SEXUALITIES

Abstract Female genital cosmetic surgery (FGCS) procedures are new, but increasing in popularity. In this article, I examine the role of female sexual pleasure in media (31 magazine items) and surgeon (15 interviews) accounts. FGCS was framed as enhancing female sexual pleasure, or specifically orgasm. I argue that the focus on female sexual pleasure functions to legitimate, and promote, FGCS. Further, it reaffirms normative heterosexuality, and promotes a generic model of bodies and sex. Moreover, in the context of consumer culture, media accounts have the possibility of creating problems, and their solutions, simultaneously.

Keywords cosmetic surgery, designer vagina, female genitalia, female (hetero)sexuality, sexual pleasure

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In Search of (Better) Sexual Pleasure: Female Genital 'Cosmetic' Surgery

In this article, I explore the role of 'sexual pleasure' in accounts of female genital 'cosmetic'[1] surgery (FGCS). FGCS procedures are some of the newest to become popularized in the arsenal of surgical and other cosmetic procedures aimed at transforming the (female)[2] body in some way. My classification of genital surgery as FGCS does not include surgery for transsexual or intersex people,[3] nor is it 'female genital mutilation' (FGM).[4] Procedures for (cosmetic) genital alteration include: labiaplasty/labioplasty (labia minora reductions), labia majora 'augmentations' (tissue removal, fat injections), liposuction (mons pubis, labia majora), vaginal tightening (fat injections, surgical tightening), clitoral hood reductions, clitoral repositioning, G-spot 'amplification' (collagen injected into the 'G-spot,' which swells it significantly), and hymen reconstruction (to restore the *appearance* of 'virginity').

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Like cosmetic surgery generally, FGCS can be seen as both *surgical* practice and *cultural* product (see Adams, 1997; Fraser, 2003b) and practice (Haiken, 2000). Dubbed the 'designer vagina', FGCS has received considerable media attention in recent years. Headlines range from the sensational – 'I've saved my sex life' (M30)[5] – to the serious – 'Designer vagina service a first for NZ' (N10). There is an apparent increase in the popularity of FGCS. One magazine reported that 'the operation is not new, he's been doing it for 20 years, but back then he was getting a couple of requests a year. Now he performs the operations once or twice a month' (M23), while another clinic performs '40 operations each month' (M23). Apparently, 'there is no question there's a big trend, . . . it's sort of coming out of the closet. It's basically where breast augmentation was 30 years ago' (M24). By some accounts, this increasing popularity is due, at least in part, to media coverage.

The material practice of FGCS, and women's participation in it, are enabled within particular sociocultural (and technological) contexts which render certain choices possible, and locate cosmetic surgery as a solution (K. Davis, 2003). The contexts of women's ongoing, widespread, and increasingly specific, body dissatisfactions (Bordo, 1997; Sullivan, 2001), ongoing negative meanings around women's genitalia (Braun and Wilkinson, 2001, 2003), and women's engagement in a wide range of body modification practices – such as hair removal (Toerien and Wilkinson, 2004) – cohere to render women's genitalia a viable site for surgical enhancement. FGCS can thus be theorized as an extension of other currently more culturally normative bodily subjectivities, desires and practices, for women:

> Logically, [labioplasty] operations are merely an extension of other procedures designed either to draw attention to female genitals . . . or to render invisible signs of secondary sexual development . . . In this context, the 'trimming' of visible labia minora . . . is part of a continuum. While labia reduction is not a well-known procedure, hair removal products and procedures are common. (Allotey et al., 2001: 197)

In this article, I focus specifically on the issue of (female) sexual pleasure in accounts of FGCS. Female sexual pleasure appears as a central concern, mirroring a broader socio-cultural shift towards the 'eroticization of female sexuality' (Seidman, 1991: 124) with women's sexual pleasure located as central in (hetero)sex (e.g. Braun et al., 2003; Gordon, 1971) and beyond. A 1996 article in *Flare* magazine ('The Sex Files') identified that 'female pleasure is officially a trend' (M27). More generally, for men *and* women, sex has become highly important (Weeks, 1985: 7), with 'frequent, pleasurable, varied, and ecstatically satisfying sex . . . a preeminent sign of personal happiness' (D'Emilio and Freedman, 1997: 340;

Weeks, 1985), and even identity (Heath, 1982). This increased attention to pleasure has also resulted in an increased attention to the body and sexual technique (Seidman, 1991), with possible concurrent increases in feelings of sexual inadequacy (Hart and Wellings, 2002). I will show that the story of FGCS is, at least in part, a story of the (legitimate) search for (better) female sexual pleasure, and argue that this functions not only to legitimate, and promote, FGCS, but also to reaffirm particular models of desirable sexual bodies and practices.

Theorizing and researching FGCS

This article is part of a broader project on FGCS which analyses data drawn from two datasets: media accounts and surgeon interviews.[6] The research is situated with a (feminist) social constructionist framework (Burr, 1995; Tiefer, 1995, 2000; White et al., 2000), which theorizes language and social representations as an integral part of the production of social (and material) realities for individuals, as well as producing possibilities for individual practices. Sexuality is thus a material, but always social, practice (Connell, 1997; Jackson and Scott, 2001).

Media data consist of 106 English-language items from print (newspaper, magazine) and electronic (television, radio, Internet) mass-media sources. My convenience sample was located primarily through Google searches using terms like 'designer vagina' and 'labiaplasty', and through surgeon websites. The sample comprises: 31 print magazine items; 24 Internet-based magazine items; 23 other Internet items; 13 news media items; and 15 other related items. My analysis in this article focuses on the print magazine data.

While the media have various potential uses for consumers at an individual level (Berger, 1998), my primary interest is in the media's roles in contributing to the social construction of FGCS. The media have a range of influences on health (Brown and Wash-Childers, 2002), and are significant contributors to the social construction of ideas about appearance, health, illness, and sexuality (Carpiano, 2001; Sullivan, 2001). They have been theorized as influential in women's decisions and 'choices' about cosmetic surgery (Blum, 2003; Gagne and McGaughey, 2002; Goodman, 1996), their feelings about the appearance of their vulva (Bramwell, 2002; see also Reinholtz and Muehlenhard, 1995), and their 'body image' more generally (Bordo, 1993; Grogan, 1999). Women's magazines, in particular, have been identified as 'a significant cultural source of ideas about appearance as a medical problem' (Sullivan, 2001: 159), and are seen to work 'in tandem with surgeons to promote cosmetic surgery' (Fraser, 2003b: 125). Surgeons consider them to be one of the most important sources of public ideas about cosmetic surgery (Sullivan, 2001).

Surgeons were primarily located via the media (except two, who were located via word of mouth). In total, 24 surgeons were contacted and invited to take part in semi-structured interviews, with 15 agreeing. The sample of surgeons varied in terms of the following.

(a) Geographical location: surgeons were practising in the USA (5), UK (4), Canada (2), Australia (2) and New Zealand (2).
(b) Surgical speciality: nine were plastic surgeons (one was also an urologist), six were gynaecologists.
(c) Type of practice: all but three surgeons who worked on the UK's National Health Service did these surgeries privately, at direct cost to the patient.
(d) Experience: the average time of doing 'cosmetic' genital procedures was more than 11 years (range 25 to 2 years). The estimated *total* number of FGCS procedures performed ranged from over 1000 to fewer than 50.
(e) Sex: twelve were male, three female.
(f) Ethnicity: one identified as black, one as Jewish, and 11 as white/Caucasian/Anglo-Saxon (two provided no ethnicity information).

Fourteen of the interviews, which lasted between 15 and 70 minutes, were conducted in person (one was via telephone), and all except one were tape recorded. Participants were told that 'the research focuses on ideas about female genital cosmetic surgery, and on the reasons for such procedures' and that I was 'interested in how ideas about women, women's bodies, and women's sexuality relate to these procedures'.

FGCS and female sexual pleasure

Women's sex lives or their sexuality was often reported to be impeded in some way, with pre-operative genitalia:

Extract 1: Woman's Day Magazine, *NZ, 2004*

> Amanda was utterly miserable. She no longer enjoyed sex with Russell, the husband she adored, and on those rare occasions when they made love, Amanda would insist they switch off the lights. (M30)

In this and other extracts, general pre-surgical sexual 'impediments' were noted. In addition, specific causes of such sexual impediments were identified in many accounts:

Extract 2: male plastic surgeon, UK

> S1: what comes in more and in my practice it is not – quite often it's not purely cosmetic but there are functional complaints with the labia the size of the labia too (Int: mhm) for example . . . it can be painful during intercourse because the labium keeps going in and out with every thrust.

Although physical pain was often discussed, the *psychological* response to genital morphology was frequently highlighted as the crux of the problem which 'hampered' or 'ruined' their sex life:

Extract 3: male plastic surgeon, NZ

S6: I think most w– of the women that I've dealt with have thought that this was a real impediment to sexual enjoyment (Int: mhm) not so much from *their* point of view but from their partner's point of view (Int: oh okay) if they were worried about their *partner* not liking whatever they could see or or touch or whatever then they felt tense themselves (Int: mhm) and so the enjoyment of everything goes (spiralling) (Int: mnn) down.

Int: Yeah so sort of sex was an area of difficulty (S6: yeah) for most of them (S6: yeah) or for (S6: yeah) all of them.

S6: Abso– oh absolutely.

Extract 4: Cosmopolitan Magazine*, AUS/NZ, 1998*

Sarah, a 27-year-old secretary is a case in point. Throughout puberty, she thought her vaginal lips were too long and was embarrassed by one that hung lower than the other.

'They ruined my sex life', she recalls. 'I never felt confident during sex – I felt like a freak. I'd never let anyone see me naked'. (M1)

Extract 5: New Woman Magazine*, AUS, 2003*

. . . the biggest problem was sex. I've been with my boyfriend since I was 15 but I always felt self-conscious when we made love. I'd engineer positions so that he'd always be behind me and couldn't see my vagina, and I'd never have oral sex because I couldn't bear him seeing me up close. (M20)

The psychological problems invoked to explain a (pre-surgery) sexual impediment included embarrassment, self-consciousness, lack of confidence, and shame. The inclusion of such concepts fits with Frank's (2003) observation of an 'inflation of the language of pain' around medicine to include such psychological concepts.[7] In my data, this negative psychological response to *appearance* often resulted, via other psychological responses like anxiety or self-consciousness, in an inability to 'receive' oral sex from a male partner, an account which fits with women's reports of various genital anxieties, particularly around oral sex (Braun and Wilkinson, 2003; Reinholtz and Muehlenhard, 1995; Roberts et al., 1996). Women's reports of genital anxiety reflect a range of negative sociocultural representations of women's genitalia (Braun and Wilkinson, 2001), and it seems some women 'live these [negative] cultural meanings in their embodiment' (Roberts et al., 1996: 119). However, my concern is not just about women's embodiment, as psychology here provides the 'moral justification' (Frank, 2003) for cosmetic surgery to alleviate this distress.

While *impeded* sexual possibilities and pleasures were central in media and surgeon accounts of why women might choose to have FGCS, *increased* sexual pleasure as an outcome of surgery was the main area in which sexual pleasure was discussed. FGCS, in a variety of forms, was represented as increasing sexual pleasure. The *aim* of sexual enhancement was often explicitly stated in the titles of magazine articles about FGCS – 'THE G-SHOT . . . plastic surgery for your orgasm' (M22) – and in the setting up of media stories:

Extract 6: New Woman Magazine, *UK, date unknown*

Would you go under the knife to improve your sex life? These four women did. (M29)

Extract 7: Marie Claire Magazine, *UK, 2000*

What are the reasons for surgery? Firstly, to improve their sex lives. (M4)

Extract 8: Marie Claire Magazine, *US, 2000*

Some women are going under the knife to change the appearance of their genitals, while others are having surgery in the hopes of better orgasms. (M3)

In some, the possibility of increased sexual pleasure was initially framed with mild scepticism:

Extract 9: Cosmopolitan Magazine, *AUS/NZ, 1998*

Doctors [in the US] claim to be able to boost women's sexual pleasure, taking them to previously uncharted erotic heights. And their secret weapon in the quest for sexual ecstasy? The scalpel. (M1)

Extract 10: Marie Claire Magazine, *UK, 2000*

The sales pitch being that sexual gratification of the female is diminished if friction is lost because of a slack vagina, so this procedure tightens up your bits and helps you reach orgasm. (M4)

Extract 11: FQ Magazine, *NZ, 2004*

Will sex be mind-blowing once you've been trimmed or tightened? Well, the jury is still out. (M31)

Any initial scepticism in reporting the doctors' 'claim' that the operations 'supposedly increase sexual pleasure' (M3) was typically not reiterated in most media accounts of surgical results and patient experiences, or in surgeon accounts. Instead, overwhelmingly, increased pleasure was noted:

Extract 12: Cleo Magazine, *NZ, 2001*

Feedback from patients suggests their sex lives have improved enormously. (M7)

Extract 13: male urologist, AUS

S7: I've known women who are mono-orgasmic to become multiply orgasmic as a result.

All procedures, even ostensibly cosmetic ones such as labiaplasty, were frequently framed as being 'successful' in terms of increased sexual pleasure:

Extract 14: Cosmopolitan Magazine*, AUS/NZ, 2004*

I am no longer embarrassed to be naked and my sex life has improved because I'm more confident. (M23)

Extract 15: Company Magazine*, UK, 2003*

I was so thrilled with my new vagina, Dan and I 'tried it out' after just four weeks. What a difference – it was like my whole sex life was beginning again. Suddenly I discovered how amazing oral sex could be, because I could finally relax and be myself during sex. I didn't have to worry about my boyfriend seeing me naked. (M18)

In these extracts, improved sexual function was identified as a key outcome of 'cosmetic' procedures. In Extract 15, psychological changes post-surgery allowed the woman to experience cunnilingus. Surgery reportedly expanded women's sexual repertoires. However, such reports continue to situate heterosex within the bounds of normative heterosexuality, through the suggestion that certain sexual acts (cunnilingus) can only be engaged in, and enjoyed, by either or both partners, within a very limited range of female genital aesthetics. This aesthetic is one where the labia minora do not protrude beyond the labia majora – a youthful, almost pre-pubescent aesthetic, and one often associated with, and derived from, the 'unreal' vulvas displayed in heterosexual male-oriented pornography (see Adams, 1997; S. W. Davis, 2002). This was explicitly noted:

Extract 16: Shine Magazine*, AUS/NZ, 2001*

A lot of women bring in *Playboy*, show me pictures of vaginas and say, 'I want to look like this'. (M5)

The genital produced is one in which diversity is replaced with conformity to this particular aesthetic, a 'cookie cutter' (I25) genital. FGCS becomes a practice of changing women's diverse bodies to fit a certain (male-oriented) 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* (e.g. Moghaddam and Braun, 2004), 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. A pathologization of 'large' labia minora has a long history, and a long association with perceived sexual 'deviance' (S. Gilman, 1985; Terry, 1995). FGCS appears to offer a surgical process for subsequently passing – to oneself, as well as others – as 'sexy' or just as 'normal' (see K. Davis, 2003).

In these accounts, sexual pleasure occupies a status of almost unquestioned good, which mirrors liberal sexual rhetoric, arguably the dominant form of sexual discourse currently available in western countries. With sex constructed as a 'domain of pleasure' (Seidman, 1991: 124), the pursuit of (more and better) sexual pleasure is situated as a legitimate, or even obligatory (Hawkes, 1996; Heath, 1982), pursuit for the 'liberated' (sexual) subject. There are 'cultural expectations that each individual has a right and a duty to achieve and give maximum satisfaction in their sexual relationships' (Nicolson, 1993: 56). FGCS is framed as a viable means to achieve this. A key question to consider, however, is what (female) sexual pleasure is being offered:

> *Extract 17:* Cosmopolitan Magazine, *AUS/NZ, 1998*
>
> Four months after the operation, Kate claims to be enjoying the best sex of her life . . . 'removing the excess fat has made me much more easily aroused. Now I achieve orgasm easily and often'. (M1)
>
> *Extract 18:* New Woman Magazine, *AUS, 2003*
>
> 'The G-Shot procedure is all about maximising sexual pleasure for women. By injecting a fluid made up partly of collagen we can increase the G spot to three or four times its normal size, so it's easier to stimulate.
>
> 'The effects last about four months and my patients tell me how even something as gentle as yoga is giving them orgasms!' (M20)
>
> *Extract 19:* New Woman Magazine, *UK, date unknown*
>
> What a result though! All I have to do is think about sex and I can feel my G spot react. Even during my spinning class I can feel the bike seat pressing on it – and I have to pretend I'm just enjoying the workout! I've also had my first ever multiple orgasm and it was great. (M29)

The conception of 'sexual pleasure' for women was typically synonymous with orgasm – or multiple-orgasm. By prioritizing orgasm over other forms of sexual pleasure, such accounts work to reaffirm an orgasm imperative (Heath, 1982; Potts, 2000). Orgasm was framed, a-contextually, as positive – the possibility of orgasm in non-sexual situations was identified not negatively (as, for instance, impeding the woman's ability to partake in exercise without fear of orgasm), but rather positively. Typically, orgasm was framed in unequivocally positive ways:

Extract 20: Cleo Magazine*, NZ, 2003*

> Rosemary is promised about four months of orgasmic delights . . . having heard about the G-Shot through a friend who raved about her endless climaxes, Rosemary had no hesitation in handing over US$1850 [NZ$3000] for a dose of heightened pleasure. (M22)

Therefore, the accounts of pleasure in heterosex – and it typically *was* heterosex – presented in the data failed to offer any radical questioning of orgasm as the pinnacle of sexual pleasure and achievement (Jackson and Scott, 2001; Potts, 2000). 'Better' sex typically meant orgasmic sex (or, sometimes, simply more sex), and more (and better) sex was inherently framed as good. By locating orgasm as so central to women's sexual pleasure, other ways in which sex could be more pleasurable – e.g. more fun, more intense, more relaxed, more intimate – were relegated to second place, if any, behind orgasm. This affirms what Seidman (1992: 7) has identified as a 'new tyranny of orgasmic pleasure'.

Although physical changes, such as an enlarged G-spot or tighter vagina, were often identified as resulting in increased pleasure, *psychological* elements were also highlighted as key in explanations for increased sexual pleasure, post-surgery:

Extract 21: male plastic surgeon, UK

> S1: when you feel better about what you look like down there if you feel happier with the cosmetic aspect of (Int: mhm) yourself of your genitalia then you are more relaxed in the bedroom (Int: mhm) and a lot of patients report back to me that they *do* feel better and therefore have better sex because (Int: mhm) they're less embarrassed.
>
> Int: 'cos they're more relaxed.
>
> S1: yeah.

Extract 22: Flare Magazine*, CA, 1998*

> What does work, according to Angela, is the boost in self-esteem that stems from feeling sexually confident. 'I spent years not feeling good about myself and my sexuality,' she says. 'I started to retreat from my husband. I tried to avoid him sexually because every time we tried, it was disastrous'.
>
> It all gets back to the psychosexual response, says Dr Stubbs. (M26)

Extract 23: Shine Magazine*, AUS/NZ, 2001*

> My sex life has improved so much since the operation – we have more sex now than we've ever had. I'm much more into my boyfriend and now that I'm tighter, I'm much more confident about initiating sex. Even better, my boyfriend is enjoying sex with me more, as there's much more stimulation for him, too. (M5)

In these extracts, the psychological was invoked as an essential ingredient in the production of female pleasure, and, indeed, situated as a primary reason this surgery was effective in producing increased sexual pleasure for women. The account was one of (psychological) transformation, from a state of impeded sexuality, to one of liberated, (multi) orgasmic sexuality (transformation is a key theme in accounts of cosmetic surgery, see Blum, 2003; K. Davis, 1995, 2003; Frank, 2003; Gagne and McGaughey, 2002; Gimlin, 2002; Haiken, 1997; Sullivan, 2001). 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 (Blum, 2003), and becomes the 'best or most effective means of attaining satisfaction' about bodily distress (Fraser, 2003a: 39).[8] Thus, the body is situated as ontologically prior to the mind, but the mind is located as the crucial variable, in sexual pleasure terms. The idea of cosmetic surgery as 'psychotherapy' can be found in Gilman's (1998; 1999) analyses (see also Fraser, 2003a, 2003b).[9]

Extract 23 is relatively unusual in that increased male sexual pleasure was noted. Women were the primary focus in accounts of sexual pleasure, with comparatively little discussion of male sexual pleasure. This is not surprising, as cosmetic surgery is necessarily often framed as 'for oneself' rather than for others (see Fraser, 2003b). Where male sexual pleasure was referred to, it was often positioned as secondary to, or less important than, female sexual pleasure. For instance, Extract 23 situates her boyfriend's increased sexual pleasure as secondary to her pleasure, as an added bonus, something that makes it 'even better'. The prioritizing of *female* sexual pleasure in accounts of FGCS can be seen in Extract 24:

Extract 24: male gynaecological surgeon, USA

Int: [Vaginal tightening] . . . is talked about as being for sexual gratification um is that um for female sexual gratification or is that um for if they're in a a relationship with a male for male sexual gratification or some combination of both um.

S5: The purpose is for the female (Int: mhm) my objective is for the female I'm a gynaecologist my ah ah I've dedicated my career my life to the healthcare of women and treating women (Int: mhm) damn the man (pause) there's plenty of things (if) I had a problem (clicks fingers) plenty of things (but we're) (Int: mhm) involved with women (Int: mhm) we're involved with women so *my* philosophy there's plenty of things out there *this* is for her I'm happy to say that women come in on their own volition and want to have these procedures *I find* women want to enjoy sex,

women want to have the best sexual experience possible that's it (pause) men have got everything okay but women want to have the best sexual experience possible.

Int: And vaginal tightening's important to that I'm just thinking about how . . .

S5: Important to (unclear)

Int: how a tightened vagina *is* necessarily more . . .

S5: Ah it's important to them.

Int: sexually preferable for women.

S5: It's important to them it's important now I've treated patients from all 50 states (Int: mhm) and it's over 30 (unclear) countries it's important to the people (Int: mhm) it's important to the people to the women (pause) *obviously* if I'm enhancing sexual gratification for a female I can enhance sexual gratification for the male (Int: mhm) yeah (Int: mn) but again if a man is *pushing* her I won't do it.

While this extract could be extensively analysed, for the purposes of this article, it is important to note how hard S5 has to work to undermine the suggestion (implicit in my question) that the surgery might 'really' be about male sexual pleasure. Instead he situates male sexual pleasure as a peripheral concern. Such accounts exist in contrast to reports of other genital procedures, such as the 'husband stitch' (Kitzinger, 1994) after childbirth/episiotomy, which tightens a woman's vagina, where *male* sexual pleasure has been emphasized (e.g. Jahoda, 1995).

Overall, the prioritizing of female sexual pleasure and general lack of discussion of male sexual pleasure, work to construct FGCS as something that is in the (sexual) interests of women, rather than in the sexual interests of (heterosexual) men. Through current accounts, FGCS is effectively constructed as a liberatory action for women – it produces sexual pleasure, which is, socioculturally, almost mandatory for women – rather than a capitulation to unreasonable patriarchal demands on women's bodies. However, while FGCS offers (apparent) empowerment to individuals who have it, albeit within a limited range of options, it simultaneously reinforces oppressive social norms for women (see Gagne and McGaughey, 2002; Gillespie, 1996; Negrin, 2002).

FGCS: normative heterosexuality, generic bodies, and generic pleasures

The central role that (female) pleasure plays in accounts of FGCS is revealing in terms of contemporary discourses of (hetero)sexuality and

what it could/should mean to be a woman in the West today. Women's sexual pleasure – or ability to orgasm – appears as a central concern for women, and indeed for society. The account is almost exclusively one where, sexually, women should be comfortable in their bodies and should be able to enjoy sex – and the more sex, and sexual pleasure, the better. Women are represented as (inherently) entitled to sexual pleasure, and indeed, inherently (hetero)sexual. That *these* women are not sexually 'liberated', sexually 'satisfied', or, even, as sexually satisfied as other people appear to be, is, at least in part, what is 'wrong' with their pre-operative genitalia. In this sense, accounts of FGCS and women's sexual pleasure fit squarely within a discourse of liberal sexuality (Hollway, 1989), and even, within some feminist discourse around the importance of equality in sex (see Braun et al., 2003). It also affirms an imperative for 'more and better sexual gratification' (Hart and Wellings, 2002: 899), by whatever means possible.

However, the construction of female sexual pleasure in relation to this surgery fails to challenge the bounds of normative heterosexuality. First, sexual pleasure was often (although not exclusively) framed as being derived through coitus, particularly in the case of vaginal tightening, and the sexual pleasure that is derived was typically orgasmic. In this sense, it can be seen to be (at least in part) a practice of designing bodies to fit certain sexual practices, rather than designing sexual practices to fit bodies. We then have to ask whether it is so different from the 'love surgery' of the now disgraced Dr James Burt, who surgically altered women's genitalia to make them more amenable to stimulation during coitus (Adams, 1997). As Adams (1997: 64) noted, such surgeries 'make women conform to traditional heterosexual values'. The same criticism applies to FGCS: the sexual 'freedom' that is being produced is a freedom to enjoy sex within a very limited frame of reference.

Moreover, at the same time as it constructs the legitimate female body as an orgasmic one, it reinforces this 'ideal' as something not all women necessarily (easily) achieve (without surgery). So sexual pleasure, through orgasm, is simultaneously situated both as what most women can/should do and as a current impossibility for some women. The very construction of FGCS as surgery to enhance or enable orgasm fits with an ongoing construction of a woman's orgasm as difficult to achieve, in contrast to a man's inevitable one (Jackson and Scott, 2001; Moghaddam and Braun, 2004). Moreover, although couched in terms of liberation of women (to a 'full' enjoyment of sex), rather than pathology, the framing of FGCS as a solution to 'sub-par' sexual pleasure on the woman's part decontextualizes sex, locating any deficiency in the woman's body/mind, and offering an individualized solution. In this way, FGCS fits within a broadening medicalization of sexual behaviour (Hart and Wellings, 2002; Tiefer,

1997), which, Tiefer (1997: 112) has argued, has 'only reinforced a limited script for heterosexual sexual life'.

These points raise the question of the generic versus the particular. The idea of a surgical 'fix' or enhancement of (lack of) sexual pleasure locates sexual pleasure at the level of the *individual* body, rather than in relation to a 'fit' between bodies/people and the practices they are engaged in. In this sense, the sexual enhancement of the body is framed as generic sexual enhancement, regardless of with whom, and how, one might be having sex. This framing disregards the particularities of sex, with different partners, with different practices, for different purposes, and, indeed, in different moods, modes, and venues. Sex, sexual pleasure, and even sexual desires vary hugely according to this range of contextualizing variables. Accounts of FGCS not only fail to account for this, but actually work to promote the idea of generic sexual pleasure as possible.

The context of consumer culture provides another angle from which to examine public discourse around FGCS. Bordo's (1997: 42) analysis identifies that a consumer system 'depends on our perceiving ourselves as defective and that will continually find new ways to do this'. Media accounts that demonstrate a 'cure' to some problem for women can be seen to also contribute to the creation of that problem in the first place. FGCS, and media coverage of it, have the potential to produce consumer anxiety (S. W. Davis, 2002). One item commented that media coverage had 'taken a very unusual phenomena and concocted a new "embarrassing problem" that could get readers squinting nervously at the privates' (M28). In the case of labiaplasty, then, there is the potential that 'a brand-new worry is being created' (S. W. Davis, 2002: 8). In these accounts, the appearance and sexual function of women's genitalia are rendered *legitimately* problematic and sub-optimal; this part of the body is legitimately commodified, and positioned as 'upgradeable' (see Negrin, 2002). More than this, these media have the potential to construct the very nature of problems and their *solutions*, simultaneously. Both the problem of aesthetically 'unappealing' genitalia and the desire for better sex have a ready worked-up solution – surgery.

While FGCS might seem relatively arcane, a form of cosmetic surgery very few women would access, and one that is unlikely to become popular, the surgeons I interviewed indicated that media coverage seems to increase demand for their services. This fits with Kathy Davis' (2003: 134) observation that media coverage of new surgical interventions 'seduc[es] more individuals to place their bodies under the surgeon's knife' (see also Wolf, 1990). The history of other cosmetic procedures does nothing to dispute this concern. Indeed, as Haiken has commented in her history of cosmetic surgery, individual change can often be 'easier' than social change.

> Americans, most of them women, found it easier to alter their own faces than to alter the cultural norms and expectations about aging that confronted them. Together, surgeons and their patients forged a new image of the face-lift as a sensible, practical and relatively simple solution to the social problem of aging. In doing so, they both became producers and products of the modern 'culture of narcissism' and created powerful incentives toward cosmetic surgery that are still in place today. (Haiken, 1997: 135–6)

The appearance of FGCS raises important questions about the alteration of the body in the pursuit of pleasure, which I have only started to address. If media coverage can contribute to the nature of, and legitimate, a 'new' problem for women, with a ready-made surgical solution, we need to continue to act as 'cultural critics' (Bordo, 1993), and question the assumptions on which such surgery rests, and the models of sexuality, bodies, and practices it promotes.

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Notes

1. My classification of these surgeries as 'cosmetic' is not necessarily the way surgeons or the women themselves would classify them. Some of these surgeries are primarily (or exclusively) done for functional reasons, and even where cosmesis is prioritized, the notion that surgery is purely cosmetic is challenged through diverse accounts of 'functionality'.
2. Although cosmetic surgery is increasingly popular among men, it is important to retain some sense of the gendered context in which cosmetic procedures originated and became popularized, such that women were (and continue to be) the primary consumers of cosmetic surgery (see K. Davis, 2003, for a discussion of the limitations of 'equality' analyses in relation to cosmetic surgery).
3. The techniques might be the same or similar in some instances. At a more theoretical level, the practices around the construction of 'normal' genitalia through FGCS are, like other genital surgeries, part of the ongoing social, and material, construction of (gendered) genital meaning and appearance. Moreover, an inappropriately 'masculine' appearance/perception of their genitalia was one of the reported reasons some women desired FGCS. The constructed genitalia tend to display *more* gendered genital difference (bigger penises, tighter vaginas, smaller labia minora). So while much cosmetic surgery can be seen to produce the surgical 'erasure of embodied difference' (K. Davis, 2003: 133), the one difference that is promoted, rather than erased, in FGCS is 'gendered' (genital) difference.
4. A comparison between these western practices and FGM was rarely mentioned in the data, and a focus on notions of 'free choice', purported low risk to health, and likely increased sexual pleasure, all rhetorically constructed

FGCS as inherently *different* to FGM. However, Manderson and colleagues (Allotey et al., 2001; Manderson, 1999) point to contradictions between how FGM and FGCS are treated in the West (see also S.W. Davis, 2002; Essen and Johnsdotter, 2004; Sheldon and Wilkinson, 1998).

5. Quotations from data are coded by letter and number: S = surgeon; M = magazine; N = news media; I = Internet material other than 'Internet magazines'. Numbers were applied sequentially across each data source, starting from 1. In the surgeon extracts, material in parentheses (like this) indicates a best guess as to what was said at that point on the tape.
6. Although there are differences between the datasets (e.g. see K. Davis' (1998) comments about media accounts of cosmetic surgery), my analysis treats all data in the same way – as cultural texts.
7. This point is demonstrated by Blum's (2003: 287) observation that 'the surgical patient's shame is intolerable.'
8. Breast surgery has been identified as 'a means of establishing congruency between the body and mind, or developing an embodied self that was comfortable' (Gagne and McGaughey, 2002: 822).
9. This dualistic construction of mind and body is questioned in Budgeon's (2003) work on young women talking about the possibilities of bodies, identity and practice around cosmetic surgery.

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