In January of 1997, Christine Drury became the overnight anchorwoman for Channel 13 News, the local NBC affiliate in Indianapolis. In the realm of television news and talk shows, this is how you get your start. (David Letterman began his career by doing weekend weather at the same station.) Drury worked the 9 P.M. to 5 A.M. shift, developing stories and, after midnight, reading a thirty-second and a two-and-a-half-minute bulletin. If she was lucky and there was breaking news in the middle of the night, she could get more airtime, covering the news live, either from the newsroom or in the field. If she was very lucky—like the time a Conrail train derailed in Greencastle—she’d get to stay on for the morning show.

Drury was twenty-six years old when she got the job. From the time she was a girl growing up in Kokomo, Indiana, she had wanted to be on television, and especially to be an anchorwoman. She envied the confidence and poise of the women she saw behind the desk. One day during high school, on a shopping trip to an Indianapolis mall, she spotted Kim Hood, who was then Channel 13’s prime-time anchor. “I wanted to be her,” Drury says, and the encounter somehow made the goal seem attainable. In college, at Purdue University, she majored in telecommunications, and one summer she did an internship at Channel 13. A year and a half after graduating, she landed a bottom-rung job there as a production assistant. She ran the teleprompter, positioned cameras, and generally did whatever she was told. During the next two years, she worked her way up to writing news and then, finally, to the overnight anchor job. Her bosses saw her as a production assistant. She ran the teleprompter, positioned cameras, and generally did whatever she was told. During the next two years, she worked her way up to writing news and then, finally, to the overnight anchor job. Her bosses saw her as an ideal prospect. She wrote fine news scripts, they told her, had a TV-ready voice, and, not incidentally, had “the look”—which is to say that she was pretty in a wholesome, all-American, Meg Ryan way. She had perfect white teeth, blue eyes, blond hair, and an easy smile.

During her broadcasts, however, she found that she could not stop blushing. The most inconsequential event was enough to set it off. She’d be on the set, reading the news, and then she’d stumble over a word or realize that she was talking too fast. Almost instantly, she’d redden. A sensation of electric heat would start in her chest and then surge upward into her neck, her ears, her scalp. In physiological terms, it was a mere redirection of blood flow. The face and neck have an unusual number of veins near the surface, and they can carry more blood than those of similar size elsewhere. Stimulated by certain neurological signals, they will dilate while other peripheral vessels contract: the hands will turn white and clammy even as the face flushes. For Drury, more troubling than the physical reaction was the distress that accompanied it: her mind would go blank; she’d hear herself stammer. She’d have an overwhelming urge to cover her face with her hands, to turn away from the camera, to hide.

For as long as Drury could remember, she had been a blusher, and, with her pale Irish skin, her blushes stood out. She was the sort of child who almost automatically reddened with embarrassment when called on in class or while searching for a seat in the school lunchroom. As an adult, she could be made to blush by a grocery-store cashier’s holding up the line to get a price on her cornflakes, or by getting honked at while driving. It may seem odd that such a person would place herself in front of a camera. But Drury had always fought past her tendency toward embarrassment. In high school, she had been a cheerleader, played on the tennis team, and been selected for the prom-queen court. At Purdue, she had played intramural tennis, rowed crew with friends, and graduated Phi Beta Kappa. She’d worked as a waitress and as an assistant manager at a Wal-Mart, even leading the staff every morning in the Wal-
Mart Cheer. Her gregariousness and social grace have always assured her a large circle of friends.

On the air, though, she was not getting past the blushing. When you look at tapes of her early broadcasts —reporting on an increase in speeding-ticket fines, a hotel food poisoning, a twelve-year-old with an I.Q. of 325 who graduated from college—the redness is clearly visible. Later, she began wearing turtlenecks and applying to her face a thick layer of Merle Norman Cover Up Green concealer. Over this she would apply MAC Studiofix foundation. Her face ended up a bit dark, but the redness became virtually unnoticeable.

Still, a viewer could tell that something wasn’t right. Now when she blushed—and eventually she would blush nearly every other broadcast—you could see her stiffen, her eyes fixate, her movements become mechanical. Her voice sped up and rose in pitch. “She was a real deer in the headlights,” one producer said.

Drury gave up caffeine. She tried breath-control techniques. She bought self-help books for television performers and pretended the camera was her dog, her friend, her mom. For a while, she tried holding her head a certain way, very still, while on camera. Nothing worked.

Given the hours and the extremely limited exposure, being an overnight anchor is a job without great appeal. People generally do it for about a year, perfect their skills, and move on to a better position. But Drury was going nowhere. “She was definitely not ready to be on during daylight hours,” a producer at the station said. In October of 1998, almost two years into her job, she wrote in her journal, “My feelings of slipping continue. I spent the entire day crying. I’m on my way to work and I feel like I may never use enough Kleenex. I can’t figure out why God would bless me with a job I can’t do. I have to figure out how to do it. I’ll try everything before I give up.”

What is this peculiar phenomenon called blushing? A skin reaction? An emotion? A kind of vascular expression? Scientists have never been sure how to describe it. The blush is at once physiology and psychology. On the one hand, blushing is involuntary, uncontrollable, and external, like a rash. On the other hand, it requires thought and feeling at the highest order of cerebral function. “Man is the only animal that blushes,” Mark Twain wrote. “Or needs to.”

Observers have often assumed that blushing is simply the outward manifestation of shame. Freudians, for example, viewed blushing this way, arguing that it is a displaced erection, resulting from repressed sexual desire. But, as Darwin noted and puzzled over in an 1872 essay, it is not shame but the prospect of exposure, of humiliation, that makes us blush. “A man may feel thoroughly ashamed at having told a small falsehood, without blushing,” he wrote, “but if he even suspects that he is detected he will instantly blush, especially if detected by one whom he reveres.”

But if it is humiliation that we are concerned about, why do we blush when we’re praised? Or when people sing “Happy Birthday” to us? Or when people just look at us? Michael Lewis, a professor of psychiatry at the University of Medicine and Dentistry of New Jersey, routinely demonstrates the effect in classes. He announces that he will randomly point at a student, that the pointing is meaningless and reflects no judgment whatever about the person. Then he closes his eyes and points. Everyone looks to see who it is. And, invariably, that person is overcome by embarrassment. In an odd experiment conducted a couple of years ago, two social psychologists, Janice Templeton and Mark Leary, wired subjects with facial-temperature sensors and put them on one side of a one-way mirror. The mirror was then removed to reveal an entire audience staring at them from the other side. Half the time the audience members were wearing dark glasses, and half the time they were not. Strangely, subjects blushed only
when they could see the audience’s eyes.

What is perhaps most disturbing about blushing is that it produces secondary effects of its own. It is itself embarrassing, and can cause intense self-consciousness, confusion, and loss of focus. (Darwin, struggling to explain why this might be, conjectured that the greater blood flow to the face drained blood from the brain.)

Why we have such a reflex is perplexing. One theory is that the blush exists to show embarrassment, just as the smile exists to show happiness. This would explain why the reaction appears only in the visible regions of the body (the face, the neck, and the upper chest). But then why do dark-skinned people blush? Surveys find that nearly everyone blushes, regardless of skin color, despite the fact that in many people it is nearly invisible. And you don’t need to turn red in order for people to recognize that you’re embarrassed. Studies show that people detect embarrassment before you blush. Apparently, blushing takes between fifteen and twenty seconds to reach its peak, yet most people need less than five seconds to recognize that someone is embarrassed—they pick it up from the almost immediate shift in gaze, usually down and to the left, or from the sheepish, self-conscious grin that follows a half second to a second later. So there’s reason to doubt that the purpose of blushing is entirely expressive.

There is, however, an alternative view held by a growing number of scientists. The effect of intensifying embarrassment may not be incidental; perhaps that is what blushing is for. The notion isn’t as absurd as it sounds. People may hate being embarrassed and strive not to show it when they are, but embarrassment serves an important good. For, unlike sadness or anger or even love, it is fundamentally a moral emotion. Arising from sensitivity to what others think, embarrassment provides painful notice that one has crossed certain bounds while at the same time providing others with a kind of apology. It keeps us in good standing in the world. And if blushing serves to heighten such sensitivity this may be to one’s ultimate advantage.

The puzzle, though, is how to shut it off. Embarrassment causes blushing, and blushing causes embarrassment—so what makes the cycle stop? No one knows, but in some people the mechanism clearly goes awry. A surprisingly large number of people experience frequent, severe, uncontrollable blushing. They describe it as “intense,” “random,” and “mortifying.” One man I talked to would blush even when he was at home by himself just watching somebody get embarrassed on TV, and he lost his job as a management consultant because his bosses thought he didn’t seem “comfortable” with clients. Another man, a neuroscientist, left a career in clinical medicine for a cloistered life in research almost entirely because of his tendency to blush. And even then he could not get away from it. His work on hereditary brain disease became so successful that he found himself fending off regular invitations to give talks and to appear on TV. He once hid in an office bathroom to avoid a CNN crew. On another occasion, he was invited to present his work to fifty of the world’s top scientists, including five Nobel Prize winners. Usually, he could get through a talk by turning off the lights and showing slides. But this time a member of the audience stopped him with a question first, and the neuroscientist went crimson. He stood mumbling for a moment, then retreated behind the podium and surreptitiously activated his pager. He looked down at it and announced that an emergency had come up. He was very sorry, he said, but he had to go. He spent the rest of the day at home. This is someone who makes his living studying disorders of the brain and the nerves, yet he could not make sense of his own condition.

There is no official name for this syndrome, though it is often called “severe” or “pathological” blushing, and no one knows how many people have it. One very crude estimate suggests that from one to seven per cent of the general population is afflicted. Unlike most people, whose blushing diminishes after their teen-age years, chronic blusers report an increase as they age. At first, it was thought that the
problem was the intensity of their blushing. But that proved not to be the case. In one study, for example, scientists used sensors to monitor the facial color and temperature of subjects, then made them stand before an audience and do things like sing “The Star-Spangled Banner” or dance to a song. Chronic blushers became no redder than others, but they proved significantly more prone to blush. Christine Drury described the resulting vicious cycle to me: one fears blushing, blushes, and then blushes at being so embarrassed about blushing. Which came first—the blushing or the embarrassment—she did not know. She just wanted it to stop.

In the fall of 1998, Drury went to see an internist. “You’ll grow out of it,” he told her. When she pressed, however, he agreed to let her try medication. It couldn’t have been obvious what to prescribe. Medical textbooks say nothing about pathological blushing. Some doctors prescribe anxiolytics, like Valium, on the assumption that the real problem is anxiety. Some prescribe beta-blockers, which blunt the body’s stress response. Some prescribe Prozac or other antidepressants. The one therapy that has been shown to have modest success is not a drug but a behavioral technique known as paradoxical intention—having patients actively try to blush instead of trying not to. Drury used beta-blockers first, then antidepressants, and finally psychotherapy. There was no improvement.

By December of 1998, her blushing had become intolerable, her on-air performance humiliating, and her career almost unsalvageable. She wrote in her diary that she was ready to resign. Then one day she searched the Internet for information about facial blushing, and read about a hospital in Sweden where doctors were performing a surgical procedure that could stop it. The operation involved severing certain nerves in the chest where they exit the spinal cord to travel up to the head. “I’m reading this page about people who have the exact same problem I had, and I couldn’t believe it,” she told me. “Tears were streaming down my face.” The next day, she told her father that she had decided to have the surgery. Mr. Drury seldom questioned his daughter’s choices, but this sounded to him like a bad idea. “It shocked me, really,” he recalls. “And when she told her mother it shocked her even worse. There was basically no way her daughter was going to Sweden and having this operation.”

Drury agreed to take some time to learn more about the surgery. She read the few articles she could find in medical journals. She spoke to the surgeons and to former patients. After a couple of weeks, she grew only more convinced. She told her parents that she was going to Sweden, and when it became clear that she would not be deterred her father decided to go with her.

The surgery is known as endoscopic thoracic sympathectomy, or E.T.S. It involves severing fibres of a person’s sympathetic nervous system, part of the involuntary, or “autonomic,” nervous system, which controls breathing, heart rate, digestion, sweating, and, among the many other basic functions of life, blushing. Toward the back of your chest, running along either side of the spine like two smooth white strings, are the sympathetic trunks, the access roads that sympathetic nerves travel along before exiting to individual organs. At the beginning of the twentieth century, surgeons tried removing branches of these trunks—a thoracic sympathectomy—for all sorts of conditions: epilepsy, glaucoma, certain cases of blindness. Mostly, the experiments did more harm than good. But surgeons did find two unusual instances in which a sympathectomy helped: it stopped intractable chest pain in patients with advanced, inoperable heart disease, and it put an end to hand and facial sweating in patients with hyperhidrosis—uncontrollable sweating.

Because the operation involved open-chest surgery, it was rarely performed. In recent years, however, a few surgeons, particularly in Europe, have been doing the procedure endoscopically, using scopes inserted through small incisions. Among them was a trio in Göteborg, Sweden, who noticed that many of their hyperhidrosis patients not only stopped sweating after surgery but stopped blushing, too. In
1992, the Göteborg group accepted a handful of patients who complained of disabling blushing. When the results were reported in the press, the doctors found themselves deluged with requests. Since 1998, the surgeons have done the operation for more than three thousand patients with severe blushing.

The operation is now performed around the world, but the Göteborg surgeons are among the few to have published their results: ninety-four per cent of patients experienced a substantial reduction in blushing; in most cases it was eliminated completely. In surveys taken some eight months after the surgery, two per cent regretted the decision, because of side effects, and fifteen per cent were dissatisfied. The side effects are not life-threatening, but they are not trivial. The most serious complication, occurring in one per cent of patients, is Horner’s syndrome, in which inadvertent injury of the sympathetic nerves to the eye results in a constricted pupil, a drooping eyelid, and a sunken eyeball. Less seriously, patients no longer sweat from the nipples upward, and most experience a substantial increase in lower-body sweating in compensation. (A decade after undergoing E.T.S. for hand sweating, according to one study, the proportion of patients who were satisfied with the outcome dropped from an initial ninety-six per cent to sixty-seven per cent, mainly because of compensatory sweating.) About a third of patients also notice a curious reaction known as gustatory sweating—sweating prompted by certain tastes or smells. And, because sympathetic branches to the heart are removed, patients experience about a ten-per-cent reduction in heart rate; some complain of impaired physical performance. For all these reasons, the operation is at best a last resort, something to be tried, according to the surgeons, only after nonsurgical methods have failed. By the time people call Göteborg, they are often desperate. As one patient who had the operation told me, “I would have gone through with it even if they told me there was a fifty-per-cent chance of death.”

On January 14, 1999, Christine Drury and her father arrived in Göteborg, a four-hundred-year-old seaport on Sweden’s southwest coast. She remembers the day as beautiful, cold, and snowy. The Carlanderska Medical Center was old and small, with ivy-covered walls and big, arched wooden double doors. Inside, it was dim and silent; Drury was reminded of a dungeon. Only now did she become apprehensive, wondering what she was doing here, nine thousand miles away from home, at a hospital that she knew almost nothing about. Still, she checked in, and a nurse drew her blood for routine lab tests, made sure her medical records were in order, and took her payment, which came to six thousand dollars. Drury put it on a credit card.

The hospital room was reassuringly clean and modern, with white linens and blue blankets. Christer Drott, her surgeon, came to see her early the next morning. He spoke with impeccable British-accented English and was, she said, exceedingly comforting: “He holds your hand and is so compassionate. Those doctors have seen thousands of these cases. I just loved him.”

At nine-thirty that morning, an orderly came to get her for the operation. “We had just done a story about a kid who died because the anesthesiologist had fallen asleep,” Drury says. “So I made sure to ask the anesthesiologist not to fall asleep and let me die. He kind of laughed and said, ‘O.K.’”

While Drury was unconscious, Drott, in scrubs and sterile gown, swabbed her chest and axillae (underarms) with antiseptic and laid down sterile drapes so that only her axillae were exposed. After feeling for a space between the ribs in her left axilla, he made a seven-millimetre puncture with the tip of his scalpel, then pushed a large-bore needle through the hole and into her chest. Two litres of carbon dioxide were pumped in through the needle, pushing her left lung downward and out of the way. Then Drott inserted a resectoscope, a long metal tube fitted with an eyepiece, fibre-optic illumination, and a cauterizing tip. It is actually a urological instrument, thin enough to pass through the urethra (though never thin enough, of course, for urology patients). Looking through the lens, he searched for her left
sympathetic trunk, taking care to avoid injuring the main blood vessels from her heart, and found the
glabrous cordlike structure lying along the heads of her ribs, where they join the spine. He cauterized the
trunk at two points, over the second and third ribs, destroying all the facial branches except those that
lead to the eye. Then, after making sure there was no bleeding, he pulled the instrument out, inserted a
catheter to suction out the carbon dioxide and let her lung reëxpand, and sutured the quarter-inch
incision. Moving to the other side of the table, he performed the same procedure on the right side of her
chest. Everything went without a hitch. The operation took just twenty minutes.

What happens when you take away a person’s ability to blush? Is it merely a surgical version of Merle
Norman Cover Up Green—removing the redness but not the self-consciousness? Or can a few snips of
peripheral nerve fibres actually affect the individual herself? I remember once, as a teen-ager, buying
mirrored sunglasses. I lost them within a few weeks, but when I had them on I found myself staring at
people brazenly, acting a little tougher. I felt disguised behind those glasses, less exposed, somehow
freer. Would the surgery be something like this?

Almost two years after Drury’s operation, I had lunch with her at a sports bar in Indianapolis. I had
been wondering what her face would look like without the nerves that are meant to control its coloring
—would she look ashen, blotchy, unnatural in some way? In fact, her face is clear and slightly pinkish,
no different, she said, from before. Yet, since the surgery, she has not blushed. Occasionally, almost
randomly, she has experienced a phantom blush: a distinct feeling that she is blushing even though she
is not. I asked if her face reddens when she runs, and she said no, although it will if she stands on her
head. The other physical changes seemed minor to her. The most noticeable thing, she said, was that
neither her face nor her arms sweat now and her stomach, back, and legs sweat much more than they
used to, though not enough to bother her. The scars, tiny to begin with, have completely disappeared.

From the first morning after the operation, Drury says, she felt transformed. An attractive male nurse
came to take her blood pressure. Ordinarily, she would have blushed the instant he approached. But
nothing of the sort happened. She felt, she says, as if a mask had been removed.

That day, after being discharged, she put herself to the test, asking random people on the street for
directions, a situation that had invariably caused her to redden. Now, as her father confirmed, she didn’t.
What’s more, the encounters felt easy and ordinary, without a glimmer of her old self-consciousness. At
the airport, she recalls, she and her father were waiting in a long check-in line and she couldn’t find her
passport. “So I just dumped my purse out onto the floor and started looking for it, and it occurred to me
that I was doing this—and I wasn’t mortified,” she says. “I looked up at my dad and just started crying.”

Back home, the world seemed new. Attention now felt uncomplicated, unfrightening. Her usual internal
monologue when talking to people (“Please don’t blush, please don’t blush, oh God I’m going to blush”)vanished, and she found that she could listen to others better. She could look at them longer, too,
without the urge to avert her gaze. In fact, she had to teach herself not to stare.

Five days after the surgery, Drury was back at the anchor desk. She put on almost no makeup that night.
She wore a navy-blue woollen blazer, the kind of warm clothing she would never have worn before.
“My attitude was, This is my début,” she told me. “And it went perfectly.”

Later, I viewed some tapes of her broadcasts from the first weeks after the surgery. I saw her report on
the killing of a local pastor by a drunk driver, and on the shooting of a nineteen-year-old by a sixteen-
year-old; she was, in fact, more natural than she’d ever been. One broadcast in particular struck me. It
was not her regular nighttime bulletin but a public-service segment called “Read, Indiana, Read!” For
six minutes of live airtime on a February morning, she was shown reading a story to a crowd of obstreperous eight-year-olds as messages encouraging parents to read to their children scrolled by. Despite the chaos of kids walking by, throwing things, putting their faces up to the camera, she persevered, remaining composed the entire time.

Drury had told no one about the operation, but people at work immediately noticed a difference in her. I spoke to a producer at her station who said, “She just told me she was going on a trip with her dad, but when she came back and I saw her on TV again, I said, ‘Christine! That was unbelievable!’ She looked amazingly comfortable in front of the camera. You could see the confidence coming through the TV, which was completely different from before.” Within months, Drury got a job as a prime-time on-air reporter at another station.

A few snips of fibres to her face and she was changed. It’s an odd notion, because we think of our essential self as being distinct from such corporeal details. Who hasn’t seen a photo of himself, or heard his voice on tape, and thought, That isn’t me? Burn patients who see themselves in a mirror for the first time—to take an extreme example—typically feel alien from their appearance. And yet they do not merely “get used” to it; their new skin changes them. It alters how they relate to people, what they expect of others, how they see themselves in others’ eyes. A burn-ward nurse once told me that the secure may become fearful and bitter, the weak jut-jawed “survivors.” Similarly, Drury had experienced her trip-wire blushing as something entirely external, not unlike a burn—”the red mask,” she called it. Yet it reached so deep inside her that she believed it prevented her from being the person she was meant to be. Once the mask was removed, she seemed new, bold, “completely different from before.” But what of the person who all her life had blushed and feared blushing and had been made embarrassed and self-conscious at the slightest scrutiny? That person, Drury gradually discovered, was still there.

One night, she went out to dinner with a friend and decided to tell him about the operation. He was the first person outside her family whom she had told, and he was horrified. She’d had an operation to eliminate her ability to blush? It seemed warped, he said, and, worse, vain. “You TV people will do anything to improve your career prospects,” she recalls him saying.

She went home in tears, angry but also mortified, wondering whether it was a freakish and weak thing to have done. In later weeks and months, she became more and more convinced that her surgical solution made her a sort of impostor. “The operation had cleared my path to be the journalist I was trained to be,” she says, “but I felt incredibly ashamed over needing to remove my difficulties by such artificial means.”

She became increasingly fearful that others would find out about the operation. Once, a co-worker, trying to figure out what exactly seemed different about her, asked her if she had lost weight. Smiling weakly, she told him no, and said nothing more. “I remember going to a station picnic the Saturday before the Indy 500, and thinking to myself the whole time, Please, please let me get out of here without anyone saying, ‘Hey, what happened to your blushing?’ “ It was, she found, precisely the same embarrassment as before, only now it stemmed not from blushing but from its absence.

On television, self-consciousness began to distract her again. In June of 1999, she took up her new job, but she was not scheduled to go on the air for two months. During the hiatus, she grew uncertain about going back on TV. One day that summer, she went out with a crew that was covering storm damage in a neighboring town where trees had been uprooted. They let her practice her standup before the camera. She is sure she looked fine, but that wasn’t how she felt. “I felt like I didn’t belong there, didn’t deserve to be there,” she says. A few days later, she resigned.
More than a year has passed since then, and Drury has had to spend this time getting her life back on track. Unemployed and ashamed, she withdrew, saw no one, and spent her days watching TV from her couch, in a state of growing depression. Matters changed for her only gradually. She began, against all her instincts, admitting to friends and then former co-workers what had happened. To her surprise and relief, nearly everyone was supportive. In September, 1999, she even started an organization, the Red Mask Foundation, to spread information about chronic blushing and to provide a community for its sufferers. Revealing her secret seemed to allow her finally to move on.

That winter, she found a new job—in radio, this time, which made perfect sense. She became the assistant bureau chief for Metro Networks radio in Indianapolis. She could be heard anchoring the news every weekday morning on two radio stations, and then doing the afternoon traffic report for these and several other stations. Last spring, having regained her confidence, she began contacting television stations. The local Fox station agreed to let her be a substitute broadcaster. In early July, she was called in at the last minute to cover traffic on its three-hour morning show.

It was one of those breakfast “news” programs with two chirpy co-anchors—a man and a woman—in overstuffed chairs, cradling giant coffee mugs. Every half hour or so, they’d turn to Drury for a two-minute traffic report. She’d stand before a series of projected city maps, clicking through them and describing the various car accidents and construction roadblocks to look out for. Now and then, the co-anchors would strike up some hey-you’re-not-our-usual-traffic-gal banter, which she managed comfortably, laughing and joking. It was exciting, she says, but not easy. She could not help feeling a little self-conscious, wondering what people might think about her coming back after her long absence. But the feelings did not overwhelm her. She is, she says, beginning to feel comfortable in her own skin.

One wants to know whether, in the end, her troubles were physical or psychological. But it is a question as impossible to answer as whether a blush is physical or mental—or, for that matter, whether a person is. Everyone is both, inseparable even by a surgeon’s blade. I have asked Drury if she has any regrets about the operation. “Not at all,” she says. She even calls the surgery “my cure.” At the same time, she adds, “People need to know—surgery isn’t the end of it.” She has now reached what she describes as a happy medium. She is free from much of the intense self-consciousness that her blushing provoked, but she accepts the fact that she will never be entirely rid of it. In October, she became a freelance part-time on-air reporter for Channel 6, the ABC affiliate in Indianapolis. She hopes the job will become full time. “You know, I don’t have a face for radio,” she says.