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Stigma, Surgery and Social Identity: Attitudes towards Cosmetic and Sexual Reassignment Surgeries

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Attitudes towards Cosmetic and Sexual Reassignment Surgeries

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ABSTRACT

This thesis uses a combination of vignettes and interviews to explore social approval of cosmetic and sexual reassignment surgeries as a means of studying sex and gender in contemporary society. It draws from poststructuralist, queer, symbolic interactionist and intersectionality theories. This study found that social approval was higher for normative surgeries than for non-normative surgeries. The main themes that emerged in regard to social approval were respondents' religious beliefs, their social distance from a person undergoing surgery, their concerns with possible risks or complications, and their views on an individual's right to control their own body. Underlying the vast majority of the responses was an essentialist view of sex that influenced how participants' viewed the various surgeries.

Keywords: sex; gender; cosmetic surgery; sexual reassignment surgery.

INTRODUCTION

This study explores social approval of "cosmetic" and "sexual reassignment" surgeries and any stigma attached to those surgeries. Using a combination of vignette questionnaires and in-depth interviews, these issues are explored as an indirect means of studying the effects of sex and gender in contemporary society. Both of these surgeries involve the same underlying process of transforming the body. However cosmetic surgeries are seen as more normative than sexual reassignment surgeries. While there is surprisingly little data on sexual reassignment surgeries, there is an abundance of information that documents how the number of cosmetic surgeries has doubled over the last decade. In 1997, there was 972, 996 surgical cosmetic procedures compared to 2,079,032 surgical cosmetic procedures in 2007 (The American Society for Aesthetic Procedure, 2007:4). There are also gender differences in the use of cosmetic surgery. Women utilize cosmetic surgery to a greater extent than men. In 2006, women obtained nearly 91% of the overall cosmetic surgeries (The American Society for Aesthetic Plastic Surgery, 2007:5).

Gender and sexuality are so deeply entrenched in our society that we are often taught that they are natural or essential to us as the result of innate or biological differences (Vance, 1989: 160). While most contemporary modernist perspectives recognize gender as socially constructed or learned, they still tend to view sex as biological or natural. Indeed, most modernist perspectives are "essentialist" in that they tend to describe both sex and sexuality as "an expression of an underlying human drive or tendency" (Vance, 1989: 160). In this way they reify sex and sexuality into something that is fixed and unchanging in individuals; that it is intrinsic to their "essence" (Epstein, 1987:135; Halperin, 1993: 416; Vance, 1989:160). Among the general public, the potency of such views is visible in the details behind the story leading up

to the Nebraska Supreme Court case *Brandon v. Richardson County*. Undeniably, this case illustrates the ultimate consequences individuals may face when they do not conform to American societies expectations in regard to sex and gender –death. This case involved an individual who was assigned a sex and gender based on their perceived anatomy at birth, but who later came to identify with a different sex and gender. Brandon Teena was designated a girl at birth, but lived his adult life a man. He was raped and later murdered in 1993 by two men who had discovered he was transgender (Lambda Legal, 2008).

This study draws heavily from poststructuralism and queer theory. It employs a strong social constructionist approach to both gender and sexual identities. Unlike modernist approaches, poststructuralists and queer theorists reject essentialist notions of sex and gender. Instead they view both sex and gender as social constructions and socio-historical products (Vance, 1989:160). Furthermore, these approaches do not equate sex acts to sexuality. Rather, the term sexuality and the meanings attributed to it are based on their cultural and historical contexts (Halperin, 1993:420; Vance, 1989:161). Hence, poststructuralists and queer theorists deny the existence of any core or essential identity.

However, just because this theoretical approach recognizes no core identities, this does not mean that identities are meaningless to people. Rather, while categories of identities are constructed, they still are very meaningful because we give them meaning in our social interactions. To better understand this process of giving meanings or interpretations to social behavior, this study draws from symbolic interactionism and its understanding of how identities are given meanings in the process of social interaction by various verbal and non-verbal signs and gestures. Symbolic interactionism is also valuable to this study because it provides a wealth of research and information on stigmas.

The third theoretical perspective that informs this study is Intersectionality Theory. That is, categories of gender and sexual identity represent different structural and social locations that reflect the different interests of dominant and subjugated social groups. Male versus female identities, masculinity versus femininity, as well as heterosexual versus homosexual, transsexual, transgendered and genderqueer identities have meaning because they reflect structural, social inequalities between people. The intersections of sex and gender based identities with class, race and ethnicity result in a multiplicity of simultaneous and interlocking oppressions and privileges, as well as a multiplicity of vantage points for viewing these issues. It is for this these reasons, that this study also examines how people of different classes, races, genders and sexual orientations view cosmetic and sexual reassignment surgeries.

People often accept or reject others based on the identities they claim or perform. These identities we claim or reject can become the litmus tests for those we accept or reject in others. They also can be used to find common interests and political solidarity. Therefore, identities are often derived from social oppressions, just as they can be used to mobilize for social change or to resist such oppressions. This is why exploring attitudes towards various cosmetic and sexual reassignment surgeries can be an important means of examining social inequalities, as well as how and why individuals accept or reject others based on their perceived identities.

PREVIOUS LITERATURE

Individuals are often treated unequally if they display characteristics that are not considered normal by the hegemonic groups in society. While there are as many varying characteristics as there are people, this paper focuses on differences based upon gender and sexual identities. For individuals who stay within their assigned gender of masculine or feminine, modifying their bodies with cosmetic surgery is becoming increasingly practiced in American society (Morgan, 1991). By the 1990's, the second most chosen elective surgery in the United States was breast augmentation which highlights the importance we place on gender roles in the United States (Morgan, 1991). The underlying reasons for obtaining cosmetic surgeries differ from sexual reassignment surgeries. Cosmetic surgeries are used generally to *enhance the body's biological anatomy's attractiveness* in terms of the gender people are performing (Dull and West, 1991). In contrast, sexual (re)assignment surgeries are used to *change the body's biological anatomy* to better reflect the sex people are performing. However, both surgeries are performed to modify an individual's body in the specific ways the individual desires. This study explores the reasons why people find some surgeries socially acceptable and others unacceptable as a means of examining their attitudes towards sex and gender.

COSMETIC SURGERY AND ACCOMPLISHING GENDER

Gender is expressed in many ways. It can be expressed through appearances, inflections or tones of voice, and patterns of behaviors, along with many other ways of expression. Many individuals, most of whom are women, seek to find ways in which they can enhance their appearances or become more attractive. While some women use techniques such as dieting, exercise and makeup, other women turn to the medical field to alter their appearances. As I

previously mentioned, in the United States, the use of cosmetic surgery has doubled in the last decade and women are vastly over-represented among those who elect these surgeries (The American Society for Aesthetic Plastic Surgery, 2007:4).

There are many reasons why individuals elect to undergo cosmetic surgery. In the arena of cosmetic surgeries, physicians are left to interpret what surgeries will improve the appearances of those they have as patients and what surgeries are unnecessary. Surgeons interviewed by Dull and West (1991:57) indicate that for women the desire for cosmetic surgery is "normal and natural" while for men it must be justified by other reasons. Therefore, they viewed women's pursuit of cosmetic surgery as a "normal" way to "accomplish gender" (Dull and West, 1991:64), while men's pursuit of cosmetic surgery is based on functional reasons (better employment, being able to breathe better). However, from a poststructuralist vantage point gender performance is neither *normal* nor *natural* (Pascoe, 2007). Rather, the desire to alter an appearance is a product of cultural expectations. That surgeons who view the desire for cosmetic surgery by women as legitimate in terms of a normal or natural desire to correct a defect that must be repaired and illegitimate for men unless surgery is used to improve some form or function, suggests the importance we place on gendered cultural expectations (Dull and West, 1991). This claim is further supported given that, for women, cosmetic surgery is becoming seen as normal, rather than deviant among the general public in the United States today (Morgan, 1991).

There are many feminist perspectives on why women choose to undergo cosmetic surgery and beauty enhancements such as wearing make-up. I will discuss three of the feminist frameworks below. The first perspective derives from poststructuralism and employs the concepts of "self policing" and "the gaze" as developed in the work of Michel Foucault

(Foucault, 1977). The "male gaze" refers to the social pressure women feel to meet hegemonic standards of beauty or femininity (Gagne and McGaughey, 2002:816; Morgan, 1991). To achieve this approval, whether the approval is actual or imaginary, women regulate their bodies in ways such as, but not limited to, weight loss, makeup, and cosmetic surgery (Morgan, 1991). The increasing normalization of cosmetic surgery is pushing the boundaries of body modification and enhancing the power of this "gaze" while allowing women to meet the expectations they feel have been placed upon them by a patriarchal society (Morgan, 1991). Additionally, some theorists argue men too are rising to the "gaze" when they are participating in cosmetic surgery to illustrate either their masculinity or their sexuality (Bordo, 1999).

The notion of the "male gaze" is derived from the panoptical gaze discussed in Foucault's *Discipline and Punish* (1977:173). Like the prisoners in Jeremy Bentham's model Panopticon prison which Foucault discusses, women engage in disciplining and regulating themselves or "self policing." The Panopticon was a high, circular tower that allowed guards standing in the towers to maintain surveillance over prisoners. The height and design of the tower allowed the guards to see the prisoners and gave the illusion that a guard was always present in the tower, even when no one was present (Foucault, 1977:201). Thus, the guards were able to exert unverifiable power over the prisoners; the prisoners assumed they were always being watched by the guards, not being able to verify when they were actually under surveillance. In a similar way, women discipline their bodies at all times because they do not know when *enforcers of society* or rather the "panopticon male connoisseur" is observing (Bartky, 1988:34). In this case, the poststructuralist perspective highlights how people are passive objects of hegemonic discourses, specifically on feminine beauty.

Moreover, Bartky concurs with Foucault that power comes from everywhere, it is pervasive. The enforcers of society are hard to target because discourses from various media sources and numerous responses from others unite in a beauty ideal in a given time and place. Men exert power on women because men are not held to the same level of gendered beauty ideals as women. Without a doubt, whether real or imagined, the panoptical gaze or rather the *male gaze* causes women to actively police themselves (Gagne and McGaughey, 2002).

In direct contrast to the poststructuralist approach which highlights women as objects of normative or structural forces, there are feminist approaches like power feminism (Henry, 2004; Wolf, 1991). This approach views women as *active subjects* choosing cosmetic surgery so they can obtain a look they desire rather than as *passive objects* of any hegemonic pressures from society (Gagne and McGaughey, 2002). According to the power feminist approach, beauty is power in this society and women can enhance their power by using modern techniques, one of which is cosmetic surgery (Henry, 2004; Wolf, 1991). In this approach women maintain power despite any social pressures (Gagne and McGaughey, 2002). Cosmetic surgery enables women to accomplish a desired identity whether it is to appear younger, thinner, more American, more Caucasian, and more feminine while allowing her to feel as if she is actively exerting control over her body (Morgan, 1991).

This approach is reflected in a study by Gagne and McGaughey (2002:824) where women reported that "cosmetic surgery was just another feature of the technologies of beauty available to women, on a continuum with makeup, hair color, diet, exercise or the use of special bras." Additionally, women in this study reported that they considered cosmetic surgery because they felt "they are worth it" (Gagne and McGaughey, 2002:825), not due to any pressures from others. Yet, the authors of this study, Patricia Gagne and Deanna McGaughey (2002) view these

choices as “false consciousness” and as reflecting the impact of the hegemonic groups cultural ideals of beauty placed on women. Rather than assuming these authors are correct, this thesis will explore if individuals who pursue cosmetic surgeries are viewed as objects succumbing to cultural expectations or as subjects empowering themselves in exercising control over their bodies. Hence, this study will examine perceptions of the issue of social structure versus social agency in relation to cosmetic and sexual reassignment surgeries.

A third feminist framework used in this study is Intersectionality theory (Collins, 1990). The crux of intersectionality theory is its recognition of simultaneous, interlocking and multiple oppressions based on the social locations of race, gender and social class (Collins, 1990). This perspective would highlight how elective cosmetic surgery is only an option for individuals in privileged social locations. Undeniably, cosmetic surgery is generally undertaken by individuals who have the economic means to afford surgery and is less available to individuals with lower incomes (Gagne and McGaughey, 2002). As Figure 1 indicates, the cost of cosmetic surgery can range from $1000 to over $10,000 (see Figure 1) depending upon the type and number of procedures an individual is electing to have done to their body (Morgan, 1991).

Figure 1.1: Average Costs of Cosmetic Surgeries

Procedure	National Average	Total Expenditures
Abdominoplasty	$5,350	$991,544,589
Blepharoplasty (cosmetic eyelid surgery)	$2,840	$683,766,194
Breast augmentation - silicone gel implants	$4,087	$644,001,114
Breast augmentation - saline implants	$3,690	$892,490,535
Breast lift	$4,341	$547,740,074
Breast reduction (women)	$5,417	$829,274,709
Buttock augmentation	$4,250	$22,629,543
Buttock lift	$4,885	$18,501,921
Cheek implants	$2,840	$6,833,664
Chin augmentation	$2,254	$41,135,210
Facelift	$6,792	$938,332,057
Forehead lift	$3,337	$203,954,225
Gynecomastia, treatment of (male breast reduction)	$3,455	$70,068,803
Hair transplantation	$5,874	$115,596,766
Lip augmentation (other than injectable materials)	$1,611	$17,194,980
Lipoplasty: Suction-assisted	$2,920	$1,065,095,608
Lipoplasty: Ultrasound-assisted	$2,963	$272,800,583
Lower body lift	$8,043	$102,232,154
Otoplasty (cosmetic ear surgery)	$3,085	$87,655,016
Rhinoplasty	$4,357	$661,376,647
Thigh lift	$4,783	$88,156,130
Upper arm lift	$3,864	$84,503,776
Vaginal rejuvenation	$2,434	$10,967,459
Total - Surgical Procedures		$8,395,851,754

Figure retrieved from (The American Society for Aesthetic Surgery, 2007:13)

Moreover, studies suggest cosmetic surgery in the United States is practiced to obtain Caucasian features which are viewed as more beautiful for women (Gagne and McGaughey, 2002). For example, an ethnographic study by Eugenia Kaw (1993) reports that Asian American women seek cosmetic surgery to modify their eyes and noses and to overcome racial stereotypes regarding Asian American women. They feel as if society labels Asian American women as passive and lacking emotion based upon their narrower eyes and smaller noses as compared with their white counterparts (Kaw, 1993). Kaw reports that cosmetic surgeons who perform these procedures characterize Asian eyes and noses as abnormal even when they are trying not to associate Asian physical features with negativity (Kaw, 1993).

Elective cosmetic surgery also reflects ageism in our society. It is used by many to restore a youthful appearance (Gagne and McGaughey, 2002). The negative attitudes associated with wrinkles, sagginess, fat deposits and other signs of aging promote the idea that facelifts, liposuction, Botox, and tummy tucks are becoming a necessity (Dull and West, 1991). Cosmetic surgeons are providing these age-conscious women with a way to attain at least an illusion of the

fountain of youth. These procedures are being used as an extension of the technology that is available to women in the same ways as make-up and clothing. This study will explore how socially acceptable these surgical avenues for gender enhancement are today and will compare and contrast them to more radical forms of surgery – sexual reassignment surgeries.

SEXUAL REASSIGNMENT SURGERIES & TRANSCENDING SEX/GENDER

There is much debate among social scientists as to why individuals participate in transgender practices. It appears that the most hegemonic view is the essentialist position that assumes a core or essential identity. Some theorists assert that transsexual individuals want their sex and gender both to match and to reflect some authentic or core self. This perspective is visible in Anne Fausto-Sterling's assertion that transsexuals identify as the "opposite sex" (Fausto-Sterling, 2000:107). Similarly, research conducted by Patricia Gagne and Richard Tewksbury (1999:63) suggests that transgendered individuals are seeking ways to "be themselves" rather than to challenge traditional gender norms.

This essentialist view of sex and gender is also reflected by individuals who state that their desire to modify their bodies through sexual reassignment surgery is to complete a transition process. For example, in interviews with pre-operative F-T-M (female to male) transsexuals (TS), one individual reported he wanted the surgery to alleviate feelings of inadequacy for lacking a penis when being intimate with others (Devor, 1993). Other respondents feared rejection from intimate partners because they thought they were not considered to be 'real' men (Devor, 1993; Wilchins, 2004).

Other trans-persons felt that having their biological anatomy reflect their gender performance was crucial even for friendships or entering the worlds of males and females. For

example, one pre-operative F-T-M transsexual reported a desire for male kinship and a threat of exposure without having the correct genitalia, a penis (Devor, 1993). Similarly, many participants in a study conducted by Patricia Gagne and Richard Tewksbury (1999) of M-T-F (male to female) transsexuals reported that they wanted access to and acceptance in the social spheres of females. Having a female body granted them access into the social worlds of women (Gagne and Tewksbury, 1999).

This essentialist position is further visible when medical professionals view sexual reassignment as a way to fix or cure individuals' genitals to "correctly" align them with their identity (Gagne and Tewksbury, 1999; Wilchins, 2004). Indeed, this viewpoint that the individuals were born with a defect and that they can be fixed is a motivating factor for medical professionals to attempt to understand and a willingness to perform sex reassignment surgeries (Gagne and Tewksbury, 1999).

Indeed, this essentialist view of sex and gender is pervasive. It is also reflected in the frequency with which transgendered individuals report experiences of having their appearances regulated in various ways such as parents enforcing what they believe to be proper clothing and hairstyles (Gagne and Tewksbury, 1999). Additionally, reports of being ridiculed and physically assaulted as children are common among transgendered youths (Gagne and Tewksbury, 1999). As adults, they are also ridiculed and assaulted as seen in the case of Brandon Teena who was raped and murdered (Lambda Legal, 2008). One of the most radical essentialist views is espoused by Janice Raymond who argues "that transsexual women are not women but deviant males and transsexual men are not men but deviant females" (Gagne and Tewksbury, 1999:63). In short, Raymond's outlook refuses to even acknowledge the sex transformations of transsexual individuals.

Even given the pervasive notion that there is an essentialist or core sex identity that should match one's gender, research suggests that it is more socially acceptable for females to appear more masculine than for males to appear more feminine. Indeed, males appearing more feminine are subject to harsher stigmatization (Pascoe, 2007). C. J. Pascoe reports in a study that females who portrayed themselves as the "penetrators rather than the receivers of sexual activity" were more socially accepted than males who appeared to take on feminine roles (2007: 153). In American society females have been considered submissive creatures and males as dominant (de Beauvoir, 1990); thus women are classified as the weaker and more passive gender. Thus, individuals who are considered feminine or effeminate are perceived as weaker and are devalued based on such perception of this characteristic. In contrast, individuals who are considered masculine are perceived as more powerful and less vulnerable. Hence, the greater stigma attributed to men who are perceived as effeminate.

A second reason given why some individuals desire sexual reassignment surgery has more to do with sexuality than a harmonious relationship between sex and gender. That is some people argue that having sexual reassignment surgery provides a way for individuals to escape identifying their sexual orientation as homosexual. However, the willingness of individuals to identify as gay or lesbian before and after sexual reassignment surgeries would seem to refute this claim (Devor, 1993). Nevertheless, the association of homosexuality with transgender contributes to the subordination and rejection of individuals who identify as transgender (Wilchins, 2004). In short, homophobia or the fear of homosexuality is an important reason why transgendered people are stigmatized in American society. According to Susan Bordo, "homosexuality became construed as a disease – of effeminacy" for men (Bordo, 1999:21); homosexual men become viewed as less masculine than heterosexual men. Although women

who are perceived as masculine are also stigmatized; simply put, the literature suggests that men who are perceived as effeminate may be subjected to harsher stigmatization. In this sense, transsexuality and transgender are also issues of sexual orientation. They not only challenge and transgress gender norms, but also resist heterosexuality.

THEORETICAL BACKGROUND

SYMBOLIC INTERACTIONISM

Symbolic interactionism is important to this study in that individuals' concepts of self are influenced by how they perceive others to view them within the context of social interactions. In particular, this study draws from the works of George Herbert Mead, Charles Horton Cooley and Erving Goffman when discussing the formation of the self (Mead, 1934; Cooley, 1998; Goffman, 1963). All of these theorists view the self concept as a product of social interaction. For example, Charles Horton Cooley used the concept of the "looking-glass self" (Cooley, 1998:164) to discuss how individuals see themselves based on how they perceive significant others to respond to them in the process of interaction. Similarly, Mead breaks the self concept into the "I" and "Me" to discuss the reflexive process by which the self is both a subject ("I") and object ("Me"), constantly acting and reflecting on others perceptions of his or her acts in the process of social interaction.

In the process of social interaction, verbal and non-verbal interaction can be communicated by gestures or signs. Gestures are social acts used between two organisms to communicate, such as a smile (non-verbal) or a verbal greeting such as hello (Mead, 1934). "The response of one organism to the gesture of another in any given social act is the meaning of that gesture" (Mead, 1934:78). An example of this could be, having someone holding a door open for a stranger. The stranger could respond to this gesture in many ways. One way is to smile and give the interaction a positive meaning; while another way is to frown and give the interaction a negative meaning.

Gestures are "also in a sense responsible for the appearance or coming into being of the new object – or new content of an old object – to which that gesture refers through the outcome of the given social act in which it is an early phase" (Mead, 1934:78). Thus, these interactions among individuals can either create new experiences or give new meanings to old experiences; individuals could choose to alter their behavior based upon the meaning they interpret from their experiences. "Objects are in a genuine sense constituted within the social process of experience, by the communication and mutual adjustment of behavior among the individual organisms which are involved in that process and which carry it on" (Mead, 1934:78).

> Two main points are being made here: (1) that the social process, through the communication which it makes possible among the individuals implicated in it, is responsible for the appearance of a whole set of new objects in nature, which exist in relation to it (objects, namely, of 'common sense'); and (2) that the gesture of one organism and the adjustive response of another organism to that gesture within any given social act bring out the relationship that exists between the gesture as the beginning of the given act and the completion or resultant of the given act, to which the gesture refers (Mead, 1934:79).

Hence, the self is created through the experiences gained by these communicated meanings through social interaction. Additionally, these social interactions and responses are used to create new meanings and definitions of the self. Thus, each individual involved in the social interaction influences the other, they are reflexive. Symbolic interactionists believe that the self is a product of interpreted social interaction.

THE SELF AND STIGMA

Erving Goffman is the symbolic interactionist who has done the most work on stigma and the self concept.[1] Individuals are stigmatized when they have an attribute that is viewed as not "normal" or "other" by society. Goffman defines stigma as "an attribute that is deeply discrediting" (Goffman, 1963:3). Goffman discusses various types of stigma's that range from "abominations of the body – to the various physical deformities" (Goffman, 1963:4) to:

> blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty, these being inferred from a known record of, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior. Finally there are the tribal stigma of race, nation, and religion, these being stigma that can be transmitted through lineages and equally contaminate all members of a family (Goffman, 1963:4).

Individuals are treated differently based upon whether they are perceived as following traditional gender norms or challenging them. In American society, when individuals surgically modify their bodies within their assigned gender it is viewed as "normal" and socially acceptable (Morgan, 1991). However, when individuals modify their bodies outside of their assigned gender it is viewed as a form of deviance and socially unacceptable; thus it becomes stigmatized (Fausto-Sterling, 2000; Gagne and Tewksbury, 1999). The stigma attached to this perceived deviance can become part of individuals' identities, subjecting them to stereotypes, such as being viewed as less than human (Goffman, 1963) and denying them human rights based on

[1] Goffman views the self is composed of two parts: one's "virtual social identity" and one's "actual social identity". According to Goffman, stigma arises when an individual's virtual and actual social identities do not coincide. Unlike poststructuralists, Goffman assumes a core identity. However, if we recognize that most individuals' assume they have core identities then, whether or not such core identities actually exist, Goffman's work can still inform the process by which individuals interpret stigma and stigmatized identities.

these stigmatized identities (Lambda Legal, 2008). As Goffman writes: "society establishes the means of categorizing persons and the compliment of attributes felt to be ordinary and natural for members of each of these categories" (Goffman, 1963:2). These ways of categorizing individuals are brought to light in the social interactions of individuals' daily lives.

Individuals who are attributed stigma have multiple ways of viewing themselves and of coping with their stigmas. "It has been suggested that the stigmatized individual defines himself as no different from any other human being, while at the same time he and those around him define him as someone set apart" (Goffman, 1963:108-109). Stigmatized individuals see themselves as undeserving of discriminatory treatment. As Goffman explains, the individual has some sort of feeling based upon the way others view them, such as pride or mortification. Yet, stigmatized individuals also recognize their differences based upon stigmas. They want to be accepted regardless of their stigmatized attribute but know they will be treated in respect to this attribute. "A desirable pattern of revealing and concealing is suggested." (Goffman, 1963:109). Stigmatized individuals may try to behave in ways that conceal their stigmatizing attributes so that they too can have access to the privileges enjoyed by normals. "The stigmatized person is almost always warned against attempting to pass completely" (Goffman, 1963:109). When stigmatized people attempt to completely conceal their stigmatized attribute from others, they can suffer additional consequences.

According to Goffman, individuals deemed as abnormal should be aware of their stigma and know their expected roles and subordination in relation to the rest of society (Goffman, 1963:129). Additionally, he asserts that individuals have few options at this point. They can conform to the expected subordinated status, they can alienate themselves from the rest of "normal society" or they can attempt to conceal the discrediting attribute by a combination of

passing and covering for a normal (Goffman, 1963:131). The concept of "passing" is when individuals present themselves other than how they internalize themselves to be (Kroeger, 2003:7). Additionally, "covering" is when others aid an individual in concealing a negative attribute; they help the person prevent the attribute from being recognized to prevent the individual from becoming stigmatized (Goffman, 1963:130). These people who are considered normal, who know about a discrediting attribute of another individual and help to conceal it are referred to by Goffman (1963:28) as the "wise." The "wise" may work in environments around "others," such as a physical therapist who is helping a person with a physical disability and who assists in concealing this fact from the rest of society (Goffman, 1963). As Goffman writes: "the self must not only be offered, it must be accepted." (Goffman, 1963:28-29). Hence, the "wise" accept stigmatized individuals the way they are and treat them as normal individuals (Goffman, 1963).

Poststructuralists and Queer Theorists take a more radical approach to these issues. By deconstructing sex and gender, as well as any notions of core identities, they argue that all notions of "normality" are suspect. In turn, poststructuralists and queer theorists position themselves against "normality" and call for fluid notions of identity that foster difference and resistance to dominant discourses and institutions as we shall see below.

POSTSTRUCTURALISM AND QUEER THEORY

While poststructuralism originated with the work of Michel Foucault, the origins of queer theory are rooted in many fields such as "feminist studies, gay and lesbian studies, social constructionism, cultural theories, poststructuralism and literary criticism" (Ritzer, 2008:637). Nevertheless, Michel Foucault's book *The History of Sexuality, Volume I* (1978) is thought to be

one of the earliest inspirations for queer theory. Indeed, the most influential theoretical perspectives in shaping queer theory generally are viewed as social constructionism and poststructuralism (Ritzer, 2008).

Unlike Goffman, Foucault's poststructuralism discusses how the concept of "normality" is a historical creation that accompanied the rise of social scientific discourses in modern societies. According to Foucault, the rise of these scientific discourses such as medicine, biology, psychiatry, sociology and anthropology typologized, categorized, and labeled people and their social behaviors (Foucault, 1977; Foucault, 1978). The typologies created by these modern sciences developed privileged discourses in terms of what was regarded as normal or abnormal, perverse or socially accepted (Foucault, 1977). Thus, these various categories or identities of sex, gender and sexual normality were created by these discourses. It is for this reason that Foucault argues that discourses (knowledge) and power create people as subjects; they create the very identities by which we define ourselves and each other. It is also for this reason that poststructuralists re-evaluate claims of knowledge, deconstruct social phenomena and challenge notions of fixed identities (Ritzer, 2008).

In terms of gender, poststructuralists argue that people acquire masculinity or femininity through cultural attachments with the "sexed body," which refers to the sex assigned to the individual (Butler, 2006). American society normalized binary constructs of sex and gender. Hence, sex is constructed to fit either of the two categories of male or female while gender is categorized by characteristics such as feminine and masculine (Meyerowitz, 2002; Fausto-Sterling, 2000). Yet these binary categories of male and female, masculine and feminine do not account for all of the variations of individuals' chromosomes, genitals, gonads, or of their performances of masculinity or femininity.

Even biological scientists have recognized the inadequacies of binary concepts of male and female. For example, Anne Fausto-Sterling discusses how the female sex can be assigned to an individual based either on XX chromosomes, the presence of a vagina, or the presence of ovaries and fallopian tubes (Fausto-Sterling, 2000). Additionally, the male sex can be assigned to an individual based on XY chromosomes, the presence of a penis, or the presence of testies (Fausto-Sterling, 2000). The person may have been born with XX chromosomes and a penis which is characteristic of Congenital Adrenal Hyperplasia, or XY chromosomes and a vagina which is characteristic of Androgen Insensitivity Syndrome (Fausto-Sterling, 2000). Hence, even biologically speaking there are many options or variations for sex identities.

No doubt this type of work complements poststructuralism and queer theory by undermining the notion of binary thinking and suggesting the possibility of multiple sexes. However, poststructuralists and queer theorists disassociate sex from the body in even more radical ways. That is by focusing on how bodies are dependent upon discourse, they illuminate how privileged discourses on sex and gender are interwoven within the institutional structures of modern societies. For example, in the Unites States, necessary documents such as birth certificates, marriage licenses, driver's licenses and other government documents fail to provide options for individuals who do not fit into the male/female categories. These practices not only force people into categories, but also privilege those who easily fit into them.

Poststructuralists and queer theorists also reject binary categories because they are constructed hierarchies that entail implicit power (Wilchins, 2004). Binary categories such as male and female, masculine and feminine, and heterosexual and homosexual all imply a dominant category and an "other" lesser one (Wilchins, 2004; Fausto-Sterling, 2000; Butler, 2006). One category represents what is normal, while the other is lesser, abnormal or

ambiguous. Feminist theorist, Simone de Beauvoir, wrote "otherness is a fundamental category of human thought" (1949:340). Individuals define themselves by who and what they are not (de Beauvoir, 1949). It is in this sense that poststructuralism locates these binaries in language and discourse. It is also in this sense that queer theory asserts that homosexuality and heterosexuality "are signs in a larger system whose meaning is derived from their relationship to one another and are part of the same underlying system of unstable and shifting cultural and linguistic signification (Ritzer, 2008:637).

The strong social constructionism of poststructuralism and queer theory seeks to "illustrate the social nature of phenomena and to debunk myths of 'naturalness' or 'inherency'" (Ritzer, 2008:637). The relationship between knowledge and power is thus an important component of poststructuralism and queer theory (Ritzer, 2008). In turn, by challenging hierarchies of identity, both approaches promote the excavation and retrieval of marginalized voices (Ritzer, 2008).

In regard to transsexuality, "it is no longer possible to derive a judgment about stable anatomy from the clothes that cover and articulate the body. That body may be preoperative, transitional, or postoperative; even 'seeing' the body may not answer the question: for *what are the categories through which one sees?*" (Butler, 1990:xxiv). The learned lenses of gender, sex, sexual orientation and gender identity restrict the ways in which people see individuals within it. In this way, the "naturalized knowledge of gender operates as a preemptive and violent circumscription of reality" (Butler, 1990: xxiv). The categories of gender (masculinity and femininity) define individuals and ignore individuals who do not conform to these categories. These individuals who are not considered part of the either or categories are subject to forms of exclusionary practices because they are not deemed to fit within the 'normal' categories of

gender. By challenging the hegemonic, dominant, constructions of gender, sex, sexual orientation and gender identity we can create a discourse that encompasses a greater reality of our society.

These exclusionary practices are exercised on individuals who are marginalized and not given a voice by the same individuals and structures that create these gender categories (Butler, 1990). In this, the individual's identity is influenced by their social interactions with others. Thus, similar to the view of symbolic interactionists, poststructuralists and queer theorists view social interactions as giving meaning to the gestures involved and as exercising power over individuals based upon a characteristic that is deemed to be abnormal by society. For example, Butler (1990) discusses the concept of compulsory heterosexuality as an exclusionary practice. The practice of heterosexuality is displayed in social interactions of individual's daily lives; through communication with others, the media, and education. These exclusionary practices set someone apart due to an attribute that is characterized as other than normal, hence, they are attributed with stigma.

These everyday life experiences of power and exclusion are what Foucault means when he claims that power is asserted everywhere (Foucault, 1978). Power and domination come from all angles, they are not just asserted from top to bottom. Therefore, individuals restrict or police their behaviors and appearances because they do not know if they are being watched and if so by whom. Hence, the panoptican normative gaze is ever present in regard to issues of gender, sex and sexuality, just as it was operative in regard to beauty ideals. Individuals police themselves because they always have the chance of having their flaws discovered and stigmatized.

One of the major purposes of queer theory "is to expose the tenuousness of gender 'reality' in order to counter the violence performed by gender norms" or the rigid behavioral

expectations based on one's gender (Butler, 1990: xxv). In drawing from poststructuralism, queer theory and symbolic interaction, I have tried to show how such exclusionary practices are done through the micro-politics of communicated meanings and gestures that exclude practices that are not deemed as normal. I will now investigate the extent to which cosmetic and sexual reassignment surgeries are deemed as "normal" by examining their levels of social acceptance as an indirect measure of attitudes toward sex and gender today.

STUDY DESIGN AND METHODS

OVERVIEW

The ultimate goal in this study is to explore social approval towards cosmetic and sexual reassignment surgeries. Drawing on a multi-method research design, this study seeks to find how individuals view various types of surgeries such as cosmetic and sexual reassignment and why they may view some forms of surgery more or less acceptable than other forms of surgery. I use two parts to conduct this study: vignette questionnaires and interviews. This study consists of 303 participants. There are 303 respondents to vignette questionnaires and 16 in-depth interviews.[2]

PART ONE: VIGNETTES

Participants:

This study sought to recruit no less than two hundred and forty (240) participants to obtain a decent sample size. This was the minimum goal so that each version of the vignette would have no less than fifteen (15) individuals of diverse backgrounds rating their levels of social approval or social acceptance. The recruitment took place in required lower level English courses and recruited both students and faculty. This study went beyond the original desired sample size, as to sample all of the classes that the researcher scheduled to sample. Participants were not offered any incentives for participation. A more detailed description of participants is provided later in this section.

[2] Additionally, there was a pretest study conducted to help ensure validity and clarity of directions.

Design:

My research uses vignettes as the primary method to test the existing theories concerning elective surgeries. Vignettes are brief descriptions of a person or situation which contain precise references to important underlying factors in the decision-making process of participants (Alexander and Becker, 1978). Social psychological research has used vignettes to assess causal relationships in regards to both human attitudes and behavior (Alexander and Becker, 1978). Inferring causality, and not merely correlation, is one benefit to using a vignette rather than a survey. We can vary the precise characteristics given in the description to see the effects on people's attitudes (Alexander and Becker 1978). Rather than the specific subject matter, the point of using vignettes is to look at the context of the surgeries and the underlying processes of social approval/disapproval. Vignettes are valuable for a number of reasons. Vignettes allow us, researchers, to directly manipulate a scenario rather than manipulate individuals within the real world. Another advantage of vignettes is that the participant "is not likely to consciously bias" their response because rather than seeing the whole range of questions, procedures and contexts of surgeries, the participants are only given information based upon the context of one surgery (Alexander and Becker, 1978:95).[3] Participants are also not always aware of their own decision-making process and the variation of characteristics and combinations of the characteristics allows researchers to more effectively locate the similarities/differences in participants' attitudes; we can locate these precise differences based upon the factorial design (Alexander and Becker, 1978). For example, in this study we will be able to ascertain whether social approval is based on the type of surgery, the body part, or the sex of the person undergoing the surgery.

[3] This is also an advantage of using vignettes rather than surveys.

This study uses 2x2x2 factorial design vignettes.[4] The vignettes provide a brief description and background that introduce the person (Pat) and surgeries as follows:

> Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features, others may feel they were born into the wrong body.
> Pat works for a computer company and has most recently paid off all of his/her student loans. When not working, he/she enjoys reading and the great outdoors.

Next, I provided the context of the surgery which varied by the normativity of the procedure and the body part and the individual's sex (see Appendix C for actual vignettes).

- A1: Non-normative, non-gendered procedure, sex is male
- A2: Non-normative, non-gendered procedure, sex is female
- B1: Non-normative, gendered procedure; sex is male
- B2: Non-normative, gendered procedure, sex is female
- C1: Normative, non-gendered procedure, sex is male
- C2: Normative, non-gendered procedure, sex is female
- D1: Normative, gendered procedure, sex is male
- D2: Normative, gendered procedure, sex is female

Versions A1 and A2 represent a male or female having a non-normative and non-gendered procedure. So in Versions A1 of the vignette, Pat is a male choosing to undergo an operation that amputates his leg. In A2, Pat is a female choosing to undergo an operation that amputates her leg. Version B1 of the vignette refers to Pat being a male choosing to have an operation to obtain breast implants and representing sexual reassignment surgery. Version B2 of the vignette refers to Pat being a female choosing to have an operation to having a penis augmented; also representing sexual reassignment surgery. Version C1 of the vignette is Pat being a male who chooses to undergo an operation on his nose, rhinoplasty. Version C2 of the vignette is Pat being a female who chooses to undergo an operation on her nose, rhinoplasty. Versions C1 and C2 represent a male or female having a normative and non-gendered procedure. Version D1 of the

[4] A factorial design "consists of a set of single-factor designs in which the same independent variable is manipulated but in combination with a second independent variable" —and, in this case, a third independent variable." (Keppel, 1991:200).

vignette is a male undergoing surgery to enlarge his penis, male penis augmentation. Version D2 of the vignette is a female undergoing surgery to enlarge her breasts, female breast augmentation. Versions D1 and D2 represent an individual having a normative and gendered procedure. Versions A and B are considered non-normative because they are rare forms of elective surgeries in American culture while versions C and D are considered more so normative because they are common forms of elective surgeries in American culture.[5] Versions B and D are considered gendered because they are associated with parts of one's biological anatomy that the greater culture employs to determine one's sex, While versions A and C are associated with body parts that are not part of one's biological anatomy that is generally associated with one's sex.

Procedure:

Each participant then received one of the eight versions of the vignette.[6] Vignettes were randomly assigned, so each individual had an equal chance of receiving any one of the eight versions. By assigning participants randomly to the various conditions, we are also able to randomly control on ability, status, and environmental factors among individuals (Keppel, 1991:15). Therefore, we can be confident that any effect observed among vignette groups will be the vignette effect and is not an effect of the participants such as their race, sex, etc.[7]

Participants were then asked to rate their degree of approval/disapproval for the surgery based on an eleven point Likert scale. The Likert scale ranged from "1" indicating "Strongly Disapprove" and "11" indicating "Strongly Approve" with a median of "5.5" being neutral. Thus, any rating below 5.5 indicates a form of disapproval and any rating above 5.5 indicates a form of approval, whether somewhat or strong. Next, six questions were asked and the

[5] As indicated by various statistics, lack of statistics, and theory in the introduction and background of this paper.
[6] I distributed informed consent forms to the participants. Each participant was given two consent forms; one to be signed and returned to the researcher and one for the participant to keep for their records.
[7] If done correctly, there should be no significant difference on the demographic characteristics of participants with regards to their means of approval within their vignette groups—as was the case in this study.

participants were asked to rate the degree in which they approve or disapprove of the questions on an eleven point Likert scale. The questions were as follows:

- I would like to *meet* Pat.
- I would not want to *work* with Pat.
- I would let Pat *teach* computer lit to my child.
- I would not want my family member *dating* Pat.
- I would be *embarrassed* to be seen with Pat
- I would *donate* to Pat's surgery fund.

Finally, each participant was asked open-ended demographic questions and whether they would be interested in further participating in this study via an interview in the concluding section of the vignette.

PART TWO: IN-DEPTH INTERVIEWS

Participants:

Participants were drawn from the vignette questionnaires. All interview participants indicated an interest in further being a part of this study on their vignette questionnaires. They were then contacted at a later date and interviews were set up. Sixteen (16) individuals participated in in-depth interviews. These individuals ranged in levels of social approval, which ranged from strong disapproval to neutral to strong approval, which allowed me to have a diverse range of views toward the various surgeries.

Design:

I began each interview by going over the participant's rights to skip any questions they did not wish to answer and their right to stop participating at any time in the interview.[8] Next, I began with the following brief introduction:

> Cosmetic surgeries are used generally by individuals to enhance their appearance while sex reassignment surgeries are used largely to modify an individual's sex. While both surgeries are very different in nature, they are both forms of body modification. We want to explore attitudes toward body modification.

Next, I ask a range of questions based on the outline below (see Appendix E for interview questions):

- Non-Surgical forms of body modification such as tattoos and piercings
- Elective versus non-elective surgeries
- Communities: how they think friends and family would view surgeries
- Personal: how they would view surgeries if a friend or family member would have them

I asked individuals about non-surgical versus surgical forms of body modification to see if their views differed based on if the modification was viewed as temporary or permanent and to see if they were concerned with physical trauma to the body. I asked individuals about elective versus non elective surgeries to compare and contrast attitudes between and within the normative and non-normative procedures/operations such as elective leg amputations, sexual enhancements, sexual reassignments and rhinoplasties. I asked individuals questions regarding their communities to see if they think their communities reflect their own views and possibly the reasons. I then asked individuals questions about how they view the surgeries if they are

[8] In-depth interviews are used in this study to expand on information I have collected from the vignettes. Interviews are qualitative research methods that help illustrate an individual's perceptions so that as the researcher, I get a more precise picture of why they view a surgery as socially acceptable or not (see Appendix E for interview questions). The interviews allowed me to probe for answers and to clarify any interview questions that may seem confusing (Babbie, 2005). Interviews allow researchers to control the line of questioning and the participants to better clarify some ideas or get more information regarding their opinions (Creswell, 2009).

undergone by someone they know such as friend or family member to see if their views would change based upon the social distance of the individual undergoing the surgery.

DEMOGRAPHICS OF PARTICIPANTS

Vignette Questionnaires

The data from the questionnaires for this study come from 303 college students and faculty from the University of New Orleans.[9] Participants ranged from 18 to 58 years of age and the average age of participants was approximately 22 years of age. There were slightly more females (54%) than males (46%) participating in this study. In regard to race, approximately two-thirds of participants identified as Caucasian and about one-fifth identified as African American (see Figure 2). A vast majority of the participants self-identified their sexual orientation as heterosexual (see Figure 2).

Figure 2: Participants Race and Sexual Orientation, by percent (%)		
Race		(279)
	White / Caucasian	58.4
	Black/African American	21.9
	Asian/Vietnamese/Pacific Islander	10.4
	Hispanic/Latino	3.9
	Biracial/Multiracial	1.8
	Other	3.6
Sexual Orientation		(259)
	Heterosexual	94
	Homosexual	2.3
	Bisexual	3.0
	Queer	<.01

[9] One class of participants was dropped from the study. After the questionnaires were already distributed, I realized that there were possible language and cultural barriers that may have biased their responses. These individuals identified as ESL students and seemed eager to indicate responses to obtain approval from the other individuals within the room. This consisted of approximately eight participants.

Interviews

I recruited participants for interviews while collecting the questionnaires. I asked individuals who were interested in participating in interviews to indicate their interest by leaving their contact information in a space provided on the questionnaire.[10] I attempted to contact each individual who left contact information; of these individuals, eighteen replied to me via email. I interviewed sixteen of the original eighteen that responded; the other two individuals were not able to participate due to scheduling conflicts.

The average (mean) age of the participants was twenty-four years of age, of which, seven identified as males and nine identified as females. Thirteen of the participants identified racially as white or Caucasian while two identified racially as black or African American, and one participant did not indicate a race. Eleven of the participants (68%) indicated their sexual orientation as heterosexual, one individual indicated his/her sexual orientation as gay (6%), one individual identified as queer (6%) while the remaining participants did not indicate a sexual orientation. Every participant identified their primary language as English. Ten of the participants affiliated themselves religiously with Christianity, one identified as an Atheist, one as a Buddhist and the remaining four indicated some other religious affiliation.

[10] Two of the individuals were recruited from the pretest.

DATA ANALYSIS

The questionnaires were coded and analyzed. Quantitative data was analyzed using statistical software.[11] I primarily drew on t-test and analysis of variance as appropriate for my independent variables. The open-ended responses on the vignettes were then organized and grouped. I looked for the various explanations given for participant's ratings and noted responses and reasons.

Furthermore, I transcribed the audio recorded interviews verbatim. I noted pauses and sighs but did not transcribe any other non-verbal cues. Additionally, I use a technique called pattern matching to analyze the interviews. I look for any patterns or themes that will emerge from the interviews by listening to the audio-tapes and reading and re-reading the transcriptions. When I discuss the themes that emerge from the interviews, I use interview numbers to discuss the interview, to help ensure confidentiality.[12]

[11] I used either STATA or SPSS.

[12] I specifically do not indicate participant's sexual orientation when discussing the interviews due to only one respondent identifying as *queer* and only one as *gay*. In the informed consent, I ensured all participants that I would take care to avoid revealing any information within my findings that could be used to relate their responses to them specifically.

LIMITATIONS

There are a number of limitations to this study. First, this study did not explore attitudes towards individuals who may use cosmetic surgery to appear more androgynous or any differences in race.[13] These were outside the scope of my vignette design but should be considered in future research.

Secondly, the interviews have geographical limitations because they drew from only one college campus; this study does not study attitudes across the state or to various populations and may have class bias because college students tend to fall higher on the socio-economic scales than non-college students.

Additionally, there is always the concern of any interaction effects. As such, I was sensitive to my appearance, facial expressions, verbal cues and body language when interacting with respondents. Also, I am asking individuals to share their thoughts along with personal information, so I must take care to ensure confidentiality to any and all participants in this study. Also, in this section participants are asked at the end of each interview if they have anything they would like to add, comment on, or discuss about the study; this allows them flexibility in directing the interview areas such as androgynous appearances or other areas.

Methods were chosen based on their complimentary nature; where the strengths in one compensate for the weaknesses in the other and vice versa. Overall, I believe this research design was strong and my results are valid.

[13] We know from previous studies that race and social class of individuals tend to effect individuals views so this was excluded due to time constraints and existing literature than informs us.

FINDINGS

This section first discusses the findings from the vignette study and then the findings from the interviews. The first section titled *Vignette Questionnaires* gives an overview of the trends in approval and the participants' justifications for their ratings of the surgeries. The next section titled *Interviews* discussed the main themes that emerge in the interviews, arranged by the frequency in which they appear, and I discuss how I analyze and interpret these themes. I present the findings in this sequential way to first illustrate the overall trends in approval and then to understand participants' reasoning behind these trends.

VIGNETTE QUESTIONNAIRES

This section will first explain trends in approval for the various surgeries by discussing the differences between the means and various significance levels (see Appendix F for detailed statistical figures). The differences in the means reflect trends in approval across a population, as previously mentioned in the methods section above.

Next, this section briefly discusses participants' justifications in rating their version of the vignette. The justifications are explained by the frequency in which they were given beginning with the most frequently expressed justification (see Figure 3.1 below for more information). The participants' justifications are important because these justifications also surfaced as major themes within the interviews.

Approval/Disapproval of the Surgeries

As previously mentioned, participants were asked to rate their approval/disapproval of a surgery on an eleven point Likert scale. Ratings below 5.5 indicated various degrees of disapproval, while ratings above 5.5 indicated various degrees of approval. The means of each

version of the vignette were used to interpret the trends in approval for the surgeries. Each surgery is broken down by the sex of the individual pursuing the surgery. The trends were as follows (See Figure 5.3 in Appendix F for additional statistics):

- Elective Leg Amputation Surgery
  - Male (m=4.0)
  - Female (m=4.3)
- Sexual Reassignment Surgery
  - Male (m=5.4)
  - Female (m=5.2)
- Penis/Breast Augmentation
  - Male (m=6.1)
  - Female (m=7.0)
- Rhinoplasty
  - Male (m=6.1)
  - Female (m=6.2)

The non-normative procedures, elective leg amputation and sexual reassignment surgery, fell below 5.5 and varied in levels of disapproval. The normative procedures, penis//breast augmentation and rhinoplasty, fell above 5.5 and varied in levels of approval. Among the non-normative procedures, elective leg amputations were disapproved of more than sexual reassignment surgeries. Among the normative procedures, penis/breast augmentations and rhinoplasties had very similar levels of approval. This is an interesting finding because among the non-normative procedures, the gendered procedure (sexual reassignment surgery) has a slightly higher rating than the non-gendered procedure. Likewise, among the normative procedures, the ratings do not seem to differ significantly. I interpret this finding as significant because based on the previous literature I expected gendered procedures to be slightly less approved of than the non-gendered procedures. I expected this because many individuals view sex as biological or essential and these surgeries, in theory, would be altering nature.

Individuals' ratings of degree of social approval/disapproval seem to be statistically significant (p=0.0084) when using analysis of variance to account for their views toward the

surgeries, meeting the individual (p=0.005) who have undergone the surgery, allowing the individual to teach their child (p=0.000), having a family member date the individual (p=0.000), and being embarrassed to be seen with the individual (p=0.001). However approval/disapproval for working with the individual (p=0.087) who has undergone the surgery and donating to their surgery fund (p=0.502) does not seem to be statistically significant.[14]

Justifications given for Approval/Disapproval of the Surgeries

While the individuals' levels of approval/disapproval varied, roughly sixty percent (60.7%) of the individuals who participated in the vignette questionnaires indicated a justification for their approval/disapproval for the version of the surgery they received. The differences between the sexes of the individuals having the surgery were not statistically significant and neither were the differences based upon the respondents' sex when using t tests. The overall approval/disapproval of the surgeries varied by the context of the surgery such as the procedure being performed and the body part it involved (see Figure 3.1 below).

Approximately half of the participants (50.5%) who listed an explanation, linked the approval of the surgeries as related to the liberal rights of an individual to control his/her own body with comments such as:

- "This is Pat's choice. He has to live with it. It does not bother me."
- "It's her body. She can do with it what she wants."
- "If she wants them it's her choice."
- "It's Pat's body and choice to do what he pleases as long as it doesn't infringe with other's life."
- "It's her choice-what she wants to do with her body parts. So, if she thinks her life will be better after the surgery, then it's her decision."

These individuals' approval of surgical forms of body modification such as cosmetic, sexual reassignment surgeries and elective leg amputation (for a few respondents) were viewed as part

[14] However, when compared by race, if individual would donate to Pat's surgery becomes significant.

of a person's right to their own body. This suggests that the ways in which individuals alter their bodies should ultimately be left to individuals to decide.

Figure 3.1 Major Justifications Respondents Given in Vignette Questionnaires for Ratings of Approval/Disapproval of Surgeries				
Major Reasons		Number (#) of Participants	Percent (%) of Participants who indicated a response (n=184)	Percent (%) of Total Sample (n=303)
Liberal Rights/ Choice		**93**	**50.5**	**30.6**
Risks/ Complications[15]		**41**	**22.2**	**13.5**
	Physical	25	13.5	8.2
	Financial	11	5.9	3.6
	Mental	8	4.3	2.6
	Social	4	2.1	1.3
Motivation		**25**	**13.5**	**8.2**
	General Motivation	14	7.6	4.6
	Structure/Society	11	5.9	3.6
Religion		**7**	**3.8**	**2.3**
* Social Distance is measured in Likert scales mentioned above but did not surface when participants explained their rating in the vignette questionnaires.				

Secondly, individuals indicated a concern for some type of risks or complications that could result from the surgery. The risks/concerns varied by physical, financial, mental health risks/stability and social risks. Roughly, sixty percent (60.9%)[16] of the risks or complications that were discussed involved some physical health risk.[17] Some of the responses that indicated a physical risk were:

- "Why does he want to have breast implants? Had a very close friend (who) died after having breast implants."
- "I think no one with good judgment would choose to amputate their limbs. They are a vital part of mobility and life."

[15] Three individuals listed multiple risks/complications.
[16] This is out of the 41 individuals who indicated a concern with risks or complications (25/41).
[17] This includes loss of physical function or use.

- "If he has got enough money then he can but if it is harmful to his body then I think he shouldn't do it."
- "Missing a leg would hinder such things such as walking and activities outdoors which he is said to like."

Concerns with financial risks include concerns about who funds the surgeries; specifically participants expressed disapproval if individuals could not afford to pay for the surgery themselves, if public funds were used to fund the surgeries, or if insurance companies funded the surgeries. Participants (4.3%) also expressed a concern if individuals pursing the various surgeries did so because they were not mentally stable. In addition, participants (2.1%) expressed a concern for any social consequences individuals may encounter once they have undergone the surgery. The following are examples of some of these justifications:

- Financial: "He can do whatever he wants to if he's got the money."
- Mental: "I believe that a person must undergo mental treatment. Feeling this way is not normal."
- Social: "I would not sit here and try my hardest to talk her out of it; however, I feel that people should not be used as 'objects' of sexual desire and breast augmentations would contribute to that."

Thirdly, individuals expressed a concern about the factors motivating (13.5%) the individual to pursue surgery. Within this, roughly eight percent (7.6%) of individuals expressed a concern about what is generally motivating someone to undergo a surgery, while about six percent (5.9%) of the participants expressed a concern of whether individuals' decisions are influenced by social views, or if individuals are doing it for themselves. Some of the explanations for their rating are as follows:

- "This is hard to understand without further explanation as to why or how he would personally benefit from losing a leg!"
- "I don't understand why he would want to. But that's him and he (can) do what he wants."
- "It depends on her state of mind. If she is getting surgery to improve her appearance for a good reason, i.e. to further her career in the business environment or exotic community. If she is doing so because she has a low self-esteem, this surgery won't help."

- "If it makes her feel better, then who am I to judge (her)? I think that people should love the body they are given but some people will never be accepting. They are probably influenced by popular culture through print and television."
- "If Pat feels like she needs to go through surgery to look 'prettier' then do it. I just wouldn't."

Finally, around four percent (3.8%) of participants indicated that their disapproval for the various surgeries is based on their religious beliefs. Such responses included:

- "God has made us who we are and we should be happy with it."
- "I strongly disapprove because this is against the Bible. By undergoing surgery, that's basically telling God he doesn't know what he is doing. She's mad…his image? Pat needs to read her Bible and be encouraged!"
- "I do believe that God gives us our bodies for specific reasons. Especially removing a limb is crazy to me. We should be happy with who we are because we are designed to be unique."

The above justifications given in the vignette questionnaires also resurface in the in-depth interviews along with the concept of social distance, which I will explain later when discussing the themes from the interviews. Now let us move on to the in-depth interviews.

INTERVIEWS

Several themes emerged within and across the interviews. Overall, the main themes that I found were risks and complications, the liberal view of an individual's right to one's body, and the issue of motivating factors for a surgery, religion and social distance (see figure 4.1 below). While there are many ways to analyze the interviews I will interpret them by discussing the main themes, at first across the surgeries and then by each specific surgery. I organized the themes by the frequency in which participants mentioned them across the interviews, starting with the most frequently mentioned theme (as seen in Figure 4.1 below). Next, I will further explain and discuss these themes.

Figure 4.1: Major Themes in In-depth Interviews (Total of Sixteen Interviews)									
THEMES		All Surgeries		Cosmetic		Elective Leg Amputation		Sexual Reassignment	
		#	%	#	%	#	%	#	%
Risks/ Complications		**15**	***93.7***	**15**	*93.7*	**10**	*62.5*	**7**	*43.7*
	Physical	11	*68.7*	7	*43.7*	6	*37.5*	5	*31.2*
	Financial	10	*62.5*	10	*62.5*	1	*6.2*	1	*6.2*
	Mental	8	*50.0*	1	*6.2*	5	*31.2*	2	*12.5*
	Social	1	*6.2*	0	*0*	0	*0*	1	*6.2*
Liberal Rights/Choice		**13**	***81.2***	**7**	*43.7*	**5**	*31.2*	**10**	*62.5*
Motivation		**13**	*81.2*	**12**	*75.0*	**7**	*43.7*	**3**	*18.7*
	General Motivation	9	*56.2*	7	*43.7*	6	*37.5*	3	*18.7*
	Structure/ Society	9	*56.2*	9	*56.2*	1	*6.2*	1	*6.2*
Religion		**7**	***43.7***	**4**	*25.0*	**2**	*12.5*	**5**	*31.2*
	Belief	6	*37.5*	3	*18.7*	2	*12.5*	5	*31.2*
	No Belief	1	*6.2*	1	*6.2*	0	*0*	0	*0*
Social Distance		**5**	***31.2***	**0**	*0*	**0**	*0*	**5**	*31.2*

Risks and Complications

In all but one interview, participants expressed a concern for individuals being well-informed of any risks or complications. This was expressed across 15 of the 16 interviews and these included risks of various health risks or surgical complications (11/16), of who funded the surgery (10/16), of mental illness or stability (8/16) and of later social consequences (1/16). The concerns with risks also included the conviction that the individuals who chose to undergo surgery were well informed as well as whether they had seriously contemplated their decision (especially for sexual reassignment surgeries). Again, the number of individuals expressing a concern for risks and complications varied among cosmetic surgeries (15/16), elective leg

amputations (10/16) and sexual reassignment surgeries (7/16). The following is one view expressed by a participant:

> I think there are dangers involved with any surgery. It's pretty much like I said before. You just really have to question, you know, whether we should evaluate why you are doing it and is changing the way you look really going to make you happier (Interview 10, white female).

Overall, participants expressed the concern for an individual's physical health or the concern for the loss of function of a body part more than other possible risks. The frequency in which these were voiced varied by the type of surgery: cosmetic (7/16), elective leg amputation (6/16) and sexual reassignment (5/16). The following are some of the concerns voiced regarding each type of surgery.

- Cosmetic
  - "I mean, I don't think they are safe. I don't think that anyone going under anesthesia for any reason is a wise decision. From my understanding it is very dangerous just going anesthesia but it's not anything I would ever choose to do" (Interview #3, white female).
  - "Yeah, most likely the aftermath of the surgery because even though they may want that done 'oh, I will be fine,' after the surgery there are so many repercussions, so. With that I think people really have to think about it, that is something you just don't jump into and I just hope that if anyone decides to do that…just wish them the best and hope they have thought it through" (Interview #9, black female).

- Elective Leg Amputation
  - "Well, I think what…hopefully before this person is able to have this done, I would hope they have to go through some type of psychological evaluation to make sure they are sane… I don't mean to use the word *sane* but to make sure they are *mentally capable* of making a decision such as cutting off your perfectly fine limb but if that is what…that is a hard one… I would agree with it if that is what they chose but I would hope they would have to go through some sort of psychological evaluation prior to having the operation done" (Interview #15, white female).

- Sexual Reassignment
  - "I don't have any…problem with that. I understand that you have to go through at least a year waiting period where you have to dress as the gender you are going to be after the operation. And I understand that some people feel different than

> they are. I would encourage people to really make sure that is the decision they want to make…because it is almost impossible to undo. At least in some cases, at least cutting off the penis and tucking everything in to create a vagina is really difficult to recreate the penis and the sensitivity with nerve endings and things. But I don't have a problem with it at all. If somebody wants to do that, then I would sign a petition saying 'let this person do it'" (Interview 4: white male).

Other participants expressed a concern for individuals using insurance or funding from the government to finance their surgeries. I interpret this to be a very significant finding. More than half (10/16) of people interviewed expressed approval "if you can afford it" (Interview1, white female). Nearly half of the participants expressed a concern for funding cosmetic surgeries (10/16), while there were many fewer concerns with funding for elective leg amputations (1/16) and sexual reassignment surgeries (1/16).

I interpret this as participants viewing cosmetic surgeries as unnecessary and as a luxury rather than a legitimate way to *improve or enhance* a person. Thus, cosmetic surgeries are only acceptable if an individual can pay for it his/her self. Additionally, if individuals cannot afford this luxury then participants disapprove of individuals pursuing it. They disapprove because participants view individuals seeking cosmetic surgery as badly managing their money.

Additionally, half of participants interviewed (8/16) expressed a concern for the individuals' mental health given their pursuit of the various surgeries: elective leg amputation (5/16), sexual reassignment (2/16), and cosmetic (1/16). The most concern was expressed for elective leg amputation surgeries. I interpret this as participants reasoning that individuals pursuing this operation must be mentally unstable because they can not understand why and individual would pursue this procedure. Thus, participants' inability to understand individuals' desire for elective leg amputation leads them to the assumption that the individual must suffer from some mental illness because a normal person would never pursue this.

Finally, only one participant (1/16) expressed a concern for any social consequences individuals may face when undergoing surgery, this concern was expressed only for sexual reassignment surgery. Thus, this participant expressed concern for individuals being socially alienated because of pursuing something the participant views as out of the ordinary.

Right to One's Own Body

One of the most common themes that emerged through both the questionnaires and interviews is the liberal view of an individual's right to their own body regardless of whether participants personally approved or disapproved of the ways in which the individual chooses to modify their own body.[18] Across the surgeries, approximately eighty percent (13/16) of participants expressed a belief that every individual should have the right to decide if and how they modify their own bodies.

There also were differences in viewpoints within the context of the surgeries. The percentages of participants who expressed the liberal view of an individual's right to control their body varied among the surgeries. The belief in persons' right to their own body surfaced more regarding sexual reassignment surgeries (10/16) than for cosmetic surgeries (7/16) and elective leg amputation surgeries (5/16). That ten of the sixteen individuals expressed a liberal belief in an individual's right to control their body in the specific context of sexual reassignment surgeries, is surprising for two reasons. First, sexual reassignment surgery is non-normative and gendered, while cosmetic is normative regardless of whether it is gendered or not. This suggests that participants may understand sexual reassignment surgery as being a more necessary fix - a fix or cure of a defect that an individual was born with. In turn, participants may be more sympathetic to individuals pursuing sexual reassignment surgery if individuals are aligning their biological anatomy to reflect a core self.

[18] Individuals commented that ultimately the decision should be up to the individual.

If such essentialist frameworks illicit more sympathy or empathy, this could have negative implications. The idea that sexual reassignment surgery is necessary to align an individual's core identity with his/her biological anatomy can be problematic if used to justify operating on intersexed infants. Surgeons have used surgery as a way to *correct* infant's biological anatomy. Yet, evidence today suggests that these operations proved harmful to the intersexed infants as they further developed (Fausto-Sterling, 2000). This essentialist framework also labels transgendered individuals as defective. Such labeling can have negative implications for these individuals' self esteem. It also reinforces the binary notion that there are only two sexes and undermines sexual diversity and the notion that there may be multiple sexes and genders. Furthermore, such essentialist views imply that identities are fixed. Thus, they also reinforce gendered expectations based on a person's biological anatomy, whether this anatomy was present at birth or constructed by surgical methods. Thirdly, the idea that there is something inherent or essential about being a man or a woman reinforces the idea that a M-t-F can never be a real woman because she was not born with that essence and that a F-t-M can never be a real man because he was also not born with that essence. The implications of this essentialist framework will resurface in the other themes below.

Motivation for Surgery

Many interviewees voiced concern about the general motivation (9/16) underlying why an individual would choose to undergo a surgery to modify their bodies, such as cosmetic surgery (7/16) elective leg amputation (6/16) and sexual reassignment surgery (3/16). In particular, participants expressed concern over whether an individual's decision is influenced by social views or if they are doing it for themselves (9/16). This concern also varied by type of

surgery; cosmetic surgeries (9/16), leg amputations (1/16) and sexual reassignment surgeries (1/16). One participant explained:

> I think it is important if you are close to somebody who is considering that (sexual reassignment surgery) to understand the motivation and ultimately it is a person's identity and their choice and how they feel about their body should be respected because it's really their choice in what they do (Interview #10, white female).

When asked why he/she did not complete the section of the questionnaire which asked participants to rate their approval/disapproval for a surgery that involves a female having a penis reconstructed (sexual reassignment surgery), a participant explained:

> I guess, it was vague, I didn't know the specifics as to why. All I know is she wants to have penis reconstructive surgery. I can't make a decision. No details, so, you know (Interview #9, black female).

Many participants expressed disapproval for cosmetic surgery if individuals were choosing to undergo cosmetic surgery to meet hegemonic, societal expectations for beauty as opposed to pursuing surgery for their own personal desires. The following illustrates one of the ways in which one participant was concerned with motivating factors for the desire for surgery:

> I just wish that it wasn't so …necessary for some people. Rather, they didn't feel that it was so necessary. Society puts a lot of pressure on people to fit into certain categories and I think that has a lot to do with the decisions people make to do certain body modifications (Interview #4, white male).

This was expressed for cosmetic surgery in many ways such as "something like face-lifts or breast enhancement surgery, I feel that is more a symptom of society's pressure on a certain physical ideal that people are supposed to adhere to" (Interview #10, white female). It was also expressed for sexual reassignment surgery such as:

> For someone who is F-t-M female to male transsexual presenting themselves to society as male but having breasts or trying to date and somebody sees you as male but, you know, they have a certain expectation of what your genitalia is supposed to look like if you identify as a male. All of that can be extremely difficult to deal with. So, I can see, in order to interact with people on a day to

> day basis, just to make your life easier, to feel more comfortable with yourself, it would make more sense to have top surgery and bottom surgery. Just so how you're seen not just how you feel inside (Interview #10, white female).

Many individuals expressed approval for surgery if done to have individuals' bodies better reflect how they internalize themselves. While some participants described their approval as using surgery as a tool to "fix" a part of one's body, whether it is cosmetic (2/16) or sexual reassignment (4/16), most participants expressed approval (10/16) if the surgery allows someone to feel more comfortable and/or happier with him or her self.

This has three implications. First, since there was more participant approval for sexual reassignment surgery than for cosmetic surgery, this may again illustrate the essentialist view that cosmetic surgeries are viewed as unnecessary, while sexual reassignment surgeries are viewed as a mean to fix or to cure nature's defects. Second, this also may illustrate how participants view surgeries as unnecessary and the pressure to pursue these elective surgeries as a way to police one's body to meet society's expectations of beauty or society's *gaze*. Nevertheless, the language participants used suggests that they believed that individuals can autonomously make choices that are separate from any influences of society. However, a structuralist theorist would disagree and view these choices as desires based on the deeply ingrained expectations and values of the larger society. Thus, they have internalized society's values as their own. It is in this sense, earlier researchers, such as Patricia Gagne and Deanna McGaughey (2002), argued that individuals claiming to undergo these surgeries for themselves had *false consciousness*.

Religion

In many of the interviews, participants (7/16) indicated that their religious beliefs (6/16) or lack of any religious belief (1/16) informed their views towards various surgeries. Thus,

individuals explained that it would be against their religion to support a particular surgery or they explained that their lack of religious beliefs allowed them to support a particular surgery. In turn, religious justifications for approval and disapproval of surgeries varied with the type of surgery. Religion was used less for cosmetic surgeries to explain both approval (1/16) and disapproval (3/16). Religion reasons were used more for expressing disapproval of sexual reassignment surgeries (5/16) than for disapproval of both elective leg amputation surgeries (2/16) and cosmetic surgeries.[19]

Some participants claimed that people needed to "work with what they were given and work with what they've got" (Interview #1, white female). Additionally, one person who knew someone who had undergone sexual reassignment surgery, who identified as transgender and who also attended the same church, described the transgender person negotiating their identity with their religion as: "maybe being transgender conflicts with the rules and standards of the bible but she felt like that part of her is like non-exclusive in terms to learning how to live as another person in reading the bible" (Interview #9, black female).

One interviewee who identified as an atheist, attributed his approval compared to others' disapproval for sexual reassignment surgery as the result of barriers as "gender and personal beliefs, religion; eventually barriers that may have been erected by people when they got older were never put up by me" (Interview #4, white male). Additionally, he explains that his affiliation with Atheism is a factor in his belief that individuals should have the right to decide if and how they modify their bodies. However, he describes religion as an important factor in how people view elective surgeries, "I know I have some people that wouldn't do it only because it is from a religious standpoint. You know, my Jewish roommate wouldn't do anything like that

[19] I think it is important to note that the same individuals who mentioned religion in elective leg amputation also mentioned with the same two other surgeries.

because he/she has to keep his body whole" (Interview #4, white male). Thus, he viewed peoples' religious beliefs as important influences on whether they would approve or disapprove of various forms of body modification.

I interpret the surfacing of religion as a significant finding, especially in light of the participants' belief in an individual's right to control his/her body. Although participants expressed their approval/disapproval for surgeries was based on their religious beliefs, some (4/7) of these participants also indicated the belief in an individual's right to control their own body among cosmetic (1/16) and sexual reassignment surgeries (3/16). This is significant because what underlies this claim is that participants triangulate their disapproval for surgeries through their religious beliefs. Additionally, these participants indicate a belief in a right to one's body, which contradicts not only their personal views toward the specific surgery but also religious ideology such as prohibiting peoples use of methods of birth control and abortion. Thus, participants are still viewing sexual reassignment surgeries as a device to fix natures defects, which in turn are essentialist views of sex.

Social Distance

While across all of the surgeries, social distance did not seem to be significant, when discussing sexual reassignment surgery approximately one-third (5/16) of participants noted that their degree of approval/disapproval may change based upon their relationship to the person, i.e. a stranger versus a friend or family member. However, among the participants who personally had a friend or partner who self-identifies as transgendered (4/16), only one indicated a difference in approval based on one's social distance. She had a close friend who identified as a transgender M-t-F (male to female) and described her viewpoint as:

> I am a little biased, one of my best friends is actually a male living as a female and she wants to get the surgery and again, I fully support her. It is a best friend

> and someone that I am really close to, so I feel like it is sort of…it's not natural I would say and honestly when I think of …uhmmm it going on for people besides this person it is sort of an unnatural thing…but for this person I feel that it's completely okay, and it's you know…completely okay for anyone whoever does it. It is sort of foreign in my mind for other people (Intervew#1, white female).

For this person, knowing the individual and being able to understand their decision made the idea of sexual reassignment surgery easier for them to accept than the abstract idea.

For some respondents, the abstract idea of a stranger or someone who was not familiar to them undergoing a type of body modification was easier to accept than someone more personal to them such as a friend or close family member. For others, knowing someone on a personal level and understanding their personal motivation(s) for surgery made the elective surgery more palatable. Additionally, participants who initially disapproved of elective surgeries for strangers said they would want to discuss the desire for the surgeries if it were a friend or family member and would ultimately support them if they decided to undergo the surgery (Interview #7).

Further, one participant explained that while he approved of anyone getting sexual reassignment surgery, he personally would not be open having a partner who identified as transgendered:

> *Researcher:* Okay, is there anything you want to add or comment on about what we have discussed so far?
> *Participant:* Maybe the last one. Just to say that for instance, one of my male friends had sexual reassignment surgery, I think I would personally still view them as male. Like I wouldn't be like…I think we should go out (referring to date or have an intimate relationship).
> *Researcher:* What about if one of your female friends would have sexual reassignment surgery…a female to male surgery, would you still view them as a female?
> *Participant:* Possibly, I guess it would depend on the person and if I feel they have made the right decision. Although, I have no idea what criterion I would base that on. I guess it would be going from…I would probably accept it and try to treat them the way they ask me to treat them but I would have to have the personal experience to back it up, I guess. (Interview 11, white male)

It is significant that these distinctions in approval based on social distance were only discussed in relation to the sexual reassignment surgeries. This suggests how contingent views of sex and gender may be; views may change if the person is a stranger, co-worker, friend or someone interested in an intimate relationship.

Additionally, that participants chose to distance themselves from individuals who had undergone sexual reassignment surgery, more than from individuals who elected cosmetic surgery or amputations reinforces how deeply ingrained gender expectations and essentialist views of sex may be. Such differential treatment suggests that stigma is more readily attributed to individuals who undergo sexual reassignment surgery. Thus, even if people support individuals' rights to control their own bodies, they may treat those who undergo sexual reassignment surgery in more negative ways than individuals who have undergone normative surgeries such as cosmetic and non-normative non-gendered surgeries such as elective leg amputation.

CONCLUSION

The findings of this exploratory study suggest that overall participants have a higher approval of surgeries that coincide with sex-linked-to-gender expectations such as breast augmentation for females and penis augmentation for males. Participants also were more likely to approve normative gender-neutral surgeries such as rhinoplasty, as opposed to non-normative procedures such as sexual reassignment surgeries and elective leg amputations. This suggests the pervasive nature of essentialist views of sex and identity, as well as the impact of social norms more generally. While across different populations the averages of the approval/disapproval may vary, the overall trends should remain the same due to randomly assigning the questionnaires to participants.

The major factors that contributed to participants' approval or disapproval of various forms of body modification included their concern for risks or complications, their views on the right to control one's own body, their perceptions of the individuals' motivation for surgery, their religious beliefs, and their social distance to the individual. Most participants ultimately deferred to the belief in an individual's right to control their own body regardless of whether they approved or disapproved of the particular surgery. Despite this more liberal view of individual rights, most participants also held a more conservative and essentialist view of sex and identity. Thus, they supported sexual reassignment surgery because it was seen as fixing a defect or matching a person's sex to their core identity.

They also demonstrated contradictory views on the role of social structure versus social agency in regard to elective surgeries. While participants were concerned that people were electing surgeries to meet societal expectations, they approved surgeries if they thought the

motivation came from the individual's desires. In short, they gave individuals a lot of free will and did not link these two issues in any consistent way.

While possible risks and complications across all of the surgeries influenced participants' views toward different surgeries, they did not ultimately affect participants' approval or disapproval of these surgeries. More important was the respondents' religious beliefs. Over half of the participants used their belief in religion to triangulate their disapproval for cosmetic and sexual reassignment surgeries. Religious beliefs were also associated with essentialist views of sex and the idea that gender expectations *should* differ for individuals based upon their biological sex or anatomy.

The issue of social distance also was salient to participants' responses. Their social distance to the individual having surgery could change their approval or disapproval of these surgeries. While participants did not believe they would treat individuals differently based upon the context of the surgeries, their level of intimacy to the person electing surgery did affect their views.

The most pervasive theme underlying most participants' responses was an essentialist view of sex. Thus, future research should examine this issue in more depth. While this study examined the approval or disapproval of elective surgeries from the vantage point of people not undergoing surgery, it would be interesting to compare and contrast these findings with the vantage point of those who elect surgeries and especially those who elect sexual reassignment surgeries. Additionally, this study does not inform us how people would view body modification surgeries if they were chosen as a means of transgressing or challenging gender norms. Given the emphasis of such transgressions in contemporary postmodernist, poststructuralist and queer theories, this would be a most interesting path for future research.

APPENDIX A: RECRUITMENT SCRIPT

Recruitment Script for Vignettes and Interviews

Hello, my name is Cheryl Mayeux and I am to recruit individuals to participate in a study on attitudes towards body modification. This study is completely voluntary and participants can choose to stop participating at anytime. The study will involve approximately 240 people and questionnaires will be given out across the UNO campus exploring what people find socially acceptable or unacceptable, the strength of acceptability, and a brief explanation of their responses. The questionnaire should take approximately five to ten minutes to fill out. I ask you to consider participating in this study, even if you do not have an interest in body modification because it will help us obtain diverse people, not just those who are particularly interested in this topic. Additionally, I will make my results available to anyone participating in the study and answer any questions you may have regarding the study.

Additionally, I ask you to consider participating short interviews that are also a part of this study by including your contact information on either the second page of the vignette or on a note card I will provide. The interviews will last approximately twenty minutes and will take place in the Social Psychology Lab in Room 196 in Milneburg Hall. Again, this study is completely voluntary and participants can choose to stop participating at any time and do not have to answer any questions that make them feel uncomfortable. This study has few risks and no direct benefits. This study does allow individuals to contribute to science by sharing their attitudes towards body modification. If you would like to participate in interviews with this study or future studies with the Social Psychology Lab please include your contact information on the second page of the vignette questionnaire or on one of the blank note cards that I will provide.

This study is not associated with any class at the University of New Orleans and class credit will not be given for participating in this study. Additionally participants will not be paid for their participation in this particular study. Pseudonyms will be used in this study and responses will be kept confidential.

Thank you for your time and cooperation.

APPENDIX B: CONSENT FORMS

Vignette Questionnaire Consent Form

Project Title: Surgical Body Modification in New Orleans: Exploring Attitudes

I agree to participate in a study that explores attitudes toward various forms of surgical body modification. The study will involve approximately 240 people and questionnaires will be given out across the UNO campus exploring what people find socially acceptable or unacceptable, the strength of acceptability, and a brief explanation of their responses. The questionnaire should take approximately five to ten minutes to fill out. I understand my participation in this study is entirely voluntary. I also understand that I do not have to answer any questions that make me feel uncomfortable and I may withdraw consent and stop participating at any time.

This study is not associated with any class at the University of New Orleans. I understand that no class credit is involved and that my participation in this study will not affect my grades now or in any future classes at the University of New Orleans. I understand that I must be 18 years of age to participate in this study and I will not be paid for my participation. This study has few risks and no direct benefits to being a participant in this study. I understand that this study may ask for personal information but that the information I give in this study will remain confidential, I can skip any questions, withdraw my consent to participate at any time and do not have to participate in any further studies. All tapes, transcripts and consent forms will be kept in a locked cabinet.

If you have any questions concerning this research study, please call Dr. Mann at 504-280-6601 or Cheryl Mayeux at 504-280-6293.

Please contact Dr. Ann O'Hanlon (504-280-6531) at the University of New Orleans for answers to questions about this research, your rights as a human subject, and your concerns regarding a research-related injury.

Sincerely,

Susan Mann and Cheryl Mayeux

By signing this consent form, you agree that you understand the procedures and any benefits and risks involved in this study. Additionally, you understand that participation is voluntary and consent can be withdrawn at any time without any consequence, prejudice or discrimination. Furthermore, you are consenting to participate in this study.

_____

SignaturePrinted NameDate

Interview Consent Form

Project Title: Surgical Body Modification in New Orleans: Exploring Attitudes

I agree to participate in a study that explores attitudes toward various forms of surgical body modification. The study will involve approximately 240 people and some of those individuals will participate in an interview to follow-up on their initial questionnaire. The interview will take approximately twenty minutes. I understand my participation in this study is entirely voluntary. I also understand that I do not have to answer any questions that make me feel uncomfortable and I may withdraw consent and stop participating at any time.

This study is not associated with any class at the University of New Orleans. I understand that no class credit is involved and that my participation in this study will not affect my grades now or in any future classes at the University of New Orleans. I understand that I must be 18 years of age to participate in this study and I will not be paid for my participation. This study has few risks and no direct benefits to being a participant in this study. I understand that this study may ask for personal information but that the information I give in this study will remain confidential, I can skip any questions, withdraw my consent to participate at any time and do not have to participate in any further studies. Additionally, I understand that my name will not be used in this study and I will be given a pseudonym. All tapes, transcripts and consent forms will be kept in a locked cabinet.

If you have any questions concerning this research study, please call Dr. Mann at 504-280-6601 or Cheryl Mayeux at 504-280-6293.

Please contact Dr. Ann O'Hanlon (504-280-6531) at the University of New Orleans for answers to questions about this research, your rights as a human subject, and your concerns regarding a research-related injury.

Sincerely,

Susan Mann and Cheryl Mayeux

By signing this consent form, you agree that you understand the procedures and any benefits and risks involved in this study. Additionally, you understand that participation is voluntary and consent can be withdrawn at any time without any consequence, prejudice or discrimination. Furthermore, you are consenting to participate in this study.

_____

SignaturePrinted NameDate

APPENDIX C: VIGNETTE QUESTIONNAIRES

Surgical Body Modifications
Questionnaire (A1)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of his student loans. When not working he enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a more appropriate body. He wants to have his leg amputated.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer.

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questionnaire (A2)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of her student loans. When not working she enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a more appropriate body. She wants to have her leg amputated.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer.

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questionnaire (B1)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of his student loans. When not working he enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a female body. Pat wants to have breast implants.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer.

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questionnaire (B2)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of her student loans. When not working she enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a male body. Pat wants to have penis reconstructive surgery.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer.

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questionnaire (C1)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of his student loans. When not working he enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a more masculine appearance.
He wants to have rhinoplasty (nose surgery).

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer.

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questionnaire (C2)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of her student loans. When not working she enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a more feminine appearance.
She wants to have rhinoplasty (nose surgery).

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer.

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questionnaire (D1)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of his student loans. When not working he enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a more masculine appearance.
He wants to have penis augmentation.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer:

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Surgical Body Modifications
Questions (D2)

Please indicate the degree to which you approve or disapprove.

Various forms of body modification have been increasing in American society. While some people may wish to enhance or change certain features others may feel they were born into the wrong body.
Pat works for a computer company and has most recently paid off all of her student loans. When not working she enjoys reading and the great outdoors. Pat wants to undergo a surgical operation in efforts to obtain a more feminine appearance.
She wants to have breast augmentation.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

Please write a couple of sentences explaining your answer:

1. I would like to meet Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

2. I would not want to work with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

3. I would let Pat teach computer lit to my child.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

4. I would not want my family member dating Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

5. I would be embarrassed to be seen with Pat.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

6. I would donate to Pat's surgery fund.
1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----11
Strongly disapprove Strongly Approve

APPENDIX D: DEMOGRAPHIC QUESTIONS

Please answer the following questions.

1. My age is: _____

2. The racial group that I identify myself with is: _____

3. The ethnic group that I identify myself with is: _____

4. My sex is: _____

5. My sexual orientation is: _____

6. The highest level of education I have completed is: _____

7. My academic major is: _____

8. My primary language is: _____

9. My religion is: _____

10. My political affiliation is: _____

Comments:

Would you be interested in participating in a follow-up interview or future studies for the Social Psychology Lab? If so, Please include your contact information below:
Email: _____
Phone: _____

APPENDIX E: INTERVIEW QUESTIONS

Surgical Body Modification: Exploring Attitudes
Qualitative Interview Questions
(Page 1 of 1)

Cosmetic surgeries are used generally by individuals to enhance their appearance while sex reassignment surgeries are used largely to modify an individual's sex. While both surgeries are very different in nature, they are both elective forms of body modification. We want to explore attitudes toward body modification.

I. Non-Surgical Forms of Body Modification

1. Would you mind telling me about your attitudes toward some types of body modification such as:
   i. When you hear the term body modification what comes to your mind?
   ii. What do you think about tattoos?
   iii. So given that, what do you think about piercings?

II. Elective Surgeries versus Non-elective Surgeries

1. Please tell me what you think of elective forms of surgery, for example cosmetic surgery.
   i. for men
   ii. for women

2. Now, please tell me what you think of sexual reassignment surgery.

3. Do you have any concerns with:
   i. cosmetic surgeries
   ii. sexual reassignment surgeries
   iii. non-elective surgeries

III. Communities

1. Among your friends how do you think cosmetic surgeries are viewed?

2. Now, please tell me among your friends, how do you think sexual reassignment surgeries are viewed?

3. Among your family how do you think cosmetic surgeries are viewed?

4. Now, how do you think sexual reassignment surgeries are viewed by your family?

IV. Personal

1. What would you think if one of your friends or family members chooses to have cosmetic surgery?

2. What would you think if one of your friends or family members chooses to have sexual reassignment surgery?

APPENDIX F: ADDITIONAL FIGURES

OVERALL APPROVAL: Descriptive Statistics, t-tests and Analysis of Variance

Figure 5.1 Descriptive Statistics of each type of Vignette by Approval for Surgery

	Sex		# of Observations	Mean	Standard Deviation	Range
A1	Male	Elective Leg Amputation	27	4	3.5	1-11
A2	Female	Elective Leg Amputation	30	4.3	2.9	1-11
A	**Combined**		**57**	**4.1**	**3.2**	
B1	Male	Breast Implants	30	5.4	3.4	1-11
B2	Female	Penis Reconstruction	24	5.2	3.3	1-11
B	**Combined**		**54**	**5.3**	**3.3**	
C1	Male	Rhinoplasty	22	6.13	2.6	1-11
C2	Female	Rhinoplasty	26	7	2.6	1-11
C	**Combined**		**48**	**6.6**	**2.6**	
D1	Male	Penis Augmentation	29	6.1	3.0	1-11
D2	Female	Breast Augmentation	27	6.2	3.3	1-11
D	**Combined**		**56**	**6.1**	**3.1**	

Based on a Likert scale in which 1 indicates "Strongly Disapprove" and 11 indicated "Strongly Approve".

Figure 5.2 Scores of t-tests for Approval by Sex of Individual Undergoing Surgery

Procedure	**Degrees of Freedom**	**Observed t-score**	**Probability**	**Significant?**
Elective Leg Amputations	55	-0.4270	*0.671*	No
Sexual Reassignments	54	-0.2257	*0.8223*	No
Sex-linked-To-Genders	52	0.1195	*0.9053*	No
Rhinoplasties	46	-1.1400	*0.2602*	No

Figure 5.3 Means of Approval by Type of Surgery								
	Leg Amputation		Sexual Reassignment		Penis/Breast Augmentation		Rhinoplasty	
	Male	Female	Male	Female	Male	Female	Male	Female
Approve	4.0	4.3	5.4	5.2	6.1	7.0	6.1	6.2
Meet	7.8	6.6	4.1	5.5	5.9	5.9	5.2	6.2
Work	4.1	4.2	4.1	4.0	3.1	2.8	3.7	2.8
Teach	6.7	7.2	6.7	6.4	8.7	8.7	7.1	8.8
Family	5.1	4.7	4.0	6.6	4.5	3.6	3.8	2.7
Embarras	3.5	3.2	4.5	3.7	3.0	2.3	3.2	2.1
Donate	3.1	3.1	3.2	2.4	2.2	3.0	2.2	2.9

Figure 5.4 Analysis of Variance (ANOVA) for Approval of Surgery by Vignette Type (when Pat's sex is either male or female) and Combined Surgeries (when Pat's sex is combined)			
	Degrees of freedom	**F score**	**Probability**
Vignette Type	214	2.80	*0.0084***
Combined	214	6.22	*0.0005****
= significant at the 0.01 level of significance *= significant at the 0.001 level of significance			

SEX OF PARTICIPANTS: FREQUENCY DISTRIBUTION, t TESTS AND ANOVA

Figure 6.1 Frequency Distribution of Participant's Sex, by percent	
Sex	**%**
MALE	46.1
FEMALE	53.9
	(297)
Six participants did not indicate their sex	

Figure 6.2 Scores of t-tests for Approval by Sex of Participant					
Sex of Person Undergoing Surgery	**Procedure**	**Degrees of Freedom**	**Observed t-score**	**Probability**	**Significant?**
Male	**Elective Leg Amputations**	25	0.8092	*0.4261*	No
Female	**Elective Leg Amputations**	27	-0.0883	*0.9303*	No
Male	**Sexual Reassignments**	28	-0.3850	*0.7031*	No
Female	**Sexual Reassignments**	22	-0.8863	*0.3850*	No
Male	**Sex-linked-To-Genders**	19	-2.6950	*0.0143**	Yes, at 0.05 level of sig.
Female	**Sex-linked-To-Genders**	24	0.2954	*0.7702*	No
Male	**Rhinoplasties**	27	1.1482	*0.2609*	No
Female	**Rhinoplasties**	25	-0.1435	*0.8871*	No
* =significant at the 0.05 level of significance Sex of Participant is only significant when looking at the Sex-linked-to-gender surgery of a male getting a penis augmentation. Females (mean=7.6) seem to have a higher average approval rating of this surgery than males (mean=4.8).					

Figure 6.3 Analysis of Variance (ANOVA) by Participants Sex, Approval and Indicators of Social Distance			
	Degrees of freedom	**F score**	**Probability**
Approval	212	0.02	*0.8747*
Meet	295	0.00	*0.9595*
Work	295	0.71	*0.4009*
Teach	295	1.86	*0.1740*
Family	295	0.07	*0.7976*
Embarrassed	295	2.55	*0.1116*
Donate	295	0.25	*0.6185*
* = significant at the 0.05 level of significance; **= significant at the 0.01 level of significance ***= significant at the 0.001 level of significance			

RACE OF PARTICIPANTS: FREQUENCY DISTRIBUTION AND ANOVA

Figure 7.1 Frequency Distribution of Participant's Race		
	%	#
White/Caucasian	53.8	163
Black/African American	20.1	61
Asian/Vietnamese/ Pacific Islander	9.6	29
Hispanic/Latino	3.6	11
Biracial/Multiracia3.3l	1.7	5
Other	3.3	10
	(279)	
Twenty-four participants did not indicate a race.		

Figure 7.2 Descriptive Statistics of Donate by Race				
	# observations	**Mean**	**Standard Deviation**	**Range**
White/Caucasian	163	2.6	2.6	1-11
Black/African American	61	2.1	2.2	1-11
Asian/Vietnamese/ Pacific Islander	29	4.2	2.9	1-10
Hispanic/Latino	11	2.18	1.83	1-6
Biracial/Multiracial	5	5.6	4.7	1-11
Other	10	4	3.4	1-9
Based on the mean, standard deviation and the range, the Hispanic/Latino population has a lower overall approval for donating to Pat's surgery than the other racial groups. Additionally, participants who identified as biracial. Multiracial have a higher average of approval for donating to Pat's surgery based on the other racial groups, however this result may be spurious do to a low frequency (f<5) of respondents in this category.				

Figure 7.3 Descriptive Statistics of Teach by Race				
	# observations	**Mean**	**Standard Deviation**	**Range**
White/Caucasian	162	8.1	2.9	1-11
Black/African American	61	7.3	3.4	1-11
Asian/Vietnamese/ Pacific Islander	29	6.8	2.4	1-11
Hispanic/Latino	11	4.9	2.9	1-11
Biracial/Multiracial	5	8	4	1-11
Other	10	5.4	3.4	1-11
Participants who identify as Hispanic/Latino or Other tend to have the lowest average approval of Pat teaching their children than other racial groups.				

Figure 7.4 Analysis of Variance (ANOVA) by Participants Race, Approval and Indicators of Social Distance

	Degrees of freedom	**F score**	**Probability**
Approval	198	2.83	*0.0171**
Meet	278	0.52	*0.7594*
Work	277	2.06	*0.0713*
Teach	277	4.20	*0.0011***
Family	277	1.82	*0.1086*
Embarrassed	277	1.42	*0.2184*
Donate	278	4.36	*0.0008****

* = significant at the 0.05 level of significance; **= significant at the 0.01 level of significance
***= significant at the 0.001 level of significance

APPENDIX G: INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

University Committee for the Protection of Human Subjects in Research
University of New Orleans

Campus Correspondence

Principal Investigator:	Susan Mann
Co-Investigator:	Cheryl Mayeux
Date:	December 17, 2008
Protocol Title:	"Stigma, Surgery, and Social Identity: Attitudes towards Sex and Gender Surgeries"
IRB#:	11Nov08

The IRB has deemed that the research and procedures are compliant with the University of Ne w Orleans and federal guidelines. The above referenced human subjects protocol has been reviewed and approved under 45 CFR 46.116(a) category 7.

Approval is only valid for one year from the approval date. Any changes to the procedures or protocols must be reviewed and approved by the IRB prior to implementation. Use the IRB number listed on this letter in all future correspondence regarding this proposal.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project!

Sincerely,

Robert D. Laird, Chair
UNO Committee for the Protection of Human Subjects in Research

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VITA

Cheryl Mayeux was born in Louisiana in 1980. She received undergraduate degrees from Delgado Community College (2003) and Nicholls State University (2006). She began attending The University of New Orleans in 2007 where she has worked as a graduate assistant and completed her Master's degree in April of 2009. Her future plans include pursuing a Ph.D. in Sociology at Louisiana State University.