

In Pursuit Of The “Designer Vagina”

by

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Dedication:

To those whose work is dedicated to liberating standards of beauty.

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Abstract

A relatively new, elective and increasing medical procedure in the West known as “female genital cosmetic surgery” (FGCS) claims to have the ability to enhance the functional and aesthetic features of women’s genitalia. Using FGCS online discussion forums, this study examines the experiences of women who have undergone, or are contemplating undergoing, genital cosmetic surgery, and explores surgeons’ websites in order to understand how FGCS is marketed and promoted online. Using content analysis, this study found that women and clinic websites reported aesthetic concerns, psychological issues, physical discomfort and sexual reasons as the primary motivations for having surgery. Furthermore, this study found that surgeons’ websites advertise FGCS as a “low-risk” procedure, which acts as a reasonable solution for correcting an “abnormal” body part (i.e., the female genitals), and which women are increasingly becoming aware of in large part due to emerging normative standards of the vulva.

List of Abbreviations Used

ASAPS – American Society of Aesthetic Plastic Surgery

ASPS – American Society of Plastic Surgeons

FGCS – Female Genital Cosmetic Surgery

NIMH – National Institute of Mental Health

RCOG – Royal College of Obstetricians and Gynaecologists

SOGC – Society of Obstetricians and Gynecologists of Canada

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Chapter One: Introduction

Women's bodies have long been subject to social scrutiny, and this is perhaps more accurate today than it has ever been. In the twenty-first century, we are increasingly exposed to images of female bodies as a result of a progressively expanding media-scape. We are currently living in an age where the most commonly viewed image of female genitalia is produced by the pornography industry and is accessible at the click of a mouse, resulting in greater attention to women's genitals. The depictions of female genitals presented by this industry, according to Blackledge (2013, p. 56), are "styled by men for men" and bear "scant resemblance to the varying beauty of unadulterated vaginas." This is to say that the images of female genitals portrayed in pornography tend to present a very specific and homogenous image of strictly groomed genitals, with labia sometimes altered through surgical means into "normal" lengths. The unfortunate outcome of this representation is that it is increasingly understood as a "normal" and accurate representation of female genitalia. Evidence for this is found among the growing numbers of women choosing to undergo FGCS with hope that their genitals will resemble the genitals they see in media outlets, such as pornography, for example (see Chapter Four and Five). These images offer a very narrow, limited, and largely problematic representation of the natural variation of the shapes, sizes and colors women's genitals come in. This increasingly specific and highly visible female genital ideal results in more and more women wanting to, and indeed, feeling pressure to, alter their genitals in order to conform to a specific idea of female genital "normality," particularly through genital hair removal but increasingly also through female genital cosmetic surgery (FGCS).

Section I: Female Genital Cosmetic Surgery

The motivation for this thesis began after having watched a documentary filmed in the UK by Lisa Rogers and Heather Leach titled, *The Perfect Vagina* (2008), which was made in response to the documentary, *My Penis and Everyone Else's* (2007), a film aimed at challenging society's stereotypes of masculinity. The purpose of Rogers and Leach's film was to look at women's insecurities surrounding their genitalia and to further explore the practice of FGCS. After watching *The Perfect Vagina*, I was shocked at how many women in this film were repulsed and mortified by their genitalia – a part of the female body I had little idea could cause such shame and resentment:

I've been picked on about it before, like my sister has, or I've been with guys and then they'd dump me the next day. I've heard "[you have] a hanging ham" and stuff like that. I just hate it! I really really hate mine. It's horrible" (labiaplasty patient) (Rogers and Leach, 2008).

The above quotation demonstrates the pain and embarrassment some women often experience surrounding their genitals on a day-to-day basis. This woman in particular expresses the degree to which she despises the appearance of her genitalia and the hardship (mockery and ridicule) that she has faced because of the appearance of her anatomy, so much so that she had elected to undergo female genital cosmetic surgery in hopes of somehow "fixing" the aesthetics of her genitalia to resemble a "normal" vulva.

Prior to this documentary, I was oblivious to the notion that a woman's genitalia – indeed my genitalia – *ought to* and *should* look a certain and very specific way. Of course I was aware of certain "feminine" trends such as Brazilian waxing, but I was unaware of the notion that if a woman's genitals did not compare to specific standards and expectations of what a vulva is "suppose" to look like, then her genitalia is often considered flawed or "abnormal," and surgery to fix this "problematic vulva" should be

sought out. Indeed, to go a step further, I was not aware that there was such a thing as “normal” genitalia, or that a significant number of women (predominantly in the United States and Canada) are taking extreme measures to achieve an idealized image of the vulva, until research for this thesis had begun.

(Female Genital) Cosmetic Surgery In High Demand

The rise in cosmetic surgery during the last decade is staggering; cosmetic surgery is considered to be the fastest growing medical specialty in North America (American Society for Aesthetic Plastic Surgery, 2013a; Stoppard, Miedema, & Anderson, 2000). In recent years, the practice of cosmetic surgery has received increased attention in mainstream media with many popular TV shows show-casing the apparent benefits of cosmetic procedures.¹ The American Society for Aesthetic Plastic Surgery (ASAPS) (2013a), the primary source of cosmetic surgery statistics in the United States, reported that cosmetic surgery procedures increased by 279% from 1997 through 2013. This increase in cosmetic procedures is also visible among female genital cosmetic surgery, a relatively new and quickly growing elective medical procedure in the West (Braun, 2010).

Female genital cosmetic surgery promises to enhance, modify, and “fix” both the aesthetic and the functional features of a woman’s genitalia.² However, medical specialists do not always agree about what constitutes a legitimate reason to perform such procedures (Braun, 2010). This disagreement stems in part from the fact that some medical specialists and professional organizations have issued public position statements

¹ See, for example, “Extreme Makeover,” “Nip/Tuck,” “The Swan,” “Plastic Fantastic.”

² It is important to note that FGCS does not refer to traditional female genital cutting, surgeries for intersex or trans individuals, or surgeries for the repairing of vaginal anomalies that are deemed medically abnormal (Braun, 2010).

and recommendations surrounding FGCS procedures. The Society of Obstetricians and Gynecologists of Canada (SOGC), for instance, suggests that such procedures “are both lacking in evidence of safety and efficacy and [are] fraught with challenges” (The Society of Obstetricians and Gynecologists of Canada, 2013, p. 3), and therefore should not be performed unless medically necessary, such as in cases of injuries following childbirth. In fact, in the month that I began this research (June of 2014), the Society of Obstetricians and Gynecologists of Canada’s 70th annual meeting was held in Niagara Falls, where the theme was, *The Ideal of Perfect – Genital Cosmetic Surgery*. Canadian gynecologists were set to debate the growing demand for “designer genitalia” procedures.

FGCS Procedures

According to the Vancouver Sun, an article posted on FGCS titled, “Is It Unethical for Canadian Doctors to Perform Female Genital Cosmetic Surgery,” reports that FGCS has become so popular that it is now one of the most Google-searched forms of cosmetic surgical procedures (Kirkey, 2014). The term “female genital cosmetic surgery” is a wide umbrella term that encapsulates a large range of procedures to alter a woman’s genitalia. Available procedures include vaginal tightening, labia majora and labia minora “augmentations,” pubic liposuction, clitoral hood reductions, “G-spot amplification,” hymen “reconstruction,” and surgery to the mons pubis (Braun, 2010). Operations to have one’s vulva “designed” are more prevalent than ever before, with growing numbers of women in Canada and the United States (and other countries in the West) opting to have one or more of the above-mentioned procedures. Furthermore, the cost of these procedures in Canada and the United States can range from \$3,000 to \$8,000 depending on the type of procedure and the number of procedures requested

(Braun, 2005). Similar to other cosmetic surgical procedures, FGCS is not covered by Canadian or American health insurance. However, female genital cosmetic surgery may qualify as a medical expense if it is deemed medically necessary for medical or reconstructive purposes (American Society of Plastic Surgeons, 2015; Canada Revenue Agency, 2015).

The idea of surgery to “enhance” women’s genitals is far from new; from “revirginations” to “clitoridectomies,” women’s genitals have long been recognized as a surgically modifiable part of the female body (Braun, 2013). Surgery on women’s genitals for primarily *aesthetic* reasons, however, is new (Braun, 2010). Although discussions of genital surgery for purely aesthetic reasons appear within medical literature as early as 1984, FGCS did not enter the broader public consciousness until 1998 when two Los Angeles surgeons, Drs. Gary Alter and David Matlock, publically announced procedures they were performing that would “beautify” a woman’s genitalia (Tiefer, 2007; Rodrigues, 2012). Increasing coverage of these procedures in clinical reports and media throughout the late 1990s and early 2000s has resulted in the “designer vagina” becoming part of public discourse (Braun, 2010).

It is reported and indeed evident through the fragmented and limited research that is available on FGCS, that data on the risks, benefits and long-term outcomes of FGCS are often unreliable, because clinical reports tend to report successful surgeries only, and often provide little evidence concerning long-term outcomes. Despite the limited and unreliable data on FGCS, it is clear that consumer demand for such procedures has grown rapidly, especially within the West. For example, labiaplasty procedures, which include the trimming of a woman’s labia in an attempt to make the labia more symmetrical and

less noticeable, almost tripled in a short time according to the National Health Service in the U.K. These procedures went from less than 400 performed in 1999 to approximately 1,200 performed in 2007 (Braun, 2010). Similarly, recently released statistics by the American Society for Aesthetic Plastic Surgery (2013b) show that labiaplasty procedures increased by 44% in 2013 (from 3,521 in 2012 to 5,070 in 2013). The number of surgeons who promote these procedures – and have established specialist clinics – have increased substantially as well. According to the American Society for Aesthetic Plastic Surgery (2013b), the proportion of plastic surgeons performing labiaplasties increased from 21% in 2012 to 29% in 2013 within the United States.

Knowledge Gap

The few studies on FGCS primarily report on the age of the women who undergo these procedures. Patients' ages range from early teens through to the 60s and 70s, with patients in their 20s and 30s predominating (Braun, 2010). However, a number of limitations regarding the data on FGCS have been recorded: for instance, data in the United States rely heavily on information from cosmetic surgeons, rather than gynecologists and other medical specialists who also perform these types of surgeries. Therefore, the prevalence of FGCS could in fact be higher than what is reported (Braun, 2010; Rodrigues, 2012).

Despite the rapidly growing demand for FGCS among women in Canada and the United States, the research available is still limited in its scope; few studies have been conducted on FGCS specifically, with most of the research focusing on cosmetic surgery as a whole. As a result, little is known or understood about the reasons women undergo FGCS. Nor do we know or understand how such procedures are being marketed on

surgeon's websites and what the implications of surgeon's marketing strategies might be. While there are multiple scholars who have attributed the heightened demand for FGCS to an increase in explicit pornography and increasing awareness of these surgeries, few qualitative studies engage in research that examined the reasons women undergo FGCS.

Section II: The Project Goal

This study will examine how women's reasons for undergoing FGCS are represented, both by women themselves and by the surgeons advertising the procedures. I examine the way women discuss their experiences with, and reasons for, FGCS as a way to evaluate the validity of claims about women's motives. Additionally, this research is concerned with the role that surgeons' websites have in promoting the procedures as well as the reasons surgeons claim women undergo such procedures. These websites have a specific purpose – to advertise and promote the surgeon(s), clinic(s), and surgeries to potential consumers. This aspect of the research will analyze whether surgeons' websites work to sell vaginal distress and anxiety to women, as well as ways in which women's genitals may be constructed as potentially inadequate or damaged, but also improvable (i.e., through medical intervention). This part of the research is significant because surgeons' websites contribute largely to the discourse surrounding FGCS and women's reasons for undergoing it. Lastly, this research will analyze the ways in which text and images (such as before and after photographs) on surgeons' websites might aim to influence women's decisions to undergo, or contemplate undergoing, FGCS with a particular interest in whether and how these images seek to regulate, reduce variation, and mimic the aesthetic ideal of the female genitals. This ideal is suggested to be “absent” and “smooth,” with no external anatomy visible (McDougall, 2013).

In this thesis I examine the rhetoric and logic used to articulate reasons for undergoing FGCS through a comparative analysis of cosmetic surgeons' and women's own representations of motives for getting FGCS. I analyze surgeons' websites as well as FGCS online forums written by women who have undergone, or are considering undergoing, FGCS. This research design aims to explore the relationship(s) between the reasons women describe for FGCS, the reasons surgeons' websites describe for FGCS, how such procedures are being promoted on these websites, and women's own insecurities about their genitalia. This will allow me to examine if there are certain similarities that suggest a shared discourse among FGCS patients (or potential patients) and surgeons' websites.

Research Questions and Objectives

This thesis aims to address two key questions, which act as the foundation for my analysis: First, how are participants in female genital cosmetic surgery online forums articulating their reasons for undergoing, or contemplating undergoing, genital cosmetic procedures? Secondly, how are surgeons' websites, which advertise female genital cosmetic surgery, articulating the reasons for women to undergo genital cosmetic procedures? While this project began with a very specific purpose – to uncover why women are choosing to have FGCS according to both women and clinic websites – important factors quickly became clear through the process of data collection. It became clear that how women's bodies and genitals are discussed by surgeons and women themselves before and after FGCS, as well as the amount of information on the potential risks and successes of FGCS presented on surgeons' websites, were likely to be important

elements that condition women's reasons for choosing FGCS, which might, in turn, contribute to the growing demand of these procedures.

My research has five, interrelated objectives. First, this study aims to provide insight into why women might be willing to undergo FGCS, despite the lack of reliable information on the potential risks and long-term outcomes. Secondly, I wish to better understand how women who are contemplating undergoing FGCS and those who have actually undergone such procedures think about FGCS, as there is only limited knowledge of this in the literature on the subject. Thirdly, this research aims to contribute to the current debate on FGCS in the feminist literature by exploring women's views on FGCS, which have not been previously investigated. The fourth objective is to examine how FGCS procedures are being marketed and presented on clinic websites, as these websites are a primary source of discourse surrounding female genital cosmetic surgery, and currently there is minimal research on them in the literature. Lastly, this research aims to explore some of the broader implications of the growing popularity of FGCS. Academic critique of elective genital cosmetic surgeries is vital, particularly as these procedures are increasingly common, and yet there is minimal evidence concerning the long-term risks and outcomes associated with them.

Section III: Thesis Structure

In the second chapter, I present my analytical framework, which has greatly influenced and helped to shape my overall approach to this study. I then move on to the literature and theoretical debates surrounding cosmetic surgery and women's bodies. I also explore literature on the "sexualization of culture," and end with an examination of the idea of an aesthetic ideal of the female genitals.

In Chapter Three I outline the methodology of this research and explain how this research was conducted. I also outline how the data were collected and analyzed, and I end with a consideration of the limitations of this research.

The purpose of the next two chapters is to report on and explore the study's findings. In particular, in Chapter Four I provide a detailed description of the reasons and motivations women articulate for undergoing FGCS, and how these reasons are represented on surgeons' websites. I also explore what it means to be an "ideal" cosmetic patient as opposed to a "passive" one and examine the potential risks and "successes" of FGCS, as reported by women themselves and the clinic websites. Finally, in Chapter Five I examine the concept of medicalization and the implications this process may have for women. I explore medicalization by examining women's experiences with FGCS as well as surgeons' websites, and I report and discuss findings on how medicalization impacts the way in which women view their genitals. This is done by examining four key themes: first, I examine medicalization occurring at both the "conceptual" and "interactional" level (Conrad & Kern, 1986); second, I discuss findings regarding the way in which women and surgeons' websites are "speaking" about women's bodies, and in particular, about women's genitals before and after surgery; third, I explore how "normal" and "abnormal" genitals are described by women and surgeons; lastly, I end with an examination of the "before" and "after" (FGCS) photographs found on surgeons' websites.

The final chapter summarizes the findings and discusses the significance of this study— focusing on why people should care about this research, and why this topic

warrants investigation. The chapter ends with recommendations for the direction of future research.

Chapter Two: Theoretical Framework & Literature Review

My analysis is situated on the razor's edge between a feminist critique of the cosmetic surgery craze (along with the ideologies of feminine inferiority which sustain it) and an equally feminist desire to treat women as agents who negotiate their bodies and their lives within the cultural and structural constraints of a gendered social order (Davis, 1995, p.5).

Section I: Chapter Outline and Theoretical Influences

Given that the increase in elective FGCS procedures raises many questions and concerns for feminist researchers, my research is heavily influenced by, and based within, a feminist framework. The questions guiding this research emerge from the conflicting feminist theories on FGCS, in particular, and on cosmetic surgery, in general.³ I draw upon several key theoretical frameworks in this chapter in order to produce a theoretical understanding of women's participation and awareness of the cultural forces that are at play in the construction of femininity and beauty.

More specifically, this chapter begins by briefly discussing the difference between cosmetic surgery and reconstructive surgery. I argue that this is an important distinction, particularly in this study, which focuses on cosmetic surgery, given that the reasons for undergoing cosmetic surgery compared to reconstructive surgery often differ significantly. Next, this chapter outlines the two main theoretical frameworks that have informed my interest in this topic as a whole and my approach to this study. I then outline the debates regarding (female genital) cosmetic surgery found within the feminist literature on women's bodies. Next, I move to an exploration of literature concerning how the "sexualization of culture" has influenced or changed the way individuals (and women in particular) experience forms of sexual involvement. As well, I examine how

³ Please refer to Chapter One, page 8 for an outline of the two primary questions guiding this research.

the “sexualization of culture” has contributed to an emphasis on women’s bodies and the impact this has on the FGCS industry. This chapter ends with a discussion of the idea of an aesthetic “ideal” of the female genitals and its possible implications.

Cosmetic Surgery Versus Reconstructive Surgery

It is important to begin this chapter by reviewing the history of cosmetic surgery in order to better understand the main differences between cosmetic surgical practice and reconstructive surgery. In his book, *Making the body beautiful: A cultural history of aesthetic surgery* (1999), historian Sander Gilman illustrates the difference between cosmetic or aesthetic surgery and reconstructive surgery. Understanding this difference is necessary because each practice is viewed, and often studied, through distinct perspectives, analyses and ideologies. In particular, because this study is focused specifically on cosmetic surgery rather than reconstructive surgery, it is worth noting the distinction between the two, since cosmetic surgery patients often differ from reconstructive surgery patients in significant ways. Most importantly, patients of non-cosmetic surgical practices often hope they do not need to undergo surgery, whereas cosmetic surgery patients *want* to undergo the surgery (Khoo, 2009). Reconstructive surgery is recognized as repairing the function to a part of the body; cosmetic surgery, however, is classified as any procedure performed without medical necessity (Gilman, 1999). Specifically, cosmetic surgery is defined as “operations or other procedures that revise or change the appearance, color, texture, structure or position of bodily features to achieve what patients perceive to be more desirable” (Khoo, 2009, p. 237).

According to Gilman (1999), it was not until the Middle Ages that a distinction was made between reconstructive surgery and cosmetic surgery. Only with the

Renaissance did surgeons begin to discuss aesthetic or cosmetic surgery (Gilman, 1999). As Gilman notes, Enlightenment ideology declared an individual was able to transform their physical self in search of happiness, and such ideologies have supplied the foundation for a modern culture entrenched with dominant beauty-ideals and cosmetic surgery. This practice, or as some scholars argue, this “culture” of cosmetic surgery (Blum, 2003), is thought to accomplish a “normal-like” appearance often promoted by popular media.

Theoretical Influences

Feminist scholarship on cosmetic surgery reveals a multiplicity of perspectives. Some scholars write of the oppressiveness of cosmetic surgery while others tout its ability to empower women. Interestingly, these perspectives are not always mutually exclusive or in opposition to one another - indeed such approaches can overlap. These feminist contributions help us frame the motives and pressures felt by women to obtain cosmetic surgery in the context of particular desired outcomes (for instance, the achievement of feminine beauty ideals).

There are two theoretical approaches in particular that have largely informed this research and which I have found most useful for attempting to understand women’s decisions to undergo female genital cosmetic surgery: Davis’ (1995) approach to cosmetic surgery and Braun’s (2010) perspective on female genital cosmetic surgery. Both feminist theorists take an original and thoughtful approach throughout their research on cosmetic surgery in general, and female genital cosmetic surgery in particular. Rather than representing the women who elect such surgeries as victims, they instead attempt to create a theoretical understanding of women’s agency in these procedures without

relegating them to the position of “cultural dupe.” These frameworks highlight women’s active and knowledgeable struggles within the cultural and structural restrictions of femininity and the beauty system.

Kathy Davis’ (1995) perspective on cosmetic surgery in general is a helpful framework, as she argues that rather than understanding women who elect to undergo cosmetic surgery as “brain-washed victims of media hype” or simply as “cultural dupes” of our patriarchal beauty culture, we ought to “explore how women actually experience and negotiate their bodies in the context of many promises and few options” (Davis, 1995, p. 49). These few options are defined and limited by the idealized beauty standards set in place for women in Western culture, where restricted notions of what is considered to be “normal” lie. Such idealized concepts of beauty tend to limit the range of bodies considered beautiful, and do not reflect the diversity of female bodily forms; by placing importance on whiteness, thinness, youth, and conventional femininity, beauty ideals leave little room for ethnic, age, physiological, or gender variations. Though a significant amount of the existing work on FGCS seems to assume that women who have undergone or who want to undergo cosmetic surgery are, to one extent or another, “cultural dupes” (see Morgan, 1991; Negrin, 2002), I aim to avoid such assumptions by viewing women’s choices to pursue FGCS as expressions of active agency.

An additional feminist standpoint that informs this research is that of Virginia Braun (2010). Braun suggests that the practice of FGCS can potentially relieve the distress a woman feels about her genitalia, while simultaneously creating a situation that is worse for women overall, creating yet another body-worry and a particular norm for women to live up to. Therefore, while the new surgically altered body of a woman is able

to make the woman feel adequate and appreciated, this newly modified body also produces new standards of “beauty” against which other women will subsequently be judged. A person’s relationship with cosmetic surgery is complex; for example, cosmetic surgery may be liberating at the individual level while also reinforcing oppressive images of female beauty and normalcy at the societal level. At the societal level the woman who undergoes cosmetic surgery is believed to help propagate the strict and limited standards of our “beauty” culture.

In this study my purpose is to employ a theoretical framework, which allows me to develop an understanding of women who choose to undergo female genital cosmetic surgery as agents who often have surgery as a way to survive, and indeed, thrive, within a cultural context that offers women few other options to choose from. I believe it is important to appreciate the agency women who have cosmetic surgery employ. However, at the time same, it is of equal importance not to lose sight of the (restrictive) social context within which women make choices regarding their bodies.

Section II: Theoretical Debates Surrounding Cosmetic Surgery

Cosmetic Surgery as Oppressive

Early feminist critiques of cosmetic surgery typically see the practice as a violation of a woman’s body for the purpose of reaching an unrealistic cultural ideal. In fact, some scholars go as far as to suggest that cosmetic surgery can be understood as an “extreme form of medical misogyny,” as explained by feminist theorist, Kathy Davis (1991, p. 22) (though Davis herself does not share this view). This perspective critiques the practice of cosmetic surgery as the ultimate invasion of the woman’s body in order

to meet current feminine ideals of attractiveness. This criticism continues to circulate in feminist discussions of cosmetic surgery today (see Abate, 2010; Negrin, 2002).

Undergoing cosmetic surgery is largely viewed as surrendering to patriarchal demands of beauty. This process tends to be understood as transforming a woman's body in accordance with prevalent ideals of feminine beauty. In fact, many feminist scholars argue that what seem to be examples of "choice" regarding women's decisions to have cosmetic surgery are seen instead as examples of conformity (Gimlin, 2000; Morgan, 1991; Negrin, 2002). A commonly held belief among feminist academics who take the position that cosmetic surgery is an oppressive beauty practice is that women who have had cosmetic surgery experience some form of extreme body-hatred. This bodily-hatred is a consequence of the coercion experienced in our patriarchal society, whereby standards and definitions of what it means to be "beautiful," "normal" and "healthy" (for women in particular) are socially and culturally dictated (Balsamo, 1996; Pitts-Taylor, 2007, Suchet, 2009).⁴ The problem with these concepts is that they are always in flux and therefore they can never be attained once and for all, but rather require constant beauty work.

In her article, *Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies*, Morgan (1991) argues that women are coerced into undergoing cosmetic surgery. She believes that cosmetic surgery creates a kind of "technological beauty imperative." That is, by making feminine ideals of youth and beauty "technologically achievable" cosmetic surgery also makes "obligatory the appearance of youth and the reality of 'beauty' for every woman who can afford it" (Morgan, 1991, p.

⁴ Women may aim to achieve one or all of these, as they are not inclusive or exclusive. For example, a woman may sacrifice "health" for the sake of "beauty," but similarly, a woman may understand "beauty" as being "healthy."

40/41). The key to this lies in what she refers to as the three “paradoxes of choice” (Morgan, 1991, p. 35), which are situations that leave women with no real options at all but to have cosmetic surgery. Morgan distinguishes three such paradoxes. First, “The Choice of Conformity,” means that what may seem like an optimal situation of consideration, deliberation, and autonomy tends to represent compliancy at a more complex level (Morgan, 1991, p. 36). The second paradox is referred to as “Liberation into Colonization” (Morgan, 1991, p. 36). This refers to the idea that while the rhetoric surrounding cosmetic surgery is of liberation, self care, and of “making the most of yourself,” in actuality, Morgan argues that a woman undergoes these procedures for the approval of others — “the lover, the taunting students, the employer, the social peers” (p. 38). The third paradox known as “Coerced Voluntariness and the Technological Imperative” refers to the notion that the “technological beauty imperative and the pathological inversion” of the normal are forcing women to “choose” cosmetic surgery (Morgan, 1991, p. 41). Morgan concludes her article by stating that in a culture such as our own where the pressure to perform a narrow and specific kind of “beauty” and femininity is constantly mounting, and which is increasingly achieved at the hands of a cosmetic surgeon, refusal and noncompliance can come at a high price (Morgan, 1991).

In similar fashion, some feminist scholars argue that living in a surgical age reinforces women’s submissiveness to what Wolf (1990) refers to as the “beauty myth.” Wolf suggests that the “beauty myth” strikes women both physically and psychologically leading them to “freely” give in to practices that are similar to torture, such as cosmetic surgery. This means that women are expected to do everything in their power to maintain attractiveness in our current “beauty culture” no matter how painful that may be. Further,

it is argued that by understanding cosmetic surgery as an acceptable beauty practice, both facial and bodily features that are not culturally acceptable become progressively contingent; “ugliness” becomes a woman’s choice and responsibility (Tait, 2007). This leads to the idea that new options for staying young and looking beautiful immediately turn into new *duties*; women are *responsible* for their “beauty” and, consequently, for their “flaws,” as if every woman has equal access to the means to “fix” them. Therefore, the cultural ideal of femininity and beauty eventually becomes the cultural *norm* and the desire for intervention (i.e., cosmetic procedures) leads to the desire to be “normal.” This idea of “beauty” set in place for women reinforces restrictive notions of normality. Concepts of beauty tend to limit possible variations of beautiful bodies, and do not relate to the majority of women; by placing importance on white, thin, young and feminine ideals, beauty leaves little room for ethnic, age, gender or physiological variations.

Finally, some feminist scholars go so far as to suggest that women who “succumb to societal pressures” (Abate, 2010, p.726) about their appearance by electing to have cosmetic surgery ought to be viewed as suffering from a sort of patriarchal brainwashing or “pathological illness” (Pitts-Taylor, 2007). Supposedly, cosmetic surgery is suggested to reveal “something deep about the individual self” (Pitts-Taylor, 2007, p. 20).

According to Pitts-Taylor (2007), some feminist scholars understand women who have cosmetic surgery as “sick” patients whose psyches have been rendered pathological as a result of a patriarchal culture. Bordo (1989) argues that within this patriarchal culture, practices such as cosmetic surgery transform women into “docile bodies” (Bordo, 1989, as cited in Davis, 1991, p. 28). Bordo further suggests that the normalization of women’s

bodies becomes “an amazingly durable and flexible strategy of social control” (Bordo, 1989, p. 14, as cited in Davis, 1991, p. 28).

I believe feminist arguments, which provide a strong critique of oppressive beauty techniques such as cosmetic surgery are useful, as they demonstrate the need for social change by showing how certain social structures influence women’s decisions to have cosmetic surgery. However, this type of argument leaves limited room to consider women’s agency. As Davis’ argument points out, it is crucial to examine women’s involvement with cosmetic surgery. Davis stresses women’s agency throughout her book, *Reshaping The Female Body* (1995), and argues that cosmetic surgery is not simply *imposed* on women, but rather they also fervently *desire* it. Women who choose to have cosmetic surgery should not automatically be understood as “cultural dupes;” rather, women who have cosmetic surgery are also capable of making decisions and taking responsibility for their actions, and their agency should not be over looked. It is important to keep in mind that while women may desire cosmetic surgery, the roots of those desires may come from the beauty standards that are imposed on them by the cultural context in which they live. This means that part of imposing standards of beauty and normality includes creating the desire to attain them.

Cosmetic Surgery as Empowering

The discussion surrounding feminist perspectives on cosmetic surgery has broadened to include autonomy and choice, largely due to Davis’ influential work, *Reshaping the Female Body* (1995). She was the first to depart from what was then the expected feminist condemnation of cosmetic surgery; instead, she saw women who undergo cosmetic surgery as cultural mediators, trying to survive in a culture where

women are judged by the sum of their parts (Davis, 1995; Gimlin, 2000). As a result of Davis's work, some (albeit a minority of) feminist scholars argue that, under certain conditions, cosmetic surgery can be seen as a form of empowerment, as it allows a woman to change her identity and, ultimately, her sense of self (Davis, 1995; Pitts-Taylor, 2007). This idea has given rise to a more diverse position than the perspective that cosmetic surgery is oppressive; it considers women who have cosmetic surgery as individuals who recognize the social pressures that surround "beauty" and who want to maintain or enhance their appearance and, respectively, their status in society (Abate, 2010). As Davis states, "cosmetic surgery is about exercising power under conditions which are not of one's own making" (Davis, 1995, p. 163). From this view, women who elect to undergo cosmetic surgery are recognized as being savvy negotiators who are able to make it in a culture where women are continually scrutinized because of their appearance. Some scholars suggest that these women attempt to negotiate their bodies within the social and cultural limitations in which they live, thereby expressing autonomy as best they can in restrictive circumstances (Davis, 1995; Pitts-Taylor, 2007). Based on this understanding, undergoing cosmetic surgery does not appear to be surrendering to existing patriarchal notions of beauty; rather, cosmetic surgery is about choosing to conduct a more consistent identity, one that may very well better suit how the woman has always imagined herself. By providing a way for women to construct a new sense of identity, it seems reasonable that some view such practices as having liberating and empowering effects by "allow[ing] women to express what they feel are more 'authentic' selves and to feel free" (Davis, 1995, p. 82 as cited in Tait, 2007, p.

121). Indeed, in a world in which women are largely judged by how they appear, the notion that they can change their appearance is certainly liberating for some.

Bodily technologies like cosmetic surgery not only give women the means and power to “freely” express their “true” selves (though the true selves they choose to alter almost always mirror the patriarchal standards of femininity and beauty); they also allow women to use these practices as a way to challenge or disrupt the cultural and social constructions of femininity and beauty (Wesely, 2003). That is, women are able to use cosmetic surgery as a way to protest the feminine body ideal by undergoing cosmetic procedures that will ultimately transform their bodies into the antithesis of what cosmetic surgery intends. In other words, one can manipulate cosmetic surgery procedures, which are most often used for the purpose of attaining cultural ideals of femininity, beauty and attractiveness, in such a way as to question the hegemonic notions of female beauty. The use of cosmetic surgery to transform the body into the opposite of the cultural feminine and beauty ideal is best witnessed when examining the case of French performance artist, Orlan. Orlan is well known for her radical body art in which she has her face surgically refashioned before the camera for people to see. With the use of a computer-synthesized ideal self, which consisted of a portrait based on features taken from women in famous works of art, such as the forehead of Da Vinci’s *Mona Lisa*, and the chin of Botticelli’s *Venus*, Orlan began the process to transform herself. She called her project “The Reincarnation of Saint Orlan” (Gilman, 1999). It is important to note that Orlan did not choose these women for their beauty, but rather for the stories that are associated with them (Davis, 1997). Thus, instead of having cosmetic surgery for “rejuvenation” or “beautification” reasons, Orlan uses cosmetic surgery as a

method for a different project. For instance, Orlan chose to change her male cosmetic surgeon to a feminist female one after the male surgeon complained about having to make Orlan too ugly and instead wanted to keep her “cute” (Davis, 1997). Orlan insisted on being the creator of her body, not just the creation. She explained that she wanted to be the one who decides what happens to her body instead of a passive subject of another’s decision.

These feminist contributions reveal a diversity of perspectives: cosmetic surgery can be empowering, oppressive, coercive, choice-based, or both. Across these perspectives, feminists continue to interpret cosmetic surgery as a means to achieve or rebel against feminine beauty ideals, and to highlight the motives and pressures women often encounter to obtain cosmetic surgeries.

While it is crucial that women who have undergone or who want to undergo cosmetic surgery are not viewed simply as “cultural dupes,” it is of equal importance to understand the multiple social, cultural, and economic influences women experience when choosing to undergo cosmetic surgery. The most popular argument in the feminist and social scientific literature is that the “sexualization of culture” and specifically the “pornosphere” are main influences on women’s decisions to have cosmetic surgery, and in particular, FGCS (see Brain, 2013).⁵ While the evidence presented in such literatures is compelling, it is also important to consider other factors that influence women’s choices to undergo surgery. In particular, feminist scholars have discussed how the construction of women’s bodies within particular social and cultural contexts will be viewed, evaluated, and treated (Bartky, 1990). As such, a consequence of living in a

⁵ The following section provides a detailed discussion of the “sexualization of culture” and the “pornosphere.”

patriarchal society is that women are continually scrutinized, critiqued, and judged by the “male gaze” (Bartky, 1990).⁶ An unfortunate consequence of the male gaze is that women are conditioned to view themselves as objects of this gaze and therefore tend to become major consumers of products and services (i.e., FGCS) aimed at altering their body parts to meet current cultural feminine ideals.

Furthermore, a third contributing factor influencing women’s decisions to have FGCS is the process of medicalization.⁷ Put simply, medicalization refers to a process through which an aspect of one’s life comes to be considered pathological and a medical problem (Conrad, 1992). For example, feeling uncomfortable about one’s appearance is now largely understood by both medical professionals and women as a medical “problem” that can be addressed with surgery. Thus, women who may be unhappy with the appearance of their genitals are turning to medical experts in order to “fix” this apparent medical “problem.”

Section III: The “Sexualization of Culture”

A significant body of literature suggests that the idealized standard of vaginal “beauty,” along with the development of a narrow aesthetic of the vulva, is linked to mainstream pornography (Braun, 2010), specifically, and the “sexualization of culture,” more generally (Attwood, 2006; McNair, 2002; McRobbie, 2009). “Sexualized culture” is a new form of sexual involvement, which refers to “contemporary preoccupations with sexual values, practices and identities, the emergence of new forms of sexual experience and the apparent breakdown of rules, categories and regulations designed to keep the obscene at bay” (Attwood, 2006, p. 77).

⁶ Please refer to page 25, “The Gaze of The Other,” for a deeper understanding of the male gaze.

⁷ The process of medicalization will be explored in further detail in Chapter Five.

Consumer goods and consumption dominate the contemporary West and are becoming progressively occupied with depictions and representations of sex. Traditionally it has been thought that men are more concerned with the appearance of their genitals than woman. However, women are proving to be more anxious about their genital appearance now than ever before. The number of FGCS procedures that have been performed in the United States and Canada within the past decade is not entirely clear. Evidence for the increasing number of women experiencing genital anxiety is manifested in the growing number of surgeons offering FGCS procedures, and the growing number of women undergoing them.⁸ Indeed, more women than ever before are now turning to genital cosmetic surgery in order to reduce the anxiety they experience towards their genitals. According to the American Society for Aesthetic Plastic Surgery, more than 3500 female genital cosmetic surgeries were performed in 2012, representing an increase of 64% from the previous year (American Society for Aesthetic Plastic Surgery, 2013). Presumably, this distress is in part due to the mainstreaming of the sex industry and the increased exposure to nudity through print media and the Internet. References to “striptease culture” (McNair, 2002), “raunch-culture” (Evans, Riley & Shankhar, 2010; McNair, 2002), “porno-chic” (Evans, Riley & Shankhar, 2010; McNair, 2002; Whitehead & Kurz, 2009), the “pornosphere” (McNair, 2002), and the “pornographication of the mainstream” (Attwood, 2006; McNair, 2002; Whitehead & Kurz, 2009) point to the argument that those who live within contemporary consumer societies are exposed to, and participate in, the increased depiction of sexualized persons as a means of commerce. A primary schema on which consumer societies rely,

⁸ Please refer to Chapter One, pages 5/6 for statistics on the growing number of surgeons performing FGCS and women undergoing these procedures.

particularly with advertising, operate under the notion that “sex sells.”⁹ Such schema creates an environment ripe with depictions of women’s bodies whereby the body becomes an object and a commodity. However, the images that are depicted through these media outlets often misrepresent the female body. As a consequence of digital modification images of women’s bodies are often airbrushed to fit a particular norm of perfection (Green, 2005, as cited in Schick, Rima & Calabrese, 2011). Such versions of perfection are well documented throughout said media outlets, however, an investigation into why and how perfection is represented in this way, as important as it is, falls outside the parameters of this research.

The Gaze of The “Other”

Bodies are visible; they can be seen, and appearance and behavior are often subject to the gaze of the other. Indeed, some feminist theorists, such as Sandra Lee Bartky, suggest that women are in “a state of conscious and permanent visibility” (Bartky, 1998, p. 42, as cited in Dolezal, 2010, p. 358). As Attwood (2006) suggests, a major drawback of the “sexualization of culture” is that such a culture makes women’s bodies (and thus their genitalia) more widely accessible for supervision and regulation, which makes women’s appearance and bodily behavior subject to constant social scrutiny. This supervision and regulation is a ramification of our “sexualized culture,” which makes women’s sexuality open to wide audiences for regular supervision. Women become the object of the male gaze when they are marketed as sexualized objects (Durham, 2008; Hughes, 2001; McRobbie, 2002). However, studies have also suggested that the

⁹ The notion that “sex sells” does not refer explicitly to the sexualization of women’s bodies – though it most often manifests as such, the idea that “sex sells” can be represented in advertisements by objects as mundane as furniture or food.

“sexualization of culture” does not simply reinforce the male gaze, but it also helps to produce a feminine “self-policing narcissistic gaze” (Gill, 2003, p. 101, as cited in Attwood, 2006, p. 83). This “self-policing narcissistic gaze” allows women to police other women’s sexual and gender identities as well as their own through the same process as the male gaze.

Neoliberal Markets

The previously mentioned self-policing behaviors are believed to have emerged from the “medical marketing model of the neoliberal markets of Western societies” (Neasbitt & Rodriguez, 2011, p. 18). This model encourages self-policing behaviors, which include taking personal responsibility over, and participating in, the self-improvement of one’s own body as well as the monitoring and policing of others’ bodies (Neasbitt & Rodriguez, 2011). Such self-policing behaviors include women taking personal responsibility over, and participating in, the self-improvement of their bodies and genitals. Neasbitt and Rodriguez (2011) argue that this medical marketing model, along with the neoliberal markets, reinforce a reward-like system whereby particular consumer behaviors are openly approved. When such behaviors are supported by media and driven by capitalist consumption they tend to become behaviors that are rewarded, and therefore striven for by others and by society as a whole. The authors use the example of the celebration of the “early adopters” to showcase this reward system. In reference to genital cosmetic surgery, these “early adopters” are the women who were prepared to undergo FGCS procedures before such surgeries were more widely accepted and advertised. According to Tiefer (2010), in discourses surrounding neoliberalism, these types of women – the “early adopters” – are thought of as brave and “empowered

consumers.” As a result, these “brave” and “empowered” women are believed to embody agency and power, and are thought to be savvy consumers who made use of new technologies in order to improve their bodies (and in particular, their genitals) (Neasbitt & Rodriguez, 2011). The highly publicized result of the women’s behavior was admiration by other women and the continuing development of an aesthetic ideal of the female genitals.

Media and Technology

To argue that media depictions of the female body have the potential to affect women’s perceptions of their own body would be to state the obvious. Indeed, we live in what Bordo refers to as “the empire of images” in which the media dictates aesthetic ideals (Bordo, 2003, p. 16, as cited in McDougall, 2013, p. 778). In the late twentieth century and early twenty-first century, media in the West produced an unprecedented amount of sexually explicit material. This material was marketed, sold, bought, and reproduced with ease as a result of our consumer societies (Gill, 2009; Holmberg, 1998). Beyond the academy, domains such as art, journalism, popular entertainment and mass media, to name a few, had used the representations of pornography (i.e., “sex-sells”) in non-pornographic ways (referred to as “porno chic”). Additionally, McNair (2002) argues that women and men have easier access to sexually explicit material as a result of emerging technology (i.e., new technological developments); he refers to this as the “pornosphere.” Indeed, it can be argued that the perceptions of female genitalia and its sexual function has been shaped and influenced by cultural aesthetic standards and ideals as a result of these sexually explicit media images. Such perceptions may be particularly instrumental in shaping women’s consciousness of their own genital appearance, thus

resulting in the development of a standard aesthetic for women's genitalia.

Section IV: The Aesthetic Ideal

It is important to explore academic literature on standardization and the aesthetic ideal because it brings attention to the way in which the construction of ideals, and their relationship with ideas of normalcy, are progressively encroaching on (women's) bodily integrity. Some scholars point to the argument that "crotch shots" in pornography have reinforced women's awareness of their genitalia to a point where women have begun to compare their genitals to a specific ideal (Appleyard & Smith, 2001, as cited in Green, 2005). Since many images of women's bodies and genitals are often digitally modified (as previously discussed), this comparison may create worry of an "abnormal" or flawed genital appearance, which is thought to reinforce the demand for FGCS. According to Schick, Rima & Calabrese (2011), women may be particularly susceptible to developing distorted impressions of their genitalia as a result of exposure to these images.¹⁰

Clear standards of beauty and normality exist for women's bodies in all cultures (Braun & Kitzinger, 2001). Braun and Kitzinger (2011) suggest that the Western ideal of the female body in particular is a site for unlimited improvements. They suggest that the idea of a "perfect vagina" is evidence that specific norms for the body have extended to the "private" domain, as well. As Jennifer Blake, CEO of the Society of Obstetricians and Gynecologists of Canada, states on her personal web blog titled, *Women and Health*, "In

¹⁰ This argument is based off a study conducted by the authors in 2008, which found that "women exposed to a set of images of vulvas pre-labiaplasty judged their own labia minora to be significantly smaller, compared to women exposed to a set of images of the same vulvas post-labiaplasty" (i.e., with surgically reduced labia minora) (Shick, Rima & Calabrese, 2011, p. 79).

the west women have for years been free to have their genitals just be, and now we are having some imposed notions of how we are supposed to look” (Blake, J., 2011, “Cosmetic labioplasty: snip cut: is it OK to cut our labia,” para. 12). It is argued that today some female genitals are thought to be more aesthetically pleasing than others by both women and men (which contributes to the development of an idealized image for female genitals) (McDougall, 2013). As previously stated, the “sexualization of culture” as well as the mainstreaming of the sex industry and increased access to the Internet, which grants (unlimited) access to various kinds of pornography, has resulted in a heightened awareness of female genital aesthetics. Women are increasingly altering their genitals in favor of the genital aesthetic ideal through such means as genital hair removal and grooming, and in more extreme and invasive cases, through the use of cosmetic genital surgeries (McDougall, 2013). The question thus remains – what is the vulvar aesthetic ideal? This increasingly specific and visible ideal of the female genitals is often described as a single “clean slit” (McDougall, 2013) or crease. More specifically, this idealized image appears to have symmetrical and very little visible labia minora, which are homogeneously pink and smooth (as in hairless or strictly groomed) (Braun and Wilkinison, 2001, as cited in McDougall, 2013). This idealized image makes women’s genitals more easily visible for regulation and scrutiny (Braun & Kitzinger, 2001, p. 264). What is problematic about this ideal other than the fact that it is largely unattainable (without undergoing FGCS) is that it works against genital diversity, and bodily variations, creating a hegemonic ideal of highly homogenous female genitalia.

The Power of Images

Through an experimental study consisting of three groups of women (one of which

was a control group), Moran and Lee (2014) found that women who viewed modified images of the vulva rated these modified images as more “normal” than the non-modified vulvas. However, the control group (those who were not pre-exposed to modified nor non-modified vulvas) rated the images of the non-modified vulvas as more “normal” than the modified vulvas. As the authors had predicted, all three groups of women rated the images of the modified vulvas as more likely to represent society’s ideal than the non-modified images. This study demonstrates that exposure to images of modified vulvas can influence women’s perceptions of what is “normal” and attractive, thereby affecting women’s (and other’s) ideas of what the female genitalia ought to resemble.

McDougall (2013) suggests that soft-core pornography plays a significant role in the development of this standard vulvar aesthetic ideal. The female genitalia visible within this type of media tend to be neat, symmetrical and altered digitally to “perfection” (McDougall, 2013). The neat and tidy genitals found in soft-core pornography have since become the ideal for female genitals, and as Kilbourne suggests in her 2010 documentary, *Killing Us Softly 4: Advertising’s Images of Women*, images are processed subconsciously, and advertisements sell us more than products. She maintains that advertisements “sell values, images, and concepts of love, sexuality, success, and *normalcy*; they tell us who we are and who we should be” (my emphasis added) (Killing Us Softly, 2010). However, images in the media, and in particular, images in pornography, give a false impression of what “normal” (female) genitalia is, since such images are both selective and digitally altered. Schick, Rima & Calabrese’s (2011) found through a content analysis of 647 centerfolds from *Playboy Magazine* that there was a noticeable similarity between the child’s toy Barbie and *Playboy Magazine*

models regarding their representation of female genitalia. They note that though Barbie is regarded as a beauty icon, her sexual anatomy is concealed and incomplete, as she lacks any defined genitalia, though her chest is clearly defined. What is interesting in the authors' study is that they found this same *misrepresentation* of female sexuality (one which evidently hides female genitalia) reappearing in human form; the images present in the *Playboy Magazine* similarly highlighted breasts and underemphasized the female genitals, depicting them as hairless and smooth in a rather prepubescent light.

Despite the fact that women's genitals come in a large range of variations, the notion of an aesthetic ideal of the female genitals remains. However, there is great difficulty in defining "normal" female genitals. To begin, describing "normal" female genitals automatically suggests that there are "abnormal" female genitals, which suggests that there is a distinct binary between "normal" and "abnormal" female genitalia. What defines "normal" and "abnormal" female genitalia tends to be contingent on socio-cultural representations of the female body and genitals, and thereby restricting the notion of what is "normal" female genitalia broadens the definition of what is believed to be "abnormal" female genitalia. The result of narrowing the idea of what constitutes "normal" female genitals again leads to an increase in desire and demand for FGCS procedures.

Body Positive Blogs

Fortunately, with the rise of technological advancements and online message boards in our technologically saturated society, there is now an increasing number of online body (and genitalia) positive blogs, websites, and forums for those women who

feel insecure, unsure or victimized about their body or genitals. These online resources offer support for individuals and work to show just how diverse bodies (and genitals) truly are. For instance, an online project titled *Large Labia Project*,¹¹ run by a twenty-five year old woman from Australia, aims to show that large labia (which are often referred to as “hypertrophic” and are believed to fall within the “abnormal” genital category) are in fact both “normal” and beautiful. Projects like this contribute to the growing demand for knowledge surrounding genital diversity, which helps perpetuate the increasing awareness of genital diversity.

Following Braun’s approach to cosmetic surgery, as more women choose to have female genital cosmetic surgery, the more limited and restricted the acceptable range of “normal” genitalia becomes. Therefore, it is reasonable to argue that female genital cosmetic surgery contributes to the near-impossible aesthetic genital ideal that women experience pressure to live up to. As Elliot argued in his book, *Making the Cut: How Cosmetic Surgery is Transforming Our Lives* (2008), “cosmetic surgery culture promotes the very anxieties it seeks to quell” (Elliot, 2008, as cited by Morgan and Lee, 2013, p. 764).

Conclusion

In conclusion, this chapter has examined the theoretical frameworks I have chosen to use, which allow me to understand women who undergo female genital cosmetic surgery as active agents, while at the same time recognizing the problematic nature of cosmetic surgery, in that it only affords women “power” through their involvement and

¹¹ Please refer to <http://largelabiaproject.org/>.

participation in an oppressive beauty system. Next, this chapter explored three areas of literature that are key in examining the practice of genital cosmetic surgery. First, I have examined the feminist debates surrounding cosmetic surgery as an oppressive act versus cosmetic surgery as an empowering practice. I then examined literature on the “sexualization of culture.” Finally, I have examined the idea of an aesthetic “ideal” for female genitals and what this ideal resembles, as well as possible implications having an idealized image of the female genitals may have.

In the next chapter I examine the methodology used for this research, explaining how the data were collected and examined, and ending with a reflection on the limitations of this study.

Chapter Three: Methods

This chapter outlines the methods and methodology that I employed to learn about and explore women's reasons for FGCS, and the ways in which such surgeries are marketed on surgeons' websites. In this chapter I begin by describing the study sample. From there I explain the data collection analytical approach and process. I then outline the processes used to code and categorize the data as well as the ethical considerations for my research. Next I discuss the strengths of my choice to conduct online research and outline some of the limitations of my chosen methodology.

Section I: The Study Sample

This thesis consisted of a comparative study and sought to first explore how participants in female genital cosmetic surgery online forums are articulating their reasons for undergoing, or contemplating undergoing, genital cosmetic procedures, and secondly, to explore how surgeons' websites, which advertise female genital cosmetic surgery, articulate the reasons for women to undergo genital cosmetic procedures. The data for my thesis was collected online between July 2014 and September 2014. Data were drawn from thirty surgeons' websites offering FGCS as well as thirty posts from online forums written by women who have had, or who are interested in having, FGCS. Qualitative research often employs an interpretive, naturalistic procedure to the subject matter; researchers who use qualitative methods seek to make sense of, or interpret, phenomena regarding the meanings and significance that individuals bring to them (Jones, 1995). Thus, qualitative research is useful for developing an interpretive understanding of the reasons and motives women experience for undergoing FGCS, as well as the ways in which FGCS procedures are marketed on surgeons' websites.

The sources of information and data collection were sampled and chosen purposefully rather than randomly in order to meet the theoretical needs of this study. The websites that were analyzed throughout this study were attained through the use of search terms such as “female genital cosmetic surgery,” “designer vagina,” “American and Canadian female genital cosmetic surgery clinics,” “FGCS message boards,” and “cosmetic genital surgeries.” The sample selected from the search results for the surgeons’ websites was chosen based on how much information the websites offer on FGCS procedures and the like; the websites which provided the most detailed information on these procedures were selected. There are a limited number of online forums for women to discuss their experience(s) with FGCS. For this reason, the sample selected for this research was based on the online forums that had the most content. For example, some online forums contain only one or two posts about FGCS, or have not been updated (e.g., a user has not posted about their experience with FGCS) within the past year. I decided to gather data from the online forums that offered the most detailed content regarding women’s experiences, reasons and feelings about female genital cosmetic surgery and forums that had been updated within the past two years, so as to generate data that reflects women’s recent experiences with and views about FGCS. Focusing on online forum posts that had been recently updated, I collected data from 30 different online users who had posted about their experiences with FGCS in 2013 or 2014.

Though I was unable to narrow down my research sample of online forums to a geographical location, as people from anywhere in the world may access and choose to use these forums, I was able to focus on American and Canadian based forums, and have

attempted to identify when possible where most women on these online forums reside. When analyzing surgeons' websites offering FGCS, I was able to be more specific with the geographical location. For the purpose of this study, these websites have been limited to Canadian and American clinics. The reason for this chosen locale is because genital cosmetic procedures were first documented in North America. More specifically, the United States is currently one of the countries with the highest prevalence of cosmetic surgeries, which makes this location an important site of investigation. Though the rate of cosmetic surgery in Canada is not as high as the United States, I have a vested interest in understanding the FGCS industry in the country in which I grew up and currently reside.

Sample Characteristics

The 30 surgeons' websites, which make up half of my sample, include 30 surgeons who are men (at times there is more than one surgeon offering FGCS per clinic website) and only three women surgeons who offer genital cosmetic surgeries. Of the 30 posts by women on the female genital cosmetic surgery online forums, only 12 women provided their location: three were from Canada; four from the United States; four from Australia; and one from the UK. Out of these 30 women, 23 provided their age, while 7 did not. The medium age range appears to be between the age of 19 and 29 years old: 7 women were between 16-18 years old; one was 15 or younger; and one woman was between 30 and 40 years old. I should reiterate that the posts from the online forums were from both women who had undergone FGCS as well as those who were considering it. The most sought-out genital cosmetic surgery among women was labiaplasty (reduction of the labial lips) with 28 out of the 30 women stating this was the procedure they had undergone (at times this was combined with another type of genital surgery, such as

clitoral hood reduction, or vaginal tightening) or this was the procedure they were considering undergoing.

Section II: The Data Collection Process

Before beginning the actual data collection, I decided to first conduct a pilot test of my research coding instruments in order to make sure that the coding categories I had designed were appropriate for the clinic websites and the online forums. This process strengthened each coding instrument, as it allowed me to adjust the categories on the coding instruments into categories that were better suited for the websites and online forums. This process also provided an opportunity for me to develop new categories for each of the coding instruments. This helped elicit specific data from the websites and online forums, which was beneficial to the study as a whole.

During data collection, I used qualitative media content analysis, “a form of media analysis [that] explores how meanings are created and communicated within media, while maintaining an openness to the emergence of new concepts” (McGannon, Cunningham & Schink, 2013, p. 893). Content analysis is extremely well suited to analyzing multifaceted, sensitive phenomena, such as FGCS (Eto & Kyngas, 2008). Specifically, I draw upon Altheide's approach, which aims to be both systematic and analytic while not being too rigid (Altheide, 1996). It involves using pre-determined categories to guide the initial coding of data, while also remaining open to new categories and themes, including an “orientation toward *constant discovery* and *constant comparison* of relevant situations, settings, styles, images, [and] meanings” (Berg 1989; Glaser & Strauss, 1967 as cited in Altheide, 1996, p. 16). As Altheide (1996) writes “[media content analysis] distinctive characteristic is the reflexive and highly interactive

nature of the investigator, concepts, data collection and analysis” (p.67). This approach encourages the researcher to develop new categories throughout the data collection. Such features are important for understanding the experience(s) of women, specifically, and the sensitive topic of FGCS more generally, as it is overly presumptuous of the researcher to assume that one person (the researcher) is capable of developing all categories that might emerge throughout the data collection. This approach requires the researcher to be cognizant of unforeseen, but equally important, categories that are likely to emerge throughout the data collection stage. This feature applies not only to written content, but extends to photographic images as well.

Using this data collection method, I analyzed thirty surgeons’ websites (fifteen Canadian and fifteen American surgeons’ websites) promoting genital cosmetic surgeries to women in order to identify how FGCS is marketed online throughout North America. Through analyzing the surgeons’ websites, I believe that I was able to address accurately the ways in which these websites articulate the reasons women undergo genital cosmetic procedures, as well as how such surgeries are currently being marketed and framed, more generally. Additionally, I analyzed thirty posts on FGCS online forums in order to examine how women are speaking about their experiences and reasons for undergoing, or wanting to undergo, FGCS. I anticipated that this was the largest sample I could reasonably analyze in the time available for a Master’s thesis.

The coding instruments used in the data collection (see Appendix A & B) included questions that were designed to address the two main areas of interest (as well as useful secondary areas of interest) in my study: 1) to uncover how participants in female genital cosmetic surgery online forums articulate their reasons for undergoing, or

contemplating undergoing, genital cosmetic procedures; and 2) to discover how surgeons' websites, which advertise FGCS, articulate reasons women undergo genital cosmetic procedures. Qualitative based questions were used to gather this information. Additional questions surrounding certain demographic characteristics (of the women in particular) were also developed. These questions were primarily based on age and geographical location.

The comparison between surgeons' websites and online forums is necessary for two reasons. First, the clinic websites and online forums are connected in the sense that the number of people using the Internet for health information¹² is increasing rapidly (this will be explored in greater detail in "Section V: Online Research"), with women often being more likely than men to acquire health related information via the Internet. Second, a comparative analysis has allowed me to explore whether the way women are describing their desires and motives for FGCS matches what the surgeons' websites promote, or if what is being said on the forums is reflective of what is being marketed on the surgeons' websites. This allows me to see if the way women talk about reasons for FGCS are similar or different from the way the surgeons talk about it, which allows me to evaluate the validity of the claim that women are mere "cultural dupes" who are simply buying into surgeons' discourse wholesale – an important question throughout this research. The analysis of surgeons' websites allow me to examine if these websites transmit the types of messages that encourage women to see their non-surgically enhanced genitals as inherently flawed and as being in need of (medical) improvement.

¹² This is commonly referred to as "ehealth."

Instrumental Section

Though this research consists of a comparative analysis between FGCS online forums and surgeons' websites, the coding instruments that were used for the collection of data are not entirely identical. Although the questions on the coding sheets are similar in nature, and in some cases are exactly the same, there are a variety of questions that are specific to each kind of website (i.e., online forums or surgeons' websites). For example, the comparative aspects between the coding instruments are comprised of questions concerning the reasons and motives for wanting to undergo FGCS, how women's bodies and genitals are described before and after surgery on the forums and clinic websites, whether outside influences that might contribute to a woman wanting to undergo FGCS are discussed, and whether the concepts of liberation, empowerment, or oppression are mentioned regarding the procedures. On the other hand, the aspects of the coding instruments that ask website-specific questions focus on questions surrounding the images that are located on the surgeon's websites (women on the online forums do not post pictures of their surgery or genitalia), questions concerning whether success rates of the procedures are mentioned, as well as whether there is a cautionary section or section for alternative resources (such as counseling services) for women experiencing genital distress being offered on the clinic websites.

Section III: The Coding Process

My analysis for this research process is influenced by grounded theory methodology. Grounded theory is used to increase understanding of social phenomena (Glaser, 2005). Grounded theory encourages the researcher to read and re-read data as a process for discovering categories, concepts, and themes that emerge throughout the

coding process (Glaser, 2005). This is precisely what I did; I completed multiple readings (and re-readings) of the websites and online forums, as well as the codes and themes that had emerged throughout the coding process. The premise of grounded theory is that empirical inquiry should explore social phenomena through examining people's experiences. Therefore, this type of research is guided by the experiences of individuals in a study and the findings mimic patterns in these experiences (Simmons, 2006). This theory guides the researcher through a primarily inductive process "from which emerges a theory that is systematically grounded in data and therefore gets at real problems or issues in a system rather than those derived from conjecture or logical elaboration" (Simmons, 2006, p. 488). Grounded theory is especially useful for my research as it is often used as a methodology in order to understand social phenomena that are minimally addressed in the theoretical literature or in previous research.

Due to the lack of research on this topic, I have adopted a primarily inductive approach to my analysis. I say primarily inductive because there are already specific codes and questions in the coding instrument(s) as the starting point for my analysis. Since I structured the coding instruments prior to data collection, my approach is not entirely inductive, as this would mean that there would not be any prefabrication or structuring of the coding instrument(s) by the researcher and the data instead would "speak" for itself. The use of an inductive approach is recommended when knowledge about the phenomena being studied is fragmented and minimal (Elo & Kyngas, 2008), as is the case with female genital cosmetic surgery. An inductive approach to research tends to begin from a specific starting point instead of a fully developed hypothesis, and meaning and understanding develop as a result of the discovery process of inductive

reasoning. At the end of the induction process, a theory about the studied problem or phenomenon is expected to arise; therefore, inductive reasoning requires the researcher to move from the specific to the general (Nicholls, 2009). This approach has helped guide my analysis, by leaving me with a grounded, theoretical, and deeper understanding of how women are talking about their experiences and reasons for undergoing FGCS, as well as how surgeons are marketing these procedures and the role that surgeons play in shaping women's views of female genital cosmetic surgery.

One coding instrument was filled out for each clinic website as well as each post from the online forums. This resulted in one coding sheet saved as a word document for every website and online forum post, leading to thirty saved coding sheets for the clinic websites, and thirty saved coding sheets for the online forum posts, for a total of sixty saved coding sheets. Further, during the coding process, I often had to add an "other" category under certain code themes, as at times there would be (important) data that did not fit into one of the pre-structured themes.

The first step of the coding process involved using the coding instruments in order to collect the actual data from the surgeons' websites and online forums¹³. The coding instruments were a necessary preliminary step, as these instruments set me up for the more complex and specified type of coding known as open coding. The coding instruments used to collect my data allowed me to gather (relevant) information from surgeons' websites and online FGCS forums, which is the first step in any coding process, that is, the gathering of data. Without data to analyze, open coding would not be possible. Therefore, while the coding instruments allowed me to collect the research data,

¹³ Please refer to Section II: "The Data Collection Process" for a more detailed description of how the data were collected.

open coding allowed me to break down this data into smaller units of analysis in order to interpret it. Once I felt that I was familiar with the material collected during the data collection stage, which is what the coding instruments helped with, I then began with the process of open coding. This process involved going through the data question-by-question, and line-by-line, with every sentence and word examined. During this analysis, concepts and categories emerged from the data and I began to write memos in order to identify possible patterns and links between the codes. I then began the process of re-coding in order to develop clearly defined categories, which were eventually grouped into conceptual ideas. The next step I took was the process of comparative coding, which is an important feature in both grounded theory methodology and qualitative media content analysis, as this type of analysis calls for “constant comparison” of emergent themes and meanings (Berg, 1989; Glaser & Strauss, 1967 as cited in Altheide, 1996, p. 16). Therefore, I engaged in the process of coding and re-coding, categorizing and re-categorizing, and a process of constant comparison and examination between the data in order to develop code themes and concepts. I continued this process until a level of theoretical saturation was reached (i.e., no new themes emerged and the code categories were well developed).

After saturation was reached, I moved on to the comparative aspect of this study. Since my thesis is a comparative study, I compared the themes and categories that emerged in each question from the clinic website coding instrument to the themes and categories that emerged in the same question from the online forum coding instrument. This provided me with a deeper understanding of the similarities and differences, as well as the interrelationships found among specific questions that were asked of both the

websites and online forums. For example, I compared the themes and categories that emerged from the question “What reasons are given for wanting to undergo FGCS?” from the clinic websites to the themes and categories that emerged from the same question from the online forums.

Section IV: Ethical Considerations

The clinic websites and online message forums analyzed for this research are publicly accessible without an account and can be easily found through major search engines such as Google Search™.¹⁴ Although the subjects in this study did not directly consent to be involved in this research, their choice to post to a website that is publicly accessible through major search engines assumes that they are aware of the likelihood that their words will be read by others. Further, the online forums that were analyzed throughout this research clearly state that messages published on the forums are accessible to the general (online) public, and recommend that personal (possible identifying) information, such as the participant's real name, should not be included since any online user is able to gain access to posts. It is also important to note that in order to further protect women’s privacy I have developed a set of pseudonyms for online user names.

Section V: Online Research

Over the last decade, the Internet has influenced how qualitative data is collected and interpreted. Choosing to conduct this research using media content analysis of online forums was a strategic decision, as this type of method is unobtrusive. The reason for undergoing FGCS is likely to be a sensitive and highly personal subject which women

¹⁴ Searching terms such as “female genital cosmetic surgery,” “labiaplasty,” or “designer vagina” yields a variety of the kinds of forums that will be analyzed in this study.

might be more likely to discuss in online discussion forums given the perceived anonymity of these virtual spaces. Online research is therefore particularly well suited to this project. I have chosen this method based on the assumption that women are more likely to discuss experiences and attitudes toward FGCS relatively freely online, to a community of their peers, than they would during face-to-face interviews with an unknown researcher.

Furthermore, given that this research is at the Master's level, both time and resources were limited and by employing online research rather than interviews, I was able to reach, in a relatively short period of time, a geographically scattered, somewhat closeted population that may otherwise be difficult to access. Additionally, because FGCS is such a sensitive topic and given that I am an inexperienced researcher with no counseling resources at my disposal to recommend to participants, I wanted to be as unobtrusive as possible in my choice of method. By not interacting directly with research participants, I am able to minimize potential harm (e.g. feelings of discomfort, loss of anonymity) to participants. Moreover, this method of data collection allowed me to sample from more (and more diverse) clinics as well as a wider range of women's accounts than would be possible if I conducted research in person.

Internet Trolling

A potential concern with this study is that, in online forums, it is easier for participants to misrepresent whom they actually are. For instance, the possibility of a man or woman who did not undergo FGCS or who is not contemplating such procedures posing as a woman who is currently in one of these circumstances, though not probable,

remains possible. However, the likelihood of an Internet troll visiting such a specific niche website, which does not garner much traffic (outside of the sub-culture at which it is aimed), seems very low.

The Internet As A Source Of Health Information

With the advent of digital culture, direct marketing for FGCS to consumers (rather than through referrals from medical specialists or health professionals) depends to a significant degree on the Internet. Surveys regularly demonstrate just how common the Internet is used when investigating health information. For instance, out of the 2.4 billion Internet users worldwide in 2012, between 60 to 80% of these users were found to have used the Internet to acquire health information (Minchieollo, Rahman, Dune, Scott & Dowsett, 2013). Further, according to a study by the Pew Internet & American Life Project (2011), 80% of American Internet users have obtained health information online, with women being most likely to do so (Fox, 2011, as cited in Hether, Murphy & Valente, 2014). Thus, it stands to reason that women seeking genital cosmetic surgeries are likely to visit surgeons' websites for information regarding such procedures. Scant published research on the marketing of FGCS on these websites has been located to date.

Because the Internet is a significant source for individuals who are seeking health information (particularly women), it is crucial to examine surgeons' websites in order to analyze how the industry is promoting and marketing FGCS to women. I have also explored how these websites are advertising reasons for women to undergo FGCS, as well as whether, and how, women's genitals and bodies pre-surgery that *warrant* surgery are being described. This research has also explored whether, and how, "right" and

“wrong,” or “normal” and “abnormal” genitals are being discussed and presented on these websites.

Section VI: Study Limitations

One limitation of my chosen methodology is the fact that I did not conduct interviews with women who have undergone FGCS or are contemplating FGCS. I believe that if I had chosen to conduct interviews with these women, the research might be more persuasive to those who are skeptical of online research because they believe online participants often misrepresent their identities and experiences.¹⁵ However, people also may lie or misrepresent themselves during interviews, either to make themselves appear more appealing, or to provide the data they think the interviewer may be looking for (this is commonly referred to as “social desirability”). Furthermore, by conducting online research I was limited to the content already provided by the women on the online forums and thus unable to further probe certain themes. For example, a theme that emerged throughout the coding process was feelings of empowerment, which some women mentioned experiencing after undergoing FGCS. Unfortunately, the women’s accounts I analyzed did not provide sufficient information to adequately understand what that aspect of the FGCS experience means to them. If I had conducted face-to-face interviews with women I would be able to explore more deeply the theme of empowerment, among other themes. Additionally, speaking with surgeons who have experience with FGCS would have provided the opportunity to further explore the reasons women undergo these procedures and the meanings behind such reasons.

In conclusion, this chapter has outlined the methodology, data collection and coding processes that were used throughout this research in order to collect, code,

¹⁵ Please refer to Section: V “Internet trolling.”

interpret, and analyze the data that will be presented and discussed in depth in the following chapters.

In the next chapter, I present and discuss key findings from this research on the reasons women choose to have FGCS from the perspective of the women themselves as well as the surgeons' websites. I then examine findings on the "ideal" or best candidate for genital cosmetic procedures, compared to the "passive" cosmetic surgery patient. I end with an examination of findings regarding the potential risks involved with FGCS as presented on clinic websites, as well as risks women themselves have experienced. I also explore how success rates and stories of FGCS are marketed on these websites and how such information (risk and success) is presented on these websites.

Chapter Four: Female Genital Cosmetic Surgery: Patient And Surgeons' Perspectives

Section I: Chapter Layout

This chapter focuses heavily on the comparative features of this research and is divided into three separate, but equally important sections. In the first section I contextualize and further discuss women's reasons for undergoing FGCS, and surgeons' reasons women undergo FGCS located on their websites. The second section of this chapter examines the ways in which the female genital cosmetic surgery patient may embody the "ideal patient" when considering FGCS, as well as how she may have to, in certain circumstances, take on the position of the passive and dependent patient. The third section of this chapter examines the potential risks and complications involved with FGCS as they are presented on surgeons' websites, and compares these to the complications that women report experiencing after FGCS. This section also explores the success rates and stories presented on surgeons' websites in comparison to the risk information provided, and analyzes whether the amount of information provided on both risks and success is an adequate and reliable representation of female genital cosmetic surgery,¹⁶ and what the possible implications such presentation of information may have.

Throughout this study, the aim has not been to portray women who choose to undergo FGCS as some type of "cultural dupe," simply having these procedures for the specific purpose of pleasing a partner, or as a vanity project. Rather, I aim to present the women in this study as those whose lives are inescapably embedded in and diversely influenced by Western "beauty" culture and practices, but who also exhibit agency.

¹⁶ This information will be compared to the peer-reviewed literature surrounding FGCS risks and successes, as well as women's own accounts of risk and success of FGCS.

Indeed, this seemed to be how women who participated in the forums wanted to be viewed. For instance, Jaclyn, a 19-year-old woman who underwent labiaplasty, states, “people need to step into the 21st century and understand what pressures women are under.” Few women in this study report they have had FGCS because of a partner; rather, most of the women explain that they are not undergoing genital cosmetic surgery for anyone but themselves. As Jaclyn explains,

What people fail to understand is while perhaps there is no "real" reason for women feeling this way - unless their protruding labia genuinely does cause them a lot of pain, mine didn't really - that doesn't change one's feeling that it is unattractive and embarrassing. I am sick of the media portraying this operation as a vanity project carried out by pathetic women desperate to appear attractive to men - I would quite happily remain alone forever rather than be trapped in a relationship with some misogynistic idiot!

While the majority of the women in this study state that they were undergoing FGCS for themselves and not for others (i.e., intimate partners), the question remains, how do women articulate their reasons for undergoing, or contemplating undergoing, genital cosmetic procedures? When women have FGCS they are responding to highly restrictive notions of normality, notions that do not necessarily apply to the larger female population (in fact, it seems a very small percentage of women actually fit these notions) or leave space for (female) genital variation. As will be illustrated throughout this chapter, women who choose to undergo FGCS should not simply be viewed as passive victims of a patriarchal culture, as these women are often critically engaged in the cosmetic surgery process, and are capable of making decisions and taking responsibility for their actions; in turn, their agency should not be overlooked.

Section II: Motivations and Representations for FGCS

Over the past year, when I discussed my research project with others, their initial reaction usually was a surprised (and sometimes horrified) facial expression, followed by two questions. I would be asked about the types of surgeries offered for women's genitals, and directly after I would be asked why a woman would undergo such an invasive and (presumably) dangerous surgical procedure to modify a part of the body that for the most part was rarely ever seen? For all of the women in this study, the choice to undergo female genital cosmetic surgery was rooted in the desire to feel content and happy with their body and self and to feel as if they were "normal." While, at first glance, opting to have elective female genital surgery may appear to be an unreasonable and extreme route to achieve these desired goals, it is important to remember that within our Western patriarchal "beauty" culture, women continue to be judged based largely on their physical appearance. Quite often women who do not conform to very specific cultural "beauty" standards face certain social sanctions. Indeed, as mentioned by Pitts-Taylor, "appearance-related worries for women [may lead to] harassment, mistreatment, and discrimination" (2003, p. 51).

Women's Motivations For FGCS

As mentioned in Chapter 3, "Theoretical Framework and Literature Review," Kathy Davis (1995) discovered that having cosmetic surgery is often a positive and empowering experience for women, as this form of surgery has the ability to "alleviate their suffering and [allow women to] take their lives in [their own] hands" (p. 158). She explains that most times, women have "good" – that is, credible and justifiable – reasons for undergoing cosmetic surgery, and that surgery is a means to "alleviate unbearable

suffering” and “reappropriate formerly hated bodies” (p. 85). Many of the women in this study who had FGCS and those who were considering it, described a long period of “suffering” and loneliness, along with feelings of dissatisfaction with their own bodies, and their genitals in particular, before they finally made the decision to have genital cosmetic surgery. Half of the women in this study (fifteen to be exact) reported general discomfort caused by what they refer to as their enlarged labia during certain physical or sexual activities, and reported feeling as if there was something “not normal” about their vulva. All of the women mentioned experiencing feelings of disgust, anger, resentment, shame and embarrassment towards their genitalia. For these women getting rid of this perceived negative body part was top priority in the hope of one day feeling comfortable and happy with their bodies. Achieving a “normal” vulva was significant for most women in this study, and the way to achieve this end goal was by undergoing FGCS. For those women who desired FGCS for other reasons than achieving a “normal” vulva, their reasoning for surgery included the desire to enhance their sex life or to stop pain caused by their labia.

Specifically, my data highlight four primary reasons women claim to undergo, or desire to undergo, female genital cosmetic surgery. The first and one of the most commonly reported reasons was for appearance and aesthetic concerns, with twenty-two out of thirty women citing this reason. Women often mentioned feeling unattractive with the desire for a more aesthetically-pleasing genital appearance. For instance, twenty-one-year-old Eden explains, “I had a lot of extra wrinkly skin and it made me feel very unattractive and... old.” Often, women refer to their vagina as unattractive or unsightly. Olive, who had a labiaplasty performed, stated, “In my eyes I had this freakish ugly

vagina.” She explained that she “hates the appearance of it [her vagina] because it’s so gross looking.” Olive came to the conclusion that her vagina was “ugly” after seeing pictures of women’s vaginas in Health class, which lead her to conclude that because her vagina did not look like those shown in the photographs, it was not normal, and was in fact “gross looking.” This explanation of how Olive came to understand her genitalia as “ugly” is particularly interesting. It is true that representations of women’s genitals in pornography serve to idealize and standardize what women’s genitals ought to resemble, however, based on Olive’s description, it appears that representations in sex education and “health” texts may very well contribute to the idealization and standardization of female genitals, too. Moreover, four of the women in this study went as far as to describe their genitals as a “dirty secret” they wanted to keep hidden. As Jaclyn explains, “I felt unworthy of any boy I liked and as if I had some dirty secret,” which she refers to as “the hideous monstrosity I was hiding underneath my clothes.” The perception of one’s genitals as “ugly” or aesthetically displeasing is so great that this belief had the power to affect women’s sexual relations, too. Seventeen-year-old Paige explained in her post that she is “scared to be sexual with a boy because [she] think[s] [her] vagina is ugly [because her] labia come out really far.” The data suggests that the desire is to have genitalia that “look pretty, feminine, neat and tidy,” as described by Susan, a woman in her early-forties who underwent a labiaplasty and clitoral hood reduction surgery in December, 2013. This brief description of what the desired vulva looks like bears close resemblance to the “ideal vulva” found throughout the literature on cosmetic surgery. The “ideal vulva” includes genitalia that are symmetrical, well groomed, with non-visible labia (Braun and Wilkinison, 2001, as cited in McDougall, 2013).

Within our culture, it is seemingly rare for women to be entirely satisfied with their *natural* appearance. There are a variety of “beauty practices” that are geared towards women and aimed at altering their faces and bodies, including their most intimate and “private” areas. Such practices are what Shilling (2003), refers to as “body projects.” According to Shilling (2003), the body is understood as a “project” that is consciously “worked on and accomplished” as part of the construction of self-identity (p. 4). While individuals (and women in particular) engage in many forms of “body projects,” such as the use of make-up and hair dye to both enhance and conceal, and razors to remove unwanted or socially or culturally “unacceptable” body hair, cosmetic surgery is perhaps the most radical, invasive, and permanent form of body project.

It is argued that cosmetic surgery, as a body project, can be a means for bringing the body into line with notions of the self (Davis, 1995). For the majority of women in this study, the decision to undergo the body project of female genital cosmetic surgery was caused by more than the typical feelings of dissatisfaction with their genital appearance. Reflected in twenty-two of the posts written by women on the online forums was the understanding that the women’s genitals were no longer simply cosmetic problems, but had now also become pathological and psychological problems that required medical attention. This brings us to the second most commonly cited reason women underwent FGCS – psychological issues. The majority of women in this study identified feelings of general unhappiness with their genitals, and reported how “it’s crazy [that] something so personal, that really no one would know about can have such a pull on your everyday life,” as described by twenty-eight-year-old labiaplasty patient, Devon. Feelings of shame were often talked about as well. Dana, who underwent

labiaplasty, explains “I have had 15 years of daily hate and shame over my long labia.” Similarly, having low self-esteem and confidence because of their genitals was another common reason for wanting surgery mentioned by most women. However, more serious psychological reasons identified were feelings of depression and anxiety. Carrie, a twenty-year-old woman, explains in her post, “my labia has caused me psychological issues to the point of severe anxiety and depression.” One woman, nineteen year-old Jaclyn, even describes thoughts of suicide due to the depression, anxiety and torment she felt about her genitalia on a daily basis:

It was at this point [when she began to long for an intimate relationship] that things became really dark. I often felt suicidal and thought that nothing would change. To people who haven’t had to deal with this problem, it is impossible to understand how deeply this can affect a woman’s psyche, and not only this, but every aspect of her life. It literally stalks you everywhere, constantly weighing on your mind, making you feel completely powerless. It is utterly terrifying.

It is important to note, however, that undergoing genital cosmetic surgery with the hope of positive psychological transformation is problematic, since currently there are a limited number of reports to suggest long-term (positive) psychological impacts, and the reports that do exist concentrate on “short term [outcomes] and lack methodological rigor” (Liao & Creighton, 2007, p. 1090).

Another reason for surgery expressed by many of the women in this study was physical discomfort or pain caused by their genitals. Fourteen of the women identified the labia minora or the labia majora as a constant source of pain and discomfort. Gail, who is eighteen years of age, explains that “It’s [the labia] a constant discomfort and sometimes it can be fairly painful.” According to eighteen-year-old Chantell, the pain she experiences is caused by labia “throbbing, [being] sore, [and] being pinched.” The women in this study who experience pain because of their “enlarged labia” explained that

it was nearly impossible to take part in physical activities. “Certain activities such as biking are so painful that I have given them up. Having a normal sex life or relationship is not even possible when the act is impossible due to discomfort and pain [caused by the labia],” as explained by twenty-two-year-old Fay. Hannah, who underwent labiaplasty at age seventeen, goes as far as to suggest that the pain she experiences when engaging in exercise makes her feel like she has a “penis”:

I like to exercise and whenever I am running or even moving around I always feel like I have a penis, I mean, I have to constantly tuck it [her labia] in and fix myself, which no other girl around me seems to need to do. It is really uncomfortable.

The fact that Hannah explains that she feels as if she has a “penis” is noteworthy, because having a penis does not seem to pose a barrier to men in sports. In fact, Liao and Creighton (2007) note that men do not request surgery to reduce the size of their genitals for comfort while cycling or walking. By describing her genitals in terms of male genitalia, Hannah is inferring that longer labia are not just physically painful (and of course aesthetically displeasing), but also masculine in nature and therefore inappropriate for a woman. Further, certain types of clothing contributed to the discomfort and pain women feel. Again, Fay explains that “everyday normal activities for men and especially women have been torture on my body, I can’t wear certain types of clothes because my labia become sore.” Likewise, Xena explains that her labia were “incredibly extended and in the way,” and her “labia would hurt after exercise [she is a dancer] and would get caught in [her] underwear making it hard to wear certain clothing (i.e., leotard).”

The final (and least cited) reason women discussed for wanting FGCS was the desire for increased sensation when engaging in sexual activity as well as to feel “tighter” around their genitals. Three women in particular were adamant that their vaginas were

not “tight” and claimed that the only way to make one’s vagina tight again is through cosmetic genital procedures. One woman reported that no amount of exercise or other methods would help to tighten a woman’s vulva. Brittany, who underwent vaginal tightening, states, “There is no way that kegal [sic] exercises would tighten it [her vagina] up that much.” While it is difficult to understand exactly how Brittany measured the level of “tightness” or looseness of her vagina, she does report that after surgery, “I asked the Dr. if he thought it [her vagina] was quite loose, he just told me it was 3 fingers wide and I think he has big fingers at that. I was made down to 1 finger size.” Additionally, three women who reported wanting a “tighter” vagina also mentioned wanting to undergo surgery in hopes it would increase, or at least help, with their sex life. For example, Brittany expressed her interest in making sexual intercourse more enjoyable for herself and her husband claiming, “before surgery sex was only a handful of times a year, [but] the interest [in genital cosmetic surgery] went both ways for us [herself and her husband] since I did not get much out of it [sex] either.”

Surgeons Representations of Reasons For FGCS

Found in the feminist and social scientific literature on female genital cosmetic surgery are several possible reasons explaining why women might be willing to undergo genital cosmetic surgery. However, little research (see Braun, 2009) has been conducted on the information presented on medical provider websites (i.e., clinic websites) Little is known, therefore, about the reasons clinics claim women choose to undergo FGCS, how these reasons are presented on websites, and the possible implications such marketing practices may have.

The majority of reasons surgeons' represent for why women undergo FGCS focused primarily on the issues of appearance and aesthetic concern. Twenty-seven of the thirty clinic websites claimed that women undergo FGCS, and specifically "labial beautification surgery," when they are looking to feel "more normal and attractive" in their genital region by removing large or protruding labia and other "disorders." The disorders include labia that are "asymmetric," "hypertrophic," or "elongated." These large and protruding labia are also apparently commonly referred to as "elephant ears," as explained by FGCS surgeon, Dr. Goodman (Goodman. 2015, "Labiaplasty," para. 1). Dr. Goodman was the only surgeon to describe women's labia in this way. By referring to women's labia as "elephant ears," that is, as resembling something other than the female anatomy, Dr. Goodman delineates large or long labia as "abnormal" and in need of help.

Further, according to Dr. Jason from the "Laser Vaginal Institute of New York," women want their labia to be symmetrical because, after all, "symmetry is beauty" (Jason, R., 2015, "Laser reduction labiaplasty New York," video). The majority of surgeons' websites analyzed in this research claimed women have FGCS because they are attempting to recapture a "youthful" genital appearance, because with age the "original-well-defined appearance" of the vagina "fades" (Jacobson, E., 2014, "Labia majora reduction surgery," para. 3). This is one example whereby age is treated as a disease. The western feminine ideal has constantly emphasized youth as beauty, and getting old(er) as unattractive (Lijtmaer, 2010). The focus on youth and the connection to beauty is further illustrated on Dr. Jacobson's website where he positions the "aging vagina," which involves sagging and drooping labia that are considered "aesthetically unpleasing [...] as yet another reminder of getting older" ("Labia majora reduction

surgery,” para. 3). The notion that to be considered beautiful and thus desirable a woman must appear youthful is largely supported within patriarchal societies, as Anton Lesit (2003) explains: “we often think that a younger body, ideally that of a healthy 20-year old, is more beautiful than an older one” (p.210). This idea is further illustrated by Dr. Jason when he reports that women are interested in having genital cosmetic surgery because they “long for the days when their bodies [and genitals] were young and attractive” (Jason, R., 2015, “Wonder woman / mommy makeover,” para. 1), and they want to “look prettier like the women they see in magazines and films” (Blatt, R., 2015, “Labiaplasty procedure – neatness counts,” para. 2). The suggestion is that FGCS has an unlimited capacity to provide youthfulness and, by definition, beauty and attractiveness. Implicit in these messages is the assumption that being (or looking) older cannot be attractive. However, once youth is retrieved, so too is beauty. These websites are promoting the idea that in order to *feel* good a woman must *look* good.

Nineteen of the clinic websites clearly implied that women’s reasons for opting to have genital cosmetic surgery are to stop feelings of embarrassment (specifically with a sexual partner) caused by women’s genitals, which lead to low confidence and self-esteem. As described on these websites, this lack of self-confidence is supposedly caused by women’s “large,” “irregular,” and “sagging” labia, thereby leaving women feeling “undesirable” (Levin, R., 2015, “Vaginal tightening,” para. 1). Here, surgeons’ websites construct FGCS as a way to transform women’s emotional health by altering the physical appearance of their genitals (Braun, 2005), situated as a way to help women’s psyches, with the assumption that a pleasing genital appearance has a direct effect on emotional health. This marketing strategy can be further understood using the “body-as-self”

paradigm explained by Gulbas (2013) in her article, “Surgical Transformations in the Pursuit of Gender.” This paradigm encourages individuals, and women in particular, to develop an understanding of one’s self based on one’s physical appearance. The “body-as-self” paradigm argues that cosmetic surgery transforms more than a woman’s physical appearance; it transforms her identity and sense of self (Davis, 2003). Such a paradigm further enables surgeons to justify FGCS procedures by laying claim to its psychological benefits.

Sixteen of the clinic websites – just over half reported that women choose to undergo FGCS due to the loss of sexual sensation. Specifically, the surgeons’ websites claimed that because of aging (hormonal changes), childbirth and pregnancy, the vagina is “no longer at its optimum physiological state” because its muscles have weakened (Jason, R., 2015, “Laser vaginal rejuvenation,” para. 2). This is said to make women’s and their partner’s sexual experience less enjoyable. As stated on the “Toronto Cosmetic Clinic” website, “looser vaginal muscles in the genital area result in sexual intercourse that is often dissatisfying, as the pleasure arising from friction is noticeably reduced” (“About vaginoplasty surgery,” 2014, para. 2). Therefore, as reported on these websites, women are believed to undergo FGCS with the hope of “rejuvenating” their vagina in order to, as Dr. Matlock explains, “achieve the best sexual experience possible” (Matlock, D., n.d. “Laser vaginal rejuvenation with designer laser vaginoplasty,” para. 3). Further, Dr. Stanton, from the “Modern Institute of Plastic Surgery,” explains:

Women, much different than men, are very concerned about beauty and how they look. If they don’t feel beautiful they don’t have high self-esteem, desire or enjoy their sexual experience. If they feel beautiful they are much more sexual and much more enjoying of the sexual experience, hence the advent of labiaplasty (Stanton, R., 2008, “What makes a good candidate,” video).

Besides the unfortunate fact that this quote contributes to a gender dichotomy and sexist culture, it is also noteworthy because of the way Dr. Stanton discusses women's sexuality. That is, he discusses the idea that women's desire to be beautiful is an obvious and natural thing. By explaining that women must feel beautiful in order to enjoy their sexuality (and apparently most aspects of their lives), this excerpt works to reinforce the idea that being physically attractive and beautiful should be top priority in women's lives. That is, if a woman *looks* good, then she *feels* good (Featherstone, 1991).

Fourteen surgeons' websites also claimed that women undergo FGCS because "long" and "unequal" labia cause discomfort during certain physical activities, or when wearing certain types of clothing (i.e., a bathing suit or workout pants). Further reasons women are motivated to have FGCS according to the websites include childbirth, aging (hormonal changes), hygienic reasons, medical reasons (for those women who "suffer" from "labial hypertrophy") and finally for certain sociocultural, religious, or personal reasons. These cultural, religious, or personal reasons may include having or wanting to have the hymen intact upon marriage, or having the desire to give a spouse a "special wedding gift" (i.e., appearing to be a virgin), as reported by Dr. Colin Hong of the "Ultimate Beauty Innovation" clinic (Hong, C., 2014, "Toronto hymen reconstruction," para. 1). These rationales are mentioned only on the surgeons' websites, the women themselves did not mention such reasons for surgery in their posts.

The clinic websites in this study promote appearance-related concerns as the main reason women undergo female genital cosmetic surgery. Likewise, unsubstantiated claims of psychological benefits as a result of modifying the genital appearance are also prominently featured on the clinic websites as reasons for undergoing FGCS. As stated

on the “Toronto Cosmetic Clinic” website, “Undergoing labiaplasty or labial reduction [...] may improve a woman's self esteem and general happiness by reducing the size of the labia so that no protrusion of the labia minora exists” (“Why labiaplasty,” 2014, para. 2). The way FGCS is marketed on the clinic websites, specifically the reasons presented for women to have FGCS – the discourse, words and sentiments used, and the statements surgeons’ websites employ – appear to reinforce or validate any feelings women might have about themselves and their genitals, and may even (further) encourage women to view themselves as having their self-worth measured or judged on the appearance of their bodies, and in particular, on the appearance of their genitals.

Section III: The “Ideal Patient” versus The “Passive Patient”

The medical risks associated with female genital cosmetic surgery work to further delineate FGCS from other (less invasive) “beauty practices.” A common technique used by feminist scholars when discussing the practice of cosmetic surgery is to put forth the significant risks associated with cosmetic surgery procedures in order to reinforce the notion of cosmetic surgery as not only an extremely dangerous and invasive practice, but an oppressive practice as well (see, for example, Jeffreys, 2005; Morgan, 1991). While feminist research provides a compelling analysis of both the normalizing and harmful effects of cosmetic surgery, it also tends to construct the women who choose to have elective surgery as largely passive victims who are unknowingly risking their lives in order to embody Western idealized “beauty” norms. In this study it became clear that to consider women simply as cultural dupes or as victims to beauty practices is inaccurate and oversimplifies the complexity of factors and decisions represented in women’s experiences with female genital cosmetic surgery. In many of the women’s narratives, it

was clear that the decision to have genital surgery was not an easy one. Almost all of the women in this study outlined the processes they went through before having surgery, or the processes they were undertaking before deciding on surgery. The women explained that deciding to have surgery is often difficult. Chantell reports that she went “through stages of being too scared, a little unsure” and finally being “prepared and certain to have surgery.” Many women explained that before deciding to have surgery they conducted research on the available procedures offered, the price of the procedures, the surgeons offering the procedures, and the recovery period after surgery. Women also explained that reading other women’s stories about FGCS helped them in their decision-making process:

When I was researching Labiaplasty surgery I found that these types of blogs completely helped put me at ease with the whole procedure & was really what gave me the guts to move forward. It was reassuring being able to read other women’s stories that were similar to mine and the detailed process of their experience (Hannah, labiaplasty patient).

This quote is particularly interesting as it suggests that not only are women getting their rationales from and making decisions based on surgeons’ representations, but women may also be getting their reasons for surgery based on other women’s representations of reasons to have FGCS. Further, women also discuss the process of how to tell their family, friends, or partner about the surgery, and explain the constant process of reanalyzing their reasons for wanting surgery, so as to ensure they are having surgery for their own happiness only. Indeed, several women in this study explained they were not undergoing surgery for someone else (such as a partner), but rather for themselves. Alex, who underwent genital surgery for self-esteem reasons, explained that she wanted to have surgery “for herself” and not for her boyfriend. She states,

[My boyfriend] would never tell me before that he didn't think my vagina was tight enough. He loved me either way and loved having sex with me. The reasons behind wanting to have a surgery like this are linked to self-esteem (for me it was anyway). I wanted to do this for myself. So I think it's really important to be with someone who helps that [self-esteem]. I'm very lucky to have someone so supportive and understanding.

Likewise, twenty-two-year-old labiaplasty patient, Uta, explains that women should have FGCS only if they are getting surgery for themselves and are not pressured by outside sources:

Only do this surgery if it is something that *you* want. Do not do this for a boyfriend or for someone who has ever made a comment about your vagina. No man that I was with ever said anything about it to me. However it made me uncomfortable for too long so I decided to do something about it. I did this surgery for me.

To be an informed patient requires that the patient give informed consent. The process of informed consent is at the forefront of modern surgical practice today (O'Brien, Thorburn, Sibbel-Linz & McGregor, 2006). In their study, O'Brien et al (2006) state that while there is agreement that patients of cosmetic and reconstructive surgery ought to be given information to better inform their decision-making process, the amount of information about undergoing surgery that they should be given is unclear. While it is suggested that different patients will require different information, the researchers state that the most critical kinds of information patients should receive are "those that would cause the patient to change their decision about surgery" or would otherwise influence their decision to have surgery (O'Brien, et al. 2006, p. 897). In this particular case, this type of information would include potential risks and complications associated with genital cosmetic surgery, but as will be illustrated in "Section IV: Risk versus Success," the information on clinic websites does not necessarily paint an accurate picture of such important information (i.e., risks and complications). While it is true that clinic websites

are not women's only source of information regarding FGCS, the websites still remain a significant contributor to the discourse surrounding FGCS and a source of information many women in this study turned to for information regarding these procedures. For example, Brittany, who underwent vaginal tightening surgery, explained that when considering which surgeon she wanted to perform her surgery she,

Researched and researched and found the Dr. [she] was going to go with and out of the few bad reviews on his website they were mostly about him being rude. 2 said they were from skill, but they did not say what the problem was and if anything they did contributed to the problem. So off to Toronto I went.

Similarly, Chantell, who has been contemplating labiaplasty for over two years, states, "I've been reading up about [labiaplasty] a lot on the web and trying to find a doctor who has a lot of experience with these types of surgeries." The fact that ten out of the thirty women in this study said they have turned to clinic websites for information regarding FGCS procedures is particularly important to note. As we will see later in this chapter, surgeons' websites may not necessarily be the best place to turn to for information on FGCS, as many times they downplay the risks associated with FGCS (please see Section IV). Judging by the online forums, women do not talk about or focus on the risks associated with FGCS (including the women who turn to surgeons' websites for information). This does not mean that women are not aware of the risks associated with FGCS, however. The majority of women would state something similar to what nineteen-year-old labiaplasty patient, Jaclyn states, which is that she "know[s] there are risks involved," but would not go into detail about the specific risks they are aware of, or the seriousness of such risks. Further, the women who mentioned having researched clinic websites tended to discuss the surgeons' reviews located on their websites, and the positive outcomes highlighted on the websites, with little to no mention of the risks the

websites mentioned. In total, a third of the women in this study turned to and relied on surgeons' websites for information regarding genital surgery. Given that these websites tend to provide inadequate, minimal, and in some cases, no information on the possible risks associated with FGCS,¹⁷ it is likely that some women have only minimal knowledge of the risks associated with these procedures.

The "Ideal" Cosmetic Patient

Another important theme that emerged on surgeons' websites was attention to who the "ideal" candidate is for genital cosmetic surgery. The idea of the "ideal patient" or consumer is entrenched in cultural values, such as individual autonomy, agency, freedom of choice, and the understanding that health is an individual responsibility (Lupton, 1997). Cosmetic surgery discourse "emphasizes the ability of the individual to become informed about the risks and benefits of surgery, and to weigh them up independently and dispassionately" (Fraser, 2003, p. 36). As stated by Sanchez Taylor (2012), research regarding women's use of cosmetic surgery shows that women who are interested in having some type of cosmetic surgical procedure (whether it be breast surgery or labia surgery) tend to research it thoroughly, along with the possible outcomes of the surgery (see, for example, Davis, 1995; Gimlin, 2010). Several of the women in this study embodied this role of the "ideal patient" through actively researching the procedures, as well as attempting to locate the "best" surgeon to perform their desired surgery. For example, twenty-one-year-old Eden explains that before deciding to have labiaplasty, she thought it was important that she conducted "research on her own" to find a surgeon whose "after" surgery photographs (of women's genitals) she liked. Eden

¹⁷ Please refer to "Section IV: Risk versus Success" for a deeper discussion on the risk information presented on clinic websites.

states that she found one surgeon and “liked his before and after [photographs], read his reviews and decided to make an appointment to have a consultation.” In the same fashion, Kayla, a twenty year-old who had recently undergone labiaplasty, reported that before setting up a consultation with a surgeon, she asked her general practitioner to recommend potential surgeons to perform her surgery so that she could, as she explains, “do my research on them.” Further, four women in this study expressed the importance of having realistic expectations after surgery. Willow, who decided to have a labiaplasty performed in order to alter the appearance of her genitalia, states that women interested in FGCS should not “have too high expectations, [because] it’s [one’s vagina] probably not going to look like a porn star vagina, [but] you have to work the best with what you have and be happy with the improvement.”

Surgeons’ narratives of the “ideal patient” or the “best candidate” (as they are commonly referred to on the clinic websites) for FGCS share similar notions to that of the ideal patient or consumer mentioned in the preceding paragraph. For instance, the “Laser Vaginal Institute of New York City,” explains that they “encourage patients to participate in their healthcare and surgical design” and describes the ideal FGCS patient as a woman who is “empowered by knowledge and choice” (Jovanovic, K., 2015, “Laser vaginal rejuvenation,” para. 3).

Further descriptions of the ideal candidate for FGCS were women who are “in good health” both physically and mentally. Dr. Matlock explains, the “best candidate for [female genital cosmetic] surgery is a physically healthy woman” (Matlock, D., n.d. “Liposculpting of the fatty mons pubis and labia majora,” para. 2), while Dr. Hong identifies the ideal candidate as a woman who is “emotionally stable” (Hong, C., 2014,

“Vaginoplasty Toronto,” para. 3). As described on several clinic websites, the ideal patient for FGCS also includes a woman who is experiencing pain caused by her genitalia, a woman who wants to reclaim or enhance her sex life, and a woman who is looking to enhance her confidence and aesthetics of her genitals.

As it is shown in the previous paragraphs, ideal patients are described on clinic websites as being involved in their surgery, and are described in positive and encouraging terms, for instance, as “empowered with knowledge and choice” (Jovanovic, K., 2015, “Laser vaginal rejuvenation,” para. 3). Consistent with the idea that success and empowerment can be achievable through consumption, which is prevalent in neoliberal societies (Leve, Rubin, & Pusic, 2012), the choice to have FGCS is positioned as an empowered, individual decision. The rhetoric used to describe the ideal patient for FGCS reinforces a sense of rational decision-making and empowerment, which could potentially serve to make the argument in favour of FGCS appear reasonable. The description of the ideal patient positions FGCS as an individual choice for a rational (i.e., “emotionally stable”) and well-informed woman, and an act of empowerment. Further, by describing the “ideal patient” using broad guidelines, such as a woman who wants to enhance her genital appearance, sex life, confidence, and to stop feelings of discomfort, the websites describe a large number of women who may be unhappy with a specific aspect of their genitalia as “ideal patients” or candidates for FGCS, which could potentially encourage women who are already contemplating genital surgery to go through with the surgery since they fit the criteria of the ideal candidate.

The Passive Cosmetic Patient

The descriptions of the ideal and active cosmetic patient are in direct opposition to those of the passive and docile patient, that is, a patient who is compliant and dependent on an expert “authoritative Other” (i.e., the surgeon), and who contradicts the contemporary ideas in the industrialized West surrounding the “importance of the autonomous self, the self who governs personal behavior via reason rather than emotion” (Lupton, 1997, p. 374). Though the passive patient is often viewed in an unfavourable light, I argue that many of the women in this study had little choice but to conform to this type of patient under certain circumstances. That is, since the women who had FGCS were facing significant and risky consumer health decisions, it would have been difficult for them to remain entirely independent or autonomous. This is apparent after reading some of the women’s narratives, which illustrate the context in which the women were making their decisions, and suggests that during their decision-making processes they were indeed passive and compliant with the surgeon. For instance, while many of the women’s narratives clearly expressed the importance of conducting one’s own research on FGCS (as discussed in the previous paragraphs), not all of the women took this particular approach. For example, in Olive’s narrative it is apparent that she chose to adopt the passive patient position when it came to gathering information on FGCS procedures, by relying solely on the expert knowledge of medical professionals. Olive, who was interested in labiaplasty, explained that she was unsure if the size of her labia were “normal,” which prompted her to set up an appointment with a surgeon because she “trusted that his opinion would be the best.” The surgeon confirmed that her labia were larger than average and that she qualified for surgery. According to Olive’s post, it is

clear she did not feel it necessary to seek additional information than that which was given to her by the surgeon, because she trusted him as the authoritative source for medical knowledge.

Finally, it becomes even more difficult for women who want to undergo FGCS not to embody the dependent and passive patient during certain instances throughout this process, due to the imbalance in the medical knowledge between the woman having the surgery and the surgeon performing the surgery. That is, women at times had little choice but to depend upon the surgeon to some extent, because the women knew far less about the surgery than the surgeons did, and therefore had little choice but to rely on them.

Section IV: Risk verses Success

A third theme that emerged on surgeons' websites is how these websites outline the risks and success associated with FGCS. Within a medical context, the patient must be informed of potential risks before providing informed consent to surgery (particularly elective surgery) (O'Brien et al., 2006). Therefore, though the surgeons' websites state that these women are informed, or at least, should be informed, about all aspects of FGCS, usually the potential risks and complications of FGCS – information crucial to informed consent — were downplayed or missing altogether from the websites. This is problematic because it highlights the positive aspects of FGCS rather than the potential risks of this surgery.

“Rare” Risks

In a report produced on the ethical considerations in relation to female genital cosmetic surgery, The Royal College of Obstetricians & Gynaecologists (2013) outline three main guidelines on cosmetic surgery marketing that advertisers are encouraged to

follow: 1) “You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate”; 2) “When advertising your services, you must make sure that the information you publish is factual and can be checked, and does not exploit patients’ vulnerability or lack of medical knowledge”; and 3) “Marketers should not imply unrealistic claims” (p. 5). However, according to the RCOG, this guidance “is systematically ignored at present” (2013, p. 5). Researchers state that women considering FGCS should be informed of all possible risks associated with the procedures. These risks include “bleeding, infection, scarring, dyspareunia, alteration in sensation, pain, wound dehiscence (which may lead to the need for revision operations), decrease in sexual pleasure, and possible dissatisfaction with cosmetic or other results” (The Society of Obstetricians & Gynaecologists of Canada, 2013), and researchers report that there are currently no available long-term data on the safety or efficacy of these procedures (Royal College of Obstetricians & Gynaecologists, 2013).

Out of the thirty clinic websites analyzed in this study, fifteen of the websites simply left out the risks associated with female genital cosmetic surgery altogether. Dr. Lee’s clinic website, for instance, reads, “the recovery is quick and easy” (“Common vaginal procedures,” n.d. para. 2). Out of the fifteen websites that did not name potential risks or complications, two made an offer regarding a risk discussion with the surgeon prior to surgery. The other half of surgeons’ websites in this study outline at least a few of the risks associated with FGCS, however, they present such risks as very unlikely or “rare.” Dr. DuPéré’s website, “Visage Cosmetic Plastic Surgery,” reads, “every

procedure comes with *some* inherent risks [,] although very rare” (DuPéré, M., 2015, “Potential risks and complications,” para. 2). It was often mentioned on the clinic websites that the majority of FGCS patients are free of complications and exceptionally satisfied with their surgery. For instance, Toronto’s “The Plastic Surgery Clinic” website reports:

Even though there may be risks or complications, most women do not experience these. [E]very operation has risks and potential complications. Fortunately the vast majority of patients who undergo [female genital cosmetic surgery] have no problems with their surgery and are extremely happy with their results (“Labia reduction risks & complications,” n.d., para. 1).

When surgeons’ websites did outline possible risks and complications associated with female genital cosmetic surgery, most of the websites would describe each risk or complication as “very rare” throughout the risk section, as though the clinic websites were trying to downplay such risks. For instance, on the “Visage Cosmetic Plastic Surgery” website, Dr. DuPéré states after almost every risk that such a risk remains “rare”:

Risks can include opening of the wounds and infections (extremely rare), fatty cysts after fat grafting to the labia minora (which will often reabsorb), excessive reabsorption of the fat grafts (possibly requiring a second fat grafting procedure), scar retraction (rare), painful scars and loss of tissue due to vascular compromise (extremely rare), hematomas (rare) and increased or decreased sensitivity – always a possibility when manipulating tissue with such specialized nerve endings (DuPéré, M., 2015, “Potential risk and complications,” para. 2).

Further techniques used on surgeons’ websites in this study included distancing the actual FGCS procedure from other, more “serious,” and complex surgeries. For example, most of the clinic websites state that FGCS procedures “typically take about one hour” to perform under local anesthesia (Benchetrit, A., 2014, “Day of surgery: What to expect,” para. 1), or under a “light sedation or twilight sleep anesthesia” (Toronto Cosmetic

Clinic, 2014, How is labia reduction performed,” para. 1). This implies that genital cosmetic surgery is less risky than other types of cosmetic surgery because it is (often) performed with minimal sedation and takes little time to perform (Stanton, R., 2008, “Labiaplasty,” para. 1). Another technique used on Dr. Jovanovic’s website, “Laser Vaginal Institute of New York,” is positioning FGCS as carrying less of a risk than childbirth: “To put risk in perspective, pregnancy is associated with far more risk than any of these procedures” (“What are the surgical risks with laser vaginal surgery,” para. 1).

FGCS Success

While risks and complications are minimized, however, these websites are full of information regarding the success of female genital cosmetic surgery. Such information takes several forms: former patient testimonials praising the surgeon, clinic and the surgery; the surgeons’ own claims of the success of genital cosmetic procedures; or studies that are referenced on the websites giving evidence to FGCS success rates. Interestingly, though the majority of the clinic websites analyzed in this study provided anecdotal evidence and did not provide high quality evidence (i.e., scholarly research) of success rates for FGCS, this did not stop these same websites from *claiming* that these procedures have a high success rate.

For the websites that did not provide reliable evidence of success rates for genital cosmetic surgery, most echoed Dr. Stanton’s clinic’s claim that “patients have a high satisfaction rate and an improved self-esteem” after surgery (Stanton, R., n.d, “Labiaplasty,” para. 1) without providing evidence to support such claims. Other success rates mentioned on one of the surgeons’ websites came from an article from the *Journal*

of *Sexual Medicine* (2010), which reports “a 90-95% satisfaction rate in women who had undergone” female genital cosmetic surgery, as cited on the “Toronto Cosmetic Clinic” website (“About labiaplasty surgery,” 2014, para. 2). Citing the growing number of women having FGCS was another technique used on the websites as evidence of the success of these surgeries. As Dr. DuPéré states, “over the past decade, women have become more aware of – and open to – the correction of vaginal irregularities. In the U.S. alone, plastic surgeons performed more than 5,000 labial procedures in 2012” (DuPéré, M., 2015, “Labiaplasty,” para. 1). However, he fails to reference a source for this statement. This kind of strategy works to further normalize FGCS procedures by emphasizing the growing number of women who are willing and “open to” having surgery on their genitals.

The success of FGCS was also presented on several clinic websites through the use of patient testimonies. These stories were often located on the websites under a link titled “Patient Testimonies” or “Patient Stories,” which brings the online user to a separate webpage where previous (and in some cases current) patients describe their gratitude and happiness after their surgery. For example, one woman who had vaginal rejuvenation surgery by Dr. Allan of the “Allan Centre” clinic reported,

Laser Vaginal Rejuvenation™ has improved my sex life and self esteem. I’m happier and more self-confident. Because of this, my boyfriend is a lot happier as well. I feel tighter, so I feel more pleasure when I’m having sex. I’m able to do all the sports I want without feeling any pain. When I used to have sex, my labia would swell from all the rubbing (“Patient stories,” n.d., para. 4).

By providing a first-hand account of a woman’s (positive) experience with FGCS, this marketing technique emphasizes the potential benefits FGCS procedures can provide women, including psychological, physical, and sexual benefits, and works to make these

potential benefits all the more realistic by showing a woman who was once unhappy with her genitals (which many women can identify with) now completely content with her body after having surgery. Additionally, if the clinic websites did not provide evidence of success rates for FGCS or patient stories, surgeons themselves presented case studies of women who successfully underwent FGCS. For instance, on Dr. Wilkie's clinic website, "New Woman Canada. Restore. Renew. Rejuvenate," he explains:

My patient in this case study had two children delivered vaginally. She was recently remarried and, although the couple had an intimate relationship, the pleasure factor was lessened due to the size of her husband's penis and her vaginal stretching from her vaginal deliveries. After her surgery, the intimacy of their sexual relationship has been greatly enhanced, making them physically more compatible. With procedures like vaginal rejuvenation, women are now able to control their own desires and sexual gratification, including the gratification of their partners ("Case study: Vaginal rejuvenation," 2015, para. 2).

Explaining that FGCS gives women the power or ability to "control their own desires and sexual gratification" is an effective marketing technique used to demonstrate that FGCS gives women a sense of empowerment, providing women the ability and solution (i.e., FGCS) to change an aspect of their lives they may be dissatisfied with.

What Do The Women Say?

As previously mentioned, surgeons' websites often state that the risks involved in genital cosmetic surgeries are "very rare" or "extremely rare," but what do the women say about such "rare" risks? Interestingly, a risk that was not mentioned on the surgeons' websites but expressed in the literature on FGCS risks, as well as by several women on the online forums was the risk of not being satisfied with one's genitalia after surgery, a possible outcome I consider to be fairly significant. Out of thirty women in this study twenty-one actually underwent FGCS, while nine women were waiting to have surgery or

were debating whether or not to undergo the surgery. Out of the twenty-one women who had surgery, four reported not being satisfied with their genitals after undergoing FGCS. For instance, Alex described her dissatisfaction with her genitalia after having undergone a vaginoplasty (vaginal rejuvenation or vaginal tightening surgery):

I have really gone up and down with my feelings on everything – some days I’m really happy, and other days I feel like it [the vaginoplasty] didn’t work out the way I wanted it to. I am too critical I think, but I realize now that I must have had kind of a subconscious “ideal image” in my mind (I didn’t even know it was there, I thought I just wanted to be “normal”) but the post-surgical reality has turned out to be quite different. But that of course leaves me open to my own endless critique (will I ever be satisfied?!).

This excerpt is particularly interesting, as it highlights the way in which the production of ideals, and their association with ideas of “normalcy,” are progressively encroaching on (women’s) bodily integrity. A specific genital ideal has developed and is described by McDougall (2013) as “a clean slit [...] where the labia are symmetrical and do not protrude” (p.776). As ideals become normalized, they impact the choices individuals make. A desire to be “normal,” as defined by cultural expectations rather than natural physical characteristics, influences the decisions women make about their genitalia, and cosmetic surgeons increasingly help women in attaining an ideal body (Braun and Kitzinger 2001).

Another form of dissatisfaction experienced with surgically modified genitals was when a woman underwent labiaplasty and the reconstruction of her labia turned out to be much more extreme than she had requested. For instance, Susan opted for the “hybrid” labiaplasty, which is described as the most common and “natural looking” type of labiaplasty, but instead she feels like she has been given the “Barbie” labiaplasty, the

most extreme form which includes almost complete removal of the labia, to the point where the labia are “basically nonexistent.”

In one circumstance, there was need for a second surgery after having FGCS in order to correct complications that arose from the first surgery. Specifically, Willow, who had undergone labiaplasty to “fix” the appearance of her genitalia as well as to increase her confidence and self-esteem, reported having a “large hard bump under [her] clitoris” which was not there prior to the surgery and which “didn’t connect to the rest of the labia.” She was forced to undergo another genital cosmetic procedure to try and get rid of the hard bump. An additional complication that a large number of the women described experiencing after surgery was an infection in the surgical area, as well as a large amount of pain after surgery (more than the amount of pain which they were told they would experience). As nineteen-year-old Taylor explains, on the seventh day after her labiaplasty, she experienced “a lot more bleeding than there [had] been previously and a *lot* more pain.” She mentions that she had “no idea where [she was] bleeding from or why and the pain was unbearable.”

Additional complications that were not mentioned on the surgeons’ websites, but which some of the women experienced, included not being able to lubricate as well after surgery. Alex states, “I don’t lubricate very well anymore, we [her partner and her] always have to use lubricant.” Internal and external bleeding from stitches that have fallen out, as well as irregular bleeding weeks after surgery, were also common complications many of the women reported experiencing.

Lopsidedness of Information

When examining the balance of information provided on the surgeons' websites, it is apparent that the representation of aesthetic female genital surgery is asymmetrical. The patient testimonies located on the clinic websites tend to be positive only, applauding the benefits of genital surgery to the woman, and the skills and services of the genital surgery experts. On the other hand, the same clinic websites often downplayed or minimized the risks, complications, and potential harm that aesthetic genital surgery may cause women. In actuality, it is not yet clear whether the benefits of FGCS actually outweigh the risks. However, women who are interested in FGCS should be well informed of both possible benefits and possible risks or complications that go along with FGCS. It is the clinic websites' responsibility, as important contributors to the medical discourse surrounding FGCS, to highlight not only the successful aspects of FGCS, but also the potential complications genital cosmetic surgeries may cause. Further, only four of the thirty surgeons offered a cautionary section on their websites, while the other twenty-seven websites do not offer any cautionary advice. The cautionary sections emphasized the importance of careful consideration before undergoing surgery, as well as careful consideration choosing a (skilled) surgeon, and advised against surgery if a woman is trying to become, or currently is pregnant (Please see Jacobson, E., 2014, "Labiaplasty frequently asked questions," para. 1; Toronto Cosmetic Clinic, 2014, "At what age can I get labiaplasty," para. 1; Lista, F, & Ahmad, J.,n.d, "The best candidates for vaginal tightening," para. 1).

It is possible, and perhaps likely, that though a large number of the clinic websites do not provide adequate information on risks and complications, surgeons may go

through these risks and complications with the patient during consultations. However, advertising on surgeons' websites to the online public encourages a consumer focus on the benefits of these procedures over the risks, which fosters a limited understanding of the implications of female genital cosmetic surgery.

Section V: Conclusion

This chapter has explored the reasons women undergo, or contemplate undergoing, female genital cosmetic surgery as explained by women themselves as well as the reasons women undergo FGCS as stated on surgeons' websites. It is clear that the motives women describe for undergoing FGCS mirror the motives presented on the surgeons' websites. Both clinic websites and women's posts present appearance and physical issues as the two most common rationales for surgery, followed by physical discomfort and sexual issues. Surgeons' websites also cite additional reasons for FGCS, which were not mentioned by the women, including medical issues, sociocultural or religious reasons, aging and childbirth, and lastly, hygienic reasons.¹⁸ What could this similar discourse mean? Perhaps this points to the idea that women, who are most likely to obtain health information online, are gathering acceptable reasons for undergoing FGCS from surgeons' websites, and/or during consultations with surgeons. Alternately, perhaps surgeons are gathering women's rationales from the women themselves (through their interactions with women who are interested in FGCS) in order to market these surgeries on their websites to the target population. Therefore, it is possible that women's reasons for FGCS and surgeon's representations of reasons women have FGCS influence upon one another.

¹⁸ Please refer to Appendix D and E for tables representing the exact number of times each reason for FGCS was presented or reported by the women and clinic websites.

Next this chapter moved to an exploration of the “ideal” versus the passive FGCS patient and the ways in which women at times embody both positions. A paradox emerges in this section: while surgeons’ websites describe the active and thus “ideal” patient as an independent woman who is empowered by knowledge and choice, at the same time women have little choice but to take up the role of the passive patient and rely on the medical expert. This is due in large part to the unequal medical knowledge between the woman and surgeon, especially because women who are interested in FGCS face serious and risky health decisions, it would be particularly hard for women to remain completely autonomous throughout this process.

Lastly, this chapter has outlined representations of potential risks and apparent successes that are associated with FGCS, how information about risks versus success is presented on surgeons’ websites, and the possible implications such presentations may have. It is clear from this section that the risks outlined on the clinic websites do not match up neatly with women’s experiences with FGCS. Indeed, though FGCS is largely marketed as a minimal risk procedure on the websites, the women’s accounts of risks after surgery reveal a different story. Several women explained serious complications they experienced after undergoing genital cosmetic surgery which were not mentioned on any of the thirty clinic websites.

The next chapter will explore the process of medicalization and how this process contributes to women’s understanding of their genitals as “normal” or “abnormal.” I then discuss key findings regarding how women’s genitals are talked about before undergoing female genital cosmetic surgery versus after undergoing genital cosmetic surgery, as well as how “normal” and “abnormal” female genitals are discussed by women themselves as

well as on FGCS clinic websites. The chapter will end with a discussion of the power of images, specifically “before” and “after” photographs of women’s surgically modified vulvas presented on clinic websites.

Chapter Five: Medicalizing The Healthy Vulva: The “Right” And “Wrong” Vagina

Section 1: Chapter Layout

To state that the majority of women in the in North America have difficult relationships with their bodies is to voice the obvious. A large percentage of women view their bodies as inadequate in some way (Harris & Carr, 2001), or as Braun and Tiefer (2009) explain, as “failing in the quest for feminine bodily perfection” (p. 1). The Western ideal of a specific feminine, beautiful, and often-unrealistic female bodily form plays an important role in rendering female embodiment problematic for many women. Among the large diversity of female bodily forms, certain bodies are often deemed pathologically different. For example, bodies that do not fit within the white, thin, youthful and able-bodied feminine ideal tend to be marked as somehow flawed.

Relevant literature suggests that within our Western consumer society, women’s bodies tend to be thought of as commodities (Negrin, 2002). These bodies are then “dissected into physical parts – eyes, lips, breasts, legs – women constantly are made aware of chronic imperfections, then [are] offered products [or solutions] that will help them attain the socially constructed ideal” (Duke & Kreshel, 1998, p. 49).

In this chapter I will draw from feminist and sociological theory, women’s experiences with FGCS, and surgeons’ websites, to discuss how the medicalization of otherwise healthy female genital variations contributes to women’s concerns and troubles with their unreconstructed genitals. I will examine the process of medicalization by looking at four themes: first, I will examine the ways in which the women experience medicalization at the “conceptual level” and the “interactional level” (Conrad, 1992); second, I will examine the process of medicalization by looking at how women and

surgeons' websites discuss female genitals before genital cosmetic surgery in comparison to female genitals after genital cosmetic surgery; third, I examine the process of medicalization by looking at how "normal" and "abnormal" genitals are being presented and discussed by the women and surgeons' websites. This chapter ends with an examination of how the process of medicalization framed women's genitals as medical objects to be "fixed" by examining the "before" and "after" photographs of women's genitals located on surgeons' websites.

Section II: Medicalization Explained

During the 1970's the concept of "medicalization" appeared throughout scientific literature. Conrad (1992) defines medicalization as a process whereby "nonmedical problems become defined and treated as medical problems," often in terms of disorders or illnesses (p. 209). As previously explained in Chapter Three, this process happens when a (previously non-identified medical) "problem" is described using medical language and when there is a medical intervention to treat this "problem" which was not considered pathological prior to medicalization (Conrad, 1992).

According to Conrad (1992), medicalization can occur on three distinct levels: conceptual, institutional, and interactional. At the conceptual level, the use of medical language is used to define a nonmedical problem. At the institutional level, physicians have the power to be "supervisors of treatment organizations" (Conard & Kern, 1986, p. 378). At the interactional level, a physician, during interaction with the patient, defines a problem as a medical problem or issue (Conrad, 1992). As will be explored throughout this section, women's narratives as well as the surgeons' websites in this study reflect medicalization at both the conceptual and interactional levels.

Arguably, the medicalization process increases the power and control already harbored by the medical profession. This increase in power occurs when problems that were not previously deemed “medical problems” start to fall under the jurisdiction of medicine. As Zola (1981) argued over thirty years ago, “medicine is becoming a major institution of social control” through medicalizing “much of daily living, by making medicine and the labels ‘healthy’ and ‘ill’ *relevant* to an ever increasing part of human existence” (p. 379). Today this argument seems to hold true more than ever. For example, in this chapter I demonstrate how the medical profession positions female genital variation as a medical and pathological problem, thus resulting in the medicalization of otherwise seemingly healthy genitals.

“Medical Markets”

I do not want to label the women in this study, or women who are not in this study who choose to undergo FGCS or other forms of cosmetic surgery, as passive and compliant victims trapped in the process of medicalization. The women in this study were often actively involved in the medicalization of their genitals – this is known as “medicalization from below” (Furedi, 2006). This form of medicalization involves self-medicalization, wherein the individual adopts the role of patient in order to pursue certain personal interests. For example, the individual adopts the medicalization strategy in order to receive certain benefits, or to avoid having to confront certain situations. This process of medicalization may at times be seen among FGCS and other cosmetic surgery patients who are looking to have their surgery covered by insurance as a result of the psychological harm their body may cause them. As Reissman (2003) claims, women work with the medical field as a way to advance their interests and needs. She states,

“both historically and currently, there has tended to be a ‘fit’ between medicine’s interest in expanding its jurisdiction and the need of women to have their experience acknowledged” (p. 57). This “fit” is particularly apparent in cosmetic surgery, because women seek out surgeons and their expertise, which creates a demand for (cosmetic) surgical intervention, while cosmetic surgeons advertise and promote cosmetic procedures to (potential) patients.

This system validates and increases the consumer demand for cosmetic surgeries, and contributes to the formation of “medical markets.” Medical markets are described as the process whereby “medical products, services, or treatments are promoted to consumers to improve their health, appearance, or well-being” (Conrad & Leiter, 2004, p. 160). What distinguishes medical markets from other consumer markets is the “uncertainty in the definition, recognition and diagnosis of disease states” (Montagne, 1992, p. 401, as cited in Conrad & Leiter, 2004, p. 160). For example, a troubling development related to the process of medicalization is the inconstancy and “uncertainty” about what constitutes health and illness, as the line that once divided health from illness has become increasingly blurred (Furedi, 2006). Similar to Zola (1981), Conrad and Leiter (2004) claim it is likely that there will be an increase of new medical markets, as well as an increasing push to “medicalize the troubles and problems of everyday life” (p.172). Consumers (i.e., potential and current patients) are necessary for medical markets to thrive and survive.

The medicalization of healthy female appearances is therefore a complex system within a capitalist society in which women are deemed complicit actors. However, as Virginia Braun’s (2010) argument discussed in Chapter Three states, the women who

undergo FGCS perpetuate the medicalization of “normal” and healthy functioning vulvas, which contribute to sociocultural ideals and norms in which this medicalization process is situated.

Conceptual and Interactional Medicalization

As we will see throughout this chapter, women who have seemingly healthy vulvas often regard theirs as wrong or “abnormal” in some way and as being in need of medical help, but why is this? I argue in this section that by looking at the process of medicalization at both the “conceptual” and “interactional” level one can better understand how women come to experience their own genitals in this way. As previously mentioned, medicalization at the conceptual level occurs when a “medical vocabulary is used to define a problem” (Conrad & Kern, 1986, p. 378). This level of medicalization is represented on almost every one of the clinic websites that are analyzed throughout this study. Specifically, the medical concepts “hypertrophic,” “hypoplasia” and “atrophy,” which were frequently used on the clinic websites to refer to female genitals that were described as having a “condition” or medical “issue,” are prime examples of medicalization at the conceptual level. A seemingly common genital variation, the protrusion of the labia minora beyond the labia majora, has come to be understood by many women as a “problem;” the medical profession converts genital variation into a medical issue by referring to it as a problem, effecting medicalization at the conceptual level. Out of the thirty clinic websites, fifteen discuss the issue of having either hypertrophic, atrophic, or hypoplasia labia, and position longer and “sagging” labia as conditions that FGCS can “treat”: “Dr. Palick treats hypertrophy with liposuction [and] more advanced hypertrophy is treated with reduction achieved by excision of [the labia]”

(“Labia majora remodeling,” 2015, para. 5). On Dr. Palick’s website it is also noted that he “treats labia atrophy.” Likewise, on the “Edelstein Cosmetic” clinic website, it reads:

“[Labia hypertrophy] is a medical condition that is characterized by the atypical enlargement of the inner vaginal lips (or labia minora). Patients who suffer from the condition present inner vaginal lips that extend beyond the typically larger outer lips (labia majora)” (Edelstein, J., “Labiaplasty,” 2015, para. 3).

“Enlarged,” or “sagging” labia, then, is not presented as a woman’s personal problem on the surgeons’ websites, but rather, it is constructed as a medical issue that can (and should) be “fixed.”

The women in this study who have undergone FGCS all share a common experience with one another – the pre-operative consultation. During this interaction between the surgeon and the woman, medicalization at the interactional level occurs. During this specific interaction, the use of medical rhetoric by the surgeon appears to be common. This type of medical language used by the surgeon works to define women’s genitals as medical problems, rather than mere issues of vanity, which are in need of medical attention. This is clear in the case of fifteen-year-old Olive, who explained that ever since she began puberty she felt as though her “labia just didn’t look normal.” She spoke to her mother about this and together they set up an appointment for her with a gynecologist who also performed FGCS procedures; she stated she “trusted that his opinion would be the best.” During the appointment the doctor confirmed, “It [her labia] was larger than average and [she] qualifies for [female genital cosmetic] surgery.” This example not only illustrates medicalization at the interactional level whereby the doctor in this situation is defining a social problem for Olive as a *medical* issue; it also serves to confirm feelings of abnormality and defectiveness and to uphold dominant beauty norms of female genitalia.

Through the interactional and conceptual level of medicalization, the women's feelings of "abnormality" were later confirmed through their interactions with the surgeons who treated women's normal and healthy functioning genitals as medical problems. These feelings of "abnormality" were also confirmed through the development of medical terminology to describe variation among women's genitals. When looking at the process of medicalization through this perspective, the women's decisions to have female genital cosmetic surgery come to be understood as reasonable and logical, rather than illogical or naïve.

Section III: Female Genitalia Before and After Surgery

In this section, I focus on the dramatic difference in how women's genitals are discussed before female genital cosmetic surgery and after genital cosmetic surgery and how this distinction further contributes to the medicalization of women's genitals. Women's and clinic website's descriptions of women's unreconstructed and reconstructed genitals begin to develop the idea of "normal" and "abnormal" or "good" and "bad" female genitals.¹⁹

Genitalia Pre-Surgery

Women's ideas and experiences of their genitals are anything but uncomplicated, simple, or objective (Braun & Tiefer, 2009). The women's descriptions of their genitals prior to genital cosmetic surgery were often used to describe why it was necessary for them to undergo FGCS procedures. Before genital surgery, all of the women described their genitals as being a constant "struggle" or "issue" they have had to (and, indeed, may still have to) deal with on a day-to-day basis. In her post, Alex explains, "for the past 15

¹⁹ This idea of "normal" and "abnormal" female genitals will be further discussed in Section IV: The "Normal" versus The "Abnormal."

years – since I was 13 I have been struggling on a day-to-day basis with this issue [of having long labia].” Likewise, twenty-eight-year-old Devon explains that she “has struggled with long labia” her entire life. Twenty-two of the thirty women described their genitals before having surgery as aesthetically displeasing due to their “very large” labia, and would often refer to their genitals as resembling something other than the female anatomy. For example, in seventeen-year-old Paige’s description of her genitals she explains, “I think my vagina is ugly. My labia comes out really far and it reminds me of a turkey.” Paige’s description of her genitals further positions long(er) labia as a problem in need of fixing. Women’s dissatisfaction with their genitals could be attributed to the fact that representations of women’s genitals in pornography and other media outlets, for example, contain highly selective and usually one-dimensional images of women’s genitals, giving a false impression of what “normal” is. For instance, Paige explains in her post that she became aware of her “long labia” after seeing other women’s genitals in the media, and states, “When I see vaginas in movies they don’t look like mine and I feel I’m not normal.” It is not surprising that Paige would identify her long labia as wrong, since genital variation is largely non-existent in pornography (McDougall, 2013), which is presumably where Paige encountered most of the female genitals she speaks of. Paige’s explanation reflects the pervasiveness of media and the effect that these normalizing images have on the way she experiences her body. Although there is little to no diversity of labia on screen, there is *actually* considerable variation of female genitals, with the labia minora ranging from 2 to 10 cm in length (Lloyd, Crouch, Minto, Liao & Creighton, 2005). Women seek labiaplasty and other FGCS procedures, therefore, even though their labia are technically considered to fall within the “normal” range, perhaps as

a result of the limited variation of women's genitals presented to the public, as Paige's account suggests.

Women's descriptions of their pre-surgical vulvas were similar to each other's. These frequent descriptions included referring to their genitals as "abnormal," "enlarged," "protruding," "long," "ugly," "unequal," "asymmetrical," "wrinkly," "loose," and "hypertrophic," with "dark pigmentation." For example, Uta, who is twenty-two years old, explains that before she had labiaplasty, her labia were "long, protruding and VERY [sic] uneven." Similarly, nineteen year-old Jaclyn, who underwent vaginoplasty, described her pre-surgical genitals as "abnormal and unattractive" and "a dirty secret," which she refers to as "the hideous monstrosity I was hiding underneath my clothes." What is particularly interesting about Jaclyn's post is her use of the term "dirty" to describe her non-modified genitals, specifically when thinking about the aesthetic ideal for female genitalia, which is commonly referred to as "a *clean* slit" (emphasis added) and a "minimalist ideal for women's genitals where the labia are symmetrical and do not protrude" (Weil Davis, 2002, as cited in McDougall, 2013, p. 776). The word "clean" to describe the female genital aesthetic ideal is often meant to describe "neat" and "tidy" genitals (i.e., small and contained labia). Women have long felt pressure to combat the stereotypes that their genitals are "smelly, dirty and leaky" (McDougall 2013, p.776). Now, however, women must also consider the shape and size of their genitals, which creates an ideal for women's genitals whereby the genitals ought to be as "clean" as possible regarding both scent and appearance.

The term "hypertrophic" used by one of the women in this study to refer to her genitals pre-surgery is particularly interesting, as the term "hypertrophy" is not regular,

everyday language, but is often found throughout medical discourse as a way to describe the enlargement or protuberance of an organ or part of the body (such as labial tissue extending beyond the labia majora) (Farahi, Lara-Torre & McCuin, 2014). Hypertrophy of the labia is an interesting qualification for cosmetic genital surgery in particular, since women's genitals show wide diversity in all features (Lloyd, Crouch, Minto, Liao & Creighton, 2005), and according to Braun and Tiefer (2009), visible labia minora are statistically "normal" and may possibly be more common than invisible labia. Yet labia minora are still described as hypertrophic if they are visible past the labia majora. The length a woman's labia must reach before it is deemed hypertrophic is a matter of much debate, with definitions (with no apparent evidence base) ranging from 2cm to 5cm (see Goodman et al., 2007; Pardo et al., 2006). Yet, this type of medical language appears to have now been adopted by women themselves to describe their "flawed" genitalia. Carrie, a twenty-year-old student who underwent labiaplasty surgery, explained that she suffers from "labial hypertrophy." In taking up this type of medical language, a certain (typically average) body variation is medicalized and pathology confirmed. With the acceptance of this "condition," a surgical solution is therefore justified, as this genital variation becomes a real "problem" requiring treatment.

Based on the women's descriptions of their pre-surgical genitals, it appears that "long" and "uneven" labia (and indeed a "loose" vagina) indicate, to some women, a body unfit for sexual activity. Once again Paige explains, "I'm scared to be sexual with a boy because I think my vagina is ugly." Veronica, who is in her early twenties, explains that before having surgery it was "so hard living with something you feel to be embarrassing to the point it affects your sexual relationships, confidence and self-

esteem.” While twenty-five year-old Yasmine explains that before surgery she was “unbelievably self conscious to the point that [she] only had a single sexual experience in [her] lifetime [because of her] large and unequal labia.” The belief that one’s genitals are unattractive deeply affects women’s conception of and relation to their own genitalia and has a marginalizing effect, whereby women feel they ought to have a particular version of female genitalia. If their genitals do not look the way they are “supposed to,” then some women may limit their sexual experience out of shame and embarrassment until they achieve the aesthetic genital ideal.

Each of the thirty surgeons’ websites analyzed in this study reported on the appearance, shape, color and size of a woman’s genitals before undergoing genital cosmetic surgery. Women’s pre-surgical genitals were described on the surgeons’ websites as “atypical,” “asymmetric,” “enlarged,” “protruding,” “hypertrophic,” “hyper pigmented,” “sagging,” “damaged,” and “defected.” The Toronto Cosmetic Clinic website reports that “vaginal defects include weak muscles, poor tone, and flaccid skin” (About Vaginoplasty Surgery, 2014, para.1). Dr. Stanton describes women’s genitals before surgery as having “excessive length, thickness, dark pigmentation, and asymmetric labia” (What makes a good candidate,” 2008, para.1). This type of medical discourse used to discuss women’s genitals before surgery positions “large” and “asymmetric” labia as a “problem” requiring medical treatment. For example, on “The Plastic Surgery Clinic” website, Dr. Lista and Dr. Ahmad explain that having “large labia” is a “problem” for women that can be easily “corrected”:

If you have lived with this problem [of having large labia] for years, you may be surprised to learn that this problem is easily corrected with a relatively minor procedure performed in the plastic surgery clinic (“Labia reduction,” n.d. para. 2).

Based on the extensive list of women's pre-surgical vaginal "irregularities," most women might meet the requirements for FGCS, as there appears to be limited room for female genital variation that would not qualify for such surgery. By presenting women's pre-surgical genitals in this way, surgeons' websites pathologize variation in female genitalia.

According to the Society of Obstetricians and Gynecologists of Canada, "there is a wide spectrum of normal anatomic variation in female genitalia" (2013, p. 3). If the women on the online forums are any indication of female genital variation, then labia minora that may be visible past the labia majora are certainly common and perhaps more average than having non-visible labia minora. Nevertheless, labia minora continue to be labeled "defective" so long as they hang past the labia majora. The description on clinic websites used to explain women's genital variations invokes notions of abnormality, with words such as "condition" and "protrusion" used to describe "hypertrophic" labia, while the diagnosis of "hypertrophic labia" locates certain natural genital appearances within the realm of the medical and the pathological. This type of discourse could perhaps serve to encourage women who may already be unsure if there is something wrong with their genitals to seek medical "help." Likewise, this use of language may also encourage others, who may not have necessarily thought about FGCS, to monitor their genitals for the above mentioned "conditions" and "problems" outlined on clinic websites. Because these descriptions of women's pre-surgical genitals come from an often-trusted source (i.e., medical provider websites), the descriptions perform important ideological work in presenting a subjective opinion – labia that are large are considered problematic by some – as an objective truth – large labia are a problem – thus, surgery is then constructed as a reasonable solution to a genuine "disorder."

Genitalia Post-Surgery

Women's descriptions of their genitals before surgery were in marked contrast to the genitals they wished to have, or desired to have, after surgery. My findings suggest that women's reactions to their post-surgical genitals fell into three main categories: satisfied; ambivalent; and discontented. It is important to restate that not all of the women whose posts are analyzed in this study had already undergone FGCS; some women were waiting to have surgery, while others were debating whether to have surgery. Thus, the descriptions of women's genitals after surgery account for the fifteen women in this study who both had genital cosmetic surgery, and described in their posts their genitals after surgery. One of the most common reactions, expressed by seven women, was feelings of happiness and satisfaction with the results of the surgery and, specifically, the aesthetics of their genitals. As Brittany explained, "I did not realize it [her vagina] hung open so much since now it seems so small." Allison, who underwent labiaplasty for comfort and aesthetic reasons, described her modified genitals after surgery as "gorgeous," "attractive," and "even," while Jaclyn described her genitals after labiaplasty as "neat and pretty and all I ever wanted it to be." These women also stated that after they had FGCS their vulva resembled a "normal" vulva. Mary, a twenty-one-year-old woman who underwent labiaplasty, states, "Today, for the first time, my vagina looks like a normal vagina." According to Mary, her vagina finally resembled a "normal" vagina now that it appeared "neat, even and symmetrical." Other descriptors women used for their surgically altered genitals were "sleek," "smooth," "small," and "thin."

Women who were happy with the outcomes of their surgery seem to reflect a shared understanding that desirable and beautiful vulvas are simultaneously "small,"

“neat,” and “attractive,” with little to no labia minora visible (i.e., the opposite of the wayward, pre-surgery genitalia). As discussed in Chapter Three, this desirable vulva is consistent with the description of the “ideal” vulva found in much of the theoretical literature surrounding female genital cosmetic surgery and the female body, which is described as resembling a perfect shape ‘V’ with symmetrical and small labia minora (McDougall, 2013). This ideal narrows the range of acceptable genital aesthetics, creating one hegemonic and homogenous idealized vulva, which women are now expected to achieve (Braun, 2010).

In contrast to these positive outcomes, six women expressed feelings of uncertainty towards their modified genitals, describing their post-surgical genitals in a very different way than the previous (positive) descriptions. Alex mentions that after having FGCS her genital region is “now a very different shape” and her new genitals look odd: “[I] look at it [her vulva] with a little handheld mirror and think it looks a bit weird, like sort of sewn up just too far.” Likewise Brenda, who underwent labiaplasty, explains that it “looks like I have three labia” instead of two after her surgery:

The right side and the left side look even and symmetrical when you look at it with my legs together and then when I spread the labia, there is this other smaller labia inside that closes the vaginal entrance. I don't know why this would happen or if this requires corrective surgery.

Finally, one woman was discontented with the results of her surgery. Susan, who is in her early forties and who underwent both labiaplasty and clitoral hood reduction together, expressed dissatisfaction with her post-surgical genitals, describing them as “unrecognizable.”

To be honest, everything down below is unrecognizable. Obviously I’m familiar with my own female anatomy and I am so worried and confused with the whole

situation and everything I see down there. I feel as though my whole vagina has been burnt off and my clitoral hood seems to be in many pieces.

The seven women in total who expressed feelings of uncertainty and dissatisfaction with their post-surgical genitals in this study explained that they felt this way due to the differentness of their vulvas, and specifically their labia and clitoral hood, verses what they are normally used to. This ambivalence towards their genitals after surgery may also stem from the issue that the ideal image these women may have had in their mind of what their genitals would look like after surgery may not have necessarily matched what their actual genitals resembled after undergoing the surgery. Further, while it appears that only one of the women in this study described complete dissatisfaction with her post-surgical genitals, these outcomes may not necessarily paint an accurate picture of the long-term outcomes of FGCS in general, since there is currently little research done or known on the long-term outcomes of these procedures (Braun, 2010). Since the women in this study who described their post-surgery genitals did so shortly after having surgery (i.e., descriptions did not include surgeries from years prior), it is possible that the same women who described their genitals in a positive way may have different feelings towards their genitals in years to come (e.g., during pregnancy and menopause when the female genitalia may change a considerable amount, see Farage & Maibach, 2006).

The positive descriptions women reported of their genitals after surgery echo the descriptions of women's post-surgery genitals on surgeons' websites. After surgery, female genitals are described on the clinic websites as "aesthetically pleasing," "contained," "tightened," "youthful," and "rejuvenated." Most of the websites report on the new and enhanced appearance of the surgically altered genitals in particular. For example, Dr. Edelstein's clinic website states that FGCS "enhances the aesthetic of the

genital area by making it look neater” (Labiaplasty: The Barbie and the traditional look, 2015, para. 5), and describes women’s genitals as having a “streamlined and flatter appearance that has everything contained.” This “containment” is referring to the labia minora no longer protruding past the labia majora. The containment of the labia is said to give the female genitals a “sleek and minimalist appearance” (Edelstein, J, 2015, “The Barbie labiaplasty,” para. 1) with a “tight and petite ‘stream-lined’” and “single crease look” (Toronto Cosmetic Clinic, 2014, “The Barbie labiaplasty,” para. 2). Further, on “The Plastic Surgery Clinic” website, women’s genitals after surgery are described as “even and small” and “more attractive to look at” (“Labia reduction,” n.d, para. 1).

A recurring description of women’s post-surgical genitals emerges on the clinic websites. The description of women’s genitals after surgery represents the female genital ideal and largely includes a “contained” and “minimalist” genital aesthetic. This female genital ideal matches existing social constructions of women’s sexuality more broadly, whereby women’s sex drive is absent and their sexual behaviour repressed. However, this portrayal of women’s sexuality conflicts with the natural appearance of women’s genitals during sexual arousal, given the swelling that occurs (Blackledge, 2004). Further, this recurring description of women’s post-surgical genitals may be grounded in historical characteristics of protruding labia minora and sexual promiscuity (Manderson, 2004). For example, over the past few centuries, women’s genitals have been the focus of scientific research whether it was because of race or sexuality. In the nineteenth and twentieth century, appropriate female embodiment and sexuality were judged based on women’s “excessive” genital tissue. For example, in the early 1800’s, the display of Saartjie Baartman, a member of the Khoi-San peoples of South Africa, was put on public display

to show her “abnormal” and elongated genitalia (Young, 1997). Similarly, in the nineteenth and twentieth century, measurements of the genitals of prostitutes and lesbian women were conducted to determine pathological difference between women’s genitals (Terry, 1990). In the twenty-first century this “excess” of the labia still remains problematic, resulting in the relatively new medical diagnosis of labial hypertrophy. Therefore, the surgeons’ descriptions of women’s surgically enhanced genitalia may portray a progression from historical social constructions of female anatomy and female sexuality.

Women’s genitals after FGCS were also described as having a more “natural elliptical contour” to the vulva (Levine, R., 2015, “Labia sculpting,” para. 1), and as having a “sleeker, thinner, more comfortable, and more appealing size and shape with typically excellent, very natural-looking results” (Rho, R., n.d., “Labiaplasty,” para. 4). What is particularly interesting about the descriptions of women’s genitals post-surgery is use of the term “natural” to describe women’s surgically enhanced genitals. This type of discourse serves to enforce the idea that FGCS improves the female genital appearance by producing “natural” looking results. Of course this idea is contradictory, since in actuality, FGCS is taking the very “natural” aesthetics of the female genital it claims to produce and instead constructing artificial (surgically modified) genitals. By describing surgically enhanced female genitals as “natural” and women’s non-surgically enhanced genitals as “problems” and “conditions,” this type of discourse points to the idea of artificially or surgically enhanced genitals as becoming the new standard of naturalness. This is ultimately a paradox: in order for women to have what the surgeon’s describe as “natural” looking genitals, women must undergo genital cosmetic surgery.

Although a pathological understanding of women's genitals is not new (see Terry, 1990; Young 1997), the rhetoric used on surgeons' websites, including adjectives such as "sagging," "loose," "uneven," protruding" and "large" as well as "conditions," "problems," and "issues," which are used to describe women's genitals pre-surgery, further pathologize variation among women's genitals. This works to promote (greater) vaginal distress and anxiety for women, while at the same time creating a consumer market for these types of procedures.

Section IV: The "Normal" versus The "Abnormal"

Consistent with the findings of previous research (Davis, 2009), I find that in the field of FGCS, the normal, non-surgically enhanced body is pathologized through an explicit differentiation between normal and abnormal/right and wrong bodies. This theme is most often conveyed through the use of language, but is also implied visually.²⁰ In 1999, cultural scholar Simone Davis (2002) consulted an FGCS surgeon who informed her that "the ideal look for labia minora was not only minimal and unextended but also symmetrical, 'homogenously pink' and not wavy'" (2002, p. 15). This notion of "normality" is often discussed in the context of an increasing change in Western cultures — a shift towards "corporeal normalization, medicalization, commodification, and self-surveillance" (McHugh, 2013, p. 8). The construction of "normality" versus "deviance" or "normal" versus "abnormal" regarding female genitals and their surgical alteration is culturally shaped in the discourses of aesthetic medicine and the media. McHugh, while speaking specifically about facial cosmetic surgery in his book, *Faces Inside and Outside the Clinic* (2013), examines the "normal" and the "abnormal" at length, and much of his

²⁰ This theme of normal and abnormal bodies portrayed visually will be discussed further in this section under "Visual Persuasion: "Before" and "After" Images."

discussion can be applied to the construction of “normal” and “abnormal” female genitals. He states, “what is deemed to be ‘normal’ is defined, in part, by the situated *milieu* – the culture, the workplace, the physical location, the time, and space – in which individuals find themselves” (2013, p. 64). That is, what is considered “normal” or correct largely depends on the context and environment in which one is situated. This means that standards of what it means to be “normal” or “healthy” are socially and culturally dictated.

The “Normal” Vulva

Among the posts written by women who have had, or who want to have, FGCS, almost all of the women indicated a longing for what is often referred to as the “normal” vulva. Alex expresses in her post that she had labiaplasty surgery because she “just wanted to be normal” in her genital region. In a similar fashion, twenty-two year-old Fay explains that she wanted genital surgery to “shape her to a normal size,” while Mary explains the reason that she had surgery was to achieve “a normal looking vagina.” According to the women in this study, “normal” genitals meant having a small(er), tight(er), and a more even vulva. According to Gail, she is “so happy that [she] now feels like [she] has a nice little normal vagina instead of an embarrassing big hole.” Willow, who underwent two labiaplasties (the second one was to fix complications from her first surgery), referred to her labia after her second surgery as “*very* tiny and normal now.” Another description of “normal” genitals, and indeed one to which I had previously given very little thought, was the idea of having light(er) pigmentation in the genital region. Specifically, Mary identified a “normal” vagina as one that does not have dark pigmentation when she explains, “Today my vagina finally almost looks like a normal

one. Everyday the color turns a healthier pinky color.” The desire to have “normal” genitals for these women can also be understood as a desire to fit in with the perceived feminine ideal. Further, these women may also be seeking a “normal” vulva in order to avoid possible embarrassment with sexual partners.

Surgeons’ websites also attempted to distinguish between “normal” and “abnormal” female genitals. Eighteen of the clinic websites gave some sort of description of what a “normal” vulva *should* look like, and unsurprisingly, the description of a “normal” vulva on each of these websites is quite consistent. The websites described a questionably narrow appearance norm, which included female genitals that are smooth-skinned, symmetrical, small and neat, with invisible labia:

The normal female external genitalia have two sets of labia: the labia majora and labia minora. The labia majora are the larger outer lips. The labia minora are the smaller inner lips. They are more delicate and are hairless. Normally the labia minora protrude *slightly* beyond the level of the labia majora (Lista, F., & Ahmad, J., n.d. “The best candidates for labia reduction,” para. 1).

Further, Dr. Rho from “The Labiaplasty Master Surgery Center of New York,” explains that “normal” female genitals (those that do not require surgery) are “sleek, thin, [with a] average shape and size” (“Labiaplasty,” n.d., para. 4). While “The Toronto Cosmetic Clinic” website states that there is “no protrusion of the labia minora” for “normal” female genitals (“Why Labiaplasty,” 2015, para. 1). Interestingly, out of the thirty clinic websites analyzed in this study, it appears that only one website mentioned that “all labia are ‘normal,’” and come in different shapes and sizes; however, this same website also mentions that just because a woman’s genitals may be “normal” does not necessarily mean she must be satisfied or happy with them, and in fact may still very well be interested in elective genital surgery:

It's all "normal." But, just because it's "normal" (like very small breasts, or breasts that have lost their shape after bearing children) doesn't mean that a woman is satisfied with the appearance and might, exactly like having breast size augmented or reduced, wish to change the appearance and size to one that better suits her desires (Goodman, M., 2015, "Genital cosmetic surgery FAQ," para. 2).

This excerpt is particularly interesting, in that it uses an alternative discourse, "everyone is different, everyone is normal," as a marketing approach to promote these types of procedures. While at first glance this form of marketing may seem preferable over the discourse used to promote FGCS on the other clinic websites, it may simply be a substitute for the normalizing discourse found on other surgeons' websites, by focusing on a more consumerist ideology, which promotes the "be all that you can be" ideology common in neoliberal societies.

The creation of an idealized image for women's genitals have significant social implications, as it establishes the notion that there is a specific way a woman's genitals *ought to* and, indeed, *should* look. As previously explored in chapter three, "Theoretical Framework and Literature Review," definitions of "normal" and "abnormal" women's bodies are always changing, as these definitions are historically and structurally contingent. Simply by referring to a part of the body as "normal" or "right" infers that there can be a part of the body that is "abnormal" or "wrong." Further, it is important to examine the construction of the genital "norm" because, as Lennard Davis (2006) suggests, "the 'problem' is not the person with the disability; the problem is the way normalcy is constructed to create the 'problem' of the disabled person" (p. 3). The new "norm" for female genitals has become a standard to which genital variations are compared and measured, and has also come to be understood as the way "correctness" (McHugh, 2013) is recognized for female genitalia. The problem with the application of

the idea of a genital “norm” is that it produces the idea of “deviant” female genitalia, and forces the normal variation of women’s genitals through a more stringent template of the way female genitals “should” look (Davis, 2006). An important concern is that with the pathologization of genital diversity for women, through the promotion of certain desirable and ideal vulvar features, any anxieties women may have about their genitals could be enhanced, and develop into more significant distress and uncertainty about their vulva. Additionally, women who may have little to no concern about their genitals may suddenly pay closer attention to, and dislike, their genitals if they do not resemble the ideal “clean slit” (McDougall, 2013) described and depicted in FGCS discourse and imagery.

The “Abnormal” Vulva

According to Lennard Davis (2006), with the concept of the “norm” comes the concept of deviation, or “abnormality.” Reflected in most of the women’s posts on the online forums, as well as on the majority of surgeons’ websites, was the understanding that women’s genitals were no longer simply cosmetic or aesthetic problems, but had become pathological and medical problems, which are in need of medical attention. “Abnormal” female genitals were not discussed in as much depth as “normal” genitals were among women in the forums; indeed, one of the women, Idelle, who is in her early twenties, went as far as to state that she was aware “abnormal” genitals do not exist: “I know there is no such thing as abnormal genitals.” Nonetheless, there was still some discussion about what constitutes “abnormal” female genitals. Descriptions of “abnormal” genitals included having a “large” vagina that “hangs wide open,” as explained by Brittany who underwent vaginal tightening. More commonly, “abnormal”

genitals were described as large or protruding. For example, Olive explains in her post that she believes her genitalia are “not normal” because of her “larger than average labia,” a conclusion she drew after comparing her genitals to other women’s genitals which she had seen in the media. Further, Paige explains, “I feel I’m not normal [because] my labia come out really far.”

All of the surgeons’ websites in this study reported at least some type of characteristic of a woman’s genitals that they would consider to be “abnormal,” “atypical,” or outside of the “norm,” with almost no recognition conveyed that genital variation is in fact common and normal (aside from Dr. Goodman’s clinic website, as previously stated). The websites imply genital “abnormality” with terms such as “asymmetric” or uneven, and “unusually shaped” to describe women’s labia (Kasrai, L., 2008 “Labiaplasty,” para. 2). Such “unusually shaped” labia includes “when the labia minora protrudes past the labia majora” (Edelstein, J., 2015, “Labiaplasty,” para. 2), and when there is “excessive length” to the labia, or if a woman “suffers from [labial] hypertrophy” (Stanton, 2008, “What makes a good candidate,” video). Dr. DuPéré explains that “vaginal irregularities” include labia that are “pronounced or long, thin, hyper pigmented or asymmetrical” (“How can labiaplasty help?” 2015, para. 2).

While measurements of male genitals are widely available in medical literature (and have been since the 1900’s), in general, there are limited descriptions of female genitals in the medical literature, specifically regarding the exterior structure of the vulva (Lloyd, Crouch, Minto, Liao & Creighton, 2005). This is why it is particularly interesting how surgeons’ websites frame common and natural genital variations as pathological problems, when in fact, the pathological genitals surgeons describe may not necessarily

be pathological at all. In a study conducted by Lloyd et al. measuring anatomical variations of adult female genitals, it was found that there are “wide variations [...] in both the appearance and dimensions of female genitalia,” all of which are considered to be healthy and common. For instance, their study found that labia minora dimensions displayed a large genital variation ranging between twenty and one-hundred millimetres in length (Lloyd, et al., 2005, p. 644).

In McHugh’s book, *Faces Inside and Outside the Clinic*, he raises the question, “since everyone is asymmetrical to some degree, what determines the amount of ‘symmetry’ that constitutes ‘abnormality’?” (2013, p. 26). Surely, if surgeons’ websites are stating that asymmetrical labia are cause for genital surgery, then the surgeons’ standards should be clear and consistent in offering some sort of reference point whereby women can examine if their labia have the “normal” or “right” amount of unevenness or the “abnormal” and “wrong” amount of unevenness. This is not the case; out of the thirty clinic websites analyzed in this research, most simply stated rather vaguely that if a woman suffers from labia that are protruding or asymmetrical then she (probably) qualifies for FGCS. The language used to describe women’s “abnormal” genitalia is vague and ambiguous, with no indication of what counts as too “large” or “protuberant,” or what degree of variability is acceptable. The use of such language implicitly relies on a comparison in order to be meaningful; this comparison, of course, is that of the ideal female genitalia, with labia that are small, contained, and thus, “normal.” A problem arises, however, regarding the way surgeons’ websites define “normal” and “abnormal” genitals. It is clear that there is incongruence among these websites with alternating between providing specific definitions of “normal” genitals, while at the same time

describing “abnormal” genitals in vague and unclear terms. While a strict standard of the female genitalia may negatively affect women’s psychological health and cause insecurity, which may drive women to seek FGCS, providing vague definitions of “abnormal” genitals may also cause women to assume that their somewhat long labia would be considered “abnormal” according to surgeons’ definitions. Therefore, the clinic websites in this study appear to describe a strict standard associated with what the female genitals *should* look like, but vague definitions when they describe the shape and size of female genitals that are “abnormal” (i.e., using general terms such as “large” and “long”). This may aid in the belief that all genitalia that deviate from “the norm” are considered unattractive, and pathological, thus, creating a larger demand for FGCS.

With such rhetoric as “vaginal irregularities” used so often to describe common and natural variations of women’s genitals, the practice and discourse of female genital cosmetic surgery as marketed on surgeons’ websites appear to promote *one* genital aesthetic as “right” and simultaneously pathologize genital diversity in women. This is achieved by creating a dominant, hegemonic model of how a woman’s vulva should look.

Also interesting is the fact that the descriptions of women’s genitals before surgery resemble the descriptions of the “abnormal” vulva, while the descriptions of women’s genitals after surgery mirror the descriptions of the “normal” female genitals. This encourages the idea that women’s unmodified genitals are inherently abnormal, and the only way to achieve a normal vulva is through surgical intervention. By describing female genitals after surgery as normal, FGCS is creating a narrow and strict category for “normal” female genitals, while conveying the idea that women’s genitals will only achieve this level of “normalcy” if they undergo surgery.

Visual Persuasion: “Before” and “After” Images

Twenty-four of the thirty clinic websites analyzed in this research provided some type of image on their website, whether of a naked woman covering her breasts and genital area with her hands paired with text such as, “Let our Cosmetic Surgeons be your beauty secret” (Jackson, R., 2015, “False Creek Health Care Centre”), or of a group of smiling, attractive women in conversation with one another (Lista & Ahmad, 2015, “Labia reduction”). Consistently, these photographs were inviting – showing women who appear youthful, beautiful, and physically fit, and who give the impression of being relaxed, happy and content.

The most common images presented on most of the websites in this study, however, were the “before” and “after” photographs of women’s genitals.²¹ The surgeons’ websites often had a separate webpage dedicated to these types of photographs and the set up appeared to be nearly identical on each clinic website; the image of a woman’s vulva before undergoing FGCS would be presented on the left side of the screen and directly to the right of this image or beneath it, a picture of (presumably) the same vulva, but after surgery, would be presented. These visual images further pathologize the non-modified female genitals. The “after” photograph often presented the woman’s genital region as more appealing by displaying a (better) groomed, and “well-kept” genital area often in conjunction with better lighting and at times a more flattering angle. The “before” photographs would at times have someone’s fingers pulling out the woman’s labia, making them longer and reinforcing the idea that long labia are abnormal. It is expected that individuals should naturally agree that the “after” image is an

²¹ These images included pictures of real anatomy and displayed women’s genital regions only. Women’s faces or other parts of the body were not visible in the images.

improvement on the “before” image. This “before” and “after” set up is used to display what the aesthetically unpleasant and “problem” vulva looks like compared to what the “neat” and aesthetically pleasant vulva looks like, and to show women what their vulva has the *potential* to look like. Therefore, these “before” and “after” photographs display how the “abnormal” genitals can be *made* “normal.” Additionally, by displaying these “before” and “after” surgery photographs, these websites are further promoting vulva distress while at the same time promoting the potential for transformation. That is, without technology, surgeries and other such means to remedy “abnormalities,” individuals would have to remain “abnormal,” however, because the means to achieve these levels of “normalcy” exist (i.e., FGCS), there is increased pressure to attain a “normal” vulva, which is a general feature of the medicalization process. For women who already have concerns about their genitals, surgery may come to occupy a position in which it is seen as the only solution to alleviate this stress. According to Mike Featherstone (1991), “media images invite comparisons: they are constant reminders of what we are and might with effort yet become” (p. 178). These images encourage women to take part in a process of self-surveillance through comparing their own natural genitals with the aesthetically displeasing pre-surgical genital images, and the “normal” and desirable post-surgical genital images.

As expected, the before and after surgery photographs displayed on the clinic websites show a limited, and very specific, range of genital appearances, whereby all of the “after” (surgery) images of women’s genitals presented on any given website bear a strong resemblance to the “after” photographs found on the other clinic websites. By posting the “after” photographs of highly sculpted, nearly identical genitalia as the

aesthetic and healthy ideal, these surgeons implicitly pathologize the female genitalia featured in the “before” photographs as being “abnormal” or unnatural in some way, and as bodies that are in need of help, which require the surgeons’ expert interpretation and hand.

Section V: Conclusion

This chapter has explored the ways in which women’s genitals are divided into “right” and “wrong” or “normal” and “abnormal” genitals through the active practices and processes of medicalization as well as the pathologization of female genital diversity through the promotion of one ideal genital aesthetic. The process of medicalization and the practice of pathologizing female genital variations were explored by focusing on FGCS discourse and imagery on surgeons’ websites as well as women’s experiences with these surgeries, which has helped to explain how women come to experience their natural genital variations as “abnormal” or flawed.

Chapter Six: Conclusion

This thesis describes a qualitative media content analysis that compares women's reasons for undergoing FGCS with surgeons' representations of the reasons women have FGCS. This study has explored women's experiences and feelings about genital cosmetic procedures, and their insecurities about their genitals. As well, this study has explored how FGCS procedures are advertised and marketed on clinic websites, and the possible implications these marketing techniques may have. In this chapter, I provide a brief overview of my main findings, the significance of this research and the importance of studying this type of surgery, and directions for future research.

Section I: Summary of Findings

This research project produced several key findings. Chapter Four explored three important categories of findings in particular: 1) women's reasons for undergoing FGCS and surgeons' representations of reasons women have FGCS; 2) the "ideal" versus the passive FGCS patient; and 3) the risks and success associated with FGCS. One of the main findings from this chapter reflected in women's posts about their experiences with genital cosmetic surgeries, was that undergoing female genital cosmetic surgery is rarely a straightforward answer to a clear-cut problem. The women's posts revealed a multitude of complex reasons for their desire to undergo FGCS. Women's reasons fell into four main categories: aesthetic concerns, psychological issues, physical discomfort caused by their labia minora, and lastly, sexual problems and the hope that surgery would enhance their sexual pleasure. The four main reasons women explained for wanting surgery were also found on the clinic websites. Surgeons' websites explained the primary reasons women undergo FGCS is to "enhance" their genital appearance, improve their emotional

wellbeing, help with physical discomfort, and increase their sexual pleasure. However, these websites also presented additional reasons why women might want to undergo FGCS, including hygienic concerns, sociocultural and religious reasons, and addressing the effects of pregnancy or childbirth.

Chapter Four also explored the way in which surgeons' websites described the "ideal" genital cosmetic surgery patient in comparison to the passive cosmetic surgery patient, and the ways in which women at times embody both patient positions. The websites positioned the "ideal" patient as an empowered and informed woman who is undergoing surgery for herself. The women in this study embodied this idea of the "ideal" patient through actively researching the surgeries, attempting to locate the "best" surgeon to perform their surgery, as well as at times explaining that they are choosing to have surgery to make themselves happy and not to make someone else happy, such as a partner, for example. The portrayal of the "ideal patient" on surgeons' websites works to position the choice to have FGCS as an empowered and individual decision, which may potentially work to make women's decisions in favour of FGCS seem reasonable. The websites oppose the "ideal" patient to the passive, and thus, least appropriate cosmetic patient. This type of patient is least desirable to many because of her unquestioning dependency on the medical expert. I found that at times some women have little choice but to embody this passive role. The difference between passive and ideal rests on the disparity of medical knowledge between the women having the surgery and the surgeons performing the surgery, which means these women have little option but to rely on surgeons and their medical expertise.

Lastly, Chapter Four examined how FGCS risks and success are marketed on surgeons' websites in comparison to women's accounts of their experiences with the risks associated with genital cosmetic surgery. Two major findings were presented in this section. First, out of thirty clinic websites in this research, half of these websites left out information concerning the risks associated with FGCS altogether, while the other half that described FGCS risks downplayed these risks. Second, while the risks of FGCS were downplayed or not described at all on the websites, the success stories of FGCS were emphasized. The websites that described FGCS risks and attempted to downplay these risks did so by distancing genital cosmetic surgeries from other more "serious" cosmetic procedures. The websites highlighted successful case studies and emphasized the apparent benefits and positive outcomes FGCS can provide women. While the websites also claimed that genital cosmetic surgeries have high success rates, they often failed to provide credible, research-based evidence for these claims. Finally, this section explored the risks women reported experiencing after undergoing surgery, which were not mentioned on the clinic websites. The main risks women mentioned included having to undergo a second corrective surgery to fix complications from the first surgery, not being able to lubricate well after surgery, and experiencing irregular bleeding weeks after having the surgery. While clinic websites promote FGCS as having more benefits for women than risks, it is not yet clear whether the benefits of FGCS actually outweigh the risks. An important note to end with, then, is that women who are interested in FGCS should be well informed of both possible benefits and possible risks that are associated with these surgeries.

Chapter Five of this study explored four key themes: 1) the process of medicalization and how women experience medicalization at the “conceptual” and the “interactional” level as well as the possible implications medicalization may have for women; 2) the dramatic difference of both women’s and surgeon’s accounts of women’s genitals before surgery in comparison to the description of women’s genitals after surgery; 3) the difference between “normal” and “abnormal” genitals and how “normal” and “abnormal” genitals are discussed by women and surgeons’ websites; and 4) the use of “before” surgery and “after” surgery photographs of women’s genitals on surgeons’ websites. An important finding from this chapter was how the medicalization of female genitals has the effect of making genital surgery seem like a reasonable solution to genital insecurities.

The first section in Chapter Five examined the process of medicalization. In particular, this section examined how women in this study experienced medicalization at the “conceptual” and “interactional” level (Conrad, 1992). An important finding in this section is how, by using the concept of medicalization, one can better understand how women come to experience their own genitals as flawed or “abnormal.” The women’s posts reflected that the medicalization of healthy female vulvas at both the conceptual and interactional levels effectively masked the underlying social causes of the women’s feelings that their genitals were defective and abnormal. The women’s accounts reflected that, at the conceptual level, the clinic websites described women’s genitals as wrong or “abnormal” by using terms such as “hypertrophic,” “atrophy” and “hypoplasia,” describing common genital variations as medical problems. The women’s individual feelings of defectiveness and abnormality were later confirmed at the interactional level

when the cosmetic surgeons defined and treated women's genitals as medical problems. By positioning the female genitals within a medical discourse, anything outside of narrowly defined sociocultural understandings of an acceptable female vulva was positioned as a medical problem, which required surgical intervention.

An additional key finding in this chapter is the dramatic difference in the ways in which women's genitals are described before and after undergoing FGCS. All thirty women in this study described their pre-surgical genitals as problems they have had to deal with for most of their lives. The women's descriptions of their genitals before surgery helped to explain why they felt it was necessary to undergo genital cosmetic surgery. Some women explained that they were deeply ashamed of their genitals to the point where they limited their sexual experience because of the shame and embarrassment they felt. Further, using words such as "damaged," "disorder" and "problematic," surgeons' websites described women's pre-surgical genitals using negative connotations. A main finding here was that surgeons' websites framed genital cosmetic surgery as a necessary or required procedure in order to "correct" women's genitals to a more "normal" size and shape.

The descriptions of both surgeons' websites and women's accounts of women's genitals pre-surgery contrast sharply with the descriptions post-surgery. After having surgery, some of the women's posts reflected that cosmetic genital surgery was ultimately worth the pain and suffering involved as it permitted them to experience their genitals as feminine, beautiful, and sexually desirable. These women expressed that their genitals were no longer sources of embarrassment, discomfort, and markers of "abnormality." Other women, however, were ambivalent about or discontented with their

genitals after surgery. These women explained they felt their genitals did not resemble what they had originally thought their genitals would look like; one woman explained that she was horrified by the appearance of her genitals after surgery and regretted her decision to have FGCS. Surgeons' websites also described women's genitals after surgery. These websites reported on the new and enhanced appearance of the surgically altered genitals in particular. On these websites, post-surgery genitals were described repeatedly as "neat," "contained," and "small." These descriptions serve to further limit the acceptable range of female genitals, thus widening the definition of "abnormal" genitals.

The third section in Chapter Five focused on the distinction between "normal" and "abnormal" female genitalia. At times, the women in this study expressed the desire for a "normal" vulva, which they described as having symmetrical and small labia minora. Specifically, the women's posts reflect that while women's genitals may be valued in our culture, one size and shape of female genitals is viewed as most valuable and "normal," and that is one that is small, neat, and even. This valued aesthetic ideal emerged on the clinic websites as well when they described "normal" female genitals. Their description of "normal" genitals represents a very narrow appearance norm, one that leaves little room for genital variation. Surgeons' websites explain that "normal" female genitals are "small" and "contained," with little to no labia minora visible; this mirrors the description of women's post-surgical genitals in section two of Chapter Five, implying that surgery is a route to normalization. Further, women did not necessarily describe "abnormal" female genitalia as much as they described "normal" genitalia; indeed, one woman in particular explained that there is no such thing as "abnormal"

genitals. Women who discussed “abnormal” genitals reflected the idea that “abnormal” vulvas were the opposite of small and even; they were “large,” “uneven,” and unattractive. Similarly, all of the surgeons’ websites reported at least some characteristics of a woman’s genitalia they would consider “abnormal.” Essentially all genital variations that did not resemble the symmetrical, contained and thus aesthetically pleasant vulva were described as “abnormal” or “atypical.” Thus, a main finding in this section was that the clinic websites described a strict standard for how women’s genitals should look, while also providing vague and broad descriptors of what “abnormal” female genitals look like. This may contribute to the idea that all genitals that deviate from the genital norm are “abnormal,” resulting in a larger demand for FGCS.

The last section in Chapter Five examined the photographs presented on clinic websites, and in particular, the “before” surgery and “after” surgery photographs of women’s genitalia. The overall finding from this section was that the “after” photographs were identical on each clinic website, and showed a limited and very specific range of genital appearances. These photographs represented visually this idea of the “normal” and “abnormal” vulva, by displaying how the “abnormal” genitals can be *made* “normal.”

In sum, this research suggests that there are many reasons why women undergo FGCS, and it is important to highlight that, ultimately, electing to have genital cosmetic surgery comes down to a perception that women’s genitals are flawed and “abnormal” (aside from the rare cases when women are being physically hampered by their genital structure). This is due in large part to emerging normative standards of the vulva, which surgeons’ websites reinforce by presenting women’s reasons for FGCS as self-evident,

medically-endorsed and “fixable” through a supposedly “minimal-risk” cosmetic procedure.

Section II: Significance of Study

This study has the potential to make significant contributions at both academic and policy-making levels. The practical significance of this study was to fill a gap in research on the reasons why women undergo female genital cosmetic surgery. While this study does provide a basis for understanding the reasons women have FGCS, it is limited because I did not speak directly to the women who have had or wish to have FGCS as well as the surgeons who perform these surgeries. Nevertheless, this project does have the potential to contribute to social policy, by producing sociological research on the online marketing and promotion of genital cosmetic surgeries. This may help direct policymakers’ decision-making regarding the regulation of cosmetic genital surgery marketing practices.

Through conducting this research, my aim was to critically explore this form of cosmetic intervention, in order to understand the meanings and reasons women and surgeons provide for why women undergo FGCS procedures. This research has the potential to help broaden the debates surrounding FGCS by soliciting and exploring women’s views on these surgeries. This is an important contribution, as for too long these views have been dismissed or regarded as the product of mere “cultural dupes” unable to resist outside influences, and assumptions have been made about these women without any rigorous investigation. This research also has the potential to provide information on the marketing practices and techniques medical provider websites employ to help

promote their clinics and surgeries and the effects these marketing techniques may have, particularly on women.

Further, this study aids in our understanding of the reasons why women may feel they must undergo cosmetic genital surgery, an important aspect of FGCS that has not previously been investigated. Such information helps to clarify the active role I believe women play in choosing to undergo FGCS. Female genital cosmetic surgery, as a form of cosmetic intervention, demands investigation, because it has the potential to intensify preoccupation and worry about the body when many women are already consumed with such worries. According to the National Institute of Mental Health (NIMH), one in five women suffer from some form of an eating disorder or disordered eating, which has been attributed to a particularly narrow and unrealistic set of standards of feminine beauty in western, consumer culture. The growth of FGCS has the potential to generate new, even more, invasive standards against which women could be (and indeed often are) judged.

Section III: Future Directions

As the rate of FGCS procedures increases there is a need for further research to better understand this phenomenon. While this thesis has produced several important findings on the topic of female genital cosmetic surgery, it has also revealed several possible avenues for future research. Specifically, there is still need for research around FGCS and patients' knowledge and perceptions of "normal" vulva anatomy. That is, where did the genital aesthetic ideal and the idea of a "normal" vulva originate? In particular, there is need for future research to engage in more longitudinal research surrounding the long-term outcomes of FGCS, as well as accurate and reliable research on the risks and success of genital cosmetic surgery over time. As well, a noticeable

absence on the online forums and several of the surgeons' websites, which warrants further study, was the cost of having FGCS. But perhaps most importantly, future research should aim to explore the stories and experiences women have to offer about their experiences with female genital cosmetic surgery.

Given the proliferation of FGCS it is important to look more closely at how women are talking about these procedures and how they are being marketed and presented on surgeons' websites. FGCS is an invasive intervention on a body part that not many can see, and until recently, it is a body part that we understood as having no standard aesthetic. Although genital distress (for women in particular) is not a new phenomenon, women's genitals were, until relatively recently, largely excluded from the self-surveillance and improvement imperatives that cosmetic surgery culture demands. My concern is that if we do not look at how surgeons are promoting this and why women are undergoing it, it may become another unrealistic ideal women feel they need to mimic in order to be "beautiful."

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**Appendix A: Coding Instrument For Surgeons' Websites Offering
FGCS**

Website Name:

Website URL:

Surgeons' Name:

Clinic Location:

1. Types of procedures offered?

examples: labiaplasty vaginal tightening g-spot amplification
clitoral hood reduction hymen reconstruction

Description

2. Is there an ideal patient mentioned?

Yes No

examples: ideal candidates for FGCS are “doing it for themselves” (not influenced by outside forces, such as a partner) a woman who is “in good health”

Description

3. How is FGCS being presented?

examples: a medical solution a way to help women a simple (minimal risk) surgery a way to enhance enjoyment of life a “beautifying” (appearance reasons) procedure

Description

4. In response to number 3, what medical solutions can FGCS offer?
examples: FGCS may help with “labial hypertrophy”

Description

5. Is there use of medical rhetoric?

Yes No

examples: suggestions that FGCS is for medical reasons (such as the use of the term “labial hypertrophy” as an indication for labiaplasty) mention of the term “cosmetic genecology”

Description

6. Are there reasons presented for why women undergo FGCS?

Yes No

examples: discomfort engaging in physical activities functional reasons appearance reasons (feeling “aesthetically unpleasant”) childbirth sexual pleasure general unhappiness large or irregular genitals aging (hormonal changes)

Description

7. Are benefits of FGCS stated or implied?

Yes No

examples: enhance genital appearance (feeling more attractive) restore youthful appearance greater confidence greater self-image less physical discomfort better hygiene

Description

8. Are success rates of surgery mentioned?

Yes No

Description

9. In response to number 8, if success rates of surgery are mentioned, what kind of evidence is provided and how is it being framed?

Description

10. Who is referenced or quoted for these success rates?

examples: Statistics Canada doctors academic scholars

Description

11. Is there mention of outside/external influences women may experience for wanting to undergo FGCS?

Yes No

examples: significant other magazines/films

Description

12. Are there colloquial terms offered for the clinical procedures?

Yes No

examples: the “Barbie” the “traditional look” the “wonder woman / mommy makeover”

Description

13. Are female genitalia pre-surgery that *warrant* surgery described?

Yes No

examples: abnormal sagging enlarged excessive
asymmetrical

Description

14. Are the female genitalia described after (post) surgery?

Yes No

examples: labia is symmetrical tight appealing clean

Description

15. Are “normal” genitals discussed?

Yes No

examples: “average size” of vagina, clitoris, labia small even

Description

16. Are “abnormal” genitals discussed?

Yes No

examples: “protruding labia” asymmetrical

Description

17. Are the concepts of empowerment and / or liberation mentioned?

Yes No

Description

18. Are concepts of oppression mentioned?

Yes No

Description

19. Is there mention of potential risks/ complications involved with the surgeries?

Yes No

examples: infection bleeding scarring dissatisfaction with outcome loss of sensation

Description

20. Is there a cautionary section presented? (Are consumers advised to think carefully before opting for surgery)

Yes No

Description

21. Are there alternative resources for helping with issues associated with genitalia?

Yes No

examples: counseling services self-help resources

Description

22. Is there mention of short-term or immediate outcomes of the surgery(s)?

Yes No

Description

23. Is there mention of long-term outcomes of the surgery(s)?

Yes No

Description

24. Is there an age restriction for FGCS stated? (Minimum age for surgery)

Yes No

Description

25. Are success stories featured? (Are there personal accounts/ stories from previous patients)

Yes No

Description

26. Is there a ‘news / media’ link (promoting the surgeon) present?

Yes No

Description

27. Are images present?

Yes No

Description

28. In response to question 27, if images are present, what are the images of?

examples: “before” and “after” pictures

Description

29. Are there people in the image(s)?

Yes No

Description

30. In response to number 29, if the answer is yes, how is the person, or people, presented? (What is the individual(s) doing in the image)

Description

31. How effective is the image as a visual message?

Description

32. Other / Miscellaneous findings

Description

**Appendix B: Coding Instrument For FGCS Online
Forums**

Blog / Online community Name:

Blog / Online community URL:

Date of Entry:

User Name:

Location of participant specified:

1. What procedure(s) has the woman undergone, or would like to undergo?

examples: labiaplasty vaginoplasty hymenoplasty

<i>Description</i>

2. What reasons are given for wanting to undergo FGCS?

examples: physical discomfort appearance / cosmetic reasons
psychological / social reasons functional / sexual reasons

<i>Description</i>

3. If physical discomfort is mentioned, how is it described?

examples: throbbing sore pinched chafing

<i>Description</i>

4. If appearance/ cosmetic reasons are mentioned, how are they described?

examples: wanting to look “prettier” desire to look/feel more attractive

Description

5. If psychological/ social reasons are mentioned, how are they described?

examples: self-loathing low confidence low self-esteem anxiety feeling “different” depression

Description

6. Are the concepts of empowerment and / or liberation mentioned?

Yes No

Description

7. Is the concept of oppression mentioned?

Yes No

Description

8. When did the woman first hear about FGCS?

Description

9. Is there mention of outside / external influences the woman experienced aiding in her desire to undergo FGCS?

Yes No

examples: significant other magazines/films (a standard ideal)

Description

10. Has the woman undergone FGCS? (Did participant already have surgery)

Yes No

Description

If number 10 is no, continue with next question then skip to number 20, or

if number 10 is yes, continue to number 12

11. In response to number 10, if answer is no, how does the woman describe her genitalia (in its current state, pre-surgery)?

examples: unappealing disfigured gross abnormal irregular

Description

12. In response to number 10, if the answer is yes, how does the woman describe her genitalia pre-surgery?

examples: unappealing disfigured gross abnormal irregular large

Description

13. In response to number 10, how does the woman describe her genitalia post-surgery?

examples: beautiful normal even/symmetrical pleasing
small

<i>Description</i>

14. Is there mention of risks or complications reported with her surgery?

examples: bleeding irregular pain itching numbness

<i>Description</i>

15. Does the woman mention short-term out comes of her surgery?

examples: sense of relief feelings of anxiety/stress

<i>Description</i>

16. Does the woman mention long-term out comes of the surgery?

examples: satisfaction regret positive self-image

<i>Description</i>

17. Has the woman mentioned wanting to have surgery to anyone else (family, friends, partner)?

Yes No

<i>Description</i>

18. How does the woman define / explain *normal* female genitalia?
examples: “average size” of vagina, clitoris, labia

Description

19. How does the woman define / explain *abnormal* female genitalia?
examples: “protruding labia” asymmetrical

Description

20. Is the age of the woman mentioned?
Yes No

Description

21. Is the instance when the woman was first exposed to FGCS mentioned?
Yes No

Description

22. When did the woman first have the desire to undergo FGCS?
examples: first partner puberty recognizing she was “different”

Description

23. Other / Miscellaneous findings

<i>Description</i>

Appendix C: Content Analysis Sources

Two female genital cosmetic surgery online forums²².

Allan, B. (n.d). *Laser Vaginal Rejuvenation*. Retrieved April 1, 2014, from <http://www.allancentre.com/>.

Alter, G. J. (2014). *Female Genital Surgery*. Retrieved April 1, 2014, from <http://www.altermd.com/>.

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²² Two North American FGCS online forums were used to gather data regarding women's reasons and experiences with FGCS. However, in order to ensure confidentiality and protect the anonymity of the women in this study, the online forum URLs nor the actual website names will be provided. This is due to the fact that if such information were provided, the women could be easily identified.

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Appendix D: Surgeons' Websites Reasons For Female Genital Cosmetic Surgery

<u>Reasons for FGCS</u>	<u>Number of times each rationale is cited</u>
Appearance / Aesthetic	27
Psychological	19
Physical Discomfort	18
Sexual	16
Medical	8
Sociocultural / Religious	6
Aging	6
Childbirth	5
Hygiene	2

Appendix E: Women's Reasons For Female Genital Cosmetic Surgery

<u>Reasons for FGCS</u>	<u>Number of times each rationale is cited</u>
Appearance / Aesthetic	22
Psychological	22
Physical Discomfort	14
Sexual	3