

Genital Anxiety and the Quest for the Perfect Vulva:
A Feminist Analysis of Female Genital Cosmetic Surgery

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Female genital cosmetic surgery procedures are relatively new, but they are swiftly growing in popularity (Braun, 2005). As they become more commonplace, they play an increasingly large role in perpetuating the very psychological pain they purpose to treat, that of genital anxieties. This paper will examine the genesis of female genital cosmetic surgery within the larger framework of the cosmetic surgery apparatus, including the perspectives and practices of the physicians who perform female genital cosmetic surgery. This paper will address the range of normality observed in women's genitals, the cultural construction of the ideal vulva and the roll of pornography in popularizing this construction.

The purpose of this paper is to examine women's genital anxieties, their sources, and what, in conjunction with these anxieties, will lead a woman to choose female genital cosmetic surgery. It will examine the cultural sources of genital anxieties, focusing on cultural concepts and representations of the ideal vulva and labia, and analyze these from a feminist perspective. Cultural ideals and models of femininity, and how these affect concepts of how women's genitals should look will be addressed, as will the current disseminator of these visual models, pornography.

The psychological and lifestyle ramifications of women's genital anxieties will be examined, showing how these anxieties have real and damaging effects on women's lives, damage which is only heightened by a cultural acceptance of plastic surgery as a legitimate way to correct these anxieties. The cultural assumption that it is the right and duty of the modern,

liberated woman to achieve sexual pleasure (Braun, 2005) will be shown to be another factor which contributes to women's choice of female genital cosmetic surgery.

This paper will also detail the procedures covered under the term "female genital cosmetic surgery" and who performs these surgeries. It will analyze their place within the larger socio-cultural framework of plastic surgery, and will address what limited clinical research has been conducted on what exactly constitutes the normal dimensions of women's labia, and what lies within the range of normality. This paper will illustrate how each of these factors combine and interact to produce the psychological anxieties women experience about the appearance of their genitals, and how they may influence a woman's decision to seek cosmetic genital surgery. Finally, this paper will cover existing feminist criticisms of the subject of female genital cosmetic surgery.

What is Female Genital Cosmetic Surgery, who Requests it, and who Performs it?

Female Genital Cosmetic Surgery covers a broad range of procedures, including Labia major liposuction or fat injections, clitoral hood removal and reductions, vaginal "rejuvenation" (which consists of tightening the vaginal canal), G-spot enlargement via collagen injections, and most popularly, labia minora reductions, or labiaplasty (Braun, 2005). These surgeries are performed almost exclusively in the private sector (in countries with socialized medicine), and paid for, as is the case with most cosmetic surgeries, out of the patients own pocket (Renganathan, Cartwright & Cardozo, 2009). For the purpose of this paper, only Female Genital Cosmetic Surgeries were included; surgeries performed for intersexed persons or those designed to correct prolapsed organs or incontinence are beyond the scope of this analysis. Reduction labiaplasty is the focus of this paper, and it is the most widely practiced cosmetic genital

operation for women (Renganathan, Cartwright & Cardozo, 2009). The earliest techniques simply clamped the excess labia tissue, cut it away, and then sutured the raw edge. This method is still practiced, but it has decreased in favor of newer procedures, such as the Wedge resection. This technique removes labial tissue from between the outer edge and the base of the labia minora, and is intended to preserve the contours and coloration of the labia edge (Scholten, 2009), (Davison & West 2008).

The first published description of a cosmetic labiaplasty (one not performed on an intersexed or male to female patient) dates to 1983 (Davison & West, 2008), and in 1998, Doctors Gary Alter and David Matlock received tremendous publicity for their vaginal “beautifying” procedures (Tiefer, 2008). This meeting of marketing and technology ushered in rapid expansion in popularity which made labiaplasty one of the fastest growing trends in cosmetic surgery (Korbin, 2004). In contrast to the long history of pelvic floor surgeries and vaginal tightening procedures, such as the once common “husband’s stitch” practiced by doctors on women after giving birth and having an episiotomy (Kitzinger, 1994, cited in Braun, 2009), or the current version, vaginoplasty (which involves narrowing and tightening the vaginal passage), labiaplasty focuses most prominently on the visual appearance of the labia, and not on any functional aspect (Tiefer, 2008).

Very little information has been collected on the demographics of those seeking FGCS, and to my knowledge, no metastudies of patient demographics have been conducted. A study by Doctors Miklos and Moore (2008) surveyed 131 patients who had undergone labiaplasty, for the purpose of ascertaining patient motives for undergoing FGCS. The study found a mean age of 35.7, years, with a mean parity of 1.7, and an ethnic composition of 95% Caucasian, 3% African American, and 2% Asian American. The American Society for Aesthetic Plastic Surgery does

not publish statistical data on labiaplasty, but it did list the number of Vaginal Rejuvenations (which include vaginal tightening but frequently also include labiaplasty or other cosmetic genital procedures) performed in 2009 as 2,532 (American Society for Aesthetic Plastic Surgery, 2009).

The age distribution for those undergoing vaginal rejuvenation in 2009 showed 35-50 year olds comprising the largest share of the procedures, at 40.9%, followed by 19-34 year olds at 30.3%, 51-64 year olds at 21.5%, those 65 and older at 4.7%, and those 18 and younger taking the final 2.5% (American Society for Aesthetic Plastic Surgery, 2009). The racial makeup of those seeking FGCS is unknown, but for all cosmetic surgery procedures, the racial composition in 2009 was 77.9% Caucasian, 8.9% Hispanic, 6.2% African-American, 4.4% people of Asian descent, and 2.6% other (American Society for Aesthetic Plastic Surgery, 2009).

As with other forms of cosmetic surgery, the practitioners of FGCS can be anyone with a medical degree, regardless of whether or not they are certified by the American Board of Plastic Surgery, the only professional body recognized by the American Board of Medical Specialties (Kuczynski, 2006). Those performing FGCS are dermatologists, gynecologists, obstetricians, and others, all permitted free reign to advertise and operate, unmonitored by any federal jurisdiction (Kuczynski, 2006). FGCS is not without controversy among medical professionals. Joining investigative journalists and feminists, those traditionally associated with criticism of the cosmetic surgery industry (Tiefer, 2008), several medical professionals have criticized or advised a cautionary approach to FGCS. A 2007 paper in the British Medical Journal (Liao and Creighton) urged restraint on the behalf of cosmetic surgeons, citing as concerns the lack of long term research on the effects of FGCS, the lack of research to inform surgeons of the range of normality which exists in women's labia, and the risks to sexual function that may accompany

FGCS. The American College of Obstetrics and Gynecology stated unequivocally that FGCS procedures had no medical basis (Tiefer, 2008), and indicated a deep concern about the merging of marketing and medicine which seems to prevail within the cosmetic surgery industry, and the ethical conflicts that may arise when doctors place a premium on public image rather than public safety.

In 1998, two cosmetic surgeons from Los Angeles emerged as the public face of FGCS during its early years, when Doctors Gary Alter and David Matlock began publicizing their procedures for labial reduction and vaginal tightening, which they would then “franchise” across Southern California, opening clinics which use their now trademarked (though academically unpublished) methods. Doctor Matlock carefully guards his intellectual property at the expense of the dissemination of knowledge which is traditional in the medical field, all while proactively managing his media exposure to maximize positive publicity (Tiefer, 2008). He uploads videos of himself performing FGCS online, providing commentary on the wonderful results he expects and the life-affirming changes the patient should expect upon recovery. Although few surgeons practicing FGCS are as aggressive in their self promotion as Doctors Matlock and Alter, FGCS is promoted much in the same way as other forms of cosmetic surgery: as a transformative and positive experience. From the cosmetic surgeon’s perspective, FGCS is simply the latest frontier of the Body to be made available to the medical gaze and cosmetic surgery apparatus.

The Diversity of Women’s Vulvas- What is a “Normal” Vulva?

FGCS is not, despite what its practitioners claim, an evidence based practice (Liao and Creighton, 2007). Like much of cosmetic surgery, there is little data regarding long term outcomes, satisfaction, or patient indicators for seeking FGCS. Isolated studies have been

conducted on patient satisfaction, but these lack methodological rigor (Liao and Creighton, 2007). There is also startlingly little evidence to justify the template cosmetic surgeons are using as a guideline when they cut a woman's labia. For a practice that aims to "improve the appearance of the external female genitalia" and cure "Labial hypertrophy" (Davison and West, 2008)", FGCS relies on precious little evidence of what, exactly constitutes labial hypertrophy, and by extension, what constitutes a "normal" labia.

Radman (Renganathan, Cartwright, and Cardozo, 2009) classifies labial hypertrophy as the labia extending more than 5cm past the edge of the labia majora, but Rouzier (Renganathan, Cartwright, and Cardozo, 2009) considers 4cm the definition of labial hypertrophy. Doctor Steven Davidson of Georgetown University Medical center has developed his own "grading system", where he defines labial hypertrophy as falling into one of three degrees. "None", meaning the labia minora are concealed within the labia major or extend only to its edge, "Mild/Moderate", where the labia minora extend 1-3 cm past the edge of the labia majora, and "Severe", where the labia minora extend more than 3 cm beyond the edge of the labia majora (Davidson and West, 2008). It is clear from the varying diagnostic criteria of cosmetic surgeons that what constitutes a hypertrophy of the labia is arbitrary at best.

From where do cosmetic surgeons derive their standards? For something to be defined as abnormal, a clear understanding of what is normal must first exist. Liao and Creighton (2007) expressed concern that cosmetic surgeons, and indeed, the medical field at large, may lack this clear understanding. Recognizing the gap between public perception (including the perceptions of cosmetic surgeons) of what constitutes normal female genitals, and the actual range of normality, Liao and Creighton, along with Minto, Lloyd, and Crouch (2005) conducted a study of the physical dimensions of 50 women's genitals, with the objective of documenting the range

of variations they observed. The women were between 18 and 50 years of age, with a mean age of 35.6, with a mean parity of 2.5, and a racial composition of 37 Caucasian, 5 Asian, 6 African-English, 1 Latina, and 1 mixed race. The diversity of the women's genitals, even within a sample as small as 50, was immediately clear. Clitoral length ranged from 5-35 mm, the length between clitoris and urethra ranged from 16-45 mm, labia majora length ranged from 7-12 cm, labia minora length ranged from 20-100 mm, and labia minora width (as measured from the beginning of the labia minora at the vestibule to its distal edge) ranged from 7-55 mm. The mean labia minora length was 60.6 mm, and the mean labia minora width was 21.8 mm. By Davidson's standard's, the statistical mean of the labial minora width in this study constitutes "Mild/Moderate Hypertrophy".

Liao et al (2005) also measured the color, texture, and hair distribution of the women's genitals. Denoting the color of the genital skin compared to the surrounding area, 9 women were classified as "Same" and 41 as "Darker". In terms of the texture of the labia, or rugosity, 14 women were defined as "Smooth", 34 as "Moderate", and 2 as "Marked". There was no statistically significant association between the age, parity, ethnicity, hormone use, or history of sexual activity and any of the different genital measurements. This puts into question the claims of surgeons like Dr. Matlock, who is quoted as saying "Longer, lose hanging inner lips is a sign of aging..." (Kobrin, 2004), and in one of his online surgery videos, gesturing to the patient's newly pruned genitals after completing a labiaplasty "She is like a 16 year old now" (Tiefer, 2008).

If age and pregnancy have no statistical correlations with the shape or size of a woman's labia, and the range of normality for a woman's genitals is diverse, then to what standards of normality are cosmetic surgeons adhering when they cut away 'excess'; what 'beautified shape'

are they marketing as normal, and on what data are they basing their treatment? It is clear that within the industry, a profound lack of data exists on what constitutes the range of normality, and what little data has been gathered seems to refute the narrow construction of normality that cosmetic surgeons hold up as evidence based truth. In the absence of good clinical data about the diversity of women's genitals, it is clear that other sources of information about how a woman's vulva should look have risen to fill the gap in public perception.

The Contributions of Pornography towards the Creation of the Cultural Construct of the Ideal Vulva

Since neither cosmetic surgeons nor the women they treat have an accurate perception of the statistical variety of women's genitals, their perceptions must have been shaped by other influences. During the last decade, the ubiquitous presence of internet pornography, along with an increasing acceptance of its viewing (Carroll et al, 2008), has contributed to what Naomi Wolf refers to as "the whole world becoming pornographized" (2008), or what is often called the culture of porn. The merging of porn and pop culture, the rise of porn-chic, and the near saturation of the young male market with internet pornography means that porn has an increasing monopoly on images of women and their genitals, one that allows for little variation in what is considered attractive.

With the growing acceptance of pornography came the dissemination of pornographic standards of beauty and grooming practices; the 'Brazilian wax' moved its way from pornography into beauty salons across the country, subjecting the now naked vulva to new levels of scrutiny (Braun, 2005). The rise of the hairless norm eliminated the hair that long labia could once hide behind, making the discrepancies between the 'average' woman's labia minora and

that of porn stars suddenly uncomfortably apparent. Women who compare their labia to those of women in pornography may not realize that they are comparing themselves to women who may themselves have had FGCS, or whose labia may have been airbrushed or photoshopped (Davis, 2002). The prevalence of smaller labia minora is most apparent in ‘upscale’ publications such as *Playboy* (Davis, 2002), a publication whose readership is 19% female (out of 9 million adults) (Playboy.com, 2009), which, when added to their online female readership of 39% (Playboy.com), represents a significant number of women who are exposed to this small lipped ideal.

The mainstreaming of pornography cannot alone account for the development of the small labia as a cultural beauty idea. Pornography’s monopoly on female attractiveness has been facilitated by a culture which accepts what pornography offers up as an example of beauty, which provides little resistance to the culture of porn’s decrees on what is normal, what is desirable, and what may be done to achieve desirability. In a 2003 article by Naomi Wolf, she describes women’s anxieties about being “porn-worthy” in the eyes of men, and their fear of not living up to the standards set by the internet pornography consumed so heavily by their partners (Kuczynski, 2006). The widespread consumption of pornography helps to engender a desire for a breasts of a certain shape, for a hairless body, and now, for a small labia. Just as the culture of porn, in conjunction with the culture of plastic surgery normalized implants as a method to achieve the large breasts “worn” by porn stars (Kuczynski, 2006), porn now dictates what must be desired, and plastic surgery dictates what must be done to achieve the desired standards: for the hairless look, waxing, and for the protruding labia minora, surgery. Again, the culture of porn merely proffers up these depictions of women as ideal; it takes the pathologizing medical gaze to render the labia a legitimate site for surgery as a way to achieve these ideals. Simone Weil Davis

(2002) quotes Doctor Matlock in a Los Angeles Times interview, and his experience with clients is an instructive look at just how the medical gaze and the pornographic ideal have united to produce demand for FGCS:

“Honestly, if you look at *Playboy*, those women, on the outer vagina area, the vulva is very aesthetically appealing, the vulva is rounded. It’s full, not flat... Women are coming in saying, I want something different, I want to change things. They look at *Playboy*, the ideal woman per se, for the body and the shape and so on. You don’t see women in there with excessively long labia minora.”

Porn and playboy are not alone in selling this minimalist labial ideal. Women’s magazines, with their long history of cozy relations with the cosmetic surgery industry (Sullivan, 2001), do their part to raise consumer awareness of FGCS, normalizing surgery as a solution to labial anxiety. Whether they cover FGCS in a sensationalist way, as in a 1998 *Cosmopolitan* article with the headline “My labia were so long, they’d show through my clothes!” (Davis, 2002), or as a hot new trend, as seen in *Salon*’s article stating “Yes, it is true....the newest trend in surgically enhanced body beautification: Female Genital Cosmetic Surgery” (Davis, 2002), the end result for their readership is the same. When magazines cover FGCS they alert women to the existence of yet another area which may not measure up to cultural ideals, ideals which, if they have not been consumers of porn themselves, they might otherwise not have been aware.

Even newspapers have covered FGCS, with the New York Times remarking on the growing popularity of such surgeries, including interviews with Dr. Alter where he is quoted as saying “With female genital surgery its predictable, and the women are extremely happy” (Navarro, 2004). The coverage of FGCS by the mainstream media, along with the mainstreaming

of pornography, all contribute to the widespread acceptance of a single genital ideal, and the normalization of cosmetic surgery as the solution to deviations from that ideal.

The Psychological Effects of Pornography on the Individual

A significant amount of research has been conducted on how the viewing of pornography, and recently, internet pornography, affects the individual (Fisher and Barak, 2010). Although there is little consensus among researchers as to whether voluntary exposure to pornography leads to an increase in antisocial sexual behavior, the basic concept that over time, pornography can become a “conditioned erotic stimulus” (Fisher and Barak, 2010), is sound and corresponds to decades of research on conditioned stimuli. The “Sexual Behavior Sequence”, proposed first by Byrne (1977), states that individuals will respond to both unconditioned and conditioned erotic stimuli with sexual arousal, and that the resulting cognitive and affective responses may guide future sexual behaviors (Fisher and Barak, 2010). Repeatedly sought and viewed pornographic images and videos become conditioned erotic stimuli, and the viewer then seeks out similar material to achieve arousal. This theory provides an excellent narrative to the increasing psychosocial acceptance of the hairless, small lipped vulva, and how it has become both popular and desirable for pornographic performers to exhibit such a vulva. Following this theory, the conditioned stimuli of the pornographic performer with the small lipped vulva will lead to, in the case of heterosexual men, a desire for a sexual partner with such a vulva, and for women, a desire to have such a vulva themselves.

How does mainstream heterosexual pornography affect the women who view it? When consumed by the woman herself, it may serve as erotic material or as a ‘guidebook’ to new and different sexual behaviors. According to a study by Rogala and Tayden (2002) found that 80.3%

of women in the study (total sample size, n=990) believed that pornography influenced people's sexual behavior, and 31.6% of women in the study believed that they themselves had been influenced by pornography, and 213 of the women who had seen pornography agreed to answer additional questions. Free statements were elicited about their opinions on how pornography and exposure to pornography influenced their sexual behavior, and these statements were organized into four categories: positive, exciting, negative, and neither positive nor negative. 53% of these statements were categorized as positive, 12% as excited, 27% as negative, and 8% as neither positive nor negative.

Examples of positive and excited statements included "A tip on new positions", "New ideas- it makes me feel more sexy", "Might dare to do more", "Get excited if I see porno film together with my boyfriend. It can wake up the lust", and "I get excited if the film is funny and wild". Negative and neither positive nor negative statements included "Gets complex", "Feel sick at sex", "Demands on performance", "I feel demands", "I don't like it. I want my partner to be turned on by me, not by someone on television", "At first excited then I feel sick", and "Open up for new ideas and at the same time it creates demands on performance". The women in the study were also asked to provide free statements on how they believed pornography influenced others' behavior. These statements were categorized as positive (19%), excited (4%), negative (66%), and neither positive nor negative (11%). Some of the positive and excited statements were "Girls might test something new and so do probably boys", "One can develop one's fantasies", "Those who don't have a partner can be stimulated by others", and "One can dare to try different things to see if one likes it". Negative statements included "That men can expect women to behave as in pornography", "Particularly boys believe that reality is as in the films",

“Wrong picture of how girls want to have sex”, and “They mix up real sexuality with the distorted picture porno feeds them, e.g. the distorted pictures of women”.

The discrepancy between women who regarded personal experiences with pornography as positive (53%), and women who regarded other’s experiences with pornography to be detrimental to future sexual behavior (66%), reveals that women may enjoy pornography while at the same time fear its influence on their male sexual partners and on other women. These findings may suggest that women are not only influenced by the images they themselves see, but by the assumptions and experiences of men who have seen these images as well.

Cultural Theories and Stereotypes of Women’s Genitals

Knowing the modern pornographic source of the construction of the ideal vulva does not explain why this ideal came to be culturally accepted and medically propagated. What is it about the “Clean Slit” look (Davis, 2002) which so fascinates? A look at before and after pictures on plastic surgeons websites will reveal a left hand column of diverse vulvas, labia of different size, shape, and texture. The right hand column reduces these vulvas to a parade of cookie cutter vulvas, each a neat, clean slit, labia minora tidily contained within the labia majora (Urogyn.org, 2004; Aventura Center for Cosmetic Surgery & Hair Restoration, 2010). This ideal is disseminated by pornography, legitimized by cosmetic surgeons who normalize the clean slit and pathologize the hypertrophied labia, and sought after by women who perceive their own vulvas as defective. Yet why was this ideal so readily embraced? The answer may be found in existing feminist theories of female vulvar anxiety and cultural constructions of physiognomy.

For centuries, the physical body has been thought to reveal the inner nature of the individual (Jutel, 2009), their bodily contours a map to both deviance and virtue. When beauty is

apparent, so too is goodness, and American culture has very specific guidelines for what constitutes beauty. Although cultural standards have changed over the years, certain qualities have always been valued. Bodies which are symmetrical, minimalist, and which conform to Classical concepts of beauty (concepts which themselves were based on a harmony between inner nature and outer appearance (Jutel, 2009)), are consistently desired. Mary Russo eloquently describes the contrast between the “female grotesque” and the classical ideal:

“The classical body is transcendent and monumental, closed, static, self-contained, symmetrical, and sleek...The grotesque body is open, protruding, secreting, multiple and changing...” (Davis, 2002)

Russo’s description of the female grotesque echoes those given by patients who have undergone FGCS in reference to their pre-operative vulvas. They are described as “asymmetrical”, “ugly” (Navarro, 2004), “flippy-floppy” (Ollivier, 2000), and “droopy” (Kuczynski, 2006). They describe their post-operative vulvas as “Clean. Tidy looking” (Kuczynski, 2006), and “...neat and new” (Korbin, 2004). Even the names doctors have coined for the surgeries speak volumes. Dr. Alinsod at South Coast Urogynecology performs two types of labiaplasty, the “Rim look”, which leaves a slight amount of labia minora intact, and, with no sense of irony, the aptly named “Barbie look”, which features a total excision of the labia minora (Urogyn.org, 2004). From its initial foundations on classical ideals of beauty, the featureless vulva has found a perfect embodiment in the age old nemesis of feminism, Barbie.

What does the clean slit look imply, beyond a classical beauty standard embodied by a plastic doll? A return to pre-pubescence (Braun, 2005), an neotenous vision of womanhood, on par with attempts to eliminate body hair and to ban fat from taking up its usual residence on women’s hips, thighs and buttocks? Both FGCS practitioners and women who seek their services

cite a fear of having “old looking vaginas” (Kuczynski, 2006), and Dr. Matlock explains his patients motives as, “longer, loose hanging inner lips is a sign of aging and women don’t want to look old there, either” (Korbin, 2004). Although the survey of vulvar dimensions and textures by Liao et al (2005) revealed no correlation between the age of the participants and the length and shape of their labia minora (or indeed any other part), the idea that the clean slit is the youthful norm which age and childbirth corrupt remains a strong stereotype. As aging becomes an unacceptable part of life, any procedure which can eliminate the ravages of age, whether real or imagined, on your face or your vulva, is bound to become profitable.

Modern culture does not only classify the minimalist vulva as good, but the protruding labia as bad. Again, Mary Russo’s concept of the female grotesque (Davis, 2002) provides an excellent framework for analyzing what the large labia minora signifies. A direct contrast to the “closed” look of the clean slit, the larger labia minora is unruly and protruding, an unacceptable openness. Davis (2002) describes the labia minora’s status as liminal area between outside and in, as part of what makes it susceptible to being accused of “excess”. Its function as an area betwixt and between cannot be tolerated in a classical world of symmetry and defined boundaries. So as culture has connected beauty with virtue and defined small labia as characteristic of youth, and by extension, beauty, what traits have been associated with the large and protruding labia?

Jennifer Terry (1995) documented a 1930’s study on “Sex Variants” (a large umbrella term which encompassed homosexuals, bisexuals, and others who failed to assume a monogamous, heterosexual and childbearing lifestyle) which sought to determine whether, just as an individual’s overall physical form could reveal their morality, specific evidence of homosexuality could be found on an individual’s genitals. This thinking was the product of the medical model of the time which viewed the moral character of an individual as inseparable from

their body, and under the clinical gaze of the physician, the “master text” (Terry, 1995) of the body would serve as the ultimate source of truth about the patient’s life and behaviors. Foucault described the medical gaze as a way of abstracting the patient in order to uncover the truth, and of seeing the patients’ words as fallible in a way that objective measures were not (Jutel, 2009). Similarly, the study’s chief physician, Dr. Robert Dickinson, believed that sex variant woman’s genitals would tell the true story of their owners’ sex lives. He described the typical sex variant female as having a large vulva, a large clitoris, thick and protruding labia, and a distensible vagina. This was in contrast to the “normal” woman, whose genitals were presented without pejorative adjectives (Terry, 1995). Large labia became associated with the sexual deviant, the loose woman, and the lesbian. Although modern society has supposedly banished physiognomy to the annals of historic quackery, along with ‘humors’ and leeches, its basic tenants go unquestioned. Women’s genitals should tell the story of youth, heterosexuality, and non-parity, and this story is physically manifest in the tight, clean slit of the ideal vagina.

The Sources of Genital Anxieties and their Effects on Sexual Behavior

The effects of genital anxieties on women’s self esteem and sexual behavior have been researched by Reinholtz and Muehlenhard (1995), who found that, in a sample of 160 male and 160 female college age participants, assessment of one’s genitals correlated strongly with sexual activity and sexual enjoyment. Higher levels of participation in and enjoyment of sexual activities (the correlation was particularly strong in regards to oral genital sex) correlated with positive assessments of ones own genitals. Reinholtz and Muehlenhard also found that Overall, men regarded their own genitals and their partner’s genitals more positively compared to females. They theorized that this gender difference was due to ingrained cultural stereotypes about

women's sexuality, where women are anxious about exhibiting sexual pleasure and comfort, and on higher beauty standards for women, which lead women to be more self-conscious about their bodies. Interestingly, this 1995 study concluded with a mention of FGCS, and cautioned that the media representations of the surgery further promote the idea that women's genitals are unattractive and "sexually inadequate", and that women should resort to surgery to correct these inadequacies. That this warning came when FGCS was in its infancy suggests that the link between genital anxieties and the choice of surgery has been long established.

The testimonies of women who have undergone FGCS have a common theme, one which is familiar to that of patients of all kinds of cosmetic surgery: psychological pain (Braun, 2005; Tiefer, 2008; Navarro, 2004; Kobrin, 2004). Before undergoing surgery, women described themselves as unable to enjoy sex, fearing the touch of their sexual partners, despairing at how abnormal they perceived themselves to be, and feeling like "freaks" (Braun, 2005). There is no denying that they were deeply psychologically troubled by the appearance of their labia, and that this resulted in real physical and relational problems. One woman describes how the appearance of her labia made her "unable" to receive oral sex (Braun, 2005), and this sentiment seems to reoccur frequently among those undergoing FGCS. After surgery, one woman describes reveling in "...how amazing oral sex could be, because I could finally relax and be myself during sex" (Braun, 2005), and another says "I'm no longer embarrassed to be naked and my sex life has improved because I'm more confident" (Braun, 2005). The women's stories follow the same narrative: the psychological pain is resolved by the application of the scalpel, and the women are finally able to enjoy sex and feel confident. Since it is not only the right, but the duty of the modern woman (Braun, 2005), of the biocitizen (Halse, 2009), to seek optimal sexual pleasure, and to demand "better than well" (Peter Cramer, quoted in Kuczynski, 2006), by choosing FGCS,

these women are fulfilling their scripted role within this narrative as proactive, liberal, self-actualized, and demanding pleasure.

Cosmetic surgery is built on this narrative; that changing one's looks can transform one's life (Pitts-Taylor, 2007). This story has its foundations in the American ideal of self transformation and a rejection of genetic determinism (Kuczynski, 2006), a belief that anyone can achieve their dreams if they just work hard enough (or in this case, pay enough). In the culture of cosmetic surgery, psychological pain is treated as physical pain, and can thus be cured only by physicians. The psychological pain of genital dissatisfaction becomes a very real handicap, and once the source of that dissatisfaction is removed, the patient can truly enjoy sex. This assumes however that the sequence of cause and effect runs thus: ugly labia and vulva cause psychological distress, which in turn causes impaired sexual function. Given that the notion of the ideal vulva is a culturally constructed one, it is the artificial existence of this construction which causes the psychological distress, not any defect of the woman's genitals. Yes, trimming and tucking may have relieved these women's anxieties, but it does nothing to address the real source of their distress, the value-laden stereotype of the ideal vulva, disseminated through pornography and normalized by cosmetic surgeons. Now made "ideal" by their surgeons, these women are able to engage in oral sex, they are able to receive pleasure, but as Virginia Braun (2005) points out, this reclaiming of their right to sexual pleasure only serves to situate that right within the very narrow confines of a "heteronormative aesthetic" (Braun, 2005), one which values form over function, and an idealistic construction over the reality of varied female genital appearances.

Conclusion- the Harm to Women is Real

Female genital cosmetic surgery (FGCS) is a relatively new yet growing phenomenon. As it increases in popularity, more women will be exposed to an unproven procedure with little information about long term psychological or physical effects (Tiefer, 2008, Renganathan, Cartwright, and Cardozo, 2009). These practices have undergone no scientific analysis of their effectiveness or safety, yet many women are consigning themselves to unnecessary surgery which may negatively affect their sexual function, causing dyspareunia or loss of sexual sensation (Renganathan, Cartwright, and Cardozo, 2009). The goal of this surgery is to achieve an aesthetic look which is grounded not in the range of observable variances in women's vulva, but in ideals borne from cultural assumptions about youth, fecundity, and femininity, reproduced and popularized by pornography. As pornography has become more mainstream and readily available through new forms of media, its role as arbiter of female physical attractiveness has only increased.

The desire to achieve this aesthetic, and the disparity between it and the actual range of shapes of vulva and labia, heighten genital anxieties, for many women. This heightened anxiety is experienced in varying degrees of severity (Herbenick, 2009), and the medicalization of these anxieties by plastic surgeons obscures their true sources, providing a medical solution to what is at its core a psycho-social problem. Female genital cosmetic surgery presents itself as a way to correct the perceived "abnormalities" and "ugliness" of the vulva and labia, taking its place as a surgical component within the larger socio-cultural framework which serves to create and perpetuate genital anxieties among women.

Intense genital anxieties are responsible for leading some women to choose female genital cosmetic surgery as a way to achieve a certain aesthetic result, which they believe will lead to a relief of those anxieties, an increase in sexual pleasure (Braun, 2005), and an improved

quality of life. It is imperative to understand exactly what these anxieties are, how women come to experience them, and how cultural factors contributing to them are disseminated and replicated in popular discourse. FGCG is a gendered practice; women are changing the shape of their bodies in order to engage in sexual activities with the required level of confidence, and relieve the anxieties they feel about their genitals. They hope to exchange anxiety for uninhibited pleasure; they hope to achieve a liberated sexual lifestyle, but only at a price- submitting to the scalpel. When they pursue FGCS, women are resorting to medical means to correct a problem that the medical gaze has created, informed by pornography and cultural stereotypes of women's genitals.

The psychological pain caused by genital dissatisfaction is real, and it has real consequences, as is clear from the testimony of patients undergoing FGCS. However, FGCS, with its medicalized solution to what is, essentially, a psycho-social problem, ignores and leaves untreated the true causes of genital anxieties. The culturally constructed ideal vulva, which is disseminated by pornography and validated by surgeons, combined with the pathologizing of the large labia, and the absence of discourse and images which show the true diversity of women's vulva, all engage to make women dissatisfied with their genitals. FGCS does nothing to correct this environment. Instead it merely moulds women to fit a cultural construction, perpetuates the sources of genital dissatisfaction, and engenders real harm to women.

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