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Chapter 3.3

Vagina Dialogues: Theorizing the 'Designer Vagina'

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Abstract

Accounts of the 'designer vagina' have frequently linked it to 'traditional' practices of FGM (or, less pejoratively, FGC), said to reduce women's sexual pleasure. Many writers claim that cuts to the vagina are particularly sinister since they are made to such an intimate and private part of the body. However, the vagina is perhaps the bodily part most likely to be cut or stitched because of childbirth. And given the technologies available to alter its appearance, from waxing to labiaplasty, we must also ask ourselves how 'private' the vagina now is. Feminists have largely correlated such practices negatively with the increasing circulation of pornography, neoliberalism, post-feminism, consumerism, and the 're-entrenchment' of sexism (Gill and Donaghue, 2013) though not with what we might call 'vaginal diversity' on body-positive websites. Certainly these are mechanisms of visibilization. However, is the 'neoliberal vagina' simply bad for women? Or are there continuities and disjunctures between feminism and neoliberalism that paint a more complex picture of the 'designer vagina'? Here I argue that within the context of the visible vagina, the privileging of patient autonomy, and the moral imperative to find happiness by 'doing something' work to reconfigure the vagina as alterable in the pursuit of pleasure.

Introduction

In 2014 an undergraduate student[1] of mine conducted a small study on the vagina, involving three interviews, with her grandmother, her mother, and her sister. Her grandmother claimed never to have seen her own vagina, explaining that in her day things like that were simply 'secret' and unknown. You would never look at your own genitals and you would never let anyone else look either. The student's mother conceded that she had looked at her own vagina in the mirror during the 1980s, largely as a response to feminist calls to be in touch with her body, but found it ugly and disgusting and had never looked again. Finally, the student's sister said she looked at her vagina often and was very happy with it because she 'had a nice one'. Pornography was not mentioned in any of the interviews. This small study is indicative of western culture's changing relationship with the vagina over the last 50 years, made explicit in the flurry of media attention around what is contemporarily known as the 'designer vagina'. Associated with female (not male) genital cutting (FGC), the designer vagina is sometimes said to be its western equivalent – the imposition of patriarchy through the cutting of female genitals (though see Pedwell, 2008, and in this volume, for an excellent critique of this position). However, unlike FGC which is said to curtail women's sexual pleasure, the surgeries associated with the 'designer vagina' are promoted as enhancing it (Braun 2005).

This chapter explores the increasing cultural visibility of the vagina, considering also its earlier emergence in relation to both popular media and feminist critiques (such as the women's health movement). It will think through the particular effects of this visibilization for women's relationships to the 'self', the aesthetics of the contemporary vagina, and the vagina's connection to different forms of pleasure - both sensual and subjective. I will examine how surgeries associated with the 'designer vagina' are

constructed as the practices of naïve and desperate victims of the 'perfect' body images circulated in popular culture, but will counter this narrative by exploring the consequences of visibilization as a space for forms of self-exploration and actualization that - while inevitably implicated by contemporary neoliberal culture – are nevertheless continuous with early feminist ethics. I will contrast two very different constituents of women most likely to undergo surgeries to their vaginas – young women with large labia minora and post-childbirth women seeking repair to birthing injuries – and how they trouble the cosmetic/ reconstructive boundary on which the discourse of the designer vagina rests.

The construction of the 'designer vagina' incorporates a number of different procedures, known as Female Genital Cosmetic Surgery (FGCS). Labiaplasty or labia reduction, sometimes also called vulvaplasty, is a surgery to reshape or reduce the labia minora. This surgery is perhaps the most common and is associated largely with young women and sometimes girls. On the other hand, vaginoplasty or vaginal rejuvenation/tightening, where the inner vagina walls and muscles can be reshaped and tightened to produce a more toned and tight vagina, is more commonly associated with older, especially post-childbirth women. Hymenoplasty, or hymen repair/re-virgination, where a torn hymen is repaired or rebuilt to a 'virginal state' is most frequently performed for religious, ethnic or cultural reasons (see Mahadeen and Wild in this volume). Other, less common but important surgeries are: hoodectomy, where the clitoral hood is reduced to tuck all the inner parts of the vulva inside the labia majora, or alternatively to expose more of the clitoris rendering it more sensitive; G-Spot Augmentation which is a non-surgical procedure using dermal fillers injected into the G-spot area, with the aim of increasing the likelihood and intensity of the

female orgasm; and fat transfer to the labia majora (outer lips) or pubic mound, to reshape these areas for a 'better' aesthetic appearance (Goodman 2009).

Many media stories and scholarly publications link technologies to modify the appearance of the vagina such as pubic hair removal (Cain et al. 2012), or FGCS (Braun and Tiefer, 2010) to the increasing availability of pornography via the internet, as well as the commodification of women's bodies, the revival of sexism, the 'mainstreaming' of sex (McNair, 1996), the sexualisation of culture and the ubiquity of the internet. However, given the diversity of the procedures associated with the so-called designer vagina these claims warrant further interrogation. In this chapter I focus on only two surgeries – labiaplasty (labia reduction) and vaginoplasty (vaginal tightening) - as even these two surgeries are marketed to very different groups of women. I will begin by considering some issues connected with labiaplasty.

Labiaplasty

FGCS is said to be increasing at over 10% annually in western nations (RCOG 2013; Simmons 2016). Alongside this rise, references to the 'designer vagina' have become commonplace in public discourse and have spawned much debate. For example, Braun (2010) argues that pornography presents only one kind of vagina: a small, hairless vagina that is neatly tucked within the labia majora. Furthermore, this small, neat, hairless vagina is said to be the vagina of a child, raising concerns in some circles that women are being sexually infantilized in a way that both reflects and encourages men's paedophilic desires (Toerien and Wilkinson, 2003). Braun and Tiefer (2010) also argue that the vagina of pornography has resulted in 'an incredibly high proportion of women [who] dislike their genitalia enough to have considered

surgery as an option [viewed as] a viable solution to multiple forms of bodily distress for many women' (n.p.) although what 'considered' means in this instance is not defined and we might argue that considering cosmetic surgery is something that we all do, but is only undertaken by a few. Braun and Tiefer, like many others, locate women's desire for (painful) surgery in the psychic pain produced by bodies that do not conform with idealized (photoshopped) media images, or the 'staged' vaginas understood as typical of pornography (I will return to these points later in the chapter). All women feel this pain, the argument goes, not only women with divergent genitalia, since the porn vagina is already 'enhanced' and thus different from the vaginas of 'normal' women. And cosmetic surgeons have also contributed to this discourse of the designer vagina, claiming that in contrast to their past experience when most cosmetic surgery was performed on women who had given birth with at least one vaginal delivery, more and more young, childless, women are now appearing in their waiting rooms brandishing pornographic pictures of vaginas which they would like their surgeons to recreate - just as one might take a photo of a hairstyle to the hairdressers (Braun 2005).

Whilst surgery to rejuvenate - to make the vagina young(er) - produces significant anxiety for feminist critics, the thought of operating on a young vagina raises the stakes even more significantly (and prompts numerous analogies with FGC discussed elsewhere in this volume) (see Earp, Hendry and Thomson, 2017). Anxieties around the 'normal', and in turn the 'real' vagina have now become so intensified that it is necessary to educate young women in 'vagina acceptance', producing a cultural context in which awareness about the vagina has to be raised in both education and healthcare.

However, in the UK, broader formal opportunities for young people to learn about the vagina and its functions, aesthetics and pleasures are extremely limited. For instance, the National Curriculum recommends that the 'structure and function of the male and female reproductive systems' are addressed in Key Stage 3 (11-14 year olds) Science. However, by the time students reach Key Stage 4 (14-16), the programmes of study in Biology offer little scope for any further exploration of this topic. The only other avenue for learning about the vagina is in PSHE (Personal, Social, Health and Economic education) which is not a statutory subject. No programmes of study are featured in the National Curriculum (compulsory for all schools). The Secretary of State's guidelines for schools which must be followed when teaching Sex and Relationship Education (SRE), recommends 'learning and understanding physical development at appropriate stages'. However, expectations of a 'normal' vagina are not covered. The document, 'SRE for the 21st Century' produced by Brook, The PSHE Association and the Sex Education Forum, offers slightly more room for discussing the vagina but largely only in terms of FGM and the impact of pornography on body image. The pornographic vagina and the vagina that has been 'mutilated' are clearly marked as 'abnormal' in these texts. Additionally, the document cautions: 'Pornographic images must never be shown to pupils, and there is no need for teachers to look at pornography to plan their teaching' (2014: 11).

Another source of information for young (or indeed older) women is the NHS Choices website where the section 'Is my vagina normal?' is considered in relation to women's health. A rather coy photograph of a woman's naked torso, her hands placed delicately over her pubic area, accompanies the article along with the text:

> Dr Suzy Elneil, consultant in urogynaecology and uroneurology at University College Hospital, London, has worked with a lot of women. ‘Like people, vaginas are completely individual,’ she says. ‘No two are the same … Don't compare yourself to anyone else – what someone else's vagina looks like is normal for them, but won't necessarily be what's normal for you. Yours is unique … Vaginas vary in shape, size and colour,’ says Dr Elneil. ‘Some are small and ovoid [egg-shaped], some are large and cylindrical, and the colours can vary from light pink to a deep brownish red-pink. The important thing is that the vagina functions normally.’ Furthermore, ‘Large labia are only a medical problem if it affects the woman's working, social or sporting life,’ and, ‘Size is really not a problem per se for most women. However, for cyclists, the length and size of the labia can affect their ability to sit comfortably on the seat, but this is a rare problem. If you're worried, talk to your GP’ (emphasis added).

According to NHS Choices, then, a normal vagina is a varied vagina, a vagina of any shape, size or colour. But: there is no need to compare. Not only should we not look at porn, not show vaginas as part of sex education, nor depict them on the NHS Choices website, but neither should we look at, or compare our own vagina with anyone else’s. Vaginas are not to be looked at according to the NHS, only their function is important. What their function is, however, is never stated.

Only one justification for altering the appearance of the vagina is permissible – an inability to engage in sport or to cycle. The ‘normal’ and ‘abnormal’ vagina must therefore be rendered transparent without ever becoming visible. Cut vaginas and

porn vaginas are marked as deviant but 'normal' vaginas, despite their almost infinite variability, cannot be seen.

The coyness of our key institutions in talking about, let alone depicting, the vagina is at odds with claims that all young people are already immersed in pornographic culture. If young people routinely view vaginas in pornography why not show non-porn vaginas in the classroom? This lack of a visual register of diverse vaginas for young people is likely, I would argue, to promote anxiety. However, luckily, there are a number of problems with this argument that make the situation more favourable for anxious young people than it might appear at first glance. Firstly, it is not accurate that only one kind of vagina is depicted on internet pornsites. Whilst mainstream soft porn may over-represent the small, hairless and neatly tucked vagina, online porn is far from homogenous and caters for many tastes (Attwood and Smith, 2014). There are sites promoting hairy vaginas, pierced vaginas, big vaginas, decorated and dyed vaginas, not to mention the plethora of intimate, amateur, 'body positive' self-representations. The idea that there is a 'vagina of pornography' seems anachronistic and the small, hairless vagina of commercial soft porn is increasingly being read as a 'professional porn convention', one 'type' of porn to choose from a massive range (Smith, 2012). Secondly, there is little evidence to show that young women are even using pornography en masse (Atwood 2005). Third, widely circulated claims by cosmetic surgeons that young women develop body dysmorphia from watching porn are based only on their experiences of patients arriving at consultations with pictures of vaginas from pornography as a guide for desired outcomes (Smelik 2015). Yet where other than in pornography might a young woman access images of vaginas to take to a cosmetic surgeon? Far from reporting deep unhappiness with their vaginas, a

recent survey has shown that more than half of women look at their vulva at least once per month and that over 80 percent are satisfied with its appearance. Whilst women aged 18-44 years viewed pornography more frequently than older women, those aged 45-72 years are twice as likely as their younger counterparts to consider FGCS (Yurteri-Kaplan et al., 2012). The relationship between images of vaginas and desire for surgery, then, warrants further and more careful interrogation (Jones and Nurka, 2015).

Vaginas in the Women's Health Movement

Whilst we spend much time reflecting on normalizing surgery to the vagina, we might also enquire where the NHS ethic of vaginal variety originates from. One answer lies in the women's health movement. During the 1980s numerous feminist accounts of rough and insensitive male doctors conducting painful vaginal examinations were recorded in the academic literature. During childbirth, episiotomies were said to sever nerve channels limiting women's subsequent sexual pleasure (Kitzinger, 1994) and the so-called 'husband's stitch' (an 'extra' suture made after birth during perineum repair) to increase vaginal tightness, was said to benefit only men's sexual pleasure whilst causing women further pain and discomfort (Oakley, 1984). Damaging forceps use was condemned as conveniencing obstetricians' schedules whilst butchering the vagina. During these processes the vagina was renamed the 'birth canal', stripping it figuratively (and in some cases, literally) of its sexual functions. The six-week check up (vaginal exam six weeks after birth) was criticized by feminists, as male doctors sending a wife home to her husband with the instruction that she was now 'ready' to

resume marital duties. Medical intervention was constructed in these accounts as an unnecessary intervention - or imposition - on women's bodies, chiming heavily with contemporary feminist critiques of procedures such as 'vaginal rejuvenation', which have been positioned in contemporary feminist accounts as unnecessary and 'for *men's* pleasure' (e.g. Braun, 2005). Tightness is associated with better sex for men, not women (Braun and Kitzinger, 2010).

These critiques of medical interventions to the vagina originated in the women's health movement, formed in the 1970s in response to the misogynistic practices followed by the largely male medical profession of the time. Beginning in California, women's health groups set out to educate themselves and other women about the female body from a very different perspective than the objectifying gaze of medical textbooks. They rejected both unnecessary medical intervention in, and false representations of, women's bodies. Lay women practiced DIY cervical examinations, inseminations, menstrual extractions and abortions and taught each other about contraception in order to 'seize the means of reproduction' from the hands of male doctors. They challenged medical textbooks for misrepresenting the vagina – especially the clitoris which was significantly smaller in medical drawings (Sloane, 2001). Michelle Murphy (2012) describes the accumulation of feminist knowledge of women's bodies as 'immodest witnessing' (after Haraway) as the woman is both possessor/experiencer of her own body and the one who has knowledge (epistemic privilege) of it. This epistemic privilege was always sensory, embodied and collective as vaginal exams were practiced in groups. They were also affective in that gaining knowledge of one's body, and shifting it from the pathologising gaze of medicine to the 'self-help' context of home remedies and shared knowledge was closely aligned

with consciousness raising and empowerment. Key to this new knowledge was the variation of women's vaginas:

> The 'not uncommon' was also a valuation of variation itself. Variation was its own epistemic virtue and, moreover, variation gave the evidence of experience a particular form, one which was concerned with searching for positively appreciating idiosyncrasies … In this way, so-called not uncommon problems were refused the label of pathology or deviance, and instead were heralded unexceptional variations that non-professionals could recognize, monitor and manage (Murphy, 2012: 86, emphasis added).

This ethos was most acutely articulated in the Boston Women's Health Book Collective's bestselling Our Bodies, Ourselves (1971). Women were encouraged not to compare themselves with schematized diagrams in medical textbooks, but rather to compare with each other, in groups, using speculums and mirrors to highlight the infinite varieties of vaginas. Women were taught to explore their individual bodies in relation to pleasure, and to note changes to their own bodies over time rather than variation from a so-called norm as guide to health. In addition, vision was only as important in this exploration as other senses such as touch, smell and taste. Early feminists encouraged all women to taste their menstrual blood in the name of self-acceptance (Greer, 1970). However, this call to think of reproductive health as 'not rocket science' and therefore accessible to and practicable by women themselves also produced an individualized ethical subject who should take responsibility for her own health.

> Feminist self-help, with vaginal self-exam as its iconic protocol, was one of the most sustained efforts to practice science as feminism … A new moral economy of healthcare arose – calling for the well educated, well informed, self-knowing patient to be prepared to advocate for herself as a consumer within corporate medical institutions (Murphy, 100-101).

Obviously, however, this entailed a very classed position and it is questionable to what extent working-class women could have either the knowledge or authority to occupy such a position. Fifty years on many of the protocols developed by the women's health movement have become standard practice in maternal medicine and healthcare. Individualized birthing plans, for instance, are now ubiquitous in the UK's NHS, which as we have seen, also advocates individual vaginal variety as the norm. I have argued elsewhere that the natural is valued by the middle class precisely because it appears 'effortless', whilst a working-class aesthetic values the labour that goes into producing an enhanced appearance – making the best of oneself (Holliday and Sanchez Taylor, 2006: 190).

Taking Control

Another issue is worthy of note: whilst the women's health movement was largely rallying against medical intervention in women's bodies, other women were looking for intervention and finding it lacking. Designer vaginas are most often associated in both feminist literature and media panics with young women having labiaplasties but the majority of women undergoing vaginoplasty – 'tightening' surgeries also

associated with designer vaginas - are older, post-childbirth women. Furthermore, whilst vaginoplasty is a relatively recently named procedure, it has been practiced for many years as repair to prolapse. It is estimated that around 50% of women will develop prolapses at some time after giving birth, resulting in symptoms ranging from a heavy feeling caused by the collapsing of the bladder (cystocele) or the bowel (rectocele) through the vaginal wall into the vagina, to a full prolapse where the uterus literally protrudes through the vaginal opening. For ten years after its formation in 1948, repair to prolapse was the most common procedure performed by the UK NHS on women who had been using various contraptions to hold prolapses in place. However, medical intervention is considered unnecessary for mild symptoms in the 'normal range' which for cystocele includes 'urinary frequency, urgency, incontinence, intermittent flow, straining to void, feeling of incomplete bladder emptying and poor stream', and for rectocele are 'difficulty in defecation … excessive straining to empty the bowels, feeling of incomplete bowel emptying, constipation' and the common necessity of manually evacuating the bowel by inserting a finger into the rectum or vagina or manually applying pressure to the perineum (Digesu et al., 2005: 971).

Both repair to prolapse and 'vaginoplasty' or 'vaginal tightening' often involve the same procedure where a (damaged) piece of the vaginal wall is removed and the edges of the removed tissue re-sutured resulting in a narrower chamber (Iglesia et al., 2013). In more severe cases a 'mesh' is used as a sling to hold the pelvic organs in place above the vagina and ease incontinence.[2] Some medical sociologists now argue that because of embarrassment not enough women come forward for surgeries to prolapse, and that the normalization of stress incontinence for post-childbirth women

when laughing or running for a bus serves only the profits of companies selling pads (Hunter Koch, 2006). The key issue here is, however, whether or not 'repair to prolapse' can be separated from 'vaginal rejuvenation' and the so-called designer vagina. In our research on cosmetic surgery tourism there was some evidence of women travelling abroad for a 'designer vagina', who in reality were seeking repair for prolapse. Whilst working-class participants in our study talked about 'enhancement', middle-class participants were much more likely to position their surgery as 'correction' or 'repair' (see Holliday et al., 2015). The difference between repair to prolapse and the 'designer vagina' may thus be a difference only of classed terms.

Women in the west today have inherited from feminism a reclaimed vagina, no longer shameful and hidden but rather a vagina to be proud of, to be looked at, explored, examined and appreciated. However, in 1970s feminism looking was a collective act of solidarity between women, and an act of political resistance and defiance of a patriarchal medical profession. It was also an act that compared between women who were similarly 'empowered' - albeit women from different ethnicities and classes – by a shared feminist disposition that acknowledged and celebrated the diversity inherent in the natural. As these values have become institutionalized they have broadened their reach beyond anything the early women's movement could have anticipated, but they have also lost something. Looking today means looking alone in a context where images with which to compare one's vagina are limited for those uninitiated in online body positivity websites, or relying on the gaze of sexual partners who may reassure or undermine according to their own level of knowledge or social skill. Rather like breast examinations which also may not be 'rocket science' we are required to

examine our own bodies and only go to the doctor if we find a 'problem' – but we are given no training, we are not encouraged to feel the breasts or view the vaginas of other women with whom we could compare. Seizing the means of medical examination in neoliberal healthcare is rather a rolling back of provision so that patients now carry out medical examination on the state's behalf (and shoulder the risk of getting it wrong). 'Good' patients have been responsibilized. 'Bad' patients who fail to self-examine are cast as irresponsible and reckless, even if they do not know what they are looking for. Women's health has been outsourced into our own hands - as cost-cutting rather than empowerment. And when it comes to vaginas by which to evaluate the health of our own, images can be limited if we do not know where to look. Meredith Jones (2017) for instance shows how porn makers' attempts to evade the prudish censorship of soft porn construct only one kind of vagina as acceptable – the small, barely open and hairless vagina. And the caution of schools and healthcare and lack of peer-to-peer discussion or investigation of other vaginas (for cis-gendered heterosexual women at least) means that judging whether or not we are 'healthy' is an extremely fraught affair.

The Designer Vagina and Cosmetic Surgery Discourse

The relationship between media images and women's bodies is given prolonged and serious attention by cultural theorist Susan Bordo (1993). Beauty, she argues, is a discourse – a 'beauty system' that presents perfect bodies as normal ones. In this discourse, women are made to see their bodies as lacking and inadequate because they can never achieve the constructed images of physical perfection that flood the media

around them. And this position has perhaps become a 'Cosmetic Surgery Discourse' much like Ien Ang's (1985) account of the 'ideology of mass culture'. In the latter critical discourses on popular culture are deployed to represent the 'masses' as lacking in sophistication or discernment – working-class or women viewers must be ignorant cultural dupes to enjoy such poor-quality low culture. Similarly Cosmetic Surgery Discourse has become the position on cosmetic surgery, invoked by feminist activists, media commentators, politicians and cosmetic surgeons alike to represent women as naïvely aspiring to mediated images of 'perfection'. Many surgeons, for example, refer sympathetically to the 'pressures on women from the media to look perfect' as a rationale for cosmetic surgery, even as they insist on 'realistic expectations' for its results (see Holliday et al 2019). It is this 'ideology' that Kathy Davis (1995) challenged in Reshaping the Female Body but that nevertheless persists in multiple accounts of the designer vagina (e.g. Braun 2005; Schick et al 2010); Fahs 2014). However, more recently, Cressida Heyes (2007) has argued that cosmetic surgery is a site where 'transformed technological possibilities, consumer capitalism, the ideology of a medical subspeciality, television culture, the body-as-self, and diverse forms of resistance to the surgically constructed body all converge' (91).

Thinking of media images and discourses as uni-dimensional impositions on the naïve bodies of 'ordinary women', as Joanne Hollows (2000: 66) puts it, is not good enough. Media representations are just as likely to represent Cosmetic Surgery Nightmares as Extreme Makeovers, as to promote body acceptance as well as aspirational images, and we have known since Stuart Hall's (1973) work on encoding and decoding that TV (and by implication other screen) audiences are far from passive. Desire for cosmetic surgery is also produced in part by technological

possibilities. Consumers of cosmetic surgery weigh benefits against potential risks so that as surgical techniques improve certain procedures become more desirable. However, Heyes is still keen to foreground pain in her analysis of cosmetic surgery. Davis, she argues, justifies cosmetic surgery as an acceptable treatment for 'unbearable suffering', despite claiming that her participants' bodies were not significantly different from other women who live more happily with their 'flaws':

> I did not necessarily share these women's conviction that they were physically abnormal or different. Their dissatisfaction had, in fact, little to do with intersubjective standards for acceptable or 'normal' feminine appearance … I rarely noticed the 'offending' body part, let alone understood why it required surgical alteration (Davis, 2003: 77, quoted by Heyes 2007: 106).

Drawing on Davis' evidence, Heyes proposes that psychological pain is attached through medical discourses, after the fact, to body parts that fail to live up to ever-shifting external standards. Heyes argues that the cosmetic surgery recipient is 'encouraged through the discourse of identity, to displace her unhappiness onto her failed body' (109). She develops this theory through an examination of the US reality TV show Extreme Makeover. Since failed body parts are not, for Heyes, the real source of pain, cosmetic surgery can never eradicate the latter. Instead, when happiness does not result from the first surgery, another body part becomes problematic and the process is repeated.

The Neoliberal Vagina

Whilst there is much of merit in Heyes' critique of Davis, (and in Davis' critique of Bordo) there are limitations in using TV as 'evidence'. Most TV shows on cosmetic surgery follow a 'makeover' format with the aim of producing visual pleasure for audiences by choosing subjects who are already beautiful in many ways, but whose bodies have the exact characteristics that the technologies of cosmetic surgery can successfully 'enhance'. According to Brenda Weber, cosmetic surgery makeover TV shows aim to produce a 'new you' who is at the same time the 'real you': 'To communicate an "authentic self" one must overwrite and replace the "false" signifiers enunciated by the natural body' (Weber, 2009: 4) – an ethic that is opposite, in fact, to that articulated by the women's health movement in which natural variation equals authentic identity. However, Extreme Makeover is rooted in a neoliberal healthcare logic of rewarding the deserving (rather than providing for those in need), thus contestants must have a better 'sob story' than their rivals to qualify for the free surgeries and other treatments provided when they appear on the show. This dramatic narrative is based in suffering as the true core of American personhood and citizenship, and the moral imperative to tell and reveal oneself according to Lauren Berlant (2008). Skeggs and Woods (2012) argue that success for contestants in US reality TV depends on emoting pain 'authentically' within an appropriate therapeutic narrative, thereby presenting a 'deep' self. We might take being 'triggered' as the most spontaneous and therefore most 'authentic' performance of a valuable subject of depth. This performance is very different from the actual cosmetic surgery patients that Debra Gimlin interviewed who talked about deserving their surgeries as a reward for taking care of their health or saving up (2012). It also departs from the narratives of UK patients we interviewed who simply wanted a specific problematic body part

made better (Holliday, Jones and Bell, 2019). Yet writers on cosmetic surgery frequently take media representations as the empirical truth of cosmetic surgery, rather than entertainment constructed for viewers' visual pleasure. Reading dissatisfaction with one's appearance as pain, then, may be taking a neoliberal TV narrative of deservingness at face value – though plenty of cosmetic surgery patient consumers also deploy this discourse to qualify for surgery in the UK NHS. We must ask the question, then, is it naïve victims of designer vagina surgery that are taken in by popular representations of cosmetic surgery or rather, cultural critics and feminist scholars?

Vaginas, of course, are largely invisible on makeover shows – they are not suitable for the classic 8-9 evening viewing slot of family TV that reality TV occupies. However, vaginas can sometimes appear – appropriately medicalized and therefore de-sexualised - on TV shows like Channel 4's Embarrassing Bodies. Embarassing Bodies presents patients seeking treatment for 'embarrassing' medical problems from psoriasis and foul-smelling perspiration to 'man boobs', haemorrhoids or vaginal prolapse. Promotional material for the show features three doctors viewed from between a woman's splayed legs. The vagina, it seems, marks embarrassment most effectively – but this does not mean it cannot be seen, discussed and 'helped' – the emphasis of the show is, after all, to throw off embarrassment. Embarrassing Bodies frequently features 'reconstructive' surgery as a solution for medical problems - carefully separated from 'cosmetic' surgery as an issue of beauty - and sanctions plastic surgery for 'medical reasons', correcting bodies that deviate significantly from the norm. However, despite deploying a standard medical discourse of correcting bodies to restore self-esteem, the programme is never finally able to make a clear

break between the reconstructive and the aesthetic (or the mind and the body). Embarrassing Bodies foregrounds 'acceptable' rather than 'beautiful' bodies, and its tone is paternally empathetic. It aims to reassure patients with problems they find too embarrassing to tell their own doctors about, that they are not alone and that they can find a sympathetic ear from the right kind of (privatised) medical professional. The show largely deals with extreme cases but it is the only place on UK TV that one might legitimately witness a vaginal prolapse or 'disproportionate' labia minora. One episode even featured a woman, anxious because she had a double vagina, and reassured her that she was potentially twice as fertile! Embarrassing Bodies hails the active, responsibilized patient in a reassuring tone, empathising with rather than dismissing the problems of women's vaginas. Freed of the NHS economic logic of healthcare rationing, Embarrassing Bodies offers technological solutions to embarrassing problems that are neither invented in the minds of 'silly' women nor constructed by the medical gaze in the pursuit of profit, but are rather co-constructed by medic and patient together as they agree what a liveable body is and create the justification for producing it. In doing so, however, the show promises outcomes that can rarely be delivered in nationalised healthcare. Embarrassing Bodies echoes Makeover TV in promoting the mechanisms and technologies necessary for improvement and the associated discourses of improved confidence and self-esteem. As Oullette and Hay (2008) put it: 'Citizens are increasingly obliged to "actualize" and "maximize" themselves not through "society" or collectively, but through their choices in the privatized spheres of lifestyle, domesticity, and consumption' (12), and, we might argue, pleasure. For instance, in our study of cosmetic surgery tourism we met Debbie who had a breast augmentation in Spain. She told us: 'I was really young

when I had them, and now I'm older, you know, and more confident, I probably wouldn't have them now …' [then, laughing] 'But then again, I have enjoyed them!'

It would be difficult to think through cosmetic surgery to the vagina without considering pleasure. Whilst feminists have associated the designer vagina with FGC and sacrificing pleasure for aesthetic norms, there is very little evidence to suggest that labiaplasty curtails sexual pleasure. For instance, a study of Aesthetic Labia Minora and Clitoral Hood Reduction of a 407-woman cohort (Alter, 2008) reported a 98 per cent satisfaction rate with labial reduction surgery and whilst some participants were too young to report on this issue, 71 percent of the total reported a better sex life as an outcome.

Conclusions

Whilst Extreme Makover represents surgery as multiple cosmetic procedures in search of beauty, validated as reward for unbearable suffering, Embarrassing Bodies aspires to a liveable body achieved through a single reconstructive surgery in pursuit of health. Both shows represent acting on the body as the key to greater happiness and thereby reflect variations of a neoliberal approach to healthcare and project of the body/self. However, Embarrassing Bodies reflects a narrative much closer to actual cosmetic surgery patient-consumers' stories than Extreme Makeover. It is also important to recognise that the women's health movement is not separate from this neoliberal ethic but rather is continuous with it. It was the women's health movement, after all, that first implored women to look at, to know, to take control of their health

and bodies, and vaginas in particular. It is looking at each other's vaginas in a collective setting that has been lost. One must now gaze, but only in private.

Feminist scholars of the vagina have tended to represent vaginoplasty as creating a tighter vagina to enhance men's sensual pleasure (Braun and Kitzinger, 2010) and labiaplasty as enhancing men's scopophilic pleasure. Alternately they have used arguments such as Rosalind Gill's (2003), that whilst (postfeminist) women may think they are now active, knowing and desiring sexual subjects, in reality they have simply replaced a traditional male gaze with an even more pernicious form of 'sexual subjectification' – the 'self-policing narcissistic gaze' (2003: 104). This has at its core a 'deliberate re-sexualisation and re-commodification of bodies' (2003: 105). Gill breaks with the idea of beauty as pain - which I have shown above to be the dominant framework in Cosmetic Surgery Discourse, and the highly contrived and sentimental mediatized narratives of cosmetic surgery in reality TV. But pleasure, for Gill, is even worse, betraying a new and tighter form of subjectification in which sexualisation is women's key or only identity. However, Feona Attwood (2011) argues that the proliferation of women-produced Alt-Porn such as Gothic Sluts, Nakkid Nerds, Beautiful Agony or Furry Girl – 'created by a real gal with a hairy pussy, hairy pits and hairy legs' – disrupts male-gaze, mainstream porn and provides an alternative vision of sexy for women. She argues that these sites promote different and divergent versions of femininity – and vaginas - that viewers can play with. In addition she claims that Alt-Porn producers and consumers are 'not only or always sexual' but that sexualisation is one performative part of a much broader identity (2011: 212). Finding the porn vagina amongst this growing cacophony of women-made porn is becoming increasingly difficult. And, as Meredith Jones argues:

> The desire to show oneself is different from a wish to be seen because showing indicates choosing: determining when, how, and in what circumstances one will be seen. Labiaplasty, along with all cosmetic surgery, is an attempt to manage and control the way one is seen. (Jones, 2017: 43)

The ‘designer vagina’ is certainly a product of the increasing visibility of the vagina, but this visibility is also indebted to feminist struggles to wrestle the vagina away from a disparaging and misogynistic medical gaze, to knowing one’s own vagina, and ‘seizing the means of reproduction’. It is also testament to feminist struggles to ‘de-shame’ the vagina, recognize its beauty and possibilities for pleasure. Women’s vaginas, once associated with sexual fumbling under the covers and in the dark, are now on display, viewed, caressed, kissed and licked - nighties have been lifted and lights are being left on. To ignore these positive developments is to tell an incomplete story of the designer vagina.

However, the vagina’s increasing visiblity has rendered it a body part in need of management, care and attention, something that can be ‘improved’ – witness the rise of ‘intimate’ shaving, waxing and dyeing and ‘vajazzling’ (the practice of decorating the pubis with stick-on jewels) or the vagina ‘facial’. On display for sexual pleasure the vagina must be shown at its best – at least in more precarious sexual encounters and new relationships. It is now something to be evaluated – nevertheless positively by 80% of women (Yurteri-Kaplan et al., 2012). But even the possibility of ‘beautifying’ the vagina would be anathema to the older women whose narratives of concealment and disgust initiated this chapter.

Exploring the 'designer vagina' in terms of both labiaplasty and vaginoplasty makes it very difficult to draw clear demarcations between 'cosmetic' and 'reconstructive' surgery to the vagina. The vagina's new visibility opens up a different space for the discussion of the damaging effects of childbirth and the possibilities of medical interventions to repair. Whilst urinary or fecal incontinence and visible injuries sustained during birth may cause anxiety at the best of times, these 'embarrassing bodies' are exacerbated in anticipation of sex. Western feminists have made problems such as incontinence resulting from post-FGC childbirth central to campaigns against vaginal cutting in 'developing' countries, but they have not defended the right to surgery for post-childbirth women experiencing such problems back home.

Feminism and neoliberalism have both told us we have a right to look and feel sexy by taking control of our own bodies and sexuality. Cosmetic surgery is a privatized response to this but it is also an ethic – a taking care of oneself, a form of 'self-optimisation'. For its consumers, the designer vagina has a number of functions: the alleviation of physical discomfort; the anticipation of being shown and receiving pleasure; the reclamation of (individual) sexuality from the (distributed) and damaged maternal body. The designer vagina, I want to ague, is not a patriarchal cut to discipline a hidden, shameful or terrifying vagina but rather the (unintended) consequence of the new visibility and value afforded the vagina through hard-won feminist struggles. The designer vagina is an investment in this new visibility for vaginas outside a liveable range, and it both produces and marks a body/self of value. As the tag line goes: *'Because you're worth it'*.

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[2] At the time of writing (November 2017) a health scandal is unfolding in the UK because the brand of mesh preferred by the NHS (manufactured and sold by Johnson and Johnson) has been found to cause severe damage to women who received it – in particular for damaging surrounding organs and rendering sex painful or penetration simply impossible. Around 100,000 women in the UK have been implanted with this mesh since 2007.