thin, wide), and two lip shapes (small, large). Following the procedures outlined by Gravlee, research participants sorted the cards according to perceived racial category, and results were analyzed using cultural consensus and nonmetric multidimensional scaling modules in Anthropac 4.0 (Borgatti, 1996). Following the pile sort, I asked a series of open-ended questions to elucidate differences in the ways that portraits were sorted.

Qualitative Interviews

In this article, I focus on a subsample of the qualitative interviews in which themes associated with race, nose shape, and desires for rhinoplasty emerged. Rhinoplasty is a prominent cosmetic procedure in Venezuela. Consultations outnumber requests for any other procedure except for cosmetic breast surgery. I interviewed 24 women who had already undergone rhinoplasty and 39 women who expressed a desire to change their nose through rhinoplasty. This sample was stratified by race and class. Of the 22 women of low socioeconomic status, 5 described their race as *blanca* (White), 8 as *morena* (brown), and 9 as *negra* (Black). Of the 16 women from a middle-class background, 3 described their race as blanca, 5 as morena, and 8 as negra. Among the 26 women of high socioeconomic status, 3 described their race as blanca, 9 as morena, and 13 as negra. These 63

women represent approximately 20 percent of the total sample of women in the larger study (Gulbas, 2008).

Interviews consisted of open-ended questions about beliefs, opinions, and perceptions of cosmetic surgery, as well as experiences with cosmetic surgeons and surgical procedures. Additionally, I explored eating and dieting behavior, income spent on appearance, exposure to television and magazine advertisements, general attitudes toward the body and body parts, and how body parts associated with perceived racial identities impacted positive and/or negative life experiences. Within this sample of women, 18 consented to allow me to observe their consultations. As part of this process, I collected patient narratives during preoperative (n = 10) or postoperative (n = 8) consultations. First, I observed the consultation with the cosmetic surgeon. Following this process, I asked participants to describe, in their own words, reasons for wanting rhinoplasty. As the interview progressed, I included probes to explore perceptions and experiences of the consultation, using specific details based on my observation of the consultation to elicit information. Additionally, I asked participants to reflect on how perceptions of the body are influenced by personal relationships and participation in social activities.

I then asked questions about specific aspects of the participant's body: height; weight; chest, waist, and hip proportions; skin complexion; facial features (eye color, nose and lip shape); and hair texture. Participants were asked to identify their personal ideal regarding each attribute, followed by an evaluation of how closely they felt their body resembled the perceived ideal. To explore issues related to racial discrimination, I began with a broader question: "Tell me about a time when someone in your life told you something negative about your body." By framing the question in this way, I was able to discuss experiences of discrimination based on appearance and race.

I conducted all interviews in Spanish, which were later transcribed by a professional transcriber in Venezuela. Transcripts were formatted for thematic analysis using a computer word-processing application (La Pelle, 2004). I analyzed the text to identify and classify themes, including ways of conceptualizing race, ideas about self-esteem or body image, reasons for having cosmetic surgery, cultural discourses on the body, and ways of thinking about and experiencing the body. I then entered codes into a computer spreadsheet for comparison of themes across cases, examining similarities and differences among participants based on their self-defined racial category.

Results

Defining Race in Venezuela

In Venezuela, race refers to a flexible system of classifying both oneself and others according to gradients in phenotypic characteristics, such as skin color, hair texture, fullness of lips, and nose shape. Because constructs of race are based on physical features, the Venezuelan system of racial categorization is fluid. As in many other Latin American countries, racial categories are defined predominantly according to gradients in skin color, ranging from blanco to negro, with a number of skin color variations in between (Ishibashi, 2003).

Many Venezuelans espouse and praise this flexible system of racial classification, which has been made possible through processes of *mestizaje*, or racial mixing. The ideology of mestizaje creates a perceived racial unity by stressing that national culture has been built by those who recognize and share a common blood heritage (Guss, 1993). This has led to the widespread belief that Venezuelans reject racial categories of Black and White in favor of more racially mixed categories. On the surface, mestizaje seems to promote equality by encouraging racial and cultural fusion, ensuring that individuals think of themselves as a "café con leche [coffee with milk] people" who share a European, Indian, and African ancestry (Wright, 1990). In practice, the promotion of a democratic racial ideal is paradoxical and has been acceptable insofar that it has led to a lightening rather than a darkening of the population. Current constructs of race in Venezuela are historically embedded in a national heritage that has prioritized light skin and European physical features.

For example, until the 1930s, Venezuelan political leaders maintained a series of policies to prohibit the immigration of people of color into the country (Wright, 1988). In an effort to downplay the miscegenational motivations behind such strategies, the government stopped documenting race in census data in 1926, claiming that the inclusion of race only served "to remind blacks of their painful experience as slaves" (Wright, 1990, p. 4). Concurrent with an effort to halt the entrance of Blacks into the country, the immigration of individuals from Italy, Spain, and Northern Europe was actively encouraged in the hopes of "whitening" the population (Wright, 1988). This historical preference for whiteness suggests that processes of mestizaje have been grounded in racial discrimination and calls into question the supposed flexibility of racial constructs in Venezuela.

Multidimensional scaling analysis of the pile-sorting activity of facial portraits revealed that contemporary Venezuelan conceptualizations of race cluster around three categories: moreno, negro, and blanco. Research participants applied the term *moreno* to describe portraits with medium or dark skin and straight or wavy hair. *Negro* was used to classify portraits with medium or dark skin and very curly hair, and *blanco* was used to describe facial portraits with light skin and straight or wavy hair. In the pile sorting, a small number of facial portraits did not cluster within the broader categories of moreno, negro, and blanco.

These outliers exhibited features considered essential to each extreme of the continuum, namely light skin (associated with blanco) and very curly hair (associated with negro). Outlier portraits were described in pejorative terms, and were perceived as violating the rules by which racial classification is supposed to operate.

Overall, results from the pile sorting reveal that racial categorization relied a great deal on assessments of skin color and hair type; yet nose and lip shape did play a role in racial classification, albeit in more subtle ways. Through analysis of semistructured interviews to explore why participants grouped certain facial portraits together, it became evident that individuals were more likely to describe a face portrait with a wider nose and fuller lips as darker. Similarly, research participants noted that a portrait described as blanco with wide nose and full lips could also be categorized as a darker racial category, such as *trigueño* (wheat-colored).

Thus, racial classification results from the perception and interpretation of a variety of phenotypic features, from skin color and hair type to nose and lip shape. Certain phenotypic features are perceived as belonging to particular racial groups, such as light skin or very curly hair. Other physical features, although not sufficient for racial classification, influence how an individual is grouped. For example, the possession of a broad nose results in the classification of a person as darker than an individual with a thin nose when all other phenotypic features are held constant. This exposes the transformative potential of rhinoplasty. In Venezuela, popular discourse links meanings of power and status to the shape of the nose. It is in this way that a race-based oppression emerges in an embodied form. An individual learns to value or denigrate her nose by linking its specific shape with value-laden attributes that privilege whiteness and denigrate non-White phenotypes.

The Well-Formed Nose: Race-Based Oppression in Embodied Form

In my interviews with participating women, questions about the nose evoked powerful and often negative sentiments. The most frequent response to the question regarding which body part a woman wanted to change (regardless of her desire to have cosmetic surgery) was the nose. Approximately 16% of women who described their race as blanca and 16% of women who characterized themselves as morena wanted to change their noses. Among Afro-Venezuelan women, nearly 50% expressed a desire to alter the appearance of their noses. In every case, the desire was for a nose that was *más perfilada* (more well-formed). *La nariz perfilada*, or a "well-formed nose," was construed as the cultural ideal—a thin, straight nose with a well-defined point. Notably, this description parallels the so-called "gold standard" in rhinoplasty: a nose that is associated with being White and characterized as tall and slender with a narrow nasal base (Cobo, 2003; see also Grimes, 2007). Cosmetic surgeons and research participants alike associated la nariz perfilada with a racial identity of blanca.

Diametrically opposed to la nariz perfilada was *la nariz achatada*, or a flat, broad nose. Whereas a thin nose was an indicator of whiteness, individuals perceived la nariz achatada as an indicator of African heritage. In its association with blackness, this nose shape had become charged with pejorative undertones that positioned it as a source of body dissatisfaction. One research participant, who described herself as morena, recalled,

> They made fun of me in school because of my flat nose. They said it made me look Black, so they called me "negra." It was worse, I don't know, because I looked at my friends, all so beautiful, and I felt so ugly—the ugliest in the group. They had beautiful faces, with small, well-formed noses. I didn't look like them. It made me so depressed.

The woman's negative view toward her nose was shaped, in large part, by the teasing she suffered, perpetrated by her classmates. Scrutinized, objectified, and labeled, her nose marked and racialized her body negatively, and the structures of power that played out in daily life encouraged her to see that body as ugly.

This woman's narrative echoes sentiments expressed by many women seeking to change the shape of their noses. In a contextual analysis of the words women used to describe their perceptions of and feelings toward their noses, the words *teased* and *ugly* figured prominently. Other common words used to describe the nose were *big, wide, Black, horrible*, and *abnormal*. Women frequently expressed hatred toward their noses. Through its association with blackness, the nose was configured as the cause of a racialized body "complex." Frequently, it was the desire to alleviate a body complex or improve self-esteem that motivated women to have rhinoplasty, yet even the underlying motivations of these decisions reflected a racialized pattern. Women who described their race as blanca often cited the desire "to look good" as their reason for having rhinoplasty. All but one of these women described their noses as crooked, large, or humped. For the most part, such attributes were devoid of racial meaning, and these women viewed the procedure in more aesthetic terms.

Among women who described their race as morena, rhinoplasty was viewed as a way "to look like everyone else." Again, we are reminded of the quote from the woman who felt that all her friends were beautiful with well-formed noses. These women perceived rhinoplasty as a way to alter a feature that they felt marked them for social judgments in the constellations of social interactions of their daily lives—in their family relations, among

friends, and on occasions when they desired to blend into a crowd at a restaurant or public event.

Among women who described their race as negra, rhinoplasty was perceived as a way to raise self-esteem, "to feel better." Cosmetic surgery was often framed as the only viable option for enhancing their sense of self. Many women viewed the body and self as being equivalent. As one research participant told me, "It is a burden to have a nose like mine. But what matters is how I feel. I look in the mirror, at my nose, and I feel that I don't like my nose. I hate my nose." Among Afro-Venezuelans, phenotypic features were invoked as the foundation for racial discrimination, and the nose figured prominently as a signifier of race.

The discourse that reproduced racial oppression permeated every aspect of daily life, and differences in physical appearance became objectified, marked, and racialized. Participants often reflected on how their parents encouraged them to "marry White." In doing so, parents were hoping to spare their offspring from the suffering experienced by the older generation. In school, classmates bullied and teased one another, reproducing a social order in which whiteness trumped all. As one research participant told me, "Everyone wants me to feel bad about myself because I am Black." In their narratives of experiences of racial marginalization and discrimination, many Afro-Venezuelan women conceptualized rhinoplasty as a beacon of hope. One woman told me, "It will help me become who I really am." By having rhinoplasty, then, some women believed they could create a self that was more aligned with the cultural ideal.

Diagnosing the Mestizo Nose

Regardless of one's motivation, the only way to change the nose is through the risky, painful, and permanent surgical procedure of rhinoplasty. During my fieldwork, I was able to observe three rhinoplasty procedures in a private clinic. The surgery, on average, lasts 2 to 3 hours. First, incisions are made along the exterior of the nose. This frees the skin to be lifted and pulled back to expose the underlying structure. The width of the nasal bone is reduced through chiseling, and the tip of the nose is enhanced by removing cartilage from the ear and sewing it to the appropriate region of the tip of the nose. Once the surgeon is finished manipulating the underlying structure of the nose, the skin is pulled forward and reattached with sutures. During reattachment, the surgeon often excises skin to reduce the width of the nostrils. After surgery, the patient must wear nasal splints and an external nose cast for up to a week. The nose is bandaged for an additional month to promote healing.

My experience in both private and public medical settings quickly demonstrated that only some women were able to fulfill their quests for la nariz perfilada. My comparative analysis of medical records in a private clinic and the plastic surgery department in a public hospital revealed a ratio of surgeries to consultations that was 20 times higher in the private clinic than in the public hospital. On the surface, this difference might seem surprising given that cosmetic surgery was free in the public hospital. The removal of financial constraints associated with having surgery led to a dramatic increase in the popularity of aesthetic procedures, contributing to the public hospital's inability to meet patients' demands. At some public hospitals, resource limitations had been exacerbated by deteriorating infrastructures. For example, during 4 months of my fieldwork, bacterial contamination, electrical outages, and medical supply shortages in the surgical facilities brought one plastic surgery department, and the entire hospital, to a standstill.

In considering ways to have rhinoplasty as quickly as possible, patients sometimes took drastic measures to have their noses surgically modified. It was not uncommon for women to elect to have surgery without general anesthesia or to negotiate deals with residents to perform surgeries outside of the public hospital. Patients could receive discounted rates for surgery from residents who moonlighted in small private clinics, even though some had not completed their medical training in plastic surgery.

In spite of the stark contrast in access between private and public health care, physicians in both settings endeavored to fulfill the desires of their patients through adherence to specific biomedical tenets. Cosmetic surgeons used the tools and technologies of biomedicine to remake the structure of the nose, shaping it to be la nariz perfilada. Drawing on canons of biomedicine that had been globally distributed and locally interpreted, surgeons diagnosed nasal appearance based on underlying structural pathologies. For example, *la nariz mestiza* (the mestizo nose) has been described as having a weak cartilage structure, poorly defined nasal tip, and flimsy nasal base (Coello Cadanet, 1987). Attributing this symptom complex to a specific nose shape was based on the prior assumption that these features "naturally" belong to certain groups of people; that is, mestizos. Variations in individual nose shapes were overlooked, and the nose became imbued with an inherently racial quality. Through the medicalization of nasal anatomy, surgeons became arbiters of knowledge who diagnosed certain nose shapes as abnormal and in need of surgical intervention.

In a contextual analysis of published medical texts used within Venezuelan medical schools, the mestizo nose was most frequently described as weak, wide, thick, and problematic. Other descriptive terms included flimsy, broad, oily, bulky, and fatty. Not only did cosmetic surgeons use medical terms to pathologize nose shape, but

by using words such as *weak, problematic*, and *flimsy*, doctors propagated ideas that any nose that was not la nariz perfilada was anatomically deficient. Cosmetic surgeons normalized this discourse by situating it as an outcome of mestizaje. As one first-year resident noted, the mestizo nose is "a problem of race mixture. It causes a deformity of the nasal tip. Weak cartilage structure creates a poorly defined nasal tip."

The so-called treatment of the mestizo nose was legitimized by invoking a psychological justification. As the Venezuelan Society of Plastic Surgery noted:

> There are people who have some physical characteristic that causes them suffering, conflict, obsession, shame, emotional instability or moral pain because they feel different from others who are supposedly normal. . . . When a person has to suffer this situation and decides to change what nature has stingily denied . . . this decision is not fickle or arrogant but absolutely necessary to maintain mental equilibrium and improve one's self-esteem. (Engel, 2005, p. 3)

The ability to demonstrate improvements in mental health through cosmetic surgery reflects global cultural expectations that doctors heal. This has been crucial to cosmetic surgery's legitimization as a valid biomedical practice, and physicians attempt to demonstrate that altering aesthetic appearance results in improvements in self-esteem and body image (Gilman, 1998, 1999; Haiken, 1997). The therapeutic grounds for cosmetic surgery presupposes that mental anguish is shaped, in part, by a perception that one's body deviates from "normal" variations in physical appearance. The psychological discourse and logic of self-esteem invoked within the cosmetic surgery industry casts the physical body as the cause of mental distress (Gilman, 1998). Cosmetic surgery, in its "treatment" of body dissatisfaction, can thus improve poor self-esteem. This has resulted in a redefinition of mental health that positions emotional well-being and selfhood as dependent on the perceived lack of abnormal deviations in appearance (Davis, 1995).

The clinically neutral notion of self-esteem, which emphasizes the individual psychology of the self, obscures how selfhood becomes embodied: how perceptions of the self are created, established, and reinforced through "being-in-the-world" (Merleau-Ponty, 1962, pp. 236-239). By overemphasizing the private, psychological nature of experiences of and reactions to racial discrimination, treatment never moves beyond the level of the individual, and instead acts as a stop-gap measure.

Not surprisingly, of those women seeking to improve their self-esteem through rhinoplasty, the majority of whom were Afro-Venezuelan, many expressed a desire to return to the cosmetic surgeon's office. Among women of all races who had undergone rhinoplasty, all asserted that they had benefited from the surgery. Many recalled their amazement at the quick change in their appearance and the initial boost in self-esteem, even if self-esteem had not been a primary motivator for having surgery. Of women with rhinoplasty, 84% conveyed that they would consider having another cosmetic operation in the future, such as breast augmentation or liposuction; yet only Afro-Venezuelans mentioned the desire for additional rhinoplasty in the future. Despite attempts to use cosmetic surgery as a way to ameliorate racial marginalization, rhinoplasty did not alleviate a system of discrimination based on the women's physical attributes. Over time, feelings of inadequacy and worthlessness resurfaced. Because improvements in self-esteem were interpreted as benefits associated with cosmetic surgery, and initially experienced after surgery, many women remained hopeful that future rhinoplasties would help them.

This was precisely the context surrounding the decision by one of the research participants, Maria, to have a second nose job. I chose the story of Maria because of the way she articulated the embodiment of racial marginalization. Maria's narrative reveals how racial difference becomes inscribed upon the body, saturating the experience of being-in-the-world with a racialized and symbolic order. The presentation of this case is not intended to be representative, yet her narrative does evoke themes presented above and sentiments expressed by many women seeking to change the shape of their noses.

A Quest for Permanent Transformation

At the time of the study, Maria was nearly 50 years old. She described herself as "negra clara" (light black), because she felt she was lighter-skinned than many Afro-Venezuelans. She lived alone in a one-room apartment located in one of the many large, sprawling barrios in Caracas, where she worked as a street vendor. On the particular day of our interview, she was wearing a large, shiny hair barrette pinned in her straight, dark hair. Maria proclaimed that she went to a neighborhood salon weekly to have her hair straightened. Recalling her childhood days, she remembered not liking her hair: "Well, it was Black hair! I mean, I did not like how it moved. It didn't move! It was all stuck together, you know, bad hair. But now, I know how to style my hair."

Maria also lamented the appearance of her nose. Her first memories of disliking her nose were intimately tied to the abuse she suffered at the hands of her first partner. At 20 years of age, she entered into a civil union with a White man. With a destructive drinking habit and angry temper, Maria's partner blamed the household's financial struggles on her. He frequently hit her, telling Maria that

she "deserved it" because all of their problems stemmed from the fact that she was Black. He often tormented her about her nose, and she remembered him laughing and pointing at her.

Although Maria insisted she had always wanted to have a nose job, she acknowledged that her partner "ruined" her "self-esteem" about her nose. She consulted with her mother and siblings about the possibility of having rhinoplasty, and they encouraged her decision. She saved what little money she had and decided to have the operation in the public hospital. At the time, although it was not free, surgery in the hospital was still cheaper than having the procedure performed in a private clinic. She was initially satisfied with the results of the surgery, but that initial satisfaction did not last as long as she expected. Soon, the teasing and bullying resumed: "My partner told me, 'That nose of yours, it looks ugly. It looks just the same.' That made me feel so depressed." Nearly 30 years later, Maria was seeking a consultation for a second nose job. Although she was in a new relationship with a supportive partner, Maria continued to feel "uncomfortable" about the shape of her nose. She described her nose as horrible and ugly. She said, "It was the worst thing I could have ever inherited. It was the worst thing my parents could have given me."

Maria gave me permission to observe her consultation, which took place in one of the public hospitals. During the consultation, she described to the surgeon that she thought her nose was too broad. When asked why she wanted her nose to look less broad, she replied, "To feel better about myself—raise my self-esteem." He agreed with her assessment, but performed an examination to assess the strength of her cartilage. Using his index finger, he palpated her nose and felt the nasal tip. He concluded that she suffered from weak cartilage structure, causing flatness and contributing to the appearance of her nose as broad. He added, though, that her nasal base was wider than "normal" because she was Black, and he assured her that this could be "fixed" during surgery. Maria hoped that her second nose job would reshape her nose to look how she always dreamed. She felt this would allow her to feel at peace with her body and herself. She reflected,

> There are some places I go where I am the only Black person. And everyone else is so beautiful. There comes a moment when I feel like, well, I find myself thinking, "That person has a pretty nose." And I do not have that. It is a burden to have a nose like mine.

Maria's attitude toward her perceived Black physical features echoed that of many Afro-Venezuelan women who participated in the study. Raised in a culture that privileged the features of White bodies, Maria literally had the perceived ugliness of her blackness beaten into her. Her social environment reinforced the brutal message of her abusive partner, telling her that the "solution" was to change the appearance of her body. Maria invested regularly in straightening her hair, yet this management practice did not make her feel less Black. Instead, when looking in the mirror, her gaze was drawn to another perceived racial feature that could only be "corrected" through a more transformative biomedical intervention. Maria's decision to pursue rhinoplasty, not once but twice, was motivated by a desire for permanent transformation.

Maria's case reveals how rhinoplasty consultations were founded on the explicit judgment of the respective patient's appearance, wherein an individual's possession of undesirable physical characteristics presented the opportunity for change, both physically and mentally. The very act of seeking treatment and submitting one's body to the gaze of the surgeon required the patient to acknowledge the inferiority of the physical feature being corrected. It also required that the patient accept an individual psychological vulnerability—low self-esteem—on account of possessing that physical feature. Rather than questioning the race-based valuations oppressing the patient, the clinical encounter reified them, offering relief only through the admission of a personal weakness in bearing such a burden.

Discussion

Decisions to have rhinoplasty cannot be reduced to a singular meaning. Rhinoplasty was viewed by patients as an aesthetic practice to enhance appearance, as a way to improve self-esteem or eradicate a body complex, as both desirable and necessary. The nuances of the decision-making process reflect how individuals actively chose cosmetic surgery to overcome situations that were not of their own making. Considering how patients' experiences of their bodies were situated within specific cultural discourses concerning appearance and perceived racial features exposes how the majority of Venezuelan women were forced to view their bodies as deviating from an idealized White body, leading them to think of, speak of, and experience their bodies in negative terms.

Patients' and doctors' constructions of the body constituted distinct systems of valuation that intersected in the clinical encounter. The body was perceived as a medium through which individuals displayed the self. This represents a collapse of the outer body and inner self—if one looks good, then one feels good (Featherstone, 2010). Patients' efforts to recraft the body revealed active attempts to change how the body was lived—a stark contrast to biomedical conceptualizations based on ideas of objectivity and expertise. The clinical neutrality

established by biomedicine failed to acknowledge how perceptions of the self and body were strongly tied to broader discourses concerning race. Rather than challenge structures of inequality in Venezuelan society, cosmetic surgeons invoked low self-esteem to reconfigure them as a psychological problem. The clinical encounter imposed an additional layer of discourse that medically reinforced the racial valuation of phenotype, at best promoting whiteness by failing to challenge its supposed superiority.

State-funded medicine offered individuals the chance to reduce inequalities, such as access to cosmetic surgery. Even though cosmetic surgery was free for all Venezuelans, the limits of the public health care system constrained the agency of lower-class patients. Those with sufficient means avoided the long lines and limited services of public facilities, seeking high-quality treatment in private clinics. Many patients turned to public hospitals for free consultations, but demand far outstripped the availability of the most popular services, so they either had to wait, or try to find the resources to finance a procedure in a private practice. Some procedures—and the bodies that advertised them—were only available for those who could pay. Those few who were able to accomplish their surgical desires in the public health care system found themselves empowered by pursuing a body type that symbolized the essence of their social marginalization.

It is important to note that although racial classification was based in perceptions of physical appearance, Venezuelan racial categories were dynamic. The application of racial categories in practice depended on numerous factors, including the social setting, the mode and style of dress of an individual, career, place of residence, and perceived class status (Wright, 1988). Moreover, the ubiquity of race-based oppression does not suggest passive acceptance of subordinate status by Afro-Venezuelans; political and social action has been directed at eliminating de facto racism (Garcia, 2002; Ishibashi, 2007). It is there that Venezuelan women might find a more enduring form of agency.

Acknowledgments

Thank you to Charles C. Gravlee for granting me permission to use Marvin Harris's standardized facial portraits in the study. I gratefully appreciate the helpful comments by Carolyn Sargent, R. Alan Covey, and three anonymous reviewers on previous versions, and I extend my gratitude to the individuals who participated in this study.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Research for this article was supported by a National Science Foundation Dissertation Improvement Grant (BCS 0612570). Preparation of this article was supported in part by the Center for Mental Health Services at the George Warren Brown School of Social Work, Washington University, in St. Louis, through an award from the National Institute of Mental Health (5P30 MH 062579).

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Bio

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