SISTERS ARE DOIN’ IT FOR THEMSELVES:
A PHENOMENOLOGICAL INQUIRY INTO THE EXPERIENCE OF
LABIAPLASTY

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DECLARATION

I declare that the work contained in this dissertation is my own original work, and that I am the owner of the copyright thereof (unless explicitly stated otherwise).
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ABSTRACT

This study explores women’s experiences of labiaplasty, which is a newly emerged procedure in the field of cosmetic industry performed on external female genitalia to alter the appearance and address discomfort with clothing, exercise and intercourse. It draws on very intimate and candid in-depth interviews with adult women living in Western Europe who have undergone labiaplasty following a lengthy and multifaceted decision-making process. Utilizing a time oriented process inquiry, this project firstly explores women’s lives before the surgery including their motivations for the procedure, the immediate social environment in which decisions to have labiaplasty were anchored and the complex decision-making process. Secondly, the study focuses on women's relationships with their surgeons, their experiences of the surgery and the recovery process following labiaplasty. Lastly, this piece reflects on the identified outcomes post-surgery and insomuch elucidates the experienced changes in women's body image, physical functioning and sexual pleasure as a result of having the procedure. Furthermore, the study also includes an exploration of participants’ views on gender, physical appearance and the contemporary Western culture in order to provide a backdrop against which women’s experiences of labiaplasty may be viewed. Specifically, drawing on a large body of research emanating from feminist scholarship and social psychology, this study explores the socially and culturally driven pursuit of female physical perfection, which is associated with the acquisition of economic, social and symbolic capital. Employing a qualitative phenomenological approach with its ‘person-in-context’ perspective, the research examines how women negotiate their subjectivity in this circumscribed socio-cultural environment. Ultimately, this study aims to shed light on an intimate procedure that has never been studied in this fashion before, and to heighten the understanding of a delicate interplay between a woman’s physique and her psyche in the context of elusive beauty standards and omnipresent gender inequality.
STATEMENT OF ORIGINAL AUTHORSHIP

I hereby certify that the submitted work is my own work, was completed while registered as a candidate for the degree stated on the Title Page, and I have not obtained a degree elsewhere on the basis of the research presented in this submitted work.
1. INTRODUCTION

1.1. INTRODUCTION

The aim of this chapter is to provide a succinct yet comprehensive introduction to the in-depth study of women’s experiences of labiaplasty, a newly emerged procedure in the field of cosmetic gynaecology. The chapter will firstly reflect on the background of the study and the researcher’s previous experiences that have ultimately resulted in this project. It will then outline the rationale for this specific research and insomuch reflect on the observable upward trend in female genital cosmetic surgery across the Western world, and an absence of qualitative studies of the aforesaid phenomenon conducted from a social science and feminist perspective. Noting the currently available empirical studies of female genital cosmetic surgery conducted often by medical practitioners (Veale et al. 2013, Dobbeleir et al. 2011, Crouch et al. 2011, Bramwell and Morland 2009, Howarth et al. 2010, Karkazis 2010, Loyd et al. 2005, Goodman et al. 2009, Rouzier et al. 2000, Liao and Creighton 2007, Michala et al. 2012, Essen and Johnsdotter 2004, Liao et al. 2009, 2012, Cain et al. 2013) and mainly qualitative studies of other body procedures undertaken by feminist scholars (Wolf 1991, Jefferys 2005, Bartky 1990, Braun 2005, 2009, Parker 2009, Bordo 2003, Davis 1991, 1995, Gimlin 2000, Kaw 1997), the chapter will demonstrate how this thesis aims to fill an identified gap in the body of knowledge pertaining to elective genital procedures. This chapter will also include a brief overview of the currently available empirical studies on female genital cosmetic surgery, which have been conducted mainly by the international medical community. Although these studies provide an important introduction into the subject, this chapter will also argue that their contribution is somewhat restricted due to the utilized methodological approach. In that context, it will be indicated why this study is innovative in reaching an in-depth understanding of women’s experiences of labiaplasty. The chapter will also outline the overarching research question guiding this project, and the four subsidiary research questions underpinning the main question. In order to enhance readability it will provide an explanation of relevant terms such as female genital cosmetic surgery, labiaplasty and body work, which will be employed throughout the piece. This will be followed by a concise summary of the methodological underpinnings of the study.
This subsumes an overview of the research principles endorsed in this thesis, data collection process and subsequent analysis. The chapter will also discuss the ethical issues pertaining to this study and the mechanisms employed to ensure that this research is conducted in accordance with the highest academic and ethical principles. Inevitably, this research did not manage to address all possible issues that emerged in the study of women’s experiences of labiaplasty, and these were identified as the limitations of the study. Lastly, the chapter will provide a complete overview of the thesis in order to set the scene for the subsequent chapters, and to enable the reader to easily engage with the piece.

1.2. BACKGROUND OF THE STUDY

I often say that I did not choose the topic of female genital cosmetic surgery and labiaplasty specifically, but that this topic chose me. I applied to this doctoral programme in January 2013 with a completely different research subject – forced marriage. I had the perfect thesis title: *What’s Love Got to Do with It? Negotiating Forced Marriage and Gender Equality*, and a well-researched proposal. However, in February 2013, after I was already admitted to this research degree, I shortly volunteered for a London-based NGO called the Iranian and Kurdish Women’s Rights Organisation IKWRO. The organisation held a large pan-European conference on female genital mutilation (FGM) in cooperation with Amnesty International, during which I assisted with some minor tasks. In between making coffee and sandwiches – what then felt like a waste of my time and skills – I got the chance to attend a few lectures. It was then that I first heard the term ‘designer vagina’, which is a sensationalist term for female genital cosmetic surgery. Specifically, one contributor from the Netherlands asked whether we can still condemn FGM that occurs in the ‘developing’ world in the light of the increasing demand for ‘designer vagina’ in the West. This question did not yield a heated debate as one would anticipate, but it had an important impact on the course of my life. Namely, that was the day that my PhD topic was conceived.
I initially considered exploring the aforesaid dilemma of condemning and criminalizing female genital mutilation/cutting in the Global South and yet condoning and advertising female genital cosmetic surgery in the Global North. However, it became apparent early on that the latter research topic would require a different methodological direction than the one I wanted to employ. Namely, that topic would have probably required a discourse analysis of some kind, whilst I was eager to converse with women who have undergone an elective genital procedure. In other words, it was the preferred methodological approach that had the most significant impact on the definition of the research problem. As I chose to focus exclusively on female genital cosmetic surgery and labiaplasty specifically, I encountered a surprising paradox pertaining to the issue. Specifically, it seemed that wherever I looked everyone had an opinion on elective genital procedures – including myself – and yet no-one seemed to have made an effort to engage directly with those who are most affected by the issue at stake – women themselves. Therefore, I began what would become an exceptionally challenging, lengthy and complex process of locating women who have undergone a genital cosmetic surgery, and wished to be interviewed about it. Little did I know at the time what would be the final outcome of this pursuit.

1.3. RATIONALE FOR THE STUDY

Even though one of the first mentions of labia reduction – a type of vaginal surgical procedure today known as labiaplasty – dates back to 1976 (Cain et al. 2013), it took more than two decades for American plastic surgeons to start advertising female genital cosmetic surgery (Moran and Lee 2013). Despite very limited data on risks and benefits associated with female genital cosmetic surgery (FGCS), there is an observable upward trend in female genital procedures across the Western societies. This primarily applies to the two most popular female genital procedures – labiaplasty and vaginal tightening. To illustrate, the number of labiaplasties in the UK performed solely on the National Health Service (NHS) more than doubled from 404 in 2006 to 1,118 in 2008, while the leading national cosmetic surgery provider received more than 5,000 enquiries for cosmetic gynaecology in 2010 (Davis 2011). In Australia the
number of requests for labiaplasty increased from 200 to over 1,500 per year throughout the last decade (Ussher 2011). In the USA over 3,500 vaginal rejuvenation procedures were performed in 2012, which is an increase of 64 per cent in comparison with 2011 (ASAPS 2013). In Ireland, one Dublin-based clinic notes an exponential 5,000 per cent increase in female genital cosmetic surgery throughout the last decade, from one request annually to one request weekly (Reynolds 2012). These numbers seem to suggest that there is something – possibly cultural – happening with regards to women’s perceptions of their external genitalia, and the associated normalization of genital cosmetic procedures.

Although there is evidence of increase in female genital cosmetic surgeries including labiaplasty, the baseline data remains very limited as will be indicated in this chapter. This is possibly due to three interrelated factors. Firstly, the field of elective genital surgery is a newly emerged one, which probably explains why very little attention has been dedicated to this issue to date. Secondly, female genitalia including genital dissatisfaction and modification is as a sensitive subject and some reticence in speaking publicly about it is to be expected. Finally, the majority of women’s requests for elective genital procedures seem to go through the private sector, which is often not audited and regulated. These three issues in conjunction seem to be the reasons why still astonishingly little scientific material on elective genital procedures is readily available. Nevertheless, the Western researchers have conducted some valuable empirical studies on female genital cosmetic surgery (FGCS) often from a medical perspective. These studies provided an overview of the possible genital surgical procedures (Dobbeleir et al. 2011), clinical characteristics and expectations of women requesting FGCS (Crouch et al. 2011), genital appearance satisfaction (Bramwell and Morland 2009), visual depictions of female genitalia (Howarth et al. 2010), norm and normality in regard to female genitalia (Karkazis 2010, Loyd et al. 2005), outcome data of FGCS (Goodman et al. 2009, Rouzier et al. 2000), clinicians’ response to requests for FGCS (Liao and Creighton 2007, Michala et al. 2012), legislation on female genital mutilation and the implications for FGCS (Essen and Johnsdotter 2004), online advertisements for FGCS (Liao et al. 2012, Moran and Lee 2012) and ethical and rights dilemmas associated with FGCS (Cain et al. 2013). Although very helpful in providing a better understanding of elective genital procedures including labiaplasty, these mainly quantitative inquiries did not attempt to examine in depth
women’s motivations for, the experiences of and the outcomes of these procedures – from women’s perspectives.

On the other hand, feminist scholarship of the body has examined beauty and body practices – including cosmetic surgery – and framed these as an instrument of women’s oppression, a cultural discourse and an opportunity for the exercise of female agency in a circumscribed socio-cultural context. The ‘oppression’ model views beauty practices as a social and political instrument introduced, and supported by men, to maintain women’s subordinated social position (Wolf 1991, Jeffreys 2005, Bartky 1990). The seemingly more liberal ‘cultural discourse’ model emphasizes that women’s choices engage in beauty practices are always embedded in a specific socio-cultural context, and thus a reflection of contemporary norms pertaining to femininity (Braun 2005, 2009, Parker 2009, Bordo 2003). Finally, women’s involvement in a beauty regime can also be regarded as an exercise of ‘agency in a restricted context’, underlining women’s knowledgeable decisions to intervene into their identities and increase their autonomy within given societal limits (Davis 1991, 1995, Gimlin 2000, 2002, Kaw 1997). Although beneficial in furnishing the theoretical underpinnings of this research and providing a theoretical platform for analysing women’s experiences of labiaplasty, feminist theories of the body have paid very little attention to female genital cosmetic procedures up to the present time.

This doctoral research therefore aims to fill the gap between the empirical and predominantly quantitative studies on female genital cosmetic surgery including labiaplasty, and the primarily qualitative studies of face and body cosmetic procedures conducted by feminist scholars. Specifically, the aforesaid surprising lack of attention given to women themselves – who opt for elective genital procedures – is the main reason driving this study. This project therefore explores women’s accounts of labiaplasty including their motivations for the procedure, the experiences of the surgery and recovery, and the observable changes in their body image, physical functioning and sexual satisfaction as a result of having the procedure. Considering that women account for over 90 per cent of all cosmetic procedures in the Western world (Moran and Lee 2013), medical intervention for the purpose of enhancing one’s aesthetics is a gendered issue. For this reasons the study also explores whether women’s preoccupation with and investment in their physical appearance is a
response to the socio-cultural climate that values women primarily for their (impeccable) looks and often shuns other, significantly more important, dimensions of their identity. A large body of research emanating from social psychology – critically appraised in this study in chapter two – demonstrates a profound difference in the way the society responds to male and female physical attractiveness, or perceived lack thereof. This double aesthetic standard violates the principles of fairness and equality in the evaluation of men and women and arguably leads to women’s body image issues. In that context, cosmetic enhancement may indeed become an instrument for restoring women’s positive relationships with their bodies, increasing their self-esteem and self-confidence, and therefore enhancing their life satisfaction. This study therefore aims to unravel women’s intimate stories and experiences of labiaplasty, and to elucidate their relatedness to the socio-cultural environment that may shape their understanding of what is a ‘normal’ and ‘beautiful’ female body and which means, if any, should be employed to achieve it.

1.4. OVERVIEW OF EMPIRICAL STUDIES ON FEMALE GENITAL COSMETIC SURGERY TO DATE

As mentioned in the previous section, over the last decade primarily the international medical community – gynaecologists, plastic surgeons and to lesser extent psychologists – began to explore the issue of female genital dissatisfaction and modification by utilizing predominantly quantitative methodological approach. A complete overview of the empirical studies on female genital cosmetic surgery available to date is presented in Appendix IV: Matrix of Empirical Studies on Female Genital Cosmetic Surgery (FGCS). These empirical studies, very scarce in number, examine the issue of female genital cosmetic surgery including labiaplasty from various perspectives – very rarely however from the perspectives of women who had it. Taking into consideration that this particular project employs a woman-centred perspective, and it is therefore anchored in feminist theories of the body and social psychology, most of these studies have not been extensively examined in the main body of the thesis. Nevertheless, it seems appropriate and furthermore necessary to succinctly summarize the most important findings pertaining to empirical studies on
female genital cosmetic surgery available to date, in order to provide an important introduction into the subject. Insomuch this section captures what is to date known about patients’ rationale for elective genital surgery, as well as the risks and benefits associated with the procedure.

The available literature on the subject matter suggests that the reasons for undergoing female genital cosmetic surgery fall within two categories: physical and psychological. The most common reason why women undergo the surgery is predominantly psychological in nature: embarrassment and anxiety over their genital appearance (Crouch et al. 2011, Moran and Lee 2013). Yet, little research that is available demonstrates a significant correlation between genital appearance satisfaction and measures of general body satisfaction and self-esteem. Namely, one study suggests that what underlies women’s emphasis on their outward appearance, including genital appearance, is poor self-esteem (Bramwell and Morland 2009). However, the same study indicated that, surprisingly, every other surveyed woman did not feel their genitalia were ‘normal’ in appearance. The problematic definition of ‘normalcy’ was also encountered by Crouch and colleagues (2011) who surveyed and medically examined thirty-three women seeking labiaplasty. The vast majority of women emphasized genital appearance dissatisfaction as their main concern, even though all of the women were within the range of normal values of female anatomy. Furthermore, when informed of this and consequently deterred from the surgery, almost every other surveyed women decided to seek a second opinion.

There is an identified lack of descriptions of ‘normal’ external female genitalia and accompanying measurements in the medical literature (Lloyd et al. 2005, Howarth et al. 2013). One study of variations in female genital dimensions (Lloyd et al. 2005) explored measurements of external female genitalia including labia minora width and length in fifty premenopausal mainly White English women. The findings suggested that labia minora length ranges from 20-100 mm, whereas labia minora width – protuberance of the labia minora from within the labia majora – ranges from 7-50 mm. The authors found no statistically significant correlation between genital measurements and age, ethnicity, hormonal use or history of sexual activity. Their conclusion was that the women vary widely in genital dimensions – far more than previously suggested. Apart from the lack of knowledge pertaining to female genital
morphology, it can be also pointed out that the information available significantly depends on the source. For instance, a comparative study of more than two hundred images of female genitalia deriving from three different sources – online pornography, anatomy textbooks and feminist publications – found that the first two sources contained a less varied range of morphologies in contrast to feminist publications (Howarth et al. 2013). However, the authors emphasized that there may not be a causative link between the imagery present in online pornography and the increasing number of surgeries, for correlation does not imply causation. On the other hand, Australian researchers (Moran and Lee 2013) suggest that the possible reasons for the increasing demand in elective genital procedures include the narrow models of female genital ‘normality’ and the normalization of Brazilian wax – a complete removal of hair in the genital area, which leaves the area bare and open to scrutiny (and criticism).

To date studies also suggest that the physical reasons for undergoing female genital cosmetic surgery include discomfort with clothing, exercise and intercourse (Cain et al. 2013, Crouch et al. 2011, Rouzier et al. 2000), although they do not elaborate on any of these issues. Present research also indicates that intervention is often sought for physical reasons even when patients themselves did not believe that the operation would actually address the problem. One study (Crouch et al. 2011) showed that almost two thirds of participants complained of physical discomfort as the main incentive for the surgery, but only every fifth participant believed the surgery would actually improve their condition. In spite of these low expectations regarding the outcome of the surgery, the participants continued to seek surgery. Another argument against physical complaints as the incentive for the surgery was formulated from a different angle, by framing genital elective procedures as a gendered desire (Liao et al. 2007). In other words, whilst women may complain that their external genitalia pose a restriction on their lifestyle; men would not require their genitalia to be reduced for such reasons.

The benefits associated with female genital cosmetic surgery are not well-documented since very few studies have explored this subject in depth. However, a large cross-sectional study of more than two hundred American women who underwent an elective genital surgery attempted to examine patients’ satisfaction
following the procedure (Goodman et al. 2009). The results indicated that about ninety per cent of women were satisfied with the results of their surgery, and a significant subjective enhancement in sexual functioning for both women and their sexual partners was noted, especially in patients undergoing vaginal tightening or perineal support procedure. Another study of one hundred and sixty-three women who underwent labiaplasty in France suggested that one month postoperatively almost ninety per cent of participants were satisfied with the aesthetic result and ninety-three per cent approved the functional outcome (Rouzier et al. 2000). The authors concluded that labiaplasty is a simple surgical procedure associated with a high degree of patient satisfaction. In the UK the first prospective study of women who have had labiaplasty on the NHS and in the private sector aimed to explore the outcomes of the surgery (Veale et al. 2013). The authors compared forty-nine women who underwent labiaplasty with thirty-nine women who did not wish to have labiaplasty, in the attempt to determine long-term psychosexual outcomes following the procedure. Interestingly, according to the research, all of the women who wanted labiaplasty were within the normal range for the general population regarding labia measurements. The results indicated that more than ninety per cent of women showed clinically significant change in genital appearance satisfaction, but small-effect sizes were found for improvements in sexual functioning. These studies therefore suggest that genital cosmetic surgery may have a positive effect on women’s body image, but more research is necessary to ascertain whether the surgery has a positive effect on their sexual satisfaction.

On the other hand, a wide range of medical literature focuses on the risks and complications associated with the surgery (Cain et al. 2013, Crouch et al. 2011, Dobbeleir et al. 2011, Liao et al. 2007, Liao et al. 2012, Lloyd et al. 2005, Howarth et al. 2013). Specifically, physical complications occur in four to eighteen per cent of women and these include: visible scarred edge; loss of pigmentation; clitoral hood overhang; frenulum distortion; fistula and sinus formation; elevation and overtightening of the introitus; infection; and pain (Cain et al. 2013). In addition, female genital surgery may result in a disruption of nerves and blood vessels and thus impair women’s ability to experience sexual sensation and pleasure in the genital area (Lloyd et al. 2005). Lastly, one study suggests that poor surgical outcomes can lead to new surgeries, for up to eighty per cent may require further
reconstructive surgery (Lloyd et al. 2005). Another problem is that the providers of elective genital procedures often minimize risks and leave out evidence for clinical effectiveness (Liao et al. 2012). This also demonstrates how polarized the medical field is in relation to female genital surgery, for the moral position and monetary interests of those involved are not necessarily complementary. For the aforementioned reasons, several professional associations such as The American Congress of Obstetricians and Gynaecologists (2007), The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2008) and The Australian Federation of Medical Women (2012) have deemed female genital cosmetic surgery potentially unsafe and medically unnecessary.

However, does rendering female genital cosmetic surgery medically unnecessary inevitably imply that it should be avoided at all cost? Could there be circumstances under which undergoing labiaplasty is a rational and sensible choice? If so, which circumstances are those? For which specific reasons do women undergo labiaplasty? For instance, when empirical studies broadly suggest that women opt for labiaplasty due to genital appearance dissatisfaction, how does the aforesaid dissatisfaction manifest? Importantly, what causes it? What is the relationship between women’s genital appearance dissatisfaction and genital appearance anxiety? Moreover, how does a woman’s body image change following labiaplasty? Physical discomfort seems to be another incentive for the surgery, but how is it actually experienced by individual women? How does physical discomfort affect and possibly restrict women’s lifestyles? Which means are employed to manage it? Additionally, when research indicates that women seek labiaplasty to address discomfort with sexual intercourse, what exactly does that mean? How does that sexual discomfort come about, and in which way is it managed before the surgery? Also, what happens after the surgery? Does labiaplasty have any positive impact on women’s sexual pleasure and, if so, which? These are only some of the questions that this project will seek to address in the attempt to provide an insightful exploration of women’s experiences of labiaplasty.
Informed by the feminist research principles and a phenomenological approach, the central question underpinning this study is: *What are the motivations, experiences and reflections of women who have undergone labiaplasty?* This broadly defined and epistemologically openly research question is a reflection of the exploratory nature of the study, and furthermore it is in line with the guidelines of the principal data analysis framework employed in this thesis – Interpretative Phenomenological Analysis IPA (Smith and Osborn 2007, Mertens 2009). What underlines the central research question is a detailed exploration of the chronology of the lived experiences of labiaplasty as experienced by several individual women. This research also aims to situate participants’ accounts of labiaplasty in the Western socio-cultural environment that arguably reinforces women’s preoccupation with and investment in their physical appearance by rewarding it with social, economic and symbolic capital.

In order to address the central research question, the project utilizes a time orientated process inquiry by asking:

1. **In the pre surgical phase:** what were the participants’ motivations for labiaplasty, their immediate social environment in which decisions to have labiaplasty were anchored, and the decision-making process underlying surgery?

2. **In the operative phase:** what were participants’ relationships with their chosen plastic surgeons like, their experiences of the surgery and the immediate recovery process?

3. **In the post-surgical phase:** what were the identified changes in participants’ body image, physical functioning and sexual pleasure as a result of having undergone labiaplasty?

4. **What are participants’ views on gender norms pertaining to physical appearance in the contemporary Western culture?**
This research will therefore chronologically focus on the three specific phases of participants’ lives – the pre-surgical phase, operative phase and post-surgical phase – in order to provide an in-depth exploration of their experiences of labiaplasty. Importantly, the study will also include an exploration of participants’ views and reflections on gender, physical appearance and the contemporary Western culture. The aim is to explore participants’ relatedness to the socio-cultural environment that may have shaped their views of gender-appropriate norms, practices and relations, and insomuch to provide an important backdrop against which participants’ decisions to have labiaplasty may be viewed and analysed.

1.6. DEFINITION OF TERMS

The field of cosmetic gynaecology is still a developing one, which explains why there is no consensus on terminology utilized to denote elective genital procedures. A definition of female genital cosmetic surgery (FGCS) can be coined here drawing on the work of Dobbeleir and colleagues (2011) as it follows:

*Female Genital Cosmetic Surgery (FGCS) is an aesthetic surgery performed on ‘normal’ female external genitalia in order to improve the appearance subjectively and potentially provide psychological and functional improvement in sexual stimulation and satisfaction.*

It is important to mention that medical studies indicate that FGCS is performed on women who are within the normal range of variation of human anatomy, with no underlying condition that requires surgery (Cain et al. 2013; Crouch et al. 2011, Lloyd et al. 2005). This distinguishes aesthetic genital surgery including FGCS from reconstructive genital surgery, which is initiated for a functional or medical indication. In practice, however, a distinction between the two is not always easy to make (Dobbeleir et al. 2011). There is a wide range of procedures that fall under the umbrella term FGCS, yet there is no standard classification. A study of FGSC online advertisements (Liao et al. 2012) from the private UK and USA providers identified 72 procedures altogether, which highlights the impossibility of determining the exact
number of available procedures on the market. Nevertheless, the authors underlined that different terminology may actually refer to the same procedure, which is why they subsequently divided the available procedures into five general categories. These are: labial surgery, clitoral surgery, vaginal surgery, hymenal surger, non-specific vulval and perineal surgery, G-spot surgery and surgery to mons pubis. Also underscoring a lack of evidence-based literature and clarity on the subject, another study of FGCS (Dobbeleir et al. 2011) identified seven different genital cosmetic procedures including labiaplasty, vaginal tightening procedure, hymenoplasty, clitoroplasty, perineoplasty, pubic enhancement and G-spot amplification. Utilizing the latter classification of FGCS, this project initially attempted to provide an in-depth exploration of women’s experiences of any of the aforesaid seven procedures. However, the data collection process demonstrated that in the pool of cosmetic gynaecology labiaplasty is the most sought after procedure among the service users. This conclusion resonated with that of The British Association of Aesthetic Plastic Surgeons (2017) that asserts that the most popular among genital cosmetic procedures is labiaplasty. Following their definition of labiaplasty (BAAPS 2017) it can be argued that:

Labiaplasty, also known as labial surgery and labia reduction, is a surgical procedure that aims to decrease the size and degree of protuberance of the labia minora of the vagina. It is undertaken primarily to address the dissatisfaction with the appearance of one’s labia, and to alleviate physical discomfort with clothing, exercise and sexual intercourse.

Another term that may not require a strict definition but rather a further clarification is the term ‘body work’. Considering that labiaplasty is a cosmetic procedure, this research inevitably examined the feminist literature on cosmetic surgery in order to theoretically situate women’s accounts of labiaplasty. The feminist scholarship of the body explored in this study employs different terms to denote women’s changes on their faces and bodies for aesthetic reasons. These include, but are not limited to, beauty practice, beautification, beauty regime, body practices and body work. This project endorses the latter term inspired by the work of sociologist Debra Gimlin (2000, 2002) who provided a study of four types of women’s involvement in body
work including cosmetic surgery. Body work is considered to be an appropriate umbrella term for women’s work on their outer self for the following reason: in-depth feminist studies of female cosmetic surgery (Davis 1991, 1995, Gimlin 2000, 2002, Kaw 1997) including this specific study suggest that medical intervention into a woman’s outward appearance seems to have little to do with beauty itself. Namely, cosmetic seems to be more about seeking ‘normalcy’ rather than ‘beauty’, in a context where, arguably, ‘normalcy’ is radically redefined by the elusive socially and culturally situated standards pertaining to women’s bodies. In the light of that cognition, any term that utilizes the word ‘beauty’ seems to be somewhat inadequate, which is not to imply that the concept of beauty does not feature in women’s accounts of cosmetic surgery.

1.7. RESEARCH DESIGN

This study employs a qualitative phenomenological methodological approach and a woman-centred perspective in exploring women’s experiences of labiaplasty. Namely, the methodological lens employed in this research is informed by a qualitative stance (Creswell 2007, Neuman 2007, De Vaus 2001, Mertens 2009) and importantly by feminist research principles. These include an exploration of gender differences and inequalities; the use of in-depth qualitative interviewing that gives voice to women and analyses their experiences; the research aim that encourages female empowerment; and the researcher’s reflexive awareness (Cancian 1992). Feminist methodologies endorsed by this project are also evident in the employ of research concepts such as epistemological privilege (Haraway 1988, Harding 2008, 2009, Hartsock 1983, Narayan 2008) and feminist standpoint theories (Hekman 1997, Oakley 1998, Ramazanoglu and Holland 2002, Smith 1974). This will be explored in depth in chapter four. A phenomenological approach is chosen in order to position subjective experience at the centre of the inquiry, and to acquire a detailed understanding of labiaplasty as experienced by several women. Specifically, this study employs an innovative data analysis framework Interpretative Phenomenological Analysis (IPA) that is appropriate for researching complex yet intersecting issues including gender, sexuality and body image (Smith 2010, Smith
One of the greatest strengths of IPA includes flexibility and accessibility, which arguably makes it an increasingly appealing qualitative method of analysis. It facilitates the freedom to uncover and examine concepts that would otherwise possibly remain concealed. Also, by avoiding a priori closed theoretical assumptions about interpreting participants’ experiences, IPA remains epistemologically open about discursive, affective and cognitive inferences (Larkin et al. 2006). Furthermore, IPA is especially suitable for this study for its ‘person-in-context’ perspective, which subsumes the belief that people’s relatedness to their socio-cultural environment is an essential part of their constitution. Insomuch, it provides a platform for an exploration of participants’ embeddedness in the world around them that may shape their understandings of gender norms, values and relations.

The primary data collection method includes semi-structured interviews with five English speaking adult women, ranging in age from 29-51, who underwent labiaplasty in the last four years. Four participants had undergone surgery with Dr Lisa Smith (pseudonym) in the UK, and one participant had the surgery with Dr John Garcia (pseudonym) in South America. Using purposive sampling technique, four participants for this study have been selected in cooperation with their practitioner Dr Lisa Smith, whereas the fifth participant was located unexpectedly as a happenstance. The small sample size is consistent with the nature of phenomenological studies and IPA specifically (Creswell 2007, Smith and Osborn 2007). It is large enough to facilitate the identification of emergent themes and accompanying convergence and divergence across accounts, but small enough to enable a rich and multi-layered account of women’s experiences of labiaplasty. Furthermore, the small sample size is a reflection of exceptional difficulties encountered in the process of participant recruitment and inasmuch underlines that, despite the increasing demand for labiaplasty and related genital cosmetic procedures in the Western world, women’s dissatisfaction with their external genitalia still remains – a taboo topic.

The majority of the interviews – four of them – took place over the phone, whereas one interview took place at the researcher’s home. This appears to be mostly a reflection of the cross-cultural nature of the study and the encountered geographical
barrier. The chosen interviewing technique is in accordance with the feminist principles that aim to empower women in order for them to share their stories and experiences. In addition to that, semi-structured interviews are the most appropriate data collection method in IPA study for their adaptability, flexibility and the opportunity to facilitate rapport. The ability to facilitate rapport is also of vital importance for conducting so called sensitive research (Liampittong 2007). The interviews were recorded and transcribed verbatim, and a detailed qualitative analysis in accordance with the guidelines of IPA followed in order to identify, classify and interpret emergent themes. The write-up included a translation of major, superordinate and subordinate themes into a narrative followed by an interpretation of these themes.

1.8. ETHICAL CONSIDERATIONS

Full consideration has been given to the ethical dimension of this research. In October 2014, following the submission of a detailed application and supporting documentation, this study received Ethical Approval from the UCD Human Research Ethics Committee for the interviews with women who have undergone female genital cosmetic surgery. Special attention was given to participants’ emotional well-being. In order to alleviate any potential distress, the participants were informed thoroughly about the nature of the study, the data collection process and their right to withdraw from the study at any given moment. Well before the interview all participants were e-mailed the Information Leaflet for Study Participants (Appendix I) and the Consent Form for Study Participants (Appendix II), explaining in detail all aspects of the research. At the beginning of the interview the researcher asked each participant whether they had the chance to read both documents, and whether they had any questions about their involvement. Additional attention was given to the protection of participants’ privacy including anonymity and confidentiality. Anonymity was achieved by employing pseudonyms instead of participants’ real names, so that they would remain ‘nameless’ and therefore no-one would be able to trace the data back to a particular participant. Confidentiality was accomplished by keeping participants’ data secret from the public disclosure to ensure their physical, emotional and social well-being.
Informed by feminist scholarship, the methodological implications of this study included an acknowledgment of the researcher's positionality; namely how the researcher relates to the study professionally as well as personally. Furthermore, feminist research values endorsed in this study are reflected in the attempt to build collaborative research relations with the study participants and to facilitate rapport. Specifically, the semi-structured nature of the interviews provided participants with the space to share as much as they felt comfortable sharing, as well as the space to introduce new topics and let the conversation unfold in a way that was most suitable for each participant. Insomuch, the study participants also had a significant role in determining the course of the interview, which proved to be of a great value. This will be explored further in chapter five. Lastly, all participants received a MAC make-up voucher in order to thank them for their time, kindness and most importantly for their collaboration in the data collection process. Having adopted the aforesaid techniques, this research attempted to minimize the power relations between the researcher and the study participants, and insomuch aimed to produce a more trustworthy doctoral dissertation.

1.9. LIMITATIONS OF THE STUDY

The limitations of this study include the exceptional sensitivity of the research topic, the related size and composition of the sample, and the data collection method. The most important issue encountered in the study of women’s experiences of labiaplasty is the sensitivity and delicacy of the subject matter. The topic of female genital dissatisfaction and subsequent modification has proven to be an extremely difficult topic to research, for neither the service providers nor the service users wanted to enter a research space where reflections could occur. In other words, the elusiveness of the subject matter made the participant recruitment process exceptionally challenging. As discussed in chapter five, the twenty-six attempts mainly in Ireland and the UK over the twenty-month period finally yielded five study participants. Although in accordance with the guidelines of IPA, the small sample size inevitably poses limits to the generalizability of the findings. This ultimately means that the main findings of this study resulting from an analysis of five individual accounts cannot be
easily extended to the population at large. Furthermore, the composition of the sample includes women of various cultural backgrounds who have undergone labiaplasty in two different countries. The cross-cultural nature of the study was not expected, but rather it is a direct result of the aforesaid difficult participant recruitment process. Considering different ethnic backgrounds of study participants, questions can be raised about the variation in human anatomy across societies. Specifically, it could be speculated whether women of different ethnic backgrounds may also be shaped differently in the genital area, and therefore have comparatively smaller or larger labia. Expanding on that idea, it could be further hypothesized whether women of specific ethnic origins may be somewhat more predisposed for labiaplasty. These are important questions that have proven to be beyond the scope of this study, and more research is necessary to indicate whether these speculations are plausible and provable.

Lastly, with hindsight it appears that the data collection technique may have posed some restrictions on the topics introduced throughout the interviews. Namely, the longest and most intimate interview was also the only face-to-face interview, whereas all the other interviews were conducted over the phone. This is largely a reflection of the already mentioned cross-cultural nature of the study for the researcher did not live in the same country as the majority of the study participants. In addition to that, arranging face-to-face interview in a different country inevitably meant postponing them, and considering how difficult it was to locate women who wanted to reflect on their labiaplasty, this did not seem like a wise idea at the time. Nonetheless, it appears that a face-to-face interview facilitated trust and rapport between the participant and the researcher in a way that surpassed the closeness established over the phone. This in turn may have translated into a long and candid interview. Questions of very personal nature were sometimes not raised during the phone interviews because, being unable to see the participant and gauge their comfort zone, there was a concern that the questions may come across as intrusive and that the participants may withdraw from the project. In that context, the data collection technique may have had an effect on the nature and the number of questions asked during phone interviews, and therefore possibly on the length and the openness of the responses received. However, it needs to be highlighted that all of the questions listed in the Interview Schedule (Appendix III) were asked of all participants. Only
additional supplementary questions of a very personal nature – those that may be viewed as ‘threatening questions’ (Neuman 2007) – were not asked of the phone interviewees. One could also speculate that the opportunity to engage in a phone interview made it easier for participants to open up about their experiences of labiaplasty precisely due to a level of anonymity that is absent during face-to-face interviews. Furthermore, considering that the participants in this study were of different cultural backgrounds, one could also assume that the cultural differences may have accounted for variation in participants’ openness in reflecting on their experiences of labiaplasty.

1.10. CHAPTER OVERVIEW

This thesis is divided in nine chapters. The first chapter, *Introduction*, aims to set the scene for the upcoming discussion by providing the foundation of this project including a succinct overview of present knowledge about female genital cosmetic surgery, a justification for studying women’s experiences of labiaplasty and the methodological woman-centred approach utilized in this research. The second chapter *Literature Review: The Implications of Physical Appearance* will argue that women’s investment in and preoccupation with their looks – positively associated with body dissatisfaction – is a result of the socio-cultural climate that encourages such action. Drawing on a large body of work from social psychology the chapter will examine the relationship between physical appearance and the acquisition of human economic and social capital. It will explore a gender-differentiated approach to body, and attempt to locate the incentives underlying such difference by reflecting on contemporary gender norms. The chapter will also explore how women’s body dissatisfaction may manifest during sexual relations and insomuch suggest that there is a complex, multi-layered and far-reaching relationship between a socio-cultural environment and an individual embedded in that environment. The third chapter *Literature Review: Feminist Approaches to Body Work* will expand on the feminist theories of the body and thus further explore women’s complex relationships with their bodies and ongoing body work from a feminist standpoint. Specifically, the chapter will elaborate on the feminist approaches to body work including cosmetic
surgery divided in three categories: ‘oppression’ model, ‘cultural discourse’ model and ‘agency in a circumscribed context’ model. Insomuch, it will provide a comprehensive yet focused approach to female body work and cosmetic surgery, and it will help furnish the theoretical underpinning of this study.

The fourth chapter of this thesis Research Methodology – Theoretical Underpinnings will outline the reasons for choosing a women-centred qualitative phenomenological study as a means of researching labiaplasty. It will explore two relatively novel concepts in feminist methodology – epistemological privilege and standpoint theories – in order to underscore that women’s experiences should be the starting point of the inquiry. The chapter will also provide an acknowledgment of researcher’s positionality that inevitably coloured the entire research process. It will discuss how the Interpretative Phenomenological Analysis (IPA) was used as the principal data analysis framework utilized in this study. It will therefore reflect on its strengths and weaknesses, the sample size and method, and the data collection technique. The fifth chapter of this thesis and the second methodological chapter is a direct result of the substantial difficulties encountered in the data collection process. Namely, Research Methodology – Empirical Implications reflects in detail on the most important and yet most difficult aspect of this research – participant recruitment. It will reflect on the on the twenty month long field-work and the twenty-six various attempts to locate participants for this study. Nevertheless, the chapter will also reveal how these practical obstacles were successfully overcome in order find and interview women who underwent labiaplasty.

The following three chapters will provide an in-depth analysis of women’s experiences of labiaplasty, in a time oriented process inquiry. Chapter six Analysis and Discussion – Major Theme One: Life before Labiaplasty will focus on the presurgical phase of participants’ lives and explore their motivations for the surgery. It will also explore the immediate social context in which participants’ decision to undergo labiaplasty were anchored, and it will elucidate the lengthy, complex and often lonely decision-making process underlying the surgery. Chapter seven Analysis and Discussion – Major Themes Two and Three: The Experience of Labiaplasty and the Aftermath will centre on the surgical and post-surgical phase of participants’ lives. The chapter will explore participants’ relationships with their surgeons and the level of
care encountered in the process of undergoing surgery. Importantly it will elaborate on the identified changes following the procedure including changes in their body image, physical functioning and sexual pleasure. Chapter eight *Analysis and Discussion – Major Theme Four: Gender, Looks and Culture* will situate participants’ accounts of labiaplasty in a wider social-cultural context in order to provide a backdrop against which these experiences may be viewed. It will explore in which ways the Western culture shapes participants’ views of gender and physical attractiveness, but moreover how participants negotiate their subjectivity in a socio-cultural context characterized by pervasive gender inequality. Finally, chapter nine *Synopsis and Conclusion* will provide a comprehensive summary of the main findings of this study, and it will tie these findings to the extant body of knowledge pertaining to female body work and female genital cosmetic surgery. It will also reflect on the value of this research and the utilized methodological approach. Drawing on the main findings, the chapter will include recommendations for clinical practice, as well as for future research on female genital dissatisfaction and modification.

1.11. CONCLUSION

This chapter provided an introduction to an in-depth qualitative study of women’s experiences of labiaplasty and insomuch provide an essential context for the subsequent chapters. It was shown in this chapter that there is an observable upward trend in female genital cosmetic surgery since mid-2000s when such procedures became available across the (wealthy) Western societies. In spite of women’s increasing demand for genital alteration, female genital cosmetic surgery including labiaplasty has received very little attention from social science researchers in the recent years. This is possibly due to the fact that it is a newly emerging procedure in the field of cosmetic industry undertaken primarily through the private sector, which is often not audited nor regulated. Furthermore, the issue of female genital dissatisfaction and modification is of a very delicate and sensitive nature, and locating women who have had it and wish to reflect on it is an arduous task. Although a number of empirical studies of female genital cosmetic surgery have been undertaken primarily across the international medical community, they seem to be
somewhat restricted by their predominantly quantitative approach that does not take into consideration the detailed perspectives of women who had the procedure in sufficient detail. On the other hand, feminist scholarship of the body examined in detail body practices including cosmetic surgery – often by taking women’s perspectives as the starting point of the inquiry – however, they paid very little attention to female genital cosmetic surgery to date. The chapter demonstrated that this doctoral research aims to fill the gap between the predominantly quantitative studies on female genital cosmetic surgery conducted often by medical practitioners, and the primarily qualitative studies of cosmetic procedures conducted by feminist scholars. Focusing on one specific genital cosmetic procedure, this study explores women’s motivations for, experience of and reflections on labiaplasty. Moreover, the study also includes an exploration of participants’ views on gender, physical appearance and the contemporary Western culture in order to provide a backdrop against which women’s decisions to have labiaplasty may be understood. The chapter also outlined the methodological approach employed in this research. Informed by feminist research principles, this study adopts a qualitative phenomenological approach in exploring women’s accounts of labiaplasty. Specifically, five semi-structured face-to-face and phone interviews with English speaking adult women who underwent labiaplasty were undertaken; the sample size being in line with requirements of a phenomenological study, but also a reflection of an exceptionally difficult participant recruitment process. The cross-cultural nature of the study raised some questions that were beyond the scope of this project. However, these identified limitations of the study also may provide the research platform for future studies on this research matter. Lastly, having provided a complete overview of the thesis, this introductory chapter paved the way for the eight upcoming chapters, first of which will tackle the issue of importance of women’s physical appearance in the contemporary Western societies, and its essential implications.
2. LITERATURE REVIEW: THE IMPLICATIONS OF PHYSICAL APPEARANCE

2.1. INTRODUCTION

This chapter will explore the importance of physical appearance in the context of unequal gender relations, and argue that women’s investment in and preoccupation with their looks is a result of the socio-cultural climate that encourages such action. Drawing on a large body of work emanating from social-psychology (Gordon et al. 2014, Hamermesh 1994, 2011a, 2011b, Langlois et al. 1995, Mobious et al. 2005, Ritts et al. 1992, Scholz and Sicinski 2011), this chapter will examine the relationship between physical appearance and the acquisition of human economic and social capital. The aim is to demonstrate that in contemporary Western societies there is another largely invisible form of discrimination – that based on physical appearance. However, it will be shown that in contrast to men, women may benefit more from their physical attractiveness, but equally a failure to conform to dominant beauty norms carries a significantly stronger negative effect on women’s social and economic status, as well as their mental well-being (Gregory and Ruhm 2009, Hamermesh 1994, Judge and Cable 2010, Mocan and Tekin 2006, Posavec et al. 1998, Quin and Crocker 1999). The chapter further demonstrate that women predominantly focus on the aesthetics, whereas men largely tend to focus on the functionality of the body. Expanding on a large research conducted by Mahalik and colleagues (2003, 2005), the chapter will locate the incentives underlying such difference, and in sumoething it will reflect on the social norms that construct, regulate and constrain men’s and women’s lives – masculinity and femininity. It will be argued that women’s preoccupation with and investment into their physique is an essential element of femininity and that, importantly, such preoccupation is positively associated with body dissatisfaction (Fredrickson and Roberts 1997, Hargreaves and Tiggemann 2004, Hesse-Biber et al. 2006, Roberts and Gettman 2004, Swami et al. 2010). The chapter will then investigate how women’s body dissatisfaction translates into the bedroom and the effects that it may have on their sexual satisfaction. The concept of ‘spectatoring’ (Masters and Johnson 1970) will be utilized in order to capture cognitive distraction.
experienced during sexual encounters that hinders one’s sexual pleasure. It will also be shown that men and women tend to focus on two different types of spectatoring, performance-based and appearance-based respectively (Cash et al 2004, Dove and Wiederman 2000, Meana and Nunnink 2006, Pascoal et al. 2012, Wiederman 2011) Drawing on objectification theory (Fredrickson and Roberts 1997, Roberts and Gettman 2004) this chapter will propose that women are more prone to appearance-based spectatoring due to the internalized observer’s perspective that results in habitual body monitoring. Lastly, the chapter will explore the effects that cosmetic surgery may have on women’s body image and therefore their sexuality (Stofman et al. 2006, Veale et al 2013) which, although inconclusive, provide much food for thought.

2.2. THE VALUE OF PHYSICAL APPEARANCE

The intersection of sociology and psychology is the realm that yielded a large number of studies exploring physical appearance and attractiveness, as well as the effects it has on men’s and women’s lives. One of the seminal studies in social psychology dates back to 1972 when Dion and colleagues evaluated whether physically attractive people are assumed to possess more socially desirable personality traits and expected to lead better lives than the physically unattractive ones. The findings suggested that the attractive people were judged as more socially desirable, expected to attain more prestigious occupations, have happier marriages and assumed to have better prospects for a happy social and professional life. The study showed that stereotyping based on physical attractiveness does occur for – as the title of the study suggests – *What Is Beautiful Is Good*. Twenty years later Dion reflected on their highly provocative research. He concluded that their study identified a violation of the principle of fairness in the evaluation of others:

“If asked whether they judged an individual’s personality and character based on his or her facial attractiveness, it seemed likely that most people’s replies would reflect sayings such as “you can’t judge a book by its cover” or other similar admonitions. We found, however, that physical attractiveness did influence
evaluations of others, with attractive individuals receiving more favourable evaluations” (Dion et al.1990).

The study found that attractive people are expected to hold more socially desirable personalities and have greater personal success, but it did not assess whether these assumptions translate into reality. In other words, are attractive people indeed ‘better’ people who lead ‘better’ lives? Subsequent studies attempted to address this question, examining the connection between physical attractiveness and life quality. This section therefore aims to reflect on that body of work in order to explore the interplay between physical attractiveness, acquisition of human, social and economic capital, and ultimately happiness, in the context of unequal gender dynamics.

A level of evidence shows that discrimination based on physical appearance happens across the lifespan, from an early age. In the family sphere, attractive children gain more attention from their parents in comparison with the less attractive children. Specifically, mothers of more attractive infants are more affectionate and playful than the mothers of less attractive infants who are more attentive to other people than to their own children (Langlois et al. 1995). This trend continues in the educational setting where attractive students receive preferential treatment from their teachers. In relation to their intelligence, academic potential, grades and social skills, physically attractive students are usually judged more favourably by the teachers than the less attractive students (Ritts et al. 1992). This in turn leads to greater social integration and lower social stigma for the attractive students, which helps them accumulate psycho-social resources to support their academic achievement (Gordon et al. 2014). In other words, the attention, support and encouragement that attractive students get from the teachers, combined with their participation in extracurricular high school activities, helps them develop self-confidence, self-esteem and social skills (Scholz and Sicinski 2011). These personal characteristics and skills known as the human capital will later ease attractive people’s transition onto the labour market, contribute to their productivity and finally lead to higher wages. Mobious and colleagues (2005) identified three reasons why ‘beauty premium’ eventually converts into higher wages. In their study Why Beauty Matters the authors suggested that physically attractive workers are more confident, considered more able by their employers and possess communication skills which place them at an advantage during negotiations about
their wages. The link between self-esteem and income was explained by Kammeyer-Mueller and colleagues (2008) who argue that, in accordance with the theory of self-consistency, people are prone to seek out roles which are consistent with their positive images of themselves:

“Positive self-esteem may therefore create a self-fulfilling prophecy (I see myself as a valuable person, and therefore I will be a valuable employee as well) that will be demonstrated in career achievement. Conversely, people with a negative self-image may end up in low-status jobs due to their negative perceptions of their own worth, and their desire to verify their poor self-concept” (Kammeyer-Mueller et al. 2008:205).

It is also interesting to note this connection between self-esteem and wages because women regularly score lower on self-confidence and self-esteem evaluations in comparison with men, which explains to a large extent why they are consistently underpaid. With regards to the interplay between physical attractiveness and economic success, a significant contribution to this field of research was made by the American economist Daniel Hamermesh (Hamermesh and Biddle 1994, Hamermesh 2011a, 2011b). He examined the impact of looks on the individuals’ economic success using interviewers’ ratings of respondents’ physical attractiveness. The findings indicated that plain people earn less than the average-looking people, who earn less than the good-looking people. The ‘plainness penalty’ ranged from 5-10 per cent (1994) which in the long run amounts to around $230,000 over the course of a lifetime (2011b). Hamermesh (1994) did not elaborate in detail on which features render a person good-looking, average-looking and plain. He suggested that the standards of beauty vary across cultures and, furthermore, they change within the same culture over time. However, based on his extensive literature review related to what constitutes beauty, including research conducted by anthropologists, sociologists and social psychologists, Hamermesh asserts that within a culture at a given point in time there is a large agreement on standards of beauty. He argues that this is most evident in high correlation in rankings found in studies in which respondents are asked to rank the appearance of people depicted in photographs. He further contends that besides having a positive effect on one’s earnings, personal beauty also improves other economic outcomes, including occupational choice and
marital bargaining. All of these factors consequently raise one’s life satisfaction and personal happiness. Hamermesh (2011a:23) asserts:

“The results suggest that a person’s beauty does increase his/her satisfaction/happiness, with effects that are not tiny. Moreover, among both men and women at least half of the increase in satisfaction/happiness generated by beauty is indirect, resulting because better-looking people achieve more desirable outcomes in the labor market (higher earnings) and the marriage market (higher-income spouses).”

Apart from increasing their economic capital, Hamermesh’s studies also suggest that beauty helps people heighten their social capital, by entering relationships with a higher-income spouse and arguably gaining access to a wealthier and more influential social milieu. Having analysed beauty in the context of discrimination in the labour market, Hamermesh concluded that beauty and ugliness are comparable to a gender gap, race gap and even physical impairment. He also emphasized that beauty in the labour market affects men and women differently, which shall be examined in the subsequent section. However, if beauty is positively correlated with the human capital which then translates into economic capital, what happens then with the less attractive individuals who fail to develop skills necessary for a successful career? The answer to this question might be found in a thought-provoking study by Mocan and Tekin (2006) with a symptomatic title – *Ugly Criminals*. Drawing data from a longitudinal study of the American adolescents, they evaluated respondents’ physical attractiveness and investigated their criminal past in order to establish a relationship between the two variables. Their findings reveal not only that the unattractive individuals have a greater propensity for criminal behaviour, but furthermore that attractive individuals may receive preferential and more lenient treatment from the judicial system. Although they admit that beauty may be related to socio-economic status, Mocan and Tekin contend that the reasons for individuals’ criminal propensity should be sought in personal and family characteristics:

“It is important to recognize that unattractive individuals might experience unfavorable treatment during the pre-labor market period of their lives, which may cause them to be endowed with lower levels of human capital when they reach adulthood… If these attitudes influence human capital acquisition as suggested by
recent research in economics, they reinforce sorting of unattractive individuals into the criminal sector” (Mocan and Tekin 2006:7).

All these studies suggest that along with discrimination based on gender, ‘race’, ethnicity, sexuality, age and physical and mental impairment there is another, possibly less acknowledged and yet prevalent dimension of discrimination which has to do with physical attractiveness. However, it will be argued here that ‘lookism’ affects women with greater intensity and frequency than men, which is in accordance with the Western notion of femininity that subsumes physical attractiveness and sexiness as essential, if not the most important, features of being a woman.

2.3. GENDER DIMENSION TO PHYSICAL APPEARANCE

Mocan and Tekin (Ibid.) not only explored the relationship between physical appearance and criminal tendencies, but also highlighted the importance of gender as a contributing factor. Namely, very attractive women are less likely to be detained by police and, if detained, they tend to receive a favourable treatment from the criminal justice system. They also highlighted that women’s appearance generates stronger positive and negative reactions than men’s does. Hamermesh and Biddle (1994) on the other hand identified two ways in which beauty affects men and women differently in the labour market. The authors utilized two broad household surveys for the United States and one for Canada, which provide data on more than seven thousand respondents’ looks and their labour-market and demographic variables. In all three surveys, the interviewer had visited and rated participant’s physical appearance on the five-point scale: strikingly beautiful or handsome, above average for age, average for age, below average for age and homely. Considering that all three surveys offer a variety of measures of earnings, the authors calculated hourly earnings as annual earnings in order to ascertain the marginal effect of looks on a person’s earnings. They concluded, firstly, that female physical attractiveness in positively correlated with labour force participation rates. This means that less attractive women have a lower participation rate in the labour market than the good-looking women, which has a negative impact on their economic situation. Secondly, a woman’s attractiveness affects her marital prospects and the quality of her future
husband(s). In other words, below-average-looking women marry men who are less educated then they are and whose earning potential is lower, which again negatively influences women's financial profile. Hamermersh and Biddle (1994:1189) assert:

"The results show that the economic penalties facing below-average-looking women are not limited to hourly earnings. Both their success in the marriage market and their likelihood of working outside the home are reduced by their bad looks. No such effects exist for below-average-looking men; and there is no apparent premium in the marriage market or extra effect on participation for either good-looking women or men."

These are the reasons why the authors conclude that any study investigating physical appearance should analyse both genders separately. However, Hamermesh and Biddle also suggest that it is possible that unobserved factors may have affected productivity and thus may have been correlated with looks. Specifically, it is possible that greater attractiveness and higher earnings in adulthood may have been a result of a privileged family background. Furthermore, it is possible that the interviewers in the three household surveys subconsciously influenced the ratings of the participants' physical appearance because they knew, or were able to intuit, the participants' earnings. Nevertheless, a level of evidence appears to suggest that the more physically attractive a woman is, the better chances she has to advance her economic situation. Conversely, the less physically attractive a woman is – attraction being evaluated according to the contemporary Western beauty standards – the fewer opportunities she may have to improve economically. One way to demonstrate how women get financially penalized for failing to conform to dominant beauty norms is by examining the relationship between women’s weight and income. The Western representation of women in the media is skewed, suggesting that an attractive woman is a thin woman. She is thinner than the man, thinner than in the past, thinner than the actual female population and often thinner than the criteria for anorexia (Judge and Cable 2010). Unsurprisingly, this restrictive social norm negatively influences all spheres of a woman’s life including the workplace. Utilizing a longitudinal German and American study, Judge and Cable (Ibid.) investigated the relationship between the male and female employees’ weight and their income. The participants in Study 1, the German Study, included more than eleven thousand individuals enrolled in the German Socio-Economic Panel Study. Participants' weight
was measured over two time periods, and their earnings were averaged over the subsequent five years. Study 2, the American study, featured more than twelve thousand individuals enrolled in the National Longitudinal Surveys of Youth. A unique feature of Study 2 was that weight was measured fifteen times over a twenty-five-year time span, opening up investigation of within-individual changes in weight and earnings. Both of the studies supported their initial hypothesis that female thinness is rewarded with a higher income, whilst the opposite is true for men whose earnings increase up to the point of obesity. To explain this double weight standard the authors employ the cultivation theory which focuses on the mass media’s repetition of ideologies in order to legitimize social order. In that context, consistent depiction of thin women as more attractive and better mate choices than women of normal weight leads to a normalization and enforcement of this ideal, whilst women’s failure to meet this norm results in financial penalties:

“This means that, all else equal, a woman who is average weight earns $389,300 less across a 25-year career than a woman who is 25 lbs below average weight. Thus, our results suggest that both German and American societies reward women who conform to the improbably thin female standard perpetuated by the media and meet out the stiffest punishments for the initial “rebellion” from this standard” (Judge and Cable 2010:15).

The authors noted an important limitation pertaining to their study. Namely, the participants in the German Study reported their weight only twice – as opposed to fifteen times in the American Study – which therefore precludes within-person analyses. In that context, the findings resulting from the German study are open to criticism of reverse causation, meaning that more successful people could have become heavier because they were able to afford richer meals. However, the authors stressed that even if that was the case, it would still not explain the differential associations observed by gender. Similar correlation between weight and income was found by Gregory and Ruhm (2009) who speculated that it is not only women’s thinness that leads into higher income, but that another factor – such as physical attractiveness – produces the observed relationship. Furthermore, besides being financially punished, overweight women are socially stigmatized due to their perceived flawed morality (Fallon 1990, Quinn and Crocker 1999). To sum up, women’s beauty pays, quite literally, in labour force participation, increased wages
and their husbands’ increased wages. However, Hamermesh (2011a) noticed one thought-provoking aspect to female attractiveness that has nothing to do with the economics. He suggests that there is a larger direct effect of beauty on personal happiness for women, implying that beauty influences women’s happiness independent of its impact on the economic outcomes such as income and marriage prospects. It seems as if for women beauty is an end in itself. This idea is hardly surprising, as it resonates with the research conducted by Lerner and colleagues (1976) that investigated the role of body attitudes to predict the self-concepts of male and female adolescents. Their findings suggested that for women a positive self-concept is dependent on perceived physical attractiveness, whereas for men it centres on physical effectiveness. Put differently, a woman’s identity – the way she thinks and feels about herself – is largely contingent on her perceived sense of physical appearance. Some forty years fast forward and it seems that not much has changed for the cultural emphasis on how women’s bodies look and men’s bodies act still persists (Murnen 2011).

If a woman’s sense of ‘self’ is interlinked with her physical appearance, it is reasonable to conclude that women who are ‘objectively’ beautiful, or at least perceive themselves that way, are also happier. What follows from this is an assumption that women who are less physically attractive, or those who think of themselves that way, have a poor self-concept and ultimately lower life satisfaction. A number of studies have indeed confirmed this assumption, stressing that while men are increasingly under pressure to conform to the male beauty standards, it is still women who get the short end of the stick. For instance, women’s exposure to mass media – which depicts a thin female body as the ideal women should aspire to – is related to increased body dissatisfaction in women (Posavac et al. 1998). It is suggested that the detrimental effect of media exposure on female body image, such as increased weight concern, results from a social comparison process whereby women evaluate their physical appearance relative to that portrayed in the media:

“...It seems intuitively plausible that a majority of young women may find media images of female attractiveness threatening. Because current media images of ideal female beauty are narrowly defined, exaggerated, and emphasize thinness, exposure to media images may make salient the discrepancy between a female
Nevertheless, when boys and girls are exposed to images of idealized beauty in the media – the muscular ideal for boys and thin ideal for girls – it was again girls who suffered from increased body dissatisfaction (Hargreaves and Tiggemann 2004). The authors suggested that the immediate impact of mass media on body image is both stronger and more normative for girls than for boys. A large international study conducted by Swami and colleagues (2010) on almost 7,500 individuals in ten major world regions indicated that exposure to Western media predicted both preferences for a thinner body type and body dissatisfaction in women. The study also demonstrated significant cultural differences in the ideal female figure – the lower the socio-economic status of a particular country, the higher the possibility that ‘bigger is better’ with regards to female physique. This study not only highlighted the detrimental effect the media has on women’s body image, but underlined that beauty ideals are contingent on socio-economic circumstances – such as the availability of food – and therefore relative.

But it is not only the images that initiate body dissatisfaction in women – words can have an equally harmful effect. Roberts and Gettman (2004) investigated how women would react if they were subtly exposed to objectifying words. They demonstrated that this exposure leads to a form of self-objectification which is followed by negative emotions such as shame and anxiety. The findings indicated that women’s body self-consciousness becomes initiated when exposed to words that emphasize physical appearance of the body, in contrast with its health and functioning. It is interesting to note this because it is in accordance with previously cited Lerner’s study (1976) which suggested that women think of their body in terms of what the body looks like (attractiveness) instead of what can be done with the body (effectiveness). Roberts and Gettman explained that in order for the words to trigger self-objectification – which is an automatic response – situations of objectification need to be commonly experienced and a mental schema concerning objectification has to be developed:
“From our results we can conclude that a significant number of women do have a specific trait concept about sexual objectification encoded into their memory and that this trait concept, once activated, carries with it significant attendant negative emotions and attitudes toward the self” (Roberts and Gettman 2004:24).

Research further suggests significant gender differences in both body image and self-esteem, with adolescent girls having lower body image and self-esteem than their male counterparts (Ah-Kion 2006). Bearing in mind that appearance anxiety is inversely correlated with self-esteem it is no surprise that in adolescence – when girls are increasingly aware of the societal norms they have to conform to in order to be considered sexually appealing to men – their self-esteem is steadily eroding while the boys’ is moderate and rising (Zimmerman et al. 1997). One possible explanation why boys’ self-esteem increases during pubertal development is that the changes in the body affect them positively. Namely, puberty is usually a positive experience for boys as the majority of them move closer to the ideal societal shape for a man, which generally means becoming bigger (Ricciardell and McCabe 2011). On the other hand, most girls are heavier than the societal shape for women, and therefore drift away from ideal societal shape that implies thinness during puberty (Wertheim and Paxton 2011). At least three more features tend to distinguish adolescent boys’ relationship with their bodies from that of adolescent girls’ (Ricciardell and McCabe 2011; Wertheim and Paxton 2011). Boys tend to focus on the functional aspects of the body including the size, height, speed, strength, fitness and endurance, whereas girls tend to centre on the physical aspects of the body including body weight and shape. Secondly, boys usually focus on positive aspects of the body in contrast to girls. Specifically, already from the age of eight boys are more likely than girls to use self-serving biases in order to produce and maintain an unrealistically positive view of themselves – “self-serving biases reflect beliefs that one is better than average on desirable traits and below average on undesirable traits” (Ricciardell and McCabe 2011:86). This cognitive schema may serve as a buffer against negative societal influences and insomuch a self-protective and adaptive mechanism. Self-serving biases may also explain why social comparisons do not make boys feel bad about themselves – they feel either positive or neutral – unlike girls who tend to feel worse having compared themselves to another female.
Research also shows that women – and White women specifically – often engage in social comparisons and express competitiveness and envy with regards to body-related issues. Franko and Roehrig (2011) conducted an extensive literature review to explore the role of culture, ethnicity and race in the development and presentation of body image issues. They suggest that African American women tend to have larger bodies and more positive body image in contrast to Caucasian women:

“Research consistently indicates that relative to White women, Black women are more likely to be comfortable with their bodies at higher weights, generally have higher self-esteem, and define attractiveness in ways that go well beyond body shape and size. That said, studies find that body dissatisfaction in Black women does exist, and may be particularly pronounced at the higher end of the weight spectrum” (Franko and Roehrig 2011:222).

The authors noted that in the United States Black women are more than twice as likely to be overweight and obese as White women. Interestingly, they suggest that overweight Black adolescent girls and women may underestimate or misperceive their body weight and shape, which in turn may explain why Black women have a higher tolerance for variation in body weight and shape. Therefore it could be hypothesized that, notwithstanding social comparisons and competitiveness, interethnic differences also feature in how weight is perceived and therefore how body image is formed. In relation to media representation and effects of sexualisation on Black women’s body image, it appears that Black women are just as susceptible to self-objectification as White women. Black girls and women are regularly exposed to rap videos that objectify them and therefore reinforce sexual and racist stereotypes. Music videos featuring black artists have higher levels of sexual content than those by white artists, and this racialized sexualisation of Black women results in their representation as wild, animalistic and endlessly sexually available (Coy 2014). This links well to the previously cited research by Franco and Roehrig (Ibid.) who assert that increased exposure and perception of Black sexual stereotypes in rap music predicted more negative body image in Black girls and women. It could be speculated that familial and peer influences may, to some extent, equip Black girls with protective skills to resist dominant cultural messages and therefore act as a buffer against these, as indicated by Granberg and colleagues (2009). Further (comparative) research into interethnic differences in body image is necessary to
understand Black women’s experiences of embodiment, relative to that of White women. In sum, whilst individual differences need to be taken into account including age, ethnicity, sexuality and ability, it is apparent from this section that there is a profound difference in the way girls and boys, and women and men relate to their bodies. One way these findings could be interpreted is by pointing out to two different sets of social norms that construct regulate and constrain men’s and women’s lives – femininity and masculinity.

2.4. FEMININITY AND MASCULINITY

Even though there is no such thing as singular form of femininity and masculinity present in a given society at a given time, one particular form of gender expression is usually more valued than the alternatives. This would imply then that an individual, male or female, has the possibility to decide for themselves which form of masculinity or femininity to conform to and furthermore whether to follow a form which is generally associated with their gender. The problem is however twofold. Firstly, having been socialized into a particular social construct from the very onset, one might take their gender expression for granted and lack the capacities to explore the alternatives. Secondly, those who decide to challenge the dominant societal norms and choose to express their gender in an alternative fashion might be penalized in the form of teasing, stigma and ultimately ostracism. Meeting societal expectations can be a path of least resistance, especially when rewarded with symbolic capital including social status, recognition and respect. So what does one have to do to fit in? Which are the standards that girls and boys in Western societies have to conform to in order to gain social acceptance?

Mahalik and colleagues (2003, 2005) attempted to address this question by conducting two large US studies in order to assess women’s and men’s conformity to a range of social norms found in the dominant culture. Starting with their second study (2005) the authors explored conformity to feminine norms, defining the latter as “adhering to societal rules and standards about how to be feminine and is demonstrated in the individual woman’s behaviours, feelings, and thoughts” (Ibid.,
The sample consisted of more than eight hundred mostly European American, heterosexual, college students in the United States. This poses a limitation to generalizability of the findings, and the related ability to extend these findings to the population at larger. The authors therefore underlined that the number of feminine norms in the dominant US culture could be higher or lower than what this study suggests. Nevertheless, Mahalik and colleagues identified eight distinct feminine norms which suggest how Western women are supposed to look and behave. These are: *nice in relationships, thin, modest, domestic, care for children, invest in romantic relationship, sexual fidelity and invest in appearance.*

Discussing the findings, the authors highlighted the relationship between these norms, feminist ideals and eating disorders. *Modesty* – refrainment from calling attention to one’s talents or abilities – was negatively related to feminist identity as well as masculinity. *Invest in appearance* norm also related negatively to feminist ideals and women’s commitment to societal inequalities. In other words, women who were more likely to emphasize their accomplishments were less likely to focus on physical appearance. Moreover, this study demonstrated a significant positive correlation between adherence to feminine norms and development of eating disorders, which occur ten times more frequently in women than in men and therefore represent a gendered issue (Hesse-Biber et al. 2006). This was specifically the case with *invest in relationship* norm which was positively related to thinness and body dissatisfaction. Mahalik and colleagues speculated that women experience their physical attractiveness as an essential factor in their ability to establish and maintain a heterosexual relationship.

“A focus upon appearance may allow women to feel a sense of control in a situation that might otherwise elicit feelings of powerlessness and confusion. It is not surprising, therefore, that women who place great value upon the attainment of romantic relationships may also experience considerable self-scrutiny in terms of their physical appearance, and thus engage in the associated dieting behaviors” (Ibid., p.431).

This indeed resonates well with the work of Hesse-Biber and colleagues (2006) who examined the role of societal institutions and industries in inducing eating disorders. They suggested that women’s self-concept is contingent on their bodies and
furthermore that women engage in body-work in order to reach an assumed ideal of attractiveness for which they expect to be rewarded with a heterosexual romantic relationship. It would be false to infer from this that men, unlike women, do not engage in body-work in the attempt to gain attention from the other sex. However, it seems plausible that men focus on other aspects of their identity and engage in different types of behaviour in order to heighten their perceived attractiveness to women. Mahalik’s (2003) study of masculinity supports this claim. The authors suggested a completely different set of social expectations that men have to meet in order to be considered masculine and none of these referred to men’s physique. Conformity to masculine norms was defined “as meeting societal expectations for what constitutes masculinity in one’s public or private life” (Ibid., p.3). The sample consisted mainly of Caucasian, heterosexual and young adult student population – men averaged twenty years of age. Specifically, seven hundred fifty-two men participated in this study, of which the overwhelming majority – or six hundred thirty-nine participants – identified as Caucasian. Considering what appears to be a lack of ethnic diversity present in this study, the authors highlighted that there may have been other masculine norms, associated with other cultural groups in the United States, which were not identified in this research. Nevertheless, the following eleven distinct factors were identified in the study: winning, emotional control, risk-taking, violence, dominance, playboy, self-reliance, primacy of work, power over women, disdain for homosexuals and pursuit of status.

Discussing the implications of these findings the authors stressed that traditional masculinity relates to greater psychological stress including anger, anxiety and depression which is consistent with the other literature on masculine roles (Cohen 2001, Kimmel and Messner 2007). For instance, they highlighted that conformity to risk-taking can serve as a predictor for a range of health-related behaviours such as violence, law-breaking, tobacco and alcohol abuse. They also speculated that this could be the reason why in the USA men die on average seven years younger than women. Unsurprisingly, higher conformity to masculine norms was associated with more positive attitude to unequal social relationships, which could explain why men who strictly adhere to traditional masculinity are less in favour of women’s rights. Despite the health-related issues following from conformity to traditional masculine norms, the authors underlined the positive side of it:
“Although these results indicate that one cost associated with conformity to masculine norms is mild levels of psychological distress, conformity is also posited to have benefits associated with it, such as group acceptance or advancing in one’s career; likewise, nonconformity is posited to have costs associated with it, such as group rejection. Thus, readers are cautioned about making the conclusion that conformity is associated with only bad things for men, whereas nonconformity is only associated with good things” (Mahalik et al 2003:19).

It needs to be emphasized though that the costs and benefits of meeting societal expectations are equally applicable to both genders. In other words, girls and women who choose to conform to a dominant form of femininity may be rewarded with social economic and symbolic capital, meaning that conformity to feminine norms is also associated with positive outcomes. In sum, if one was to have a closer look at these two sets of attributes and behaviour men and women have to integrate and manifest in order to be considered masculine and feminine, it would seem as if not much has changed since the beginning of the women’s rights movement. ‘Feminine’ women are still relegated to the private sphere, restricted sexuality, child rearing, caretaking and beautification. ‘Masculine’ men are self-contained, dominant, promiscuous and emotionally non-expressive professionals. It appears indeed that everything a feminine woman is – a masculine man is not, and vice versa.

For instance, it is symptomatic how two out of eight feminine norms – thin and invest in appearance – refer to female physical attractiveness, while not a single norm regarding male physical appearance was identified in Mahalik’s study of masculinity. In this context, women’s attentiveness to physical appearance can be understood as a means of consolidating their difference from men. Furthermore, not a single feminine norm referred to women’s personal or professional development, which is again something that sets femininity apart from masculinity. Nice in relationships, domestic, care for children, romantic relationship, sexual fidelity are all norms with at least two implications about femininity. Firstly, these norms suggest that a feminine woman is first and foremost embedded in a web of relationships. Her identity is defined predominantly in terms of relations. She is a partner, a mother, a daughter, a sister and a friend. Only then she is an individual human being. Secondly, a feminine woman is attentive to the needs of people around her including her partner, children, family and friends. She channels her energy and affection outward to meet the
physical and emotional requests of those dear to her. It is not clear however who nurtures this feminine woman besides, presumably, her equally feminine girlfriends.

This is interesting to note because one of the central themes pertaining to cosmetic surgery is *I'm doing it for myself* theme. This shall be elaborated further in the subsequent chapters, but suffice to say that this theme implies two things. When a woman says that she is undergoing a cosmetic surgery for herself, it somehow implies that she is first and foremost the one who benefits from the surgery. Her current or potential involvement in a heterosexual relationship has nothing to do with her autonomous decision. This assumption comes into question if we accept Mahalik’s findings, which show that romantic relationships are high on the agenda for heterosexual Western women and, as demonstrated previously, women’s self-concept is highly contingent on their physical appearance. Furthermore, studies have shown that men who are unhappy with their romantic relationships have female partners who are unhappy with their bodies (Pascoal et al. 2012). In that sense, a woman’s investment into a cosmetic surgery *for herself* may be beneficial for two persons at the end of a day – the woman and her male partner. However, *I'm doing it for myself* can also mean that the cosmetic surgery is ‘me’ time. It is a time when I put myself and my needs before the others, a time when I care for myself. Indeed, as Mahalik’s study shows, femininity is centred on taking care of the other people. In that context, cosmetic surgery can be viewed as a departure from this societal expectation and perhaps even considered as a subtle form of revolt. This could in turn explain why it is usually women who encourage other women to undergo cosmetic surgery *for themselves* (Davis 1995, Kaw 1997).

On the other hand, socialization in accordance with dominant masculine norms leads to a development of men’s highly individualized sense of self. The masculine norm which illustrates this perfectly is *self-reliance*, but it is equally evident in other ones including *dominance, power over women, disdain for homosexuals, violence* and *winning*. All of these norms encourage competition that can have an isolating effect, and simultaneously can discourage cooperation and caring behaviour as an alternative mode of interaction. *Emotional control* disables any display of vulnerability, which is a precondition for an establishment and maintenance of deep emotional connections among humans. This masculine imperative of emotional
control could help explain why men seem to develop less intimate friendships in comparison with women or, at least, perceive their friendships as less intimate (Swain 2001, Rubin 2007, Walker 2007). Dolgin (2001) for instance found that college men build friendships by revealing self-flattering facts about themselves, in contrast with college women who develop friendships by revealing unflattering facts about themselves. However, the cost of this emotional distance researched and perfectly captured by Rublin (2007:319) – “go away a little closer” – is well-documented. Evidence suggests that depression and suicide are rife among men. For instance, in comparison with women, men tend to manifest depression in less well-recognized ways and they are less likely to seek help (Real 2001). At the same time, men have consistently higher suicide rates than women and typically deploy more violent means of attempting suicide (Sabo 2007). It seems reasonable to conclude that, in terms of mental health illnesses, depression and suicide for men are what eating disorders and self-induced starvation are for women.

Having said all that, recent research into men’s body image suggests that men are under increasing pressure to achieve a lean and muscular body ideal, which may lead to body image disturbance, body dysmorphic disorder and muscle dysmorphia (Pope et al. 1998). For instance, a cross-cultural study of body image perception among two hundred Western European and American men demonstrated that men’s perceived male body ideal was about thirteen kg more muscular than themselves (Pope et al 2000). Furthermore, this study highlighted men’s belief that women prefer a male body type which is, again, about fourteen kg more muscular that the study participants, even though the authors found that actual women preferred an ordinary male body without the added muscle. The authors suggested that the wide discrepancy between men’s actual muscularity and their body ideals may help explain the apparent rise in disorders such as muscle dysmorphia and anabolic steroid abuse. Another study exploring male body image of boys and men suggests that men are becoming more concerned with their bodies and tend to associate a lean and muscular male physique with being fit, healthy, self-confident, powerful and finally masculine (Grogan and Richards 2002). Paradoxically, although the study participants indicated that they ‘could not be bothered’ about their body image – which was often framed as female-appropriate behaviour – at the same time they admitted to exercise in order to maintain their weight. The authors assert:
“Men and boys in all groups resisted representing men’s bodies (including their own) as objects of aesthetic interest by discussing how bodies looked in relation to function (athletic, fit) and by stressing the trivial nature of concerns to look slender and muscular for its own sake, although they were clearly concerned that their bodies looked socially acceptably slender and muscular and reported that a positive body image would make them more confident/happy” (Ibid., p.230).

In other words, this study underscores a discrepancy between men’s attitudes and behaviours in relation to body issues. Namely, boys and men did not view their bodies in the light of physical appearance, but insisted on the functionality of their bodies. Yet, they engaged in body-work for the purpose of maintaining and achieving physical attractiveness and a positive self-concept. Grogan and Richards’ study therefore conflicts with that of Lerner and colleagues (1976) who argued that men view their bodies primarily in terms of effectiveness instead of attractiveness. It is plausible to conclude that men’s body image is changing in response to contemporary ideal body types. Nevertheless, this doctoral research attempts to demonstrate that physical appearance is more closely tied to feminine than masculine norms, for men may feel pressured to deploy other resources – primarily economic and symbolic – to assert their manhood.

To summarize, the work presented here attempts to highlight the importance of what is deemed physical attractiveness for the social construction of femininity, and demonstrate the implications of conformity to dominant feminine and masculine norms. However, one implication of conforming to societal norms remained relatively unexplored until recent years. Namely, whilst social scientists examined the advantageous potential of one’s physical attractiveness in the public realm, they also remained confined to that very realm. Only recently have the researchers made a bold step forward – towards the bedroom – and started investigating the implications of people’s perceived physical attractiveness for their sex life. The following section explores how men’s and specifically women’s perception of their bodies influences their flow of thoughts during sexual interactions, and thus theirs and their partner’s sexual satisfaction. This appears to be of great importance considering that labiaplasty seems to be undertaken by women in order to address issues that are sexual in nature, as indicated in chapter one and further elaborated in chapters six and nine.
2.5. BODY IMAGE AND SEXUAL SATISFACTION

Body image refers to one’s experience of embodiment. It is a multi-faceted construct incorporating persons’ perceptions and attitudes about their body, including one’s appearance-related cognitions, emotions and behaviors (Cash et al. 2004). Since sexual pleasure is experienced through the body, there is an intrinsic connection between body image and sexual satisfaction. Namely, studies show that persons who are dissatisfied with their physical appearance experience body image self-consciousness during sexual interactions, and this cognitive distraction has a detrimental impact on their sexual functioning. Spectatoring is a term coined by Masters and Johnson (1970) in order to capture this form of cognitive distraction, and it refers to one’s self-consciousness regarding their body’s function and/or appearance during sexual activities. In other words, instead of immersing oneself in the experience and focusing on their own and their partner’s satisfaction, a person who is prone to spectatoring may adopt a third person perspective during sex and centre on their own functioning and physical appearance. Unsurprisingly, cognitive distraction has a negative effect on a person’s sexual satisfaction, for it reduces one’s focus on their and their partner’s sexual arousal and pleasure. This is the reason why spectatoring often results in sexual dysfunction, as recent studies have indeed confirmed. For example, the leading researcher in the field of body image Thomas Cash (Cash et al 2004) conducted a study in the States which explored men’s and women’s body image concerns in a sexual context. More than two hundred sexually active college men and women, predominantly White and heterosexual, completed several questionnaires developed to measure attentional focus on and avoidance of body exposure during sexual relations. The findings suggested that cognitive distraction during sexual interactions has a negative effect on one’s sexual satisfaction, although the correlations were higher for women:

“Both women and men with more anxious/avoidant appearance self-focus during sex indicated less positive experiences vis-à-vis most aspects of their current sexual functioning. They reported less enjoyment of their sex life, less frequent desire for sex, as well as less consistency and quality in their experiences of sexual arousal and orgasm” (Cash et al. 2004:7-8).
The authors stated that although both men and women focus on body weight and gender-relevant attributes, men were more preoccupied with their genitals, which is in line with other research on spectating (Wiederman 2011). Interestingly, in relation to concerns over body weight, the authors underlined that participants’ self-consciousness was more clearly related to being weight-preoccupied than to actual weigh. Put differently, it is not what one looks like, but rather how one perceives oneself. Other studies have emphasized this as well (Wiederman 2000, Pascoal et al 2012), which potentially has positive implications for people with body image issues. Namely, one doesn't necessarily need to change their body, but their state of mind. Similarly, research undertaken by Pascoal and colleagues (2012) on 669 cohabitating heterosexual Portuguese adults indicated that body image concerns – body dissatisfaction and focus on specific body parts – predict cognitive distraction during sex and thus sexual dysfunction in men and women both. Although women reported concern with a greater diversity of body parts in comparison to men, the two most common areas of concern were abdomen and genitals for men, and abdomen and breasts for women. Again, participants’ concerns with their body weight had no correlation with their actual weight. It is fascinating how the results showed that satisfaction with one’s partner’s opinion about one’s physical attributes was strongly positively correlated with global relationship satisfaction in both men and women. In other words, if for instance a woman believes that her male partner feels positive about her body, the likelihood is that she will be happy with the relationship. This again suggests that in order to have a satisfying sex life, it is less important how one actually looks. In other words, what really matters is how one thinks of themselves, and how they think their partner views them. It is plausible to conclude then that a woman’s sexual and relationship satisfaction can be enhanced by altering her way of thinking about the body, instead of altering the body. In sum, there is a well-established link between body dissatisfaction, distracting thoughts regarding one’s body during sexual interaction and sexual functioning.

However, studies have also shown that men and women seem to engage in different types of spectating. Namely, men seem to be more concerned with the functional aspect of their body – the ability to achieve and maintain erection – and therefore performance. Women on the other hand tend to be more concerned about their perceived body imperfections – including body weight and the appearance of gender-
specific attributes – and therefore the aesthetics. In other words, men primarily worry about how their bodies act; women primarily worry about how their bodies appear. It needs to be emphasized though that social scientists have traditionally focused on female body image issues and male sexuality, and largely ignored male body image issues and female sexuality. Therefore, drawing connections between body image and sexual functioning for either of these two genders may be somewhat challenging and more research is needed in these two realms. Nevertheless, one of the prominent researchers in the field Michael Wiederman (2011) elucidates why is it that men seem to focus more on the functional aspects and women more on the aesthetic aspects of their body during sexual interactions. He asserts:

“Because the perceived “success” of a male-female sexual interaction usually depends on an erect penis, spectatoring for men may revolve around monitoring erection quality. For women, however, being a desirable sexual partner may have less to do with performance or degree of physical arousal, and more to do with being an attractive (“sexy”) visual stimulus” (Wiederman 2011:273).

In their pioneering study Meana and Nunnink (2006) demonstrated that although both men and women experience distractive thoughts during sexual interactions, men self-report higher levels of performance-based spectatoring, whereas women self-report higher levels of appearance-based spectatoring. The authors asserted that appearance-based distraction experienced by the women was predicted by negative body image and psychological distress. In other words, if a woman doesn’t generally feel happy in her own skin, this dissatisfaction will inevitably have an impact on her and her partner’s sex life and therefore their relationship. Indeed, women who are unhappy with their bodies have male partners who are unhappy with the relationship (Pascoal et al 2012). It remains unclear though whether correlation implies causation – does women’s dissatisfaction with their bodies have a negative effect on those couples’ sex life and therefore their male partners’ satisfaction with the relationship, or whether women feel unhappy with their bodies because they are essentially unhappy with the relationship, just like their male partners, and therefore project dissatisfaction with the relationship onto their own bodies. Nevertheless, it can be concluded that men seem more likely to experience performance-based spectatoring, whereas women appear more likely to experience appearance-based spectatoring.
So why is it that during sexual interactions women think about the aesthetics? Objectification theory developed by social psychologists Fredrickson and Roberts (1997) possibly provides a valuable insight to this dynamic. The theory provides an analysis of female bodies as social constructions in a culture that sexually objectifies women, as well as the psychological consequences resulting from such objectification. It proposes that girls and women in Western culture are acculturated to internalize the observer's perspective as a primary view of their physical selves, and in the process learn to treat themselves as objects to be observed and evaluated. Fredrickson and Roberts contend that the most profound effect of the exposure to sexual objectification is that girls and women adopt a peculiar view of their bodies, and treat themselves as sex objects evaluated exclusively on their physical appearance:

“…A critical repercussion of being viewed by others in sexually objectifying ways is that, over time, individuals may be coaxed to internalize an observer’s perspective on self, an effect we term self-objectification. Girls and women, according to our analysis, may to some degree come to view themselves as objects or ‘sights’ to be appreciated by others. This is a peculiar perspective on self, one that can lead to a form of self-consciousness characterized by habitual monitoring of the body’s outward appearance” (Ibid., pp. 179-180, emphasis in original).

The authors suggest that self-objectification is an outcome of socialization in a culture that encourages women’s preoccupation with their physical appearance and rewards it with social, economic and symbolic capital. Put differently, Fredrickson and Roberts argue that women’s attentiveness to physical appearance – which need not be consciously or deliberately chosen – can be understood as a strategy to influence how the others will treat them, and ultimately an attempt to advance their life outcomes. Fredrickson and Roberts are interested specifically in psychological and experimental consequences that result from self-objectification, two of which are of special interest for this study. Namely, according to their analysis, self-objectification is associated with negative mental health outcomes of shame and hindrance of flow. The negative emotion of shame happens when women compare themselves to an internalized or cultural ideal, and fail to measure up to expectations. The internalization of outsider’s perspective is central to the feeling of shame, for shame not only reflects how one feels about themselves, but also what one thinks that the
others are thinking about them. Shame is therefore deployed to socialize societal standards, which is why Fredrickson and Roberts regard it as a moral emotion. In that context, maintaining one's physical attractiveness can be viewed as a moral imperative:

“Viewed in this light, women's ongoing efforts to change body and appearance through diet, exercise, fashion, beauty products, and, perhaps most dangerously, cosmetic surgery and eating disorders, reveal what may be a perpetual and hardly adaptive body-based shame. The extent to which body ‘correction’ is motivated by shame elevates the task of meeting societal standards of beauty to a moral obligation. Thus, women who fail to live up to this obligation have been deemed civilized and immoral” (Ibid., p.182).

The authors assert that shame is associated with feelings of worthlessness and powerlessness, and an intense desire to hide and escape the gaze of the others. The other relevant outcome of self-objectification is an obstruction of peak motivational states or flow. Flow can be defined as a rewarding and enjoyable state that occurs when one is fully absorbed in a challenging mental or physical activity. In order to achieve this state of mind one must completely lose self-consciousness, which is impossible for as long as one is concerned with their physical appearance. The authors expand on the work of Iris Marion Young (1980) who also demonstrates that consistent body monitoring limits the flow of women’s physical activities. In her essay *Throwing Like a Girl* (Ibid.) Young analyses women’s bodily experiences in patriarchal societies and, among other things, focuses on one particular source of feminine bodily experience. Namely, she contends that women live their bodies as subjects and objects at the same time. In her view, a patriarchal society defines women – subjects – as bodies – thus objects – which results in women’s self-consciousness about their experiences of embodiment. Young asserts:

“An essential part of the situation of being a woman is that of living the ever present possibility that one will be gazed upon as a mere body, as shape and flesh that presents itself as the potential object of another subject's intentions and manipulations, rather than as a living manifestation of action and intention. The source of this objectified bodily existence is in the attitude of others regarding her, but the woman herself often actively takes up her body as a mere thing. She gazes
at it in the mirror, worries about how it looks to others, prunes it, shapes it, molds and decorates it” (Ibid., p.154).

This consequently impedes their physical movement and, as Fredrickson and Roberts also contend, interrupts the flow. The interruption of flow is even more problematic in sexual encounters when a woman monitors her body’s outer appearance instead of losing herself in the experience and accompanying pleasure. To summarize, Fredrickson and Roberts assert that women’s self-conscious body monitoring, and the related shame and hindrance of flow, have a direct negative effect on a woman’s sexual satisfaction, which ultimately may result in female sexual dysfunction.

Objectification theory received a lot of empirical attention in the recent years across the Western world. For instance, in his two studies of more than four hundred heterosexual primarily White college women Weiderman (2000) demonstrated that a third of surveyed women experience distracting thoughts about their body during physical intimacy with a male partner. More importantly, those who experienced the greatest degree of body image self-consciousness were less sexually assertive with partners and reported more avoidance of sexual activity. This is very relevant bearing in mind that anxiety and inhibition during sexual interactions are the most common forms of sexual dysfunction. Another study (Dove and Weiderman 2000) of seventy-four predominantly White young adult women showed that higher cognitive distraction during sexual activities is associated with lower sexual satisfaction, sexual esteem and the consistency of orgasm(s). Interestingly, the authors reported that women in the study experienced overlapped appearance-based and performance-based distraction. They hypothesized why this may be so:

“One explanation is that women are socialized to believe that to be an adequate sex partner, one must conform to societal norms regarding physical attractiveness and what is considered “sexy.” It may be that the women in our study believed that being attractive equates to performing well as a sexual partner by simply being an engaging visual stimulus. Those who did not consider themselves attractive may have viewed their sexual performance negatively because they believed they did not fit the stereotype of what makes a woman “sexy” (Dove and Wiederman 2000:74, emphasis added).
It would be very interesting to know how many of the female participants watch mainstream pornography that downgrades women to their admittedly flawless bodies in order to visually stimulate men who then perform. Women appear and men act is an astonishingly tedious script that still seems to be replicated in real life sexual interactions. Fredrickson and Roberts (1997) speculated that the traditional sexual scenario – whereby men are experienced, proactive and assertive, in contrast with women who are inexperienced, passive and responsive to men’s needs – is at least partly responsible for sexual dysfunction among women. However, they contend that the other part of the problem is women’s self-conscious body monitoring and the related state of shame, anxiety and inattention to internal body states. Expanding on their ideas, Schick and colleagues (2010) tried to investigate precisely this hypothesized relationship in the context of genital appearance dissatisfaction. The sample consisted of more than two hundred female undergraduates from a US university. They demonstrated that greater dissatisfaction with genital appearance – which may be result of repeated subjection to physical inspection – is associated with higher self-consciousness during intimacy, which is then in turn related to lower sexual satisfaction. The authors assert:

“...There is a clear path that links body image to body image self-consciousness, body image self-consciousness to sexual esteem, and sexual esteem to both psychological and physical components of sexual wellbeing among women. That is, a woman’s dissatisfaction with her physical appearance is likely to heighten her self-consciousness about the way she appears, resulting in the devaluation of herself as a sexual being and ultimately threatening her sexual safety and satisfaction” (Shick et al. 2010:3).

The researchers’ conclusion supports the basic premise of objectification theory which is that women’s objectification of their own bodies results in a heightened awareness about how their bodies appear to their partners during sexual intimacy. This in turn impairs their ability to immerse themselves in the experience and thus hinders women’s abilities of having a satisfying sex life. Bearing in mind all the evidence presented in this section, which shows that women’s body image dissatisfaction negatively influences their sexual functioning, it seems only logical to assert that an improvement in body image will also positively reflect on their sexual satisfaction. One way a woman can achieve a positive change in her body image is
simply by – changing her body. It could be hypothesized then that the women who have had a cosmetic surgery also have more satisfying sex lives. But is this really the case?

The findings are inconclusive and more research is necessary to reach a reliable inference regarding the sexual outcomes following a major cosmetic surgery. For instance, Veale and colleagues (2013) conducted the first prospective study of women who have had labiaplasty on the NHS and in the private sector in the UK. They compared forty-nine women who have undergone labiaplasty against thirty-nine women who do not want a labiaplasty, in the attempt to determine long-term psychosexual outcomes following the procedure. Both groups matched for age, sexual orientation, ethnicity, and marital status. The women who have had labiaplasty were predominantly White, mainly or exclusively heterosexual and in their thirties. Interestingly, all of them were within the normal range for the general population regarding labia measurements. The results indicated that more than ninety per cent of women showed clinically significant change in genital appearance satisfaction three months after the procedure took place, but small-effect sizes were found for improvements in sexual functioning. At a three month follow-up again a very high number of women were content with their genital appearance, but no longer reported improved sexual functioning. It can be speculated that the absence of improvements in sexual functioning could have to do with the side-effects following the procedure, which were experienced by every fourth woman. Either way, increased satisfaction with their body appearance did not translate into increased sexual satisfaction.

On the other hand, a study conducted in the United States by Stofman and colleagues (2006) on women who have had a face or body procedure indicated the exact opposite – body cosmetic procedures indeed result in improvements in women’s sexual functioning. The sample consisted of seventy women, with a mean age of thirty-eight years, who had undergone a major aesthetic procedure (breast, body and face surgery) conducted by one of the authors of the study. Only participant in this study had undergone labia reduction (labiaplasty). The participants were asked to fill out an anonymous postal questionnaire regarding preoperative versus postoperative psychosexual health and sexual behaviour. The findings suggested that women who had a body procedure including breast augmentation,
abdominoplasty and lipoplasty not only experienced enhanced body image and sexual life, but their partner’s sexual satisfaction also improved. Women with breast augmentation – followed by women with other body procedures – reported the highest increase in body image satisfaction, sex frequency, sexual satisfaction and their partner’s sexual satisfaction. A similar improvement in sexual functioning was not observable among women with a face procedure – a group comprised of the eldest study participants – although they also achieved a higher body image satisfaction. Drawing on the previous research which shows that women with cosmetic procedures have higher self-esteem and life satisfaction postoperatively, the authors concluded that the effects of cosmetic surgery extend well beyond the arena of emotional well-being. They assert:

“Cosmetic surgery does much more than enable women to “feel better” about her physical appearance. The effect of cosmetic surgery on the lives of patients and their partners also extends into the bedroom. Perhaps the aesthetic plastic surgeon is not only a “psychosurgeon,” as indicated earlier, but also a “psychosexual surgeon,” given the sexual benefits that can accompany successful surgery” (Stofman et al. 2006:17).

The findings of this study are thought-provoking insofar as they suggest, among other things, that women became more proactive in the bedroom following a major body procedure. They appeared to have had sex more often, wear provocative clothes and engage in novel positions. Therefore, the authors concluded that cosmetic surgery enhanced theirs and their partner's sex life. However, this study did not explore responses from participants’ male partners with regard to the effects of surgery on their sex lives. In that context, the suggestion that male partners’ sexual satisfaction also improved – as a result of participants’ body procedure – is based on participants’ self-reporting. It may also be important to note that this study was conducted by the plastic surgeon and surgical residents who themselves performed cosmetic surgery on study participants. In sum, this research suggests that cosmetic surgery may have a positive effect on women’s self-confidence, which in turn may result in enhanced sexual esteem and heightened sexual agency. Therefore, cosmetic procedures – which are argued to reduce women’s agency for women have them to conform to dominant beauty norms – may liberate some women, and expand their repertoire of activities in a sexual context. In other words, however intrusive, painful and
potentially harmful, successful cosmetic procedures may paradoxically serve as a route towards women’s empowerment in and outside the bedroom. However, notwithstanding exceptionally limited data on sexual outcomes following cosmetic surgery including labiaplasty, it remains unknown whether the same findings may be transferable to female genital cosmetic surgery.

2.6. CONCLUSION

This chapter explored the interrelatedness between physical appearance, accumulation of desirable human, social and economic capital, and the implications for sexual functioning in the context of gender-differentiated cultural norms. It was demonstrated that physical attractiveness is associated with positive personal characteristics and a general preferential treatment, which therefore represents a violation of principle of fairness. Namely, it was shown that the attention and support that attractive people receive translates into heightened social skills, self-confidence and self-esteem, higher labour participation and higher wages, as well as favourable marital bargaining. However, it was also highlighted that aforesaid connection is not equally applicable to both genders, for the societal responses to male and female attractiveness and the lack thereof is profoundly different. In that context, it was shown that less attractive women have lower participation in labour market, lower wages and lower-educated and lower-income spouses. On the other hand, no similar observable relationship between physical attractiveness and economic and social outcomes was apparent in less attractive men. Put differently, the society tolerates men’s but penalizes women’s physical imperfections. Considering that dominant beauty standards are largely transmitted through mass media, the chapter also explored the effects of exposure to such content. It was shown that the images and words communicated through media have stronger and more normative negative effects on girls and women. The increased body dissatisfaction initiates body objectification, which may result in negative mental health outcomes and ultimately may erode one’s self-worth. It was asserted that this is one important reason why girls and women consistently score lower on levels of self-confidence and self-esteem than boys and men. In order to understand why that massive disparity with
regards to looks and gender, the chapter also explored the two sets of behaviours that men and women need to embody and display in order to be considered masculine and feminine respectively. Drawing on some of the largest studies of the aforesaid issues, it was demonstrated that attentiveness to physical appearance is a significant element that distinguishes masculinity from femininity. Insomuch, women’s preoccupation with their looks may be viewed as a means of consolidating their difference from men. However, this preoccupation with the aesthetics is inevitably accompanied with increased body monitoring and self-objectification that may lead to increased body dissatisfaction and mental health issues. In a sexual context, body dissatisfaction may translate into cognitive distraction known as ‘spectatoring’, whereby one becomes self-conscious about the appearance and performance of their body. It was shown that men tend to engage in performance-based spectatoring and women in appearance-based spectatoring probably because it is conventionally believed that the ‘success’ of sex depends on an erect penis, which is a result of women’s visual stimulation. Both types of spectatoring are associated with lower sexual satisfaction, difficulties orgasming, and anxiety and inhibition during sex. One way to address body dissatisfaction that leads to negative mental health and sexual outcomes is to – change the body. It was shown that studies are inconclusive about whether this indeed may be the case. It seems plausible to assume that an altered body may have a positive effect on a woman’s body image, which in turn may manifest as reduced self-consciousness during sexual intimacy. However, another way to address body dissatisfaction would be to critically examine where that dissatisfaction stems from in the first place, and to replace those beliefs, thoughts and behaviours that may negatively affect one’s body image. In other words, one can also address body dissatisfaction by altering their state of mind. In many ways, this is what the feminist scholarship of the body attempted to underscore, for it largely views women’s body dissatisfaction as a highly problematic and systematic social phenomenon. This is precisely what the next chapter will explore.
3. LITERATURE REVIEW: FEMINIST APPROACHES TO BODY WORK

3.1. INTRODUCTION

This chapter draws on the feminist theories of embodiment in order to explore further women’s complex relationships with their body – identified in the previous chapter – and its implications from a feminist standpoint. The chapter explores the three feminist approaches to body work – and therefore cosmetic surgery – divided in the following clusters: ‘oppression’ model, ‘cultural discourse’ model and ‘agency in a circumscribed context’ model. It is necessary to underline that these are not clear-cut groups, but rather roughly divided clusters of theories that may and indeed do occasionally intersect. This perfectly illustrates how theoretically complex the nature of female body work is, and furthermore how diverse and often colliding feminist perspectives with regards to this issue may be. Specifically, at one end of the continuum are arguably proponents of the ‘oppression’ model, who contend that beauty and beauty practices should be viewed as a social and political construct whose aim is to maintain women’s subordinated position in the society. In order to explore this approach, the contribution of a Shiela Jeffreys (2005) and Naomi Wolf (1991) will be presented. A different position is that of advocates of the ‘cultural discourse’ model, who assert that women’s choices to undergo to body work are always embedded in a specific socio-cultural context, and thus a reflection of contemporary norms pertaining to femininity. This section will largely draw on the work of Virginia Braun (2005, 2009) and Rhian Parker (2009). Lastly, supporters of the third and arguably most liberal approach to body work, ‘agency in a restricted context’, largely argue that women engage in beauty practices to alter their bodies and identities, and insomuch exercise their agency within the given societal limits. In that context, the contribution of Kathy Davis (1991, 1995) and Debra Gimlin (2000, 2002) will primarily be explored. This chapter therefore attempts to provide a comprehensive yet focused approach to body work, including cosmetic surgery, and to help furnish the theoretical underpinning of this research.
3.2. ‘OPPRESSION’ MODEL

It would seem almost unthinkable to explore female body work in the context of women’s oppression without considering the work of Naomi Wolf (1991) as the first point of reference. Her book *The Beauty Myth* is considered a classical feminist text on women’s problematic relationships with their bodies mediated through beauty practices. Wolf’s basic premise is that images of female beauty – ‘the beauty myth’ – are used as a political weapon against women’s advancement. She argues that the backlash against feminism is so violent because myths about motherhood, domesticity, chastity and passivity have already been deconstructed. The social ideology of beauty is the last one remaining of the feminine ideologies:

“During the past decade, women breached the power structure; meanwhile, eating disorders rose exponentially and cosmetic surgery became the fastest-growing medical specialty... More women have more money and power and scope and legal recognition than we have ever had before; but in terms of how we feel about ourselves physically, we may actually be worse off than our unliberated grandmothers” (Ibid., p.10, emphasis in original).

Wolf asserts that beauty is a currency standard determined by politics, and employed to assign value to women according to a culturally defined physical standard. It is an expression of power relations in which women must compete for resources that men have appropriated for themselves. Wolf’s analysis centres on six spheres in which the beauty myth operates including work, culture, religion, sex, hunger and violence. For the purposes of this discussion sex, hunger and violence require further attention. Starting with sex, Wolf presents data which shows that a third of women are strongly dissatisfied with their bodies, which leads to higher social anxiety, lower self-esteem and sexual dysfunction – all of the issues that have been identified in the previous chapter. She contends that this is largely an outcome of the asymmetry in sexual education wherein men learn to desire women and women learn to be desired by men. Consequently, both men and women are taught to eroticize men’s desire and women’s body. This pattern is an extension as well as a reflection of Western culture in which men look at women, and women watch themselves being looked at. The problem is however that this unequal relationship determines not only the relationship
that men have with women, but the relationship women have with themselves. The result of this social conditioning is that female sexuality is negatively defined and constructed:

“Women are vulnerable to absorbing the beauty myth’s intervention in our sexuality because our sexual education is set up to ensure that vulnerability. Female sexuality is turned inside out from birth, so ‘beauty’ can take its place, keeping women’s eyes lowered to their own bodies, glancing up only to check their reflection in the eyes of men” (Ibid. p.155).

Wolf asserts that suppressed female sexuality – catering to men’s needs and desires instead of focusing on their own – maintains male power for when men control female sexuality they are free from sexual objectification and evaluation. To support her claim, Wolf cites novelist Margaret Atwood who asked men and women what they feared most from the other sex and the findings were telling: women are most afraid that men would kill them, whereas men were most afraid that women would laugh at them (Ibid., p.153). If women were encouraged to experiment sexually, men would be at risk of becoming subjects to outspoken criticism in relation to their physical appearance and sexual prowess the same way women already are. This evaluation already takes place, albeit behind a closed door:

“A man is unlikely to be brought within earshot of women as they judge men’s appearance, heights, muscle tone, sexual technique, penis size, personal grooming, or taste in clothes – all of which we do. The fact is that women are able to view men just as men view women, as subjects for sexual and aesthetic evaluation… Given all that, women make the choice, by and large, to take men as human beings first” (Ibid., p.153).

Therefore Wolf contends that if women learn how to be desired instead of how to desire, then female sexuality becomes confounded with beauty. This however has a detrimental impact on women’s body satisfaction, mental health and ultimately their freedom. Another interesting element of her analysis that intersects with sex is female hunger. Wolf views female thinness, dieting and eating disorders as politically, socially and culturally induced states of women’s physical and psychological debilitation. She begins with an observation that dieting and thinness became
women’s preoccupations around 1920 when women received the vote. Regressive 1950s relegated women to a domestic sphere and female curves became socially acceptable and moreover desirable. In mid 1960s – with the advent of the pill and the strengthening of women’s reproductive rights – along came Twiggy as an epitome of female weakness, huger and asexuality. Wolf contends that cultural desirability of female thinness is a reaction to women’s improved political social and economic situation. She highlights that modern fashion models, actresses and dancers are thinner than ninety-five percent of the female population, and thinner than they have ever been historically. The implicit message communicated to men and women across the age spectrum is that a ‘beautiful’ woman is a thin woman, which probably explains why on any day twenty-five percent of American women diet with another fifty percent finishing, breaking or starting one (Ibid., p.185). Wolf points out that in the US more men are medically overweight then women and, furthermore, that fat is more dangerous for men’s health than for women’s. Yet, the public debate is hysterically focused on women’s weight. In her view, this cultural fixation with female thinness has nothing to do with female beauty, but female obedience:

“The great weight shift must be understood as one of the major historical developments of the century, a direct solution to the dangers posed by the women’s movement and economic and reproductive freedom. Dieting is the most potent political sedative in women’s history; a quietly mad population is a tractable one” (Ibid., p. 187, emphasis added).

Wolf examines food in the light of a public agenda and asserts that within a family setting food means love, but within the public realm food is status for “whom a society values, it feeds well” (Ibid., 189). In that context, food apportioning is not about beauty, but about maintaining unequal power relations. Interestingly, Wolf highlights the gender dimension to food concerns for both men and women associate dieting with femininity. Food restrain was viewed as a socially desirable trait by women, in contrast with men for whom it signified a socially undesirable trait. Referring to the work of feminist psychoanalyst Susie Orbach, Wolf emphasizes that eating disorders begin a sane response to an insane social reality in which women are encourage to feel good only when in the state of semi-starvation. Ultimately restricted food intake undermines women’s minds, sexuality, strength and self-esteem in order to undo
feminism. The last dimension of the beauty myth explored here is framed as violence that women inflict on their bodies in the form of cosmetic surgery. Wolf compares the development of what she calls the modern ‘surgical age’ with the Victorian era. She demonstrates how throughout the nineteenth century women were equated with their reproductive organs and treated for ‘conditions’ that did not require medical treatment. In this ‘surgical age’ however women are equated with their ‘beauty’ and undergo cosmetic procedures which are, again, medically unnecessary. In her view, the main culprit is the cosmetic industry working in tandem with women’s magazines not only to advertise for a share of the market that already exists, but to create ones. Wolf focuses on cosmetic surgeons’ direct interest in selling women a feeling of terminal ugliness:

“If you tell someone she has cancer, you cannot create in her the disease and its agony. But tell a woman persuasively enough that she is ugly, you do create this ‘disease’, and its agony is real. If you wrap up your advertisement alongside an article promoting surgery, in a context that makes women feel ugly, and leads us to believe that other women are competing in this way, then you have paid for promoting a disease that you alone can cure” (Ibid., p.234).

Wolf focuses specifically on breast surgery, which she views as a form of sexual mutilation. It needs to be highlighted that Wolf’s research is rather old at this stage. This however does not automatically imply that her arguments do not hold water any more. For instance, back in the late 1980s when Wolf was researching for her book, breast operations were the most popular cosmetic procedure with over 150,000 operations performed annually only in the US (Ibid., p.241). Two decades fast forward, little has changed in terms of women’s preferences. According to the American Society for Aesthetic Plastic Surgery (ASAPS 2016) breast augmentation was the most sought-after surgical procedure in 2015, after liposuction, with more than 305,000 procedures performed. Notwithstanding significant differences between the two, Wolf draws a thought-provoking parallel between breast surgeries and penis surgeries in the attempt to underscore how radical and intrusive cosmetic operations are:

“Imagine this: penis implants, penis augmentation, foreskin enhancement, testicular silicone injections to correct asymmetry, saline injections with a choice of
three sizes, surgery to correct the angle of erection, to lift the scrotum and make it
pert. Before and after shots of the augmented penis in *Esquire*” (Ibid., p. 242,
emphasis in original).

Lastly, Wolf tackles the universally deployed argument in any debate on cosmetic
surgery – choice. Women freely choose cosmetic procedures. They are the agents.
They are doing it for themselves. Wolf finds this argument too simplistic and asserts
that women conform to dominant beauty standards as a survival strategy in the
context of restrictive societal expectations. This subtle form of coercion that pushes
women into cosmetic procedures derives from two threats: the threat of losing love
and loving relationships, and the closely related threat of becoming invisible. Wolf
concludes that women will have real choices about cosmetic surgery only when they
are able to keep their livelihood, identities and places in the community even if they
did not conform. Until then, choice remains an illusion. More than two decades fast
forward, Wolf’s critique of contemporary beauty practices remains equally
provocative, powerful and exhaustive. *The Beauty Myth* endowed women with a
vocabulary to articulate their dissatisfaction for having to conform to something so
trivial and yet so harmful – dominant beauty norms.

Sheila Jeffreys (2005) contends that precisely because Wolf’s analysis was strong
and influential – almost radical – Wolf needed to publish another book three years
after *The Beauty Myth* (*Fire with Fire: The New Female Power and How To Use It
1994*) to separate herself from the radical feminist scholarship. Jeffreys criticizes Wolf
for failing to question why women – and not men – engage in beauty practices in the
first place. She asserts how precisely that omission makes *The Beauty Myth* a liberal
feminist book instead of a radical one. One could infer that implicit to her critique of
Wolf’s book is Jeffreys’ belief that only a radical feminist analysis of beauty practices
is a good feminist analysis of beauty practices. This probably explains why Jeffreys
herself provided that analysis in her controversial book *Beauty and Misogyny* (2005),
in which she examines not only ‘traditional’ beauty practices, but also new cosmetic
surgeries, piercings and tattoos in order to underscore how men use female sexuality
for domination. Jeffreys’ central premise is that beauty practices are the most
important aspect of women’s oppression, regardless of how ‘freely’ and passionately
women choose to adhere to them. Furthermore, she argues that Western beauty
practices – from lipstick to labiaplasty – should be understood as harmful traditional practices under the following UN definition:

“Harmful cultural or traditional practices in UN terms are identified as: being harmful to the health of women and girls; arising from the material power differences between the sexes; being for the benefit of men; creating stereotyped masculinity and femininity which damage the opportunities of women and girls; being justified by tradition” (Ibid., p. 29).

Jeffreys explains how the concept of harmful traditional practices originates from the UN efforts to identify and eliminate those harms inflicted on girls and women that may not easily fit within the human rights framework. The 1995 UN Fact Sheet identifies the following harmful traditional practices: female infanticide and son preference, early marriage and pregnancy, traditional birth practices, dowry price, fertility and nutritional taboos and forced feeding (Ibid., p. 30). She draws analogies between these and Western practices, including a comparison between FGM and labiaplasty, or force feeding and dieting, in order to highlight the detrimental nature of Western beauty practices for women’s health and their social status. She addresses the Western inconsistency in labelling practices as cultural, and the rhetoric employed to disguise this bias:

“Indeed it is likely that the idea that the west has a ‘culture’ that produces ‘practices’ at all may seem foreign. Harmful practices in the west will most usually be justified as emanating from consumer ‘choice’, from ‘science’ and ‘medicine’ or ‘fashion’; that is, the law of the market. Culture may be seen as something reactionary that exists in the non-west. The west has science and the market instead” (Ibid., p. 28).

Jeffreys argues that the culture creates sexual difference, which is often regarded as natural or biological in order to conceal the fact that men and women stand in relation to one another in positions of dominance and subordination. In her view, beauty is the most important instrument to create this sexual difference and moreover deference. Beauty practices then, as the central element of femininity, are necessary in order to consolidate sexual difference/deference and the accompanying unequal power relationship. Jeffreys contends that femininity is not only socially, but politically constructed as the behaviour of a subordinate social group. It is also expressed
through how much space one can take, whom one can look in the eyes, or touch. To support her argument Jeffreys refers to the work of feminist psychologist Dee Graham (1994) who views femininity as a ‘societal Stockholm syndrome’. Graham made a rather radical analogy between feminine behaviour and that of hostages in situations of captivity, who begin to bond and identify with their kidnappers that simultaneously threat them with violence and kindness. Similarly to Jeffreys, Graham contends that masculinity and femininity are codes for domination and subordination, and beauty practices are behaviours women engage in order to win men over. According to Graham, these practices reflect:

“(1) the extent to which women seek to make ourselves acceptable to men, (2) the extent to which women seek to connect to men, and thus (3) the extent to which women feel the need for men's affection and approval and (4) the extent to which women feel unworthy of men's affection and approval just as we are (unchanged)” (Graham 1994 in Jeffreys 2005:26).

Graham asserts that women have an interest in thinking that femininity is ‘natural’ for to believe differently they would have to acknowledge that their behaviour is controlled by men’s use of force. Jeffreys endorses Graham’s argument and concludes that the fact that women take pleasure in beauty practices is not inconsistent with their role in maintaining the subordination of women – some women simply make a virtue out of necessity. Furthermore, even though women claim that they engage in beautification for their own sake or for other women, Jeffreys contends that it is still men who ultimately benefit. When women are attentive to their physical appearance, men have the advantage of having their superior sex class status marked out and being sexually stimulated by beautiful women. In that context, women complement and compliment men:

“Women complement men by being the ‘opposite’ and subordinate sex. Women compliment men by being prepared to make an effort to adorn themselves for men's sexual excitement. Thus men can feel both defined in manhood and flattered by women’s exertions and, if the women are wearing high heels for instance, pain endured for their delight. Those women who refuse beauty practices are offering neither complement nor compliment and their resistance can be deeply resented by members of the dominant sex class” (Ibid., p. 32).
Jeffreys views cosmetic surgery, as ‘self-harm’, ‘sadomasochism’ and ‘self-mutilation by proxy’ (Ibid., pp. 149-150). The proxy is a surgeon who takes a role in self-mutilation for a financial gain, sexual excitement or both. Jeffreys conveniently calls him a ‘sadist’. In her view, women engage in ‘self-injuring’ because they have no other outlet from the pain they experience from male dominance. Namely, this type of ‘self-mutilation’ is an expression of women’s lower social status. However, she contends that these practices are condoned because the ‘body modifiers’ have transformed private self-mutilation into a socially positive activity. Nevertheless, when women are rendered more physically and sexually attractive through cosmetic surgery, the people who ultimately benefit from this are – men.

Jeffreys’ analysis is thought-provoking, yet rather controversial. The most striking shortcoming of Beauty and Misogyny is Jeffreys’ essentialism. The implication or her analysis is that the human body is good only when it is intact. She seems to endorse the notion of a ‘natural’ or ‘normal’ body – a physical object completely devoid of social and cultural influences – that should be preserved in its original form. Any form of attentiveness to one’s physical appearance, let alone modification, is harmful, pathological and masochistic. Secondly, her rhetoric is arguably patronizing and therefore may be viewed as offensive. Jeffreys refers to women who have had cosmetic surgery as ‘victims of a harmful cultural practice’ (Ibid., p. 155) completely depriving women of their agency. By deploying the rhetoric of victimhood, Jeffreys appears to assert that she understands what has indeed happened to adult women with cosmetic surgery, even though they may not perceive it themselves. Therefore she seems to implicitly endorse the argument of ‘false consciousness’. In spite of the aforementioned limitations, Jeffreys offers a valuable contribution to feminist critique of female body work insofar as she goes beyond the common understanding of Western beauty practices as inherent or natural, and highlights their cultural and often harmful background.

To conclude, the contribution of Wolf and Jeffreys lies in the ability to provide a theoretical platform for framing female body work, including cosmetic surgery, as a system of oppressive practices that have a detrimental impact on women’s social standing and psychological well-being. The imposed standards of beauty – unattainable, unsustainable and unhealthy – are viewed as a backlash against
women’s advancement and exploited to maintain women’s subordination. However, this approach to female body work has also been heavily criticised for failing to acknowledge any form of women’s agency (Davis 1991, 1995). Specifically, framing women’s body work as a repercussion and an example of women’s subordination and men’s domination leaves no room for an exploration of women’s motivations for the aforesaid body work. Insomuch the ‘oppression’ model restricts the possibilities of feminist analysis of women’s experiences of cosmetic surgery. It has also been argued that women actively and often enthusiastically partake in body work including cosmetic surgery, and that the positive and gratifying aspects of such practices need to be taken into account as well (Ibid.). Therefore feminist scholars largely moved away from ‘oppression’ model towards the ‘cultural discourse’ approach to female body work. Namely, rather than focusing strictly on male-female power dynamics, the ‘cultural discourse’ model underlines that female body dissatisfaction – and all the body work endorsed to address the distress related to the aforesaid – is a largely product of an inequalitarian Western culture.

3.3. ‘CULTURAL DISCOURSE’ MODEL

In order to explore the ‘cultural discourse’ approach to female body work this section firstly examines the work of feminist scholar Virginia Braun (2005, 2009), whose area of research includes specifically female genital cosmetic surgeries (FGCS). The section draws on her thought-provoking work that explores the use of ‘choice’ rhetoric deployed by Western women in the context of elective genital cosmetic surgery, and the role of female sexual pleasure in legitimizing and promoting the aforesaid procedures. In her paper ‘The Women Are Doing It for Themselves’ The Rhetoric of Choice and Agency around Female Genital ‘Cosmetic’ Surgery (2009) Braun makes a compelling argument that the ‘choice’ rhetoric is constructed and utilized in the Western world in order to distinguish female genital cosmetic surgery from its polar opposite, female genital mutilation. By doing so, the ‘choice’ rhetoric overlooks the essential social aspect of choice – the culture – and renders female genital cosmetic surgery socially acceptable. Braun asserts:
"Any ‘choice’ a (non-Western) woman may (want to) make to undergo a ‘traditional’ genital cutting procedure is seen to be overdetermined by culture, and therefore impossible. So ‘we’ are culturally free, agentic and empowered; ‘they’ are culturally oppressed, duped and victimised, unable to step beyond culture into autonomy and agency. The issue of choice plays a central role, making Western women’s engagement in FGCS socially acceptable” (Braun 2009:235).

Braun’s central argument is that a woman’s choice to undergo an elective genital surgery is never an individual act; rather it is a product of structural and contextual constraints. She contends that a woman’s choice to alter her body is positioned as if prior to and beyond any cultural influence. In other words, the social dimension of women’s choices to have cosmetic surgery is disregarded, if not negated. Furthermore, Braun underlines that cosmetic surgery is an instrument for defining and achieving ‘normality’ and therefore eradicating diversity and difference among women. Therefore whilst women are represented as rational agentic subjects making individual choices about their bodies, these choices however are choices towards the socially and culturally defined norm.

“The focus on individual choice removes the myriad of (gendered, racialised, classed, sexualised) structural, societal and ‘personal’ factors which result not only in the person coming to the situation where they face that particular choice, but also the very options that are, or that they perceive are, available. (…) The question is how real or viable all the options can be, when societal norms and expectations effectively mandate one course of action over another, the choice for ‘the norm’” (Ibid., p.236, emphasis in original).

Taking into consideration that in contemporary Western societies women tend to make similar choices about their bodies – choices that move toward the prevailing norm – Braun assert that these choices should be rather understood as acquiescence. Nonetheless, Braun contends that the very appeal to choice rhetoric – for a woman has genital cosmetic surgery for ‘herself’ – legitimizes the practice and easily dismisses any criticism. It begs the question, could a woman ever make an informed choice about altering her external genitalia? Braun appears to assert that such circumstances would exist provided that women had easy access to a whole variety of female anatomy. She further suggests:
“The ethics of FGCS are in question on the assumption that ‘informed choice’ cannot really be seen to exist because the exposure to real vulvas is so (presumably) limited that women’s ‘choice’ for a certain aesthetic cannot be seen as a valid, authentic, real and informed choice. The implicit position is that lack of ‘real’ choice is where the problem lies; this suggests that if only (heterosexual) women were exposed to multiple vulvas, then the surgery would be ethical because it would be an informed (and implicitly free) choice. ‘Choice’, if real, would render FGCS acceptable” (Ibid., p. 238, emphasis in original).

Braun’s analysis touches on another important feature of elective genital surgery – medicalization of women’s bodies and their physical appearance. Namely, cosmetic surgery is perceived as a tool that mediates between the physique and psyche, and thus becomes a solution to socially and/or psychologically induced distress. Braun argues that the process of medicalization of women’s bodies locates the aforesaid problems and their solution within the biological framework, rather than the social or psychological. Consequently, problems that may be socially, culturally and interpersonally induced are treated via medical intervention. Braun focuses further on this particular issue in her paper In Search of (Better) Sexual Pleasure: Female Genital ‘Cosmetic’ Surgery (2005) in which she explores how medical intervention is presented as a means of addressing women’s sexual problems. Namely, she demonstrates how the focus on women’s sexual pleasure legitimises and promotes not only genital cosmetic surgery, but furthermore normative heterosexuality and a generic model of sex. Drawing on media accounts in relation to female genital cosmetic surgery as well as interviews with plastic surgeons that perform it, Braun reflects on women’s negative psychological responses to the appearance of their external genitalia. Namely, psychological issues such as embarrassment, self-consciousness, shame and low self-confidence impede women’s ability to engage in specific sexual acts such as oral sex, and insomuch have an adverse effect on their sexual satisfaction. This impeded women’s sexual pleasure in turn provides a moral justification for elective genital surgery. Braun reflects on this identified physique-psyche connection:

“In such accounts, the psychological was framed as a reason why surgery was necessary, and, in the form of psychological change, an explanation of why the surgery was successful. The mind was implicitly constructed as impervious to change without surgery, but then as changing once surgical alteration was
completed. Cosmetic surgery is thus about changing the body to change the mind” (Ibid., p.416, emphasis in original).

Her analysis shows that following surgery women were more content with the appearance of their external genitalia, which resulted in an increased repertoire of women’s sexual practices and increased sexual pleasure. Braun however asserts that genital cosmetic surgery not only reinforces the idea that medical intervention is a solution to a psychological problem. Furthermore, it supports the traditional notion that women are expected to provide visual stimulation to men during sexual intimacy through their bodies, which are expected to look in a very specific way. This consequently strengthens normative male-oriented heterosexual views of sex. Braun highlights this point:

“FGCS becomes a practice of changing women’s diverse bodies to fit a certain (maleoriented) aesthetic of what women’s genitals should look like, if they are to engage in cunnilingus (or other sexual activities). With male (hetero)sexuality continuing to be constructed as visual, with desire based on the aesthetic, such accounts reinforce a traditional model of male sexuality, and female sexuality alongside it. FGCS effectively becomes surgery to change bodies to fit, and to enable certain sexual practices, through psychological/emotional changes enabled by bodily transformation” (Ibid., p. 413).

Braun also raises one important issue in relation to genital cosmetic surgery and female sexual satisfaction. Namely she underlines that what largely underpins the discourse on the aforesaid surgeries is the assumption that women derive sexual pleasure primarily through intercourse. This runs against the growing research on female sexual satisfaction that consistently shows that seven out of ten women, or more than two thirds, cannot orgasm though penetration alone (Nagoski 2015). This is hardly surprising bearing in mind that the female equivalent of the head of penis – the most sensitive part of male sexual anatomy – is the clitoris. With its 6,000-8,000 nerves, two times more than the head of penis, stimulation of the clitoris is the primary source of female sexual pleasure. Specifically, this study demonstrates that between 80-90 per cent of women masturbate by stimulating the clitoris and sensitive area around it, with no or very little vaginal penetration. Novel projects such as OMGYES (2015) further demonstrate how diverse and creative this clitoris-centred
stimulation really is. OMGYES is based in an extensive mixed-methods study of women’s sexual pleasure conducted by the Indiana University and The Kinsey Institute. That scientific research was then transformed into a series of explicit demonstration prepay videos that portray the most prevalent techniques of clitoral stimulation, as identified by the research. Such ground-breaking projects demystify women’s self-pleasure and confirm what most women know anyway – sexual pleasure is ‘within one’s hand reach’. In the light of that knowledge, it can be asserted that intercourse is not an effective way to stimulate the clitoris and help women reach the peak of sexual pleasure. This in turns raises the question why the emphasis on intercourse in the first place, and this is precisely what Braun does in her paper. Insomuch Braun concludes that via genital cosmetic surgeries women are designing their bodies to fit specific sexual practices – practices that may not even be very conducive to their sexual pleasure.

Braun’s analysis is intriguing, provocative and inspirational for she successfully tackles the notion of a ‘free’ choice to alter one’s external genitalia prior to and outside of a cultural context. She demonstrates that the cultural pressure towards the aesthetic norm is so prevalent that it leaves one virtually ‘choice-less’, whereby one has to then make a ‘choice’ to conform to the aforesaid norm. Apart from highlighting the social aspect of choice, Braun also deconstructs the use of impeded female sexual satisfaction as a motivation for a genital cosmetic procedure. Insomuch she shows that surgery becomes a solution to psychological problems that hinder women’s sexual pleasure and thus a tool to change one’s body in order to alter one’s state of mind. On top of that, she underscores that female sexual pleasure is still framed from a heterosexual male-centred perspective with its excessive emphasis on the visual aspect of sex and intercourse. It would be rather difficult to contradict Braun’s conclusions. However, Braun’s analysis and findings are also a reflection of her methodological approach. Namely, she based her research on interviews with plastic surgeons and media analysis. It would be interesting to see what her conclusions would have been had she utilized direct interviews with women who have had an elective genital procedure.

Another scholar who did precisely that, albeit in the context of face and body cosmetic procedures, is Australian sociologist Rhian Parker. In her book Women,
Doctors and Cosmetic Surgery: Negotiating the 'Normal' Body (2009), Parker tackles the issue of female cosmetic surgery by drawing on her large empirical study that included thirty-two interviews with women who decided to opt for elective surgery, as well as nineteen interviews with surgeons who perform it. Seemingly, neither an advocate of the ‘oppression’ model, nor so much ‘agency in a restricted context’ approach, Parker wants to move beyond this polarizing dilemma and explore the complex interactions underpinning cosmetic surgery. Considering her argument that both women who have cosmetic surgery and the surgeons who perform it are socially and culturally influenced – and so are their views of gender and physical appearance – Parker’s work seems to fit well under the ‘cultural discourse’ model. Namely, she argues that women’s visions about how they wish to look is constructed through their individual experiences of the world surrounding them, but also via cultural norms of what constitutes femininity in Western societies. She asserts:

“What women end up with after a cosmetic procedure is a result that is affected by a plethora of discourses and meanings, mediated by technological (medical) knowledge/power, historical and cultural definitions of femininity and the normative definitions of ideals of feminine beauty” (Ibid., p.8).

In other words, Parker contends that women who engage is such form of body work do so against the backdrop of seeing themselves in relation to their world, and this includes being subject to an external gaze. The latter includes a societal gaze, but also the gaze of the surgeon who is usually male. Parker emphasizes that cosmetic surgery is a gendered practice not only because the patients are predominantly women, but also because the surgeons are predominantly men. In her view this inevitably creates a tension between divergent assumptions about the nature of women’s bodies. Considering that the surgeons do not exist in a vacuum, but rather they are just as embedded in a specific social and cultural structure, cosmetic surgery is an opportunity for them to inscribe on women’s bodies the culturally and socially situated norms of female beauty. However, importantly, in a male-driven industry the aforesaid norms are also male norms. In the light of this cognition, Parker argues that a woman’s choice to undergo a cosmetic surgery simultaneously demonstrates her agency and an abdication thereof. Namely, the very act of choosing to go forward with a medical intervention is, at least in theory, an
autonomous act of an individual woman who seeks much desired intervention into her body and often identity. Nevertheless, taking into account that another person is a gatekeeper and an ‘executor’ of one’s wishes – with their particular understanding of standards pertaining to female appearance – the woman’s autonomy is inevitably compromised. Parker contends:

“If women do exercise agency in making the decision to have a cosmetic procedure, the limits of that agency are very much defined by the doctor who carries it out. Once the procedure begins, woman’s self-determination or agency is compromised and power over the outcome lies in the hands of the doctor” (Ibid., p. 58).

Parker therefore asserts that a woman’s agency cannot stay intact if someone else is reshaping her body. She also explored the characteristics of women seeking cosmetic surgery and their motivations for the surgery. Her findings suggest, like other feminist scholarship exploring this issue (Davis 1991, 1995, Gimlin 2000, Kaw 1997) that none of the women had the surgery on a whim. On the contrary, deliberation was a long, lonely and often secretive journey undertaken in the attempt to address an issue that had become a large source of unhappiness. Parker also found that cosmetic surgery was primarily about enhancing one’s physical appearance, rather than heightening their physical functions. The three identified broad motivations for cosmetic surgery included a longstanding problem, changes experienced due to child-bearing, weight loss or weight gain, and finally changes experienced due to aging. Women in her study were not dissatisfied with their bodies on the whole, but rather with one particular feature. However, arguably the most interesting aspect of her findings is that women did not seek cosmetic surgery in order to look beautiful; rather, they wanted to look ‘normal’. They were self-conscious about their bodies, and felt that they were the object of other people’s unwelcomed gaze. Women no longer wanted to adapt their behaviour to minimize other’s attention to their perceived problem – they simply wanted to blend in.

“The reasons women gave for wanting to change something about their bodies were underpinned by their need to fit into the society they lived in. Contrary to some popular ideas about cosmetic surgery recipients, these women did not come across as exhibitionists, unduly vain or as wanting extreme intervention but as
wishing to be ‘normal’ and to blend in to their surroundings. While these needs may be culturally constructed and influenced by a society that sees the body as a commodity, they had very real implications for the way these women felt about their interactions in that society” (Ibid., p.82).

Parker’s study therefore suggests that women’s motivations for cosmetic surgery had very little to do with standing out, but rather with blending in. This is interesting to note since other studies of female cosmetic surgery yielded similar findings (Davis 1991, 1995, Gimlin 2000, Kaw 1997) including this very research. This issue will be explored in detail in chapter nine. Interestingly, whilst the women in Parker’s study asserted that they underwent cosmetic surgery ‘for themselves’, the gaze of the others appeared to be a significant issue. The identified gaze was not viewed as a specifically male gaze, but rather a societal gaze. Utilizing cosmetic procedures woman sought to escape the feeling of being looked at, or indeed the very action of being looked at. In turn this would have a positive effect on their self-confidence is social situations. Insomuch, it could be argued that cosmetic surgery, at least for women in Parker’s study, was an exercise of normalization in order to heighten social confidence. This perfectly captures the paradox of cosmetic surgery – women assert they do it ‘for themselves’, but they do it ‘for themselves’ to be able to easily fit into the wider social structure. Moreover, Parker suggests that the surgeons in her study underlined that they needed to be satisfied with women’s motivations for the surgery. Specifically, they wanted to make sure that no external force or pressure had been applied to the women; that they indeed opted for cosmetic procedures ‘for themselves’. Parker contends that this further undermines women’s agency for when surgeons insist on patients’ ‘right’ motives for the procedure, they inevitably play a defining role in the process pertaining to cosmetic surgery.

“In clarifying that women are ‘doing it for themselves’, doctors are supporting the repertoire of agency that permeates the process of cosmetic surgery. However, they seem careful to control this agency by acting as gatekeepers to those they deem to be seeking cosmetic surgery for the wrong reasons. (...) Thus, while doctors may be keen to ensure that motivation lies within the self, they ensure that control of the process lies with them. Women can only be self-directing up to a point” (Ibid., p.92).
Parker’s work suggests that although women do exercise their agency in choosing to have cosmetic surgery, that agency is neither perfect nor intact. Another significant element of Parker’s analysis of women’s motivations for cosmetic surgery – closely related to seeking ‘normalcy’ – is of psychological nature. What emerged from her interviews was a range of women’s emotional and behavioural responses to their perceived physical imperfections. Emotional issues such as self-consciousness, anxiety, lack of self-confidence and self-esteem, discomfort with their bodies and a negative body image all featured in her analysis. Importantly, women also believed that they needed to undergo cosmetic surgery in order to successfully compete in the workplace, for they felt that their physical appearance was tied to their wages. In is interesting to note this in the light of the previous chapter that explored and indeed demonstrated that the society rewards female physical attractiveness and penalizes its absence. In addition to that, some women in Parker’s study spoke of various strategies that they employed to shift the attention away from the problematic part of the face or body. This is also important to emphasize, for the same behavioural patterns have been identified by this particular study. What all of this suggests is that women in Parker’s research largely had cosmetic surgery in order to address psychological problems and alleviate unhappiness caused by these issues.

“The physical feature or perceived failing that led women to have cosmetic surgery made many of them feel self-conscious and lacking in self-esteem. In their minds, it made them stand out when they wanted to blend in to a society that values and applauds the healthy, attractive body. These feelings about their bodies were reported by women irrespective of the cause of the problem identified by them. Three main categories of feelings, that had to do with presenting themselves to the world around them, reported by women were: blending in, being self-conscious and enhancing social confidence” (Ibid., p. 81-82).

In other words, women underwent cosmetic surgery because they did not feel emotionally aligned with their bodies, and as a consequence they experienced a range of negative mental health outcomes. Cosmetic surgery was therefore largely an intervention into the physique in order to address the psyche. The plastic surgeons interviewed by Parker were also highly conscious of the psychological aspect of women’s motivations for the surgery. They viewed medical interventions as psychologically beneficial for women; to the extent that some of the surgeons
considered cosmetic surgery as more successful in alleviating psychological issues than mental health support. Having said that, the surgeons also highlighted that cosmetic surgery should be performed only on women who are mentally stable, even though their assessments of women’s mental stability was purely subjective. Specifically, only one of the nineteen interviewed surgeons reported referring to psychologists and psychiatrists regularly in their practice to assess patient’s mental health. This issue inevitably creates a paradox succinctly captured by Parker:

“To reiterate, these two issues are intertwined, yet contradictory. On the one hand, it is only psychologically ‘stable’ women who are deemed suitable for surgery, but on the other they are seen to be psychologically affected by their flawed bodies to such an extent that only cosmetic surgery can ‘cure’ them” (Ibid., p. 183).

Another paradox identified by Parker revolved around another set of motivations for cosmetic surgery, as viewed by the surgeons. Namely, surgeons were also conscious of the socio-cultural influences that shape women’s views of the aesthetics and ‘normality’, and in that process add to their body dissatisfaction. Whilst aware of the external influences such as women’s magazines that negatively affect women’s body image, Parker also notes that the surgeons often collaborated with those same magazines in order to promote their practice. Insomuch it seems that the surgeons not only respond to the demand for body and face alteration, but also create it by advertising via commercial avenues. Therefore, Parker contends that the surgeons themselves support the socially and culturally situated female beauty standards though the procedures that they carry out.

“It is ironic that some health professionals, when dealing with some aspects of women’s body image such as anorexia and bulimia, are working to counteract the influence that social, cultural and media pressures have on women, while others, through cosmetic surgery, are carrying out procedures that maintain and support these pressures” (Ibid., p. 90).

Parker’s work is not only valuable for this particular research, for she explores several important issues that will emerge in the analysis of women’s experiences of labiaplasty, presented in chapter nine. Her work is also important because she examines women’s motivations for cosmetic surgery alongside surgeons’ perceptions
of women’s motivation for those procedures. In that context, her ‘double’ analysis highlights the important contradictions pertaining to medical intervention into female bodies, and furthermore places these issues within a larger socio-cultural reality that shapes women’s and surgeon’s understandings of the contemporary beauty standards. Parker’s study, in combination with Braun’s work explored earlier in this section, attempt to provide a concise overview of debates and perspectives in feminist scholarship pertaining to cosmetic surgery, with their emphasis on the contextual and structural forces that frame and influence women’s choices to undergo elective procedures. Nevertheless, the ‘cultural discourse’ model has not managed to avoid criticism. For instance, Kathy Davis (1990, 1995) contends that in contrast to the ‘oppression’ model, the ‘cultural discourse’ model is a more advanced approach for exploring women’s beauty practices in a broader cultural context of gender inequalities. However, Davis also argues that this model relies on a conception of women embedded in a cultural discourse of female inferiority, and insomuch precludes the possibility of exploring cosmetic surgery as women’s actively chosen decision. In other words, it omits to pay sufficient attention to women’s feelings of embodiment and practical activities associated with that embodiment. In the words of Shelley Budgeon (2003), female body work is not necessarily about transforming its surface, but rather about transforming the way in which that body is lived. It could be said that based on these critiques of the ‘cultural discourse’ module, the arguably more liberal ‘agency in a restricted context’ approach emerged.

3.4. ‘AGENCY IN A RESTRICTED CONTEXT’ MODEL

Framing cosmetic surgery as women’s exercise of agency in a circumscribed socio-cultural context is arguably the most liberal approach to female body work associated primarily with sociologist Kathy Davis (1991, 1995). Her extensive study of cosmetic surgery in the Netherlands included face-to-face interviews with women who have had elective face and body procedures. Through her work she demonstrates that although highly controversial, cosmetic surgery can be a reasonable choice under some circumstances. Davis’ most prominent published pieces exploring this subject include Remaking the She-Devil: A Critical Look at Feminist Approaches to Beauty
Davis also highlights that cosmetic surgery is not only a risky but also expensive business, and insomuch not accessible to every woman. On top of that, women who opt for elective procedures have to justify their decisions not only to their surgeons, but to their families, friends and colleagues. Nevertheless, in spite of all the aforesaid disadvantages of cosmetic surgery, women remain very keen on having their faces and bodies altered by surgical means. Why is that so? Davis’ central argument is that cosmetic surgery should not be viewed in the context of beautification, for it has very little to with beauty itself. Instead she asserts that elective procedures should be viewed primarily in the light of three interrelated motivations: trying to look ordinary, ending suffering, and exercising one’s autonomy under the conditions that were not of one’s own choosing. In other words, Davis’ analysis suggests that the three central issues pertaining to female cosmetic surgery are normalcy, justice and agency. The first emerged issue ‘normalcy’ is very similar and indeed overlaps with the issue of ‘normality’ that Parker (2009) identified in her analysis. Namely, women in Davis’ study did not opt for cosmetic procedures in order to look beautiful, but rather to look ‘normal’. Again, the reoccurring theme is a woman’s desire to blend into the wider society. Davis contends that the theme of ‘normalcy’ requires a rather challenging exploration of what constitutes ‘normal’. Insomuch, Davis argues that the issue of ‘normalcy’ is an issue of boundaries:
“Understanding cosmetic surgery becomes, essentially, a matter of understanding boundaries: how can some part of the body be experienced as unacceptable? Where is the line between the "normal" deficiency, to be dealt with within the usual routines of body maintenance and improvement, and the abnormally ugly, that which can no longer be endured?” (Ibid., p. 38, emphasis in original).

Davis openly reflects on a common question that she gets asked in relation to her study of cosmetic surgery – are women really ‘ugly’ enough to need a surgical fix. She states that in her interaction with women she usually has a hard time perceiving what the problematic feature is. Furthermore, once she is familiar with the perceived problem, she is often surprised that a woman wants a medical intervention to address, in her view, a minor physical imperfection. Elaborating further on this illustration, Davis clearly emphasises that her evaluation of another’s woman appearance – and the accompanying ‘no’ to the question raised above – is not to imply that a surgery should not be undertaken. Rather, it suggests that her normative assessment of a woman’s physical appearance does not coincide with a woman’s evaluation of herself. Put differently, the inevitable discrepancy in people’s views of what constitutes a ‘normal’ female physique does not undermine nor alleviate women’s suffering associated with their perception of themselves. Davis underlines the importance of this cognition:

“A woman might be perfectly attractive to me (and to others) and still experience some part of her body as irredeemably ugly, casting a shadow over her entire life and influencing how she feels about herself, her relationships, her sexuality, her work, and so on. In her perception, her appearance crosses a subjectively defined boundary between the normal and the deviant, between what a woman should and should not "normally" be expected to endure” (Ibid., p.37, emphasis in original).

Davis’ work therefore underscores ‘normalcy’ is largely an issue of one’s perception that may not, and indeed isn’t, consistent among different individuals. Closely associated with the issue of ‘normalcy’ is the issue of suffering. Namely, in her study women’s perceptions of their bodies as abnormal were a great source of unhappiness, despair and ultimately suffering. This is why Davis frames cosmetic surgery as an issue of justice. She argues that cosmetic surgery is an issue of fairness, for it provides a possibility for creating justice in a situation that is
experienced as unjust. In this context Davis raises a thought-provoking question: how much suffering is fair? If cosmetic surgery is a potential solution to women’s suffering, then should not women be entitled to end their misery by surgical means? Can and should cosmetic surgery be viewed as a ‘right’? Davis is conscious that these questions require a complex and multi-layered discussion. Her study was based in the Netherlands where cosmetic surgery is available to anyone for as long as one can prove that their suffering has passed the threshold of what one would usually have to bear. This enables Davis to view cosmetic surgery not only as an issue of justice, but also morality:

“In a context where women suffer under the constraints of feminine beauty and at the same time begin to feel that they should not have to suffer, it is not surprising that cosmetic surgery might begin to be framed in the language of morality. It becomes a matter of justice and rights – the right to an ordinary appearance, the right to happiness and well-being, the right to services available under the welfare state, or simply the right not to suffer” (Ibid., p. 39).

Therefore Davis asserts that cosmetic surgery can often be a one-way, albeit limited, solution to alleviate a woman’s’ suffering that is experienced as unjust. Her third identified and interrelated issue pertaining to women’s motivation for cosmetic surgery revolves around agency; namely taking one’s life into one’s own hands. Although an ambivalent solution – for it does not guarantee a satisfactory outcome, and it may result in numerous and often serious side-effects – Davis suggests that cosmetic surgery stands in a contrast to a woman’s former situation that is often experienced as worse. Insomuch, a woman’s decision to have an elective procedure may be viewed as a courageous and therapeutic act in itself. She highlights that women are very aware of the oppressive nature of female beauty standards. However, although women comply with socially and culturally defined norm pertaining to femininity by having cosmetic surgery, that does not necessarily imply that they agree with the norm. Davis is careful to make the distinction between the two, for compliance and agreement need not go hand in hand. Once viewed in this light, cosmetic surgery may be seen as a reasonable choice under circumstances that were not of one’s own choosing. Herein lies the central element that separates ‘agency in a restricted context’ model from the previous two, for Davis contends that
agency is a central concern in the examination of women’s experiences of cosmetic surgery.

“Taking agency as a relevant feature in how women experience cosmetic surgery, the decision can itself become a radical and courageous act. By deciding to undergo cosmetic surgery, they initiate a dramatic change, becoming agents in the transformation and remaking of their lives as well as their bodies. This would account for how it would be possible to experience exhilaration about the decision even while disapproving of the practice itself” (Ibid., p. 35).

In other words, Davis argues that cosmetic surgery is neither imposed on women, nor is it purely a matter of individual choice. Cosmetic surgery remains a complex act at the best of times, and it often requires ongoing deliberation and justification. Having said that, Davis also underscores that women who have it are not oppressed ‘cultural dupes’, unaware and ignorant of the problematic female beauty ideals surrounding them. On the contrary, they are conscious and critical of dominant beauty standards, and they may not even agree with these. However, in spite of the aforementioned, women knowingly and actively choose to change their faces and bodies in the attempt to change a situation that is experienced as unbearable. Interestingly, Davis’ work also highlights one important aspect of deliberation post-surgery, which will be of importance for this particular study. Davis states that very rarely had she met a woman who had serious regrets about undergoing cosmetic surgery. Namely, even when, medically speaking, the operation was not entirely successful Davis found out that women were still happy with their choices. She reflects on this paradox:

“It was surprising how pleased women were with the surgery even when it did not live up to their expectations. One woman, for example, who had undergone breast augmentation said that she didn’t mind the fact that one of her breasts was hard because at least now she had one breast that was just what she had always wanted!” (Ibid., p.43)

It seems as if women in her study were satisfied with their decisions to have the surgery regardless of the outcome, possibly for the decisions themselves were a moment of triumph. Davis therefore suggests that, even when not fully satisfactory, the outcome of cosmetic surgery is always experienced as better than the situation before. She suggests that for these women it was better to have tried and failed than
never to have tried at all. It is interesting to note Davis’ conclusion for the findings of this study may indicate the same thing – an unanticipated outcome of cosmetic surgery and yet no regret present post-surgery. In sum, Davis’ work paved the way to ‘agency in a restricted context’ approach to female body work, in the attempt to explore the complexities pertaining to deliberation about cosmetic surgery, without negating or undermining women’s autonomy in the process. Her analysis initiates further questions about what constitutes ‘normalcy’ when it comes down to female bodies. In other words, how does a woman decide what is ‘normal’ and what is ‘abnormal’? Which factors, possibly personal, familial or otherwise social influence a woman’s perception of and pursuit of ‘normalcy’? In sum, Davis’ work on cosmetic surgery remains one of the most influential and inspiring pieces on female body work and cosmetic surgery specifically.

Another feminist scholar whose work explores cosmetic surgery from a very similar perspective to that of Davis’ is sociologist Debra Gimlin (2000, 2002). Similarly to Davis, Gimlin views cosmetic surgery primarily as a tool for women’s inner transformation. She elaborates on this perspective in her paper Cosmetic Surgery: Beauty as Commodity (2000) and the subsequent book Body Work Beauty and Self-Image in American Culture (2002). Although Gimlin clearly states that women live under a system of gender oppression, she also contends that they are knowledgeable cultural negotiators who locate space for personal liberation within those given social and cultural limits. Gimlin grounds her conclusions in an extensive study of women’s experiences of face and body cosmetic surgery, wherein she conducted interviews with one American plastic surgeon and twenty of his female patients (2000). Taking into account the feminist criticism associated with cosmetic surgery, Gimlin asserts that cosmetic surgery is primarily an intervention into one’s identity. Namely, she argues that a human body is fundamental to the self, for it inevitably indicates who that individual is internally – the body ‘talks’ about the person’s habits, social values and importantly their character. Considering that women are incapable of meeting contemporary beauty standards – for the standards themselves are impossible to reach – women inevitably violate modern cultural imperatives. Therefore they engage in body work in order to repair their ‘flawed’ identities symbolised though their ‘imperfect’ bodies. For Gimlin the very essence of
body work is work on the self. She reflects on her interviews with women in order to illustrate this point:

Significantly, the women I talked to provided accounts in which they attempted to dissociate themselves from responsibility for perceived bodily flaws. Each woman’s body was imperfect not because she had erred in her body work but because of aging, genetics, or some other physical condition that the woman could not control. In effect, they argued that their flawed bodies were incorrect indicators of character, and, as such, effectively lie about who the women really are. Accounts like these not only justify cosmetic surgery but attempt to convert it into an expression of a putatively true identity. Plastic surgery becomes for them not an act of deception, but an effort to align body with self (Gimlin 2000:88-89).

In Gimlin’s analysis a woman’s body is therefore a symbol of her character – a symbol that need not be accurate and indeed often isn’t – which then enables her to view cosmetic surgery in the light of identity construction. Focusing further on women’s motivations for cosmetic surgery, in some respects Gimlin’s findings are astonishingly similar to that of Parker (2009), Davis (1991, 1995) and other feminist scholars who have research this particular topic (for instance see Kaw 1997). Specifically, Gimlin also emphasises that women do not opt for elective procedures in order to look beautiful, but to look ‘normal’. They insisted that they have cosmetic surgery for their own satisfaction – ‘for themselves’ – in order to create a ‘normal’ physical appearance. In turn, the women in Gimlin’s study expected that their ‘ordinary’ appearance would then enable them to live ‘ordinary’ lives. For some this included the much desired romantic relationship that they lacked before surgery, and for others it included the desire to advance their career prospects and ensure their work ability. In other words, women largely underwent a physical transformation, guided by the notion of ‘normality’, in the attempt to transform their lives. However, Gimlin highlights that by utilizing cosmetic surgery women respond to the highly restrictive notion of ‘normality’, which reflects a plethora of inequalities. This brings a strong element of intersectionality to her analysis, which many other feminist analyses often lacked. Namely, Gimlin underscores that apart from gender issues, cosmetic surgery also includes issues related to age, race, ethnicity and socio-economic class. For instance, women have cosmetic surgery not only to erase signs of aging, but also signs of their ethnic belonging.
“Many women surely undertake plastic surgery, most notably in the case of breast
enlargement, to enhance distinctively female attributes. Others, however – Jewish
and Italian women who have rhinoplasty, Chinese and Japanese women who have
their eyes reshaped – do so in a distinctively ethnic context. And many others have
plastic surgery in an attempt to reproduce the bodies of their youth. If plastic
surgery speaks to the depredations of gender domination, we should recognize
that it also speaks to the depredations of Anglo-Saxon ideals of beauty and the
attachment of ideals of beauty to youth” (Ibid., p.80-81).

A similar point with regards to cosmetic surgery and ethnic identity was made by Kaw
(1997) who demonstrated that women of different ethnicities choose different
procedures, largely to erase the negative value associated with their racial identity.
This only adds to the already present controversy surrounding cosmetic surgery, for it
may not only be a tool for removing differences between individual women, but also
an instrument for eradicating ethnic diversity. In spite of that, Gimlin’s work shows
that women who had cosmetic surgery were determined in their claim to have
benefited from the procedure. They asserted that the decisions to have their bodies
surgically altered were carefully thought-out and logical responses to address
otherwise distressing life circumstances. As a result women perceived themselves
more ‘normal’, socially acceptable and attractive, which in turn heightened their self-
confidence. For instance, women were keener on wearing revealing feminine clothes
post-surgery, which enabled them to perceive themselves as attractive, and
consequently had a positive impact on their perception of the self. This part of
Gimlin’s analysis perfectly captures the interaction between a women’s outer self, her
body, and a woman’s inner self, her identity. Gimlin also found out that although
women’s partners shared the pleasure resulting from their altered bodies, they did
not find the procedures necessary to begin with. Specifically, in almost all cases the
women told Gimlin that their partners did not find the surgery necessary. Gimlin views
this in the context of those women’s need to assert themselves, and underline the
importance of their ‘free’ choices to undergo elective procedures. By making such
assertion women would exclude the possibility of having been subject to an external
pressure or coercion from a lover, but also dismiss the possibility that they have
undergone surgery to please men. Gimlin asserts:
Plastic surgery cannot be both something women “deserve” and something that they were forced or manipulated into doing. In their accounts, plastic surgery is positioned as a final option for women who could not otherwise live peacefully with themselves. This conception of plastic surgery is clearly inconsistent with an image of acts forced upon them by others – particularly others who might actually benefit more from the procedures than do the women themselves (Ibid., p. 94).

Gimlin’s conclusions therefore support her central argument that women are savvy cultural negotiators who make the most out of their bodies and lives within the given circumscribed socio-cultural context. In other words, she suggests that although the culturally situated notions of female beauty indeed shape these women’s decision to undergo surgical intervention, they do not challenge that very culture. Instead, they actively and knowledgeably choose to operate within it. Apart from framing women’s body work as identity work, Gimlin also strongly emphasises the intersectionality embedded in women’s decisions to alter their features. Insomuch, her analysis in some ways introduces another layer of complexities pertaining to cosmetic surgery. The question that one may ask following an in depth engagement with her work is why don’t women challenge the cultural notions of beauty. She makes it perfectly clear that women choose to work under the circumstances that were not necessarily of their own choosing, but the question remains – why not challenge the aforesaid circumstances? Although at the very onset this particular piece ambitiously aspired to address that question, the exceptionally difficult participant recruitment process somewhat restricted the variety of topics that could have been explored during the interviews. This issue is addressed in chapter five as a limitation of this study. Therefore, even though ‘agency in a restricted context’ model is principally the model within which the findings of this research will fall, this approach however remains neither perfect nor absolutely complete in addressing women’s preoccupation with and investment in their physique. Possibly, however, such comprehensive and undisputable theoretical framework may not even exist.
3.5. CONCLUSION

This chapter attempted to succinctly outline and critically appraise the three most prominent feminist approaches to female body work, and to reflect specifically on those scholars’ work whose contribution is particularly relevant for this research. The three identified approaches to body work – arguably sliding from the least to the most liberal – are ‘oppression’ model, ‘cultural discourse’ model and ‘agency in a restricted context’ model. The chapter first expanded on the work of Naomi Wolf (1991) Sheila Jeffreys (2005) in order to capture, what proponents of ‘oppression’ model claim to be, the gendered, oppressive and harmful nature of female beauty practices. In this model, it was shown that female body work may be viewed as part of a wider system of social and cultural practices, which have a detrimental effect on women’s social standing and psychological well-being. The imperative of conforming to dominant beauty norms that are unhealthy and unattainable is viewed as a tool to undermine the women’s advancement brought forward by the feminist movement, and insofar to maintain unequal gender dynamics. Jeffreys (2005) convincingly demonstrates that Western female beauty practices are no different from the non-Western traditional practices – that are regularly viewed in the light of male domination and female subordination. Wolf (1991) persuasively tackles the issue of autonomy in order to highlight that women’s ‘choice’ to later their bodies becomes a survival strategy in the attempt to keep their livelihood and identities in place. In spite of its contribution, this approach also restricts the possibilities of feminist analysis of women’s motivations for and experiences of the aforesaid body work. It may not be a coincidence that from a methodological point of view the scholars who endorse the ‘oppression’ model rarely seem to conduct direct interviews with women who partake in body work. The second, ‘cultural discourse’ model, departs from the dominant focus on male-female power relations, and views female body work in the light of unequal and thus restrictive social and cultural structures. In this model, the work of Virginia Braun (2005, 2009) was explored in order to underline that women’s seemingly free choices to engage in body work do not exist prior to and outside of a cultural context. Rather, these choices are formed, shaped and enmeshed in that precise context. Furthermore, it was demonstrated that women’s psychological issues and impeded sexual satisfaction – largely framed from a normative heterosexual male-centred
perspective – serve as a motivation and justification for cosmetic surgery. Importantly, this raises a question about whether cosmetic surgery becomes a tool for altering a woman’s body in order to alter her state of mind. Rhian Parker (2005) also focused on the contextual and structural forces that affect women’s choices to undergo elective procedures, as well as plastic surgeons’ understandings of contemporary female beauty standards. Insomuch, her work clarifies that women demonstrate agency by choosing to undergo surgery, yet once the surgery begins and someone else reshapes their bodies their agency is compromised. It was also shown how Parker’s study confirmed what Kathy Davis (1991, 1995) and Debra Gimlin (2000, 2002) also found out – the latter two being associated with the most liberal ‘agency in a restricted context’ model. This model largely proposes that women have cosmetic surgery in order to look ‘normal’ and blend into the wider social reality. Cosmetic surgery therefore becomes a means of achieving aesthetic ‘normalcy’, social acceptance and belonging. Therefore such medical intervention into the body may be viewed as an intervention into one’s identity. Both Davis’ and Gimlin’ studies showed that women are neither oblivious of the socially and culturally situated beauty standards, nor do they necessarily approve of these. However, their work showed that even though women do not agree with the contemporary beauty standards and the given socio-cultural context, they actively and knowledgeably choose to operate within it. In summary, the work presented in this chapter provided diverse and yet essential theoretical underpinnings for this study. As the findings will demonstrate, although all of these three approaches provided most beneficial frameworks for understanding women’s body work, ultimately the last two models, and especially ‘agency in a restricted context’, will be the one that captures women’s experiences of labiaplasty in the most accurate fashion.
4. RESEARCH METHODOLOGY – THEORETICAL UNDERPINNINGS

4.1. INTRODUCTION

This chapter will identify and elaborate on the theoretical foundation of the methodological approach employed in his study. Firstly, drawing on the work of Creswell (2007), Neuman (2007), De Vaus (2001) and Liamputtong (2007), it will outline the reasons for choosing a qualitative study over a quantitative inquiry as a means of researching labiaplasty. This chapter will explore feminist research and methodology as the principal theoretical lens adopted in this research, which emerged from the feminist critique of social sciences. The problematic aspects of traditional social science and positivist research approach – as identified by feminist scholars – will be explored, as well as the valuable contribution of feminist scholarship resulting from this critique. Specifically, further attention will be dedicated to epistemological privilege and feminist standpoint theories. Both of these concepts will be elaborated upon in order to demonstrate how the underprivileged may have the possibility to perceive the world more clearly, for their ‘vision from below’ may enable them to see the real power relations that remain largely concealed from the perspective of the dominant social group. Consequently, it will be argued that the most accurate and empowering way to analyse social reality is by taking the underprivileged – and in this situation women’s – experiences as the starting point of the inquiry. Drawing on the work of Haraway (1988), Harding (1991), Hartsock (1983), Narayan (2008) and Smith (1974) this chapter will also explore the notions of ‘partial’, ‘situated’ or ‘contextual’ knowledge in order to highlight that ‘value-free’ and thus ‘objective’ research is not only unattainable, but also undesirable. Expanding on that idea, this chapter will address researcher’s reflexivity and the acknowledgment of one’s subjectivity that may colour the research process. In that context, an intellectual autobiography (Woodward 2000) of the researcher will be provided. The chapter will also reflect on phenomenological approach adopted in this study, and a variation of this approach called the Interpretative Phenomenological Analysis (IPA) developed by Jonathan Smith (2007, 2010). In the recent years, IPA has become a popular qualitative method primarily in health and social research (Boyle et al. 2005,
Jones 2010, Safari 2013, Marriot et al. 2008, Dürr 2008, Leve et al. 2011, Nunn 2009). The reasons for choosing IPA as a data analysis method will be outlined, as well as the strengths and the weaknesses of this particular method. Finally, the sample size and the primary data collection method employed in this research will be identified – all of which are in line with the guidelines of IPA and feminist research principles.

4.2. WHY A QUALITATIVE STUDY?

Female genital cosmetic surgery (FGCS) including labiaplasty is a newly emerged procedure in the field of cosmetic industry. To this point, empirical studies looking into FGCS were conducted mainly by medical practitioners exploring various aspects of these procedures, as indicated in chapter one. These studies to date include an overview of possible genital surgical procedures (Dobbeleir et al. 2011), clinical characteristics and expectations of women requesting a procedure (Crouch et al. 2011), genital appearance satisfaction (Bramwell and Morland 2009), visual depictions of female genitalia (Howarth et al. 2010), norm and normality in regard to female genitalia (Karkazis 2010, Loyd et al. 2005), outcome data of a genital surgical procedure (Goodman et al. 2009, Rouzier et al. 2000), clinicians’ response to requests for FGCS (Liao and Creighton 2007, Michala et al. 2012), legislation on female genital mutilation and the implications for plastic genital surgery (Essen and Johnsdotter 2004), online advertisements for FGCS (Liao et al. 2012, Moran and Lee 2012) and ethical and rights dilemmas (Cain et al. 2013). Although helpful in providing an understanding of elective genital procedures including labiaplasty, the aforesaid studies did not attempt to examine women’s experiences of labiaplasty in depth, by taking women’s perspectives as the starting point of the inquiry. Adopting a qualitative and specifically phenomenological approach this research aims to fill this identified gap, as discussed in chapter one. This section specifically aims to examine further the reasons for choosing a qualitative approach, as opposed to a quantitative approach, in researching women’s experiences of labiaplasty.
Creswell (2007:37) defines qualitative research as an inquiry into the meaning individuals or groups ascribe to a social or human problem. Following Creswell’s advice on when to use qualitative research methods, it will be argued that this approach is appropriate for exploring a complex and sensitive issue such as labiaplasty. Firstly, the lack of qualitative research investigating women’s increasing demand for genital cosmetic procedures suggests that there is a need to explore this particular group. Secondly, adopting a feminist theoretical framework, this study begins with the belief that women are still an oppressed, marginalized and silenced social group (Devault 1990:98). Qualitative approach in turn allows for women’s voices to be heard, and aims to empower women in order for them to share their stories. Furthermore, the intent of this study is to minimize the power relationship between the researcher and the study participants in order to establish trust and rapport. This also explains why qualitative methods are preferable and sometimes the only appropriate route for conducting so called sensitive research (Liamputtong 2007).

Qualitative research is also recommended when needing a complex and detailed understanding of an issue, which can be best achieved by talking directly to a particular population. In relation to that, not only does this study seek a detailed account of individual’s experience of labiaplasty, but it also seeks an understanding of women’s relatedness to Western socio-cultural context in which requests for these procedures are located. Qualitative researchers acknowledge that “we cannot separate what people say from the context in which they say it” (Creswell 2007:40). This highlights the necessity to explore the setting in which study participants encounter a particular issue. Qualitative methods are also advised when quantitative measurement and statistical analysis simply do not fit the research, which seems to be the case here for the aim is not to generalize the findings to the entire female population seeking cosmetic procedures, but rather to provide an in-depth understanding of several women’s experiences and ultimately say something about what is it like being a woman in a contemporary Western society.

Drawing on Neuman’s (2007:84-90) distinction between quantitative and qualitative research, several more arguments could be identified for choosing the latter one. The very nature of the data dictates which of these two approaches to employ –
quantitative methods usually require and produce ‘hard data’ in the form of numbers, in contrast with qualitative methods which work with ‘soft data’ including impressions, words and sentences. Another important feature used to distinguish between these two approaches is whether the research aims to test a theory or to build one (De Vaus 2001). Theory testing, often found in quantitative research, begins with a theory and subsequent observations should provide a test of the worth of the theory. Theory testing therefore uses deductive reasoning, starting with the general and going into specific – top-down. In contrast, theory building, normally associated with qualitative research, starts with observations that will eventually generate a theoretical foundation. Theory building therefore uses inductive reasoning and proceeds from specific to the general – bottom-up. Lastly, qualitative methods are more ‘tolerant’ to non-linear and cyclical research paths, enabling the researcher to slowly narrow down the topic and develop the research questions during the data collection process. This seems to be important for the exploration of women’s experiences of labiaplasty. Namely, this issue can be approached from various standpoints and focusing the topic before any data collection began may be rather challenging. In other words, the emergent data will to a large extent dictate how to frame the final version of research questions. All of these reasons explain why a qualitative approach has been chosen in order to explore women’s experiences of labiaplasty. The following sections elaborate on feminist methodologies and research principles that are relevant for this study.

4.3. FEMINIST RESEARCH AND METHODOLOGY

The theoretical lens used in this doctoral research is broadly informed by debates on feminist research principles, which sometimes seem to be used interchangeably with feminist methodology. Drawing on the work of Harding (1987), DeVault (1996:31) offers her definition of feminist research and methodology:

“I understand “feminist research” as a broader category including any empirical study that incorporates or develops the insights of feminism. Feminist studies may use standard research methods, or they may involve explicit attention to methodological critique and innovation. I would like to reserve the term “feminist
methodology” for explicitly methodological discussion that emerges from the feminist critique.”

Gorelick (1991) argues that this critique of social sciences from a feminist perspective – which Devault identifies – took place on three interrelated levels. On a philosophical level the main culprit was positivism and the conviction that knowing can be ‘value-free’, unbiased and objective. Introducing the notions of ‘strong objectivity’ (Harding 1991), ‘situated knowledges’ (Haraway 1988) and ‘contextual knowledge’ (Narayan 2008) feminist scholars contend that perspectives are located and that knowing is always partial. Narayan for instance suggests that knowledge is not gained by solitary individuals, but by members of groups that are socially and historically situated:

“Important strands in feminist epistemology hold the view that our concrete embodiments as members of a specific class, race, and gender as well as our historical situations necessarily play significant roles in our perspective on the world; moreover, no point of view is “neutral” because no one exists unembedded in the world” (Narayan 2008:760-761).

In other words, subjects are located in a particular time and place – a geo-cultural space – that enables them to know the social world only partially. Nevertheless, feminist scholars also argued that “knowledge that is admittedly partial is more trustworthy than partial knowledge presented as generally true” (Collins 1990 in Devault 1996:41). Furthermore, the partiality of one’s perspective can be compensated by looking at things from a different position in order to reveal the constructedness of both (Sprague and Kobrynnowicz 1999). Secondly, on a moral level, Gorelick underlines the unequal power relationship between the researcher and the researched that may include objectification and furthermore exploitation of the study participants. ‘Data raid’, ‘smash and grab’ and ‘colonization’ are all the terms that Liamputtong (2007:57) deploys to capture this power imbalance, wherein the researcher gets in, get their data and gets lost, completely disregarding study participants. Baker and colleagues (2004) discuss their concept of a ‘hit and run’ model of research in which the oppressed become the subject of inquiries conducted by members of the privileged social group. There might have been good intent on the
researchers’ part to begin with, but arguably the outcome is that the researchers own a part of the oppressed people’s world and therefore a part of them:

“The very owning and controlling of the stories of oppression adds further to the oppression as it means that there are now people who can claim to know and understand you better than you understand yourself; there are experts there to interpret your world and to speak on your behalf. They take away your voice by speaking about you and for you” (Baker et al. 2004:174).

Finally, on a practical level, Gorelick argues that this hierarchical relationship between the researcher and the researched may result in distortions, lies and manufactured results. This is so because the subject population may not tell the truth to those in power. Moreover, she contends that large-scale projects produce two subject populations – the people being studied and the people doing the routine labour involved in studying them. The problem is that the latter group may find ways of cutting short their work, and therefore may alter the findings of the study. Gorelick summarizes (Ibid. p. 461):

“Between the creative dissimulation of the objectified research subjects and the subversive creativity of the research workers, both responding to their different modes of exploitation, the results are often not science but science fiction.”

While some argue that there is no such thing as a distinctive feminist method, there appears to be an agreement in feminist scholarship concerning the elements that constitute feminist methodology. Cook and Fonow (1986 in Cancian 1992) provided a comprehensive statement of these features. First and foremost, the main concern of feminist methodology is gender and gender inequality, although recently scholars have emphasized the importance of the intersectionality of gender and other characteristics including ‘race’, ethnicity, class, sexuality, age and physical and mental impairment. Secondly, feminist methodology is dedicated to giving voice to women and describing, critically analysing and interpreting their everyday experiences that were neglected by traditional social sciences. Thirdly, feminist research is carried out with the express aim of encouraging a social transformation in order to improve the conditions of women’s lives. Furthermore, influenced by postmodernist thought, feminist researchers take a critical stance towards traditional
social sciences and underline that the research process is shaped and influenced not only by the researcher’s identity, but also by the wider socio-cultural context in which the researcher works. Finally, some feminist researchers rely on participatory methods that alter the traditional separation between the researcher and the researched, and therefore aim to bring the study participants inside the research process.

Demonstrating that social sciences are “sexist, biased and rotten with patriarchal values” (Stanley and Wise 2002:26) feminist researchers aim to amend these fundamental shortcomings and therefore they place women at the centre of the inquiry. It can be concluded then that feminist research is research carried out on women, by women and for women. However, Stanley and Wise contend that feminist research carried out on women can lead to a ‘ghetto effect’ whereby feminist work has little or no implication for the rest of the society. Although feminist research is essentially research on women, they assert that it should not be confined to women exclusively: “If ‘sexism’ is the name of the problem addressed by feminism then men are importantly involved, to say the least, in its practice” (Ibid., p. 31). Furthermore, Stanley and Wise contend that feminist research should be conducted solely by women. Namely, they argue that men cannot be feminists for they lack the possession of feminist consciousness that is rooted in concrete and everyday experiences of being a woman. In their view, feminist consciousness is essential to being a feminist. Stanley and Wise also assert that feminist research needs to be carried out for women in order to formulate policies that enable feminist action. Going back to their second point, as to whether feminist research should be conducted exclusively by women who are in possession of feminist consciousness, the question that follows is whether women, as the oppressed social group, hold an epistemological privilege over men?

4.3.1. EPISTEMOLOGICAL PRIVILEGE

In order to address the question raised in the previous section, the concept of epistemological privilege will be explored now. Epistemological privilege implies that
the oppressed may have the possibility of perceiving the world more clearly for they may see their oppressors and understand their experience of oppression. This ‘clearer’ perspective may be argued to lead to a less distorted view of social reality. In other words, women’s experiences of oppression and subjugation may enable them to inhabit two social realms at the same time, which in turn could have epistemological implications:

“Women’s present marginality within ‘male society’ means that women know about two different ‘worlds’, men know about only one. Including women’s ‘world’ in academic work would lead to the concerted reordering of established beliefs and perspectives, and also to a greater understanding of the many different stratifications which exist within society” (Stanley and Wise 2002:30).

One of the pioneers of such an approach is Nancy Hartsock (1983) who developed a feminist perspective on the sexual division of work drawing on Marxist ideas. She argues that the realities of women’s lives are profoundly different than those of men and, in order to illustrate this, she drew a comparison between the oppressed male workers in Marxist theory and women. Hartsock argues that women do the double work of reproduction – subsistence and childrearing – that renders them different from the male workers whose engagement in the process of production does not consume the whole of their lives. Secondly, a larger proportion of women’s time than men’s is spent in the production of use-value which, unlike surplus-value, has utility only in the process of consumption and not in the process of market exchange. Finally, women’s production is structured in repetition differently than men’s production. Hartsock observes the radical transformation of the male worker’s social position from that of an oppressed class in the factory to that of the dominant one in the private sphere:

“He who before followed behind as the worker, timid and holding back, with nothing to expect but a hiding, now strides in front while a third person, not specifically present in Marx’s account of the transaction between capitalist and worker (both of whom are male) follows timidly behind, carrying groceries, baby and diapers” (Hartsock 1983:291).
Hartsock argues that this division of labour between men and women, just like the one between the worker and the capitalist, has epistemological consequences. She paraphrases Marx and asserts that a gendered society produces a dual vision in the form of the ruling gender vision and the ruled gender vision. In her view, if we are to understand gender inequalities then we need to adopt the vision of the ruled gender:

“Women’s lives make available a particular and privileged vantage point on male supremacy, a vantage point which can ground a powerful critique of the phallocratic institutions and ideology which constitute the capitalist form of patriarchy” (Ibid., p. 284).

However, epistemological privilege may not be acquired easily to women. It can be struggled for whenever women experience gender subordination and have the possibility of developing feminist political consciousness. In a similar fashion, Sandra Harding (2008, 2009) contends that gender difference can be a scientific resource because it raises questions about the nature of social relations from the perspective of devalued and neglected. Harding’s main point is that one has to either live as a member of the oppressed group or do the necessary work in order to gain a deep understanding of how the society functions, for “what one does both enables and limits what one can know” (Harding 2009:194). She argues that the oppressed and dominated have fewer interests in ignorance about social reality, and therefore they offer a view different from the ‘winner’s stories’. In other words, they provide a better understanding of gender relations within a given culture. Therefore, adopting the perspective of women’s daily experiences voices what it is like to be on the other side of gender battles:

“It starts though in the perspective from the life of the Other, allowing the Other to gaze back shamelessly” at the self who had reserved for himself the right to gaze “anonymously” at whomsoever he chooses. It starts thought in the lives of people who are unlikely to permit the denial of the interpretive core of all knowledge claims. It starts thought in the perspective from lives that at this moment in history are especially revealing of broad social contradictions.” (Harding 2008:748).

While underlining the pitfalls of the ‘vision from below’, Donna Haraway (1988) concurs with Harding in relation to the value associated with this perspective.
Haraway argues that the standpoint of the subjugated is preferred because they are least likely to allow denial of the critical and interpretative core of all knowledge:

“The subjugated have a decent chance to be on to the god trick and all its dazzling – and, therefore, blinding – illuminations. ‘Subjugated’ standpoints are preferred because they seem to offer more adequate, sustained, objective and transformative accounts of the world” (Haraway 1988:584).

The vantage point of the subjugated is better than the perspective of the powerful as long as it is a responsible knowledge claim. It seems that Haraway is using the term ‘responsible’ here in order to highlight that the subjugated and their claims need to be held to account. She warns against the danger of romanticizing and appropriating the vision of the subjugated and highlights the necessity to critically analyse their positioning:

To see from below is neither easily learned nor unproblematic, even if “we” “naturally” inhabit the great underground terrain of subjugated knowledges. The positioning of the subjugated are not exempt from critical re-examination, decoding, deconstruction, and interpretation; that is, from both semiological and hermeneutic modes of critical inquiry” (Ibid., p.584).

A detailed and yet concise critique of the epistemic privilege was provided by Uma Narayan (2008) who stresses the shortcomings the notion of ‘double vision’ generates. She contends that it is a mistake to assume that people who inhabit a different social context can never attain some understanding or sympathy for the oppressed. If that was so, in her view, we would be committed to a relativistic view of knowledge whereby a person could comprehend only those things she had experienced personally. She does agree though that it is easier and more likely for the oppressed to have a critical insight into their state than for those outside that social structure, but she asserts that their experiences can be communicated across social contexts:

“Not only does this seem clearly false and perhaps even absurd, but it is probably a good idea not to have any a priori views that would imply either that all our knowledge is always capable of being communicated to every other person or that

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would imply that some of our knowledge is necessarily incapable of being communicated to some class of persons” (Ibid, p.762).

Narayan argues that the notion of ‘double vision’ – that enables the oppressed to have an insight into two fundamentally different and incompatible worlds – is problematic for at least three reasons (Ibid, pp. 763-765). Firstly, a person might dichotomize her life and reserve each vision for a corresponding social context which happens, for instance, when a woman of a minority culture lives a westernized public life and yet returns to her traditional lifestyle in the private sphere. Secondly, an individual might reject her identification with the oppressed and attempt to resemble the members of the dominant group. To illustrate her point, Narayan stresses that women may expunge stereotypical female traits like emotionality, and acquire those usually associated with men such as aggressiveness. There is a possibility of critically inhabiting both social worlds, which is in her view a more useful option. Nevertheless, it comes with a price that manifests in the lack of roots, or of any space where one feels at home. Finally, Narayan stresses that some oppressive contexts render people devoid of the skills necessary for functioning as an independent entity. For instance, girls and women from poor backgrounds, who are economically dependent on their fathers until passed to their husbands, were never trained for anything beyond household tasks and childrearing. Therefore, they may not have the capacity to locate the causes of their oppression in a larger social structure. Narayan summarizes this dark side of ‘double vision’:

“I suspect that nonwestern feminists, given the often complex and troublesome interrelationships between the contexts they must inhabit, are less likely to express unqualified enthusiasm about the benefits of straddling a multiplicity of contexts. Mere access to two different and incompatible contexts is not a guarantee that a critical stance on the part of an individual will result” (Ibid., p.763).

Narayan does not seem to reject the notion of ‘double vision’ altogether. She rather highlights that the focus on the epistemological privilege should not shift out attention from concrete social analysis, and real material and psychic deprivations inherent to the lives of the oppressed. The second issue to be explored in this section refers to a particular perspective from which one may obtain a ‘clearer’ picture and therefore better understanding of gender relations – feminist standpoint theories.
4.3.2. FEMINIST STANDPOINT THEORIES

If the oppressed have an epistemological privilege which enables them to see the real power relations that remain concealed from the perspective of the dominant social group – men – then the most accurate and empowering way to analyse this oppression is to take women’s daily experiences as the starting point of the inquiry. Notwithstanding differences between feminist theories, it may be argued that adopting a feminist standpoint assumes that the most adequate knowledge can be reached by starting with women's experiences, and developing these through analysis and action (Cancian 1992). Ramazanoglu and Holland (2002) acknowledge the number of approaches that this notion subsumes, and thus provide an overarching definition of a feminist standpoint.

“…It can tentatively be said that the notion of standpoint is a way of taking women’s experience as fundamental to knowledge of political relations between women and men (of which people may or may not be aware). Taking a standpoint means being able to produce the best current understanding of how knowledge of gender is interrelated with women’s experiences and the realities of gender. Knowledge can be produced from a feminist standpoint wherever women live in unequal gendered social relationships, and can develop a feminist political consciousness” (Ramazanoglu and Holland 2002:60-61).

Building on the work of bell hooks, Ramazanoglu and Holland (Ibid.) compare the notion of a feminist standpoint to the critical black gaze. Translating hooks’ conclusions into this discussion about feminist standpoint theories, they argue that a feminist standpoint serves to identify maleness as a privileged social identity. Furthermore, they assert that this privilege is part of an institutionalized system of gendered inequality. Two conditions need to be met in order for a feminist standpoint to emerge: firstly, women need to live in unequal gendered social relations and secondly, they need to develop a feminist political consciousness. Ramazanoglu and Holland therefore contend that a feminist standpoint is an achievement grounded in the experience of gender subordination, and constituted as feminist theory.

Drawing on the work of Hekman (1997) who critically reviewed the contribution of Collins, Harding, Hartsock and Smith to feminist standpoint theories – and their
somewhat agitated responses to Hekman’s analysis – Ramazanoglu and Holland (2002) extracted five key characteristics of a feminist standpoint. Firstly, a feminist standpoint explores relations between knowledge and power, and insofar it assumes and problematizes the inseparability of politics, theory and epistemology. Secondly, a feminist standpoint deconstructs the ‘knowing feminist’ and recognizes that when feminists speak, they do so from a specific and partial social location. This process of deconstruction has two important implications – it reveals the specificity of the researcher herself, and the power relations between the researcher and the researched. Thirdly, a feminist standpoint is grounded in women’s experience including emotions and embodiment, which raises questions about the nature and relations between experience, knowledge and reality. Furthermore, a feminist standpoint takes into account diversity within the category called ‘women’ and the interconnecting power relations between different women. Finally, the knowledge acquired from a feminist standpoint is always partial, which means neither total nor impartial.

In spite of their nuanced understandings of a feminist standpoint, all of the scholars mentioned above employ the notion of ‘partial’, ‘situated’ or ‘contextual’ knowledge in order to highlight the impossibility of acquiring objective, ‘value-free’ and universally applicable knowledge. Dorothy Smith (1974) for instance develops a feminist standpoint from a critique of sociology as a discipline based on and built up within a male social universe. Smith argues that the relationship between the observer and the object of observation is a specialized social relationship:

“The only way of knowing a socially constructed world is knowing it from within. We can never stand outside it. A relation in which sociological phenomena are objectified and presented as external to and independent of the observer is itself a special social practice also known from within.” (Smith 1974:11).

In like manner Sandra Harding (2009), one of key theorists in the field of feminist standpoint theories, argues that a standpoint is neither value-neutral nor relativist. This is what she views as one of the four commitments of standpoint theories. The other three include starting from the daily lives of the oppressed, critically examining what is wrong and explaining what the oppressed need and want, and finally
struggling to achieve a standpoint. She discusses what she calls value-free ‘objectivism’ and relativism as epistemological stances often presented as the opposites, and subsequently examines how these two stances appear from a feminist standpoint. Harding argues that ‘objectivism’ and relativism are both problematic – the former for its persistence on value-neutral, impartial and dispassionate objectivity that is supposed to guide scientific research, and the latter for its denial of the possibility of locating standards for making judgments between competing claims (Harding 2008:742). On the other hand, she contends that feminist standpoint theories recognize people’s social situatedness and yet do not lead to cultural relativism, for they seek a scientific account of the relationships between historically located belief and maximally objective belief:

“The standpoint epistemologies call for recognition of a historical or sociological or cultural relativism – but not for a judgmental or epistemological relativism. They call for the acknowledgment that all human beliefs – including our best scientific beliefs – are socially situated, but they also require a critical evaluation to determine which social situations tend to generate the most objective knowledge claims” (Ibid., p.743).

Feminist standpoint theories then increase the objectivity of the research results by examining the relationship between the subject and the object, and challenging the practices that seem natural from the perspective of the dominant group. The previously discussed work of Nancy Hartsock (1983) also points to women’s lives as a privileged vantage point on male supremacy:

“A standpoint is not simply an interested position (interpreted as bias) but is interested in the sense of being engaged. It is true that a desire to conceal real social relations can contribute to an obscurantist account, and it is also true that the ruling gender and class have material interests in deception. A standpoint, however, carries with it the contention that there are some perspectives on society from which, however well-intentioned one may be, the real relations of humans with each other and with the natural world are not visible” (1983:285).

Expanding on Marxist theory, Hartsock examines five epistemological and methodological claims in the light of gendered realities, in order to develop a feminist standpoint theory. The first claim is that the material life limits the understanding of
social relations. This has already been explored in the previous section in the attempt to show how women’s lives are profoundly different from men’s, and therefore enable women to have an epistemological privilege over men. Secondly, if material life is structured in fundamentally opposing ways, then the vision of each group represents an inversion of the other. Hartsock’s third claim addresses the power relations between the two sexes by stressing that the vision of the ruling gender structures are constructed in the material relations in which all parties are forced to participate. This means that the oppressed have to struggle for the vision that goes beneath the surface level of social relations in which we all partake. Finally, the adoption of a standpoint position reveals the real relations among social groups and helps facilitate a process of liberation. To conclude, Hartsock argues that feminist standpoint position needs to be struggled for in order to understand the experience of women’s subjugation and consequently to work towards liberation.

“Feminist theorists must demand that feminist theorizing be grounded in women’s material activity and must as well be a part of the political struggle necessary to develop areas of social life modeled on this activity. The outcome could be the development of a political economy which included women’s activity as well as men’s, and could as well be a step toward the redefining and restructuring of society as a whole on the basis of women’s activity” (Hartsock 1983:304).

Nevertheless, feminist standpoint theories have not remained outside a theoretical critique. The most powerful one stems from the postmodern thought. Emerging out of the perceived shortcomings of modernism – primarily the notion of metanarratives as definitive statements about how something is – postmodernism as a historical moment and epistemology raised questions about knowledge production, power, reality and truth (Leavy 2007, Letherby 2003). With regards to feminist thinking, postmodern thought raised several questions, two of which seem to be of vital importance for feminist standpoint theories. Firstly, as postmodernist argue, if there is no objectivity, reality or one truth to be discovered – but rather many constructed within different legitimate discourses – then where does that leave feminist standpoint theories? Secondly, if there is no coherent and stable category of ‘women’, and furthermore if gender is a social construct, in whose name can feminists demand anything? Concerning the first issue and the impact postmodern thought has had on
feminist epistemologies, questioning their legitimacy, feminists have flipped things around and emphasized that the timing of these approaches is not coincidental:

“Of course, it is curious that just when women and ethnic minorities have begun to demand a voice in creating knowledge, an epistemology emerges claiming there is no truth to be known” (Sparague and Kobrynowitz 1999:27).

Donna Haraway coined the term ‘epistemological electroshock therapy’ in order to capture the impact postmodernism and radical constructivism had on modern feminist theory:

“I, and others, started out wanting a strong tool for deconstructing the truth claims of hostile science by showing the radical historical specificity, and so contestability, of every layer of the onion of scientific and technological constructions, and we end up with a kind of epistemological electroshock therapy, which far from ushering us into the high stakes tables of the game of contesting public truths, lays us out on the table with self-induced multiple personality disorder” (Haraway 1988:578).

Discussing feminist scholars’ resistance to postmodern thought, Ramazanoglu and Holland (2002:96) suggest that postmodernism is not apolitical, but a specific form of knowledge that emerged at a particular time and tells particular truths. In their view, feminists will find themselves undermined by postmodernism only if “lured into an academic agenda of male-centred philosophy, relativist deconstructions and abstracted theory in male-dominated institutions” (Ibid., p. 97). In relation to the other postmodern critique of feminist thinking – deconstruction of the category ‘women’ – it does seem challenging to acknowledge a number of differences and hierarchies between women, and yet avoid the paralysis that this differentiation generates and possibly impedes any further joint action against oppression. Letherby (2003:57) explored this issue and, referring to bell hooks’ work, suggested that feminism is not possible because women share the same experiences, but because it is possible for women to federate around common resistance to all forms of oppression. Letherby asserts:

“Therefore, the aim is not to establish a feminist standpoint as a generator of true stories about social life, but rather feminist oppositions and criticism of fake stories,
to lead to an understanding of women’s lives that both illuminates their experiences and is respectful to them” (Ibid., p.57, emphasis in original).

Recognition of differences between women with regards to ethnicity, class, sexuality, age, physical or mental impairment, and any other relevant aspect of their identities is the reasons why in this section feminist standpoints have been explored – in the plural form – instead of a one single theory. In sum, incorporating differences among women themselves, feminist standpoint theories aim to capture women’s experiences of subordination in the attempt to build more complete knowledge, and to initiate and facilitate a social action. Dedication to feminist methodology also incorporates a researcher’s greater emphasis to reflect on oneself – one’s knowledge, beliefs and attitudes – and well as on the relationships that the researcher establishes with the study participants. The following section will address these two important issues in detail.

4.3.3. REFLEXIVITY AND RECIPROCITY

Reflexivity is an integral component of feminist research. It stems from its critique of traditional positivist research and the notion of ‘value-free’ research that ‘objectively’ and therefore ‘accurately’ represents social reality. This was acknowledged by Baker and colleagues (2004:169) who contend that academy in particular is deeply implicated in the operations of power:

“Research is inevitably politically engaged, be it by default, by design or by simple recognition. No matter how deep the commitment to value neutrality, decisions regarding choice of subject, paradigmatic frameworks and even methodological tools inevitably involve political choices, not only within the terms of the discipline, but even in terms of wider political purposes and goals.”

A ‘value-free’ research could be defined that which is free from any prior assumptions, theoretical stand, or value position, and research that is conducted free of influence from an individual researcher’s personal prejudices and beliefs (Neuman 2007:64). On this view, the researcher is capable of locating the Archimedean perspective – a ‘God’s-eye view’ – from which her or she observes and reflects on
the events taking place in the natural world. Feminist scholars such as Sandra Harding (1991:753) find the notion of ‘value-free’ research highly problematic:

“Value-free objectivity requires also a faulty theory of the ideal agent—the subject—of science, knowledge, and history. It requires a notion of the self as a fortress that must be defended against polluting influences from its social surroundings. The self whose mind would perfectly reflect the world must create and constantly police the borders of a gulf, a no-man’s-land, between himself as the subject and the object of his research, knowledge, or action.”

Feminist critique of primarily positivism highlights that the Cartesian ideal of transcending one’s locatedness and achieving this ‘view from nowhere’ cannot be achieved. We are all deeply embedded in a particular historical, social and cultural context that inevitably affects the way we perceive the world around us, and any research we conduct (Bordo 2004, Haraway 1988). Feminist scholars consequently understand ‘objectivity’ as “male subjectivity” (Caplan 1988 in Oakley 1998:710). Furthermore, feminist scholars question whether ‘value-free’ research is a good idea to begin with, for not all social values have the same (adverse) effect on research. For instance, as discussed previously in this chapter, gender difference can be a scientific resource since it introduces questions about the nature of social relations from the perspective of the devalued and neglected Other (Harding 2008, Hartsock 1983). Therefore, feminist scholars largely assert that ‘value-free’ and objective research is not only unattainable, but also undesirable. This is why they flip things around and emphasize the importance of reflexivity. For instance, Harding (2008) argues in support of ‘strong reflexivity’ that requires a development of oppositional theory from the Others’ perspective. It is an attempt to achieve a reciprocal relationship between the researcher and the researched:

“A notion of strong reflexivity would require that the objects of inquiry be conceptualized as gazing back in all their cultural particularity and that the researcher, through theory and methods, stand behind them, gazing back at his own socially situated research project in all its cultural particularity and its relationships to other projects of his culture” (Ibid. 2008:756).
Researcher’s reflexivity could be then defined as an acknowledgment of one’s subjectivity, including the experiences, values, beliefs and expectations that inform the researcher’s understanding of the social life. Following on from this, positionality may be defined as the location from which the research process begins, and how the researcher is personally and professionally related to it. Reflexivity demands an awareness of the self in the process of generating knowledge. This includes a clarification about how the researcher constructs their beliefs and how these beliefs in turn influence the data collection process (Liamputtong 2007). Researchers’ reflexivity is of significant importance for the reader who is then in the position to understand the researcher’s point of departure and identify their locatedness in relation to the overall study. Reflexivity is also closely related to self-disclosure which asks of the researcher to share their own experiences with the study participants:

“Researchers are urged to be aware of and disclose their own histories, values, and assumptions that they bring into the field to simultaneously decrease the sense that they are neutral, objective observers and to increase their awareness of how knowledge is produced in the relationship, within specific dynamics of power and positionality” (Bloom 1997:112).

Researchers conducting studies on sensitive subjects suggest that self-disclosure is a good feminist practice. Self-disclosure may put the study participants at ease, and facilitate trust and rapport (Reniharz 1992). Researcher’s self-disclosure also attempts – but may not succeed – to put the researcher and the researched on the level playing field. In the words of Sandra Harding, reflexivity helps to place the researcher on the same critical plane with the researched, whereby the researcher no longer appears as an invisible, anonymous voice of authority, but as a real individual with concrete desires and interests (Harding 1987 in Bloom 1997:112). Finally, self-disclosure helps minimize unequal power relations between the researcher and the study participants. Along with reflexivity, the equalization of power relations is often viewed as one of the pillars of feminist research. Imitating natural science, traditional social science relied upon a strict separation of the researcher who is characterized by action – the researcher is the knower and the expert – and the researched who is barely more than a passive object of the researcher’s inquiry.
Oakley (1988:711) argues that this hierarchical power relationship not only results in invalid data, but furthermore raises ethical concerns:

“The essential objection is that the unequal power relationship between the knower and the known conflicts with the moral obligation at the heart of feminism to treat other women as you would yourself wish to be treated, and in this sense is seen to be at odds with feminism’s emancipatory ideal.”

The aim of feminist and other emancipatory research is to build a reciprocal relationship between the researcher and the study participants, which enables the latter to gain knowledge and control over their situation in order to transform it (Baker et al. 2004). However, despite feminists’ devotion to non-hierarchical and non-authoritarian research principles, some power inequalities between the researcher and the researched are difficult to eradicate. In her study of the public and private forms of patriarchy among South-Asian women in Britain, Bhopal (2000) found out that the relationship between the researcher and researched is by definition an unequal relationship. While the study participants have significant influence in the research process, which manifests in withholding information from the researcher as well as leaving the research unexpectedly, she argues that the power is ultimately in the researcher’s favour. It is evident in the researcher’s ability to introduce questions, control what is written down and voice-recorded, and finally in their ability to interpret and report the findings in a particular fashion. Bhopal concludes that in relation to power relations, the role of the researcher is a privileged one:

“Our status as researchers often gives us the power to initiate research: to define the reality of the ‘other’, to translate the social lives and language of the ‘other’ in terms that may not be their own. In the final analysis, the researcher departs with the data and the researched stay behind, sometimes no better off than before. To this extent, the researcher/researched relationship is an inherently unequal one, with the balance of power weighed disproportionately in favour of the researcher” (Ibid, p.75).

Notwithstanding this attempt to minimize the unequal power relationship between the researcher and the researched, the notions of reflexivity and self-disclosure in the research process have been contested. Sharing personal information minimizes the researcher’s bracketing, which could have an adverse effect on the construction of
meanings in a phenomenological study such as this one (Creswell 2007:142). In other words, there is a fine line between the researcher’s openness with the study participants that facilitates rapport, and the maintenance of a distance that is an integral part of a professional relationship. This distance may not be important only for the production of valid and reliable data, but also essential for the researcher’s mental wellbeing. Too much emotional involvement on the researcher’s side can transform the research into an emotionally draining experience – emotional labour. Morse and Mitcham (1997 in Liamputtong 2007:82) coined the term ‘compathy’ in order to capture this sensation:

“Accordingly, ‘compathy is the acquisition of the distress and/or physiological symptoms (including pain) of others by an apparently healthy individual following contact with the physical distress of another’. When we see others experience pain or distress, we may ourselves have the ‘compathetic response’; that is, we may feel the pain or distress too.”

There is also another problem that may occur when the researcher takes too much for granted because they operate in a shared reality with the researched. Namely, Bhopal (2001) notes that this presumed familiarity may result in blindness to certain details that could be of significant importance for the research. This issue could be addressed by establishing a pretence awareness context wherein the researcher acts as if they are unfamiliar with what the participants are discussing, in order to preserve the necessary distance (Ibid.). With regards to emotional involvement, building a strong social network could help the researcher maintain their mental wellbeing, and to provides a safe space for exploring any professional and personal concerns that may arise in the research process. To conclude, informed by the feminist scholarship, the methodological implications of this study include an acknowledgment of my positionality as a researcher in relation to the study, and an attempt to establish collaboration with the study participants. This should help generate more trust-worthy data and minimize distress – which may or may not result from the interviews – for the participants and ultimately myself. Expanding on the issue of positionality, the next section provides an intellectual autobiography in order to reflect on my personal experiences that have led me into this research in the first place, but also guided and coloured this study.
4.3.4. INTELLECTUAL AUTOBIOGRAPHY

An intellectual autobiography aims to explain the origin of the researcher's decisions by revealing their history, personal beliefs and values, and biases that have shaped the research (Woodward 2000:42). I do not endorse the idea of a neutral and disinterested researcher that manages to perceive and describe the world objectively and therefore accurately. On the contrary, I believe that each and every person, including myself, is embedded in a particular historical and socio-cultural moment that shapes their understanding of the world around them. This section therefore attempts to reflect on my own positioning in relation to the research, including my values and beliefs that inevitably informed this study. It also helps the reader to place this study in a larger context and understand where I – as a researcher – am coming from. In doing so, the research process becomes more transparent and straightforward.

Although I clarified at the very beginning of this thesis what led me to study labiaplasty, there is also another dimension to my choice that, I believe, should be acknowledged. I would need to admit that my decision to study women's body work has to do with my own prior experiences, although I became conscious of that fact only months into my research. At the age of eighteen I was diagnosed with anorexia nervosa followed by compulsive eating disorder, which resulted in a decade of therapy, introspection and healing. With hindsight, this was one of the most valuable and insightful periods of my life for it provided me with an intense – and indeed experiential – course in the complex workings of the human body, mind and soul. Ultimately, it also resulted in my own qualifying as a therapist. At the time when I had anorexia I made a decision to migrate from my native country and build my life from scratch elsewhere. I knew I could achieve that aim only via my studies. Five years of intense work brought me my first scholarship, which took me to a post-graduate degree in Germany and Poland. Afterwards another post-graduate scholarship enabled me to study in Sweden, Norway and England. Finally, in 2013 I migrated to Ireland to begin my PhD. These, to date, seven years of living abroad in very different social and cultural settings provided me with the most valuable on the spot education about women’s relationships with their bodies. What I observed over the years and
across cultural boundaries were profoundly different attitudes towards female physique and related body work. I got to observe how women of different nationalities and ethnicities attend to their bodies in significantly different ways, as a precursor or a consequence (probably both) of their relationships with themselves. I also observed how women’s body work is hugely dependent on the culture, for what is considered attractive in one society would most certainly not be endorsed in another one. Lastly, it helped me to position myself in relation to all of that. Although I have come to view my eating disorders as a form of self-harm and, paradoxically, a coping mechanism, I also became aware of that fact that I was brought up in a society which disproportionally focuses on female thinness and inevitably fuels mental health issues.

Drawing on these experiences, I became deeply convinced that there is nothing innate about women’s preoccupation with the aesthetics, nor do I believe that a genuine choice about such investment can ever be made. Choice, in my view, is always socially, culturally and historically situated, and insomuch never free. These attitudes are reflected in the theoretical underpinnings of this study, especially chapter two that reflects on the gender-differentiated approach to body and all its implications. Nonetheless, I also believe that the environment cannot be held completely responsible for the incidence of women's body issues; otherwise every woman in a given society would have a negative body image and a subsequent mental health problem. There seems to be a complex interplay between a woman’s inner self including her psychological make-up and the outer context in which that inner self is formed. This attitude is apparent in my choice of the methodological approach, especially the use of Interpretative Phenomenological Analysis (IPA) with its ‘person-in-context’ perspective.

If I was asked to outline where I stand on cosmetic procedures, I would say that I am generally not in favour of cosmetic surgery for two reasons. I say ‘generally’ because I would agree with cosmetic surgery in two situations. Firstly, as a solution to physical discomfort and pain caused by one’s body that importantly cannot to be resolved utilizing other non-invasive means. It is unclear though whether such surgery would be classified as cosmetic or rather reconstructive surgery. Secondly, I would agree with cosmetic surgery when one’s body is outside the standard variation of human
anatomy and when such difference presents a large problem for the individual. Apart from that, the first reason why I am not in favour of such body work is due to my general approach to human well-being. I endorse a holistic approach to health that takes into consideration the complex interplay between one’s physical, emotional, mental and spiritual self. In that sense, I believe that a perceived aesthetic problem may be resolved via cutting into the flesh, or by undergoing some form of therapy in order to understand why the aforesaid problem is perceived to be a problem in the first place. The literature on cosmetic surgery (explored in chapter two) often demonstrates, and so will this study, that cosmetic surgery may be a solution to psychologically induced problems, for a change in the physique may initiate a change in the psyche. I wonder however is it really necessary to undergo an invasive procedure to alter one’s state of mind. Can’t one do that directly? I ask this question in light of my own problematic relationship with my body wherein over the course of my twenties I managed to slide from one side of the spectrum – hatred of my body – to the other end – acceptance, gratitude and love of my perfectly imperfect body. When I say one can radically change the relationship with their body – I speak from experience. In a nutshell, I am not in favour of cosmetic surgery because I believe there are other – less invasive and often less expensive, although more personally challenging – routes towards the same destination.

The other reason why I am not in favour of cosmetic surgery has to do with the gendered nature of this practice. Namely, I cannot overlook the fact that the vast majority of patients are women and the vast majority of surgeons are men. I cannot shake the feeling that there is something rather disturbing about this picture. This inevitably makes me think about the Western culture, which is highly saturated with unattainable, unsustainable and unhealthy images of women – usually highly sexualized, often sexist, but almost always demeaning for an average woman. These images are demeaning because they send out the message that a woman’s physical appearance is the most significant aspect of her identity, and the beauty standard itself is elusive. Being bombarded with such images and messages from the very onset, it is hardly surprising if women feel inadequate in their bodies and thus seek remedies to address that painful state of never being good enough. In other words, I view this gendered desire for cosmetic surgery largely as a direct outcome of the pervasive socio-cultural imperative of female beauty. In that context, it seems that
whenever a woman has a cosmetic surgery she inadvertently colludes with the beauty imperative and furthermore reinforces it. Her enhanced looks may help her individually in a short-run, but in a long run I do not believe that it helps women collectively (see Gillespie 1997). On top of that, studies demonstrate that women’s preoccupation with their looks subsides as their identity development increases (Grogan 2011). The more a woman is concerned with the personal, professional and familial development, the less she is worried about her looks. It seems plausible to conclude that if a woman derives a strong sense of worth from her personal and professional accomplishments, the importance of physical appearance diminishes. Identity development builds and consolidates one’s self-esteem and self-confidence in a way that may render excessive body work redundant. This in turn challenges the culturally assigned gender norms that place women’s looks at the top of the priority list, and thereby challenges the culture itself. In sum, I do not think that women’s bodies are in need of a ‘makeover’ – it is rather the Western culture that needs it.

Lastly, I wish to highlight that this section is the only part of the thesis where I openly express my views on cosmetic surgery. However, these are precisely that – my views expressed at a very specific time of my life. I do not contend that other women should agree with me, not do I think that my approach to life is necessary the best way to go about it. It is the best way for me, but it may not be applicable to other women. My views are very much a product of my early socialization, cultural affiliation, educational background and personal experiences. I am neither unbiased nor objective, and I certainly do not claim to have reached an ultimate understanding of female body work. Finally, my views on cosmetic surgery may change over time. Taking that into consideration, I would like to be respectful of other approaches even when I may not personally agree with them, and insomuch leave it up to each person to decide what their preferred path through life is. In that context, I have been very conscious of my attitudes and I have kept them in check throughout my data collection, analysis and write up. That way I was able to focus completely on my participants during the interviews, support them and listen empathetically, and to present their stories in an honest fashion.
4.4. PHENOMENOLOGICAL APPROACH

Phenomenological approach and specifically Interpretative Phenomenological Analysis (IPA) is the chosen data analysis framework utilized in this study. This section provides a brief overview of the approach, before narrowing it down further and focusing specifically on IPA as a variation of phenomenological research. As a philosophical movement, phenomenology draws primarily on the work of Edmund Husserl and his mentee Martin Heidegger. Both Husserl and Heidegger viewed an individual as embedded and intertwined in the world they inhabit, and thus argued against the separation of the subject and the object (Larkin et al. 2006). This could be illustrated by examining Heidegger’s understanding of an individual as a ‘person-in-context’. Our relatedness to a meaningful world is an essential part of our constitution, and to believe that we could position ourselves outside of this context is a fallacy:

“It is a mistake to believe that we can occasionally choose to take up a relationship with the various somatic and semantic objects that ‘make up’ our world, because such relatedness is a fundamental part of our constitution. We cannot occasionally jump out of an isolated subjective sphere to impose meaning on a world of otherwise meaningless objects, because we are always-already ‘out there’ in a meaningful world” (Ibid. p. 106).

The implications of this concept are, firstly, that we can only be understood as a function of our involvement with the meaningful world and, secondly, that the meaningful world can only be disclosed as a function of our engagement with it (Ibid.). This impossibility to remove ourselves from the world and view it ‘objectively’ can be seen as problematic from a positivist point of view. This research does not rely on such approach nor does it endorse it in any way. However, the aforementioned embeddedness in the world also creates the space for an exploration of different understandings of the same concept from the perspective of social constructivism. This is precisely the route that this study will take.
4.4.1. DATA ANALYSIS METHOD – INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA)

Interpretative phenomenological analysis (IPA) is a variation of a phenomenological research developed in the UK by Jonathan Smith as a particular qualitative approach in psychology. Although developed in the early 1990s, IPA has become an increasingly popular qualitative method primarily in health and social research, and across a range of subject areas including physical illnesses, psychological distress, sex, sexuality and gender (Smith 2010). Due to its flexibility and adaptability it is viewed as particularly useful in healthcare research where the participants fall under difficult-to-reach groups (Pringle et al. 2011). IPA has therefore been deployed in a number of studies exploring sensitive issues that affect women’s lives. Examples of this include adult genital surgery for the intersex (Boyle et al. 2005), female genital mutilation (Jones 2010), deinfibulation (Safari 2013), vulval pain (Marriot et al. 2008), low female sexual desire (Dürr 2008), facial cosmetic surgery (Leve et al. 2011) and eating disorders (Nunn 2009).

A typical research question in a phenomenological inquiry would be: “What is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people” (Patton in Mertens 2009:235). Similarly, in IPA questions are framed broadly and openly in order to explore an area of concern in detail (Smith and Osborn 2007:55). This method is phenomenological inasmuch as it seeks to provide a detailed examination of participants’ world:

“The aim of interpretative phenomenological analysis (IPA) is to explore in detail how participants are making sense of their personal and social world and the main currency for an IPA study is the meanings particular experiences events, states hold for participants” (Ibid., p.53).

In other words, the phenomenological aspect of IPA is concerned with uncovering meanings of a lived experience and focusing on the participants’ world. Therefore the first objective of this method is to acquire an ‘insider perspective’ and to understand ‘what it is like’ for the participant to experience a particular phenomenon (Larkin et al 2006). The other two theoretical underpinnings of IPA have roots in hermeneutics and
idiography. Hermeneutic as a theory of interpretation is necessary in order to analyse participants’ experiences of a particular phenomenon, by engaging with them and positioning their description into a wider socio-cultural and theoretical context (Ibid.). However, Smith (2007, 2010) argues that IPA includes double hermeneutics consisting of two stages. Smith (2010:10) explains this two stage process succinctly: “The researcher is trying to make sense of the participant trying to make sense of what is happening to them”. Idiography as the third pillar of IPA is a term originally employed to distinguish between studies of particularities from those of ‘things-in-general’ (Larkin et al 2006). Therefore a study of any specific situation might be regarded as idiographic. It is a “highly intensive and detailed analysis of the accounts produced by a comparatively small number of participants” (Ibid., p. 103). Smith (2010) asserts that IPA’s commitment to idiographic is apparent in its detailed examination of a phenomenon, which usually includes a detailed analysis of each individual case followed by a search for patterns across cases.

So, what makes an IPA a good IPA? In order to address this question, Smith (2010:24-25) conducted a review of almost three hundred studies published from 1996-2008 that adopted this research method. He outlined the seven criteria that should be met in order to produce a good IPA paper. These include a clear focus, strong data, rigour, sufficient space dedicated to each theme, interpretative analysis, emphasizing convergence and divergence, and careful writing. One of IPA’s greatest strength includes flexibility and accessibility, which is partly what makes it an increasingly appealing qualitative method. It allows the researcher the freedom to uncover and examine concepts that would otherwise perhaps remain concealed. Also, by avoiding a priori closed theoretical assumption about interpreting participants’ meanings, IPA remains epistemologically open about discursive, affective and cognitive inferences (Larkin et al. 2006). Finally, by highlighting that people are entrenched in their socio-cultural environment, IPA provides the possibility to explore that embedment further, and investigate the relatedness between the individual and the context.

On the other side, generalizability – or the lack thereof – remains an important shortcoming of this method. It has been argued that idiographic studies are potentially subjective, intuitive and impressionistic (Malim et al. 1992 in Pringle et al.
However, Smith contends that the aim of IPA is not to make general claims, but to provide an insight into one particular issue:

“The logic is similar to that employed by the social anthropologist conducting ethnographic research in one particular community. The anthropologist then reports in detail about that particular culture but does not claim to be able to say something about all cultures. In time, of course, it will be possible for subsequent studies to be conducted with other groups, and so, gradually, more general claims can be made, but each founded on the detailed examination of a set of case studies.” (Smith and Osborn 2007:56).

The issue of generalizability in relation to this particular doctoral study will be explored in detail in chapter five as a limitation of the study. Another possible shortcoming of IPA is related to the size and type of the sample. IPA aims for a small and homogeneous sample size through purposive sampling (Smith and Osborn 2007). The underlying idea is that – bearing in mind IPA's requirement for a small sample size in order to get a detailed account of a particular phenomenon – it would not be helpful to employ random sampling. Rather, the aim is to seek a closely defined group that will recognize the significance of the research question. This in turn relates negatively to the previously discussed generalizability, as well as to the transferability of the findings (Pringle et al 2011). Lastly, since the researcher is an inclusive part of the world that they explore, questions could be raised about the power dynamics between the researcher and the study participants, as well as about the researcher’s positionality. The quality of IPA therefore relies heavily on researchers’ reflexivity, and thus the ability to identify and acknowledge their previous knowledge and attitudes that may shape the research.

4.4.2. SAMPLE SIZE AND METHOD

The participants in this study included five adult women that have undergone a genital cosmetic surgery called labiaplasty. This rather small sample size is consistent with the nature of qualitative research whose aim is not to generalize the information, but to elucidate the particular (Pinnegar and Daynes 2006 in Creswell
Phenomenological studies in general rely on a small sample size. Creswell (2007) suggests that the numbers range from one to ten participants, while Mertens (2010) contends that the recommended sample size for phenomenology includes six participants. IPA in particular requires a very small sample size due to its commitment to a detailed interpretative account of the cases. Smith and Osborn (2007) argue that there is no right answer to the question of sample size. This depends on the degree of commitment to the analysis and reporting, the richness of the individual cases and the constraints one is operating under. However, they assert that the researchers conducting IPA for the first time should aim for approximately three participants. This would allow an in-depth engagement with each case, but it would prevent the newcomer from becoming overwhelmed with data.

This study employed a purposive sampling technique, which will be explored in detail in chapter five. This approach is suitable and furthermore recommended for phenomenological inquiries (Smith and Osborn 2007), as well as for researching hidden populations (Newman 2007). Besides smaller sample sizes, phenomenological studies also rely on a narrow sampling strategy, since it is essential for all the participants to have experienced the same phenomenon. This is why Creswell (2007) suggests criterion sampling for this particular method, wherein the researcher identifies a set of criteria that all the participants need to meet in order to take part the study. Mertens (2010) contends that a useful sampling strategy for a phenomenological study is homogenous sampling, meaning that the researcher seeks to describe the experiences of people who share similar characteristics that are of relevance for the study. Smith and Osborn (2007) note that IPA researchers usually adopt purposive or criterion sampling, in the attempt to locate a closely defined group. Sampling has been the most difficult aspect of this research, as will be explained in the subsequent chapter.

**4.4.3. SEMI-STRUCTURED INTERVIEWS**

The data collection method deployed in this research included semi-structured face-to-face and phone interviews. The chosen interviewing technique is in accordance
with the feminist principles that aim to empower women in order for them to share their stories and experiences. Furthermore, the interviewing technique is in line with the guidelines of IPA. Smith and Osborn (2007) contend that semi-structured interviews are the most appropriate data collection method in IPA study for their adaptability, flexibility and the opportunity to facilitate rapport. Semi-structured interviews also allow an exploration of novel areas and normally produce rich data. The ability to facilitate rapport is of vital importance for conducting ‘sensitive research’. It helps put both parties – but especially the study participants – at ease, and therefore creates a safe space for the participants to share their personal stories with the researcher. In other words, establishing trust and rapport enables the researcher to be seen as someone with whom the study participants are comfortable spending time and sharing their lives (Miller and Tewksbury 2001 in Liamputtong 2007:56). Furthermore, establishing trust and rapport makes it easier for the researcher to introduce the ‘threatening questions’, for which the respondents may believe threaten their presentation of self (Neuman 2007).

The downside of this data collection method is that it reduces the researcher’s control over the situation. Semi-structured interviews also take longer to carry out and they may be harder to analyse. However, what seems to be the most important shortcoming of the interviewing technique is the so called interviewer’s bias. The interviewer’s visible characteristics – their ‘race’, ethnicity, gender, age, physical and mental impairment and any other visible characteristic – their expectations of the research, and the social setting in which the interview takes place all affect participants’ response and may create significant bias (Newman 2007). One way to ameliorate this is for the researcher to acknowledge and critically reflect on their positionality – their previous knowledge, beliefs and attitudes – in order to become conscious of these elements and the potential effect that they may have on the research. Positionality and reflexivity are also of vital importance for the feminist methodologies, which is why these issues have already been addressed in this chapter.
4.5. ETHICAL CONSIDERATIONS

This project was conducted in accordance with the highest ethical principles, which is reflected in the ethical approval that was granted on the 17 October 2014 by the *UCD Human Research Ethics Committee*. The three most important supporting documents produced in the process of seeking ethical clearing are: *Information Leaflet for Study Participants (Appendix I)*, *Consent Form for Study Participants (Appendix II)* and *Interview Schedule (Appendix III)*. Although the process of obtaining ethical approval was relatively straightforward, issues related to participants’ emotional wellbeing, anonymity and confidentiality were highlighted. It also turned out that these were some of the issues raised by an Irish plastic surgeon whom I met in person, as well as two potential study participants who ultimately decided not to partake in the study (as explored further in chapter five). Therefore this section will explore the importance of informed consent, as well and anonymity and confidentiality, all of which were implemented and strictly adhered to in this research.

The purpose of an informed consent is to make sure that the participants fully understand what it means for them to participate in the study, and that they have genuinely consented to do so (Virginia Dickson-Swift 2005 in Lianmuuttong 2007:33). Bearing in mind the sensitive nature of this research, the issue of informed consent was of significant importance. Namely, the procedure may have left the study participants feeling content and self-confident about their ‘new’ body. However, the procedure may have also left them feeling vulnerable and anxious if the experience or the aftermath of the surgery did not proceed as expected. In order to alleviate any potential distress, the participants were thoroughly informed about the nature of the study, data collection process and their rights. Specifically, they were informed of their right to decline to answer any question that makes them feel uncomfortable. Furthermore, it was emphasized that they had the right to withdraw from the study at all times. This was of vital importance not only for alleviating any distress that may have resulted from the interview, but also for empowering the participants and making them feel in control over how much they were willing to share. In other words, identifying and underlining participants’ rights in the *Information Leaflet* and *Consent*
Form was also means of establishing a balanced power relationship between the researcher and the researched.

Another ethical issue that is of vital importance for sensitive research revolves around participants' privacy – anonymity and confidentiality. Anonymity includes a protection of participants’ identity by making sure the participants remain nameless, whereby confidentiality includes participants’ names and personal information but this data remains secret from the public disclosure (Neuman 2007). The research materials generated in this study – namely the Information Leaflet and Consent Form – clearly explained that participation in this study is voluntary, anonymous and confidential. Specifically, the Information Leaflet highlighted that anonymity would be achieved by employing pseudonyms instead of participants’ real names, and that if participants’ names got mentioned during the interviews then these names would be replaced with pseudonyms as the interviews were being transcribed. It was emphasized that participants’ real names would not be used in further data analysis, final report or any subsequent publications resulting from this research. This meant that I would be the only person familiar with participants’ ‘true’ identity. This material also underlined that confidentiality would be accomplished by keeping data secret from the public to safeguard participants’ physical, emotional and social well-being. Finally, it was stated that the anonymised transcripts would be archived through the Irish Qualitative Data Archive (IQDA) in order to enable the future researchers in using it, whereas the original transcripts and the audio recordings would be destroyed.

4.6. CONCLUSION

This chapter attempted to reflect on the theoretical foundation of the methodological aspect of this thesis and clarify why I adopted a qualitative, cross-sectional and specifically phenomenological approach – informed by feminist research principles – in researching labiaplasty. Bearing in mind the complex and sensitive nature of the topic, as well as the surprising lack of qualitative studies looking into this particular issue, a qualitative approach was the most appropriate route to take. It was chosen as it minimizes the power relations between the researcher and the researched and
facilitates trust and rapport, which in turn creates the space an in-depth inquiry into participants’ experiences of genital cosmetic procedures. The flexibility and adaptability of this approach renders the research process epistemologically open and more tolerant to non-linear research paths, which was of immense value when trying to locate the participants who are a hard-to-reach group. This issue will also be explored in detail in the next chapter. Interpretative Phenomenological Approach (IPA) was chosen as the data analysis framework in order to acquire a deep understanding of labiaplasty as experienced by several women, and to identify and elaborate on what bonds these women in their experiences. Furthermore, highlighting that individuals are always intertwined in the world they inhabit, IPA creates the space for an exploration of the interplay between the women’s inner selves and the socio-cultural context that may shape these individuals. The small and homogeneous sample size employed in this study is in accordance with the guidelines of IPA, for it enables a detailed account of participants’ experiences of the surgery and in that process elucidates the particular. It is however also a reflection of substantial difficulties encountered during participant recruitment, which will be addressed in the following chapter. Finally, conducted by a woman, about women and for women, this thesis was first and foremost informed by feminist research principles. It is concerned with gender and inequality, and it attempts to give voice to women and empower them in order to initiate a constructive social change. This study also relies on participatory methods and brings the participants into the research process in order to balance the power dynamics inherent in the research process. It acknowledges the researcher’s positionality in the attempt to underline that the knowledge resulting from the study is always situated in a specific socio-cultural context and historical moment, and therefore partial. My positionality in this relation to this study was acknowledged, as well as my previous experiences, beliefs and values that influenced this piece. Not only does this help the reader to situate this research in a wider context, but it also helps them understand where I – as a researcher – am coming from. Ultimately, the ability to critically reflect on my own positionality makes the research process more transparent, open and authentic. Finally, ethical issues including informed consent, anonymity and confidentiality were also addressed in the attempt to safeguard the mental, emotional and physical well-being of study participants. The upcoming chapter places these theoretical underpinnings into
practice and reflects on the empirical side of the research process – data collection process – and the significant difficulties encountered along the way.
5. RESEARCH METHODOLOGY – EMPIRICAL IMPLICATIONS

5.1. INTRODUCTION

Following the theoretical underpinnings of the methodological aspects of this project, this chapter elaborates on the empirical implications of this research and insomuch reflects on the obstacles faced in the attempt to locate the study participants. Namely, the most important and yet most difficult aspect of this research was the data collection process. In spite of the lengthy and thorough preparations for the fieldwork including the demanding ethical clearing – and what appeared to be immediate success in gaining access – the process of recruiting women who have undergone labiaplasty and wanted to be interviewed was immensely challenging. The chapter will set the scene by identifying the target study group including the criteria that had to be met in order to partake in the research. Importantly, it will reflect on the twenty-month long field-work during which twenty-one privately run clinics that provide labiaplasty or female sexual health services were approached, as well as five academics working in the field of female body-work or women’s sexual health. Notably, a meeting with the plastic surgeon and the manager of one Irish private clinic will be described in detail, which will in turn highlight important issues regarding difficulties in establishing access. Furthermore, this chapter will reflect on the exchanges with the academics that research women’s body-work or sexual health, in order to underline different approaches utilized in participant recruitment. Finally, the lack of success with data collection not only highlighted that labiaplasty may be a taboo topic, but inevitably it had an impact on the entire study. These difficulties will be examined in order to demonstrate how unpredictable – and at times unrewarding – a research process can be. However, the chapter will also reveal how these practical obstacles were overcome in order to successfully complete the research. Lastly, the data collection process will be described in detail, and the limitations pertaining to this study will be discussed.
5.2. STUDY PARTICIPANTS AND SAMPLING CRITERIA

As indicated in chapter one, the issue of female genital modification is a very delicate topic and some challenges in recruiting women who have undergone labiaplasty were anticipated. The selection criteria in this study were initially defined broadly, in order to encompass a range of procedures that fall under the umbrella term of FGCS, and thus a range of women’s experiences. In other words, by defining selection criteria broadly, I wanted to ensure that at least three women who have had a genital cosmetic surgery would be recruited. The small sample size would be in line with the guidelines of IPA, as was discussed in the previous chapter. I also decided not to use the timing of the operation as a sampling criterion due to recognition that I may already face some challenges with participant recruitment. Therefore, in order to take part in the study, the potential participants needed to meet the following criteria:

1. Female gender/sex
2. Minimum of eighteen years of age
3. Ability to communicate their experience in English language
4. Experience of FGCS including one or more of the following procedures: labiaplasty, vaginal tightening procedure, hymenoplasty, clitoroplasty, perineoplasty, pubic enhancement and G-spot amplification.

The selection criteria were also outlined in the Information Leaflet for Study Participants (Appendix I). They remained unchanged throughout the course of the study. I was hopeful that I would be able to recruit participants who have undergone the exact same genital cosmetic procedure. Early in my research it became apparent that labiaplasty was the most popular procedure amongst the female genital cosmetic surgeries, since labiaplasty was most commonly advertised and offered by private clinics in Ireland and the UK. This conclusion was unsurprising considering, as indicated in chapter one, that the associations of medical practitioners such as The British Association of Aesthetic Plastic Surgeons (2017) indicated that labiaplasty is the most sough-after procedure among women, alongside vaginal tightening. Therefore, I personally hoped to recruit women that have undergone the exact same genital cosmetic procedure – labiaplasty.
5.3. FIELDWORK OVERVIEW

The fieldwork has proven to be the most difficult aspect of this study. It began in December 2014 and lasted until July 2016. During that time I approached a large number of privately run clinics that offer labiaplasty. These include – in a chronological order – six clinics in Ireland, eleven clinics in the UK and one clinic in my country of origin Croatia. This will be explored in detail in the upcoming section. I also approached three different sexual health clinics in Ireland that provide sexual healthcare services to women, with a request to leave leaflets about my study in their practices in order to advertise the research and possibly attract potential participants. In spring 2015 it became obvious that the recruitment process may demand a different type of effort on my behalf. That is why I decided to write to a number of academics in the field, who researched either cosmetic procedures or labiaplasty specifically, with a request for assistance or advice with regards to locating study participants. The following two sections explain in detail the steps that I took in order to successfully complete the fieldwork.

5.3.1. CLINICS APPROACHED

My initial intention was to recruit the participants from the private clinics based in Ireland that offer labiaplasty and related genital cosmetic procedures. I planned to identify the clinics by examining the database of the Irish Association of Plastic Surgeons (IAPS) and the Royal College of Surgeons in Ireland (RCSI), as well as through a Google search. Ultimately, I did not find the first two sources helpful in locating my study participants, so I relied entirely on a Google search. That search yielded five Irish clinics that offer labiaplasty. I embarked on what would become the first round of fieldwork, which lasted from December 2014 until the end of February 2015. I approached the managers of those clinics in writing, by sending each clinic a research package that included hard copies of the Introduction Letter – tailored for each clinic – the Information Leaflet for Study Participants (Appendix I) and Consent Form for Study Participants (Appendix II). The research materials clearly outlined and elaborated on all the important segments of the study – the background of the study,
the research objectives, the selection of study participants, the interview process, the ethical issues including anonymity and confidentiality, the potential benefits and risks associated with the study, and the participants’ rights. I asked managers of the clinics to consider informing their patients that have undergone labiaplasty about the study.

Having sent the research materials to five Irish clinics, I received two positive replies within days, one of which was from the Clinic One. The plastic surgeon from Clinic One stated in his email that they would be happy to go forward with the research. We set up a meeting that took place in their clinic in February 2015. As I was waiting to meet Dr Colin Jackson and clinic manager Ms Ann Green (both pseudonyms) I was being referred to as ‘the girl’ several times by the receptionist. Even after I introduced myself again and repeated my name, I was being referred to with a different name that did not even resemble mine. This may seem like a minor accident, but to me it was symptomatic of how I as the researcher – and consequently my research as well – was perceived by the Clinic One. It also got me thinking about how the researcher’s visible characteristics – and in this specific case my gender and age – affect people’s responses and thus may create significant bias (Newman 2007).

The meeting with Colin very brief. He immediately expressed his concern about participants’ anonymity. Specifically, it was stated in the Consent Form for Study Participants that the supervisor and the examiner may request access to the interview transcripts. Colin was worried that someone else – besides me – would have the access to the transcripts and thus may have the ability to identify the participants. Secondly, he was concerned about his patients’ emotional well-being. Namely, he was worried that his patients may become distressed during or after the interview. The material that provided a list of Support Services – including a number of Irish NGOs and other resources where participants may seek help in case of emergent distress – yielded a very negative reaction. I should emphasize here that I designed that material – along with a range of other materials – at the request of the UCD Research Ethics Committee in order to receive ethical clearing. The final issue that was raised was about those patients who were not happy with the outcome of the procedure. Colin asserted that a negative reaction to a labiaplasty that he performed would not reflect well on his business. However, he also acknowledged that we could not exclude participants who were not happy with the outcome of the
procedure because that would distort the findings on the study. In sum, three important issues were raised in this brief meeting. Afterwards the clinic manager Ms Ann Green and I talked through the issues that Colin previously identified. We agreed that I would edit the Consent Form to highlight that the supervisor or examiner may request access only to anonymised transcripts, after all the identifying markers have been removed. We also agreed that I would not share the Support Services material with their patients and that I would be very mindful of their emotional well-being. Finally, we agreed that I would email them the interview questions, so that they are fully informed about the form and the content of the interview. Within days I made the edits as agreed and provided Clinic One with the required materials. However, in spite of my efforts, I received an email from Ann in which it was stated that unfortunately Clinic One will not be able to take part in my study.

Apart from the Clinic One, I also received a positive response from Clinic Two. The person that I was in touch with was Ben. I never managed to get his surname, nor was I able to locate him among the employees of Clinic Two on their official web page. In his reply Ben stated that they would be in touch after the Christmas break. I tried to get in touch with Clinic Two on many occasions during January 2015 via phone and email. I was told that Ben was the only person that I could discuss this issue with; however he never returned any of my calls nor emails. Another Irish private practice that I approached was Clinic Three. It took me several weeks to receive a response from them – they stated that they are already involved in several studies and thus would not be able to participate in this research. Finally, I also contacted Clinic Four and Clinic Five. In both cases I was told that I would be contacted if the doctors were interested to take part in the study. However, I never heard from them again. In sum, the first round of my fieldwork lasted for three months and, in spite of what appeared to be a very promising and successful start, it demonstrated that participant recruitment would be a challenging process. Table 1 provides an overview of the clinics approached, the research materials shared and the outcome for each clinic.
Table 1: Overview of the private cosmetic clinics in Ireland that provide labiaplasty, contacted from December 2014 to February 2015

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Location</th>
<th>Materials</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic One</td>
<td>Ireland</td>
<td>Introduction Letter; Information Leaflet; Consent Form (hard copies)</td>
<td>A meeting with the plastic surgeon and clinic manager took place in Clinic One in February 2015. Concerns were raised about anonymity, patients’ emotional well-being and patients’ possible negative reaction to the outcome of the surgery. It was agreed that I would edit the Consent Form and share it again with the clinic. However, despite the edits, Clinic One withdrew from the study in the following days.</td>
</tr>
<tr>
<td>Clinic Two</td>
<td>Ireland</td>
<td>As above.</td>
<td>In his first email Ben from Clinic Two stated that they feel ‘very positive’ about the study and that they will stay in touch after the Christmas break. I tried to contact Clinic Two and Ben personally via email and phone many times throughout January and February 2015. My phone calls and emails were never returned.</td>
</tr>
<tr>
<td>Clinic Three</td>
<td>Ireland</td>
<td>As above.</td>
<td>It took me several weeks to get a hold of them. The hard copies apparently never got through, so I emailed the supporting documents. However, these were never forwarded to the plastic surgeon. Therefore I emailed the whole pack for the second time. They stated in their reply that Clinic Three is already involved in several studies and therefore would not be able to participate in this one.</td>
</tr>
<tr>
<td>Clinic Four</td>
<td>Ireland</td>
<td>As above.</td>
<td>I spoke with them on the phone. I was told that I would be contacted by the doctors if they were interested in participating. I never heard from them again.</td>
</tr>
<tr>
<td>Clinic Five</td>
<td>Ireland</td>
<td>As above.</td>
<td>I spoke with them on the phone. I was told that I would be contacted by the doctors if they were interested in participating. I never heard from them again.</td>
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</table>
The second round of fieldwork was very straightforward, albeit equally unsuccessful. It took place between March and April 2015, and I approached private clinics in the UK that offer female genital cosmetic surgery including labiaplasty. I sent a research pack to five clinics that offer the aforesaid procedures, which were identified through Internet (Google) search. I did not hear back from any of these clinics, which meant that I had to follow-up with emails and phone calls. On two occasions I was referred to the clinic’s main office that was no longer located in that part of the country; one clinic stated that they perform very few genital cosmetic procedures and thus their involvement would not benefit me, and I did not hear back from the other two clinics. It also seemed that two clinics – Clinic Nine and Clinic Ten – are linked, even though this was not stated anywhere on their web pages. The overview of these clinics is provided in Table 2.

Table 2: Overview of the private cosmetic clinics in the UK that provide labiaplasty, contacted in March and April 2015

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Location</th>
<th>Materials</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Six</td>
<td>UK</td>
<td>Introduction Letter; Information Leaflet; Consent Form (hard copies)</td>
<td>I spoke with them on the phone. I was referred to their marketing office in a different part of the country, but I was given no further information.</td>
</tr>
<tr>
<td>Clinic Seven</td>
<td>UK</td>
<td>As above.</td>
<td>I tried calling the clinic, but I could not get through. I emailed them using the feed-back form on their webpage. I received an automatic reply, but I never heard from them personally.</td>
</tr>
<tr>
<td>Clinic Eight</td>
<td>UK</td>
<td>As above.</td>
<td>I tried calling the clinic, but I could not get through. I emailed them using the feed-back form on their webpage. I received an email shortly stating that ‘they get so very few requests for this procedure that their involvement wouldn’t benefit me.’</td>
</tr>
<tr>
<td>Clinic Nine</td>
<td>UK</td>
<td>As above.</td>
<td>I spoke to them on the phone. I was referred to their main office in the other part of the country.</td>
</tr>
<tr>
<td>Clinic Ten</td>
<td>UK</td>
<td>As above.</td>
<td>Clinic Ten seems to be linked to Clinic Nine. This is not stated on the website.</td>
</tr>
</tbody>
</table>
The third round of fieldwork took place in May and June 2015. I tried to implement the lessons that I took from the previous two rounds and therefore I no longer sent research packs to each and every clinic. Namely, posting hard copies of the study materials proved to be a time-consuming and costly process that yielded no success. The only exception to this rule was Clinic Eleven, a private practice run by Dr Lisa Smith (pseudonym). I decided to send Lisa a full research pack because I felt that I would like to collaborate with her, and I was therefore willing to invest additional effort. Namely, I found Lisa’s sensible approach to cosmetic surgery very appealing. Specifically, she argues against cosmetic surgery for women under the age of eighteen, and she also contends that cosmetic surgery is not to be taken lightly to begin with. Lisa responded positively to my invitation to assist with participant recruitment. In her email she stated that she wanted to take part in this research in order to “dispel the myths surrounding the procedure” (Personal Communication, 2015). Lisa was also the only UK-based practitioner that agreed to partake in my study. Namely, I also approached five other private clinics that offer female genital cosmetic procedures including labiaplasty, all of which were identified through Internet (Google) search. I approached the clinics via email and I tailored the Introduction Letter for each plastic surgeon in order to tie my research to their earlier work, and therefore to emphasize how they may benefit from taking part in this study. This newly implemented approach also yielded no success. Table 3 provides an overview of the UK clinics approached in that time.
In parallel to this process, I also expanded this round of fieldwork to include one more clinic in Ireland that offers labiaplasty, which did not show up during the first round of my search. I also contacted one Croatian plastic surgeon just to gauge their interest in taking part in my study. Finally, I approached three different clinics in Ireland that provide sexual healthcare services for women, with a request to leave the research flyers in their clinics and therefore advertise the research. Table 4 provides an overview of the five clinics that I approached in July and August 2015. However, I had no luck in establishing a cooperation of any kind.
Table 4: Overview of the clinics in Ireland and Croatia that provide sexual health services for women and labiaplasty respectively, contacted in July and August 2015

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Location</th>
<th>Materials</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Seventeen</td>
<td>Ireland</td>
<td>An introductory email to inquire whether I could leave the research poster and information leaflets about my research in their clinics.</td>
<td>I emailed them and followed up with a reminder. I received a reply stating that my email will be forwarded to the appropriate person. I never heard from them again.</td>
</tr>
<tr>
<td>Clinic Eighteen</td>
<td>Ireland</td>
<td>See above.</td>
<td>No reply</td>
</tr>
<tr>
<td>Clinic Nineteen</td>
<td>Ireland</td>
<td>See above.</td>
<td>No reply</td>
</tr>
<tr>
<td>Clinic Twenty</td>
<td>Ireland</td>
<td>Introduction Letter</td>
<td>I emailed them and followed up with a reminder. I never received a reply.</td>
</tr>
<tr>
<td>Clinic Twenty-One</td>
<td>Croatia</td>
<td>Information Leaflet</td>
<td>I emailed the plastic surgeon, but I never received a reply.</td>
</tr>
</tbody>
</table>

5.3.2. ACADEMICS APPROACHED

In spring 2015 I decided to write to academics working in the field of women’s body work and sexual health, with a request for support in relation to participant recruitment. The first person I wrote to was Academic One, who had extensively researched the issue of FGCS and labiaplasty specifically. Having in mind their previous academic work as well as their clinical expertise, I wanted to explore whether Academic One could be in position to assist me with participant recruitment. I quickly received a response in which they stated the following:

“I'm afraid I can't help with recruitment – we are known as people who question and don't perform the intervention on women. So we don’t see women who have been operated on. Recruitment may be difficult even in clinics that perform these interventions because women mostly don’t want to be reminded that they’ve had it done. My advice to you is to collaborate with a private surgeon in [location] and recruit that way” (Personal Communication 2015).

My exchange with Academic One confirmed what my experience to that point seemed to indicate – despite the increasing demand for labiaplasty, the issue itself
remains hidden. In June 2015 I approached Academic Two, who was known for their previous research on female cosmetic surgery. Having been familiar with their study, I understood that participant recruitment was a time-consuming and challenging process for them as well. I was therefore curious to hear about their experience of acquiring access. Academic Two responded promptly to my email and indeed confirmed that they also initially approached plastic surgeons in writing, without success. Eventually they managed to locate a plastic surgeon that was willing to cooperate with them, which was in their words more of a ‘happenstance’.

“I've always started with surgeons. I've usually managed to cultivate one or two who would get their office staff to contact patients and get their approval for me to approach them -- some met me anonymously; some invited me to their homes. It was always a mixed bag. Other methods, like newspaper ads and signs posted here and there never worked well” (Personal Communication 2015).

In terms of participant recruitment, the words of Academic Two resonated with me. Based on the literature review on body work and cosmetic surgery specifically (presented in chapter three), it seemed that most researchers would go about this issue in a similar vein – by approaching plastic surgeons who act as gatekeepers between the researcher and study participants. Academic Two only confirmed what seemed to be true in my experience, which is that acquiring access via plastic surgeons in writing does not seem to be a very successful strategy.

“I’d say that the best approach is to get yourself into the office or at least to phone. It’s harder for them to turn down a person than a letter or email. It’ll mean going by the offices to try to schedule your first time to see the surgeons, but more investment in a few sites will ultimately pay off” (Personal Communication 2015).

I would have taken this advice on board has I not exhausted all possibilities in Ireland and most possibilities in the UK at that point. Nevertheless, I shifted my attention to other aspects of gaining access that may be put into practice. Academic Two shed a light on two different aspects of participant recruitment that I had not considered up to that point. These included, firstly, paying the participants for their involvement and, secondly, introducing additional questions during the interview that would be of benefit for the surgeon. Academic Two highlighted these issues in their email:
“When I was a PhD student I gathered respondents without paying honoraria. Once I had a job, I was able to get funding, so that helped bring in respondents. Surgeons, though, require more than money. I'd suggest that you need to try to get an appointment with them and convince them that your research is valuable in some way that they'll recognise. You might, for example, offer to provide them with your findings and to ask patients about their satisfaction with treatment. (...). Offer to provide them with a summary of your findings, anonymised of course – something that they'll see as helping their own business. Make yourself useful if at all possible” (Personal Communication 2015).

I found these two pieces of advice immensely helpful. I was very keen on the idea of rewarding my study participants for their time and contribution. Compensation for participating in social research is a controversial issue, but it is often practiced when researching sensitive subjects. Liamputtong (2007) explores this issue in depth and suggests that the most compelling reason against compensation is that payment may be seen as coercion if the study participants include very poor people such as homeless, or those that desperately need money including drug users. In other words, people’s disadvantaged economic position may draw them into the research, which then raises questions about their free choice to participate in the first place. This argument did not seem applicable to this study, for the study participants had to undergo a very expensive elective procedure to partake in the project. Therefore, while my study participants may be perceived as vulnerable, most likely they could not be classified as economically underprivileged. On the other hand, Liamputtong (Ibid.) also demonstrates that compensation may be crucial when researching hard-to-reach populations, and may even result in snowballing. Monetary incentives are not the only means of expressing gratitude for participants’ involvement. An equally meaningful way of saying thank-you is to provide gift vouchers and gift bags. MAC Cosmetics conveniently provided the option of E-Gift Cards, which could be easily emailed to each study participant. Therefore I decided to opt for £30 MAC Cosmetics gift vouchers.

Another valuable piece of advice that Academic Two gave me was to make my research appealing to plastic surgeons. For instance, introducing questions about clients’ satisfaction with the treatment could provide the practitioners with independent findings about the quality of their work. In addition, sharing the final
report of the study with the practitioners provides them with a detailed exploration of women's experiences of labiaplasty from a social science perspective which is – in comparison with the medical perspective – a different and yet a complementary approach to understanding cosmetic surgery. I took this piece of advice on board and therefore emphasized these aspects in my letter to Lisa when I first approached her to seek collaboration with participant recruitment. I offered her an opportunity to add any question to my already drafted list of interview questions, which she had the chance to review. Lisa was happy to go forward with my Interview Schedule (Appendix III) and added one question, which I found helpful.

Another person that I approached was Academic Three, who had previously researched labiaplasty and spoke directly to women who were considering this procedure. I wrote to Academic Three in October 2015 to familiarize them with my research and see whether they would be willing to assist me with participant recruitment. Unfortunately, I did not get to hear from them back. I also emailed Academic Four, who had previously researched FGCS and labiaplasty specifically, again with a request for assistance with locating participants. Academic Four responded to my email within days, but the news was not encouraging.

“I am sorry you are having such difficulty recruiting. This has been a problem for us in the past even for [the name of the project]. Many other researchers in this area have found similar difficulties. Women are very reluctant to discuss labiaplasty in detail either before or afterwards. I am afraid I don’t see this group of women or offer labial surgery of any kind. The NHS is doing significantly less labiaplasties - not because of less demand but because they are no longer funded. You will need to focus your efforts in the private sector and I presume you have done this already in Ireland? There are numerous clinics in [location] although I am not sure how you would access them” (Personal Communication, 2016).

I found the exchange with Academic Four helpful because it highlighted that researching labiaplasty specifically is a very challenging issue to investigate for other researchers in the field as well. Although I was not happy to hear that other researchers are faced with the same problems as me, I no longer felt that I was doing something wrong in the research process that in turn impedes my ability to locate the participants. The last person that I approached was Academic Five, who was at the
time conducting a study on FGCS as well. Academic Five was very approachable and they shared with me their experiences in researching FGCS.

“The U.S. has very strict patient privacy laws, and genital cosmetic surgeons here have been reticent to speak with researchers (at least myself and other researchers that I have spoken with about this) since some not-so-flattering press several years ago. I will try to go through my sources and see if I know anyone who has done actual patient interviews; I myself have been reaching out to OB/GYNs to conduct oral histories (…) with some luck. Other than that, I have had to utilize chat rooms and testimonial sites for my chapter on narratives of FGCS (and thus have also had to explore all of the ethical and methodological questions that this raises)” (Personal Communication, 2016).

My exchange with Academic Five pointed out to practitioners’ reluctance to discuss the issue of genital elective procedures with researchers, which in turn prevents the researchers from acquiring access to the target population. All of this had led me to believe that women’s genital appearance dissatisfaction and subsequent modification is indeed a taboo topic. Table 5 below provides an overview of academics approached from May 2015 until February 2016.

Table 5: Overview of the academics working in the field of body work and/or women’s sexual health, contacted from May 2015 to February 2016

<table>
<thead>
<tr>
<th>Source</th>
<th>Objective</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic One</td>
<td>Request for assistance with participant recruitment based on their previous/current research on FGCS.</td>
<td>Email exchange. Unable to help further with locating study participants specifically.</td>
</tr>
<tr>
<td>Academic Two</td>
<td>As above.</td>
<td>Email exchange. Unable to help further with locating study participants specifically.</td>
</tr>
<tr>
<td>Academic Three</td>
<td>As above.</td>
<td>No response.</td>
</tr>
<tr>
<td>Academic Four</td>
<td>As above.</td>
<td>Email exchange. Unable to help further with locating study participants specifically.</td>
</tr>
<tr>
<td>Academic Five</td>
<td>As above.</td>
<td>Email exchange. Unable to help further with locating study participants specifically.</td>
</tr>
</tbody>
</table>
5.4. DATA COLLECTION AND PARTICIPANT PROFILE

To reiterate, Dr Lisa Smith was the only plastic surgeon who responded positively to my invitation to partake in the research. In June 2015 Lisa invited patients of hers who have had labiaplasty in the last twelve months to take part in the study, by contacting me directly. I received an email from only one of Lisa’s patients, expressing her wish to participate by stating the following “I am happy to take part in your study as long as like you say it is all anonymised” (Personal Communication, 2015). This woman was also the only patient who responded to Lisa’s invitation. In September 2015 Lisa initiated another round of emails in order to get more participants, which yielded two new responses. It seemed at that point that I managed to locate three women who have had labiaplasty and who were willing to be interviewed about it. However, the latter two women withdrew as soon as I emailed them. One woman never returned any of my emails, whereas the other one stated the following:

“"I'm so sorry - but I am just too busy at the moment to partake in the study and on top of that on reflection I don't think I am that happy to discuss it. Sorry for changing my mind - hope you can understand it is a very private operation” (Personal Communication, 2015).

This illustrates not only how difficult it was to locate a plastic surgeon that was willing to let me interview their patients, but also to locate women who were willing to share their stories. In the same vein, the woman who was supposed to be my first participant also withdrew from the study. We exchanged a number of emails from July 2015 until January 2016 trying to arrange an interview, but something always seemed to get in the way. In her final email she stated the following:

“"I'm sorry but I don't think I'm going to do this research now, I think the moment has passed. I have too much on and it's been a while, so I am going to leave it. Good luck with the research, it sounds like a really worthwhile thing to do” (Personal Communication, 2016).
Fifteen months into my fieldwork and twenty-one clinics approached, I was still to locate my first study participant. Although ultimately I managed to recruit most of the participants with Lisa’s help, meeting the first participant Sarah was a fortunate stroke of serendipity. Sarah was originally from South America, but she had been living in Ireland for several years at that time of the interview. She had labiaplasty prior to her arrival in Ireland and, importantly, she was happy to be interviewed about her experience. Eighteen months into my fieldwork, on the 18th May 2016, I conducted an interview with Sarah – two hours of insightful conversation and laughter that gave me the impetus to continue this research. Following that interview I travelled to the UK to meet Lisa in person, and explore other possibilities of recruiting study participants. Lisa struck me as a very kind and warm person. She acknowledged the work that I’ve done so far, and expressed her wish to help me successfully complete this project. With Lisa’s generous support I was linked to another four women who had labiaplasty and wanted to reflect on their experiences. In July 2016, within a space of a week, I conducted phone interviews with Carla, Leah and Natalie – and another participant came three weeks later – Mia. All participants were very kind, approachable and most importantly willing to help me complete this study. With hindsight, I am unsure whether I would have gone to the UK – and completed this research the way I did – had I not conducted the interview with Sarah beforehand. In other words, I believe that meeting Sarah was the catalyst that opened the flow.

To reiterate, my fieldwork started in December 2014 and it was completed in July 2016. I aimed initially for three study participants – the small sample size was in accordance with the guidelines of IPA, but also a reflection of substantial difficulties encountered with participant recruitment – and I managed to supersede that number and interview five women: Sarah, Carla, Leah, Natalie and Mia. Sarah had labiaplasty with Dr John Garcia in South America, whereas Carla, Leah, Natalie and Mia had their labiaplasties with Dr Lisa Smith in the UK. With regards to the timing of the operation, one participant had labiaplasty in 2012, another in 2014, one had the surgery in 2015 and two participants had the procedure in 2016. The participants’ age ranged from late twenties to early fifties. All participants identified as White and heterosexual. One participant was married, whereas the other four were single at the time of the interview. However, at the time of labiaplasty all participants were either single or dating casually. One participant in this study was also a parent. Two
participants had additional cosmetic procedures alongside labiaplasty, and one participant had a labia reduction prior to labiaplasty.

One of the five interviews was a face-to-face interview, whereas the remaining ones were conducted over the phone. The dominance of phone interviews was a direct result of the cross-cultural nature of the study and the related geographical distance. Namely, Sarah was the only participant who lived in the same country as I did, whereas the other four participants were residents of the UK. Therefore, phone interviewing seemed to be the most straightforward and least time-consuming approach. Furthermore, no participant expressed their specific desire for a face-to-face interview, even when explicitly asked about it. It could be therefore speculated that phone interviewing may have added another layer of anonymity – in contrast to a face-to-face interview – which may have been perceived as desirable by the participants. This would be in line with the literature on phone interviewing, which suggests that such data collection method may be very suitable for obtaining sensitive information from so called hard-to-reach participants (Creswell 2007, Liamputtong 2007, Neuman 2007). Furthermore, phone interviewing may help elicit information that would not otherwise have been easily accessible (Hammersley and Atkinson 2007). The differences between a phone interview and a face-to-face interview will be further explored in this chapter under the limitations of the research.

All participants received an electronic copy of Information Leaflet for Study Participants (Appendix I) and Consent Form for Study Participants (Appendix II) well in advance of the interview. They were asked to review these two documents, so that they were fully informed about their involvement. I highlighted that I was happy to address any questions at any point about the study and their participation. Participants’ consent was obtained over the phone, with the exception of Sarah whom I met in person and thus obtained a signed copy.

The interviews lasted from fifty minutes up to two hours. Guided by the literature on phone interviewing in social research (Creswell 2007, Liamputtong 2007, Mertens 2009, Neuman 2007), I opened each phone call by asking the participant ‘Is this a good time to talk?’, and by providing a brief purpose of the interview including the expected duration of the interview. All interviews were semi-structured, and supporting questions were developed in the course of the conversation. I saw my role
as a guide and facilitator of the conversation, and in that sense I wanted to provide my participants with the space to share with me as much as they felt comfortable sharing. I understood that the sensitivity of the topic may require of me to take the back seat at times, and let the conversation unfold in a way that is most suitable for a particular participant. Therefore, my participants also had an important role in determining the course of the interview, which I thought was in line with feminist research principles (explored in chapter four) that aim to empower women to tell their stories – in their own way. This proved to be of value for it enabled me to tap into areas that may have not been explored otherwise. I also underlined at the beginning of each interview that we did not need to address any topic that made the participant feel uncomfortable, and that the participant had the right to decline to address any of my questions. Throughout all five interviews not a single participant expressed their discomfort with the topics explored, nor did any participant decline to answer any of my questions. I believe this was a result of the rapport established before and throughout the interview. All of the interviews were recorded with two recording devices in order to have a back-up copy. These included a voice recorder and either my phone or Amolto free recording software that normally works in conjunction with Skype, but that can also be used independently. The interviews were transcribed verbatim.

The research materials – *Information Leaflet for Study Participants (Appendix I)* and *Consent Form for Study Participants (Appendix II)* – indicated that should the participants express their wish, the interview transcripts would be shared with them. My intention was to make sure that all aspects of participants’ involvement in the study were addressed in these two research materials, to ensure that they had the opportunity to review these well in advance of the interview, and finally to make sure that I addressed all of their questions in relation to the study before the actual interview. However, I did not want to overwhelm the participants with the information that was already covered in the aforesaid documents before or after the interview. In other words, I wanted to keep things simple. Sarah, who was my first participant, expressed her wish to receive the transcript of the interview. She said that she wanted to remind herself of all that we talked about, and she made no changes to the transcript. The second two participants did not take the opportunity to receive the interview transcript. After that I did not explicitly ask whether the participants wanted
to receive the transcript or not, considering that the choice to request the transcript was already offered in the Information Leaflet and Consent Form. However, all five study participants were asked at the end of the interview whether they wanted to receive the final report once the study is completed. All participants responded affirmatively to this question, and upon successful completion of this research they will receive the final report of the study.

5.5. DATA ANALYSIS

Having conducted, recorded and transcribed verbatim interviews with five participants, a detailed qualitative analysis in accordance with the guidelines of IPA followed in the attempt to identify, classify and interpret emergent themes. The analysis included a detailed examination of each individual account, followed by a search for emergent themes and patterns across all cases, and finally an analysis and interpretation of these themes against the backdrop of feminist and social-psychological theories underpinning this research (explored in chapters two and three). I engaged with each individual transcript in-depth at least ten times. With each reading I made comments in one margin, which signified a summary of a particular passage, initial interpretations of what was being expressed and possible connections with other accounts or theories supporting this research. In this process the themes started to unfold. With each individual transcript I wrote a list of emergent themes on a sheet of paper. I sought connections between the initial themes in order to form clusters and identify major themes. Within IPA the order of themes is normally chronological to begin with, but ultimately the order of themes is analytical (Smith and Osborn 2007). However, I decided to adhere to a chronological order of themes, for this piece really explores the whole complex process underpinning that one act of surgery. In other words, I wanted to utilize a time-oriented process inquiry and to explore the chronology of women’s experiences of labiaplasty including their lives prior to the surgery, the experience of the surgery and recovery, and finally the impacts that the procedure has had on their lives. It seemed logical to present the themes in a chronological way in order to preserve the thread and the narrative embedded in each account.
As I completed the table of themes for each transcript, I began to seek similarities and differences across accounts. This cross-case analysis led to a final table of major, superordinate and subordinate themes that encompassed all five accounts, at which point I prioritised the themes and therefore reduced the final number. The write-up included a translation of major, superordinate and subordinate themes into a narrative followed by an interpretation of these themes. Due to the complexity and richness of the collected data, I decided to explore major theme one *Life before Labiaplasty* in one chapter, major themes two and three *The Experience of Labiaplasty and the Aftermath* in another chapter, and lastly I reflected on major theme four *Gender Looks and Culture* in the third chapter. Adhering to the principles of what makes a good IPA (Smith 2010), each section included a brief summary of the theme, extracts from at least three participants in order to sufficiently support the theme and interpretations of these extracts. I wanted to underline convergence and divergence across accounts in order to demonstrate how participants manifest the same theme in similar or different manner. Finally, I also made an effort to highlight prevalence of the themes.

### 5.6. THE WRITE-UP

During the write-up I translated emergent major, superordinate and subordinate themes into a coherent narrative. In this process some minor changes were implemented in order to improve readability. For instance, minor hesitations such as ‘I mean…’, ‘Like…’, ‘You know…’ or ‘Hmm…’ were often removed. If the participant talked about one subject and then digressed before going back to the original topic, then that digression was left out of the excerpt and the missing material was indicated by dotted lines in brackets (...). Occasionally further explanations were added to the excerpts in order to provide the context to what was being said, and therefore make it easier for the reader to engage with the text. In those situations the added material was clearly indicated in squared brackets. Every attempt was made to carefully divide the emergent themes and the excerpts accordingly. However, this process proved to be somewhat challenging, for the themes often intersected. For instance, although clothing and physical discomfort were treated as two minor
themes – under the subordinate theme of physical motivation for labiaplasty – they often overlapped as participants spoke of discomfort with clothing. In such situations it was indicated that a significant overlap takes place. It should be emphasized that all names used in this study are pseudonyms and every effort has been made to ensure that other potentially identifying details have been removed or altered. Occasionally, even the pseudonyms initially attributed to specific quotations have been removed, and instead the term ‘the/one participant’ was employed, in order to safeguard participants’ anonymity.

Another issue that needs to be highlighted revolves around the terminology deployed in women’s accounts of labiaplasty. Namely, terms such as ‘down below’ ‘down under’ or simply ‘vagina’ were used when participants were referring to external female genitalia. It may be necessary to emphasize again that vagina refers to internal reproductive tract that leads up to the uterus, whilst vulva is the term that denotes female external genitalia. I wanted my participants to feel comfortable and therefore I did not interfere with their choice of terms, even when these terms themselves were not accurate (vagina/vulva). I did so largely because three of the five study participants were not native English speakers, and this confusion may had more to do with a language barrier rather than a lack of information. Finally, a conscious effort was made to provide a truthful and balanced representation of participants’ experiences. However, as indicated in chapter four, a researcher is just as much a human being embedded in a specific socio-cultural context and historical moment. In other words, although I cannot claim that I was completely ‘objective’ and ‘unbiased’ as I conducted the analysis and the write–up – for I do not believe that such objectivity can ever be achieved – I was guided by the notion of integrity, and I have therefore made a significant effort to present participants’ stories in the most honest manner.

5.7. LIMITATIONS OF THE STUDY

The limitations of this study refer to the exceptional sensitivity of the research topic, the related size and composition of the sample, and the data collection method. The
first and most important issue encountered in the study of women's experiences of labiaplasty is the exceptional sensitivity and delicacy of the subject matter. Considering that female external genitalia, let alone female genital dissatisfaction, is an issue that is rarely publicly addressed with honesty and openness, some minor challenges with participant recruitment were anticipated. However, the topic of female genital cosmetic surgery has proven to be a very difficult topic to research, for neither the service providers nor the service users appeared to be willing to reflect on it. This research indicated that in spite of the increasing demand for female genital cosmetic surgery, the issue itself seems to remain a taboo. Therefore the delicacy and the elusiveness of the subject made it very difficult to recruit the study participants. The twenty-six attempts mainly in Ireland and the UK over the aforesaid twenty-month period yielded five study participants – a sample size that is in accordance with the requirements of IPA (as discussed in chapter four), but that nevertheless poses limits to the generalizability of the findings. In other words, the main findings of this study resulting from an analysis of five individual accounts cannot be extended to the population at larger. However, the very nature of a phenomenological study is that it focuses on and elucidates the particular rather than the whole. Specifically, an idiographic study like IPA is a highly intensive and detailed study of persons’ experiences of a particular phenomenon, and this is reflected in the small sample size.

The composition of the sample included women of various cultural backgrounds who underwent labiaplasty in two different countries by two different practitioners, and who also underwent labiaplasty at different times. The cross-cultural nature of the study was neither anticipated nor sought after, but it is a direct result of the aforesaid immensely difficult data collection process. Considering different ethnic backgrounds of study participants, questions can be raised about the variation in human anatomy across societies. Put differently, one could wonder whether women of different ethnic backgrounds may also be shaped differently in the genital area, i.e. have comparatively smaller or larger labia. Questions about the standard variation in female anatomy across cultures has proven to be beyond the scope of this study, and further research is necessary to determine whether women of specific ethnic origins may have somewhat larger labia and thus may be somewhat more predisposed for labiaplasty. Furthermore, although all participants in this study underwent labiaplasty
in the last four years, they did so at very different times. For instance, Sarah underwent the surgery in 2012, four years before the interview took place, which arguably enabled her to reflect on her labiaplasty with a certain perspective that may not have been present in, for example, Natalie who had her procedure merely six weeks before the actual interview. In other words, whilst Sarah was able to reflect in detail about how labiaplasty affected her life including her sexuality, Natalie was not in a position to do so for she was still healing from the surgery at the time of the interview and therefore has not yet been sexually active. The timing of the undertaken surgery thus had an effect on the nature of the topics explored during the interview, and it may have had an effect on the findings of the study.

Thirdly, it could be argued that the dominance of telephone interviews posed some restrictions on the topics introduced throughout the interviews, and therefore may have had an effect on the results of this research. Namely, it appeared that the longest and most candid interview was that with Sarah, which was also the only face-to-face interview. The other four interviews were conducted over the phone. This is predominantly a direct result of the already mentioned cross-cultural nature of the study, for Sarah is the only participant who lived in the same country as I did. It was therefore possible to converse with Sarah in person. All other participants who were located via Lisa were also residents of the UK. Therefore phone interviewing seemed to be the most straightforward and least time-consuming approach to access participants. Indeed, this appears to be one of the strongest advantages of phone interviewing for it enables the researcher to access populations that would otherwise not have been interviewed (Creswell 2007, Hammersley and Atkinson 2007, Liamputtong 2007, Mertens 2009, Neuman 2007). Furthermore, nineteen months into my fieldwork I was also worried that if I postponed the interviews until I arranged my transport and accommodation in the UK, my potential participants may decide to withdraw from the study. It appears therefore that, on the one hand, considering the sensitivity of the research topic, a phone interview may have added another layer of anonymity in contrast to a face-to-face interview. It could be speculated that this may have been perceived desirable by the participants, for no participant requested a face-to-face interview even when explicitly asked. This would then suggest that phone interviewing may be beneficial in conducting so called sensitive research (Liamputtong 2007).
On the other hand, it could also be hypothesised that an increase in anonymity, associated with phone interviewing, may have somewhat hindered the ability to establish a higher level of trust and rapport between the participant and the researcher. This in turn may have had an effect on the number and importantly sensitivity of questions asked during the phone interviews. Namely, the interview with Sarah – the only face-to-face interview – may have been the most detailed interview because, since we had established strong trust and rapport, I felt comfortable asking her sensitive questions. I sometimes did not feel comfortable asking sensitive questions during the phone interviews because, being unable to see the person and gauge their comfort zone, I was afraid that the questions may come across as intrusive and that the participant may withdraw from the project. This indeed proves to be one of the greatest shortcomings of phone interviewing, for the researcher cannot observe participants’ body language and the contextual surroundings as a part of the interview (Mertens 2009). In other words, the important non-verbal aspect of communication gets lost during phone interviewing, and this arguably may have an effect on the types of questions asked (Creswell 2007, Neuman 2007). In order to resolve this issue, when I was about to ask a question of a sensitive nature during the phone interview, I told my participant beforehand that they did not have to answer. I also paid attention to the tone of participant’s voice in order to gauge whether they felt comfortable discussing a particular subject. This appears to be a good practice in phone interviewing (Mertens 2009).

Finally, a face-to-face interview carries the most valuable propensity to stop and re-start recording according to the natural progression of the conversation – a propensity that phone interviews mainly lack. Namely, having addressed all the questions, Sarah and I had formally completed the interview. I stopped recording the conversation and we continued to chat informally. The subject of sex toys was casually brought up by Sarah. It was during that informal conversation that Sarah began to reflect on the ways in which labiaplasty had changed her willingness to engage in self-pleasure and her use of sex toys. Considering that this is a very valuable piece of information, I asked her if I could turn my phone on again and record what she was saying. She happily agreed and this resulted in a two-piece interview recording with a delightfully surprising twist at the end. This would have not been possible with the phone interviews, for when the interviews ended so did all the
conversing. In sum, the data collection technique may have had an effect on the nature and the number of questions asked, and therefore on the length and the openness of the responses that I received. It needs to be highlighted though that cultural differences may have also accounted to some extent for the participants’ willingness to open up about sensitive topics.

5.8. CONCLUSION

The objective of this chapter was to expand on the empirical side of this research – the recruitment of study participants – and to reflect on the lengthy, difficult and at times very unrewarding process of locating women who have undergone a labiaplasty and wished to be interviewed about it. The chapter provided a thorough overview of the twenty-one clinics that offer labiaplasty or sexual health services for women set in Ireland, UK and Croatia, which were approached over the twenty-month span with a request for cooperation with participant recruitment. This immensely challenging process highlighted how problematic it was not only to identify a plastic surgeon who was willing to let me access their patients, but also to then identify patients who were willing to share their stories. In total, fourteen out of twenty-one clinics never responded to my invitation to collaborate, even when I followed-up with additional emails or phone calls. Despite the rigorous preparation for the fieldwork including meticulous research materials, the various strategies employed in seeking access, and finally the different social and cultural settings of these clinics, the overall success rate in securing a response to my invitation was less than five per cent. The meeting with one Irish plastic surgeon highlighted possible reasons for such low turn-out. These included concerns about patients’ anonymity and emotional well-being, as well as the risk of generating findings which may suggest that patients were not satisfied with the outcome of the procedure. Furthermore, even when access was finally established, the subsequent recruitment proved to be very demanding due to women’s low response rate to invitation combined with a high rate of withdrawal. All these drawbacks encountered along the way indicated that female genital dissatisfaction and modification is indeed a taboo topic, despite the heighten interest and increasing numbers in genital surgery. Finally,
this chapter also reflected on other approaches utilized to maximize the chances of locating the participants, including four exchanges with academics who work in the field of women’s body-work and sexual health. These exchanges proved that participant recruitment in relation to labiaplasty is a universal struggle in Europe and the U.S., which in turn possibly clarified why no study to date has been conducted on this particular issue. Nevertheless, it was also demonstrated how the situation quickly flipped around for the better. Meeting Sarah, the person who would become my first study participant, was more of a happenstance. The interview with Sarah helped me fall in love with my research again and gave me the impetus to travel to the UK and meet Lisa in person, which resolved the entire situation. Therefore, with Lisa’s generous support I recruited four more participants – Carla, Leah, Natalie and Mia. In sum, I conducted one face-to-face and four phone interviews with five women of different ages, nationalities and professions, all of whom were united not only in their experience of labiaplasty, but also in their kindness and willingness to help me complete this research successfully. The following three chapters are the culmination of – up to that point – three years of hard work in researching female genital cosmetic surgery. They offer a detailed examination of participants’ experiences of labiaplasty divided in four major themes and explored in a chronological order.
6. ANALYSIS AND DISCUSSION – MAJOR THEME ONE:
LIFE BEFORE LABIAPLASTY

6.1. INTRODUCTION

This chapter is the first of the three chapters that provide in a chronological order an analysis and discussion of the findings resulting from five in-depth interviews with women that have undergone labiaplasty. Specifically, the chapter focuses on the first phase – major theme one Life before Labiaplasty – and the three superordinate themes – Motivation for Labiaplasty, Immediate Social Environment and Decision-making Process. The aim was to explore the issues that participants experienced due to genital appearance dissatisfaction and accompanying discomfort, to place these accounts in a wider interpersonal context, and to elucidate the multifaceted process that ultimately led to labiaplasty. The chapter firstly provides a detailed exploration of participants’ motivations for labiaplasty that fall in one of the three identified groups – aesthetic, physical and sexual incentives – and insomuch heightens the understanding of the observable upward trend in female genital cosmetic surgery. However, these three groups that encompass participants’ motivations for labiaplasty are not clear-cut categories, but rather they are clusters of identified motivations that may, and indeed often do, intersect. Secondly, the chapter explores the immediate social environment in which participants’ decisions to undergo labiaplasty were anchored. It centres on social comparisons and commentary in relation to genital appearance, as well as the social support that was present, but importantly often absent, during deliberation. Thirdly, this section reflects on the decision-making process underlying the procedure and examines the silence surrounding the issue of female genital dissatisfaction and labiaplasty specifically. It also explores the research mechanisms deployed by the participants in the attempt to access information about the surgery, as well as the financial aspect of labiaplasty and the ability to afford the procedure. Finally, the section looks into the inner dialogue and the process of introspection in which all participants engaged – at least to some extent – in order to reach a solution to their experienced problem. Table 7 provides a summary of emergent superordinate and subordinate themes related to major theme one.
6.2. MOTIVATIONS FOR LABIAPLASTY

Superordinate theme one *Motivations for Labiaplasty* explores the identified reasons for labiaplasty divided in three groups as subordinate themes: aesthetic, physical and sexual motivations. Although every attempt was made to situate excerpts from participants’ accounts neatly into one of the aforesaid clusters, in reality the motivations for the surgery intersected and reinforced each other.

6.2.1. AESTHETIC

All participants spoke of the aesthetics as one of the main reasons for having labiaplasty. The aesthetic motivation for labiaplasty encompassed two interrelated issues – genital appearance dissatisfaction and genital appearance anxiety. Genital appearance dissatisfaction refers to participants’ dislike of the physical appearance of their external genitalia. Genital appearance anxiety denotes an emotional strain that emerged in situations in which participants had to undress in front of the other people. This anxiety seemed to be more prevalent that the actual dislike, however both themes are present in all accounts. For instance, Carla reflects on a dislike for and the lack of acceptance of her labia experienced from an early age.
It was something that I had a big complex about, since puberty. And I think I got to a point as a mature woman that I could not live with that anymore. (Carla)

I thought that was something that grew in my body and didn’t belong to me. So I always had a bit of trauma because no-one explained [to] me as a little girl anything about, you know, menstruation, your body changing. So, it was something that I didn’t accept from the beginning. (Carla)

The concern about the appearance and a lack of acceptance of her labia was an ongoing problem for Carla. It was especially prominent in situations in which Carla had to undress, such as when wearing a bikini or getting intimate with a partner.

[The labia] was something that I would think about, I don’t know, six-seven times a day to be honest. When you go pee, you have a shower, you get dressed… That’s bothering you all the time there. You know? You have sex… It’s something I was constantly thinking about. (Carla)

If I was in my bikini I was like: ‘Oh my God, can you see this?’ So I was quite self-conscious about it. Of course having sex and everything… When you’re married it’s okay, but when you are single it’s different. To me it’s like a problem I had for all these years. (...) So it is I think not only physically, but it was something that was bothering me psychologically. (Carla)

The last excerpt seems to capture two issues pertaining to women’s motivations for labiaplasty that are of great importance. When Carla says ‘when you’re married it’s okay, but when you are single it’s different’, she seems to implicitly suggests that a woman’s romantic relationship status may be a significant factor when deliberating about the surgery. The issue of how women’s involvement in romantic relationships affects their choices to alter their bodies will be explored in the upcoming sections of this chapter. In addition to that, Carla states that the appearance of her labia made
her feel very self-conscious about her body. This experience captures the negative psychological outcome associated with the dislike of one’s body, and therefore highlights the complex interplay between the human physique and the psyche. This will prove to be a reoccurring theme throughout this and the subsequent chapters. Similarly to Carla, Mia was discontent with and conscious of the appearance of her labia from an early age. This led to a lack of acceptance of her labia, which is evident in the language that she employs.

_I always have had a… You know, the deformity kind of a thing, when one labia was longer than the other one. And I’ve always been aware of that, since I was quite young. So I remember at the age of early twenties I was considering having it done._ (Mia)

Utilizing the term ‘deformity’ Mia seems to be saying that she believed that her labia was not ‘normal’, or otherwise outside the normal variation of human anatomy. As with Carla, situations in which Mia had to take her clothes off in front of a partner proved to be challenging, and adjustments took place in order to conceal her labia. Again, romantic relationship status was identified as an important factor in the exploration of women’s motivations for the surgery.

_I suppose because I don’t have a stable partner, I’m not married, have no kids, so it’s something that I… You don’t like it when you have to get intimate with someone and, you know, you have ‘that’._ (Mia)

_Before I used to, if I was getting undressed in front of a man, I used to… Especially if I didn’t know him, I used to kind of almost push it in, so that he couldn’t see._ (Mia)

Besides undressing in front of a partner, Mia also felt self-conscious when she had to disrobe in presence of her female friends. This may suggest that it is not an exposure to a male gaze that makes women feel uncomfortable about their labia, but rather an exposure to a more general societal gaze.
For example, I’ve been away this weekend with girlfriends, right? It was, you know, we get in the shower, and one is having a shower, the other one is brushing her teeth. Before I would probably push that in a little bit, so that they couldn’t see it if I was having a shower. ‘Cos I don’t like… You don’t want them to see ‘that’. (Mia)

Leah experienced a similar dislike for her labia and a heightened self-consciousness in situations in which she had to undress in front of other people. This included sexual intimacy and professional hair removal.

I’d always felt uncomfortable with down below. Not just around guys, but just like, if you go for a bikini wax or something like that, I’d just feel uncomfortable. Obviously, it didn’t look right, sort of the flabs, or whatever you wanna say, were hanging out. And I just felt, people would sort of look at me and stare. I don’t know. I just felt really uncomfortable about how I look down below, I guess, for years and years. (Leah)

Professional hair removal was also problematic for Sarah, who in addition felt uncomfortable when she had to undress on the beach.

When I go to wax session, it’s not nice ‘cos I need to be pulling the skin and pulling back. (Sarah)

Especially in my country Tina (…) we used to go a lot to the beach. And we love to sunbathe. So, if you put a bikini, it’s something… Okay, you’d need to look really near, but you can see there is a fluff there. [Laughs] There is some random piece of meat there that needs to be removed. (Sarah)

Sarah’s strong dislike for her labia – arguably genital appearance dissatisfaction that translates into genital appearance anxiety – is easily captured in the following sentence.
Sometimes I feel I just wanted to get a knife and rip this off. (Sarah)

It appears from the above excerpts that situations in which participants' labia may have been exposed to an external gaze were those that made them feel especially uncomfortable. In addition to the identified genital appearance dissatisfaction and anxiety, Carla and Mia assert that aging was another factor that added to the discontent with the appearance of their labia.

I guess also as you get older it keeps hanging more and more. So, when you’re younger, even if there is lots of tissue it kind of stays more in place. But as you get older gravity has its effect in every part of the body. (Carla)

I think that during the years, I’ve noticed lately that it was bigger or kind of enlarged a little bit more. And it was still uncomfortable. (…) So it was a bit of discomfort, something that was uncomfortable, and something that it kind of got larger with years. So, therefore it was more obvious than before. (Mia)

In sum, all participants experienced genital appearance dissatisfaction that appeared to translate into genital appearance anxiety, which largely manifested as self-consciousness, insecurity and a lack of self-confidence. This most often happened in situations in which their genitalia may have been subject to an external gaze such as sexual intimacy – especially with a new male partner – professional hair removal, undressing on the beach and in front of friends. In some instances, participants' romantic relationship status may have been another element that influenced their decisions to go forward with the surgery.

6.2.2. PHYSICAL

All participants spoke of physical discomfort and occasionally pain experienced in their day-to-day lives due to their labia. They reflected on discomfort experienced as
a result of body posture and movement, as well as on the adjustments employed in order to manage that discomfort. Another area of concern was discomfort due to clothing but also, intimately, issues related to menstruating. In relation to physical discomfort and pain experienced due to body posture and movement, the two most common problems were sitting and exercise. These issues were experienced by all participants with varying degrees.

_Sometimes I’d just be sitting for five minutes and it would cause me a great deal of pain. I would have to stand up. I couldn’t do things, like, work in a bank and things like that. It was too painful. So it affected me very much at work. At the time I was a receptionist, so I had to sit down all day. And it was just, it was just extremely painful._ (Natalie)

_It’s uncomfortable as well because you’re sitting down in general, you have tight trousers or something, it would be quite uncomfortable. Get sort of an irritation almost. So, it wasn’t just cosmetic. It was also comfort._ (Leah)

_There was too much tissue in the area and it’s quite uncomfortable when you do sports, when you move._ (Carla)

_If I went on like a bike for example, like, I’d do a spinning class, I would realize that it kind of rubs… It’s uncomfortable._ (Leah)

Besides physical discomfort, pain was another problem experienced primarily by one participant. Her story is somewhat different than other participants’ for she already had labia reduction on the NHS years prior to labiaplasty. She explains what the problem was and what might have caused it.

_About eight years ago, I had a problem with my labia, where one side was extreme swollen and a lot longer than the other side. And it was really, really painful. Day to day it was extremely painful to me. So, through the NHS I had an operation to reduce these labia, the left_
It was just one side, the one part of the labia that was swollen. She just cut that down.

They explained to me that the reason I was having the pain was probably because it was so much bigger than the other one, and longer. So it was pulling, rubbing, just causing me like a throbbing pain. I don't really know why, they didn't really explain to me why that happens. They just said by reducing it, it should take the pain away.

Following the operation, this participant experienced an improvement with regards to pain, but the ongoing discomfort and the aesthetics had a negative impact on her self-confidence.

And after my operation, eight years ago, it took all of my pain away, but I was left with still these labia that just came, like, hanged outside. Not as much as before, it they still did. And I was very uneven. And ever since then really, I didn't have the pain anymore, but physical discomfort I had for these eight years and it just got to a stage where I was just very uncomfortable and insecure.

Not fully happy with the outcome, the participant engaged with the NHS again in order to address the aforesaid issues. However, the response that she received was not what she was looking for. She reflects on the interaction with the NHS medical staff and how it made her feel at the time.

When I went back to the NHS, because I didn't have the pain, they said that my issue was just cosmetic. Because even though it was causing me discomfort, like, you know, just walking, it caused discomfort, the way it was coming outside. And they said that because it wasn't actually causing pain, it was more of a cosmetic procedure. But it still caused me a lot of discomfort and it was irritating.
They made me feel like it was more kind of a psychological issue, and it was just something that I just had to deal with. Because if I haven’t got bad pain, like I had before, then it’s just me, like, making a big deal out of something. So they actually wanted me to see a psychologist about it, but I didn’t. [Chuckles] So yeah, I didn’t really like the way that was handled, because it made me kind of feel… I don’t know, like I just should have gone on with it. But, if I have discomfort every day that’s causing me issues, then I don’t feel like I should just have to live with that.

This participant seems to be saying that by having been suggested to see a psychologist, she felt pathologized in the process. Although labia reduction on the NHS successfully addressed the pain, discomfort accompanied by the dislike for the physical appearance for her labia were the reasons that finally made her seek labiaplasty. As explained earlier, this is not the only participant who experienced physical discomfort. Three participants spoke of the physical adjustments that they used to employ on a daily basis, in order to manage these issues. Interestingly, all of them said that they did so unconsciously.

I used to do something that I didn’t notice. Just to show what is it, okay? [Sarah stands up and demonstrates] It’s like, you have pants. But if you have small pants, because it’s something common in my country, I used to do this [Sarah takes up a position as if she is going to squat, but lowers in her knees only a little]. Because each kind of [my labia], was touching on my pants, and touching each other, and [it] hurts. (Sarah)

I used to sort of shift about position and try to get comfortable when I was sitting down for too long. And I hadn’t… I didn’t really even realize I was doing it. But now, obviously, I haven’t got that problem. I’ve realized now that I used to kind of shuffle on my feet quite a bit to feel comfortable. (...) Yeah, it’s weird, because I didn’t know I was doing it until now when I think: ‘Oh yeah!’ (Leah)
I haven’t realized that I used to rearrange unconsciously when I sat. ‘Cos I could feel, you know, it’s almost like you can feel something there. (…) So it’s sometimes you almost realize things that were happening before and they don’t happen now. But you kind of discover that now, you know, because you probably were so used to it that you didn’t pay that much attention to it. But you knew it was there somehow. (Mia)

Another situation in which participants experienced physical discomfort had to do with tight clothing, primarily tight jeans and thongs.

If I was wearing tight trousers, because there is excess skin obviously, you could call it, it would rub into the trousers because it wasn’t protected inside. It was like hanging out. So I guess that was rubbing against my trousers. (Leah)

I remember sometimes being uncomfortable with tight jeans, something like that. I used to rub, I used to feel… Sometimes I had to stop, if I was walking on the street, I had to almost rearrange myself. (Mia)

Another thing is sometimes if you’re wearing thongs, before the labia used to go to the side sometimes. It almost like it kind of goes out. (Mia)

Menstruation was another situation in which some participants experienced physical discomfort. Namely, three participants reflect on difficulties encountered when trying to insert and remove a tampon.

It was awful when I was having my period. It was really annoying. (…) Because especially when you have period, your body, you’re all emotional, your body it’s all sensitive, and you have something that’s pinching you… Before I had labiaplasty I didn’t really like… What it’s
called? Tampons? Didn’t like… Because to take off was just a mess and it was awful. (Sarah)

I didn’t like it and then I found [the labia] was in the way all the times. Sometimes, it sounds disgusting, but even when you got your period and putting the tampon in and out, even that, it’s something that you almost have to… It was just all those things. (Mia)

You know, getting a tampon in. (…) [The labia] is something that is there in the middle of the way. So before [labiaplasty] it’s something that is messy. (Carla)

Lastly, Sarah was the only participant who experienced difficulties when urinating due to her labia.

When I used to go to toilet, one example, and then you pee, you go to dry, it was like it needed to be a little more effort. Because, let’s say, I need to open and it’s a little bit disgusting looking back, you know? And it was something I didn’t really notice because I didn’t know. (Sarah)

In summary, the second set of reasons why participants sought labiaplasty revolved around physical discomfort experienced due to body posture and movement such as sitting and cycling, as a result of tight clothing such as jeans and thongs, and lastly discomfort experienced at the time of menstruation whilst inserting and removing a tampon. Three of the five participants unconsciously utilized physical adjustments in order to manage the aforementioned discomfort.

6.2.3. SEXUAL

Sexual motivations for labiaplasty mostly revolved around issues pertaining to intercourse, vaginal lubrication, orgasm and self-pleasure. Four out of five
participants complained of discomfort experienced during intercourse due to their labia. Sarah explains succinctly what the problem was for her.

Sarah: Let’s say you are having sexual intercourse, relations etc. And then this part of the labia goes into your body.
Tina: Inside?
Sarah: Exactly, with the penis. And it hurts. You know? It’s kind of somebody pinching you. It’s not good.

In other words, the most common problem with intercourse was that during friction the penis would pull the labia along, sometimes all the way into the vagina, which inevitably led to discomfort. Carla, Mia and Natalie had the exact same problem as Sarah.

Having sex, you know, it’s something that is there in the middle of the way. (…) [It was] very uncomfortable, you know. Because it’s pulling, you know, it’s something that the penis is pulling inside. It’s pulling a part of your body that… It’s something that is hanging there, that is in the middle of the way, but it’s just, it’s not very easy. I mean, if someone is very careful, you make it with lots of folding and everything. But it’s not very perfect, it’s difficult and not very enjoyable. (Carla)

It is in the way. So sometimes, obviously, sometimes it goes in [the vagina]. As obviously, you know, the penetration, it sometimes, it can go in. So, you have to manually pull it out. It can go in. So obviously, that was another [reason for labiaplasty]. I used to all the time put my hands and I almost, you know, put it out of the way. ‘Cos it would just cover the vagina, so… So, I used to, yeah, I used to do that. (Mia)

Because it came outside, I thought like, they were always in the way. It was just uncomfortable because of the… I don’t know. I felt like it was maybe pulling. It just caused me, caused me to have some pain and discomfort. Because they were so… They were too long, too...
Like, getting in the way. It must have been the pulling and the friction, I don’t know. It just caused me pain and discomfort. (...) Not so much actually going inside [the vagina], but I know it was pulling, tugging about, where it shouldn’t have been. (Natalie)

‘It was in the way’ is the expression used by all four participants to capture the problem experienced during intercourse prior to labiaplasty. In addition to that, Carla reflects on two related issues pertaining to intercourse. These are vaginal lubrication and the lack thereof, as well as the process of aging that may affect men’s ability to achieve and hold an erection.

Because it’s something that’s outside, so it doesn’t get wet easily. So, yes, that’s exactly how I would describe it, you know? It has to go inside with the penis. It gets inside. And then, you know, if you’re young and you have a good erection and you’re very wet and everything, you can manage afterwards to kind of get everything done. (Carla)

When you have sex, if your labia is too long, it folds inside your vagina. So, you know, if you’re trying to penetrate something that is covered by the tissue, it’s very difficult. And as you get older you know… When you’re in your twenties it’s easier because men tend to get an erection and everything. But when you get older men don’t get that erection anymore, it’s very difficult to actually have intercourse. When you have long labia, it’s not easy at all. (Carla)

Sarah also raises the issue of vaginal lubrication, which in her case impeded her desire to engage in self-pleasure.

Sarah: Before it was too much, [I] don’t know, I couldn’t really… I even didn’t have the effort to masturbate, because it was so hard to get there…

Tina: Would you focus on doing it internally, or would you stay on the clit?
Sarah: No, outside.
Tina: On the clit. Okay.
Sarah: Outside, yeah.
Tina: ‘Cos the labia should be, you know the way [a vulva] is, labia should be here and then the clit is on top [demonstrating with her hands].
Sarah: Yeah, but you need to keep it wet.
Tina: Huh?
Sarah: You need to keep it wet. You know?

It appears from this excerpt that due to the sheer size of the labia, Sarah may have had a problem achieving and maintaining the necessary level of natural lubrication to enjoy self-pleasure. Unsurprisingly, the aforementioned issues experienced during sexual intimacy had an adverse impact on Sarah’s ability to enjoy her sexuality.

Sarah: It’s like an elastic, let’s say. So I could pull [it] and if I leave it, it comes back. But I could stretch it. And [it] could be up to three centimetres, four centimetres long. Maybe more, I don’t know, I’m not good at sizes. But it’s something that was there. So, let’s say, if I’m having sex and then penis is there, the thing is in the way, so, you know? You have something pinching there, the pain… It’s harder for you to relax and, you know…
Tina: Enjoy it.
Sarah: Enjoy yourself. Exactly.

Another participant also reflects on her inability to experience sexual pleasure before labiaplasty. However, she acknowledges that her previous negative sexual experience may have had an effect on her sexual functioning.

I am fifty-one and I’ve never had an orgasm with a man in my life. Never. And I have had a few lovers. [Laughs] Maybe once, I had a very good lover once, and once with a vibrator I managed to come with him. Once! Once in my life! It might be that this big trauma had an impact on me and I kind of locked. It could be. (...) And it’s not like
I’m frigid. When I masturbate, I have absolutely no problem with that. It could be also because my ex-husband was quite abusive and I met him when I was very young. So maybe, you know, my first sexual experience was not great and then it lasted for a long time, so I don’t know.

Notwithstanding issues related to her labia, this participant seems to suggest that her (impeded) sexual functioning may have been caused not only by her previous negative sexual experiences, but possibly due to the interaction between her and her male partners and the nature of sexual acts they had engaged in. Namely, if the participant emphasises that she can easily orgasm though self-pleasure, that raises the question why does not that satisfaction translate into sexual intimacy experienced with another person. It may therefore be speculated that the type of sexual activity that one engages in, as well as the match between the two persons, may be a far more significant factor in experiencing sexual pleasure than the size of one’s labia. In contrast to these accounts, Leah was the only participant who did not encounter any of the aforesaid problems.

I think sex wasn’t painful for me before and it was obviously not after either. (…) But the actual pain side, no. I know, I have read that it has made a difference to some people; that it was painful before. Maybe the extent of mine wasn’t as bad as someone has in that respect I guess. I was quite lucky in that respect. (Leah)

In a nutshell, an important sexual motivation for labiaplasty seemed to be participants’ desire to enjoy sexuality intimacy with their male partners and themselves, without having to manage discomfort as a result of friction and a lack of natural lubrication.
6.3. IMMEDIATE SOCIAL ENVIRONMENT

The second superordinate theme elucidates the social context in which participants’ decisions to undergo labiaplasty were anchored. Insomuch it reflects on the three subordinate themes: social commentary, social comparisons and social support that were either present or absent during the decision-making process.

6.3.1 SOCIAL COMMENTARY

This theme explores whether the participants may have received a comment in relation to their labia that may have influenced their decision to undergo labiaplasty on some level. Specifically, it reflects on comments about the genital appearance and one comment in relation to adjustments – explored earlier in this chapter – that a participant used to utilize to manage physical discomfort. None of the participants reported any negative comments from their male partners that had made them feel uncomfortable about their labia. The only exception to this was Sarah who received a comment from her previous boyfriend, although it seems that the comment was based more in ignorance rather than judgement.

*I actually had a comment before from an ex-boyfriend. It was not something mean or anything. Was just, I suppose, we were quite young and he didn’t really know how it’s supposed to be [female external genitalia]. And you know how we live in a perfect world; everybody wakes up with fresh breath and brushed hair and everything… [Laughs] So I think the first time he saw, he’s like: ‘What’s that?’ And then I was like: ‘It’s my vagina.’ You know? I never really… It’s funny ‘cos talking to you, I never really thought about these things. (Sarah)*

Sarah states that this comment was received years prior to labiaplasty, and that it had not made her feel self-conscious about her labia. Carla, Leah and Mia did not experience any negative comments from their previous male partners.
Not really, no. I have to say no. That’s why I think men tend not to support you because for them it’s kind of a normal thing. They really cannot care less. (Carla)

No, no-one’s actually said anything. Obviously with an area like that… I haven’t got a boyfriend, but I’ve had obviously boyfriends in past. And no-one has actually said: ‘Oh my God, what’s going on down there?!’ or anything like that. (Leah)

I have had few relationships in my life and no-one, none of the men have said, you know, that they have been put off by that. You might think that they do, but actually I haven’t experienced that. (Mia)

It is interesting to note this lack of negative commentary from male partners since they were also least likely to support participants to go forward with the procedure. This will be explored in the upcoming section of this chapter. Mia however experienced negative comments from her friends, although these were not directed at her personally.

Sometimes when you watch TV, there’s programmes like [the name of the show] and you can see that labia, you can see that. Sometimes I’m with people, and obviously they don’t know what you got, and they might say: ‘Oh my God, look at that! Ugh! I wouldn’t like to have that!’ and make those comments like: ‘Ugh’. So obviously, you feel a bit like: ‘Actually, you are making those comments and you have no idea what I’ve got under my clothes.’ (Mia)

Apart from Mia, Sarah also experienced a comment from her friend in relation to the adjustments that she used to employ in order to manage physical discomfort caused by her labia. She however emphasizes that this comment should be understood as a friendly tease coming from someone with whom she had a loving friendship.

My best friend – he’s a man and he knows I did [labiaplasty] (...) Yeah, so I do movement, and this movement he used to slag
because his niece, they used to do ballet. So you have ‘plie’, and I was doing this all the time. And after I had the surgery when I was recovering, we used to go out for beer and you know, with our friends. He was always slagging me: ‘Plie, plie!’ Because I used to do these involuntary and nobody knew. (Sarah)

This comment should therefore be viewed as benign teasing, especially since it did not make Sarah feel uncomfortable in any way. It seems therefore that apart from an odd comment based predominantly in ignorance and a lack of information, the participants largely did not experience negative comments from people close to them that would make them feel self-conscious about their labia.

6.3.2. SOCIAL COMPARISONS

Another question that participants were asked was to what extent social comparisons had an impact on their genital appearance satisfaction, and therefore their deliberation about the procedure. Namely, the issue of mainstream pornography was raised as one possible source of comparisons with regards to labia. Sarah presented herself as someone who is very open about sex and engages with pornography. She admits that viewing pornography may have made her think twice about the appearance of her labia.

If I look at a picture of my vagina before, look at my vagina and think ‘Oh my God!’ and then watch porn like: ‘Jeez, something is wrong with her vagina!’ And then I’d think: ‘No, maybe something is wrong with my vagina.’ (Sarah)

However, interestingly, Sarah underlines that pornographic images would not make her seek labiaplasty, for it seems that Sarah engages in social comparisons selectively by focusing on specific parts of the body.
If I see nice boobs, let's say in a movie or porn or whatever, even a magazine, Playboy or something. I would bring that magazine to the surgeon, show it to him and say: ‘Listen, I want these boobs. Put me these boobs, or this belly, or whatever.’ But not the vagina. (Sarah)

Natalie and Carla also contend that pornography can have an adverse effect on a woman’s relationships with her bodies, and in addition to that Carla underlined that it also influences our views of sex.

Yeah, it does have an effect! You see things on social media about… about like, making jokes of women that don’t have conventionally beautiful, you know, naked body, so it can make you feel really insecure. I felt really insecure about that before, when I’ve seen things like that. ‘Cos I didn’t look the way that you would say a beautiful body looked in that [genital] area. And it does make me feel really insecure. I felt really insecure about that, alongside the discomfort. Yeah, it does have an effect on how you feel, how confident you feel with your body. (Natalie)

Tina: You feel like pornography also affects our idea of what is a beautiful body?
Carla: Of course! And what is sex, you know? You see this pornography that is all aggressive and it’s just to please men. I mean, nothing to do with giving pleasure to a woman. And it’s there. It’s in your mobile. It’s in your iPad. You can just Google it and you get all tons of pornography. And the last thing they care about is the pleasure of the woman. It’s just all about giving pleasure to the man.

These excerpts demonstrate that Natalie and Carla are critical of the images and sex portrayed in mainstream pornography. Furthermore they are aware that such media consumption can and does have an effect on women’s relationships with their bodies. Mia is equally critical of mainstream pornography and explains why she does not watch it.
To be honest, I don’t watch pornography at all. I probably have watched a few times, mainly when there’s like a [documentary] program about it. I’m not sure about it. (…) I reckon that the women, they look very… Again, it’s all these massive boobs and all! I don’t agree with that. (…) For me, I think a person’s body is something… It looks healthy, it’s functional. It’s not about looking plastic. No, I don’t… Not for me. (Mia)

Sometimes you’re on a late night and you’re watching TV and you skip through it, you know, those programmes. And it might have been something: ‘Oh my God, what is that?!’ And you change. I find it really boring to be honest ‘cos it’s so… (…) If you look at it, it’s the same thing. It’s the same thing all over again. I don’t need it myself to turn me on. (Mia)

Mia points out that although pornography is not a medium she utilizes to compare her labia to that of other women; she does however engage in comparisons in a completely different setting – the gym.

I go to the gym and also being a [therapist] I am very aware of getting undressed. But when you are in the gym and, you know, people around you get undressed, I do look at people’s bodies. And I’ve never seen anyone with that. So it obviously makes you more aware of it. Because you look at people when they get completely undressed. And they don’t have… At least I can’t see it, whereas if I was getting undressed completely people could see that. So I would avoid being completely undressed in the gym because I wouldn’t like people seeing that. ‘Cos I could see all the other ones, you know, lots of women every day, and I couldn’t see anyone having what I had. So I avoided being completely undressed. (Mia)

This excerpt therefore suggests that social comparisons in relation to female genitalia may and do take place in those settings in which women undress themselves, and insomuch may lead to increased dissatisfaction with one’s own body. To summarize,
social comparisons were only to some extent experienced by participants. These mostly included comparing their labia to those of women in mainstream pornography, and women they encounter in specific social settings such as the gym.

6.3.3. SOCIAL SUPPORT

The final subordinate theme explores the relationships in which participants were embedded at the time of deliberation – including relationships with family, friends and their partners – and the effects that their support and the lack thereof had on participants’ decision-making process. Female family members, namely mothers and sisters, seemed to be the first persons to turn to for some participants.

My mum and my sister they agreed with it. Especially, my sister, she said: ‘Yeah, you don’t like it, that’s it then!’ And they said that yeah, it did look bigger than how it used to be so yeah… My mum was a bit reluctant in the beginning. (…) I think it’s because she was scared of an operation. Because we never, no-one in our family have gone through surgery, ever. So it probably was more the concern of going through surgery and how… Is this going to repair really quickly, are you gonna have an infection…? More like thinking, you know, that nervous feeling of: ‘What’s gonna happen? Is it going to be really quick and easy, or is it going to be like a nightmare?’

The participant who had labia reduction before labiaplasty was also content with the support that she received from her family members during deliberation.

Participant: I’ve got two sisters and obviously my mum I’ve spoken to. None of them had the same problem that I had.

Tina: That’s excellent that you have open communication with your mum and your family.

Participant: Yeah… Well I did feel like that before I had my first operation [labia reduction]. The reason I was in pain for so long was
because I didn't tell anybody what the issue was cos I was too embarrassed. So I actually had that pain for a long time before I had the operation, and not being honest about what the actual problem was, cos I was too embarrassed. So, it took me a long time to have that first operation. But after that I became more confident talking about it.

In addition to that, all of the participants spoke about the surgery with their friends. Sarah came across as the participant most comfortable talking about the surgery with her friends. She also singles out her best male friend, the same one who used to tease her about the adjustments, who was very caring during the recovery.

I don't really have a problem to talk to my friends and everything… I showed [it] to everybody after! [Laughs] (Sarah)

When I said I'm going to have a plastic surgery on my vagina, and he was like: ‘Oh my God, I can't believe it! Tell me how is it?’ He's not even gay, you know? But we have a really good relationship, and I'm like: ‘Yes, that's what's going to happen etc.’ So after I did, he was always with me: ‘Is it annoying, it's uncomfortable? Do you need to go home or something?’ I was like: ‘No, I’m grand.’ (Sarah)

On the other hand, Mia, Carla and Leah were very selective with regards to sharing their decision-making with their friends. All of them reflect on the possible reasons for such selectiveness.

[Labiaplasty] it's something that you feel like you don't want people to know. (...) I have mentioned to a couple of friends actually, just weeks before doing it, and they were like: ‘Yeah, you just go for it! If it's something that you don't like, and it's there, you just get rid of it!’ But obviously, it depends on mentalities. You might not tell everyone, even though they are your friends cos they might think that, you know: ‘Oh, you're gonna spend all that money on that!’ And also because you sometimes feel that you… For example my closest
friends, you almost feel that they might thing that you’re being vain if you spend all that money for doing that. So you don’t want to have, you know, you don’t want them to see you that way because it’s not like that. (Mia)

One of my friends came with me to the hospital, she waited until I came out. And even though she has not done anything on herself, she didn’t kind of judge me for having it done. ‘Cos she knows that it’s something that bothered me. And that was it really. (Leah)

Female friends tend to gossip. It’s a very private issue. You don’t want them to go and tell their husbands ‘cos they will, and husbands tell their friends so… I’m just a very private person. I don’t like to, you know… I think you have to be careful with the things you say because people talk. (Carla)

The two issues that emerged here as possible reasons for selectiveness are trust – the ability to confide in a friend and rest assured that the information will stay between the two people – and acceptance that can be manifested as a lack of judgement for the decisions of another person with which one may not personally agree. Although she talked about labiaplasty with her best female friend, Carla experienced a general lack of support during deliberation.

People really think you are crazy. (…) You would be surprised about how little support you will get from your partner, your parents, your sister, you know? So, yeah, it’s quite a lonely place to be in. (Carla)

Apart from Sarah who did not discuss labiaplasty with her previous partners, four participants shed some insightful light on the male support and importantly its absence. At the time of deliberation all participants were single, although some of them were dating casually. Carla reflects on her former partners’ reactions about her labia that ultimately affected her willingness to open up about this topic.
My first husband was crazy about it. He loved it! He would have… If I would tell him now that I had this operation, I’m telling you, he will kill me. [Laughs] (Carla)

It’s actually funny because I was dating someone [at the time of deliberation]. Actually, I remember telling him [about labiaplasty]. He told me: ‘Are you out of your mind?! Don’t even consider it!’ So, that was the only person I suggested I was going to do, and he said to me: ‘I mean, you don’t need it at all! This is normal. This is perfect. This is beautiful. You know? Don’t do it! And it’s crazy!’ So I thought I better not tell anyone, because no-one is going to understand. (Carla)

The issue of perceived ‘normality’ again seems to be a significant element in considering participants’ motivations for labiaplasty. Namely, whilst Carla’s former partner found her labia ‘normal’ and therefore did not see a valid reason for undergoing labiaplasty, Carla experienced a different perception of her body. This appears to highlight that ‘normality’ is an individually constructed and thus subjective notion that guides one’s assessment of the aesthetics pertaining to human bodies. Mia’s previous partner was equally against surgery, which in turn had an adverse effect on her deliberation. She speculates why her partner had not been more supportive.

I remember with my last partner, I mentioned to him I really want to have it done and he didn’t like the idea. So, it kind of… You know, I thought: ‘Well, I’m just gonna leave it and, you know, see…’ So I didn’t do it then because he was, you know, he was a bit against it, saying you don’t have to do it blah, blah. So I kind of left it a little bit. And now, since I’ve been living on my own, it’s when I started researching a little bit. (Mia)

I suppose he didn’t… He thought it was silly to just go through surgery and pay for it, as obviously it’s not a cheap procedure. I just have a normal job. It’s not like I’m making thousands of pounds a
year. I have like a good salary, but... So obviously, he probably though that it is a good money for a few days to have that done, something that no-one sees. And, you know, that's probably why he thought that it was just, it was something normal that lot of women have and it's not a problem. Obviously I didn't like it and then I found it was in the way all the times. (...) They don't experience that, but I do. (Mia)

It appears from Mia’s experience that a lack of male support may have to do with the financial cost of labiaplasty accompanied by the ‘invisibility’ of the procedure, as well as a possible lack of understanding for the problems faced due to having larger labia. Mia further reflects on two possible reasons why men may not be very enthusiastic about the surgery, which seemed to be antithetical. These are care and selfishness.

You can see that a man’s gonna be concerned if you have a massive surgery, to have your boobs and your tummy tuck and your facelift – all in one go. And I think hang on a second, you’re gonna go through all this?! He’d be more careful about it, thinking [what] if something’s gonna happen to her. And I understand that, you know, they might be concerned. But when it’s something that little, that is just only a little bit... (Mia)

I think sometimes probably men get put off by telling them that you’re gonna have to not have sex for a month. And they’re very selfish that way. So they might not like the idea. And I reckon that’s probably one of the reasons – ‘Oh, by the way, we might not have sex for four weeks!’ Unless I got an infection, it might be six weeks. So they probably wouldn’t like that. (Mia)

Finally, Mia concludes that a partner’s support and the romantic relationship in which a woman is partaking may actually be the determining factor in the decision-making process.
If you’re considering having a surgery, depending on that relationship you got with your partner, you might find that it’s not necessary. Because the man says: ‘Oh you know…’ and you say: ‘Well actually, you know, yeah, maybe I don’t need it.’ And then you might not in the end go through it. I think that it’s also important, depending on how your life is, whether you got this type of relationship with that person, that he doesn’t care, he doesn’t mind, you know, he’s happy with what you got and how you are… You might think: ‘Well actually, I’m not gonna go through it.’ (Mia)

In contrast to these accounts, Leah’s and Natalie’s former partners also did not think that they needed labiaplasty, but at the same time they did not discourage them for taking that step either. On the contrary, they were understanding and supportive.

I was seeing someone at the time when I had it done and he was like: ‘I don’t think you need anything done, but obviously you need to feel comfortable.’ And he said his ex had mentioned about hers as well, the same sort of thing. It’s actually quite common, but obviously people don’t talk about it. (Leah)

My ex-boyfriend, he is the only boyfriend that I had. I was with him for a long time. And he, he never... He was very supportive. He understood that I was insecure, and also was uncomfortable. (...) So, he knew that I was thinking about it, about these reasons, and he was supportive about it. He never commented like, look-wise, he said that I was fine. (Natalie)

It appears therefore that the participants felt most content with the support provided by their female family members, namely mothers and sisters. Friends also proved to be a good source of support, although participants selectively chose whom to tell about labiaplasty, namely friends that accepted their choices and whom they completely trusted. Finally, two participants seemed to experience resistance from their partners with regards to labiaplasty, and two participants encountered the exact opposite from their partners: understanding and support.
6.4. DECISION-MAKING PROCESS

The final superordinate theme in this chapter expands on the complex and lengthy decision-making process underlying labiaplasty. It explores the silence surrounding the issue of genital dissatisfaction and modification, the research in which participants engaged in order to reach a decision, the ability to afford the procedure and lastly the inner dialogue in which all of the participants engaged.

6.4.1. SILENCE AROUND THE ISSUE

This theme captures the lack of information about labiaplasty as well as the lack of communication about female genitalia, as experienced and told by the participants. Most of the participants encountered a gap with regards to knowledge about and understanding of labiaplasty, which may have prolonged the time it took to go forward with the procedure. This was apparent in Sarah’s situation.

[Larger labia] is something really common in my country. Actually by the time I, when I had the surgery, the doctor told me [it’s common]. Even though it’s much more [common] then Ireland, he said most of women they don’t really know that something could be done, you know? And that was my case. (Sarah)

One participant highlights that the lack of information about labiaplasty is a pressing concern. She tells the story of her friends’ teenage daughter who wishes to have labiaplasty, but her parents are not very enthusiastic about it, possibly due to the aforesaid issue.

I’m very happy to be part of this kind of research because maybe other women… One of my best friends told me the other day [that] her teenage daughter wanted to have it done. And they live in New York, the father is a professor, and she said: ‘My husband had said: ‘This is impossible! We cannot… I mean, this is crazy! Is she out of
her mind to feel…” For a young girl who has that complex, you know, with parents that, you know, he’s a professor and she’s very open-minded, no-one is willing to help this girl who is eighteen to correct that because of a lack of information. You just go to the Internet trying to find a bit, but there is nothing really scientific or serious that you can read and say ‘Oh, okay, it’s not such a big deal!’ You know? She can have it done and maybe she’s gonna be much more happy, she’s gonna enjoy more her sexual life. So there is still a big taboo...

This participant also reflects on the absence of scientific research that looks into labiaplasty and women’s sexual pleasure post-operatively.

As I said there is not much information, nothing scientific for you to read. For instance, nothing related to sex, to that side of things.

A possible reason why there is very little scientific and other information about labiaplasty is the fact that there is very little open communication about female genitalia to begin with. This includes conversations within the family and specifically with female family members, among women generally, but also communication on the wider societal level.

My oldest sister she’s quite, you know, conservative. So if I say I’m having plastic surgery on my vagina, she’s like: ‘Jeez, you can’t say vaginal!’ You know, it’s just a word, a six-letter word, what’s the problem? [Laughs] (Sarah)

I don’t know how many people would be willing to talk about it. (…) So when Lisa asked me I thought:’ Oh well, there’s no reason I wouldn’t be’, ‘cos I was happy with the result. I thought it helps with research, then I feel like I’ve done, like I’ve contributed a bit to some research, so why not? (Leah)

I was educated in an extremely Catholic way where sex was something never to be talked about. You couldn’t touch yourself. You
couldn’t… So it was all very repressive. And I said to my friend the other day when she told me, you know, my daughter asked me to have this and I think: ‘God Lora, you’re so lucky.’ I wish when I was a teenager I had that trust in my mum to be able to go to her and ask her for help. But I never felt that way. Also, no, I couldn’t really talk to anyone.

The participant who had labia reduction prior to her labiaplasty reflects on the years of pain and physical discomfort experienced precisely due to a lack of communication and the closely related feeling of shame.

The reason I was in pain for so long was because I didn’t tell anybody what the issue was ‘cos I was too embarrassed. So I actually had that pain for a long time before I had the operation, and not being honest about what the actual problem was, ‘cos I was too embarrassed.

Mia suggests that the feeling of disgust may be the reasons why there is a lack of conversation about female genitalia and larger labia specifically.

[Labiaplasty] it’s something that you feel like you don’t want people to know. A bit like uuuu… It’s sounds like something that people don’t wanna know. You know, people classify that as disgusting, you know, that you got ‘that’ there.’ (Mia)

In relation to the absence of open communication about female genitalia, Mia raises one interesting point that may explain why some men are not very supportive about their female partners having labiaplasty.

Maybe if you have, you know, a longer conversation, I don’t know whether… I didn’t really talk about it that much with my ex, I have to say. But I don’t know whether you explain [to] them, you know: ‘It’s this, and this, and this, and that.’ There might be women that don’t wanna explain all that, they might feel a bit like: ‘I don’t want him to
know all these things.’ Or there might be women that explain exactly
all those things that they experience – that it’s uncomfortable – that it
might change their minds and say: ‘You wanna have it done – have it
done’. (Mia)

This section therefore highlighted that during deliberation participants faced a lack of
information about labiaplasty and a general lack of communication about genitalia.
The latter may be due to the feelings of shame, embarrassment and disgust, as well
as repressive (Catholic) early socialization.

6.4.2. RESEARCH

All participants engaged in online research to familiarize themselves with the
procedure and the outcomes during decision-making process. Although all
participants did general research on the Internet, Leah specifically focused on one
particular website. She found that online source very helpful in reaching a decision.

Leah: I’ve been reading up the RealSelf site… That’s very good.
Actually I’ve been on it, RealSelf.
Tina: RealSelf. I’ve never heard about that one. What’s that all
about?
Leah: Oh! Well, that’s got all sorts of stories on labiaplasty and every
other cosmetic procedure going. But that might be useful for you
because there’s people on there with real stories. And they got
pictures. I mean, I wouldn’t put pictures. Some people have put
pictures on, of before and after, and their whole experience. (Leah)

They’ve got every single procedure you could imagine on there. And
quite candid reports, like detailed etc. So it’s actually really good. You
can kind of read up on everything on there. And obviously I was
looking on there, looking at before and after pictures, reading like
how people got on, and that’s when I realized that some people, if
you went to the wrong person, and then it could turn out really bad. Like some people had an infection afterwards, they kind of lost, lost some of their skin, more then they liked… Things went quite wrong. And so obviously I was determined to going to someone who had a good history of the procedure. (Leah)

This online source ultimately helped Leah to locate Lisa and have the procedure with her, as will be explored in the following chapter. Those participants who were not living in their countries of origin at the time of deliberation also faced a dilemma with regards to location – where to have their labiaplasty.

I went home for a bit. And I normally go to my gynaecologist at home, purely because I got… I still have private health [insurance] at home. And I mentioned that to her this year, that I want to have it done – ‘Do you do it?’ And she said ‘We do do it’. But it was probably about time when I thought they could do it, but then I have to come home, have it done, then if I have revisions, ‘cos I’m self-employed, I have to be travelling back… And then I thought I better look for someone who’s probably doing it all the time, all the time, rather than probably a gynaecologist. (Mia)

I looked first in the United States because, as I told you, my friend from childhood lives in [U.S.]. She’s married to a professor so she did a bit a research for me there. And then, you know, I thought: ‘No, I cannot go all the way to America.’ And, you know… Because I didn’t know how bad it was going to be after the operation, and not being in my home and not being comfortable. And then having to have another flight, jet lag… So I ruled it out.

It seems therefore that for participants who did not live in their native countries, apart from all the other questions that a potential surgery raises, an additional dilemma was where to have the procedure. Unlike other participants who had to seek out information about labiaplasty and potential surgeon themselves, Sarah was the only
participant to whom labiaplasty was proposed by her gynaecologist during one of the routine appointments.

I talked to him, I said Doctor John – John is his name – ‘This is annoying me, you know?’ And it was funny ‘cos there were my open legs and it’s not something that happens here. And I was like: ‘This is not nice and it’s something that we could do.’ Sometimes I feel I just wanted to get a knife and rip this off. And he was like: ‘Oh yeah Sarah, there is something we can do.’ (...) ‘Ah, it’s really a simple procedure and you might go, might come to the hospital in the morning; night you’ll be going home.’ That’s what he said, but he knew how I was, so [that] was his way to approach me. Because if he actually, if he told me what’s actually happened, maybe I wouldn’t have done, let’s say. But, I don’t regret in any moment. (Sarah)

It is apparent from this excerpt that Sarah was not fully informed about the procedure. This is an important issue that will be explored in the upcoming chapter. To summarize, participants in this study mostly sought information about labiaplasty utilizing Internet research, which included specialized web pages for cosmetic surgery and videos and clips that address the issue of labiaplasty.

6.4.3. AFFORDABILITY

Labiaplasty is an expensive procedure and some women may have a hard time meeting the financial cost. Although no specific questions were raised during the interviews in relation to affordability, four participants reflected on that specific issue. Both Leah and Natalie experienced a financial windfall that enabled them to afford the surgery.

I’ve been made redundant from my old job, so I had money from the redundancy, the redundancy money. (...) And also, I had the time off work because they gave me garden leave, so basically it was garden
leave eleven weeks, so I was at home being paid, but obviously I
wouldn’t be at work. So, I knew I had the time off as well, so I had
recovery time without having to work. (Leah)

It also took a long time because, obviously money as well. I have
recently split up with my partner and I had sold my flat and it gave me
a lot of money. [Chuckles] So, I decided that I would use this to
make, to be able to finally make the decision and go ahead with it.
(Natalie)

Mia on the other hand reflects on how she wanted to have had labiaplasty earlier, but
the financial means have proven to be an obstacle.

I hope I would have done it in my thirties, you know, thirty-two,
something like that. So, almost like, ten years earlier than now. But,
you know, I’m happy. I have the money. I probably wouldn’t have had
the money when I was thirty anyway. So, I had the money to do it
now, so probably it was, yeah, it was the right time. (Mia)

All of these three excerpts in a way highlight the importance of timing in life, since a
number of things needed to fall into place for participants to finally have the
procedure. Sarah on the other hand did not have to contemplate finances since her
labiaplasty was covered by the medical insurance. This enabled her to go forward
with the procedure immediately.

Sarah: And when we talk about like plastic surgery, in my country
things are quite expensive, but this type of surgery he said he could
put on my health insurance as a, how can I say, a medical, a really
medical need.
Tina: Like a medical reason?
Sarah: Exactly. You know? And I was like: ‘Oh yeah, that’s great.’ So
if the insurance is going to cover, let’s book it for next week.
Sarah clarifies that her gynaecologist suggested having labiaplasty on the health insurance because the surgery addresses a physical issue of discomfort as well as a psychological issue of genital appearance dissatisfaction.

*But he said: ‘Sarah… You need this. It’s a medical procedure, it’s not just aesthetic. It will help the aesthetic as well, but if I say it’s aesthetic, the health insurance won’t cover. I need to put this, it’s for a treatment, or… You know? Because, if I say it’s psychological, they don’t understand it, you know? They think it’s aesthetic purpose. And it’s not.’ It’s the same way for example, if a woman has too big boobs and they need to reduce the boobs [because it] could affect her spine or back. (Sarah)*

Sarah’s case is therefore unique, which probably explains why her deliberation about the procedure was very straightforward. In summary, three out of five participants did mention affordability as one of the aspects that had an impact on the decision-making process, which only highlights that although labiaplasty is a choice, it is a choice that cannot be made by just any woman.

**6.4.4. INNER DIALOGUE**

This final theme captures the participants’ examination of their own attitudes towards their bodies, their views of plastic surgery and the risks resulting from the surgery. It focuses on the introspection in which – to a different degree – all participants engaged in order to reach the final decision. This was perhaps most evident in the following excerpt that reflects on Carla’s meeting with her surgeon.

*Tina: So how was it like meeting her for the first time?  
Carla: To be honest, it was quite quick. It was quite straightforward and hmm… Because am I exaggerating? Is it something that you’re creating in your mind?*
In a similar vein, the participant who had labia reduction prior to labiaplasty engaged in an inner dialogue in which she reflected on her relationship with her body and finally herself.

*Because I had such bad pain all those years ago and the operation that I had took this pain away. And then when I was back to the NHS, they kind of were not being able to talk to me. It was kind of a physiological issue because of the pain that I had for so long and now it’s just a cosmetic issue, but also like a psychological issue: ‘I’m looking into it too much, I think I’m not normal when really I am’, that kind of thing. And I started to think maybe I should be more, you know, just be more confident with my body.*

It is interesting to note how this participant experienced her labia as somehow not normal, which in conjunction with other reasons made her seek labiaplasty. This would then suggest that women may opt for labiaplasty in order to achieve ‘normality’ rather than ‘beauty’. Put differently, cosmetic surgery such as labiaplasty seems to be less about standing out, but rather about fitting in. This inference is consistent with other literature on cosmetic surgery, explored in chapter three and discussed further in chapter nine. Apart from that, these two excerpts show that deliberation is indeed a multifaceted process and the decision to undergo a surgery was largely not taken lightly by the participants. On the contrary, it was a lengthy and well thought-out process. One participant draws a parallel between her decision to have labiaplasty and her friend’s decision to have rhinoplasty (nose surgery) to highlight this specific issue.

*We grew up together. We were best friends since we were seven years old, our parents were best friends. And she had this huge complex with her nose. And she is extremely beautiful. But I remember, still, other children would make fun of her and bully her. So, she told: ‘You used to tell me don’t do your nose and, you know, last year I had it done.’ So it’s funny that both of us, age fifty, kind of went for our physical complex and our issues that we had from childhood. It’s funny how long it takes to kind of face it and to… Yeah,*
just be able to talk about it. Sometimes when I listen to people who have been sexually abused and they say I couldn’t talk about it till I was fifty-five. And I think: ‘What a strange thing.’ But actually you are done that way. Because it takes a long time to kind of, for you to face your traumas, your things that really bother you from your past.

This excerpt underscores that deliberation is a complex process that may take years, but also touches on the suffering that seems to present before the resolution is reached. This theme of suffering was also present in other accounts, although the term itself had not been used. Both Natalie and Leah reflected on the moral dilemma surrounding cosmetic surgery, as in when is it acceptable to alter your body. Happiness and the lack thereof – arguably suffering – were prominent answers.

I know other people wouldn’t feel the same. They think like ‘Oh, you should be happy with what you got.’ But I think, well, if you can change something and it’s gonna make you feel happier, why not do it?! (Leah)

Why should you have to put up with something that’s restricting your life and making you feel uncomfortable?! If you don’t have to, you shouldn’t have to. (Natalie)

The final excerpt also touches on another interesting theme – how the body may affect one’s quality of life – as will be explored in the subsequent chapter. Sarah also had second thoughts about labiaplasty, seemingly because she felt uncomfortable with the notion of cosmetic surgery in the first place. She recalls the first conversation about labiaplasty during which her gynaecologist John suggested having the procedure.

Before the surgery I actually had gone to the doctor, a proper plastic surgeon, for abdominoplasty, but then [I decided] I’m not gonna do this now. And when he [John] said plastic surgery, I felt a little bit like cosmetic, and I was like: ‘I don’t know’… But he made me feel really comfortable. (Sarah)
It appears that the gynaecologist’s reassurance put Sarah’s mind to rest and helped her reach a decision. One possible reason why some participants may have been apprehensive about labiaplasty may have to do with incorporating the notion that they did seek and undergo cosmetic surgery, and may need to realign their identities accordingly. This issue will emerge again in chapter seven. Three participants also experienced concern in relation to the health risks associated with the surgery. Leah reflects on her immediate reaction to labiaplasty and how her attitude changed prior to the surgery.

*Obviously, you sort of think: ‘Oh no, to have anything done would be very risky’, you know, ‘Don’t even think about that kind of thing.’* (Leah)

*There is a risk with everything, but weighting up, if I don’t do it, I’m always gonna be unhappy. And obviously, I was thirty-six at the time. So, if it’s something that I’m gonna do, there is no point weighting 50-50, I might as well do it now because it’s something that I thought of for a while. And I thought well, I’m the kind of person when I decide something I just got for it.* (Leah)

Carla and Mia were equally concerned about the health risks associated with the surgery and the recovery process at an inner dialogue level. Carla in addition contemplated about how her decision to undergo a surgery may affect those that depend on her – her children.

*Even though it was always something that I didn’t like and I was not happy about it, it really took me a long time to just go for it. Of course you’re scared to go for a surgery. You know, I’m a single mum. My children have special needs. One of them is properly disabled. So, if something happened to me going to full anaesthesia… It was something that I’ve been considering for years, but I was too scared to do it.* (Carla)
I've never had anything done in my body, so… I never had a surgery. So I was a bit scared thinking: ‘How it this gonna be?’ You know, is it going to be something that will take me long to repair or no… So I thought I can’t be resting for too long. And my job is very physical. I’m standing all day. So I just wanted to make sure that when we done it, it was gonna minimize the side-effects as much as possible. (Mia)

All of these excerpts demonstrate that participants engaged in often lengthy and multi-layered process of deliberation that yielded a carefully thought-out decision to go forward with the surgery. The only exception to this rule may be Sarah. Namely, Sarah was not fully informed about the surgery and the risks by her gynaecologist John. However, because she had been a patient of John’s for almost a decade, she had sufficient trust in him to go forward with labiaplasty. This will be explored further in the upcoming chapter. Furthermore, Sarah is the only participants whose procedure was covered by the medical insurance so – in contrast to other participants – she did not have to worry about meeting the financial cost of the surgery. This also may have made the deliberation more straightforward. Other participants also reflect on their final decision to have labiaplasty.

I kind of made the decision on my own. I’m a kind of a person, like, if I want to do something I just do it. That kind of thing. So once I booked the consultation, I have made my mind. It took kind of that step. And once I kind of booked [the consultation] and I felt happy with Lisa – that was it really. I didn’t need to think about it. I kind of booked [the surgery] straight away. (Leah)

I did a bit of research and I decided I would consider it for a moment, going to [location]. But then I saw Lisa and I liked what she was doing, and then it was all very straightforward and I decided to go for it. (Carla)

It just got to a stage where I was just very uncomfortable and insecure. And yeah, it wasn’t like a quick decision. I’ve been thinking
about it for years and I decided that I would do it, because I was just too uncomfortable. And I went to have the procedure. (Natalie)

Apart from possibly Sarah whose story is rather specific, the participants in this study contemplated about their relationships with their bodies, cosmetic surgery in general and the risks and outcomes associated with the surgery during decision-making process. This in turn suggests that for participants in this study cosmetic surgery was not taken on a whim, but rather following a careful consideration.

6.4.5. CONCLUSION

This chapter explored major theme one Life before Labiaplasty in order to acquire a detailed understanding of the experiences that have led participants into having the procedure. The chapter reflected on the aesthetic, physical and sexual motivations for the procedure. It was demonstrated that all participants experienced a genital appearance dissatisfaction that seemingly translated into genital appearance anxiety, which largely manifested as self-consciousness and insecurity. This emotional strain was most prominent during professional hair removal, sexual intimacy – especially with a new male partner – and other social events that required taking one's clothes off. In other words, participants felt most uncomfortable when their labia were subject to an external social gaze. In addition, all participants experienced at least some physical discomfort due to body posture and movement including sitting and exercise, and discomfort with tight clothing such as jean and thongs. Three participants used to utilize physical adjustments – largely unconsciously – to manage the aforesaid discomfort. Some participants also felt uncomfortable during menstruation with tampon insertion and removal. In relation to sexual motivations for labiaplasty, is was shown that four out of five participants experienced discomfort during intercourse as a result of friction, and two participants experienced difficulties with reaching the necessary level of natural lubrication. The chapter also explored the immediate social environment in which participants’ decision to undergo labiaplasty where formed. Insomuch, it was shown that participants to some extent engaged in social comparisons about external genitalia whilst viewing pornography or when...
observing women in the gym. It was also apparent that apart from an odd comment based in ignorance, the participants did not experience negative comments from their previous male partners. Furthermore, their male partners were the least enthusiastic ones with regards to labiaplasty. Specifically, two participants stated that their partners were against the surgery, and two other participants indicated that although their partners did not believe that labiaplasty was necessary, they were understanding and supportive. It was speculated that the partners may not have been very enthusiastic about the procedure due to financial cost and ‘invisibility’ of the procedure, but also simply due to a lack of understanding what the problem was. Female family members proved to be a great source of support during deliberation for some participants, and others confided in their friends. However, participants would carefully choose which friends to confide in, for trust and acceptance of one’s decisions without judging these were the necessary requirements. The decision-making process was predominantly a lengthy and multi-faceted process that included online research in order to familiarize oneself with the surgery, as well as managing finances since labiaplasty is an expensive procedure. Participants reflected on the lack of scientific information about labiaplasty, which is probably somewhat linked to a general lack of conversation about female genitalia. Lastly, all participants engaged in some introspection and an examination of their attitudes towards their body, cosmetic surgery and health risks associated with the surgery. As a result, decisions made were carefully thought-out, which probably explains why all the participants were ultimately happy with their choices. And that is what the next chapter is all about.
7. ANALYSIS AND DISCUSSION – MAJOR THEMES TWO AND THREE: THE EXPERIENCE OF LABIAPLASTY AND THE AFTERMATH

7.1. INTRODUCTION

Building on the previous chapter that looked into participants’ lives before labiaplasty, this chapter will provide an exploration of their experiences of the surgery and the changes that took place as a result of having the procedure. In that context, major theme two – *The Experience of Labiaplasty* – will encompass the relationship with the surgeon, the experience of surgery and recovery process. It will elucidate the process of choosing the surgeon and insomuch the importance of gender of the practitioner, as well as their personal characteristics. The section will reflect on the consultation process, as well as the communication between the participants and their chosen surgeons. The latter theme was of interest considering that communication sometimes proved to be a challenge, predominantly due to a lack of information. The chapter will also reflect on the day of the surgery and the level of care encountered in the hospital, as well as the home recovery and the first check-up with the surgeon. Major theme three – *Life after Labiaplasty* – will focus on identified changes following the procedure. Corresponding to motivations for labiaplasty discussed in chapter six, these have been classified as aesthetic, physical and sexual changes. In addition to that, all participants spoke about experienced heightened personal happiness following labiaplasty, as will be demonstrated in the chapter. Lastly, drawing on participants’ positive experiences of labiaplasty, the section will also look into whether they intend to undergo any other cosmetic procedures and, if so, which procedures and why. Table 8 provides an overview of major themes two and three that explore participants’ experiences of labiaplasty and their lives following the surgery.
7.2. RELATIONSHIP WITH THE SURGEON

Major theme two The Experience of Labiaplasty firstly captures the superordinate theme Relationship with the Surgeon. Specifically, the theme explores how the participants located their surgeon, and which personal characteristics – including gender – did they find welcoming and desirable in their practitioner. The theme also reflects on consultations and patient-surgeon communication.

7.2.1. CHOOSING THE SURGEON

It was indicated in the previous chapter that Sarah had labiaplasty in South America with her gynaecologist John. He was the one who proposed having the procedure following her expression of discontent with her labia. All the other participants – Carla, Leah, Natalie and Mia – had labiaplasty in the UK with Lisa. All of them had located Lisa though Internet research. Leah for instance utilized a specialized web page for cosmetic surgery in an attempt to familiarize herself with labiaplasty and the surgeons that perform it. She explains why she decided to go with Lisa.
I was on there, reading up on it, and obviously there is horror stories where for people it had gone wrong. But then, obviously, with Lisa there seemed to be positive reviews. So, I thought, well, I’ll go and see her because it’s something that’s been bothering me. (Leah)

Similarly to Leah, Natalie and Mia also engaged in online research in order to locate a plastic surgeon. They both viewed the same video clips of Lisa on various TV shows that ultimately convinced them to have their consultations with her.

I was doing a lot of research online and I came across Lisa. And I watched; she had some clips where she’s been on [TV shows]. And I was just doing a lot of research about all this, where people go to. And she was the one that caught my eye the most because, actually, I could see the clips online and I know how experienced she is. So I decided to have my consultation with her. (Natalie)

I did look at Internet. So then at time I was just coming up with her name. I did know that she was on [TV show] as well, and that she has done that procedure before, you know... (Mia)

Carla on the other hand had several consultations with other surgeons, gender unknown, prior to seeing Lisa. She explains that she felt more comfortable collaborating with a woman. In the same fashion, Leah also preferred a female surgeon.

Carla: I saw a few doctors in the UK and I though Lisa was… Yeah, she’s really kind. I thought, mentally you know she’s a woman and it makes you feel…
Tina: Comfortable?
Carla: More comfortable than with a man.

Leah: And I just think having it done with a woman as well, something like that, it’s nicer as well.
Tina: Makes you feel more comfortable?
Leah: Yeah, especially it doesn’t matter much, but for that I just felt like a woman would understand more.

This would then suggest that for some participants the gender of the surgeon may have been a deciding factor when considering labiaplasty. It is possible that the participants assumed that a female surgeon, having the same anatomy and physiology as the patient, would be more understanding than a male surgeon, and that cognition may have put the participants at ease. However, not all participants preferred a female surgeon. On the contrary, Sarah had strong feelings about female doctors and gynaecologists specifically. Interestingly, she believes that precisely due to aforementioned similarities, female doctors may overlook differences between female patients.

_I partially don’t like woman doctors, especially if it’s gynaecologists or something, because I think that they think that they know everything about your body by the fact they are woman. (...) It’s like hair-dressing. They either need to be a man or gay, otherwise I don’t like them. [Laughs]_ (Sarah)

Sarah however elaborates on where her negative attitude towards female doctors stems from. She reflects on her prior experience with a female gynaecologist.

_The first gynaecologist I went [to]… ‘Cos it’s normal when you’re fifteen-fourteen years old, your mum brings you to the gynaecologist: ‘Is everything okay?’ You know? It’s something I see is a little bit of taboo in Ireland, you know? So, that’s what happened to me. My mum brought me to a doctor and I said I’m never coming back to a woman again. I just didn’t like her. And then I found this doctor myself and I’m comfortable to go to him. He’s a really old gentleman. (...) I used to go to see him, every six months, you know? And I had like really… I was with him maybe eight years already._ (Sarah)

Sarah’s preference for a male surgeon may be largely due to a previous negative experience with a female gynaecologist, but it also may have to do with the quality of
the relationship that she had already established with her gynaecologist. In sum, no consensus was achieved with regards to the gender of the surgeon, but these excerpts do illustrate that the gender itself may be a deciding factor.

7.2.2. CONSULTATIONS

This theme captures participants’ first consultations with the surgeon. Consultations proved to be straightforward and quick, and it appears that each participant underwent one consultation prior to surgery. This theme also reflects on what are perceived as desirable qualities in potential surgeons by participants. Carla looks back on her consultation with Lisa, during which she was able to openly express her doubts about her relationship with her body.

To be honest, [the consultation] was quite quick. It was quite straightforward and she said, you know, she said it’s something that… Because am I exaggerating? Is it something that you’re creating in your mind? And she said: ‘You know, it depends on you. You’re perfectly normal, but if it’s something that is bothering you and you’re thinking about it too much then…’ So, she was very helpful. She was understanding. (Carla)

Considering that participants sought labiaplasty because they often did not find their labia ‘normal’ – which is apparent across all the three data chapters – it is interesting to note the participant’s recall of Lisa’s response and her assurance that the participant is within the ‘normal’ variation of female anatomy. On the other hand, in Leah’s case the perceived excess tissue was identified during the first consultation. Similarly to Carla, Leah was very content with the consultation, and furthermore highlights how her surgeon went the extra mile to perform the procedure at short notice.

It was quite informal. It was a bit like, obviously you know, I put my knickers off, she had a look and said: ‘Oh yeah, I can see, obviously,
you’ve got the excess.’ And [she] basically explained what she’s do. She’d trim it down basically. I kind of trusted her, I kind of, whatever she felt that needed to be done. (…) I trusted her judgement and knew that she would give me the good result just from reading up the reviews and knowing the experience that she had. (Leah)

She managed to fit me in on quite a short notice. She actually extended her hours for me at the hospital, so I could get it done. Because otherwise it was gonna be January at some point. And I didn’t know when I would be working again, so I wanted to get it done in November if possible. (Leah)

When discussing participants’ relationship with their surgeons, trust, understanding and flexibility were the qualities that participants found especially valuable. In addition to that, other desirable qualities included surgeon’s sympathy for the perceived problem and a grounded and friendly approach.

She made me feel comfortable straight away and she understood everything that I said. She completely understood. She knew exactly what I wanted to do, and she was very sympathetic as to the reasons that I needed it, have it done. (Natalie)

I found that, you know, I felt very confident on her hands. I think she was very approachable, very natural. You didn’t feel that she was, you know, a surgeon. You know, that kind of… Sometimes you almost feel a little barrier between you two. She was very natural, kind of explained everything to me. (Mia)

It seems from the last excerpt that Mia specifically appreciated her surgeon’s amicable approach that was devoid of the power disparity often encountered when interacting with highly qualified practitioners. Finally, during the consultation, two participants – Carla and Leah – discussed the possibility of having additional cosmetic procedures along with labiaplasty with their surgeon. Carla decided to have liposuction on the thighs, and she also had fat tissue removed from her abdomen and
inserted into her inner labia. She had already undergone one liposuction about eighteen years ago, following her first pregnancy. Carla reflects on the conversation she had with her practitioner during the consultation.

*I saw Lisa… [Carla recalls her conversation with Lisa] ‘Because, you’re gonna put me to sleep, which is the thing that scares me the most. Will you do this or that?’ And she said: ‘Actually, that is a perfect combination because sometimes people want to have that done and then have breast implants or something, and another [procedure] works well’. (Carla)*

*Lisa told me that she will take a little bit of fat out of my tummy and put it in my lips, in my vagina, to make them look a little bit fuller. So that’s another procedure… It’s not another procedure, I mean, but that’s something that also she does. (Carla)*

Leah was another participant who had an additional cosmetic procedure along labiaplasty – breast enlargement. She reflects on the rationale for two cosmetic operations at the same time.

*Leah: Well because the breast I wanted done since I was eighteen. I had always wanted them done.*

*Tina: So that’s been a long time coming?*

*Leah: That, yeah, that had been a long time coming. Because I looked into it and obviously Lisa, she did the breast implants as well for women anyway and she could do them both at the same surgery. I thought why not for the recovery, because I’m gonna need to rest anyway for either procedure. So this way I had like one-two week rest period where I do nothing obviously and then it’s done, out of the way. So it was more this convenience, really. Because I was off work and I had the time off work. And I just wanted to get it all done, out of the way. And it worked out really well because by the time I started working again I was fully recovered.*
Convenience therefore seems to be the primary reason why Carla and Leah had additional cosmetic procedures alongside labiaplasty. This shed some very interesting light on labiaplasty specifically, as both participants commented on how the pain following those additional cosmetic procedures was significantly more intense than the pain following labiaplasty. Furthermore, no complications following labiaplasty were experienced either by Carla or Leah, but additional follow-ups with the surgeon were necessary due to other procedures. These issues will be examined further in the chapter. To summarize, the participants experienced consultation process with their surgeons as very straightforward. They found it easy to open up with regards to the experienced problem, and encountered helpfulness, understanding, sympathy, flexibility and friendliness from their surgeons. An established trust between the patient and the surgeon proved to be of significant importance. For two participants, consultations were also an opportunity to discuss additional cosmetic procedures coupled with labiaplasty, with which they decided to go forward.

7.2.3. COMMUNICATION

Communication is an important aspect of patient-surgeon relationship that proved to be challenging for some participants. Namely, three participants had excellent communication with their surgeon and they felt well informed about the surgery, the risks and the outcomes associated with the surgery.

When I had my consultation Lisa, she... She went through everything with me, made me aware of everything, answered my questions. I felt very comfortable. I knew everything that I needed to know.

She [Lisa] explained everything and there was all this reading to do as well. They gave me information. I mean, I was confident that they would be fine.
Tina: So were you fully informed about the procedure, the risks and the outcomes?
Participant: Yes. Yes, I was.

In contrast to that, two participants did not feel as well-informed about the surgery or the outcome, but interestingly they had mixed feelings about it. Namely, one participant experienced a mismatch between her expectation of labiaplasty and one aspect of the outcome of the procedure. She reflects on the conversation with her surgeon before the actual surgery.

I explained I just want to have the excess labia cut so that you leave it at the level of my clit. I don’t want you to touch my clit, even if it’s a little bit sticking out. [Participant echoes surgeon’s response] ‘Of course, I would never touch your clit!’ And, I just want you to cut this. But when I came out of the theatre I feel like the stitches are going to the hood of my clit.

The mismatch between this participant’s expectation of the surgery and an aspect of the outcome left her feeling surprised after the surgery. However, she clarifies that it is quite possible that the mismatch happened due to communication issues before the surgery.

Maybe I didn’t understand exactly what she said, or maybe we misunderstood each other, or maybe there was no other way – in order to cut she had to go all the way up. I don’t know.

Once asked whether she voiced her surprise to the surgeon following the procedure, the participant responded negatively. She highlights that despite the experienced mismatch, she is altogether very content with her labiaplasty.

To be honest, it’s done. So, when I found out I thought: ‘It’s done, so…’ I don’t mean I’m disappointed! I’m very happy with the operation. It has really made a huge improvement for me, mentally and in every way. But, I thought it was a little bit pointless. It’s done.
But maybe I actually should have told her, so that she tells other people exactly what they are going to have.

This story highlights the importance of clear and comprehensive communication between the surgeon and the patient before and after the procedure, in order to ensure that all the questions have been answered and all the doubts have been resolved. However, it also underlines the importance of patient’s assertiveness necessary to raise an issue with the practitioner and to address it openly. Sarah had a somewhat similar experience inasmuch as her expectations of the surgery did not match an aspect of the surgery. In contrast to the above story of a possible miscommunication, it seems that Sarah’s surgeon may have withheld from her important information about the surgery. Namely, Sarah did not know that in order to have labiaplasty she would need to have an epidural. It also seems that the surgeon withheld that information about the anaesthetic deliberately – according to Sarah – in order to make her feel more comfortable about the procedure.

Sarah: I have epilepsy and he knows I hate surgeons, blood and needles and everything. So, he knew how to approach me. He knew me, he knows me really well. You know what I mean?
Tina: You have built some kind of trust?
Sarah: Exactly, because like, we were almost ten years, like eight years maybe, you know? I was his patient, and it’s a nice relation we had.

The above excerpt provides Sarah’s rationale for her gynaecologist’s seemingly unconventional approach. She explains how things went on the day of the surgery.

Sarah: He booked the hospital for the surgery at like 1pm for me to arrive. And I arrived at 1 pm, and I went to the room and everything and then I was waiting… Finally, the surgical centre opened for us and they made me change my clothes. So I took off my clothes and I put the stuff with the open back. But, I just found out that I would need to have the…
Tina: Epidural?
Sarah: Yeah, the one where you don't move your body.
Tina: Epidural.
Sarah: Yeah. When I was in the surgical centre, to have the surgery, and I faint. Because I think he knew if I knew I was going to take it, I would be desperate. [Laughs]

Following this incident Sarah’s labiaplasty proceeded as planned and, unlike other participants who had a general anaesthetics, Sarah was mainly conscious during the surgery. Once asked whether she wished to have been fully informed about the surgery and the anaesthetics by her gynaecologist, Sarah responded the following.

No, I prefer he wouldn't [inform me]. The same way he was – that’s how it should be. Because I wouldn't like him to tell me. Because, if he told me, maybe I would decline or, you know, not go for [the surgery]. And then I would have all my labia now. [Laughs] (Sarah)

This excerpt illustrates how different people have different needs. Whilst the former participant would have preferred to have had more information prior to surgery, for the latter one the exact opposite was true. Despite the unexpected proceedings in the operating theatre, Sarah remained very content with her gynaecologists’ approach. Another thing that Sarah’s story demonstrates is how important the patient-surgeon relationship is, for it was the length of their relationship and the closeness that seemingly enabled Sarah’s gynaecologist to adopt a different approach. This whole section therefore highlighted that one size certainly does not fit all, and sometimes it may be up to the surgeon to gauge how to interact with a specific patient. It also underlined that when issues do occur, patients may find it rather challenging to bring these out in the open with their chosen practitioner.
7.3. THE EXPERIENCE OF SURGERY AND RECOVERY

The second superordinate theme in this section explores patients’ experiences of the surgery and the level of care encountered in the hospital. It also reflects on the recovery process at home and the consultations following labiaplasty.

7.3.1. THE SURGERY

Apart from Sarah, who fainted before the actual surgery, all other participants experienced a very straightforward and a rather quick surgery. Sarah was the only participant who had labiaplasty under epidural, whereas all other participants had general anaesthesia. She was also the only participant who stayed the night in the hospital, whereas all other participants had a day procedure. Mia, Natalie, Leah and Carla all reflect on their day procedure, asserting that it was a straightforward and quick experience.

I just went to the hospital, so they did all the check ins. (…) And then Lisa came in and said she gonna do the procedure in how ever long time, and that was it really. And then they came, got me in and it just went really quickly. That quickly that when I went to that room again I thought: ‘Oh my God, I haven’t done it.’ It was like feeling nothing you know, maybe they haven’t done it?! So just have that feeling a bit… It went really quick! (Mia)

I was really nervous about it. It wasn’t… I didn’t really need to be nervous about it. It was nice, it was relaxed. I went to the hospital. I had my own room, which I waited there maybe one-two hours, I can’t really remember. (…) And when I went to actually have the surgery, I was asleep, and then, so I wasn’t really aware of anything. And then after that, when I woke up, I had some pain, so I was given some painkillers, to take the pain away. Yeah, and I had something to eat and went home later that day. It was a nice easy day really. (Natalie)
On the day, I just basically arrived at the hospital. My friend went with me. And they took me down. I woke up and had a good recovery from the general anaesthetics, which was good. And yeah, that was it really. I had some blood, like the first time I went for a wee. That kind of thing. But I was told to expect that. And that was it really. It wasn’t terrible. (Leah)

It was quick. And it was easy. (...) I think it lasted for maybe two hours. I think it’s a normal thing. And then you stay for a little bit in the hospital and then you go home. But you don’t need to sleep over or anything. (Carla)

It is apparent from these excerpts that four participants experienced a very straightforward surgery. As mentioned earlier, Sarah was the only participant who was operated on under an epidural, and she was awake during the procedure. However, she highlights that she was under the influence of the anaesthetics, which in turn influenced her ability to think and speak clearly during the surgery. Sarah recalls the sensations and feelings during the surgery.

Sarah: I was awake, but sometimes I was a little bit... I don’t really know if I was talking really sense, you know? But I was having a conversation, and then they were having a conversation. And I remember like... I don’t really know if it’s burnt, but like after he sewed, he burnt something on my skin. I couldn’t feel anything, but I could smell. You know? I could smell. Looks like they were sealing it, burning...

Tina: Was it frightening at any point, or did you feel safe and secure?
Sarah: No, I felt safe and secure.

Although the actual surgery proceeded very well for all participants, most of them experienced discomfort and some pain immediately following surgery.

When I’ve woken up, obviously you struggle a little bit to talk. I felt a little bit sick, but I wasn’t sick. They were asking me: ‘Have you got any pain? Have you got any pain?’ And I said I have, I felt my lower
belly a bit. You know, it’s almost like, it was more like when you have period pain. That’s what I felt. I didn’t feel anything on the labia. I just felt like period pain. And they said: ‘Well, I’m gonna give you some Tramadol’, so they just put that in. And that was it. No more pain. I didn’t take any painkillers from that point on. So I just went to the room and then they were checking on me all the time: ‘Have you got any pain? Have you got any pain?’ And I never reported any more pain, yeah, since that point. (Mia)

In the first day when I woke up [it] was awful, you know? Especially I think was more the fact of the anaesthetics then the actual procedure. Because I’ve read before about these kinds of anaesthetics. In my head it was the main problem, you know? Because when you come back from the anaesthetics your body will respond somehow. So I think that’s why I felt so little bit drugged the following day. But, [recovery] was fast, the pain was gone. (Sarah)

Leah and Carla had other cosmetic procedures in addition to labiaplasty. Both of them emphasized that breast augmentation and liposuction respectively proved to be far more painful that the actual labiaplasty.

To be honest, ‘cos I had my breast done at the same time, they were more painful that that [labiaplasty]. And I found out in general the breasts were more painful and the recovery was harder. The actual labiaplasty for me was a bit of a breeze to be honest. I was very lucky. I kind of most of the time forgot I had it done, especially after, say, the first week. I didn’t have that much pain or anything really. (Leah)

I mean, you feel as you feel when you wake up from anaesthesia. I got a bit of a liposuction in my thigh. When I was going to that [labiaplasty] I decided to do a bit of liposuction at the same time. It was extremely painful in my legs, absolutely nothing, nothing at all for the labiaplasty. (Carla)
Almost all participants were happy with the level of care they received in the hospital. Leah for instance highlights the procedures that were in place to assure that patients are minded at all times.

*And what they do, they give you an emergency number at the time, when you first get it done, so that if you’ve got any problems, like out of hours, you can ring up. So yeah, they provided levels of service where if you got any issues or any problems, they’re always kind of on the line.* (Leah)

In contrast to that, Carla was the only participant who was not fully content with the level of care that she received in the hospital. She explained that her surgeon held consultations in her private clinic, but in order to perform the procedure she booked an operating theatre in a different clinic. In other words, consultations and the actual operation took place in two different settings. Carla reflects on her experience immediately following surgery.

*Liposuction was terrible. I remember opening my eyes and it was a very nasty woman that I wanted to write the hospital about it who wasn’t just nice. And I said: ‘Please, I’m in so much pain. Give me some medicine!’ ‘Oh no, I don’t want you to throw up! And, I said: ‘I won’t throw up, I just, I cannot put up with this pain. And she was just not very nice. She was calling me a different name. My name is Carla, but she was calling me Clare. So they didn’t even read the paper properly.* (Carla)

Whilst this may be an isolated event, Carla’s account shows that incidents may have an effect on one’s overall experience. It also demonstrates that the relationship with the surgeon is not the only relationship that colours one’s experience, but rather extends to relationships with all practitioners encountered in the process. In spite of this, it can be said that the participants in this study have generally experienced a quick and straightforward surgery with no complications.
7.3.2. RECOVERY PROCESS

For all participants the recovery process was straightforward, although those participants that have had additional procedures encountered some issues, as will become apparent later in the text. Both Mia and Natalie experienced a smooth recovery, even though Natalie was still healing at the time of the interview since she had her labiaplasty merely six weeks before the interview.

I had two full weeks off work, so that week I stayed at my sister’s with my mum. And they just fed me and, you know, just looked after me. So the first two days I stayed in bed because I remember Lisa say: ‘Just stay, lay down, for at least twenty-four hours, you know, forty… as much as you can at the beginning. So you heal properly’. So I was in bed for about two days, two and a half days, something like that. So, basically only just got up to go to the toilet. (...) I stayed in house for a full week. (Mia)

To be honest, I was expecting a lot more pain in the first few days than I actually had. Because from the first operation that I had all those years ago, the pain was a lot more then than it was this time. The only thing is… I was quite… I remember that I was quite nervous about the outcome of the surgery. Because for the first few weeks you can’t really tell what’s it gonna be, ‘cos everything is really swollen and stuff. So, yeah, that’s why I shouldn’t have worried. (Natalie)

Sarah also had a relatively easy recovery, even though she experienced some discomfort during urination in the first few days. She compares the experienced sensations to a kidney infection.

I had one before, and it’s the same way. You kind of keep your pee, like, you don’t want to go to toilet, just because you’d be like: ‘Oh my God, that’s going to burn’, you know? (...) [It] was like quite swelling
and then after a few days it starts to go down, the pain was gone. I didn’t really have the burning sensation when I go to toilet anymore.
(Sarah)

Sarah also reflects on one very interesting aspect in relation to body modification – the necessity of adjusting to a changed body by aligning the mind with the body.

Sarah: I was talking about with a friend of mine the other day – she just put breast implants – she was like: ‘It’s funny ‘cos if you’re going to sit somewhere you forget how big your boobs are. So you would think you would still have small boobs, and then your boobs hit on the table or something like this.’ And then I was like: ‘It’s exactly what I felt ‘cos part of my vagina was not there anymore.’ So, I didn’t have the discomfort physical anymore, but in my head it’s still there.
Tina: It’s like your head needs to catch up with your body?
Sarah: Exactly. Exactly. I need time for my brain to assimilate I did it, and it’s not there, it’s not hurting anymore.

It seems therefore that at least for Sarah there was a transition period during which she was fine-tuning with her newly altered external genitalia. On the other hand Leah and Carla, both of whom have had additional procedures alongside labiaplasty, reflected on the pain experienced post-surgery.

The labiaplasty, like I said, it was very straightforward. It was just the shower, shower lightly at first and then eventually have a bath to kind of take out dissolvable stitches. It was a little bit uncomfortable but nothing… It wasn’t that bad at all. It wasn’t what I was expecting. Like I said, the breast, the implants were the worse bit, because obviously that would hurt more afterwards than the labiaplasty by far, definitely.
(Leah)

I had [liposuction] years and years before, so I knew that it was extremely painful. But I though after fifteen years things have improved. Actually, Lisa warned me. She said things are pretty much
the same – liposuction as it were fifteen years ago when you had the first one – so don’t expect big changes. I mean, it has improved a bit, but not much. So yeah, basically, getting the fat out of your body is much more painful than having a labiaplasty. It’s not painful at all, by the way. (Carla)

In relation to the pain experienced in the genital area post-surgery, Carla – who is also the only mother among the participants – made a thought-provoking point that may challenge the way one would normally view genital cosmetic surgery.

But it’s actually a very resilient part of the body. I mean, it’s designed for children to go through, you know, for you to give birth. So even though people may think: ‘Oh my God, it’s crazy to cut yourself there!’ But actually, it’s not that painful or that horrible after the operation. (Carla)

About ten days after the procedure all participants had at least one, but often several follow-ups either with a surgeon or with a nurse, especially in situations where additional procedures caused problems. Mia and Leah recall their follow-ups post-surgery.

Again, it was very quick. She just kind of asked me whether I had any problems, whether there was itching, whether I had any concerns. And I said: ‘No, everything was fine.’ [It was] itchy a little bit now, but I think it’s because of healing. It feels that kind of itching, like when you got a wound and it’s healing, and it itches a little bit. But that was it. And she said you can use some oil in your bath if you want to, just to make it, violet oil, to make it a little bit more moist. And that’s what I did and I’m fine. (Mia)

I’ve been back quite a few times to see her, to follow-up. So mainly because of breasts. Because I think I’ve been more annoyed with that, ‘cos I’ve actually put something in. And that is more invasive. But you wouldn’t think. You’d think that labiaplasty would be very
invasive. Like I said, it was a breeze. Maybe ‘cos I recovered so quick. When I first went back and she was quite surprised how well I’ve healed, so she said I’ve healed very well. (Leah)

Leah makes an interesting point here with regards to invasiveness of cosmetic procedures, for not all procedures are equally invasive. It could be easily argued, as Leah states, that inserting two completely foreign objects into a woman’s body is far more invasive than cutting what is perceived to be excess tissue. Her recovery process and the issues encountered along the way – which will be explored in this chapter – certainly demonstrate that. On the other hand, Sarah has established herself as a very sexual person, and this was reflected in the interaction with her gynaecologist during the first check-up following surgery.

Sarah: And then the first question I asked is like: ‘When can I have sex?’ [Laughs]
Tina: [Laughs]
Sarah: He said forty days.
Tina: What did he say?
Sarah: He said forty days.
Tina: Forty days? Four-zero? That’s a lot!
Sarah: Yeah, forty. Quarantine! [Laughs]
Tina: [Laughs]
Sarah: But I actually wait just one month. [Laughs]
Tina: Ah, that’s not too bad. [Laughs]
Sarah: Yeah. [Laughs]
Tina: And you were still in South America then?
Sarah: Yeah, because I was coming to Ireland and I was like: ‘No, I need to test drive this before.’ [Laughs]

Sarah further recalls the conversation that she held with her gynaecologist during the check-up, which illustrates the closeness, honesty and humour present in their relationship.
Sarah: And he saw me and he actually joked. He was like: ‘Oh my God, it’s ready to be used!’

Tina: What did he say?

Sarah: He said: ‘Oh my God, it’s perfect!’ It was funny ‘cos he said like: ‘It’s really beautiful! Oh my God, so pretty!’ And I was like: ‘How can you tell a vagina is pretty?!’ He’s like: ‘But look at the job that I did! It’s perfect! Ready to be used!’

Tina: What did he say – ready to be used? [Laughs]

Sarah: I tell you, we have a really high level of intimacy. [Laughs] Not really personal, but…

Tina: That’s so funny!

Sarah: We’ve built this trust, you know? And so, they can say it. He was like: ‘Ready to be used’ and I was like: ‘Dr John, I have to tell you the truth. I have used it already!’ [Sarah echoes John’s response] ‘I can’t believe! But, that’s okay.’ He joked. He slagged me and said: ‘That’s okay, because you’re going to move.’ I was like: ‘I needed to have sex with this guy ‘cos I didn’t know would I have a problem there.’ [Laughs]

Although this excerpt reflects on the closeness present in Sarah’s relationship with her gynaecologist, it possibly captures her latent attitude towards the appearance of female external genitalia when she asks her surgeon: ‘How can you tell a vagina is pretty?’’. Carla on the other hand also experienced a straightforward recovery following labiaplasty, but she was not fully happy with the scar resulting from liposuction – the additional procedure that she had alongside labiaplasty. In the following excerpt Carla reflects on the first consultation following the two surgeries (labiaplasty and liposuction), and on the subsequent consultations that took place about two years later.

I went to see the nurse and she said: ‘This is okay, it’s healing well, the stitches will dissolve.’ And there was one of the stitches for the liposuction that was infecting a little bit… Actually I saw [the surgeon] yesterday, because the scar for the liposuction is still not looking good. (Carla)
It appears therefore that the participants who had additional cosmetic procedures had a straightforward recovery with regards to labiaplasty, but they experienced some issues post-surgery due to those other procedure (breast enlargement and liposuction). Although the majority of participants were happy with the level of care experienced post-surgery, one participant stated that she would have preferred to have a check-up with the surgeon as opposed to a nurse.

> Of course, I understand that she has thousands of women to have all kind of operations, so there’s a demand. But yeah, I would have been nice probably for her to see, as in: ‘How you feel about it, is this what you expected, how are you feeling, are you having any problems?’ (...) So yeah, there should be more of a follow-up and talking.

In summary, all participants experienced a quick and straightforward recovery following labiaplasty, although Leah experienced some issues related to breast enlargement and Carla due to liposuction. For Leah this resulted in a second breast augmentation surgery, which will be explored in a later section. The majority of participants were content with the level of care received post-surgery, with the exception of one participant who would have preferred to have a check-up with a surgeon rather than a nurse.

### 7.4. CHANGES FOLLOWING LABIAPLASTY

Major theme three – *Life after Labiaplasty* – utilizes this superordinate theme in order to explore in which ways have participants’ lives changed due to having labiaplasty. Specifically, this section will reflect on changes post-labiaplasty including aesthetic, physical and sexual changes experienced by the participants, as well as an identified feeling of general happiness.
7.4.1. AESTHETIC

When discussing aesthetic changes following labiaplasty, the participants did not seem to focus so much on the actual appearance of their labia following the procedure. Interestingly, they seemed more centred on how the altered labia affected their body image. Put differently, the participants largely focused on the psychological changes following labiaplasty. The two terms that participants mostly utilized to describe how they felt post-labiaplasty included ‘comfortable’ and ‘confident’. Leah reflects on the effects that labiaplasty had on her body image.

*I feel much more comfortable in general. It’s not a day to day impact as such ‘cos obviously most, a lot of people wouldn’t know, well nearly everyone wouldn’t know I had it done. (...) I just feel more comfortable. (Leah)*

*Now when I go to like get a bikini wax etc. I just, I don’t feel uncomfortable. I can just take my knickers off and not worry. I don’t kind of think ‘Oh God, you know, I wish I didn’t have this hanging down’. I just feel normal, normal now. (Leah)*

It appears from these two excerpts that Leah’s feeling of being ‘normal’ may be the missing link between feeling uncomfortable with one’s body and reaching a state of comfort. In that sense, it seems that labiaplasty enabled Leah feel ‘normal’ indicating that a physical change initiated an inner change that finally led to a place of comfort. This highlights the delicate interplay between a person’s physique and their psyche. In the same vein, Natalie spoke about how she felt more comfortable following the procedure, even though she has not fully recovered yet.

*I don’t think I’m fully healed yet. I saw Lisa a few weeks ago and it’s still swollen on one side. And I have pain when I sit down, so it’s not completely healed. But, straight away though, I know that I’m a lot more comfortable because everything is completely inside now, which is what I wanted. (Natalie)*
I don’t think it’s been long enough for me to tell yet [about the effects of the procedure], because it hasn’t completely healed. But I feel more comfortable. I don’t have anything hanging out. Everything is completely inside. So that makes me feel more secure, more comfortable with my body. (Natalie)

It is interesting to note the first paragraph that suggests that even though Natalie still experiences pain – probably due to healing – the fact that her inner labia is smaller and therefore tucked into the outer labia had an immediate positive impact on her body image. In other words, an alteration of her labia had a positive effect on her body image to the extent that it surpassed the actual pain resulting from surgery. This could then indicate that how one feels about their body is far more important than how the body itself is. Mia on the other hand did not use the term ‘comfortable’, but it is apparent from the following excerpts that she experienced the same state of peace with her body as did Leah and Natalie. She reflects on two situations that previously would have made her self-conscious about her labia, whereas now that is no longer the case.

If I have to undress in front of a man, I don’t mind doing that. I don’t rearrange myself to make it look a little bit better, whereas before I used to, if I was getting undressed in front of a man, I used to. Especially if I didn’t know him, I used to kind of almost push it in, so that he couldn’t see. (Mia)

When I got to the gym I don’t have to be careful that it doesn’t drop and things like that. I don’t mind if I get completely undressed. (Mia)

As implied in the previous excerpt, some participants also assert that labiaplasty had a positive impact on their self-confidence, especially in situations in which they have to undress in front of other people. For instance, Leah speaks about unrobing in front of her former male partner, whereas Mia reflects on taking her clothes off in front of her female friends.
I was still with someone after labiaplasty. We’ve split up a while ago now, but I was with him after for a while, so… I guess I felt a bit more confident. I don’t think it made a difference to him, but I did feel a bit more confident I guess. So, I would say that. (Leah)

Before I would probably push that in a little bit, so that they couldn’t see it if I was having a shower. ‘Cos I don’t like… You don’t want them to see that; whereas now I don’t have to. I don’t do that anymore because it’s not there. So it makes you more confident in that way. If you get completely undressed, you feel a little bit more confident because it’s not… It doesn’t look… It didn’t look nice. So now, actually, it’s nice. (Mia)

In sum, participants experienced a shift in how they perceive, think and feel about their bodies following labiaplasty. This positive change in their body image arguably translated into heightened self-confidence is situations in which their bodies may be subject to an external gaze.

7.4.2. PHYSICAL

With regards to physical issues that made participants seek labiaplasty, various changes were noted. For example, some participants spoke of discomfort with tight clothing that was no longer present.

I don’t have discomfort, rubbing that I had before on my clothes, so that’s a positive thing straight away. (Natalie)

Another thing is sometimes if you’re wearing thongs, before the labia used to go to the side sometimes. It almost, like, it kind of goes out. Now it doesn’t happen. (Mia)
Sarah and Carla on the other hand talked about difficulties experienced during menstruation, which were resolved post-labiaplasty.

It was awful when I was having my period. It was really annoying. It really annoyed me, you know? But back in that time I didn’t realise. Now, after I had it, I was like: ‘Jesus, how could I live with that?!’ (…) Before I had labiaplasty I didn’t really like… what it’s called? Tampons? (…) Because to take off was just a mess and it was awful. Now, it’s something so simple. (Sarah)

To start with, keeping clean is much easier, you now? I think that when there’s so much tissue, it’s very difficult to keep it clean. (…) You know, getting a tampon in. (…) [After labiaplasty] there is nothing there to bother you. (Carla)

As explored in the previous chapter, almost all participants used to employ adjustments to manage discomfort as a result of body posture and movement. For Leah and Mia this was no longer an issue post-surgery.

I used to sort of shift about position and try to get comfortable when I was sitting down for too long. And I hadn’t… I didn’t really even realize I was doing it. But now, obviously, I haven’t got that problem. (…) Like, when I sit down now, I don’t kind of like… I don’t kind of move around as much as I used to, cos I’m comfortable sitting down. (Leah)

Sitting is different. I didn’t realize, but I remember I’ve got like a stool. ‘Cos when I work, depending what I’m doing, If I’m doing dailies, I’ve got this stool where I sit. And the first thing I noticed is that when I sat on that stool after the operation, it felt different. And I thought actually it feels more comfortable. I haven’t realized that I used to rearrange unconsciously when I sat. (Mia)
It appears therefore, corresponding to physical motivations for the procedure, different participants experienced improvements with regards to discomfort present with tight clothing, menstruation and physical adjustments that used to be employed to manage aforesaid discomfort.

7.4.3. SEXUAL

In relation to discomfort present during intercourse, only two participants reflected on the issue. This is probably due to the fact that the other two participants had not been sexually active post-labiaplasty at the time of the interview, whereas the fifth participant had been sexually active but never experienced any discomfort during intercourse in the first place. Sarah reflects on the first time she had intercourse after labiaplasty.

[Laughs] Imagine you are a virgin ‘cos it’s completely new, you know? (...) Let’s say it was casual sex, so he’s not really a partner, okay? It’s like, it’s a friend (...) But it was really different. I think I was afraid because I knew I needed to wait forty days at least, and I didn’t. But, all the stitches were gone and it was really healed. The first time I think I was nervous and then I felt like: ‘Oh my God, maybe it’s the pain.’ But, [I] was much more comfortable. Much more comfortable, far away. (Sarah)

Sarah expands further on her sexual experiences following labiaplasty, and asserts that having the procedure made it easier for her to reach an orgasm.

Sarah: And especially a lot of women Tina, they don’t really know their body. For example, for me it was really hard to have an orgasm before, you know? Because it was a kind of barrier, you know? Now, it’s something much easier. And that makes everything much easier. Sexual life, personal life, health life, to go to the gym for example,
you know? Everything is much much nicer. Even to buy pants, you know?

Tina: Wait, so we need to go back to this, because it is really important! [Laughs]
Sarah: [Laughs]
Tina: So it’s easier to come now, to have an orgasm, than before?
Sarah: Yeah! It’s like, I had a little bit of barrier before. You know?

One participant stated that labiaplasty had a positive impact on her sex life, for the procedure had a positive impact on her body image. Orgasm on the other hand is still challenging for her to experience during intercourse with a male partner, even though she easily orgasms through self-pleasure.

Of course, I feel more relaxed now when I have sex with someone. I’m not so self-conscious about this anymore. It’s something I’m learning. I’m learning. I’m in a process of kind of learning to relax and trying to learn to have an orgasm with a man. But I can’t. And it’s not like I’m frigid. When I masturbate, I have absolutely no problem with that.

Speaking of pleasure and self-pleasure specifically, Sarah on the other hand asserted that labiaplasty had a positive impact on her relationship with herself.

Sarah: Let’s say in sexual life, I’m much more resolved to myself than I was before because…
Tina: Much more what?
Sarah: Resolved… You know what I mean?
Tina: Resolved.
Sarah: Yeah, because, even in the… Let’s say masturbation. It was not something that I used to do because didn’t really have like… Didn’t really work for me. You know what I mean? It was harder and… It’s too much trouble to go through, you know? [Laughs] I’m much more confident about these things now, because I know I can get it easier. (…) Now it’s something that’s much easier, you know?
Masturbation is not something that I do really often because I have a husband now. [Laughs]

Sarah further explains why self-pleasure may be more enjoyable following labiaplasty. Namely, she finds it easier to achieve the necessary level of lubrication in order to stimulate herself.

Sarah: For example, my vibrator, it’s the bullet…
Tina: Is that any good?
Sarah: Yeah, it’s really good. It works well! [Laughs]
Tina: [Laughs]
Sarah: So, it’s not something that goes inside. But let’s say before I would usually need to open [my labia]… Imagine like a flower, the petals… You would need to open to do it. And then sometimes [labia] would go all the way, and now you have nothing there. So, it’s easier to keep it wet when you do it yourself…

It is apparent from these excerpts that Sarah was the one participant for whom labiaplasty had a very positive impact on her sexuality. On the other hand, the two participants who were single at the time of the interview, and were yet to have sex post-operatively, express positive expectations about sex after labiaplasty.

[I] Haven’t been [sexually active] actually, because it would be hard to joggle dailies and stuff. I haven’t, I haven’t done that yet I’m afraid. But I’m sure that will be completely different.

Going forward, once I’m with a guy, whenever that will be, I will feel more confident.

Considering the already small sample and the fact that two participants had not have sex post-surgery it is very challenging to draw any conclusions with regards to the effects that labiaplasty may have on a woman’s sexuality. Sarah’s experience however proves to be encouraging.
7.4.4. PERSONAL HAPPINESS

All participants spoke of a general feeling of happiness and satisfaction for having undergone labiaplasty.

*I’m really happy I got it done. I feel like, it’s sort of couple of months, I feel I’ve completely forgotten in a way. I just feel it’s always been like this. You kind of forget what you had before. And because I don’t get any pain or anything, it just feels normal to me now. (Leah)*

*I’m very happy with it. I couldn’t have been any happier! ‘Cos it’s just gone really well. No side-effects, no issues, no painkillers, no nothing. Gone back to my normal life very quick; working out as I used to, in two weeks. So all very good! (Mia)*

*It’s like a huge weight of my shoulders fell off. So it is, I think, not only physically, but it was something that was bothering me psychologically. Huge improvement. (Carla)*

Sarah and Natalie were equally happy with their labiaplasty. They both emphasize that the procedure had a positive effect on the quality of their lives.

*It was a positive experience for me because it was something I wanted for so many years. It’s something that’s affected me for so many years. And the fact that you can have surgery and it can make such a big difference to your whole life is just really positive for me. (Natalie)*

*It’s funny because it’s something in your body and you think it’s normal. You don’t know that it annoys you until that thing is not there anymore. You know what I mean? It’s like, if you have a big what’s called wart isn’t it, wart on your face, on your hand, you know? And*
you’re like: ‘Ah, that’s grand.’ But then if you take this off, it’s much better life, you know? (Sarah)

Considering that all participants were very satisfied with the outcome of their labiaplasty, most of them unsurprisingly also express their regret for not having undergone the surgery earlier.

When I look back I was like: ‘Jesus, why didn’t I do this before?!’ You know? (Sarah)

Oh I wish, I mean, really wish I had done it when I was fifteen, you know? Definitely. I mean, I think: ‘Why did I wait so long?’ (…) I wish I had it done when I was a teenager. (Carla)

I think I should have done it much earlier! (…) Yeah! Ten years earlier probably! (…) I hoped I would have done it in my thirties, you know, thirty-two, something like that. So, almost like, ten years earlier than now. But, you know, I’m happy. (Mia)

7.5. OTHER COSMETIC PROCEDURES

All participants were asked whether they would prefer to have any other cosmetic procedures in the future. The responses were mixed. Carla, Mia and Natalie gave a negative answer to this question, although Mia expressed the possibility of having a minor cosmetic procedure somewhere down the line.

No, nothing. I said to my sister: ‘That’s it with me!’ [Laughs] I’m done for the rest of my life because nothing really bothers me. In fact, it was something that I would think about, I don’t know, six-seven times a day to be honest. (…) But no, I’m not a plastic surgery person. I just… No, I will not have other plastic surgery. (Carla)
There is nothing else that I have really thought of at the moment. That’s the one thing that I had on my mind for years. So I haven’t actually thought about having any other cosmetic procedures. (Natalie)

I don’t think there is anything that I think I need to have done. Not at this time. Obviously I’m sure that as I get older you’d see it on my eyes, getting a little bit puffy or, you know, things like that. I might want to do something little. But not like… No, nothing. I’m not. No. I might do in the future, but at the minute there isn’t anything else that I would like to have altered. (Mia)

Leah, who had a breast augmentation alongside labiaplasty, was planning to undergo another breast augmentation surgery at the time of the interview. The following excerpt provides a rationale for her decision.

Leah: Well funny enough, at the moment, I’m gonna have my breast, I’m gonna have them done again. Probably with Lisa, ‘cos the result isn’t what we expected. Yeah, she’s agreed, we’ve agreed at the moment that she’s gonna weight her cost kind of thing. So, yeah, I’m looking at having them done again at the moment.
Tina: You wanna tell me why the result wasn’t what you expected?
Leah: It is the sizing. Because I’m very tall and my shoulders are very wide, so… And I haven’t got the gap as I wanted. So Lisa agreed. And one is… They’re very asymmetrical as well, so they’re not the same size. So the same implants were put in, but I must have had different sizing before and now they’ve been put in, one looks bigger than the other. So, I’m gonna get them resized, so that I’m gonna have one implant slightly larger than the other, so it will match them up better. And go slightly bigger. But it’s still not… I’m not looking to be Jordan, put it that way. Or you know, like, Pamela Anderson or something. I’m not… I just want… ‘Cos I’m tall and broad, I can kind of get away with a bigger size.
It is apparent that Leah will undergo another breast augmentation in order to resolve the problem with sizing caused by the first operation, and also to have larger breasts than originally intended. Breast augmentation is also the procedure that Sarah wishes to have alongside abdominoplasty, which a procedure that includes a removal of excess skin and fat tissue from the middle and lower abdomen. Sarah explains why she would prefer to do both operations in her home country.

*My country is the second country in plastic surgery in the world. They are just beaten by the USA. You know? So, the volume that they have of surgery, it’s much bigger than here. (...) I would do it in there for two reasons. The quality. Because the volume of surgeons they have… They have much more experience, the quality is much better. And the price. Because in my country you would pay around R$6000 and that is equivalent of €1500. (Sarah)*

In order to illustrate her point about differences between Ireland and her home country with regards to cosmetic surgery, Sarah reflects on her female friends’ experiences of breast augmentation in both countries.

*Sarah: So, I have a friend, she did in a clinic… Can I say the name?*  
*Tina: Yeah, of course!*

*Sarah: In [the name of the clinic].*  
*Tina: Oh yeah! Was it labiaplasty?*

*Sarah: No. Boobs. She paid like €4500-5000 for the boobs. But, she showed me and there was… ‘Cos I always like to ask, and I always like to touch, okay? [Laughs]*  
*Tina: [Laughs]*  
*Sara: Yeah! ‘Cos it’s something you want to how is it!*

*Tina: Yeah!*

*Sarah: And usually who has plastic surgery, Tina, they have no problem to talk about [it], you know? So, I saw… They kind of made this with her nipples [Sarah demonstrates with her fingers that the nipples face different directions]. It’s one up and one down, and it’s…*  
*Tina: Really?
Sarah: Yeah. It’s not something that a man could see, but we are quite detailed. We focus on details. You see, it’s like… Especially, I have OCD…

Tina: [Laughs]

Sarah: [Laughs] So, last Friday, I met my friend that I told you about, that put breast implants as well. And I was talking about my surgery as well. And she did [the surgery] in my country. Her boobs were just perfect. You know? So, it’s natural, it’s nice, you have a nice gap. It’s something…

Tina: Did you feel it? What’s the texture like?

Sarah: It’s like hmm… It’s a little bit… It’s kind of… I don’t know, like snooker balls? They are quite rigid, but at the same time they are kind of soft. You know what I mean?

Tina: But it feels a bit different than a natural boob then?

Sarah: Not really. It’s just because they are like… rigid and etc. Couldn’t compare it to mine! [Laughs]

Although this story could only be viewed as anecdotal evidence, the excerpt however captures closeness present between Sarah and her female friends – a closeness that may have helped Sarah reach a decision with regards to future cosmetic procedures. It also demonstrates that cosmetic surgery carries an unforeseen risk, and the final outcome may be rather startling. In sum, three participants in this study do not plan to have any other (major) cosmetic procedures, whereas for the other two, breasts were the main area of concern.

7.6. CONCLUSION

The objective of this chapter was to reflect on major themes two and three; namely participants’ experiences of labiaplasty and their lives post-surgery. The findings indicated that apart from one participant – who already had an established relationship with her gynaecologist/surgeon – all other participants located their surgeons through online research, by viewing videos and clips and reading reviews
from patients who collaborated with that surgeon. The participants sought a surgeon who was skilful, helpful, understanding, sympathetic, flexible, kind and friendly. Participants did not feel pathologized during the consultations, and furthermore in one situation the patient was told that she was ‘normal’ prior surgery. It is however not known whether this implies that other participants external genitalia was outside the range of normal human variation. Consultations proved to be very straightforward. Apart from labiaplasty, two participants took that opportunity to have additional procedures with their surgeon. Consequently, those two participants had a breast augmentation and liposuction respectively alongside labiaplasty. Although most participants felt well-informed about the surgery, the risks and the outcomes, communication and a lack thereof was identified as somewhat problematic for two participants. Namely, due to communication issues – a possible misunderstanding, but also a lack of communication post-surgery – one participant experienced a mismatch between her expectations of the surgery and one aspect of the outcome. The other participant was not fully informed about the actual surgery, which led to an unexpected event in the operating theatre. Interestingly, the participant herself was content with her surgeon’s approach, for had she been fully informed she may have not gone for the surgery. These two situations highlighted how the needs of specific patients vary dramatically, which in turn underlined the importance of surgeon’s tailored approach for each individual patient. The surgery itself was quick and straightforward for all participants, and no complications resulted from labiaplasty. However, some issues were present in those participants that had additional procedures; one of whom needed to have a second breast augmentation. All participants experienced positive changes resulting from labiaplasty, including an improved body image and enhanced self-confidence, which demonstrates the interplay between the human physique and the psyche. They also reflected on practical improvements with clothing, menstruation, and body posture and movement following labiaplasty. Two participants revealed that their sex lives had improved post-surgery, although only one participant encountered specific changes related to self-pleasure, lubrication and orgasm. The sample is too small to draw any substantial conclusions, so it remains unclear to what extent does labiaplasty support female sexual empowerment. However, all participants were very happy with the effects that the procedure had on their lives, and some of them expressed their regret for not having it done earlier. Lastly, it was demonstrated that three participants do
not plan any (major) cosmetic procedure in the future, whereas two participants plan to have a breast augmentation. One of these is a result of the participant's first breast augmentation that did not yield a desirable outcome, and the other is a wish of a participant who alongside breast surgery also wants to have abdominoplasty. Again, considering the small sample, it is almost impossible to ascertain to what extent one cosmetic surgery normalizes body alteration as such. However, it can be concluded that labiaplasty appeared to be perceived by the participants as a constructive solution to their long-standing problem.
8. ANALYSIS AND DISCUSSION – MAJOR THEME FOUR: GENDER, LOOKS AND CULTURE

8.1. INTRODUCTION

The final chapter resulting from the analysis of women’s experiences of labiaplasty aims to situate these accounts in a wider social-cultural context in order to explore the relatedness between the participants and the contemporary Western culture in which they operate. The chapter therefore explores in which ways the Western culture shapes participants’ views of physical attractiveness and gender, and how participants negotiate their subjectivity in the given socio-cultural context. The two superordinate themes examined in this chapter are Gender Inequality and Agency in the Given Socio-Cultural Context. The first theme captures what could only be described as gender inequality experienced and expressed by the participants in several ways. The most common issues articulated by the participants revolved around the pressure to be beautiful, and the closely related double standard whereby no similar pressure regarding physical appearance is placed on men. This theme inevitably reflects on social system and specifically patriarchy as – still – an ongoing mode of operation. Participants’ views on mainstream media will also be explored, as well as their critique of the aforementioned. Considering that several participants are also migrants, the section will provide a comparison of gender norms as experienced by the participants in their native countries and countries of residence. The second superordinate theme – Agency in the Given Socio-Cultural Context – reflects on ways in which participants negotiate their subjectivity in this unequal environment. It explores how participants differentiate between cosmetic procedures, and therefore seemingly separate labiaplasty from the pool of cosmetic surgeries. Corresponding to the title of this study, the section also captures participants’ expressions of autonomy – despite the unenviable social circumstances – in a powerful yet symbolically loaded phrase: I’m doing it for myself. Table 9 includes an overview of major theme four.
Table 8: Overview of major theme four exploring participants’ views on gender, physical appearance and the Western culture

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8.2. GENDER INEQUALITY

Towards the end of the interview all participants were asked for their opinion with regards to the enormous disparity in the number of men and women who seek cosmetic surgery. This section therefore aims to present the findings in order to explore why body modification – and cosmetic surgery specifically – is a gendered issue. The superordinate theme Gender Inequality reflects on the pressure to be beautiful as experienced by women, and double standards with regards to physical appearance and gender. It also explores the social system, media and culture – all of which shape our beliefs and attitudes about the aforesaid issues. The themes repeatedly overlapped and reinforced each other.

8.2.1. PRESSURE TO BE BEAUTIFUL

All participants agreed that women are under a lot of pressure to invest in physical appearance, and almost all participants highlighted that the aforesaid pressure is one of the reasons why cosmetic surgery is a gendered issue. Sarah reflects on the impossible expectations that women are supposed to meet.
Sarah: The world, the society, demands too much from women, from us. To be always impeccable, no f…
Tina: No flaws?
Sarah: No flaws. Exactly. That’s exactly the word I was looking for. Thanks. No flaws. And you need to be always perfect, clean, nice smell, brushed hair and everything. (...) [Women] are never… It’s never enough. We can do everything – it’s never enough. For a man, it’s okay. So, I suppose that’s why you have this [disparity in cosmetic procedures]. And especially because you can’t be fat, you can’t have small boobs, you know? Last century it was nice if it was a little bit fat; now you need to be anorexic. The society is never happy with what we have to offer.

In a similar vein, Carla commented on the pressure placed on girls and women with regards to physical appearance – including the imperative of youth – and the general treatment of the other sex.

*I just think the pressure is huge on girls. I think also as you get older the society does not want to see old people. So anything that is ugly or fat or old – we want to hide it. It doesn’t exist. And girls are just growing up with wrong values and with the wrong idea.* (Carla)

*Complete unfair treatment. And it’s terrible. So, I think plastic surgery and all these kind of phenomena (....) go from a travesty society that is giving false messages that you have to be pretty, young, skinny, with these characteristics, or you’re worthless.* (Carla)

Carla’s last sentence seems to grasp the essence of the problem – highly problematic social and cultural values transmitted on girls and women (as well as boys and men) that explicitly indicate what is highly regarded in contemporary Western societies. On top of that, Carla importantly emphasised that gender intersects with age, for what is considered beautiful is almost exclusively youthful. In the same vein, Mia concurred with the above and elaborates further on why women invest their time, energy and money into their looks. She offers several reasons for
that, one of which is desirability. Namely, she draws a link between women’s desire to be desired by men – which is mediated through physical attractiveness – and women’s positive view of themselves.

*Women want to feel pretty and sexy, and that men look at them. And when they look at them, they think oh, you know, they feel like they like what they’re seeing. And I think it’s purely for that. If they look at themselves and they feel good, you know, they look at the mirror and think: ‘I’m not too bad, I’m sexy’, they will feel that. They will project that.* (Mia)

The above excerpt seems to capture the connection between looking and feeling. Namely, if a woman is perceived as physically attractive by a man, that in turn seems to have a positive effect on her relationship with herself. Implicit in this statement is the notion that women are looked at by men, from which a sense of worth may be derived, but it does not seem to run the other way around (to the same extent). Put differently, women are looked at but men look, meaning women appear but men act. Mia elaborates on this further and makes a though-provoking point about the internalization of dominant social and cultural norms pertaining to gender.

*I think it’s becoming so intrinsic in women, that I don’t think you do realize about it. I don’t think we do. It’s something that you do, but you don’t really realize you’re doing it, or why you’re doing it. You probably think you’re doing it ‘cos you wanna look better, you wanna look sexy, you wanna look… I think it’s because it will probably take you further where you want to go, than if you’re not looking as good.* (Mia)

Interestingly, it appears that Mia does not view physical attractiveness as an end to itself, but rather means of achieving other goals such as increased self-worth, but also respect and ultimately visibility.

*You probably make people to listen to you more, to see you more, to respect you more, than if you don’t look that good. So you almost try*
to look after yourself because at the same time at work it’s almost like you’re more respected, or you’re being listened more. I think it’s also a bit of that. And again, I have heard that from patients of mine that they have had procedures and they said: ‘You know, I work in this kind of a business and I have to look good. Otherwise, it’s almost like you’re not there.’

Tina: It’s like you’re invisible?
Mia: Yes.

Lastly, Mia also reflects on the aging process and the body changes that inevitably accompany this process. In her view, visible body changes are more prominent in women than in men. She concludes that women may opt for cosmetic surgery more than men as a means of closing the gap between what has been and what has appeared to been lost.

_I always have this theory that I think women in a way they go through so many different changes in their lives, especially having kids. I mean, I haven’t had kids myself. But it [is] almost that the body changes a lot. So, they have this perception of how the body was and how the body is after, you know, hormones, kids and menopause…_ (Mia)

All of these excerpts demonstrate that participants view women’s investment in their physical appearance largely a result of external expectations and pressures, rather than internal wants and needs. However, when the latter is present, namely one’s own (seemingly) autonomous desire to invest in their looks, it is rather possible to view that as a result of internalized external values. This again underscores that people are always embedded in their environment, and the possibility of removing oneself from that environment intact is rather challenging.
8.2.2. DOUBLE STANDARDS

This section continues to explore unequal expectations placed on men and women with regards to physical appearance. This time however the focus is mostly on the disparity as such. Sarah takes the example of grey(ing) hair to illustrate the lack of equality between men and women.

Sarah: Now it's kind of trend, white hair, full white hair, for a woman. But you need to have a really strong personality for white hair.
Tina: You mean grey hair?
Sarah: Yeah, grey hair. C'mon, we are not all Meryl Streep in ‘Devil Wears Prada’ to have that lovely grey hair! But when we're talking about grey hair – it's okay for men to have grey hair, ‘cos it’s sexy. And for a woman – Jesus Christ, she had one, I don't know, half white hair, little grey hair on her head, and it’s not acceptable.
Tina: I totally know what you mean. Even in Croatia we have this saying that men are like wine, the older the better. [Laughs]
Sarah: Exactly! You are talking about it. That’s another thing. If the man is older, you see a lot: ‘Oh, she got that man!’ And if the woman is twenty years younger than the man, the man is forty-fifty, it's like: ‘Oh, but he’s so sexy.’ I have a friend, she’s fifty years old, her boyfriend is my, a little bit older than me, thirty-five maybe. And everybody’s like: ‘Oh, he’s with her because of her money!’ (...) If it was a young woman and older man, that’s okay ‘cos old men are cool. Greyed-hair men are cool. But, a greyed-hair woman is not that cool? So, it's not fair.

Mia expressed similar views on double standards with regards to gender and physical appearance.

I think men definitely don't have to look... As long as he looks tidy and clean, it's fine. It's enough. Thy can get away with wrinkles, and with a bit of belly, and all those physical flaws, that's fine. Whereas
woman, thinking of those that are in the business, I think they have to also push that step forward. And I think one of those would probably be the physique – looking better, looking stronger, people looking at you, and listen to you, take you probably more seriously, than if you look, you know, ten years older. (Mia)

Carla also reflects on the unequal treatment with regards to looks encountered by men and women. Her following statement underlines the aforesaid gender inequality.

_ I think the pressure on women is absolutely appalling. I am so glad that I have two sons, because I think being a woman is very difficult. It’s been always difficult, but I think now all the… All my friends’ teenagers already have an eating disorder because the pressure is disgusting! (Carla)_

Leah on the other hand also reflects on double standards albeit in a completely different way. She believes that the reason for the disparity in cosmetic procedures is connected to the support, or the lack thereof, that men and women receive when considering or undergoing a procedure. Specifically, Leah thinks that women receive understanding from men and women, whereas men are ridiculed by other men.

_ I think with men, if they want to change something, they’re too scared about other men laughing at them perhaps. If they want to get something done, if it’s something that can be noticed, as a man, I think all the mates would kind of take the mickey out of him maybe. You know, the lad culture kind of thing. Especially I think with the nose for example, then I can imagine down the pub ‘Oh, big nose, cosmetic surgery!’ Sort of take the mick a bit more. While with women it’s kind of you get sympathy if anything. (Leah)_

The above excerpt then captures a different type of gender inequality – the one that works to men’s detriment – whereby men encounter mockery where women encounter support. The excerpt also highlights the wider acceptance of cosmetic surgery as a ‘female thing’, and it is rather possible that cosmetic surgery may be
ridiculed among men as it may be seen as emasculating. In sum, there is a common understanding among the participants that the society places different expectations with regards to looks before men and women, and also responds in different ways to male and female body alteration.

8.2.3. SOCIAL SYSTEM

As the participants dwelled more and more on gender relations, they inevitably started to reflect on the social system under which we all operate. Namely, Sarah, Carla and Mia all underscore that the contemporary world is still a man’s world. Patriarchy remains omnipresent.

Sarah: We live in a world Tina that demands a lot from women.
Tina: Can you repeat that?
Sarah: That demands too much from women, you know? So, if you are a man, you just wake up. If you want to take a shower that’s what you do. If you don’t, you just shave your hair, put some clothes that are decent clothes, and you go to work. We need to have the hair brushed, cleaned, make-up on, and we need to be ready. (...) Oh, but a man… Even in my country, you have these jokes. A man can have a little bit [of a] belly. They slag it, say it’s…
Tina: Say it’s sexy. [Laughs] That’s what they say in Croatia.
Sarah: No, in my country it’s a little bit dirtier. [Laughs]
Tina: It’s a little bit what?
Sarah: Dirtier! They say it’s, what’s called … It’s sexual blister!
Tina: Really?
Sarah: It’s really machist. It’s really machist this world.

Carla expresses similar views, and in addition to that highlights that ingrained hatred and dislike of women is ultimately expressed by women themselves.
All this sisterhood doesn’t work out really well. I think men are better at sticking together and helping each other. I think women are really good at stabbing each other’s backs and not being very supportive to each other. So, we have to learn the lesson and try to make the world a better place for us. You know, ‘cos the world…. It’s a man’s world. They got it! It’s their world and we are just there trying to please them. So, it’s just very wrong. (Carla)

Look at this Monika Lewinsky – no one supported her. All the women, all the journalists writing, you know… Because you can almost expect this as a woman. No-one supports you. The world is misogynist – not only men, but women. (Carla)

Lastly, Mia concurs with Sarah and Carla in relation to patriarchy, and argues that women’s investment in their physique is an attempt to reach the same heights that men reach without the additional work.

Maybe this is a macho man, or machist world, where women almost have to look better to get more and to keep there, whereas a man probably doesn’t have to do as much. Because it comes more naturally, it comes easier. (Mia)

In sum, most of the participants were highly conscious of gender inequality present in contemporary Western societies and the accompanying social system that works primarily to women’s – but also in some important ways to men’s – disadvantage.

8.2.4. MEDIA

Some participants were very conscious of the mainstream media and the effects that it has on shaping our perception of the world around us. This was discussed primarily in the context of looks and sex. Both Carla and Mia were highly critical of the images present in the media and the message they communicate to girls and women.
They should be completely forbidden… Women’s magazines, all these models, anorexic girls, should be… As a society we do nothing, nothing to support women. We just put pressure! It’s all about being beautiful. And I just think it’s very sick. So, all girls, you know, as a teenager you want guys to be crazy for you and to… So, you just want to be perfect and look like these impossible women in the magazines. No-one really appreciates someone being clever or intelligent or good. They just want, you know, a pretty fake girl. (Carla)

I think all these programmes on TV, all these magazines, all these girls, for example TOWIE and all these programmes where you see girls. Actually, they are only twenty and they got these faces that look like dolls, where there’s completely no wrinkle, no expression, everything perfect, and make-up, the eyelashes and all that. It’s almost becoming, it’s becoming the norm, rather than not. So I think people feel that they have to somehow look like that. (Mia)

In addition to that, Carla and Natalie were asked whether mainstream pornography shapes our understanding of what a woman's (and man's) body should look like. These are their responses.

Yeah, it does have an effect! You see things on social media about making jokes of women that don’t have conventionally beautiful naked body, so it can make you feel really insecure. I felt really insecure about that before, when I’ve seen things like that. ‘Cos I didn’t look the way that you would say a beautiful body looked in that area. And it does make me feel really insecure. (…) Yeah, it does have an effect on how you feel, how confident you feel with your body. (Natalie)

Of course! And what is sex, you know? You see this pornography that is all aggressive and it’s just to please men. I mean, nothing to do with giving pleasure to a woman. And it’s there. It’s in your mobile.
It’s in your IPad. You can just Google it and you get all tons of pornography. And the last thing they care about is the pleasure of the woman. It’s just all about giving pleasure to the man. We are still in the dark ages. This matter is sort of taboo, we cannot talk about it openly. It’s a very macho world still. (Carla)

This section demonstrates that the participants are not just passive consumers of mainstream media. On the contrary, they are mostly conscious and critical of the content and images represented in the media, as well as the negative effects that media consumption has on women’s body image and one’s views of gender, looks and sex.

### 8.2.5. CULTURAL DIFFERENCES

Although three of the five study participants have migrated from their native countries, two of them specifically reflected on cultural differences between their countries of origin and countries of residence in relation to gender and looks. Sarah, who is originally from South America, has been living in Ireland for four years at the time of the interview. She reflects on the physical appearance and the importance thereof in both countries. Insomuch she makes a very interesting point about one possibly unforeseen element that has a direct effect on the societal pressure to look perfect as experienced by women – the climate.

Tina: You’ve lived in South America for most of your life, and then you came here. How would you describe these pressures on women in Ireland, in comparison with your home country? Where is it better to be a woman?

Sarah: Here. Yeah, here. [Laughs] Especially because of the weather there. It demands much more from women to be, especially with your body.

Tina: Because it’s hot?
Sarah: Yeah, ‘cos you use bikinis a lot. So, the body culture in my country, it’s much bigger than here. Especially, I’m from [the name of the city]. So we would spend most of our spare time or free time on the beach; shorts and tops. If you are not body ready, body shape ready for the summer – and it’s summer 360 days in the year – so you are not really acceptable for the society.

Tina: So there is a lot of pressure to look perfect?

Sarah: Exactly. Here, we have I think the kind of the same pressure, but it is slightly different because you can cover up a little bit more. You know? So, by these things I think it’s a little bit easier being a woman here.

In addition to that, Sarah draws a comparison of gender norms and relations as experienced in Ireland and South America, and the implications for women’s social standing.

Sarah: If I look my background – where I am from – the society there is much more machist then here. For example, I was an au-pair here, and I lived with a family. Clearly the woman was the boss who wears the trousers, and it’s something that the partner, the man, can accept. And, even in my marriage, we know who wears the trousers there. And it’s me. [Laughs] In my country it’s not something that would be really acceptable. For example, my mum would never think I would marry somebody. Because the society imposes that you need to be a woman, you always need to be ready for your husband, you can’t have flaws, and you need to serve. And I don’t agree with this. [Laughs] I think it’s much… Not easier in a… [Silence] It’s easier to be a woman here, but it’s not easy anyway.

Mia has been living in the UK for thirteen years now. She concurs with Sarah inasmuch that gender norms are framed and expressed differently across societies. Mia utilises her own experience of having lived in two different countries to reflect on the vastly different perception of the importance of physical appearance.
When I studied [name of the therapy] in [the UK], I studied at [name of the college]. It was very European, but very kind of world-wide. So there were all people from completely different countries. And I found that those that come from places like Norway, Sweden, I think they're different. I don't think they look at themselves as much as we do. I might be wrong. But that was the impression that they gave me. Even men, men and women, they didn't seem to be that much concerned about it. So I think it depends on nationality somehow. (Mia)

Mia further elaborates on the differences in relation to gender and looks in her native country and her country of residence.

I think at home for example, if I compare home, the south, where I come from with here where I live, there is a difference. (...) Here [the UK] women spend far much more money and they are much more obsessed with their looks then at home. I think at home people are being more relaxed about it. Oh yeah, they have a bit of cellulite and they have a bit of things that they [don't] like. But unless it's something really in the way... (...) They don't have the same look as here. People don't do their eyebrows as much as people here do, their eyelashes, the Botox, the fillers. They don't! I mean, I'm not saying that no-one does. There are people that they do it. But even then, they're the minority. There's not that many people that would do that, whereas here it's almost... It's difficult to find someone who doesn't do it. (Mia)

The above excerpts illustrate that gender norms, gender expression and gender relations are highly dependent on the socio-cultural context in which they are formed. In conjunction with the previous sections explored in this chapter, these excerpts also demonstrate that women's body image is very much context-dependent, and what is perceived to be a problem in one society may have never been framed as such in another one.
8.3. AGENCY IN THE GIVEN SOCIO-CULTURAL CONTEXT

The final superordinate theme explores how study participants draw a distinction between labiaplasty and other cosmetic procedures, and insomuch seemingly distance themselves from other cosmetic surgery consumers. The theme also reflects on participants’ expressions of agency in the given socio-cultural context, for they all emphasized that they had cosmetic surgery for themselves.

8.3.1. DIFFERENTIATING BETWEEN COSMETIC PROCEDURES

In one way or another, almost all participants recognize a difference between labiaplasty and other cosmetic procedures, and therefore a difference between women’s motivations for the procedure. For example, Sarah and Mia both draw a comparison between labiaplasty and breast augmentation in order to highlight what they believe is an important feature that distinguishes between the two – visibility.

Sarah: *When you put breast implants, everybody can see your boobs are bigger. [Labiaplasty] is something that’s more, you know…?*
Tina: *Private?*
Sarah: *Yeah, for yourself to know.*

*Because it’s something that you don’t want to… It’s not probably like having a boob job that everyone is going to see and you’re happy with it and you just show it. It’s different. Everyone is going to notice that. But [labiaplasty] is something that you feel like you don’t want people to know.* (Mia)

In addition to visibility of the procedure, participants reflected on women’s possible motivations for different types of cosmetic surgery. Carla contends that some cosmetic procedures are done in the effort to attract male attention; however, others are done to heighten women’s well-being.
I think you do the specific plastic surgery to attract men. People put huge implants to attract men, not to like themselves. I mean, as a woman, you cannot like yourself with these big implants. You just do it to attract men. As a woman you have put this filler in your face not to like yourself. You do it to attract certain type of men that like certain type of fake women. (Carla)

Some plastic surgery – that you get your ears, you know, close to your skull – that you make it for yourself because you had this trauma as a little child and you didn't wear a ponytail because your ears are sticking out, people are making fun of you…. You don't do that plastic surgery to attract men. You do that plastic surgery, which is on your head, which is in the middle of your face, your ears, to feel good about yourself. The same thing with labiaplasty. I don't think any woman does labiaplasty for men. (Carla)

In similar fashion, Leah and Mia did not endorse all types of cosmetic surgery. On the contrary, they highlighted the importance of a balanced approach to body alteration.

I know other people wouldn't feel the same. They think like ‘Oh, you should be happy with what you got.’ But I think, well, if you can change something and it's gonna make you feel happier, why not do it? Obviously some people are against surgery and that's their... That's fine, it's up to them. But I'm always, if you don't do something that's gonna make you look ridiculous, then my not do it?! Obviously, things people get, when they end up with these huge lips and things like that, I don't agree with that. ‘Cos I think it's gonna make you look worse. But anything that makes you feel more confident, then why not go for it?! (Leah)

But the idea of a woman with massive boobs and things like that, for me it's not attractive. I don't think that is... I don't like it. For me I think a person's body is something... It looks healthy, it's functional. It's not about looking plastic. (Mia)
Although the aim of this research was not to ascertain participants’ general perceptions of cosmetic surgery, the above excerpts do touch on a careful deliberation with regards to body modification, for participants did not endorse all types of cosmetic surgery. On the contrary, they made a distinction between visible-invisible, healthy-plastic and importantly for myself-for men.

8.3.2. I'M DOING IT FOR MYSELF

Throughout the interviews the participants were never asked for whom they had labiaplasty, and yet at some point during the conversation that precise topic would emerge. All participants concurred that labiaplasty is something they did for themselves. Sarah for instance highlights her independence and autonomy, regardless of the actual context.

Sarah: I did it for myself. And, I'm not the kind of a person Tina, I don’t really bother with another people’s opinion...
Tina: I kinda got that. [Laughs]
Sarah: Just to explain how I am. I bought my wedding dress by myself. I didn’t have help from anybody. I was like: 'I like it, I'm going to buy', take my money and then I went home! [Laughs] I don't have these things: ‘I don’t know...' – I know!
Tina: [Laughs] It's like you are your own woman.
Sarah: Yeah!

It was evident in the previous sections in this chapter that Sarah is very critical of patriarchy and gender inequality that she encountered in South America and, to a lesser degree, in Ireland. Despite the unfavourable social circumstances, Sarah still believes that women can locate the space for autonomous action.

The society is never happy with what we have to offer. And I think these… That’s what makes women go more [for cosmetic
procedures]. But, at the same time, I think women, they are finding out, they are finding more ways to be happy with themselves. That’s my case for example. Because, I wouldn’t do this surgery or any other surgery because of the society. I do it because it’s something that annoys me. (Sarah)

Interestingly, although Sarah acknowledges and criticises gender inequality in South America and Ireland – whereby amongst other things women are under enormous pressure to look impeccable – she also positions herself outside of that context when she asserts that she would not undergo labiaplasty for the society. Whilst Sarah underlines that she did not have labiaplasty for the society, Carla emphasizes that she did not have labiaplasty for a man. She reflects on the day of the surgery and the conversation she had with the nurse.

I remember the nurse who was getting me ready to go to hospital theatre, and she asked me, she said: ‘What does your husband think?’ And I said no, I don’t do it for my husband or for anyone, you know? I have a boyfriend and I told him I’m gonna have it done and he said ‘Are you crazy? You’re perfect!’ I do it totally for myself, you know? It’s a bit like liposuction. I do it for myself because I’m a fashion designer. I like to wear certain clothes and this is kind [of] in the middle of [the way]. But not because I think a man is gonna like me better like that. Not at all. (Carla)

Carla further expands on this issue by recalling the conversation that she had with her sister who is also considering labiaplasty. She emphasizes that labiaplasty is a procedure a woman undergoes to improve her sense of wellbeing.

My little sister was telling me: ‘I’m still thinking about having a labiaplasty. Because you have babies and everything is looking messy and maybe labia is covering up that. However, I have one of the sides much longer than the other one.’ And then I said ‘You have to fix it, you know? Because if you’re not happy with that and the right side is longer than the left side, just have it done.’ I’m not sure you do
that for men. I think you do it to feel good about yourself. (...) You’re not thinking about the boyfriend that you’re sleeping with at the moment. You’re thinking about your future. (Carla)

Similarly to Carla, Natalie reflects on the relationship with her previous boyfriend, and concludes that she had labiaplasty for her own well-being rather than the anything or anyone else.

*I think my ex-boyfriend, he is the only boyfriend that I had. I was with him for a long time. And he, he never... He was very supportive. He understood that I was insecure, and also was uncomfortable. The problem I had with the labia, it also gave me discomfort during sex, during sexual intercourse. So, he knew that I was thinking about it, about these reasons, and he was supportive about it. He never commented like, look-wise, he said that I was fine. It was just something more for me, something that I wanted. My personal discomfort really, not because anybody said anything. (Natalie)*

Leah is one of the two participants who had an additional procedure alongside labiaplasty. Although she did not speak specifically about labiaplasty, Leah emphasizes that she had cosmetic surgery – namely breast implants – for herself. In her view, the upper part of her body (breasts) and the lower part (backside) were not in proportion. Therefore, she opted for breast augmentation in order to balance them up.

*Tina: Do you feel like on a societal level there is a lot of pressure on women to look good?*
*Leah: There is, but I've done it more for myself really ‘cos I never felt in proportion. I’ve got a bum, put it this way, I’ve got quite a, not a big bum, but it’s certainly ample. So, some people obviously put bum implants and things like that. Well, I’ll definitely never need any of that, so that’s good! But then my top part, it got forgotten kind of thing, so it didn’t balance up. So, it was more about me looking in proportion. Before I looked silly ‘cos I’d wear a dress and be almost*
flat on top, compared to my bottom part, ‘cos I’ve got like quite wide hips and the backside so... It was more about that for me, really, wanting to feel good in clothes, just in general.

This last excerpt and the question asked perfectly illustrate the complexities faced by women in contemporary Western societies when they deliberate about cosmetic surgery and justify their choices. On the one hand, yes, women are under a substantial social pressure with regards to physical appearance, and they are expected to conform to specific beauty standards in order to be considered conventionally attractive. But on the other hand, no, cosmetic surgery is a carefully considered decision of an autonomous woman that has not been under any duress or pressure resulting from her immediate environment and specifically close relationships. This paradox will be explored further in chapter nine that also provides concluding thoughts on women’s experiences of labiaplasty and places these in a wider theoretical context.

8.4. CONCLUSION

The purpose of this chapter was to provide a focused discussion pertaining to gender and beauty standards in the contemporary Western cultures. In doing so, this chapter attempted to provide a backdrop against which women’s choices to undergo labiaplasty have been formed, and thus should be understood. It was demonstrated that women in this study are conscious and largely critical of gender inequalities present in the Western societies. Interestingly, it seems that the participants that were most critical of the existing inequalities were those that were also migrants. It can be speculated that this is due to the fact that the ability to inhabit more than one society provided those participants with the valuable cross-cultural experiences of gender dynamics. Nevertheless, all participants were aware of the societal and cultural pressure to look beautiful that is placed on and experienced by women. They agreed that societal expectations stipulate women’s impeccable physical appearance, even though that is an impossible goal. Most participants also concluded that this is the reason why cosmetic surgery is a gendered issue. Some participants also underlined
that in modern Western cultures gender intersects with age, for what is considered a beautiful woman is almost exclusively a young woman. Participants also suggested that women invest disproportionally more money, time and energy into their physique – in contrast to men – in order to heighten their desirability to men, self-confidence, respect acquired from other people and ultimately social visibility. Once considered in this light, it may be argued that women’s attentiveness to their physical appearance is not an end to itself, but rather a means of achieving other personal and professional goals. Interestingly, one participant also suggested that women tend to internalize this external societal and cultural pressure to look beautiful, and thus engage in ongoing body work without fully comprehending where that desire stems from in the first place. Closely related to the pressure of being beautiful is the theme of double standards. Namely, almost all participants agreed that with regards to physical appearance highly unequal expectations are placed before men and women. They asserted that whilst women are expected to look physically perfect and their physical appearance is tied to their perceived social worth, male physical imperfections are socially acceptable and largely an insignificant aspect of their identities. In sum, there was a common understanding among the participants that the society responds to female and male physical attractiveness and a lack thereof in profoundly different ways. Three of the five participants asserted explicitly that we still operate under the social system of patriarchy, which colours men’s and women’s attitudes of gender in a regressive manner. One participant interestingly suggested that women’s investment in their physique is an attempt to reach the same heights that men reach without the additional work. Furthermore, almost all participants provided a critique of the mass media, particularly women’s magazines and reality TV shows, that have a negative effect on women’s body image and, more generally, women’s views of gender, looks and sex. In addition to that, two participants specifically reflected on the experienced cultural differences pertaining to gender and the aesthetics, and insomuch highlighted that gender norms are framed and expressed differently across societies. This captured the interplay between the culture in which one is born and operates, and their intrinsic attitudes and beliefs that are very much a product of that same culture. However, in spite of these critical accounts of the restrictive social and cultural structures – that were provided at least to some extent by all participants – this chapter also captured participants’ desire to assert their autonomy within this given context. This was arguably evident in the way that participants recognized a
difference between labiaplasty and other cosmetic procedures, and thus made a
distinction between visible-invisible, healthy-plastic and importantly for myself-for
gen. In relation to the latter, all participants argued that they did not have labiaplasty
in order to please their husbands, boyfriends or the society. They asserted that they
had labiaplasty to address a range of issues caused by their larger labia and
therefore improve their well-being. In other words, notwithstanding the restrictive
social and cultural structure that they were conscious of, participants in this study
concluded that they had labiaplasty ‘for themselves’.
9. SYNOPSIS AND CONCLUSION

9.1. INTRODUCTION

The final chapter of this thesis aims to reflect on the knowledge and insights acquired in the study of women's experiences of labiaplasty, and to situate these findings and its implications in a wider context informed by feminist and social-psychological theories endorsed by this research. The chapter will firstly provide a summary of the relevant findings and conclusions pertaining to this empirical study. These findings will be explored as part of the four identified subsidiary research questions, which were outlined in the first chapter, and the main conclusions will be tied to the extant body of knowledge that has been reviewed and critically appraised in this thesis. This chapter will also provide an exploration of the methodological considerations pertaining to the study, including the chosen qualitative, phenomenological and woman-centred approach. Insomuch, it will capture the identified strengths and weaknesses of the selected methodological approach. The chapter will also reflect on the identified value of the research and the contribution to the academic community, cosmetic industry and importantly individual women who may opt for labiaplasty. Expanding on the main findings of the study, recommendations for service users and providers will be documented. The recommendations for service users will not be solely based on the conclusions of this study, but also on participants’ specific advice to women who may be considering labiaplasty. In that way the suggestions given may not be only beneficial to prospective patients, but moreover they meet and reinforce feminist research principles due to taking women’s voices specifically into consideration. Furthermore, this chapter will draw on the relevant questions that emerged in the course of the research, but whose exploration was beyond the scope of this study. In doing so, it will outline the implications that the current study may have on further research pertaining to female genital dissatisfaction and modification, and therefore provide a valuable starting point for future studies.
9.2. PRÉCIS OF THE FINDINGS AND CONCLUSIONS

The central question in which this empirical study was anchored was: *What are the motivations, experiences and reflections of women who have undergone labiaplasty?* In order to address this broadly defined question, this project endorsed a time-oriented process inquiry. It therefore focused on the three subsidiary questions that explore the chronology of the participants’ experiences of labiaplasty. These encompassed participants’ motivations for the procedure, the experience of the surgery and recovery, and the observable changes in their body image, practical functioning and sexual satisfaction as a result of having undergone labiaplasty. The fourth subsidiary research question initiated a focused discussion on gender, physical appearance and the contemporary Western culture in order to explore participants’ relatedness to the socio-cultural environment in which they operated, and to provide a backdrop against which their choices to have labiaplasty may be viewed. Therefore, in accordance with the aforesaid research questions, as well as the identified major themes resulting from data analysis, this section will summarize the relevant findings of the study. It will also analyse these findings and tie them to the existent literature on female body work and, when possible, currently available scientific knowledge on elective genital procedures – explored in chapters one, two and three.

9.2.1. PRE-SURGICAL PHASE: LIFE BEFORE LABIAPLASTY

The first subsidiary research question was the following: *In the pre surgical phase: what were the participants’ motivations for labiaplasty, their immediate social environment in which decisions to have labiaplasty were anchored, and the decision-making process underlying surgery?* The findings suggested that all participants underwent labiaplasty for usually a combination of the following reasons: aesthetic, physical and sexual. It was indicated that all participants were unhappy with the physical appearance of their inner labia and, in line with the previous research on female genital cosmetic surgery (Crouch et al. 2011, Moran and Lee 2013, Bramwell and Morland 2009), the aesthetic motivation for labiaplasty featured in all accounts. It
was also shown that the experienced genital appearance dissatisfaction seemed to translate into genital appearance anxiety, which largely manifested as self-consciousness, insecurity, lack of self-confidence, embarrassment and shame. Therefore participants’ dissatisfaction with the appearance of their labia appeared to result in negative mental health outcomes. It could be therefore suggested that labiaplasty may have been sought after as a solution to psychological issues induced by genital appearance dissatisfaction. Namely, it was indicated in this research that cosmetic surgery may be an intervention that mediates between a woman’s physique and her psyche, and thus provides means to reduce or eliminate a psychologically induced distress. Insomuch, the findings of this study support previous research on female cosmetic surgery, and underline the importance of the interplay between the human physique and the psyche (as per Braun 2005, Parker 2009, Davis 1991, 1995, Gimlin 2000, 2002, Kaw 1997, Stofman et al. 2006).

This study also showed that the aforesaid genital appearance anxiety was most prominent in social situation in which participants had to undress in front of other people. This included sexual intimacy – especially with a new male partner – undergoing professional hair removal, as well as unrobing in front of friends and at the beach. In other words, participants felt most self-conscious when their external genitalia may have been subject to an external gaze. This gaze was not necessarily a male gaze, but rather a societal gaze. This discovery significantly overlaps with previous feminist research on cosmetic surgery (Parker 2009, Davis 1991, 1995, Gimlin 2000, 2002). It appears then that the participants decided to undergo labiaplasty against the backdrop of seeing themselves in relation to the world they inhabit, which importantly underlines their relatedness to the socio-cultural environment. Specifically, some participants implicitly suggested that they opted for the surgery because they did not think that their labia looked ‘normal’. In such instances, labiaplasty may have been an exercise of ‘normalization’ or a pursuit of what an individual perceived to be ‘normal’ female external genitalia. Considering that none of the participants stated or otherwise implied that they underwent labiaplasty to look ‘beautiful’ in the genital area, whereas several of them mentioned in one way or the other that they wanted to look ‘normal’, it could be argued that the participants largely had labiaplasty in order to blend into the wider society rather than stand out. In other words, labiaplasty seems to be a means of seeking an ‘ordinary’ genital
appearance, social acceptance and belonging. This is consistent with other research on female cosmetic surgery (Parker 2009, Davis 1991, 1995, Gimlin 2000, 2002, Kaw 1997), all of which suggest that cosmetic surgery is a tool for achieving what is perceived as ‘normal’ physical appearance and a related ability to easily fit into the wider social structure.

The study demonstrated that the second set of motivations for labiaplasty included physical discomfort experienced due to body posture and movement including sitting and exercise, and discomfort with tight clothing such as jean and thongs. In addition to that, one participant stated that she experienced physical pain, especially when sitting, due to the sheer size of her labia, which is why she opted for labia reduction years before deciding to undergo labiaplasty. Several participants stated that only after surgery they became aware of the physical adjustments unconsciously employed before the surgery, in order to manage the aforesaid physical discomfort. Some participants also felt uncomfortable during menstruation with tampon insertion and removal. It is unknown whether some of the issues related to physical discomfort could have been addressed by simple lifestyle changes, i.e. wearing less tight clothes or using pads instead of tampons. Although the findings of presently available empirical studies on female genital cosmetic surgery (Cain et al. 2013, Crouch et al. 2011, Rouzier et al. 2000) coincide with the identified physical motivations for labiaplasty resulting from this project, this currently available body of knowledge is also very limited and precludes the possibility of comparing the results in depth. This exploratory study therefore provides a valuable insight into the complexities underlying the physical incentives for labiaplasty.

This research also discovered that participants underwent labiaplasty to address a range of sexual issues. Although the extant literature on female genital cosmetic surgery suggest that women may undergo labiaplasty due to discomfort with intercourse (Cain et al. 2013, Crouch et al. 2011, Rouzier et al. 2000), this study however suggested that penetration is the most prevalent yet only one identified sexual issue as experienced by women seeking labiaplasty. Other reasons however relate to vaginal lubrication, self-pleasure and orgasm. The findings demonstrated that almost all participants experienced physical discomfort during intercourse, for during friction the penis would pull the labia along. According to one participant, this
seemed to have been aggravated by the men’s aging process and the (in)ability to achieve and hold an erection. In addition, two participants experienced difficulties with reaching the necessary level of natural lubrication, which for one participant resulted in an impeded desire to engage in self-pleasure. It remains unknown whether the issues related to natural lubrication, which is necessary for intercourse, could have been addressed with the use of lubricants. Nevertheless, these issues combined have had a negative effect on sexual satisfaction and ability to achieve an orgasm for two participants. One of them, importantly, suggested that the reason for her inability to orgasm may have had to do with her previous negative sexual experience. Interestingly, this participant stated that although she cannot orgasm during sexual relations with a man, she however easily orgasms via self-pleasure. It is therefore hypothesized that the type of sexual activity that one engages in, as well as the match between the two persons, may be a far more significant factor in experiencing sexual pleasure than the size of one’s labia. Namely, the theoretical findings of this research also addressed the issue of female sexual functioning. It was underscored that the assumption that women will easily derive an orgasm from intercourse is a false one, for penetration is not an effective way to stimulate the most sensitive part of female sexual anatomy – clitoris (Nagoski 2015). The growing research on female sexual satisfaction consistently shows that seven out of ten women, or more than two thirds, cannot orgasm though penetration alone (Ibid.). Furthermore, between eighty to ninety per cent of women derive pleasure through masturbation by stimulating the clitoris and the sensitive area around it, with no or very little vaginal penetration (Ibid.), and they do so in most creative and diverse ways (OMGYES 2015). It could then be questioned whether there is a disproportionate emphasis on intercourse as a means of attaining female sexual pleasure and orgasm, at the expense of other types of sexual play – oral and manual – that provide direct clitoral stimulation. In other words, one could speculate that what underlies intercourse as a sexual motivation for labiaplasty is the normative male-oriented heterosexual understanding of sex with the excessive emphasis on penetration (Braun 2005). In sum, the identified yet unanswered dilemma that results from this study is whether a woman should alter her body so that it fits her sex life, or whether she should alter her sex life so that it fits her body (Ibid.).
In relation to the immediate social environment in which participants' decisions to have labiaplasty were formed, the findings indicated that participants did to some extent engage in social comparisons about external genitalia whilst viewing pornography or when observing other women in the gym. The issue of mainstream heterosexual pornography – sexually explicit visual material designed to sexually arouse the viewer – as a possible source of comparison was addressed in the majority of the interviews. Namely, an exploration of participants' views of pornography was viewed as a question of very personal nature. Therefore it had not been included in the Interview Schedule (Appendix III), but it was asked as a supporting question in four out of five interviews. The findings indicated that pornography did not seem to be a major source of comparisons and therefore a strong predictor of participants' genital appearance dissatisfaction. This would be in line with the research of Jones and Nurka (2014) who conducted the first exploratory study to determine whether pornography consumption is the primary driver of the increasing incidence of labiaplasty. Their research surveyed more than a thousand primarily Australian women online, and indicated that while pornography was associated with openness to labiaplasty, it was not a predictor of genital dissatisfaction. Whilst challenging a linear 'porn thesis' – that women watch pornography, compare themselves unfavourably with the images presented therein, become dissatisfied with genital appearance and seek surgery – the authors noted that the sample was self-selected and it may be possible that women who were unhappy with their vulvas chose not to disclose this information to the researchers. Interestingly, Jones and Nurka (Ibib.) found a significant correlation between education and openness to labiaplasty, and hypothesized that women who pursue a university degree may be less likely to adhere to traditional feminine norms and thus modify their bodies.

Interestingly, one participant in this study highlighted that the negative commentary about women’s bodies on social media did have an adverse effect on her body image. This suggests that not only imagery, for instance in pornography and mainstream media, may have a negative effect on women's body image, but also words can have an equally harmful effect. As the previous research demonstrates (Fredrickson and Roberts 1997, Roberts and Gettman 2004), women’s body self-consciousness becomes initiated when exposed to imagery or words that emphasize
physical appearance of the body. The findings also suggested that apart from an odd comment based on ignorance and a lack of information, the participants largely did not experience negative comments from people close to them – including their male partners – in relation to their labia. Furthermore, participants’ previous male partners seemed to be the least enthusiastic ones about surgical intervention, which overlaps with other relevant research on female cosmetic surgery (Davis 1991, 1995, Gimlin 2000, 2002). It was speculated that male partners may not have been very enthusiastic about the procedure due to the financial cost and ‘invisibility’ of the procedure, but also simply due to a lack of understanding what the problem was. Further, it was demonstrated that decision-making process was predominantly a lengthy, multi-faceted and often lonely process, all of which corresponds to previous research of female cosmetic surgery (Parker 2009, Davis 1991, 1995, Gimlin 2000, 2002, Kaw 1997). What made this process rather challenging for some participants was a lack of scientific information about labiaplasty, which is probably linked to a general lack of conversation about female genitalia on the societal level. However, none of the participants underwent surgery on a whim, but rather following a long, careful and multi-layered deliberation based on the information they could obtain.

9.2.2. SURGICAL AND POST-SURGICAL PHASE: THE EXPERIENCE OF LABIAPLASTY AND THE AFTERMATH

The second subsidiary research question was the following: In the operative phase: what were participants’ relationships with their chosen plastic surgeons like, the experiences of the surgery and the immediate recovery process? Although in many ways this study was mostly concerned with women’s lives prior and post-surgery, the very experience of the surgery was included in the inquiry in order to explore and present women’s experiences of labiaplasty in a chronological and time-oriented order and thus preserve the narrative account. The findings suggested that the majority of participants utilized online research to locate their potential plastic surgeon, often by reading reviews of former patients and watching video clips of potential plastic surgeons. It was also indicated that the desirable skills sought in a practitioner included professional expertise and experience, helpfulness,
understanding, sympathy, kindness and a friendly grounded approach. The gender of the surgeon proved to be an important feature as well in some instances. None of the participants reported feeling pathologized during the consultations, and in one situation the participant was told that she was ‘normal’ by her surgeon prior to the surgery. This is somewhat in line with the other research on female genital cosmetic surgery, which suggests that potential patients were often told by their practitioners that their labia was within the standard range of human variation (Veale et al. 2013, Crouch et al. 2011). It is however not known whether this implies that the other participants' external genitalia were outside the aforementioned range.

The vast majority of participants established a successful collaboration with their practitioner, and they felt fully informed about the risks and the outcomes associated with the surgery. However, due to communication issues – a possible misunderstanding, but also a lack of communication post-surgery – one participant experienced a mismatch between her expectations and one aspect of the outcome of labiaplasty. In this instance, it is not clear which communication tools were used when negotiating the final outcome of the surgery, and whether her plastic surgeon relied on the use of before and after photographs of past patients, computer imaging or simply drawing. These types of images seem to be the most common communication tools deployed in the deliberation about the outcome of cosmetic surgery (Parker 2009). The other participant was not fully informed about the anaesthetic used during surgery, which led to an unexpected event in the operating theatre. Interestingly, she was content with her surgeon’s approach, for had she been fully informed about the anaesthetic (epidural) she may have not undergone labiaplasty. These two situations underscored that the needs of specific patients vary dramatically, which in turn underlined the importance of individualized care and challenges of communication in doctor-patient relationship. The surgery and recovery were straightforward for all participants, and no complications resulted from labiaplasty. Nevertheless, the two participants who opted for additional cosmetic procedures alongside labiaplasty, namely breast augmentation and liposuction respectively, experienced some issues following surgery. For instance, the participant who had breast augmentation alongside labiaplasty needed to have a reconstructive breast augmentation, in order to address the issues caused by the first surgery. This shows that medical intervention for the purpose of enhancing the aesthetics is a risky
business and often reconstructive surgery is necessary to address the unanticipated outcome (Lloyd et al. 2005). Lastly, one participant highlighted that she would have preferred to have her follow-up consultations with the plastic surgeon as opposed to the nurse, whereas the other participants had no complaints. Previous studies of cosmetic surgery (Parker 2009) show that clinics often employ support staff in order to provide an important bridge between the plastic surgeon and the patient. Although this practice is probably very beneficial from the perspective of the surgeon, studies also demonstrate that women are not always content with such approach (Ibid.). In that context, this research also indicated that different people have different needs, and for some this includes an ongoing support from their plastic surgeon.

The third subsidiary research question was the following: In the post-surgical phase: what were the identified changes in participants’ body image, physical functioning and sexual pleasure as a result of having undergone labiaplasty? The findings demonstrated that all participants reported positive changes resulting from labiaplasty, primarily an improved body image and closely related enhanced self-confidence. This indicated that a medical intervention into the human body may initiate a positive change in person’s mental and emotional well-being. This further reinforced the notion that cosmetic surgery may mediate between a human physique and psyche (as per Stofman et al. 2006, Davis 1991, 1995, Gimlin 2000, 2002). Labiaplasty also helped relieve physical discomfort experienced by, to some extent, all participants, which had a positive impact on their body posture and movement, as well as on their lifestyle and the ability to wear tight clothes or easily use tampons during menstruation. With regards to changes experienced in the sexual realm, it remains unclear to what extent labiaplasty had an impact on participants’ sexual functioning. Although two participants revealed that their sex lives had improved post-surgery, only one participant encountered specific changes related to natural lubrication, self-pleasure and interestingly orgasm. Specifically, in relation to sexual outcomes following labiaplasty, one participant stated that prior to surgery she had difficulties with reaching an orgasm, which she attributed to the size of her labia. This would then suggest that labiaplasty may be conducive to women’s ability to orgasm more easily. Conversely, it would also imply that women with larger labia may find it difficult to climax. However, these speculations run against the currently available scientific knowledge on female sexual functioning.
Drawing on a large body of latest research on female sexuality, as well as her own data, sex researcher Emily Nagoski (2015) explores a myriad of ways in which women can reach an orgasm. Her research demonstrates that orgasm – an involuntary release of sexual tension – is a reflection of brain activity rather than a genital response. Namely, women report to have had an orgasm from direct genital stimulation (clitoral, labial and vaginal stimulation), extra-genital stimulation (breast, back, toe stimulation) and interestingly irrespective of body stimulation. With regards to women’s ability to orgasm through extra-genital stimulation, a pioneering research by social psychologist Hanny Lightfoot-Klein (1989) demonstrated that women who have undergone female genital mutilation (FGM) type III (the excision of the clitoris, labia minora and inner layers of the labia majora) still have an ability to experience orgasm. Lightfoot-Klein conducted a five year long ethnographic study in Sudan during which she interviewed more than three hundred Sudanese women, who have undergone FGM, about their sexual experiences. Noting the physical and psychological trauma experienced by women as a result of undergoing FGM, Lightfoot-Klein reports that nearly ninety per cent interviewed women said that they experience/d orgasm at various stages of their marriages. They did so through intercourse, but also by having their necks, breasts and thighs stroked and stimulated. Considering that many women in her study expressed satisfaction with their marriages and love for their husbands, the author concluded that mental and emotional factors play a primary role in eliciting orgasm in these women. Whilst Lightfoot-Klein’s findings challenged the notion that genital stimulation is a prerequisite for female orgasm, Gina Odgen’s (2007) research contested the notion that body stimulation of any kind is necessary for a woman to climax. Feminist sex researcher Ogden conducted laboratory research with women who were asked to bring themselves to an orgasm with and without touching, whilst having their physiological responses (blood pressure, pupil dilation and pain threshold) measured before and after they reported an orgasm, to verify that a climax. Ogden found that what Western sexology rendered as ‘spontaneous orgasm’ was not spontaneous at all, for it was deliberately and relatively easily inducted by women in her experiment. Her later research (ibid.) suggested that more than sixty per cent of surveyed women were able to experience a fantasy-stimulated orgasm, with no physical stimulation whatsoever and, interestingly, that such behaviour can be learned.
The research presented here therefore suggests that a woman’s ability to reach an orgasm may not be necessarily contingent on her genitalia (Nagoski 2015), her labia minora (Lightfoot-Klein 1989), nor is it exclusively confined to body stimulation of other kind (Ogden 2007). In the light of this cognition it can be questioned whether the size of participant’s external genitalia posed a restriction to her ability to experience an orgasm. Namely, previous research (Stofman et al. 2006) on women’s sexual functioning indicated that women experienced enhanced body image and sexual life – including an increase in the ability to orgasm – following a major body procedure such as breast augmentation or abdominoplasty. It was suggested that women’s higher self-esteem and self-confidence postoperatively may have translated into heightened sexual esteem, sexual proactivity and ultimately sexual satisfaction. Taking that into account, it could be hypothesized that an improved body image and genital appearance satisfaction following labiaplasty may have had a knock-on effect on participant’s sexual functioning, including the ability to orgasm. This would also be in line with the research on appearance-based spectatoring (Cash et al. 2004, Meana and Nunnink 2006, Pascoal et al. 2012, Wiederman 2011), for the cognitive distraction experienced during sex due to genital appearance dissatisfaction and anxiety may have precluded the participant’s ability to experience sexual enjoyment. Another issue that may have affected participants’ ability to orgasm is related to contextual and emotional factors. Women are reliably more orgasmic within committed relationships than through casual sex, i.e. hook-ups, as a large mixed-methods U.S study demonstrated (Armstrong et al. 2012). The authors of this study also suggested that female orgasm is more common in relationships due to the presence of more sexual practices conducive to women’s orgasm (e.g. oral sex). An exploration of possible discrepancy in participants’ ability to orgasm in steady relationships in contrast to casual sex prior to their labiaplasties – as well as the quality of these relationships and the type of sexual play – was beyond the scope of the study. In sum, although the findings of this study related to sexual outcomes post-operatively are positive and thought-provoking, it cannot be easily inferred that labiaplasty enables women to orgasm more easily without accounting for personal, contextual and emotional factors.

However, it is interesting to note that those participants who had not yet been sexually active post-surgery at the time of the interview expressed positive
expectations. Considering that labiaplasty appeared to have addressed genital appearance dissatisfaction experienced by all participants, and the aforesaid dissatisfaction used to manifest as genital appearance anxiety during sexual relations, it seems sensible to assume that an improved body image may have a knock on effect on participants’ sexual functioning. Namely, a large body of research (Cash et al 2004, Meana and Nunnink 2006, Pascoal et al 2012, Wiederman 2011) demonstrates that women with body image issues tend to monitor their bodies during sexual encounters and engage in appearance-based spectating, which impedes their ability to fully immerse themselves into the moment and experience sexual pleasure. All of the participants expressed their previous concerns about their genital appearance, and some participants engaged in specific behaviours during sexual intimacy in order to minimize the attention devoted to that part of their body. Since all of these aforementioned issues constitute appearance-based spectating, it seems plausible to assume that an enhanced body satisfaction following surgery would translate into decreased self-consciousness and heightened sexual satisfaction. More research on the subject is necessary in order to determine to what extent a genital cosmetic surgery affects women’s sexual functioning, and whether other non-surgical means can be employed to yield the same outcome. Furthermore, in relation to changes following surgery, the findings also indicated that labiaplasty resulted in experienced personal happiness for all participants, which is consistent with other research on the effects of female cosmetic surgery (Davis 1991, 1995, Gimlin 2000, 2002). Lastly, it was indicated that three participants do not intend to have any (major) cosmetic procedure in the future, whereas two participants plan to undergo a breast augmentation. One of these, however, is a result of the participant’s first breast augmentation that did not yield a desirable outcome. Again, considering the small sample, it is almost impossible to ascertain to what extent one cosmetic surgery normalizes body alteration as such. However, it can be suggested that the participants in this study experienced labiaplasty as a constructive and rational solution to their long-standing problem.
9.2.3. FOCUSED DISCUSSION: GENDER, LOOKS AND CULTURE

The fourth and final subsidiary question was the following: What are participants’ views on gender norms pertaining to physical appearance in the contemporary Western culture? An exploration of participants’ views on gender, physical appearance and the contemporary Western culture was necessary in order to examine their relatedness to the socio-cultural environment that may have shaped their views of gender-appropriate norms, practices and relations, and thus may have informed their decisions to undergo labiaplasty. Insomuch, this exploration provided an important backdrop against which participants’ decisions to have labiaplasty may be viewed and analysed. The findings suggested that the participants were conscious and largely critical of gender inequalities pertaining to physical appearance present in the Western societies. Interestingly, it appeared that those participants who had not been living in their countries of origin, and who thus had the experience of migration, were also most critical of the aforesaid gender inequalities. It is plausible that the ability to inhabit more than one society provided those participants with the valuable cross-cultural experiences of gender dynamics. Nonetheless, the findings indicate that all participants were aware and predominantly critical of the societal and cultural pressure to look beautiful experienced by women in the Western world. This conclusion therefore supports some of the previous and arguably more liberal feminist research on female body work and cosmetic surgery (Davis 1991, 1995, Gimlin 2000, 2002, Kaw 1997).

Specifically, most participants in this study asserted that women are expected to meet the impossible beauty standards, which in their view is the reason why cosmetic surgery is a gendered issue. These findings largely coincide with the central premise of this research, elaborated on in chapter one, which is that women’s attentiveness and investment in their physique is a direct result of social and cultural conditioning. It was indicated that women’s investment in their physical appearance may be undertaken to heighten their desirability, self-confidence, respect acquired from other people and ultimately social visibility. The empirical findings of this study therefore concur with the theoretical findings of this research. For instance, it could be argued that women’s desirability and social visibility is an important incentive underlying their
adherence to dominant beauty norms (as per Wolf 1991). Women’s desire to be desired may be viewed as a direct result of asymmetry in sexual education, wherein men learn to desire women and women learn to be desired by men. Consequently, both men and women are taught to eroticize women’s bodies, and women’s sexuality becomes confounded with beauty. Similarly, women’s choices to engage in ongoing body work may be driven by the threat of becoming invisible, which may suggest that women’s preoccupation with the aesthetics is a means of maintaining their social visibility and livelihood (Ibid.). It may be valuable to clarify that the threat of becoming invisible emerged in the interviews when participants reflected on the gendered practice of cosmetic surgery, and why women undergo medical intervention for aesthetic purpose in general. Specifically, some participants speculated that women undergo cosmetic surgery in order to maintain their visibility in the society, and therefore acquire respect and recognition. Therefore, the threat of becoming invisible is a possible explanation to why women undergo face and body cosmetic surgery in general, as opposed to an explanation why participants in this study had labiaplasty – for they largely had the surgery to blend into the wider social structure. This arguably demonstrates how women’s motivations for cosmetic surgery may be rather complex and even contradictory, depending on the ‘visibility’ of the procedure they are undergoing. In relation to the identified pressure to be beautiful, one participant suggested that women tend to internalize the aforementioned pressure, and thus engage in ongoing body work without fully comprehending where that desire stems from. This assertion concurs with the work of Fredrickson and Roberts (1997) who contend that socialization in a culture that rewards female adherence to dominant beauty norms with social, economic and symbolic capital results in self-objectification. Specifically, women become acculturated to internalize the observer’s perspective as a primary view of their physical selves, and learn to treat themselves as objects evaluated on their physical appearance. Objectification theory thus may explain how women’s seemingly autonomous desire to engage in body work may be rather viewed as a result of internalized societal norms. However, this view was expressed only by one participant and, considering the small sample size in this study, it is impossible to draw any substantial conclusions.

In addition to the identified pressure to be beautiful, the findings indicated that almost all participants were aware of double standards pertaining to male and female
physical appearance. Namely, there was a common understanding that the society responds to female and male physical attractiveness and a lack thereof in profoundly different ways, for it sanctions female yet tolerates male physical imperfections. For instance, several participants underscored the double weight standard, whereby female thinness is a social imperative yet no such expectation is placed before men. This is in accordance with previous research on gender and weight. For instance, Judge and Cable (2010) demonstrate that consistent depiction of thin women in the media as more attractive than women of normal weight leads to a normalization and enforcement of this ideal. Consequently, women’s failure to meet this societal norm results in, among other things, financial penalties—female thinness is rewarded with a higher income, whilst men’s earnings increase up to the point of obesity. Similar correlation between gender, weight and income was identified by other researchers (e.g. Gregory and Ruhm 2009). On top of that, studies have shown that overweight women are socially stigmatized due to their perceived flawed morality, in a way that men are not (Fallon 1990, Quinn and Crocker 1999). The findings indicated that most of the participants were critical of the mainstream media, particularly women’s magazines and reality TV shows, which in their view have a negative effect on women’s body image. This conclusion is unsurprising considering the relevant cross-sectional, longitudinal and cross-cultural studies on detrimental effects of Western media content on female body satisfaction (Hargreaves and Tiggemann 2004, Swami et al. 2010, Fredrickson and Roberts 1997, Roberts and Gettman 2004). Furthermore, this study also suggested that cultural differences pertaining to gender account for gender-differentiated approach to body. This was particularly evident in the reflections of those participants that had the possibility to inhabit more than one society. It could be speculated that those participants’ experiences of migration provided them with a cross-cultural perspective on gender and female body work. This may capture the interplay between the culture under which an individual operates, and the individual’s intrinsic attitudes and beliefs that are very much a product of that same culture (as per Anderson-Fye 2011).

Although participants’ views on pornography were not intentionally investigated in the study, three out of four participants expressed their dissatisfaction with the manner in which women’s bodies are portrayed in pornography, as well as the way pornography depicts sexual relations between men and women. It could be inferred that these may
be the reasons why some participants in this study avoid pornography. This inference would be in line with research conducted in the U.S., which consistently shows that men tend to use pornography more than women and women tend to feel more negatively about pornography than men (Stewart & Szymanski 2012). For instance, a survey by Lottes and colleagues (1993) examining young adults’ attitudes about pornography found that, in contrast to men, women more often believed that sexually explicit materials are harmful and should be restricted. Shaw (1999) suggested that women’s reactions to pornography, especially violent one, were consistently negative because pornography had a negative effect on women’s identities, women’s relationships with men and men’s views on women. Interestingly, the study found that many women felt that their opinions were somehow not legitimate, and therefore the identified resistance to pornography was often muted. A more recent survey by Carroll and colleagues (2008) on pornography acceptance among young adults found that two thirds of men and one half of women found pornography consumption acceptable, and nearly nine out of ten men yet every third women reported using it. Researchers (Stewart & Szymanski 2012) suggested that women hold more negative attitudes towards pornography possibly because women in heterosexual pornography are often portrayed merely as objects for men’s sexual pleasure and immediate gratification.

Another issue of concern related to sexual objectification of women in pornography is the incidence of sexual aggression against women. Indeed, this was precisely highlighted by one participant in this study, who asserted that the widespread availability of aggressive male-centred pornography indicates that we are still in ‘dark ages’. This participant also highlighted that we are yet to facilitate on open discussion about aggressive pornography, for the issue is still a taboo. The increasing incidence of aggressive pornography has been reported by feminist social scientists (as per Dines 2012, Jensen 2007) and social psychologists (e.g. Bridges et al. 2010). To illustrate, the first empirical study to tract the increasing portrayal of aggressive and degrading sexual practices in heterosexual pornography is that of Ana Bridges, a psychologist who specializes in pornography consumption, and her colleagues (2010). The authors analysed thirty best-selling and most-rented videos – more than three hundred pornographic scenes – published by Adult Video News, the leading American pornographic trade journal. The results demonstrated that women were
physically aggressed against in almost ninety-five per cent of all scenes, by being subject to spanking, gagging and open-hand slapping. Hair-pulling and choking were also identified, but to a lesser extent. In almost every other scene a woman was subject to verbal aggression, mainly name-calling. In seventy per cent of scenes the perpetrators were male (male-to-female aggression) and in almost twenty per cent of the remaining scenes the perpetrators were women (female-to-female aggression). In contrast to that, female-to-male aggression featured in only four per cent of all scenes. Women overwhelmingly expressed pleasure or responded neutrally to physical and verbal aggression (ninety-six per cent). With regards to types of sexual acts, scenes most often portrayed fellatio, vaginal intercourse and anal sex, whereas a high incidence of ‘non-normative’ sexual acts encompassed ass-to-mouth sequence ‘ATM’ (a woman performs oral sex on a man immediately after he penetrated her anally) and double penetration ‘DP’ (two men simultaneously penetrating one woman vaginally and/or anally). Importantly, the authors found that the type of sexual activity is related to the incidence of aggression, since women were most likely to be physically and verbally aggressed against in scenes that depicted fellatio, vaginal/anal intercourse and most importantly ‘ATM’. Men almost always ejaculated outside a woman’s vagina, most frequently in her mouth. In sum, this study was the first to track an increasing portrayal of sexual practices that are humiliating and harmful to women. This research however focused on adult videos that could be rented or purchased. A level of evidence suggests that Internet transformed pornography, for the availability and accessibility of online pornography (primarily gonzo pornography), coupled with user’s anonymity, led to a demand for more rough and degrading sex (Dines 2010, Jensen 2007).

It is therefore unsurprising that prominent feminist anti-pornography activist Gail Dines (2010) asserts that in mainstream pornography men *make hate* to women. Dines asserts that pornography represents women as always available for sex regardless of how painful, humiliating or harmful the act may be; without sexual agency of their own evident in the fact that they rarely expect of demand reciprocity and pleasure; and content to have sex with men who express contempt and hatred for them through verbal and sexual violence. She traces male inclination towards aggressive sexual behaviour to cultural socialization and traditional masculine norms, which render men dominant, aggressive and unfeeling. Her argument concurs with
the empirical study of Mahalik and colleagues (2003), explored in chapter two, which identified dominance, power over women and emotional non-expressiveness as traditional masculine norms – conversely associated with men’s inclination towards women’s rights and gender equality. On the other hand, Dines asserts that increasingly narrow images of femininity promote an excessive emphasis on women’s appearance and the body, and therefore celebrate female hyper-sexualisation as pseudo-empowerment. This assertion overlaps with the findings of Mahalik’s study of feminine norms (2005), which indicated that investment in physical appearance and the body are the pillars of contemporary femininity – yet negatively associated with adherence to feminist ideals and thus gender equality. Since pornography does not stand outside culture but it is very much embedded in the structure, then the sexualized aggression and violence against women in pornography may be viewed as an (extreme) extension of cultural socialization induced, sustained and reinforced by strict adherence to traditional gender norms. Put differently, femininity and masculinity as codes for subordination and dominance (as per Jeffreys 2005) play out in a pornographic context. This is why feminist anti-pornography activist Robert Jensen (2007) contends that pornography is a mirror that shows how men – who accept the conventional conception of masculinity – see women. A detailed feminist critique of pornography and sexual is beyond the scope of this study, but the findings indicated that some participants were discontent with the way pornography depicts sexual relations between men and women, and ultimately women themselves.

This research also explored participants’ desire to assert their autonomy within the given socio-cultural environment characterised by gender inequality. This seemed to be most evident in the way they distinguished labiaplasty from other body cosmetic procedures, which thus yielded a related distinction between visible-invisible, healthy-plastic and importantly for myself-for men dichotomies. Specifically, the findings captured participants’ assertion of autonomy and agency reflected in a powerful and yet symbolically loaded expression: ‘for myself’. All participants argued that they had not undergone labiaplasty in order to please their husbands, boyfriends or the society, but to address a range of issues caused by their labia and therefore improve their physical, mental and emotional well-being. In other words, notwithstanding the restrictive social and cultural structures that they were conscious of, participants in
this study concluded that they had labiaplasty ‘for themselves’. Women undergoing cosmetic surgery ‘for themselves’ is a reoccurring theme in feminist research on women’s experiences of face and body elective procedures (Davis 1991, 1995, Gimlin 2000, 2002, Parker 2009, Kaw 1997).

However, the very notion of undergoing cosmetic surgery ‘for oneself’ does not preclude any criticism. Namely, it appears that no external pressure to undergo labiaplasty was present in any of the accounts – if anything, participants were often discouraged by their male partners from having the procedure. However, what did feature in all accounts was an external gaze that the participants felt subject to in social situations in which they had to take their clothes off. It seems that although participants had not been under any identifiable pressure to undergo a surgical intervention, their choices did feature a strong social component – a desire to attain a ‘normal’ genital appearance and blend into the wider social reality. If the social dimension of choice is taken into consideration – that women’s choices to alter their bodies are enmeshed and influenced by a specific cultural context – then women’s decisions to undergo labiaplasty may also be viewed as a product of structural and contextual constraints (Braun 2009). Within the neoliberal discourse women choosing to have cosmetic surgery may be seen rational, calculating and self-regulating individuals making informed choices, yet these choices are not socially and culturally dislocated. This argument was put forward by Gill (2007) who problematizes the notions of agency, autonomy and choice, and their relationship to feminism. Gill’s argument is somewhat similar to that of Braun (2009), Parker (2009) and even Jeffreys (2005) insomuch as it views women’s choices to engage in body work as socially and culturally embedded. Considering that women are expected to live up to ever narrower judgements of female attractiveness, and their bodies are routinely monitored, surveyed and disciplined, Gill argues the relationship between the psychic and the social or cultural needs to be taken into consideration. Yet, fetishisation of autonomous choice may overlook the internalization of socially constructed ideas of beauty (as per Fredrickson and Roberts 1997).

In this study of women’s experiences of labiaplasty, the social aspect of choice is also evident in the pursuit of a ‘normal’ genital appearance – for all participants appeared to believe that their labia was somehow not ‘normal’. However, the notion of
‘normalcy’ pertaining to human bodies is a socially and culturally positioned, and historically dependent construct. Braun (2009) asserts whilst women who undergo cosmetic surgery are often represented as rational agentic subjects making individual choices, these choices however are going towards the socially and culturally defined norm. In that context, cosmetic surgery may become an instrument for defining and achieving ‘normality’ and therefore eradicating diversity and difference among women (Ibid.). Similarly Gill (2007) wonders if there is a disproportionate emphasis on women pleasing themselves though body work, for the look they achieve is very similar. In other words, she contends that if women’s choices to attend to their bodies were the outcome of their idiosyncratic preferences, then they would have resulted in a greater diversity. A further problem with deconstructing women’s choices to undergo cosmetic surgery is that an evocation of the rhetoric of ‘choice’ may silence a critical discussion and interrogation of the aforementioned choice. Ferguson (2010) contends that ‘choice feminism’ is a political attempt to escape the dilemmas of feminism in our personal lives, and therefore make feminism more appealing to wider audiences. It is utilized to sidestep the need to make a judgement about women’s choices – to depoliticise that which is personal. In that process ‘choice feminism’ omits to differentiate between who can and who cannot choose. For instance, whilst labiaplasty was a choice exercised by women in this study, it was an expensive choice that could not be easily exercised by just any woman. Even the participants in this study underwent labiaplasty only after they were able to meet the financial cost of the surgery, which significantly prolonged their deliberation. Further, Ferguson (Ibid.) contends that since choices are individual and they apparently have no social consequence, women are therefore relieved of responsibility for considering the broader implications of their decisions. This assertion could be linked to that of Braun (2009) who contends that cosmetic surgery eradicates difference and diversity among women. Normalization of surgical intervention for aesthetic purposes may have broader implications for the social standing of women – those repercussions may not be evident just yet, but they may be experienced by generations of women to come.

Is it possible to explore the notion of agency from a different angle? Perhaps participants’ assertion of autonomy – as in I did it for myself – may be viewed as an attempt to reclaim their subjectivity in a socio-cultural context that routinely objectifies
women’s bodies. Young (1980) for instance asserts that women’s bodily experiences in patriarchal societies are characterised by a dichotomy, for women live their bodies as subjects and objects at the same time. Young contends that patriarchal society defines women – subjects – as bodies – thus objects – which results in women’s self-consciousness about their experiences of embodiment. This view was further reinforced by Fredrickson and Roberts (1997). They argue that women become acculturated to internalize the observer’s perspective as a primary view of their physical selves, and learn to treat themselves as objects evaluated on their physical appearance. This self-objectification is associated with heightened self-consciousness and negative mental health outcomes. In this study women often sought labiaplasty to address genital appearance anxiety and address feelings of discontentment, self-consciousness, shame and arguably inadequacy (i.e. feeling ‘abnormal’) caused by their larger labia. All of them expressed their satisfaction with the procedure and the physical and psychological outcomes post-operatively. Could then the eliminated or even alleviated negative mental health issues post-surgery enable women to live more ‘fully’ as subjects, for they no longer engaged in habitual body monitoring? Could their (heightened) agency become evident in the way their experiences of embodiment no longer negatively affect and restrict their lives post-operatively? In other words, could it be beneficial to move beyond the subject-object dichotomy and view the body as an event?

Budgeon (2003) argues for a development of an approach that envisions a body beyond the binary of materiality and representation. On this arguably alternative view, cosmetic surgery may be understood as a means to transform the way in which the body is lived. Changing the body through surgical intervention may allow the self, which has become more confident, to enter situations with an increased sense of efficacy. Therefore, cosmetic surgery is about looking, but also about doing. This issue appeared to be most evident in the way participants reflected on their lives post-labiaplasty and how the surgery changed their lives for the better. It enabled them to sit down without having to consistently ‘adjust’ themselves; it allowed them to wear tight clothes without experiencing uncomfortable ‘rubbing’; it permitted them to wear tampons when did not want to wear menstruation pads. Labiaplasty also made them less self-conscious when they had to take their clothes off in social situations, such as when on the beach, in front of friends or during sexual intimacy. Could this
increased social confidence enable them to go to the beach more frequently, to disrobe in the shower when on a ‘girls’ weekend’ without feeling ashamed, or to more fully immerse themselves in sexual pleasure for they no longer engage in appearance-based spectating? Put differently, could a body change result in a series of life changes – those that may appear small, but that add up to something significant and meaningful? Could one view body as an event constantly in the process of becoming – in a process of transformation that enables a different, more diverse and possibly expanded way of living? This (rhetorical) question does not seek to bypass the complexities and contradictions inherent in a critical examination of cosmetic surgery. Rather, it aims to incite a different way of thinking – that which may help us achieve a more comprehensive understanding of why women undergo cosmetic surgery. In conclusion, it appears that women’s choices to undergo labiaplasty were largely informed and arguably brave acts of individual women seeking a solution to their long-standing problem. Women in this study appeared to be conscious and critical the constraining context in which their choices to have labiaplasty were formed. Even though women in this study did not appear to be a part of a counter-culture (such as body positivity or body neutrality) that aims to challenge dominant beauty norms pertaining to female bodies – and therefore the aforesaid constraining context – they chose to actively operate within the given socio-cultural environment largely aware of the omnipresent gender inequality.

9.3. METHODOLOGICAL CONSIDERATIONS

The qualitative phenomenological and woman-centred methodological approach in the study of women’s experiences of labiaplasty had been chosen for its anticipated value and contribution. However, in the course of the research some methodological issues inevitably arose. This section therefore reflects on the strengths and weaknesses of the chosen methodological approach. To date studies on female genital cosmetic surgery have been primarily conducted by the international medical community adopting largely a quantitative approach. This study therefore aimed to fill the identified gap in the body of knowledge pertaining to this issue. A qualitative approach rendered this project epistemologically open, flexible, adaptable, and
tolerant to a non-linear research process (Creswell 2007, Neuman 2007, De Vaus 2001). This study was also informed by feminist research principles that are apparent in the exploration of a gendered issue such as cosmetic surgery, the use of interviewing technique that gives voice to women and brings their experiences forward, researcher’s acknowledgment of her own positionality in relation to the study, and the overall aim of the study that ultimately encourages female empowerment (Cancian 1992). In addition, this thesis argued that the most accurate way to analyse social reality is by taking the underprivileged – women’s – experiences as the starting point of the inquiry, for their position enables them to perceive the world more clearly. Although their vision of social reality may still be ‘partial’, this thesis argued that ‘value-free’ and thus ‘objective’ knowledge is unattainable (Harding 1991 Haraway 1988, Hartsock 1983, Smith 1974, Narayan 2008).

Phenomenological approach was chosen in order to position subjective experience at the centre of the inquiry, and to acquire an in-depth understanding of labiaplasty as experienced by individual women. Considering that Interpretative Phenomenological Analysis (IPA) is appropriate for researching complex yet intersecting issues including gender, sexuality and body image (Smith 2010), this innovative qualitative framework was adopted. It facilitated flexibility, accessibility and freedom to uncover concepts that would otherwise remained concealed. IPA was especially suitable for this study for its ‘person-in-context’ perspective and the belief that people’s relatedness to their socio-cultural environment is an essential part of their constitution. The primary data collection method included semi-structured interviews with five adult women. The small sample size in line with the guidelines of IPA (Smith and Osborn 2007) for it seeks a rich and multi-layered account of women’s experiences of labiaplasty. The data collection technique included face-to-face and phone interviews, which is again in accordance with the guidelines of IPA and feminist research principles. It enabled the researcher to facilitate rapport and trust with the participants, which is of vital importance for conducting so called sensitive research (Liamputtong 2007), and this arguably translated into an in-depth exploration of participants’ accounts.
However, what appeared to be the greatest challenge encountered in the research process was the exceptional sensitivity of the subject matter. Labiaplasty has proven to be an extremely difficult issue to research, considering that neither the service providers nor the service users were very keen on partaking in the study. Twenty-six different attempts mainly in Ireland and the UK over the twenty-month period finally resulted in one positive reply and five study participants. All clinics that offer labiaplasty were sent a research pack containing hard copies of the research material, including the *Introduction Letter* tailored for each clinic, *Information Leaflet for Study Participants* and *Consent Form*. The research pack was followed up by emails and phone calls in order to ascertain whether the materials have been received and if the clinic wanted to partake in the study. It appeared that the elusiveness of the research topic reflected negatively on the participant recruitment process and made the data collection process immensely difficult. Although a small study sample was expected and sought-after, it was also a reflection of the obstacles faced in the process of recruitment. Therefore the small sample size posed limits to the generalizability of the findings of the study, and the conclusions could not be easily extended to the population at larger.

Another unanticipated outcome of the challenging participant recruitment process was the cross-cultural nature of the study. The composition of the sample included women of various cultural backgrounds and it is not known whether, and to which degree, the standard variation in female genital anatomy varies across societies. Thus it remained unknown whether women of specific ethnic backgrounds may have comparatively larger or smaller labia, and thus they may be more or less predisposed for labiaplasty. Finally, the data collection technique may have had an impact on the final outcome of the study. Only one interview was also a face-to-face interview, whereas all the others were conducted over the phone. The face-face interview was significantly longer and more detailed than the phone interviews, for it appeared to have facilitated trust and rapport that surpassed the closeness established over the phone. Consequently, it felt appropriate to ask questions of a more personal nature and these were addressed by the participant in great detail. Such personal questions were sometimes not asked during the phone interviews due to a concern that the questions may come across as intrusive and may result in participants' withdrawal from the project. It could be therefore assumed that the data collection method may
have had implications for the findings of the study. However, one could also speculate that the opportunity to partake in a phone interview provided participants with another layer of anonymity – which would have been absent during a face-to-face interview – and therefore resulted in their willingness to participate in this project. Lastly, it is unknown to what extent did cultural differences and personal characteristics account for the variety in the length and detail of participants’ responses.

9.4. CONTRIBUTION OF KNOWLEDGE

This study is original and timely for it employs an innovative qualitative methodological approach and a woman-centred perspective in exploring a novel body procedure in the field of cosmetic industry. The detailed literature searches have indicated a significant research gap in the body of knowledge pertaining to female genital cosmetic surgery and labiaplasty specifically. Namely, this thesis documented very limited data on female genital cosmetic surgery, an absence of qualitative studies on this subject, and finally a lack of qualitative research on the identified issue conducted from a feminist perspective. It was speculated that these research gaps could be due to the novelty of the procedure, the sensitivity of the subject matter, and the absence of regulation and audit of the private market in which the vast majority of genital elective procedures take place. This research however managed to break the silence and bring women’s voices and experiences of the increasingly popular genital cosmetic surgery forward. In doing so, not only did it provide a significant contribution to the body of knowledge pertaining to female body work and genital cosmetic surgery, but it provided a much needed qualitative analysis of women’s experiences of labiaplasty aided by emancipatory feminist research principles. This study filled the identified gap in knowledge between predominantly quantitative studies on female genital cosmetic surgery conducted largely by the international medical community, and qualitative studies on other female cosmetic procedures conducted by feminist scholars. This empirical study has therefore made a valuable contribution to the existing scholarship on female body work and labiaplasty specifically, and the gender and feminist fields within academia.
This study may also yield a positive impact on the cosmetic industry and the developing cosmetic gynaecology in the Western societies. Due to the aforementioned lack of social and feminist research in the field, cosmetic gynaecology is still an unexplored dimension of cosmetic industry. Elucidating the motivations for, as well as the experiences and outcomes of labiaplasty, this study has provided an in-depth exploration of female genital dissatisfaction and modification. This in turn may be very useful for those concerned with the cosmetic industry, including service users and service providers. Expanding on the main findings generated in the course of the research process, this project provided an important platform for the application of accumulated knowledge pertaining to the issue. Namely, drawing on the conclusions of the study, important suggestions have been made for prospective patients – women seeking labiaplasty – and those who provide it – aesthetic plastic surgeons. By consulting this study, the prospective patients may easily access the findings and reach a detailed understanding of what the experiences of labiaplasty have been for several individual women. In doing so not only may prospective patients gain a thorough understanding of the surgery, recovery process and the possible outcomes and impacts on one’s body image, physical functioning and sexual pleasure, but they may also learn from participants’ experiences and implement the currently available knowledge. The service providers on the other hand may deepen their understanding of the desirable nature of the patient-surgeon relationship, from patients’ perspectives, and the required level of care. This could consequently have a positive impact on practitioners’ professional success, for the present knowledge may further furnish their understandings of prospective patient’s needs and wants. Ultimately this could result in a greater number of satisfied patients and practitioners.

Finally, another contribution resulting from this study is evident in a creative application of a relatively new yet growing data analysis framework. Interpretative Phenomenological Analysis (IPA) is a variation of a phenomenological approach that had been developed only in the early 1990s in the UK. Emanating originally from psychology, this approach has become an increasingly popular qualitative method primarily in health and social research. Chosen for its flexibility, adaptability and the propensity to explore participants’ experiences of a particular phenomenon in depth, IPA has provided a useful methodological framework for successfully addressing the
identified research problem. This study therefore adds to the already growing social scholarship that employs this specific methodological approach, and it specifically makes a contribution in adding to the currently scarce feminist studies of body work that adopt this framework. It can be further argued that the application of IPA has provided the much needed freedom in the data collection process, and insomuch enabled an open exploration of women’s lived experiences of labiaplasty. Some of these identified issues may provide a beneficial starting point in further examination of female genital dissatisfaction and subsequent modification, and therefore widen and deepen the extant knowledge on this subject matter.

9.5. RECOMMENDATIONS FOR CLINICAL PRACTICE

Taking into considerations the small sample size, which is in accordance with the guidelines of IPA, the conclusions of the study should not be generalized without caution. Nevertheless, based on this empirical study of women’s experiences of labiaplasty, the following recommendations for service users and service providers may be provided. The recommendations for service users are not only a reflection of the results of this research, but moreover these are based on participants’ advice to women who may be considering labiaplasty. Namely, towards the end of the interview all participants were asked which advice would they give to other women who are contemplating the same surgery. Their suggestions are captured in this section not only for these may prove to be very beneficial to prospective patients, but furthermore because taking women’s voices into consideration is an essential aspect of feminist research principles.

9.5.1. RECOMMENDATIONS FOR SERVICE USERS

What appears to be the central element in deliberating about labiaplasty is a patient's comprehensive understanding of the surgery including the risks, complications and outcomes associated with it. This underlines the importance of primarily Internet research, which can be a most useful first step in locating the necessary information.
Specific web sites on cosmetic surgery provide the relevant information pertaining to labiaplasty, as well as reviews and occasionally photos of patients who had undergone that very procedure. Previous patients’ feed-back may be a valuable opportunity for prospective patients to familiarize themselves with the surgery and the outcomes.

Before proceeding with the surgery, it may be worthwhile to double-check with oneself the motivations for undergoing labiaplasty. Namely, could some of the reasons for labiaplasty be addressed in a non-surgical way? Specifically, could physical discomfort due to labia be addressed via simple lifestyle changes? In relation to genital appearance dissatisfaction, it may also be useful to consult different sources that depict external female genitalia, in order to familiarize oneself with the standard variation in female genital anatomy. For instance, *The Great Wall of Vagina* (2017) is an outstanding art project that captures four hundred plaster casts of vulvas and therefore demonstrates how diverse female external genitalia really is.

In sum, it is necessary that the woman is fully aware of her motivations for the procedure and happy to address these via surgical means.

Internet research is not only helpful in reaching a detailed understanding of labiaplasty, but furthermore it may be a useful tool in locating the right plastic surgeon. When considering one specific surgeon, it may be advantageous to seek online feed-back and reviews from patients’ who have previously collaborated with that practitioner. An initial consultation with a potential practitioner should provide additional information not only about the surgery, but about the person who performs it as well. The qualities that appeared to be most desirable in a potential practitioner included previous experience and expertise in the field, helpfulness, understanding, compassion, kindness and a friendly manner. The gender of the practitioner may also matter to some patients. The initial consultations therefore may provide a great opportunity to evaluate whether one feels comfortable with their choice of the plastic surgeon.

Closely related to the importance of locating the right practitioner, is the imperative of direct communication with the chosen practitioner. The ability to communicate openly and honestly with the one’s practitioner is of a paramount importance. It is necessary
to ensure that the patient and the practitioner share a common understanding of the outcome of the surgery. If necessary, it is advisable for a patient to seek further elaborations from their potential practitioner with regards to the results of labiaplasty. These may often include before and after photos of previous patients, computer imaging or simply drawing. These methods may reduce or fully eliminate the possibility of attaining an outcome that had not been anticipated.

Following labiaplasty, it would normally take about four to six weeks for the body to fully recover from the surgery. During this time it is advisable to fully adhere to the practitioner’s advice with regards to healing, which often includes the importance of hygiene, gentle physical activity and abstinence form sex. Drawing on experiences of participants in this study, it is also advisable not to worry (excessively) about the outcome of the surgery while the body is still healing, for the final result will be rather different once the labia is no longer swollen. The external use of diluted violet essential oil may be beneficial during the recovery process in case of itching. In sum, proper after-care and reduced anxiety over the outcome of labiaplasty are conducive to a quick and straightforward recovery.

To summarize, based on the findings of this research the recommendations for service users include:

1. A conduct of a comprehensive Internet research to acquire an in-depth understanding of labiaplasty including the risks, complications and outcomes associated with the surgery.
2. An examination of one’s motivations for the surgery including potential non-surgical means of addressing the identified issues.
3. A thorough Internet research of potential plastic surgeons that perform labiaplasty in order to locate a practitioner that is experienced, skilful and kind to their patients.
4. An establishment of direct and honest communication with the chosen practitioner in order to ensure a common understanding of the outcome of the surgery.
5. An adherence to practitioner’s guidelines in relation to healing post-surgery in order to ensure a quick and straightforward recovery.
9.5.2. RECOMMENDATIONS FOR SERVICE PROVIDERS

The recommendations for service providers resulting from this research in some instances overlap with recommendations aimed as service users. An important issue pertaining to the doctor-patient relationship is direct and comprehensive communication. It is necessary that the practitioner and patient have a shared understanding of not only risks and complications, but also the final outcome associated with the surgery. In order to negotiate the outcome the practitioner may wish to utilize before and after photos of their previous patients, computer imaging, drawing or any other creative strategy that will help resolve any dilemmas that the patient may have. When it comes down to deliberation about the final outcome of the surgery, it is better to be safe than sorry.

Furthermore, in relation to patient-doctor relationship, the findings indicate that some patients may wish to engage in an ongoing one-to-one relationship with their plastic surgeon and therefore avoid any dealings with support staff such as nurses. Specifically, some patients may wish to be seen by their practitioner after the surgery during the follow-up consultations. This may be due to previously established trust and rapport with the surgeon, but it also may be useful in order to personally address any issues that may have resulted from the procedure. Not all patients wish to be consistently seen by their chosen practitioner, however in some patients the absence of the aforesaid may result in dissatisfaction with the service. Therefore the practitioners could improve their patient’s satisfaction by utilizing a tailored approach to each patient, for individualized care will arguably result in higher patient satisfaction and may positively reflect on practitioner’s professional credibility.

Lastly, drawing on participants’ expressions of the desirable qualities in a plastic surgeon, it could be suggested that practitioners who engage in ongoing professional and also inner development will attract more prospective patients and successfully retain the present ones. The qualities that patients seek in their practitioner are professional expertise and previous experience in relation to the specific surgery, understanding and sympathy with regards to patients’ motivations for the procedure, and importantly a friendly and kind manner devoid of a power gap and practitioners’
assertion of authority often present in doctor-patient relationships. It is therefore advisable that the practitioners develop and display these attributes and behaviours in order to attract new clients and keep the present ones content with the service.

To conclude, the recommendations for service providers include the following:

1. An establishment of open and comprehensive communication with the prospective patients in the attempt to ensure a shared understanding of the outcome of the surgery.
2. A commitment to an individualized care in order to meet the personal needs of each patient, and therefore to attract more prospective patients and successfully retain the present ones.
3. A development and presentation of professional and personal attributes that are perceived desirable by the patients, including expertise and experience, understanding and sympathy, as well as friendliness and kindness in their interaction with prospective and current patients.

9.6. IMPLICATIONS FOR FURTHER RESEARCH

The unfolding of this research raised several relevant issues whose exploration has proven to be beyond the scope of this study. However, these very issues may serve as a valuable starting point for future research pertaining to female genital cosmetic surgery. The first issue that emerged in the study of women's experiences of labiaplasty is related to 'normalcy' pertaining to female anatomy and physiology. If women chose to undergo cosmetic surgery in the attempt to reach physical 'normalcy' as this study and other relevant studies on this issue suggest (Davis 1991, 1995, Gimlin 2000, 2002, Parker 2009, Kaw 1997) than that begs the question – how do women’s perceptions of what constitutes a 'normal' female body come about? In other words, when it comes down to human and especially female bodies, what guides one's perception of 'normality'? How do women decide what constitutes a 'normal' body? Which sources do they consult in the process? Closely related is the issue of practitioners' perceptions of 'normalcy'. Specifically, to what extent do women's perceptions of 'normal' female anatomy match those of the international
medical community? When gaps with regards to understanding of ‘normalcy’ between patients and practitioners arise, how are these managed by the medical professionals? These are only some of the questions that would address an important issue of ‘normalcy’, which often seems to underlie women’s choices to undergo cosmetic surgery including labiaplasty.

Another issue that this qualitative study did not manage to address, for the research process would have required a significantly different methodological approach, relates to the biological variation in female genital anatomy prevalent across societies. In other words, one could wonder whether women of different ethnic backgrounds may also be shaped differently in the genital area, i.e. have comparatively smaller or larger labia. If there is an identified significant cross-cultural difference in female anatomy, is this difference inevitably correlated with the occurrence of female genital cosmetic surgery and labiaplasty specifically? Moreover, if there is a significant association between the size of women’s labia and the incidence of labiaplasty, can it be inferred that correlation immediately implies causation? Are there societies in which women with comparatively larger labia do not experience physical and sexual issues and closely related genital appearance dissatisfaction, and therefore do not require any labial surgery? Questions about the standard variation in female anatomy across cultures would probably require a large international study, but it would also potentially provide enlightening findings.

This study also suggested that women partake in social comparisons pertaining to female bodies, which may and often does have a negative effect on their body satisfaction. Present research indicates that White women especially tend to engage in social comparisons and express competitiveness and envy with regards to body-related issues (Franko and Roehrig 2011), as outlined in chapter two of this thesis. Black women on the other hand generally feel better about their bodies in comparison with White women, largely because they are more supportive of each other and tend to define beauty in ways which go beyond body shape and size. It would be interesting if this qualitative study was replicated in the Black community in order to ascertain whether and to what extent do social comparisons and competitiveness – that (White) women tend to engage in – drive the demand for genital alteration. Project such as that one would also explore the important interplay
between gender and ‘ethnicity’ and insomuch provide a valuable intersectional element in the study of female genital cosmetic surgery.

Another issue that was beyond the scope of this study is concerned with individual intrapersonal characteristics of women who seek cosmetic surgery. Namely, present research suggests that women who have a positive body image also share some common characteristics. Apart from the above mentioned ‘ethnic’ factor, body satisfaction in women is often associated with participation in sports (Petrie and Greenleaf 2011), older age (Grogan 2011), involvement in a monogamous romantic relationship (Meana and Nunnink 2006), media literacy and interestingly spirituality (Tylka 2011), as well as unsurprisingly feminist credentials that are largely evident in the belief that women’s normative body dissatisfaction is the result of cultural pathology, rather than individual pathology (Murnen and Seabrook 2012). In that context, a study of women’s individual characteristics and personal predispositions for elective procedures would be very beneficial, even more so if it encompassed a comparative analysis of individual characteristics of women seeking and women not seeking cosmetic surgery.

Lastly, female genital cosmetic surgery endorsed by the Western societies raises very controversial comparisons with female genital mutilation/cutting. The latter is an internationally recognized human rights violation for its documented detrimental effect on girls’ and women’s physical, mental and emotional wellbeing (WHO 2008). In the attempt to eradicate the practice, fifty-nine countries across the globe have implemented acts which criminalize it (UNICEF 2013). Notwithstanding important differences between the two, it could be argued that female genital mutilation/cutting and female genital cosmetic surgery may be somewhat comparable, for they are both cultural practices that include a medically unnecessary removal of female external genital tissue. What seems to be the most important issue that distinguishes between the two is the notion of informed consent (Braun 2009) – a woman’s knowledgeable and active agreement to have her external genitalia altered in accordance with her wishes. Therefore, what are the legal and moral implications of the developing cosmetic gynaecology in the context of simultaneous criminalization of female genital mutilation/cutting (as indicated by Essen and Johnsdotter 2004)? If one takes into consideration the relational – cultural – aspect of choice enmeshed in women’s
deliberation about genital cosmetic surgery, is informed consent enough to
differentiate between the two? Could female genital cutting migrate from an
underground prohibited practice into one easily undergone in a medical setting,
provided a woman’s informed consent? Furthermore, if a patient was not happy with
the outcome of her genital cosmetic surgery, could she hold her practitioner legally
accountable under the anti-female genital mutilation act? In sum, what are the
implications of developing cosmetic gynaecology for Western women, non-Western
women, but also Western practitioners?

To reiterate, based on the findings of this study and the above identified issues, the
following research questions may require further future investigation:

1. An exploration of women’s perceptions of ‘normalcy’ pertaining to female
genital appearance.
2. A cross-cultural examination of a biological variation in female genital anatomy
and appearance.
3. An investigation of women’s experiences of female genital cosmetic surgery
among Black women.
4. A comparative study of individual intrapersonal characteristics of women
seeking and women not seeking cosmetic surgery
5. An exploration of legal and moral implications of developing cosmetic
gynaecology in the context of criminalized female genital mutilation/cutting.

9.7. FINAL CONCLUSION

The concluding chapter of this thesis attempted to provide a thorough overview of
this entire project, and also a constructive reflection on the overall implications of this
research. It was demonstrated that this study answered the core question of what are
the experiences of women who have undergone labiaplasty by addressing the four
main objectives: the experience of the pre-operative phase, operative phase, post-
operative phase and by providing a discussion about gender, physical appearance
and the contemporary Western culture. The main findings of this study have been
carefully tied to the extant body of knowledge related to female body work and genital cosmetic surgery, and insomuch significant overlaps were identified as well as digressions from the currently available research. The chapter also captured the contribution of knowledge initiated by this project, which is primarily evident in plugging the identified research gap pertaining to elective genital procedures and thus making a significant contribution to the gender and feminist fields within academia. Furthermore, it is envisaged that this study may have a positive impact on the developing field of cosmetic gynaecology in the Western societies, by providing beneficial input for service users and service providers. The value of this research is also visible in its application of an innovative research framework, and thus adding to the number of IPA studies conducted from a feminist perspective. In relation to the latter, the chapter also reflected on the qualitative phenomenological methodological approach adopted in this study and its strengths – flexibility, epistemological openness, non-linear research process and the ability to elucidate the particular – and its perceived weaknesses including the small sample size, the data collection technique and the issues that had not been addressed for they were beyond the scope of the study. Based on the main findings, the chapter proposed which elements should be into consideration when deliberating about labiaplasty. The importance of patients’ careful examination of their motivations for labiaplasty was underlined, as well as their comprehensive understanding of the surgery including the risks, complications and outcomes. Recommendations were also made in relation to locating the right surgeon, establishing a constructive patient-doctor relationship, and with regards to after-care. The recommendations for service providers revolved around the importance of practitioner’s behaviour perceived as desirable by the patients in order to add to their service satisfaction. The importance of communication with prospective and current patients was stressed, and a commitment to an individualized care in order to meet patients’ needs and heighten their satisfaction with the service. Lastly, the chapter indicated that the issues that had not been addressed in this thesis may provide a valuable research platform for future research. These refer to women’s perceptions of ‘normal’ external genital appearance, biological variations in female genital anatomy and a possible variation in genital dissatisfaction across the ethnic boundaries. Further research is also necessary in order to determine which interpersonal characteristics may be associated with a request for cosmetic surgery, and what are the legal and moral
implications of cosmetic gynaecology in the context of criminalized female genital mutilation/cutting. These appear to be relevant issues that had also been beyond the scope of this study. In conclusion, this research suggested that women who opt for labiaplasty do so in the attempt to address genital appearance dissatisfaction and to improve their physical, emotional and mental well-being. Their decisions to undergo a surgical intervention are carefully thought-out and appear to be a constructive solution to otherwise distressing life circumstances. These individual decisions are however formed in a context of pervasive gender inequality, most evident in the socio-cultural pressure to look beautiful as experienced by women, and the related ever tightening concept of ‘normalcy’ pertaining to female bodies. Whilst women in this study appear to be largely conscious and critical of this identified injustice, they seemingly do not choose to challenge these socially, culturally and historically situated gender norms. They however choose to operate within the given socio-cultural framework and they do so knowledgeably, courageously and therefore – successfully.
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The Royal Australian College of Obstetricians and Gynaecologists RANZCOG (1997) “Female genital mutilation: Information for Australian health professionals”,


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Table 4: Overview of the private cosmetic clinics in Ireland and Croatia that provide sexual health services for women and labiaplasty respectively, contacted in July and August 2015 (p.127)

Table 5: Overview of the academics working in the field of body work and/or women’s sexual health, contacted from May 2015 to February 2016 (p.131)

Table 6: Overview of major theme one exploring participants' lives before labiaplasty (p.145)

Table 7: Overview of major themes two and three exploring participants’ experiences of labiaplasty and the aftermath (p.184)

Table 8: Overview of major theme four exploring participants’ views on gender, physical appearance and the Western culture (p.220)
APPENDIX I

INFORMATION LEAFLET FOR STUDY PARTICIPANTS

My name is Tina Bedenik and I am a PhD Candidate at University College Dublin (UCD), School of Social Policy, Social Work and Social Justice. I am conducting this research under the academic supervision of Valerie O’Brien, who is the Director of Postgraduate Studies at the School. The study is funded by the Irish Research Council.

Thank you for taking the time to read this information leaflet and consider your involvement in this study. Your participation is entirely on a voluntary basis. Please do not hesitate to ask me for any further information before you make your decision about participation.

Should you wish to participate in this study, please contact me directly at tina.bedenik@ucdconnect.ie or +353 (0)85 8211 596. Thank you.

RESEARCH TITLE: ‘SISTERS ARE DOIN’ IT FOR THEMSELVES’: A PHENOMENOLOGICAL INQUIRY INTO THE EXPERIENCE OF FEMALE GENITAL COSMETIC SURGERY

What is this research about?

This research is about the experiences of adult women who have chosen to undergo a genital cosmetic procedure including labiaplasty. Female genital cosmetic surgery (FGCS) is an umbrella term covering a number of procedures which alter the appearance of female external genitalia and potentially address discomfort with intercourse, clothing and exercise. It is a newly emerged and fast-growing procedure in the field of cosmetic industry. For example, the number of labiaplasties in the UK performed solely on the National Health Service (NHS) increased from 404 in 2006 to 1,118 in 2008 while a similarly sharp increase can be observed in Australia where throughout the last decade the number of requests for labiaplasty increased from 200 to over 1,500 per year. In Ireland one Dublin-based clinic notes an exponential 5,000 per cent increase in genital cosmetic procedures throughout the last decade – from one request annually to one request weekly.
Despite this rapid increase in demand for female genital cosmetic procedures, surprisingly little research has been undertaken to date from a social science perspective. This study aims to address this issue with its in-depth exploration of women’s experiences of genital cosmetic procedures and labiaplasty specifically. It aims to elucidate the decision-making process underlying the procedure, the experience of the surgery and the effects it has had on individual women’s lives. It also attempts to explore the social, cultural and personal factors which influence women’s perception of their bodies.

Why am I conducting this research?

As already mentioned, research data on female genital cosmetic surgery is very limited due to three interrelated factors. Firstly, these are newly emerging procedures, which probably explains why surprisingly little attention has been dedicated to this issue to date. Secondly, genital dissatisfaction and modification may be viewed as a sensitive subject and some reticence in speaking publicly about it is to be expected. Finally, many requests for these procedures go through the private sector which is often not audited. Up to this point a number of quantitative studies have been conducted largely by the British medical personnel exploring various aspects of these procedures, but rarely going in depth addressing women’s reasons for having the procedure and their reflections on the outcome. This study attempts to fill that gap with its in-depth one-to-one interviewing technique.

Who can take part in this research?

The aim of this research is to provide an in-depth understanding of women’s experiences of genital cosmetic procedures. Potential participants would need to meet the following criteria:

1. Female gender/sex
2. Minimum of eighteen years of age
3. Fluency in English language
4. Experience of FGCS including one or more of the following procedures: labiaplasty, vaginal tightening, hymenoplasty, clitoroplasty perineoplasty, pubic enhancement and G-spot amplification.

This study will unfortunately have to exclude persons with language difficulties, as well as persons with mental and intellectual impairments. Please note that if a large number of women wish to take part in this study, then the researcher may not be in the position to invite all the potential participants. Thank you for your understanding.
How will the data be used?

This study will be conducted in accordance with a high level of ethical principles. Special attention will be given to the protection of your privacy including anonymity and confidentiality (see below). The recorded material from the interview will be stored securely by the researcher at the UCD office during the course of the study. Afterwards – once all identifying markers have been removed – the transcripts will be archived at the *Irish Qualitative Data Archive (IQDA)* which is a specialist service for archiving qualitative data in Ireland. The original materials will be destroyed.

What will happen if you decide to take part in this study?

Your participation in this study is on a voluntary basis. However, upon successful completion of the interview you will receive a £30 Gift Card for MAC Cosmetics.

If you decide to participate I will e-mail you a copy of *Information Leaflet* and *Consent Form*. The *Consent Form* is necessary in order to ensure that you have fully understood what it means to participate in this study and have consented to do so. You will be asked to suggest a time and place where you would like to be interviewed. At the beginning of the interview I will run through the *Consent Form* once again together with you to clarify any misunderstandings and ensure that you are fully informed.

The interview should last for about an hour. It will resemble a conversation during which I will ask you to tell me about yourself, your experience of the procedure and the aftermath. I will audio record the interview and make a written transcript of the interview based on that recording. You will receive a transcript of the interview so that you will have an opportunity to make changes, should you wish. The transcripts will then enable me to seek similarities between your story and other participants’ accounts, and to identify emergent themes. If you express your interest, I will be happy to keep you updated on the progress of the study. Upon request, I will share with you the final report in an electronic form after the study has been finished.

How will I protect your privacy?

All the necessary procedures will be in place in order to ensure your anonymity and confidentiality. Instead of using your real name, I will assign you a pseudonym which means that I will be the only person who knows your ‘true’ identity. In other words, all the markers which may identify you will be removed. This applies to this particular study as well as any subsequent publication resulting from the study. Confidentiality will be ensured by keeping your data in a locked cabinet at the UCD office in order to protect your physical, emotional and social well-being.
In accordance with the UCD Code of Good Practice in Research, the data generated in the course of research will be stored by the researcher in a locked cabinet at the UCD office, until after the PhD has been awarded. After this, anonymized data will be archived under the Irish Qualitative Data Archive (IQDA), which is a specialist service for archiving qualitative data in Ireland. The original materials will be destroyed.

**What are the benefits of taking part in this study?**

Your involvement in this research will help highlight the incentives which push the increasing and yet unexplored demand for female genital cosmetic procedures. Women account for more than ninety percent of cosmetic procedures which suggests that the desire for altering the body has a gendered dimension. Your story would help elucidate why this is the case. It will point out to norms, practices, institutions and relations which possibly shape and influence the way Western women perceive their bodies, as well as the body work in which they engage in the attempt to reach an assumed ideal.

The findings of this research will be disseminated at conferences and in the form of scientific articles, which will ultimately help in developing a comprehensive understanding of not only genital surgeries, but also the bodily experiences of contemporary Western women. This research will influence policy frameworks around cosmetic surgery in a manner that is woman-centered. Finally, your experience of genital cosmetic surgery might help other women who are contemplating the same procedure and lack the relevant sources to consult in the decision-making process.

Finally, in order to thank you for your time and cooperation, you will receive a Gift Card for MAC Cosmetics as we successfully complete the interview.

**What are the risks of taking part in this study?**

Although the issue of genital cosmetic surgery is a sensitive topic, this study carries no significant foreseeable risks. As addressed earlier, I will safeguard your privacy – anonymity and confidentiality – in accordance with established academic ethical principles. The sensitive nature of the subject may at times cause some discomfort which will be addressed in a tactful and respectful manner. I have extensive experience in conversing about sensitive subjects and I will provide a safe and non-judgmental space for an exploration of your experience. Since the interview will be conducted in a conversational tone, you will also have the opportunity to introduce topics and not engage with those that make you feel uneasy. Finally, upon request, you will be provided with the contact details of services where you can seek emotional support.
Can you change your mind and withdraw from the study?

Your participation in this study is voluntary. You have the right to withdraw from the study all times during the interview, at the end of the interview and at the stage when you are reading the transcript of the interview. Namely, you have the right to withdraw you consent and require the interview to be cancelled and the interview material not to be used. Your decision will be dealt with confidentiality and respect.

How will you find out what happens with this project?

If you express your interest, I will keep you updated on the progress of the study. Furthermore, upon request, I will be happy to email you the electronic copy of the report once it has been finished. Should you have any other queries, please do not hesitate to contact me. Thank you for taking your time to consider your involvement with this study.

Researcher Tina Bedenik, tina.bedenik@ucdconnect.ie, mobile: +353 (0)85 8211 596
Academic Supervisor Valerie O’Brien, valerie.obrien@ucd.ie, office number: +353 (0)1 716 8254
APPENDIX II

CONSENT FORM FOR STUDY PARTICIPANTS

I ______________________________________ volunteer to participate in the research conducted by Tina Bedenik from University College Dublin (UCD), which is designed to collect information about my experience of a genital cosmetic procedure including labiaplasty. I have read and understood the Information Leaflet.

My participation in this project is voluntary. I may withdraw from the study at any time without any consequences. I will not be paid for my involvement. However, upon successful completion of the interview, I will receive a £30 Gift Card for MAC Cosmetics.

My participation in this study is anonymous and confidential. I understand that the researcher will not identify me by name in the final report, or any later publication resulting from the study. The supervisor or examiner may request access only to anonymised transcripts, after all the identifying markers have been removed.

The interview format will include a face-to-face interview with the researcher. If I feel uncomfortable during the interview, I have the right to decline to answer any question or to end the interview. The interview will be audio recorded and a subsequent transcript of the conversation will be made. Should I wish so, I will receive a transcript of the interview that will provide me with an opportunity to make changes.

I understand that this research has been reviewed and approved by the UCD Human Research Ethics Committee.

I have had all my questions answered to my satisfaction and I voluntarily agree to participate in this study.

Study participant: _______________________ Researcher: _______________________

Researcher Tina Bedenik, tina.bedenik@ucdconnect.ie, mobile: +353 (0)85 8211 596
Academic Supervisor Valerie O’Brien, valerie.obrien@ucd.ie, office number: +353 (0)1 716 8254
APPENDIX III

INTERVIEW SCHEDULE

- Age
- Ethnicity
- Sexual orientation
- Profession
- Relationship status
- How long ago have you had labiaplasty?
- Why have you decided to have it?
- Who was your greatest support in the decision-making process?
- Has anyone in your family had a cosmetic procedure? What about friends?
- Where did you first hear about the procedure?
- How did you decide which clinic and surgeon to see?
- What was the consultation process like?
- Were you fully informed about the procedure, the risks and the outcomes?
- Can you tell me about the surgery?
- What was the recovery process like?
- What kind of impact has the procedure had on your life?
- How do you feel about your body following the procedure?
- If sexually active, what kind of an impact has the procedure had on your sexual satisfaction?
- If in a romantic relationship, what kind of an effect has the procedure had on your relationship?
- Is there any other cosmetic procedure you have had, or wish to have?
- Women account for about 90 per cent of all cosmetic procedures in the Western world. Why do you think that is the case?
## APPENDIX IV
### MATRIX OF EMPIRICAL STUDIES ON FEMALE GENITAL COSMETIC SURGERY (FGCS)

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year of Publication</th>
<th>Location of Study</th>
<th>Type of Study</th>
<th>Study Aim</th>
<th>Methodology</th>
<th>Participants</th>
<th>Main Findings</th>
</tr>
</thead>
</table>
| Bramwell and Morland     | 2009                | UK                         | Psycho-social     | • Develop Genital Appearance Satisfaction (GAS) scale  
• Apply GAS to describe genital appearance satisfaction in a general population sample  
• Explore its relationship to self-esteem, body satisfaction and appearance schemas | Quantitative; Questionnaires | 135 women                                                                   | Almost a third of women felt that their labia were too large at least sometimes  
Reasons for labia reduction included concerns about appearance and discomfort with clothing and exercise  
Poor self-esteem underlies an emphasis on appearance and poor genital appearance satisfaction |
| Braun                    | 2005                | Australia New Zealand UK USA Canada | Social            | • Explore the use of ‘choice’ rhetoric in relation to Western women’s bodies and genital cutting practice including female genital cosmetic surgery (FGCS) and female genital mutilation (FGM)                                                                 | Mixed methods; Surveys, Interviews | 133 students (106 women) 15 surgeons (3 women) | Deployment of choice rhetoric around FGCS serves to render Western women’s choice an empowered, individual and decontextualised act  
Choice rhetoric renders FGCS as an event that occurs interior to the subject, |
| Braun                    | 2009                | New Zealand Australia UK USA Canada | Social            | • Explore the role of female sexual pleasure in accounts of FGCS, including media and surgeon accounts                                                                                                               | Qualitative; Media analysis, Interviews | 15 surgeons (3 women)                                                         | FGCS is presented as a means of achieving better female sexual pleasure  
Search for female sexual pleasure legitimates and promotes FGCS and reaffirms particular models of desirable sexual bodies and practices |
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Country</th>
<th>Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crouch et al.</td>
<td>2011</td>
<td>UK</td>
<td>Medical</td>
<td>Assess clinical characteristics and expectations in well women</td>
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<td></td>
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<td>requesting elective labia reduction surgery (labiaplasty)</td>
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<td>Mixed methods; Interviews, Measurements of the labia minora</td>
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<td>33 women</td>
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<td>The labia of all participants were within normal published limits</td>
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<td>The majority of complaints were regarding genital appearance or discomfort</td>
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<td>Expectations were to alter the genital appearance with surgery</td>
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<tr>
<td>Goodman et al.</td>
<td>2009</td>
<td>USA</td>
<td>Medical</td>
<td>Explore reasons for FGCS</td>
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<td></td>
<td>Explore patient’s pre-operative and post-operative sexual functioning</td>
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<td>Assess overall patient satisfaction with FGCS</td>
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<td>Examine complications post-surgery</td>
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<td></td>
<td>Quantitative; Questionnaires</td>
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<td>258 women 12 gynaecologists</td>
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<td>The reasons for FGCS divided into five categories are: functional, appearance, feeling ‘abnormal’, feeling ‘loose’, to enhance a partner’s sexual experience</td>
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<td>Functional and appearance/self-esteem issues predominated</td>
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<td>91.6% of patients were satisfied with the results of their surgery after a 6–42 month follow-up</td>
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<td>Significant subjective enhancement in sexual functioning for both women and their sexual partners was noted</td>
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<td>Complications were acceptable and not of major consequence</td>
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<tr>
<td>Howarth et al.</td>
<td>2010</td>
<td>The Netherlands</td>
<td>Psycho-social</td>
<td>Analyse visual depictions of vulva from human anatomy textbooks, feminist publications and online pornography</td>
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<td>Determine if visual depictions of the vulva differ according to their sources</td>
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<td>Quantitative, Media Analysis</td>
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<td>Labial protuberance was significantly less in images from online pornography compared to feminist publications, indicating a less varied range of differences in organ proportions than the other sources</td>
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<td>Author(s)</td>
<td>Year</td>
<td>Country</td>
<td>Type</td>
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<tr>
<td>Loyd et al.</td>
<td>2005</td>
<td>UK</td>
<td>Medical</td>
<td>Quantitative; Measurements of the external female genitalia</td>
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<tr>
<td>Moran and Lee</td>
<td>2013</td>
<td>Australia</td>
<td>Psycho-social</td>
<td>Qualitative; Discourse analysis</td>
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<tr>
<td>Moran and Lee</td>
<td>2014</td>
<td>Australia</td>
<td>Psycho-social</td>
<td>Quantitative; Survey</td>
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<tr>
<td>Study</td>
<td>Year</td>
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<td>Medical Area</td>
<td>Primary Objective</td>
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</table>
| Rouzier et al.   | 2000 | France  | Medical      | Describe the surgical procedure of reduction of labia minora (labiaplasty), the results, and the complications                                                                                                  | Quantitative, Questionnaire | 98 women    | • 83% respondents found the results of the surgery satisfactory  
  • 89% were satisfied with the aesthetic result  
  • 93% approved the functional outcome  
  • No surgery-related significant complications were noticed                                                                                             |
| Veale et al.     | 2013 | UK      | Medical      | Explore the psychological and social factors associated with the desire for labiaplasty                                                                                                                           | Quantitative, Questionnaires | 125 women   | • Negative comments or reactions about their labia were prominent in women seeking labiaplasty  
  • Television programmes and women’s magazines normalise and legitimise labiaplasty, and may fuel the demand                                                                 |
| Veale et al.     | 2014 | UK      | Medical      | Determine psychosexual outcome after labiaplasty in the long-term with specific measures of genital body image and sexual dysfunction                                                                               | Quantitative, Questionnaires | 88 women    | • 96 % women showed a clinically significant improvement in genital appearance satisfaction three months after the procedure, and 91.3 % showed an improvement at the long-term follow-up  
  • Small-effect sizes were found for improvements in sexual functioning                                                                                     |