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Sociocultural Representations of Beauty: Body Image in the 21st Century Through a Case Study on Female Genital Cosmetic Surgery

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**SOCIOCULTURAL REPRESENTATIONS OF BEAUTY:
BODY IMAGE IN THE 21ST CENTURY THROUGH A CASE STUDY ON
FEMALE GENITAL COSMETIC SURGERY**

**A thesis submitted to
Regis College
The Honors Program
In partial fulfillment of the requirements
for Graduation with Honors**

by

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Preface and Introduction

Since high school I have held a fascination about women's rights and health, yet I put aside these interests on the backburner as I entered college to take on neuroscience and pre-medicine classes. Throughout my four years at Regis, so much of who I am has been molded and altered, and I recognize that my interests are now a passion. This thesis is a small undertaking to look deeper into a perplexing and riveting area of medicine: female genital cosmetic surgery (FGCS).

I chose to write about genital cosmetic surgery for females because I feel this will unnecessarily become a more common surgery for women in the future. Our society has made young women like me feel insecure, not beautiful, and feel burdened to look a certain way and to become a certain person acceptable to society. I do not have any desire for any type of cosmetic surgery, but my relationship to my body has plummeted and summited constantly day after day since junior high. And who knows what my relationship with my body will be a decade or two down the road. Wrinkles, noses, and breasts are just some of the many areas of the body that can be altered by the \$15 billion dollar cosmetic surgery industry (Kuczynski, 2006). However, these are outward appearances that can be seen by the outward world. When a woman wants surgery on her genitals, something only she and her intimate partners can see, I feel that this is a different dialogue a deeply personal choice. The need to change a fundamental part of your body because you saw a pornstar who had a better vulva than you, or your partner asked you to change, or a friend commented on your intimate area in the locker room are

in reality not firm enough reasons to discount your beauty as a female or having self-esteem in that knowledge.

The documentary *The Perfect Vagina*, contains the video of a 20-year old British woman undergoing labiaplasty is more than gut-wrenching, it is nauseating. She had the choice to do this, and for what? Why cut off perfectly healthy tissue? To me, and from an anatomical viewpoint her vulva looked absolutely “normal,” meaning it fit the range most labia fall under. But normal may not be the best word to describe her, because all vulva are different. Just as no two humans have the same eyes or fingerprints or hands or forearm lengths, who is to say what the dimensions of a ‘perfect’ vulva are to be? Cosmetic surgery decreases the diversity of what society could deem beautiful.

In Chapters 1 and 2, I will explain that the advancement of medical technology has led to new procedures and surgeries, and with the changes in economics and viewpoints of psychiatry, cosmetic surgery became more and more successful. Surgeries on women’s genitalia during the past two centuries in the U.S. have led to the advancement of where FGCSs are today; as the descriptions and procedures from the past seem unethical. Since the 19th century there has been removal of healthy genital tissues through oppressive surgeries aimed at controlling female masturbation, menstruation, hysteria, and other ‘disorders’. And through those techniques and processes we arrive at the current day’s FGCS which are more ethical and safer.

In Chapters 3 and 4 the variations and purposes of FGCSs involving the vagina, labia minora, labia majora, clitoris, hymen, and other genital tissues will be explored. There are functional and aesthetic purposes to these surgeries to enhance the appearance

and/or sexual simulation, as well as risks and benefits to the procedures as we know them today.

In Chapter 5, societal influences will be broadly reviewed and narrowed into the certain reasons why they influence women to choose FGCS. Pornography is one of the greatest influences that affect the perceptions men and women have on vulvas. Aging, childbirth, hygiene changes in diminishing pubic hair, and technological advances (including Internet) have affects onto this current phenomena as well.

The cosmetic surgery industry in an advanced capitalistic society has a strong effect on why women are advertised and oppressed by ads and images, as well. This is the topic of Chapter 6, and why biomedicine and cosmetic surgeons are medicalizing the vulva as well as other body parts to create a drive and ‘desire’ for certain products and services.

Lastly, I want to tie in some philosophical arguments to the self, beauty, and body image. The cosmetic surgery industry validates itself with psychiatry and psychological needs, yet it perpetuates this cycle of creating more patients and more consumers of cosmetic surgery through constant creation of more psychological problems. Are we making our own choice and are women really oppressed by FGCS even if individuals “make” their own decision on the surgery using their own money? And can improving the outside body really make the inner mind feel more true to your entire being?

In conclusion, the validity of these surgeries and long term effects, particularly on sexual self-esteem and well-being of women, *must* be intensely studied before allowing more and more surgeries. However, even as entire medical boards oppose FGCS, it will

continue, and the best hope is to educate women about what the surgeries can and cannot do, as well as provide psychological counseling before every cosmetic surgery to provide holistic healthcare. I believe some reasons for FGCS make it valid enough that a woman can make her own choice, so long as she knows she is the driver of that decision and not a backseat passenger to either her sexual partner or societal influences.

Chapter 1: Definitions and History of Cosmetic Surgery

Plastic surgery is a broad field of medicine that derives its name from the Greek word *plastikos*, meaning “to form” or “to mold” (Kim, 2015). Plastic surgery is just one of many categories of surgery, categorized by area of body, purpose, type of procedure, invasiveness, and by the equipment used. According to the OED, “plastic surgery” is defined as “the branch of surgery dealing with the construction and reconstruction of superficial parts of the body that are defective, injured, or absent, and also using such procedures for cosmetic purposes” (“Plastic surgery,” 2016).

Plastic surgery can be further divided into cosmetic/aesthetic and reconstructive surgery; however, the boundaries between the two realms is hard to define. According to the American Society of Plastic Surgery, cosmetic surgery “includes surgical and nonsurgical procedures that reshape normal structures of the body in order to improve appearance and self-esteem” (“Cosmetic procedures,” 2016). The use of “normal” in this statement give an unclear answer to what body parts are considered “normal” or not. Hence a surgical procedure could be considered both reconstructive and cosmetic. “Reconstructive surgery is an attempt to return to normal; cosmetic surgery is an attempt to surpass the normal” (Gillies & Millard, 1957, p. 13). Shiffman (2013) writes that cosmetic (aesthetic) surgery is beautifying and that reconstructive surgery repairs a deficit or defect.

Covino (2001) even details aesthetic and cosmetic surgery as being different fields of surgery. “Cosmetic” procedures and products are seen to be temporary and a surface disguise while “aesthetic” signifies a lasting alteration. These differences in terminologies between cosmetic, reconstructive, and aesthetic creates some confusion, as most surgeries will have both a functional/reconstructive value and a cosmetic/aesthetic value. Hence, for this thesis the use of cosmetic surgery in terms of FGCS will refer to a surgery that serves to beautify the body but has no functional purpose. FGCS can have both a reconstructive and cosmetic purpose. This will be discussed further in Chapter 3.

Records of the first cosmetic surgeries have been found dating back to 600 BC, as described by Kuczynski (2006). Various surgeries were performed by physicians and healers for centuries, but few were able to be replicated until the world wars in the 20th century. During these wars, many men suffered from the trauma wounds of war. It was here that cosmetic surgery was intensely focused and standardized. Men’s faces were reconstructed and made aesthetically pleasing once again after being burnt or torn into shreds. The first training program and fellowship for plastic surgery in the U.S. was established in 1924 (“History of plastic surgery,” 2016). By the end of World War I, two doctors took their war field hospital experiences and created the first cleft lip repair that could be accurately replicated in 1929 (Shiffman, 2013). The advancement in knowledge and the technologies in the field gave credibility to plastic surgery, and the American Society of Plastic Surgeons was founded in 1931 (“History of plastic surgery,” 2016), followed by the American Board of Plastic Surgery in 1937 (American Board of Plastic Surgery, 2016).

Over the following decades, plastic surgery continued to grow through trial and error. Liposuction took decades to reach where it has come today, as it was first successfully done in 1977 (Shiffman, 2013). In 1982, after safety measures and studies were performed the technique began use in the US (“History of plastic surgery,” 2016). Due to all the technical and medical innovations and increase in safety, cosmetic surgery became more popular. Today, the most common areas of body to modify through either minimally invasive procedures, like Botox, or more invasive surgeries in the face, hair, lips, eyes, nose/ears, neck, arms, abdomen, nails, skin, calf, breasts, buttocks, and genitals (Ashong & Batta, 2012).

Psychological inventions like ‘inferiority complex’ gave doctors and patients a reason for justifying cosmetic surgery – these changes in practice were driven by the theory to recreate oneself in order to be happy came about in the 19th century with enlightenment in philosophy (Dorneles de Andrade, 2010). Also, the growing acceptance of psychiatry gave credence to using cosmetic surgery to address mental health issues by changing the body to change the self (Kuczynski, 2006). Tagliacozzi, considered the founder of plastic surgery, was quoted by Kuczynski that the job of a plastic surgeon was:

To restore, repair and make whole those parts of the face which nature has given but which fortune has taken away, not so much that they might delight the eye but that they may buoy up the spirits and help the mind of the afflicted (Kuczynski, 2006, p.67)

There are questions that arise when considering what it means to delight the eye (body), spirit, and mind of a person by altering the physical body to a youthful nature that

nature had taken away. Does this truly benefit the self or cause a false sense of happiness while in actuality causing oppression and harm? Who created the ideals to look young and 'beautiful' in given defined standards. Does true happiness come from conforming to look a certain way in a certain culture? More on changing the self through cosmetic surgery will be discussed in Chapter 7.

Cosmetic surgeries are done for vastly different reasons including: avoiding ethnic discrimination, direct or indirect coercion from a loved one, fear of aging, to decrease shame or social anxiety, to look young and healthy/fertile, and to look powerful for a career (Donohoe, (2006b). Likewise, body parts are stretched, pierced, tattooed, and decorated for various reasons including overcoming past abuse (Davis, 2002). The top five procedures of 2014 included breast augmentation, rhinoplasty, liposuction, eyelid surgery, and facelift ("Top five cosmetic surgical procedures of 2014," 2016). It is interesting to note that a majority of these procedures have a direct relationship with oppression of various social groups. For example, eyelid surgery is commonly engaged in people of Asian descent to, in part, hide their phenotype. Women may feel the need to augment their breasts to appeal to male hegemony or cultural schemas of women as having perfect (not too large but also not too small) breasts. Older individuals may feel the need for a face-lift to hide their age, as it can be seen as a form of weakness and or frailty in some societies. Clearly, this field that purports to "buoy up the spirits" is also a potential response to conform to the oppressive structures in our society.

Additionally, there are the 'bizarre' operations where some are potential oddities of curiosity and individualism - surgeries to add jewels to the sclera in the eye, cosmetic

surgeries for pets and show animals, and a rare minority of service women and men who have undergone surgery to create fake battle wounds/scars to become more a part of their culture (Kuczynski, 2006). While other bizarre operations are clearly responses to societal oppression - a man-made hymen to give the illusion of virginity, and genitalia redesign for men and women (Almroth et al., 2001). Clearly, body modifications and surgeries have many potential underlying factors, but we cannot ignore the extent that numerous operations appear to be both in response to and in support of societal oppression.

Plastic surgery has become a core element of our culture where many celebrities have undergone cosmetic surgeries, and several reality shows such as *Dr. 90210*, *Extreme Makeover*, *The Swan*, *Botched*, and countless other shows glorify plastic surgery and the surgeons who engage in these acts (Doheny, 2015). Similarly, cosmetic surgery has increased from 9.2 million procedures in 2004 in the U.S. to 15.6 million procedures in 2014 (Mirivel, 2008). Interestingly, 92% of total cosmetic procedures in the U.S. in 2014 were performed on women (ASPS, 2015), a fact that is consistent with the main idea presented throughout this thesis: plastic surgery is a potential response of women of all ages who are oppressed by a misogynistic society and may itself also be a form of oppression perpetuated against women and against the natural and beautiful diversity of women.

Chapter 2: History of Females in American Surgery: From Clitorectomies to Love Surgery to Female Genital Cosmetic Surgery

For thousands of years various oppressive procedures have been done on women's bodies in the name of "beauty" enhancement, including female genital cutting/mutilation in African nations, the binding of feet, rolling of breasts, tightening of ribs into corsets, and others. In Western societies, corsets, brassieres, bras, and other clothing were used to create a certain aesthetic for women that men found sexually appealing. Following a similar oppressive vein, the first breast enlargement surgery was performed by Dr. Vincenz Czerny in 1893 (Kuczynski, 2006). In 1899, the first breast implants were created with paraffin, beeswax, vegetable oil, ivory, glass, metal rubber, and other materials (Kuehn, 2006 and "History of plastic surgery," 2016).

Similarly, in 1903, Surgeon Charles Miller added braided silk, silk floss, celluloid, and other materials to women's chests, thus performing the first breast augmentation surgery in the U.S. (Donohoe, 2006b). As can only be imagined, terrible pain, swelling, and infections resulted from inserting foreign materials into the body. By the 1950s, surgeons had inserted and experimented with shellac, epoxy resins, and petroleum jelly as breast implants (Donohoe, 2006b). Silicone implants were thought to be a step in the right direction, but in 1982 the FDA restricted the use of silicone implants (ASPS, 2016, "History of plastic surgery"). Silicone implants were associated with

causing hematoma, infection, scarring, contracture, rupture, pain, and loss of sensation. Furthermore, at least 15% of these implants ruptured between the 3rd and 10th year of insertion. However, after considerations and changes in surgeries, the FDA re-allowed silicone implants in 2005, but saline implants are much more popular in use (Donohoe, 2006b). Clearly, numerous oppressive and tortuous acts have been focused on women's breasts in particular.

Yet it is not just breasts that have been surgically shaped to become more "female" or "beautiful". "Minimally" invasive procedures also are rampantly in use: Botox, microdermabrasion, laser hair removal, chemical peels, soft tissue fillers are some of the most common cosmetic procedures today ("Top five cosmetic minimally invasive procedures," 2016) and seem hardly to be minimally invasive. This evidence provides a clear pattern, the entire external and internal female body can be modified by numerous, painful, and oppressive surgical operations, including the vulva.

Female genital cosmetic surgery has its origins in clitorectomies, or the removal of the clitoris. Clitorectomies are a surgical category of female genital cutting that began in Arabic countries as early as 450 BC (Donohoe, 2006a). In the U.S. and in the U.K., clitorectomies, female castrations, and hysterectomies were performed from the early 1800s as recent as even the 1970s (Haiken, 1997; S.W. Rodriguez, 2008). These procedures were performed for lesbianism, hysteria, debility, masturbation, and nymphomania (Donohoe, 2006a). Since the sixteenth century, doctors alleged that a large labia contributed to or even caused hypersexuality, onanism, and even possible

“tribadism” or lesbian tendencies (Davis, 2002). Unsurprisingly, this entire oppressive movement was founded on pseudoscience.

For example, clitoral surgery was also used to treat masturbation and other “sexual disorders.” Doctors performed circumcisions (removing hood of clitoris), clitoridectomies, removal of smegma (material secreted from labia minora and glans of foreskin), and separated adhesions between clitoris and clitoral hood (Rodriguez, 2008). These procedures were done when a woman had a lack of sexual response when with her husband. Yet doctors knew that clitoral stimulation was healthy and necessary for pleasure. So why remove or damage any part of the clitoris? Some doctors thought, with no science or evidence supporting their “thought”, that excessive masturbation or no interest in sex with the spouse were all problems of the clitoris, and decided that surgically modifying the clitoris would be the best way to change behavior. The pseudo theory at the time was that the only good sex for women was penetrative sex with the husband with the goal of procreation. Even though doctors knew that the only purpose of the clitoris was for pleasure, solely stimulating it for pleasure was considered immoral, and that women would only want sex when prompted by their husband’s desire (Rodriguez, 2008).

In a similar pseudoscientific vein, masturbation was considered unhealthy in the 19th century. It has actually been considered a wicked practice since Hippocrates was alive, but was not considered a “disease” until the 1700s. Masturbation was thought to be “correlated” with madness, idiocy, epilepsy, and other psychological and mental problems (Gollaher, 1994). In fact, during the Victorian age of the 19th century,

masturbation, menopause, pregnancy, and menstruation were all considered diseases (Wolf, 2002).

Clitorectomies were performed because doctors erroneously believed in pseudoscience stating that masturbation was a mental disorder and not a willful action. It was a physical response to the clitoris being itchy, or irritated. These doctors knew that removing the entire clitoris would cause harm, so the doctors tried carefully to only stop the “irritation” (Rodriguez, 2008). “Doctors acknowledged the seriousness of removing the entire organ, for when “full excision of the clitoris (clitoridectomy) may be performed” to cure the patient of her extremely unhealthy sexual behavior, the “surgeon should seek consultation with one or two expert colleagues” and “the nervous condition of these patients should be fully and carefully considered and treated” to ensure that such radical treatment would be effective (Taylor, 1905).

Clitorectomies and other surgeries were not considered as a treatment option if the woman had hysteria or a psychological disorder with masturbation symptoms. These signs were theorized to come from an inherited mental disorder that did not arise from the clitoris but rather the mind (Shorter, 2008).

In the late 19th century, the idea of sex being more than an act of procreation became a more conceivable idea (in Western societies). It was a healthy and necessary part of marriage to unite a married couple (Rodriguez, 2008). In 1879, Dr. James Kent wrote that both men and women should experience orgasm because if a woman did not, it was “very detrimental and causes disease” and that sexual abuse, a misunderstanding of how sex organs function, and two individuals not consensually have intercourse

(“unrequited passion”) (Kent, 1879, p. 21). Yet to orgasm from direct intercourse doctors knew the penis has to stimulate the clitoris, as Eugene Bernardy explained, thus the clitoral hood could be removed to expose the clitoris (Bernardy, 1894). One doctor wrote about a patient of his who had been married for seven years and never responded to sexual acts from her husband, even though she loved him. The doctor circumcised her clitoral hood and she apparently “became a different woman” and was lively and began to enjoy sex (Waiss, 1901).

Not only was cosmetic surgery considered necessary in order to change for the woman, but also for the relationship of husband to wife. “Because heterosexual, presumably missionary position, sex was the only healthy and appropriate—perhaps, for many, even conceivable—way to have sex, it may have seemed logical to doctors to fix the female body to better “fit” the male body so that both could enjoy the act increasingly regarded as important for marital happiness.(Rodriguez, 2008, p. 346).

While the idea that orgasms are healthy and important was an important societal change, this idea became downright gruesome when paired with the medical model and the infatuation with surgical procedures. For example, in the 1970s the idea of sexual enhancement surgery emerged, and grew with ideas on pubic hair grooming too (Cain, Iglesia, Dickens & Montgomery, 2013). One gynecologist took the theory of better fitting a woman’s body to a man’s to the extreme. Between 1954 and 1966, Dr. James Burt began to make alterations in episiotomy repairs to unknown women. He added more stitches, thereby decreasing the vagina entrance and tightening the surrounding area. Women reported back to Dr. Burt that they had greater sexual response and satisfaction,

which when added to Burt's knowledge of the function of the clitoris, led to him to begin hypothesizing that anatomically the clitoris was too far from the vagina (Rodriguez, 2013). He believed that the female anatomy was not created correctly for sexual intercourse... an anatomical dysfunction and God's mistake (Davis, 2002). He created a new procedure he called "love surgery" that included the following: vaginal rejuvenation by tightening the vagina, tilting and elongating the vagina, cutting the puboccygeus muscle beneath the vagina, and circumcising the clitoral hood. Now the vagina was almost vertical when a woman lay down and was closer to the clitoris and directly contacted the penis, creating an easier and better orgasm. The local newspaper did a story on the surgery and many women in Dayton, Ohio, and elsewhere came to get the surgery to help them have better sex, providing one of the first examples of media perpetuating and spreading FGCS (Rodriguez, 2008).

Increasing female sexual pleasure seemed like a good goal, but by 1975 Dr. Burt performed these surgeries on over 4,500 women, none of whom provided informed consent due to them being under anesthesia for another procedure (Davis, 2002). In 1975, Dr. Burt started to inform his patients about his Love Surgery because the US Supreme Court ruled it constitutional for doctors to advertise, leading Dr. Burt advance his practice by publicizing and informing women of his surgery (Rodriguez, 2013). He even hired a public relations firm to publicize the love surgery, and co-authored a book with his wife titled *Surgery of Love*. Nonetheless, this story does not have a happy ending.

Dr. Burt's practice ended in 1989 after 20+ years of surgeries. Following civil litigation, he voluntarily gave up his license. Feminists rightfully criticized his surgery

for changing the female body for the pleasure of males. Medical doctors and scientists said that he focused solely on the clitoris and that women have several erogenous zones., Gynecologist and sex therapist Selig Neubardt called the surgery an “[expletive] assault on the vagina” (Murray, 1977, p.96). Critic Morgan even suggested that men educate themselves about the clitoris and female anatomy, instead of allowing a male doctor to transform the female body to fit men’s sexual pleasure (p.346-7). However, the strongest critique comes from the fact that the surgery caused irreparable harm such as bleeding during intercourse, inability to have intercourse entirely, incontinence, infections, and pain. While only nine women sued Burt for malpractice between 1976 and 1986, more women not only felt medically raped but essentially were as these surgeries and alterations were conducted on non-consenting women and had in some cases cause irreparable harm (Lander, 1978 and Rodriguez, 2013).

Once Burt had stopped his surgeries in the late 1980s, it wasn’t long for designer vaginas to appear again in society (Rodriguez, 2008). In fact they never really went away. The current form of FGCS was first mentioned in Radman’s labial reduction description in 1976 (Cain et al., 2013). In 1998, *Cosmopolitan*, *Marie Claire*, and *Harper’s bazaar* had articles on designer vaginas and labiaplasty (Davis, 2002). The three doctors who are given credit for creating the labiaplasty procedure are Doctors Alter, Stubbs, and Matlock. Dr. Matlock, said that his patients looked at *Playboy* and wanted to look like the women in there, who did not have excessively long labia minora (Davis, 2002).

The entry of societal acceptance to these surgeries has many roots. One was Ellen Frankfort’s *Vaginal Politics*, written in 1972 that describes the liberation of women, in

part by learning to self-examine/self-explore their bodies. Frankfort helps assert the women's liberation statement, "the personal is political" (Davis, 2002). The mantra of second wave feminism was the need to know "our bodies" to know "our selves" (Boston Women's Health Collective, 1973). FGCS was done in part by women looking down between their legs for the first time without feeling guilty or super self-conscious of examining their hidden bodies. But, once they became conscious of it and conscious of the male dominated idea a perfect vagina, this led to insecurity and the rise of FGCS. These ideas will be discussed later.

Dr. Burt's surgery echoes in today's FGCS talks in how male surgeons transform the female body, the ethics of informed consent and knowledge of what is being done to the body. Medical ethics has changed since the 1970s and 1980s, but the implications are how women's bodies are treated in medicine is still important to FGCS and other medical treatments for women. Male ideals are still perpetuated in our patriarchal society, with oppression and use of surgery to make female bodies more incline with the male ideal. We can take FGCS to be something empowering for women, but by taking a step back and looking at history, the same procedures and areas of the body are removed as during medical 'remedies' for female problems. Who is to say the surgeries today are not 'remedies' for a problem of oppression hidden under the guise of improvement of the beautiful body and self-esteem? These questions will be augmented and expanded on the present day purposes of FGCS; however, first the different methods of changing the female genitals in the 21st century will be discussed.

Chapter 3: Types of Modern FGCS Procedures

In order to best understand the various genital surgeries a woman can undergo, one must understand the anatomy and physiology of a woman's reproductive system (See Figure 1). As seen in Figure 1, this is the standard anatomy for female genitalia, but there can be variations in the appearance. The misconception of variations in the female vulva is one of the largest problems of determining what normal vulvovaginal anatomy is.

Cartwright and Cardazo (2014) list common FGCSs as being: reduction labiaplasty, augmentation labiaplasty, vulvar lipoplasty, G-spot amplification, hymenorrhaphy/hymenoplasty, and perineorrhaphy (aka vaginal rejuvenation). Interestingly some of FGCS procedures are copyrighted and trademarked: the O-spot®, Vaginal Rejuvenation®, the FemiLift™ and the Real Mommy Makeover™ (Aguirre, 2015 and Serrao, 2015). Nonetheless, I aimed to develop a semi comprehensive list of FGCS practices and perceptions.

In order to accomplish this goal, I examined five cosmetic surgery practice websites, located in New York City, Orlando, Denver, Los Angeles, and San Antonio. All doctors offered different procedures, and a complete index is provided in Table 1. I examined the terminology, pictures, FAQs, and overall descriptions of what these procedures are, including before and after pics. Comparing and contrasting these websites provided a deeper understanding of (1) surgeons' descriptions of the procedures, (2) the

use of verbal persuasion tactics and arguments for FGCS, and (3) the variations in procedure nomenclature across geographical region.

This analysis replicated much of what is already known about surgeons' perceptions of FGCS. The goals of aesthetic surgery of the female genitalia are to enhance the appearance and potentially add psychological and functional improvement in sexual satisfaction and stimulation (Dobbeleier, Van Landuyt & Monstrey, 2011). There are surgeries for the outer genitalia: labiaplasty, clitoral hood reduction, labia majora augmentation, and mons pubis liposculpting. Then there are surgeries for the internal genitalia: vaginoplasty, vaginal tightening (vaginal rejuvenation), perineoplasty, and hymenoplasty, to name the most popular surgeries. And the pictures, word choice, and outlay of the websites all marketed the surgeries as seeming necessary, fulfilling, and safe.

There are also goals for FGCS to solve functional problems, not just about aesthetics. Some FGCSs are considered reconstruction surgeries, such as vaginoplasty and perineoplasty for genital prolapse, cystocele, rectocele, stress urinary incontinence, and sequelae of perineal tears at delivery (Barbara, Facchin, Meschia, & Vercellini, 2015). In fact, according to the website of Dr. Oscar Aguirre, MD, FACOG, FAACS, he divides cosmetic gynecologic surgery into two groups: sexual enhancement surgery and cosmetic enhancing surgery (Aguirre, 2015).

Labiaplasty

As seen from Table 1, the most common FGCS in my analysis is labiaplasty, which is meant to reduce the size of the labia minora and/or make the lips symmetrical,

and according to one website, can give women greater confidence and self-esteem (Manhattan Center for Vaginal Surgery, 2015). Women in their 20s and 30s are the age group most likely to request to have labiaplasty (Braun, 2010). But in the U.K. women as young as 18-24 years old look into receiving labiaplasty (O'Connor, 2014).

Reduction labiaplasty was first reported in peer-reviewed medical literature in 1971. During puberty, hormonal changes cause the labia minora to extend beyond the labia majora. This change can be seen as abnormal to young women without proper sex education and make them feel insecure about how they look down there, not to mention the rest of their developing body (Dobbeleier, Van Landuyt & Monstrey, 2011).

The normal function of the labia minora is to funnel urine and keep the vagina from drying out (Scholten, 2009). For all procedures, minimally at least 1 cm of labia minora is kept in order to aid in micturition (funneling urine) and preventing the vagina from drying out . As well, if the labia minora was less than 1 cm, there could be unaesthetic scarring causing dyspareunia, sensory loss, or chronic pain (Choi & Kim, 2000).

The normal labia minora ranges from 2-10cm in length. However, there is no accurate medical information on what is considered to be “normal” vulva measurements, meaning that doctors use their own personal opinion/education and public opinion to base if a woman’s vulva is within a “normal” range (Andrikopoulou et al., 2013). However, some research does provide estimates of average vulva measurements. Waldeyer first described female genital anatomy in 1899 and described normal labia as being 2.5 to 3.5 cm, as cited from Dobbeleier, Van Landuyt, and Monstrey (2011). Yet in a later study

Lloyd et al. (2005) found that the natural variation in labia minora was found between 7 mm and 5 cm using methods of direct and reliable measurement. The most common cause of the enlargement of labia minora is congenital, and can become more enlarged during puberty, pregnancy, or with age (Alter, 2008).

Labiaplasty can be performed for women who have significant labial asymmetry and hypertrophy from excess androgen or congenital anomalies (Barbara et al., 2015). Other women whose labia are too large may have pain when cycling, during intercourse, inserting a tampon, wearing tight clothing, etc. (Cartwright & Cardazo, 2014; Goodman et al 2010). In a study by Goodman et al. (2010), 75% of 258 patients cited functional issues for why they needed labiaplasty. Alter (2008) reported 85.5% of 348 patients undergoing surgery for aesthetics and discomfort. Many women seek labiaplasty and other FGCSs for psychological concerns, but think surgeons will only perform the surgery for functional purposes, and hence put more emphasis on functional problems when explaining to surgeons of their desire to have surgery (Braun, 2010). Overall, it appears that the most women choose labiaplasty is for aesthetic purposes (Dobbeleier, Van Landuyt & Monstrey, 2011).

Labia majora augmentation and reduction

Other external genital surgeries are labia majora augmentation or reduction, depending on the women's aesthetic desires. Reduction of the labia majora is performed if there is sagging and skin excess and results in the excess skin tissue being removed. Also, if a woman is overweight or obese, the labia majora may resemble a small penis and can have liposuction performed on the labia majora (Dobbeleier, Van Landuyt &

Monstrey, 2011; Triana & Robledo, 2015). Labia majora augmentation can also be done if a woman underwent massive weight loss or if a woman is thin, with the procedure entailing fat injections from a fatty area of the body, usually the inner thigh or abdomen (Triana & Robledo, 2015).

Clitoral hood reduction

Clitoral hood reduction is performed to decrease tissue around the clitoris that may reduce sensitivity and thereby decreasing sexual function (Triana & Robledo, 2015). Thus the clitoris is more exposed, and the procedure can be combined easily with labioplasty (Dobbeleier, Van Landuyt & Monstrey, 2011). This differs from clitoral hoodoplasty which is performed with women whose clitoris is buried under the skin and can lead to no sexual function and sensitivity as well as hygiene complaints such as rash and fluid buildup (Ostreznski, 2013). There is also clitoroplasty which removes part of the clitoris that is 'too large' and is considered socially and medically abnormal (Dobbeleier, Van Landuyt & Monstrey, 2011). Clitoropexy is the reduction of the clitoris and moving the clitoris and the labia minora anterior and superior to make the clitoris looked reduced and make a female feel more acceptable to society (Dobbeleier, Van Landuyt & Monstrey, 2011). What is fascinating is that throughout history, a lot of these procedures have been performed for different reasons, but all were primarily for social acceptance.

G-spot amplification

G-spot amplification is a procedure for functional improvement to enhance sexual stimulation by increasing the size of the Grafenberg spot (G spot). The G spot is a highly

erogenous zone first described in the 1950s medical literature. However, its existence is yet to be determined, as King's College London did not find evidence of its existence, reports Dobbeleier, Van Landuyt, & Monstrey (2011). Collagen or hyaluronan, a synthetic collagen, is injected under local anesthesia into the G-spot to temporarily augment it from four to nine months, depending on the accuracy (Dobbeleier, Van Landuyt & Monstrey, 2011; and Serrao, 2015).

Vaginal Rejuvenation

Vaginal rejuvenation, aka perineorrhaphy, aka vaginoplasty is the procedure for tightening and reconstructing the lower third of the vagina. Vaginal tightening surgeries have existed since the mid-1950s when gynecologists tightened the entrance to the vagina after childbirth. The stitches repaired the tears of the vagina or perineum after an episiotomy or natural tearing. However, an additional extra stitch called the "husband's stitch" was sutured in order to make the vaginal entrance small and tighter than it was before childbirth (Dobbeleier, Van Landuyt & Monstrey, 2011). Today, vaginal rejuvenation is targeted towards women who have had vaginal births or have aged and have stretched (Serrao, 2015). Normally the women who want vaginal rejuvenation are healthy without any true functional disorders and solely want to decrease 'looseness' and increase muscle tone, control, and sexual sensitivity (Dobbeleier, Van Landuyt & Monstrey, 2011). Yet there are some reported testimonies on various surgery pages about the wonders this surgery has done to improve women's sex lives (Aguirre, 2015; Serrao, 2015).

Hymenoplasty

Hymenorrhaphy, or hymenoplasty is a surgical procedure meant to recreate the hymen, thus “recreating” a virgin appearance. The hymen is a partially closed mucous membrane that has no biological function in adults, thus its repair has no functional benefit (Raveenthiran, 2009). The procedure narrows the vaginal opening and the hymenal caruncles that were torn are sutured together with enough space for vaginal and menstrual fluids to pass through (Triana & Robledo, 2015).

Aguirre Specialty Care states the reason why women want hymenoplasty is for cultural, ethnic, or religious reason, or perhaps in traumatic cases of child abuse or rape (Aguirre, 2015). Hymenoplasty is very controversial as it creates deception and perpetuates misogynist myths about virginity (Cartwright & Cardazo, 2008). However for the purpose of this thesis this specific FGCS procedure cannot be fully explored in the depth it is granted.

Real Mommy Makeover

Skin Deep magazine featured an article about new mothers getting a tummy tuck “to remove the stigma of having delivered a baby: ‘Pregnancy is a special time in a woman’s life but the invariable ‘the mark of pregnancy’ produces changes in her body which are less than desirable. Fortunately, excellent treatments are available.’” (Kuczynski, 2006, p.81).

With pregnancy, the brain becomes wired differently, hormones are set to a different level, and the body does grow a little weaker in areas as it bears another body inside it. The Real Mommy Makeover is to address urinary and/or bowel issues that result from childbirth, as well as “correcting” cosmetic vaginal concerns (enlarged labia

and vaginal looseness), sexual gratification, excess fat, loose abdominal skin, changes in the breasts, skin issues (like melisma or hormonal acne), as well as wrinkles and lines (Aguirre, 2015). In this way, some components of the Real Mommy Makeover® are for reconstructive/functional purposes. Some are both functional and aesthetic (skin issues), and some are solely aesthetic (wrinkles, excess fat, loose abdominal skin, tightening vagina).

In the FAQs of the ASC website, a woman states – she cannot have as gratifying of sex as she could before vaginal births, and even though she has used Kegels, vaginal weights, and tantric workshops, she and her husband do not enjoy sex as often. The answer on the website responds with,

You're not alone! Millions of women have precisely the same problems you're describing and there are treatment options for you. Women today are taking their sexual health and gratification into their own hands, *not blindly accepting* that the joy of having children comes with *the high price-tag of their sensual selves*.

They're empowered to make the choices that will enrich their lives in and out of the bedroom". [Emphasis mine] (FAQs, 2015)

I find the answer to this question about how her sexual health and life has changed and came with “the high price-tag” of losing her sensual self to childbirth to be somewhat discordant. Women are looking for a quick fix or to care for themselves, but their brain is wired differently after childbirth, sense of self, physical body... why revert? Would the essence of motherhood be stolen or altered in a way that can be damaging?

Would one think that they are okay and in the right to change with their body to a new creation after the creation of another new life?

Testimonies to FGCSs

There are two personal stories about labiaplasty to share. The first comes from Mrs. X interviewed by Kuczynski (2006). Mrs. X had tons of surgeries and had a long ritual every day for caring for her body, for it was her “profession, hobby, passion, and primary relationship” (2006, p. 126). She saw two or three plastic surgeons about three times a year for consultations, and usually had one surgery per year to remodel her body. She has had two breast implants, liposuction, tummy tuck, brow lift, two face-lifts, eyelid surgery, and then one day... “It was after a bath, and I was looking at myself [between legs] and I noticed that the inner, you know, were protruding a bit, and the outer, you know, were looking kind of, well, droopy” (p. 128). Mrs. X decided to get labiaplasty and described the area as being painful for a week and had pain when using the bathroom. However, one day, “It was fresh. Clean. Tidy looking. Do you know what I mean? ... I’ve spent so much money for the rest of me to look like Dolly Parton. So why should that [glancing downwards] look like Willie Nelson?” (Kuczynski, p. 130, 2006).

The second woman wrote a testimony on the website of her experience receiving vaginoplasty, rectocele repair, and labia majora reduction, followed four days later by VASER Lipo with Brazilian Butt Lift surgery. She writes:

Although my husband claimed he was very happy, I thought it must be impossible for him to feel anything during intercourse. It had definitely gotten to the point that I couldn’t. Not only was I loose there, I had altogether lost most of

the sensation in that area and found it very hard to experience pleasure of any kind during any kind of sex. (Real Mommy Makeover, 2013).

These two stories add depth to why women pursue FGCS (or in these cases, multiple surgeries) to reclaim their bodies. Since the 20th century women have taken control of their bodies in line with the 2nd wave of feminism described earlier.

As can be seen, physicians' wording and terminology can help impact the women to choose FGCS, and as they two women have stated, it has made them feel happier sexually and physically. Comparing and contrasting the websites and types of FGCS help to envision how prominent the surgeries are and how vast and different each surgery is. Knowing how each surgery works and what area on female anatomy it changes are helpful background knowledge in deciding if all, some, or no FGCS procedure is ethical, moral, or favorable towards women.

Chapter 4: Risks, Benefits, and Ethics

“At the present time, the field of female cosmetic genital surgery is like the old Wild, Wild West: wide open and unregulated” (Goodman, 2009, p. 156).

Risks

The risks for labiaplasty have been the most well studied of all FGCSs. Cain et al. (2013) reported that complications were seen in 4-18% of women including visible scarring, loss of pigmentation, clitoral hood overhang, fistula and sinus formation. Goodman et al. (2010) found complications including wound healing, pain with sex, vulvar vestibulitis, excess bleeding, infection, and over tightening of the perineum 2013. Vaginal rejuvenation complications involve infection and bleeding (Dobbeleier, Van Landuyt & Monstrey, 2011).

With any surgery there is a risk of complications. And with genital surgery, there could be potential loss or destruction of sexual or urinary function, nerve damage, and even poorly performed surgeries. Besides physical complications, there are psychological complications that become more visible or become worse through having surgery. One of the largest mental disorders found in women who undergo cosmetic surgery is body dysmorphic disorder (BDD). The definition of BDD, according to the DSM –V and cited by Barbara et al. (2015) is:

Characterized by extreme preoccupation with minor or nonexistent defects or flaws in physical appearance associated with intrusive thoughts, persistent distress, significant impairment in social and occupational functioning, and repetitive behaviors, such as mirror checking, seeking reassurance from others, and even requesting unnecessary cosmetic surgery. (p. 916)

The onset of BDD is early adolescence with obsessions on physical appearance and deep sufferance, and is co-morbid with multiple biological, psychological, and sociological factors (Barbara et al., 2015).

Another issue is women undergoing the surgery to try to fix an issue they are facing in their lives, such as a defect in their sense of self or professional lives, marriage, personal relationship, or change in job. But changing the body will not fix the life problem (Ericksen & Billick, 2012). Doctors are trained to look out for this when consulting a potential candidate for surgery. ACOG, the American Congress of Obstetrics and Gynecologists, also recommends women (seeking FGCS) should be evaluated for sexual dysfunction, perhaps have counseling and/or psychiatric review (American Congress, 2007). The ASPS goes on to say that plastic surgery “is a personal choice and should be done for yourself, not to fulfill someone else’s desires or to try to fit an ideal image” (American Society of Plastic Surgeons, 2016).

Nonetheless, the American Congress of Obstetricians and Gynecologists (2007) strongly stands against FGCS being performed. They claim there is no accurate data on safety and efficacy of these surgeries. They go on to say it is deceptive to acknowledge these surgeries as normal and routine surgical practices. Until safety, complication rates,

and long term satisfaction are known from peer-reviewed scientific studies, as well as marketing and franchising of surgeries are held to higher standards, ACOG will continue its stance against FGCS, and this has been reaffirmed in 2014 (ACOG Committee, 2007).

The benefits of FGCS are sexual satisfaction seen in some studies. Goodman et al. (2010) found that 91.6 % of patients in a large cross-sectional study were satisfied with the results of the surgery. Yet the patients were surveyed at a time differing in each clinic ranging from 6-42 month follow-up. Alter (2008) found that out of patients who returned the questionnaire, self-esteem improved in 93% of patients, sex life improved in 71%, and 98% of patients would undergo the surgery again. However, Dr. Alter is a famous cosmetic surgeon with offices both in Beverly Hills and Manhattan, and his bias must be questioned in how this study was conducted.

But what is quality of these studies in efficacy, safety, measurements of sexuality and satisfaction, and long term outcomes? Comparing before and after symptoms and sensitivity of female sexuality, such as orgasms, etc., was not done in some studies, there are no validated questionnaires, and the information on long term effects five, ten, twenty years down the road is not included. There is limited scientific evidence and the reliability is questioned. And due to the effort justification theory, by willfully experiencing pain, that in itself leads to a desire to justify the very pain (Klein, Bhatt & Zentall, 2005).

Nonetheless, where the only validated, tangible benefit of FGCS is an increase in self-esteem in a society where misogyny leads to reductions in self-esteem, there were 2,142 cosmetic vulva surgical procedures in 2011. And the amount of actual procedures

is even more, as no gynecologists were surveyed in this survey of surgeons and dermatologists Yuteri-Kaplan 2012). The benefits seem to outweigh the physical harm, but the emotional and psychological harms have yet to be fully understood. However, FGCS will still continue to rise in popularity as our patriarchal culture and medical scientific advances continue.

Chapter 5: Cultural and Social advances- medicine, technology, sexuality, knowledge

“As more of us get fatter, the more we hate fat. If beauty is a religion, fat is a cardinal sin. To be fat is to be perceived as weak and morally lazy. Women who belong to the cult of the beauty junkie will resort to any means to remain thin. Thin is beautiful. Thin means you are smart, sexy, powerful, and in command of your own destiny.”

(Kuczynski, 2006, p.174)

“Advertising is the art of convincing people to spend money they don't have for something they don't need” – comedian Will Rogers (2016)

Female genitals are commonly given a negative construction. The term that strikes me as the most offensive is “Vagina dentate” (a vagina having teeth). However, some have referred to the vagina as contain fatal odors and other “horror” stories about female genitalia. Chapter 2 suggests that male doctors think (they still do it) of female’s reproductive system as needing repair and the cause of numerous disorders and impairments. Nonetheless, the vagina is a paradox that is the subject of both abhorrence and adoration. In today’s world this paradox exists in the fact that genitals are less hidden and more on display (Davis, 2002). There are provocative, skin-showing ads,

almost pornographic in nature, seen in media, advertisements, and the general day to day. However, a non-photo shopped or artistically enhanced vagina is rarely, if ever, shown. The paradox is simple, people want to see the vagina, but they are afraid to see an “imperfect” vagina.

It should be no surprise that our culture has created a uniform on the idea of what vulvar anatomy should look like, especially with the rise of technology, especially the Internet. Women can look up images of what the outer vulva and vagina “should” look like, and they will most likely find images depicting the labia minora not surpassing the labia majora. This hypothesis is supported by recent research showing that most women believe that it is normal and best-looking for the labia minora to not surpass the labia majora in length (Yuteri-Kaplan et al., 2012). Yet, assuming this knowledge is coming from an internet full of photoshopped and unnatural vaginas, the quality of these beliefs must be questioned because this “pressure” arising from the Internet is unlikely to represent reality. Furthermore, the (internet) standard for the vulvovaginal is extremely strict especially as the normal range is so diverse (Barbara et al., 2015). Nonetheless, women believe this unnatural rule to be true, and this thesis must examine why.

Pornography

Pornography is widely cited in the literature as a top reason to why women have alternative ideas of imagery of vulvas. Labiaplasty is commonly utilized by sex workers, exotic dancers, and nude models, the very demographic of individuals who participate in pornography (Kuczynski, 2006). In mainstream pornography (e.g. *Penthouse* and *Playboy*), labias are tucked away during photo shoots (Davis, 2002). Pornographers and

for advertisers use numerous technical alterations (i.e. lighting and Photoshop) to construct the perfect yet unrealistic vulva. Even the surgical websites “enhance” pictures of women via make up, lighting, and Photoshop (Davis, 2002). Yet even imaginary images are powerful. Perception is reality and what we see can affect our ideas of self.

Many may believe that women do not utilize pornography. However, in the United States, the Internet pornography industry generates a \$16.9 billion per year, and almost one third of pornography viewers are women (Carroll et al., 2008, & "Internet Pornography by the Numbers," n.d.). Furthermore, porn sites have more visitors per month than Netflix, Amazon and Twitter combined (Paint Bottle, 2013). The pornography industry has not only crafted the imaginary vulva, they have distributed this image to the world.

The usage of porn for young men highlights and increases some of the destruction pornography can have on women. Pornography consumption has risen since 1995 due to the accessibility, affordability, and anonymity of Internet pornography, which is the primary source for pornography among young adult men (Manning, 2006). Young adult men (ages 18-26) are the most frequent viewers of pornography, with about 87% reporting that they view pornography. Half of the men surveyed reported viewing it weekly and 20% view it daily or every other day. The study also reported that 67% of young men and 49% of young women agreed that viewing porn is acceptable (Carroll et al., 2008).

Surgeons seeing potential female patients report that women say they or their male sexual partners compare them with pornography (Kuczynski, 2006), and these

interactions are where modern misogyny and objectification of women arises. “When women know that their male partners view pornography, their concern regarding their partners’ sexual attraction toward their own body increases” (Schneider, 2000). Horrocks et al. (2015) found that in a survey of 248 young men in college, 49.2% of them did not have a preferred appearance of the labia minora, and that 53.8% of men did not believe FGCS is a good idea. That means men are divided in half, and 46.2% of men approve of FGCS. Furthermore, only 14% of men supported genital cosmetic surgery. Yet despite their own statements and personal behaviors indicating an aversion to GCS, 48% of men had a preference for labia, mostly saying “small and tucked in” appearance. This labia is likely rare and thus obtaining one will require surgery. Furthermore, 45% men preferred a completely hairless pubic region, a hygiene point to be looked at further in this thesis. Almost a fourth of the male participants in their study said porn influenced their opinions on how female genitalia should look (2015); indicating a complete lack of understanding of the differences between a real vagina and the aforementioned porn-industry constructed vagina. (Note: A key point to take away from this survey is only 57% of men responded to take this survey, so that varies the data and what the men who didn’t respond to the survey may have.) However, if this study could be taken as an accurate portrayal of young men’s preferences, it seems that at around half of men prefer women with a hairless, small vulva while the other half has no preference. And about half of young men do not support the idea of FGCS.

These studies provide some evidence that pornography use does have an influence on how men perceive women’s bodies. Some reports from women suggest that women

with male partners were distressed upon learning of their partner's pornography use. These women sought emotional support from professionals as they had feelings of sexual inadequacy, more awareness of their bodies as sex objects, and an overall negative body image (Bergner & Bridges, 2002). The aforementioned evidence, suggests that their fears are not simply "all in their heads" either, as men are influenced by the consumption of these unrealistic and oppressive images.

Even women themselves feel pressure coming from these images. As viewing these images create an expectation of what a proper labia entails. For example, a study of Australian women ages 18-30 years found that most women (after viewing a series of vulva) rated modified vulvas to be more like society's ideal vulva (Moran & Lee, 2013). These results argue that women prefer modified vulvas that had a smaller tucked in appearance with no or minimum labia minora sticking out. Thus, a large proportion of men and a large proportion of women prefer this appearance; society has created an unrealistic perception of what a vulva should and does look like. Barbara et al. (2015) describes this situation well, "... healthy women and girls who undergo FGCS (and cosmetic surgery in general) represent the expression of a contemporary drama, which is the impossibility of dealing with diversity" (p. 916).

Aging

Aging has an impact on having FGCS as well, since it is a common fear of humans to grow old and have wrinkled and loose-skin, even in the vagina. Menopause begins in the early and mid-50s and there is a decrease production of hormones. The lack of estrogen and progesterone specifically makes the vagina dryer, looser, and a loss of

tissue and fat in the surrounding vulva. Pubic hair grays and thins; there is a decrease in blood flow to the vagina, less lubrication, and diminished muscle and skin tone. (Saxon, Etten & Perkins, 2015). Yuteri-Kaplan et al. (2012) found that older women (mean of 55 years) are more likely to consider cosmetic vulvar surgery than any other age group. The authors suggest it could be due to child bearing and lack of estrogen during menopause that changes the vulva, resulting in a dissatisfied look and body image.

Hygiene

In American culture, there have been two new movements in hygiene and beauty modifications in women over the past few decades – hair grooming and “maintenance.” Hair grooming and pubic hair removal have been linked to increased rates of FGCS (as spoken above with ties to pornography), because women can see more of their labia minora and its ‘abnormalities’ (Yuteri-Kaplan et al., 2012). Brazilian waxes, thong underwear, laser hair removal, skimpy bikinis, and other new trends have caused an increase in awareness of a woman’s body between the legs (Barbara et al, 2015; Ashong & Batta, 2012).

A recent study by DeMaria & Berenson (2013) found that pubic hair removal was seen to be “extremely common,” and that it correlated with being white, young, under or “normal” weight, and having five or more lifetime sexual partners. Also, Smolak & Murnen (2011) found that the women who remove pubic hair report more self-surveillance and self-objectification than women who do not remove pubic hair.

Some plastic surgery is seen as ‘maintenance’, as it is called in New York City. “Maintenance is what you have to do just so you can walk out the door knowing that if

you go to the market and bump into a guy who once rejected you, you won't have to hide behind a stack of canned food" is what Nora Ephron, writer and director of *O* wrote (Kuczynski, 2006, p.197). And her maintenance schedule takes at least 8 hours a week. Taking care of one's physical appearance is part of a life and health routine.

"Admitting you've had the latest wrinkle filler is no longer a mark of shame; on the contrary, it is a status symbol in the mind of the twenty-first-century consumer who believes that self-maintenance and an abiding respect for personal aesthetics are deeply moral obligations" (Kuczynski, 2006, p.199). The world is a visual place naturally, as eyesight is keen in humans and being attractive is an essential for reproduction in the natural world. And personal aesthetics are important in these means, but to be a moral obligation and a status symbol is only a cultural product of our misogynist, materialistic American culture. Caring for one self is essential, but to the extremes is needless.

A moral obligation to have a good-looking vagina can be a very hard argument to follow normally, but Kuczynski (2006) makes a valid argument. Some women would argue that taking care of hygiene and looks of the vulva is categorized under maintenance, namely private maintenance. But the vagina is seen in a negative connotation to being 'dirty' and 'smelly.' There are specific soaps and washes marketed for vaginas, bikini razors, trimmers, and other tools and products solely designated for one body piece. Hygiene of the vulva and keeping it maintained is a daily routine for most women. Surgery to keep the pre-adolescent, youthful look of a vagina could someday become the norm in society, just as in New York having Botox or the latest wrinkle filler are seen more often as the norm.

Kuczynski (2006) suggests that in the end, the desire to have FGCS, or any cosmetic surgery comes down to sex and being admired by men and women alike. “What else could provoke us to drain our resources, invite a surgeon to slice us open and insert a foreign object into our bodies, and then endure an excruciating recovery?” (p. 246). Sex is also about pleasing others, and if the male partner wants a tighter, trimmer companion, is it wrong to please with an expensive surgery? Yes, it is.

Besides cultural or personal influences, there are also self-influences. Veale et al. found that women seeking labiaplasty were concerned about their labia for a mean of 10 years (2014). Ten years of angst, anxiety, and fear, all because their vagina does not match the unrealistic standard of pornography. This ties into women regularly self-examining and internalizing outer problems into a deeper and deeper mindset of something needing to change, even years later after first becoming concerned.

The ensnaring of females can be used to be/make powerful statements. Women are conscious of how their bodies are used against them and use that knowledge to empower themselves and gain power (Tong & Lindemann, 2006). “It is easy, when participating in practices of beautification, to lose sight of the fact that femininity is a social construction working to the systemic advantage of men and the systemic disadvantage of women. To ‘sound female’ and carry oneself in feminine ways requires constant, habitual self-monitoring” (Tong & Lindemann, 2006, p. 191). We should never forget these words.

Kuczynski echoes this by saying our culture is rooted in “vanity and self-invention” and that we will do anything and embrace any new technique if it gives us

more physical beauty (2006, p. 222). It is easier to fix your body to fit society than to change social attitudes and powers that govern our society. It seems the options are limited to fixing the body to blend in with society or face discrimination from that society (Tong & Lindemann, 2006).

One overarching factor is the influence and discourse of FGCS in the public, the media, this thesis, by women talking in locker rooms and hair salons and anywhere conversations of beauty and aesthetics take place; FGCS is talked about more and more in our world. Disseminating news through family and friends (such as ‘Have you heard about that new cosmetic surgery treatment?’) and overall exposure through mass media produce a sufficient condition for an idea to take hold in an individual’s mind. This is media contagion, where ideas are transmitted like a disease to ‘infect’ the individual and their emotional state (Marsden, 1998).

Philip Rieff, a sociologist in the mid-1960s wrote that Americans were not citizens but patients of culture. Only others judgments, like Oprah or personal trainer or Dr. Phil, can tell us our self-worth. Rieff says, “When so little can be taken for granted, when the meaningfulness of social existence no longer grants an inner life at peace with oneself, every man must become something of a genius about himself” (Kuczynski, 2006, p. 112). He continues, “For us, the culture of therapeutic – the culture of well-being – has given way to the cultures of celebrity and cosmetic surgery. We no longer focus on bettering of the self but have gone one step further. We focus only on creating the beautiful carapace” (Kuczynski, 2006, p. 112). This analysis on the psychology of how

we think of beauty is very similar in thought to media contagion. What we see and hear every day affects our thoughts and views of the world and of ourselves.

There are several voices that are in support of general cosmetic surgery that can relate to FGCS as well. One woman, Amy Richards, said in an interview,

I don't think these women are saying 'I'm going to be female, going to be objectified, going to wear sexy clothes and so on and be part of the backlash against feminism.' I think they're saying, 'I'm going to do all these things because I want to embrace my femininity. (Bailey 2002, p.144 as cited in Tong & Lindemann, 2006)

For the majority of cosmetic surgery cases, women could control themselves and not get addicted to continuing to get cosmetic surgery. They know cosmetic surgery is not a radical change and will not entirely transform their appearance, but give them an outlet to address a negative aspect of themselves, one "flaw". And they did it to please themselves or to create a more approximate vision of themselves (Tong & Lindemann, 2006). This makes sense with FGCS as it is a private surgery out of the public eye. However, how much of this is a choice? How much desire would one have if one did not know the perfect vagina as presented in pornography? Thus, is one's free behavior to engage in FCCS really free?

Nonetheless, much like male circumcision we may be moving towards a world where women who don't get surgeries, will be seen as deviant to not use technologies "refusing to be all that they could be" or as "granola heads" (Morgan, 1991, p. 40).

Improving the body through aesthetic means can be seen as a form of self-worth, and by

denying or dismissing cosmetic surgery it implies a person who thinks they are worthless and undeserving of the good life surgery can give them (Covino, 2001).

To counter, Johnsdotter and Essen argue that women who change their bodies can be seen as “victims of patriarchy, the beauty industry, the pressuring ideals of today or their inner insecurities.” (2010, p. 32). The choice of the word “victim” seems to imply the negative, sullen connotation that a surgery a woman ‘freely’ chooses is a decision she made as an object, or prey, of a society that wanted her to obsess over her body and pay money to change it. To go along with this idea, Kuczynski (2006) says she was “relatively obsessed” with cosmetic surgery and became an addict herself after entering investigative journalism on cosmetic surgery and beauty products (p. 200).

The arguments against cosmetic surgery are based on going against the vanity of finding physical perfection, and the immoral choice to change one’s self. Cosmetic surgery is a shallow, too-easy option for the privileged, and that it is unfair to have cosmetic procedures that others cannot afford (Kuczynski, 2006). But Kuczynski defends cosmetic surgery saying not all people who get it are vain, immoral and ignorant. As for economic unfairness, that’s just life and part of the human condition. And, what is human nature? And if free choice exists, women are indeed the ultimate decision-makers of their bodies. Agency and choice come into an ethical debate on why we make certain decisions over others.

Suzanne Fraser states that one should not generalize motives of women and their feelings about themselves (Tong & Lindemann, 2006). And if a woman’s goal is to improve herself, do the background motivations even matter if the final result makes her

happy? But they make her happy in an oppressive world... So it's also a paradox not only between the real vagina and the fake constructed one..it's a paradox between self and the society the self lives in.

Chapter 6: Cosmetic Surgery Industry – Ethics and Rights

“Doctors have sold us on the notion that surgery is no longer an issue as crass as mere cutting and suturing; it is merely part of the journey towards enhancement, the beauty outside ultimately reflecting the beauty within.” (Kuczynski, p. 7, 2006)

The cosmetic surgery industry is a gigantic industry both worldwide and in the U.S. It is a \$15 billion dollar industry (Kuczynski 2006). It is \$62 billion industry in China (“Inside China’s,” 2016). Arroba (2003) summarizes a critical view of the industry’s impact on women’s lives as,

One third of women’s lives are marked by aging, one-third of our bodies are fatty tissues, and both... have been transformed into surgically-correctable problems... behind it all is profit – it’s all about money in the end.... In order to guarantee their [cosmetic surgery industry] income, plastic surgeons distort women’s self-perception and magnify their self-hatred and rejection. We see it every day in the media, the magazines, medical brochures, television, the movie industry, the newspaper, and advertising... (p. 2)

Cosmetic surgery is given a moral justification through psychology... through correcting ‘inferiority complexes’ and recreating oneself in order to be happy (Dorneles de Andrade 2010; Covino, 2001; Braun, 2010). It legitimizes and defines itself by

declaring that changing the body changes the mind. There is a tri-partite model of the individual in the industry: an essential self, a susceptible mind, and an amenable body. The essential self is similar to the mind but the mind will grow or diminish with changes in confidence, satisfaction, and security about oneself. The essential self never changes and is also called the soul. One surgeon, Alan Engler, argues that fixing the body brings the body, mind, and spirit into harmony (Covino, 2010).

Since the World Wars, the standards of beauty have risen and been influenced from economics (cultural and financial), technological shifts, and innovations in surgeries. The innovations discovered and perfected in reconstructive surgeries from World War injuries made the industry more respected (Davis, 2002). According to Shiffman (2013), plastic surgery principles are to be more accurate, precise, economical, and perfect.

There are some flaws of regulation and perfection in the industry. The first is how the procedures for cosmetic surgery are being conducted. Increasingly, procedures are being performed in doctors' offices and surgical centers, rather than in hospitals. More procedures are being done concurrently, therefore the risks of infections and anesthesia reactions have increased. Also, some practitioners have not completed the 5 year residency training required by the American Board of Plastic Surgery. However, they are still able to legally perform the procedures, even though they have never had proper training (Donohoe, 2006b). With a lack of education/credentials, consumers of plastic surgery are at more risk for botched procedures, infections and other issues. In many states, doctors without hospital privileges can still performed certain procedures, like

liposuction, in their own office operating rooms. And not only can surgeons perform cosmetic surgeries, but so can obstetricians/gynecologists, dentists, dermatologists, and other specialists (Kuczynski, 2006).

The trustworthiness of the cosmetic surgery industry is hard to rely on as there are no third party insurance companies to help regulate and approve the procedures and credentials of surgeons. Cosmetic surgery is not covered by insurance if it is elective and thus there is competition in price and quality. Surgeons compete with one another to obtain the most patients and profit. Also, information about physicians is difficult to find and confusing. In one example, a person could read that a certain doctor is certified by the American Board of Cosmetic Surgery or the American Academy of Cosmetic Surgery. However, these are *not real* boards for plastic surgery. The American Board of Cosmetic Surgery is a certification and training board in otolaryngology or dermatology, but not in plastic surgery. The American Board of Plastic Surgery is the only board for plastic surgery recognized by American Board of Medical Specialties (Kuczynski, 2006). This shows how the consumer can be put at risk. With FGCS, a botched surgery could result in worse sexual function, nerve damage, etc. as said previously.

Wolf (2002) gives another perspective on how cosmetic surgery gained popularity, which differs from the belief that cosmetic surgery is respected and strives for perfection. Wolf believes that the market for cosmetic surgery was created for surgeon profit and to keep women from mobilizing in politics, education, and social needs. Their time spent on correcting “flaws” could have been spent on educational and occupational

goals. But instead, Wolf says cosmetic surgeons today have a direct financial interest in keeping women in a role that makes them feel ugly (2002).

Surgeons and the medical industry in general are taking advantage of the perception that vulvas that women view through pornography use/acceptance and creates a 'fear' and capitalizes on pre-existing embarrassment (Davis, 2002). To create anxiety and a new 'problem,' body parts are medicalized. Medicalizing the vulva and bringing in authoritative language creates anxiety in women. Using medical language creates a stronger impact, making more insecurities so something can be marketed and sold. For example, "micromastia" is the "disease" of flat-chestedness. And "halitosis" is a 'disease' of bad breath that can cause social, romantic, and medical risks (Davis, 2002). "Cellulitis" was a term created by *Vogue* in 1973 (Arroba, 2003). And the purpose of the invention of these diseases is to make the insecurity to make a profit.

For centuries the term "ill" has meant to be used in a way to create social control over women. Now cosmetic surgeons define "health" as beauty, and that hunger is health, and pain and blood are health. Just as in the 19th century when women were medically coerced to believe menstruation, masturbation, pregnancy and menopause were diseases, today we have come to believe our normal healthy bodies are diseases (Wolf, 2002). Now ugliness is defined as an illness, such that wrinkles, shape of breasts, changes in body after childbirth, are considered an illness (Arroba, 2003). And the media has told us that the cure to feeling better is to buy more clothes, more makeup, and more cosmetic surgeries. In other words, more consumerism and materialism will make a woman happier. Advance capitalism, and the need to create a new product/problem to make

people insecure and feel a need to purchase goods they do not need is the way companies make profits, especially in the health and pharmacy industries; and sad people buy more products (Wolf, 2002).

With some FGCSs, particularly vaginal rejuvenation and vaginoplasty, doctors agree their surgery will help mothers after vaginal childbirth(s) to have their old wonderful and sexual lives back by tightening the vagina. There is no physical disease or problem to a looser vagina and weaker muscles itself post pregnancy unless something went wrong in the birth. It takes months for all women to heal from the trauma of childbirth, but there is still no evidence that the vagina is actually looser after birthing than before. But if websites of cosmetic surgeons say so, a woman will internalize those thoughts and ideas through time and exposure to become susceptible and insecure (this goes for all humans, not just women). Kuczynski (2006) reverberates,

It is a dance between patients and surgeons that takes place every day.

Emotionally fragile patients are willing to pay anything to hear that their sagging jowls can be fixed. Doctors who have to pay for expensive public relations agents and advertising campaigns are just a tad more likely to operate on someone who doesn't need surgery. (p. 101)

Davis (2002) believes that due to “advertising propaganda” and “questionable publicity”, the cosmetic surgery industry paralyzes normal women to believe something is wrong, and become self-conscious about that. This creates inferiority complexes about different parts of the body. Yet the entire purpose of cosmetic surgery is to fix inferiority complexes as stated above. The cosmetic surgery industry perpetuates the exact idea it is

trying to fix, thus more and more people succumb to paying for surgically altering their bodies.

Relating this idea of profiting off of surgeries to FGCS, a study by Reitsma et al. (2011) found that plastic surgeons are more likely to perform labiaplasty than gynecologists. And male physicians are more likely to do the cosmetic procedures than female physicians. What does this say about profits and male cosmetic surgeons? In the cosmetic surgery industry itself, only about 10% of cosmetic surgeons are female, while 90% of patients are male (Bernard, 2012). This reaffirms the idea of women going to men in higher authority, seeking approval for correcting “flaws”. This ratio of male surgeons to female patients also supports the idea that a woman’s idea is more valid if a man approves and supports it, since “male perspective is seen as more rational and authoritative” (Tong & Lindemann, 2006, p.185).

Yet with this said, the job and training of a cosmetic surgeon is a long and stressful one. Many women have not yet entered this field due to the years of training, less time off to raise children, and highly competitive, uninviting sexist atmosphere (Bernard, 2012). And in the U.S. healthcare systems, where HMOs place constraints on physician pay, some doctors and surgeons cannot make enough profit to keep their practice running unless pursuing patient’s income to help keep their job (Blum, 2005).

However, some critics of cosmetic surgery still call this a fact of the patriarchal system to control and “correct” women, particularly their bodies. This control of female bodies is necessary for patriarchal sovereignty and the economy. By controlling women’s bodies – attitudes, sexualities, pregnancies, menopause, overall health, beauty, and labor

– the medical industry can make a profit, becoming wealthy at women’s expense (Arroba, 2003).

The medical system operates on a cultural paradigm, and it is through the medicinal institution that bodies are regulated. The western medicine paradigm is “medicine is science,” which is supported by three assumptions: western medicine is the best; doctors know what is best for patient; and using invasive and expensive procedures and technologies should not be questioned. It also creates the idea of dualism, of separation of body and mind. Another paradigm is “the body is a machine” with different components that can independently be broken and fixed, a focus on disease in sick parts without looking at entire body’s wellness. (Arroba, 2003).

A disease-centered, instant gratification, invasive medical culture is what we exist in. This, as well as the business and profit-making side to the medical industry, are all added components to consider when a person is looking at getting cosmetic surgery. It is not just a female issue for changing the body, but an overall societal concern. How much money are we willing to give surgeons, qualified or unqualified, male or female, to alter the body? By each person getting cosmetic surgery, it perpetuates the cycle of more and more cosmetic surgeries, and increase in surgeons to fulfill those needs and demands, and the media contagion and spread through word of mouth to all people in the U.S. What a person considers an illness and how to treat it are both influenced by our culture. And our medical world today contributes to this ever increasing need for cosmetic surgery including FGCS.

Chapter 7: Discourse on Sense of Self, Body Image, and Beauty

“There’s nothing new about adoring beauty. Every epoch has nurtured its idea of perfect beauty and developed means for achieving it. What is different about our culture’s approach to beauty is the extreme degree to which we believe beauty matters. Advances in medicine and technology in the last century, particularly in the last decade, coupled with the flourishing of mass media in more forms than we could have possibly imagined a quarter of a century ago, have taken our normal animal concerns and magnified them into an obsession.”

(Kuczynski, 2006, p. 268)

“We have always known that inner psychic and spiritual changes bring about a new external radiance, but we are now discovering that the process also works in reverse: Change the external appearance-restore the lost years-of a person struggling continually against indifferent or negative social reactions, and the inner light that has died within begins to glow once more.”

(Gonzales-Ulloa, 1985, p. vii)

Beauty

I could never fully articulate what beauty means in a way that resonates clearly with everyone, but to me beauty is a cultural product that changes over time and has slightly different meanings to each individual within that culture. Beauty can be thought of as something divine, highly, holy – which can be defined to be a god or a nematode or

a dance or a laugh. Beauty is influenced by gendered narratives, which could be too narrow and create negative psychological effects and feelings of unattractiveness when there are deviations from the norm (Barbara et al., 2015).

Beauty differs and varies from person to person, culture to culture, and epoch to epoch. The desire for beauty dates back to ancient Egypt ca. 4,000 BCE (Covino, 2001). Even in terms of female genitals, genital beauty differs culturally. In some African tribes, elongated and stretched labia minora are considered attractive, in the Western nations short, tucked in labia minora are attractive, and in Japan a winged ‘butterfly’ look to the labia minora is a beauty (Dobbeleir, Van Landuyt, & Monstrey, 2011). Genital beauty is very much culturally defined.

Overall, human beauty is defined differently by the individual and the people around the individual, for each has different perspectives. Body image is that individual’s perspective on how their beauty seems to appear. Body image is defined as “the subjective picture or mental image which a person has of his or her body, especially ... in relation to its shape” (Oxford University, 2010). Body image is a multidimensional construct used in reference to affective (e.g., shame, dysphoria), cognitive (e.g., discontent, desire for change), and behavioral (e.g., avoidance, concealment) aspects of an individual’s reaction to his or her perceived physical being (Cash & Pruzinsky, 2002; Davison & McCabe, 2005)

The entire human is seen as pieces and not cohesive... a dualistic point of view on how cosmetic surgery works. Ulloa’s quote at the beginning of this chapter speaks to one of my most bothering question about cosmetic surgery – does doing a physical action

alter the sense of self more than a nonphysical action/thought change? Covino (2010) argues yes, that by improving the body the mind grows happier in self-confidence while the soul remains unchanging. By having cosmetic surgery to make the mind happier with the body, the entire harmony of body, mind, and spirit is accomplished.

One study found evidence that this idea of changing the physical self alters the sense of self. Aitken (1969) found women undergoing breast surgery successfully changed their body image, and over the course of 6 months their femininity and sexual attractiveness views increased. Grossbart and Sarwer (1999) hypothesized that when body image improves, there are changes in emotional states, improved interpersonal relationship's, and altered reactions of society to that person. And by changing interpersonal relationships, body image can be improved, too. Yet there have been very few studies on how genital self-image is affected by genital cosmetic surgery, and this specific paragraph ignores the injustices in society that drive the inadequacies in the first place

As seen in Chapter 5, most of the causes, if not all, for getting cosmetic surgery are to appear more presentable and acceptable to yourself and others in our American social context. Sarwer and LaRossa (2003) say most satisfied patients get surgery to improve self-esteem, improve confidence, and align inward sense of self/feels with outward appearance.

But cosmetic surgery and our society's ideas of beauty prey on this idea and enhance the view...

With the rise of commodity culture and widespread uses of fracturing women's bodies into a series of parts—whether showcasing their “dismembered” legs on television, asking women to care about the size of their butts, or focusing on the shape and quality of breasts in advertisements—women have overwhelmingly learned to internalize notions of their bodies as not entirely whole. (Fahs, 2014, p. 210-211)

A hard part about understanding the phenomenon of increasing cosmetic surgeries is that there is still less understanding about the female body than the male body, especially in terms of sexuality. Female sexuality is very complex, as the anatomy and psychology play large roles in female pleasure and orgasm (Barbara et al., 2015). If a woman is dissatisfied with her physical appearance, she is likely to have a heightened self-consciousness about how she looks, and that will cause a “devaluation of herself as a sexual being and ultimately threatening to her sexual safety and satisfaction” (Schick, Calabrese, Rima, and Zucker, 2010, p. 395). Schick et al. (2010) wrote women’s preoccupation with how their bodies look in sexual activity can make their sexual experiences lower in quality. Snell and Papini (1989) describe sexual esteem as being “positive regard for and confidence in the capacity to experience one’s sexuality in a satisfying and enjoyable way place” (p. 256). Likewise, Mayers, Heller & Heller (2003) describe sexual self-esteem in a similar manner as it being “the value one places on oneself as a sexual being” (p. 270). Nonetheless, while surgery may enhance sexual self-esteem, cultural changes such as realistic vaginas and vulvas in pornography and outlawing the use of Photoshop in advertising and pornography may lead to less painful

methods for enhancing sexual self-esteem. Low sexual self-esteem may simply be a symptom of male oppression, and a male dominated FGSC system may be the male answer. However, is it the best answer for women?

As porn, movies, and images of media portray women with an “unnatural genital appearance ideal”, women have a larger chance of being threatened and having lower satisfaction with their own bodies (Schick et al, 2010, p. 396). By adolescence, females have seen endless advertisements, movies, TV shows, etc. that display how a young woman should look, dress, and behave. From an early age, females internalize this social construction (Schick et al., 2010). There are even phone app games for young girls to give different characters – boyfriend, celebrity, etc. – a cosmetic plastic surgery makeover. As a female teenager grows, her sense of self degrades and lowers, as she has so many expectations to reach. A woman first experiences the “culture of sexual objectification” during adolescence when physical changes they have make them aware of being complimented or criticized not as an integrated body but as a collection of body parts. This can make women more concerned about their individual body parts (Schick et al., 2010). Neighbors and Sobal (2007) conducted a survey that found that 90% of female college students reported dissatisfaction with their body weight. Schick et al. (2010) performed a study on female college students in America looking at physical appearance and sexuality. They found that genital appearance dissatisfaction has a negative impact on genital image self-consciousness and sexual esteem, which leads to have harmful consequences on sexual risk and sexual satisfaction. Appearance is linked strongly to personal identity.

Chapter 8: My Thoughts

Part I – Are You One, Two, or Three Entities?

The hardest question I had while creating this thesis is “do you change the outside to change the inside, or the inside to change the outside”? In other terms, do ‘you’ exist as two separate entities, an inside and outside – a mind and a body? Or is the concept of ‘you’ one entire entity, and changing a piece of you changes the entire piece?

If considering ‘you’ as a single entity, a non-dualistic look at one’s sense of self, changing anything about your thoughts, actions, outer experiences and perceptions, or language, will have an impact on everything else that you define as your entire self. From a neuroscience perspective, the neurons wired in certain patterns of firing with certain neurotransmitters create the thoughts and movements and entity of you. There is no distinction from who you are as a whole and you cannot be against yourself. When you die and the neurons stop firing that is the end of your entire existence.

In terms with body image, if you believe you look bad (mind does not feel in union with body) or you are not in figure with your internal true sense of self, this can bring about the dilemma of creating a division in internal and external self, thinking of the body as not aligned with one’s internal perception.

This is the common theory of dualism established and supported in most fields of western societies: that matter (body) and mind are separate. Even the psychological terms we use to describe feelings have a reference back to dualism. As stated earlier, the

Oxford English Dictionary defines body image as, “the subjective picture or mental image which a person has of his or her body, esp. (in later popular use) in relation to its shape” (Oxford University, 2010).

Likewise, the disparities and alterations the mind can place on our sense of self can contribute to an unrealistic view of the world (ie thinking one is too fat). Like the sense that your body has gone ‘wrong’... but has it? What do you listen to internally to find truth? Your outer body or your inner mind? Or do you have to listen to an outer voice?

Part II – Are You under Your own Choice?

Why do you exercise? This question is so simple to answer, yet such a complex analysis of what that answer means. If you answer, “I exercise to stay healthy,” vs. “I exercise because I need to stay healthy” vs. “I exercise to feel good” vs. “I exercise to look good” vs. “I exercise to eat more” etc., etc. Are these all valid reasons to exercise? What about “I exercise because the magazines, school, and government have ingrained a cultural idea into my mind and I take that to internalize and consciously project it as my own thought, that I have to exercise in a certain manner with certain clothes in a certain way to stay ‘healthy’”?

To put the question of validity into another question, why do you (i.e.. a woman in her 20s) get a Brazilian wax? Is it for yourself to feel clean? Is it to please your partner? Is it because in the year 2016 it is the ‘norm’ for young women (and more so men too) to be a hairless body minus the high maintenance head hair and eyebrows? I would suggest this is another example of the internalization of our social experiences, for

we do not live in vacuums and reflect solely off of our own thoughts and beliefs. If a woman reads magazines with beauty articles, views pornography, listens to the news, talks to friends, and saw or heard about the way women should look, did she truly make an autonomous choice in waxing herself? Where do you define the border between self and society in making decisions for your body and mind that exist surrounded by that societal pressure?

Economically yes, the woman made an autonomous choice, since waxing is a direct financial payment from consumer to business, a contract in getting a hairless body in exchange for money. But after this the practice becomes ingrained into your self-perception. Same for exercising, you will pay to go to a gym, or pay for equipment to use. And the reasons for exercising may differ each time you go. The reasons for waxing may differ as well. The important consideration is who are you doing this for? Are you looking thin/feeling good/appearing hairless for yourself? Or for others? Does it even matter if you internally feel good?

And why not appear good for both you and others? I believe this is where most if not all of our decisions fall, including the decision for FGCS. Because FGCS is in such a private body area one can almost see it as a change for yourself solely. To feel sexual satisfaction again, have confidence in your body... those are all personal goals towards having healthy tissue cut away. But at the same time, this area of your body is one you intimately share with a lover, someone you trust, someone you want to make happy. The utility of FGCS may be worth the financial and psychological payments, but this is still an inconclusive statement in the scientific and medical fields.

Part III – How Do We go Forward with Unanswered Questions?

Finding who you are, what is true, and what creates a meaningful life are all philosophical questions that cannot be answered by one person but must be answered by us all in our own ways. Our own journeys through and between the outer physical world and our inner mental world, construct the way we view our physical bodies and our mental body image. Our sense of independence and utility also add into the decisions we make. The thoughts we establish as our own must be questioned, as one must ask, “Why do I think this way” (without going insane).

At what point will you be satisfied with yourself? How much money, time, and effort do you need to spend on products to become a better person? Only you can decide that, yet the influences of society are always with us. Creating a sense of self separate from the pressures of society, family, and friends can be one of the toughest mental constructs to create. If you want to alter your breasts, nose, eyelids, vagina, penis, who knows those organs better than you? You determine your sense of self-worth and how much that flesh is worth in dollars and time and pain. The body can be viewed as the agency of the soul and can reflect the inner goodness (Covino, 2001).

One should always question the role of mirrors, magazines, friends, other people, and objects surrounding your existence when the self is unsatisfied, as they all reflect you and sway you simultaneously. If one’s self is unsatisfied in the body this negative attitude towards the body can contribute to a lower self-esteem. This doesn’t make the process of accepting yourself or changing yourself any easier. In fact, looking at yourself and your surroundings too analytically can become a mentally taxing route to take. But, I believe

in this day in age, where eleven year old girls are taught to dress a certain way, to start wearing makeup, where twenty-two year olds will consider removing healthy labia minora tissue to make their self-confidence increase and where aging mothers feel the cost of childbirth is a burden to their sexual lives, it is the time to reflect and consider where we are headed. Mental disorders are rampant among young men and women with pressures of body image and diet

And the mental health of women is not being fixed or improved by the cultural influences of beauty magazines, pornography, and cosmetic surgery. Yet our society throws out the suggestions to either: Accept yourself, get surgery, work it off, wear chemicals and clothing to create an image... Sometimes the same women's magazine can have messages about improving self-esteem while a page away is how to put on the perfect eyeliner, followed by ab workouts to improve sex with a model doing crunches in a bra and short shorts.

How does one make oneself more in tune with their self image? Cosmetic surgery is a way for a woman "to renegotiate her relationship to her body and through her body to the world around her" ... not "just a body" but "a subject with a body" ... woman doing the best she can in a "sexist, ageist, and deeply moralistic environment about physical appearance" (Davis, 1995, p.5). There are many views and theories, opinions and facts, on how to live and how best to live true to oneself. And it may never be a fully completed question. The best way, I believe, is to find a self-image that is true and holy to what you are made of, your identity of your soul, and the way you envision your body and self interacting with the world.

Chapter 9: Conclusion & Personal Statement

Why does female genital cosmetic surgery matter in the great scheme of things, where there is economic strife, poverty, inequality, and more important factors that affect a greater proportion of the world? I think this topic highlights to where we are heading in terms of sociocultural beauty and what it means to be a human with a sense of self determined by others. This topic of FGCS broadens to how our society looks at beauty, standards, and diversity.

Barbara et al. (2015) believe FGCS won't be stopped, but it could be regulated better through more psychological counseling. For any elective surgery, there are four criteria to be considered before the patient goes under the knife: the psychological and surgical goals must be realistic, that there is a good chance of success towards those goals, the patient understands that there is "no guarantee of a specific or perfect results or of absolute personal satisfaction, and that the patient has psychological maturity to deal with complications (Adamson and Chen, 2008, p. 196). Ericksen and Billick (2012) also indicate that certain patients should avoid surgeries, such as those undergoing or avoiding a life crisis, are unhappy with a previous surgery, have BDD, a sexual dysfunction, or are cross cultural patients. Transgender surgery is another controversial surgery that was unexplored in this thesis as it could be seen as functional and not cosmetic depending on the party.

FGCS still has consequences that many women do not know, and this could be prevented through more research and education (towards physicians and consumers alike). “Physicians must be aware that perceptions may be influenced by a distorted perception of normal or a desire to restore anatomy because of age and child-bearing. As physicians, we are obligated to educate our patients on the variation in vulvar anatomy and potential risks of these surgeries.” (Yuteri-Kaplan et al., 2012, p. e6). There *must* be education to patients to help them understand in the best of terms what the doctor can do, may do, and can’t do.

Yet, education can only go so far. Women, unaware of the wide range of labia sizes that are normal, because only one form of vulva is depicted in media (Cartwright & Cardozo, 2008). Even when women know and accept that labia vary and that their labia are entirely normal, they could still have feelings of ugliness or abnormality (Veale et al., 2014). This is why educating the general public on the normal variations is very critical. Artists create sculptures, paintings, and other art works that depict the variations of genitals as well that give the message of diversity. (One artist, Jamie McCartney, has created several panels of molds of vaginas so show how diverse women’s genitals are, see Figure 2.) This is not to say pornography or pornographic messages should be banned, as I cannot speak for these areas with the limited research I have done. However, the way the pornography and pornographic-media has increased, the standards *must* be reconsidered to help decrease mental disorders and raise confidence and self-esteem in both men and women alike.

Body modification arises ethical, philosophical, and policy questions to how our society will change over time. Cosmetic surgery will keep promoting anxieties of body image which it tries to stop, thus keeping the cycle of surgery continuing and propagating as more and more women get surgery and see and hear more about the surgeries of celebrities and other women (Elliott, 2008). Donohoe (2006b) believes the media should portray characters and celebrities with values based upon personal, intellectual, and emotional attributes rather than superficial, outward physical characteristics.

Not only is it a physician or artist or advocacy group's responsibility to educate, but also the consumer's duty to become aware of their own bodies, surgeons, and procedures. Kuczynski (2006) says, "Only accept physician board certified by the American Board of Plastic Surgery. Consumers not as assertive, because surgery is about their vanity, and patients feel they don't have right to fully ask a question about the doctors' credentials. Or they are women and have grown up learning not to confront, especially male doctors" (p. 244). By having an awareness of the way the cosmetic surgery industry works, through self-research online and talking to reliable friends, and becoming an advocate for one's self as a patient, women can make the right decisions as the right time for themselves and no one else.

There are so many studies and research that still needs to be conducted. Future studies include comparing outcomes of aesthetic surgery and urogynecology in terms of anxiety, depression, body image, sexual function, and global satisfaction (Cartwright & Cardozo, 2014). Veale et al. (2014) suggest looking at the motivations for women who have BDD or without BDD. The long term psychological and functional outcomes of

women five, ten, or more years down the road from FGCS must be researched, too (Dobbeleir, Van Landuyt, & Monstrey, 2011). Psychosexual counseling is important as well to consider and can be part of the reassurance and education before a woman decides to alter her body.

I hold my stance that there must be more research before FGCS can continue to grow, as well as the fullest education possible for women to understand the many components that affect their decision to alter an intimate and a sometimes deemed ‘ugly’ area of their body. But it’s not.

I believe reconstructive surgeries are a necessary and vital surgery to continue forward, as women who suffer incontinence, prolapse, and other wounds and diseases postpartum. But deriving from pain and suffering to normality seems to be different than going from normality to artificial brilliance. Soraya Miré, a writer, director, and activist on FGM disclosed:

I’ve learned that American women look at women like me to hide from their own pain... In America, women pay *the money that is theirs and no one else’s* to go to a doctor who cuts them up so they can create or sustain an image men want. Men are the mirror. Western women cut themselves up voluntarily. (Muscio, 1998, p. 134-5)

I cannot know what is best for someone else, only what is best for me if at best. We are normally fighting death, fighting aging, fighting change. As one woman wrote, “I’m fifty-seven and I look thirty-seven. I’d rather spend my money on Botox and a procedure here and there than something that is not a part of me. All we have in this life

is ourselves, and what we can put out there every day for the world to see. The world is not going to see my great record collection or the stuff I have at home. They're going to see me. And Me is all I got.” (Kuczynski, 2006, p. 82). Do all we have is our body, or is there more depth to ourselves to give away? Is it just skin deep they're going to see? Can we find hope that we, as collective humans, will see more than skin deep?

So much research has been done on how our culture insinuates the drive for cosmetic surgery and body insecurities. The activist organization dosomething.org reports that over 40% of women and around 20% of men reported in a survey that they would consider cosmetic surgery in the future – regardless of gender, age, marital status, or race, this finding was constant. Another statistic they report shows that college students, particularly women, who are mass consumers of media place a higher importance on appearance and sexiness than those who do not consumer as much media (“11 facts”). And people who watch more reality cosmetic TV shows make up a large proportion of women who end up getting cosmetic surgery (Kron, 2015). Another example, by Brown University health website, stated that negative body image and thinking about oneself and “feeling fat” can be ways for yourself to not deal with larger problems in life.

All of these studies give the outstanding revelation that most people know but never take for granted – you are what you see and experience externally. The external media, friends, and environment directly affect your inner mind. The prevalence of cosmetic surgery is ever increasing in more extravagant or absurd formats, as well as the amount of advertising done for cosmetic services.

The documentary *The Illusionists* illustrates the globalization problem of beauty and the beauty markets created by corporations for profits. Susan Linn, an educator on the effects of media on childhood, writes about how society is owned by a handful of corporations that define masculinity, femininity, and sexuality. But it is a basic human right to decide our own world, not corporations. The documentary continues to offer the best way to fight back is to use the Internet, which levels the playing field and allows average people to generate attention and create a digital army (Burger, 2006). Individuals must take a fight and recognize who they are, where they are in regards to quality and quantity of media absorption, and – especially for young women – take and embrace what it means to be a gratified human being.

The National Eating Disorders Association (NEDA) gives a list of ways to turn negative body thoughts into positive thoughts that include the following: appreciate what your body can do; remember that true beauty is a state of mind, not a state of your body; look at yourself as a whole person, not specific body parts; surround yourself with positive people and positive thoughts; become a critical viewer of social media messages, and “use the time and energy that you might have spent worrying about food, calories, and your weight to do something to help others” (NEDA, n.d.).

Likewise the New View Campaign, a grassroots organization from New York, advocates against the over-medicalization of sex. They have several messages for women and the entire U.S. society, summarized by Tieffer (2001):

- “Vulvas are beautiful, multicolored and no two are alike
- Female genital surgeries have consequences

- The Food and Trade Commission should ban ads promoting cosmetic genital surgery
- Long labia are normal and desirable
- Women should keep their vulvas away from the surgeon’s knife
- Women should oppose the marketing of designer vaginas
- Genital cosmetic surgery guarantees no satisfaction
- There is need for more scientific research and none for advertisements promoting violence against female genitals”

Before and throughout this thesis, I have realized that I have a body image problem and a negative body image. Since junior high that I have never been happy with my weight or how I looked for over a 24 hour period and it is hard to be positive about my body on a daily basis today. Through this thesis, my negative body image is becoming more revealed to me, and am I starting to recognize how big of a parasite it is and how much it affects my daily life. I see other women my age on campus, on television, on advertisements, that all seem more gorgeous. I’d stress myself to eat better, eat less, work out more, find a perfect outfit to cover my ‘flaws,’ and worry more and more. But as I can give myself the ability to feel sad and uncomfortable in my body, so can I let myself see who I am as a beautiful woman. What type of power and control over my feelings am I giving to a weight? Too much. For it doesn’t matter how my body looks... it’s how my soul feels in my body and what I surround and put into my body.

This is why I want to pursue a career where I can work with women in a holistic manner – to encompass the physical, mental, and spiritual components of what makes that person unique and holy – to empower them to explore their thoughts and actions, analyze the society and environment around them, and make the best choice for

themselves and for their health. For I believe health is where the spirit finds a home in the body... where your soul is comfortable and feels welcome to be in the physical body, no matter the size, shape, or color.

I cannot have a final summarizing statement, for this topic has been narrowed and broadened through my research and involves so many components I could spend years researching and still feel as if I know nothing. I think cosmetic surgery will never go away and will continue to have a presence in our American lives. The world grows in love with cosmetic surgery and creating a 'perfect', beautiful body, which implies a perfect human. And the ways the surgery can now be done in such intimate, sexual areas propels the need to explore what makes our world today a better – or worse – place to live in. Women who have undergone FGCS praise what it has done to them in terms of loving themselves and their bodies more. But would they love their vaginas more if the cultural portrayals of what gives a woman a good and meaningful life changed?

Is it fair that a surgery is looked down upon if its main goal is not to fix a problem but to augment sexual sensitivity? Vaginal rejuvenation, clitoral hood reduction, and other surgeries have this purpose. Creating a more beautiful labia minora can increase a woman's confidence and sexuality – is this a bad thing that needs to be stopped? No, I believe it shouldn't be stopped. But a woman pursuing her goal towards creating a better vulva should reach a stoplight and pause to look around herself. She needs to look at whether she is driving that decision or is solely a passenger in the car driven by her partner, a pornstar, her plastic surgeon, advertisers, or society, for they could also be a backseat driver.

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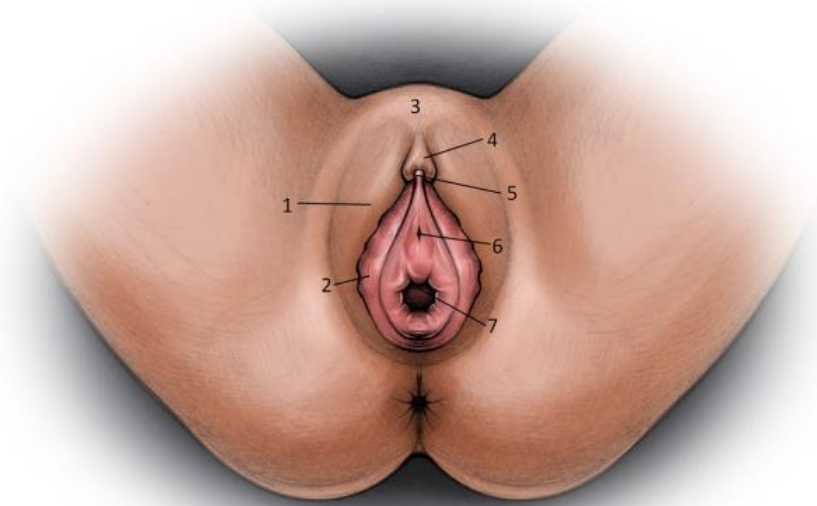
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Illustrations



<http://asi.oxfordjournals.org/> by guest on January 13, 2016

Figure 1. Illustration of the female genitalia, with anatomic areas indicated: 1, labia majora; 2, labia minora; 3, mons pubis; 4, clitoral hood; 5, glans clitoris; 6, urethra; 7, vaginal opening.

Figure 1. Illustration of the female genitalia, with anatomic areas indicated: 1. Labia majora; 2. Labia minora; 3. Mons pubis; 4. Clitoral hood, 5. Glan clitoris; 6. Urethra; 7. Vaginal opening. From Triana & Robledo, 2015



Illustration 2. The Great Wall of Vagina Panel 4, from McCartney

Table 1. List of procedures that various doctors perform across the country.

Note. This is a relative generic example of the vast differences in some procedures and

Procedures	Dr. Troy Robbin Hailpam, San Antonio	Dr. E John Serrao, Orlando	Dr. Aguirre, Denver	Dr. David Matlock, Los Angeles	Dr. Ronald D. Blatt, New York
Labiaplasty (& related)	x	x	x	x	x
Enhancement of Labia Majora	x			x	
G-spot amplification	x	x			
Hymenoplasty	x	x	x		x
ThermiVA	x	x			
Mons pubis liposculpting	x	x		x	
FemiLift®			x		
O Shot®			x		
Vaginoplasty (& related)		x	x	x	x
Wonder Women/ Real Mommy MakeoverTMs			x	x	
Labia majora augmentation				x	
Clitoral Hood Reduction					x
Mona Lisa Touch					x

similarities in others. (Aguirre Specialty, 2015; Manhattan Center, 2015; Cosmetic

Gynecology Center of San Antonio, 2016; Serrao Rejuvenation Center, 2015;

Procedures, n.d.)

