“Designer Vagina”
A Study on Women’s Choices for Labia Reduction

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1. Introduction

After the appearance of Eve Ensler’s ‘The vagina monologues’ in 1998 the vagina became a topic of public discussion and inspired many women to share the stories of their vaginas as well (2001). Vaginas were mainly discussed in relation to sexual violence and sexual dissatisfaction. My first encounter with the new topic of vaginal cosmetic surgery was when I watched the 2006 Dutch documentary ‘Over the hill’ (‘Beperkt houdbaar’ in Dutch) by Sunny Bergman. Bergman’s main message was that modern women are exposed to too many images of unrealistic beauty. In the film, Bergman discusses the different effects of (unrealistic) beauty ideals on women. A part of the documentary revolves around labia reductions when Bergman visits a clinic in Los Angeles. The main argument of this part of the movie is that vaginas in porn magazines and porn movies are photoshopped or the actresses and models already had a labia reduction. This makes women feel insecure about their own vaginas because theirs do not look like the ones in porn images. According to Bergman, the number of women who want vaginal cosmetic surgery in The Netherlands is rising because of this. There is a lack of statistics on labia reductions in The Netherlands. Many labia reductions are performed in private clinics and these clinics do not have to provide statistics. Another factor is that the surgery is often not performed by plastic surgeons. Gynaecologists, urologists and even family doctors perform the surgery as well. The surgery is then not labelled as plastic surgery which makes it even harder to find statistics.

The idea of a “designer vagina” is that it is hairless, with smaller inner labia than outer labia. The outer labia of a “designer vagina” are also “tight”. This is what the plastic surgeon in ‘Over the hill’ describes as a “beautiful" vagina (1). The term “designer vagina” is used in recent feminist arguments (such as the argument by Bergman) to designate vaginas that are “created” by plastic surgeons, photoshopping or both. The term is also more widely used, for example in design and art. An example of this is the picture on the cover page (2).

Labia reduction is the most popular form of vaginal cosmetic surgery. In this procedure, the inner labia are cut as to make them smaller so that they will not peek out the outer labia (3). Since all the women I spoke with during my research had a labia reduction I will focus on this form of vaginal cosmetic surgery only. In ‘Over the hill’ this is also the focus of Bergman’s search. Whereas Bergman only investigated the American practice of labia reductions, I will only investigate the Dutch case. In her documentary, Bergman comments that this is a form of cosmetic surgery that becomes more popular in The Netherlands as well. She speaks of thousands of women and girls having it each year. Since this documentary has received wide acclaim in The Netherlands, I believe it is also very
relevant to discuss the Dutch case as well. Since I think the Dutch case differs from the
American one. One of these differences is described by Davis (1995). She writes that in the
United States, a market model of medicine is obtained, which is based on the principle of
“fee-for-service” (1995, p. 29). ‘In a market model of medicine, controversies about care tend
to center around the problems of risk, informed consent, and malpractice’ (1995, p. 30). The
Netherlands have a welfare model of medicine which in theory means that ‘…a patient has a
right to any form of health care he or she needs’ (1995, p. 32). ‘In practice, however, many
health care services are too expensive for the state to fund’ (1995, p. 32). Therefore there
exists a discourse in The Netherlands about whether or not a medical service or surgery is
really necessary. Thus in the United States people are mainly concerned with the quality of
health care since people should get what they paid for. In The Netherlands, people are
more concerned with “unnecessary” health care since it is often paid for by the whole population.

While searching for literature about vaginal cosmetic surgery, I noticed there was very
little specific social scientific literature to be found about vaginal cosmetic surgery. Quite a lot
has been written about cosmetic surgery in general, but vaginal cosmetic surgery is often left
out of these analyses. Most texts I could find that were specifically about vaginal surgery
were medical texts. These texts however, did not elaborate on cosmetic surgery but on surgery
for reproductive purposes and more physical, health-related issues. Only one text, by Virginia
Braun, a psychologist, is both social scientific and specifically about vaginal cosmetic surgery
(2005). In her article ‘In search of (better) sexual pleasure: Female genital “cosmetic”
surgery’, she focuses especially on female genital cosmetic surgery with regard to sexual
pleasure. I will analyze the topic of sexual pleasure in more detail below. Aside from the fact
that there is very little known about vaginal cosmetic surgery, I also believe it is a relevant
topic because it is a fairly recent and increasing phenomenon in western societies (Braun,
2005). According to Braun, the surgery itself is not new but it is carried out more. She argues
this through analyzing an interview with a plastic surgeon who performs these surgeries since
twenty years (2005, p. 408). Braun does not clarify in which country this surgeon works, only
that it is a western country where English is the main language. Two decades ago this surgeon
did a couple of surgeries a year, now he performs one or two surgeries every month. Sheila
Jeffreys, a theorist in gender studies and sexuality studies, provides a potential reason why
these surgeries have increased in popularity (2005, p. 79). Since the 1980s it has become a
trend for porn models and porn actresses to have completely shaven vaginas. She writes: ‘As
a result of Brazilian waxing, women became more aware of their labia because they were now
visible in a way they had not been before’ (2005, p. 82). In other words: shaven vaginas made the labia more visible.

Aside from this scientific relevance, I believe the topic of vaginal cosmetic surgery has a social relevance as well, especially for those women contemplating whether or not to have a labia reduction. Doctor Ozer (a Dutch plastic surgeon in training and sexologist and also one of my informants) told me that very little is known about the effects of labia reduction on sexual sensation, both physically and psychologically (3). I intend to ask my informants about differences regarding their sexual pleasure before and post surgery. My research will contribute (although for a small part) to the ongoing research on this topic.

In feminist representations such as Bergman’s, the practice of labia reduction is viewed as a problem, subjugating women to looking pretty. What I usually miss in these representations are the voices of women themselves. In both documentaries, one or two young women are interviewed about their motivations. I did however not agree with the biased questions they were asked to answer and the general way these women were portrayed: as victims of the beauty industry and their own self-confidence problems. There was also some kind of moral superiority present in these depictions. As if the documentary makers wanted to say: ‘Thank God we are smart women and that we are not as superficial to think plastic surgery will actually make our lives better’. Rather than bluntly stating which motivations women who choose a labia reduction have, I hope to achieve something else. One of the aims of this thesis is to provide insight in the process of choice women who have had a labia reduction went through. Another aim is to provide women an opportunity to explain what their personal motivations were for having a labia reduction. Therefore I would like to answer the central question: Which factors influence Dutch women’s decisions to have a labia reduction?

I situate my data in the theoretical debate about structure and agency regarding cosmetic surgery. This feminist debate revolves around the question where the choice for cosmetic surgery comes from: structural forces such as the beauty industry (or beauty ideals) or personal motivations and deliberations. I will describe this debate in further detail in chapter 2, the theoretical frame. After describing my theoretical framework I will describe the methods I used during my research in chapter 3. Then I will present and analyze the results of my research in two chapters. Chapter 4 will mainly deal with ‘structural properties’ as described by Anthony Giddens (1979, p. 235). Giddens views ‘structural properties’ as the conditions according to which individuals act. I distinguish three ‘structural properties’ in relation to the topic of labia reduction, namely: beauty ideals, shame, and the medical gaze.
“Shame” is a concept which I derived from the interviews with my informants who had a labia reduction. ‘Beauty ideals’ and ‘the medical gaze’ are concepts which I derived from social scientific literature on structure and agency regarding cosmetic surgery. I relate these concepts or ‘structural properties’ to the ways my informants acted upon them. In chapter 5 I will deal with the more personal motivations my informants had for a labia reduction. I focus on ‘private suffering’, surgical experiences, and the result of the surgery (Davis, 1995). I choose to focus on structural forces in one chapter, and personal motivations in the other chapter, because it reflects the structure/agency debate. With ‘personal motivations’ I mean the individual and unique motivations my informants had for their labia reductions. During their lives, one or more events occurred which proved to be essential factors in their choices for a labia reduction. In chapter 6 I will give a theoretical analysis of the results of my research. In this chapter I will build towards a middle ground theory based on the concepts of structure and agency by linking the structural influences on my informants’ decisions to the personal motivations behind their choices. To conclude, I will answer my central question in chapter 7. We will see that during the individual processes of choice for a labia reduction it is difficult to distinguish structural influences from agency and that in fact, the choice for a labia reduction is made in a space I call the middle ground, where structure and agency interact, instead of counteract.
2. Theoretical frame

The theoretical debate with which I intend to analyze my data is the structure/agency debate. From this debate a specific feminist debate about cosmetic surgery follows. This debate is about whether having cosmetic surgery emanates mainly from structural forces or from individual motivations. In order to describe the feminist debate about cosmetic surgery it is important to define the concepts of structure and agency first.

Giddens defines ‘structure’ as ‘structural properties’ providing the binding of time and space in social systems (1979, p. 235). He argues that ‘… these properties can be understood as rules and resources, recursively implicated in the reproduction of social systems’ (1979, p. 235). In other words: structure provides agents or individuals conditions according to which they act. He defines agency as a continuous flow of conduct (1979, p. 232). ‘Power is generated by definite forms of domination in a parallel way to the involvement of rules with social practices: and, indeed, as an integral element or aspect of those practices’ (1979, p. 237). In other words: agency is the capability of individuals to act under structural relations of power.

Structure/agency debates are often about whether human action has followed from structural forces or from individual motivations. I would like to describe the feminist structure/agency debate about cosmetic surgery using the theories of two feminist thinkers: Naomi Wolf and Kathy Davis. Naomi Wolf is most famous for her book The beauty myth which appeared first in 1990. She is an American writer and received her Bachelor of Arts at Yale University. In The beauty myth Wolf describes the effects images of beauty have on women (1990). Her main argument is that it is because of unrealistic images of beauty that women feel ugly and want to have cosmetic surgery. Therefore, women who have it are victims of the patriarchal system. She writes: ‘The contemporary ravages of the beauty backlash are destroying women physically and depleting us psychologically’ (1990, p. 19). In other words: Wolf believes women merely have cosmetic surgery because the beauty industry tells them to have it. She regards the beauty industry as a structural force according to which women have cosmetic surgery. Therefore I consider her a representative of the ‘structure side’ in the structure/agency debate about cosmetic surgery.

Kathy Davis is an American scholar and has taught psychology, sociology and gender studies at several universities in several countries. Since 1990 she works and lives in The Netherlands. In Reshaping the female body Davis opts for a new way of looking at cosmetic surgery by being critical of it, but at the same time by taking seriously women’s choices to have it (1995, p. 160). Davis argues cosmetic surgery is a choice women make and that it is
not necessarily a bad choice. She writes that cosmetic surgery ‘…can provide an avenue toward becoming an embodied subject rather than an objectified body’ (1995, p. 114). Thus Davis believes that women have good reasons to have cosmetic surgery and feminists should take these reasons seriously. Since *Reshaping the female body* is about the way individual women act under government rules and beauty ideals, I consider Davis a representative of the ‘agency side’ in the structure/agency debate about cosmetic surgery.

My data mainly consists of interviews with women who had a labia reduction. From these interviews I derived the main concept of shame. In the context of this thesis, I regard ‘shame’, together with the concepts ‘beauty ideals’ and ‘the medical gaze’, as ‘structural properties’ which provide women conditions under which they choose a labia reduction (Giddens, 1979). I view agency as women’s personal motivations to have a labia reduction. A focus should be the process of choice these women have gone through which resulted in their choice for vaginal cosmetic surgery. I will describe these motivations in chapter 5. Now I will provide some theoretical backup about the three main concepts.

Wolf defines the beauty industry as some sort of political tool of female suppression:

“Beauty” is a currency system like the gold standard. Like any economy, it is determined by politics, and in the modern age in the West it is the last, best belief system that keeps male dominance intact. In assigning value to women in a vertical hierarchy according to a culturally imposed physical standard, it is an expression of power relations in which women must unnaturally compete for resources that men have appropriated for themselves. (1990, p. 12)

Ideas of what a “beautiful” woman looks like are disseminated in the form of millions of images (1990, p. 16). These images are “retouched”, as Wolf calls it (1990, p. 82). In 1990 the term Photoshop was not as widely used as it is nowadays. But the practice of artificially making women in pictures look more “beautiful” did exist. Wolf writes: “‘Computer imaging’ – the controversial new technology that tampers with photographic reality – has been used for years in women’s magazines beauty advertising” (1990, p. 83). The practice of “computer imaging” or “photoshopping” fits with Michel Foucault’s logic of censorship (1998, p. 84). This censorship has three forms: affirming that something is not permitted, preventing that such a thing is talked about, and denial of its existence. By artificially altering pictures of women to suit a beauty ideal, the existence of women who do not fit this ideal is denied. Unlike Wolf I will not regard the beauty industry as a political tool used by men in
order to remain dominant over women. I will regard the beauty industry as a ‘displayer’ of beauty ideals which can influence individual women’s contentment about their own bodies. I choose to do this because I do believe the beauty industry to be the main supplier of beauty images in mass media. Beauty ideals displayed by the beauty industry influence women’s perceptions of their own bodies. Therefore I decided to name this ‘structural property’ ‘beauty ideals’ instead of ‘the beauty industry’ (Giddens, 1979).

The ‘structural property’ that emanated from the interviews with my informants is shame (Giddens, 1979). Perhaps it seems somewhat odd to consider shame a ‘structural property’ since it is a very personal emotion (Giddens, 1979). Shame is however also related to beauty ideals since it has to do with the wish to confirm to a norm of what one should look and act like. Sandra Bartky, a philosopher, wrote an article about female shame called *Shame and gender* (1990). Bartky’s definition of shame is as follows:

Shame is the distressed apprehension of the self as inadequate or diminished: it requires if not an actual audience before whom my deficiencies are paraded, then an internalized audience with the capacity to judge me, hence internalized standards of judgment. (1990, p. 86)

Thus one is ashamed because one internalizes certain feelings of what one believes is appropriate and what is not. Bartky further states that shame and feelings of inadequacy are difficult to distinguish (1990, p. 89). She writes about internalization:

Something is “internalized” when it gets incorporated into the structure of the self. By “structure of the self” I refer to those modes of perception and of self-perception which allow a self to distinguish itself both from other selves and from things which are not selves. (1990, p. 77)

A second sense of internalization is that ‘…one knows how to do’ (1990, p. 77). Thus, social norms and morals can be internalized as part of oneself. Bartky calls shame ‘profoundly disempowering’, because: ‘The experience of shame may tend to lend legitimacy to the structure of authority that occasions it, for the majesty of judgment is affirmed in its very capacity to injure’ (1990, p. 97). Thus individual shame confirms the authority that makes a certain act shameful in the first place. Therefore, shame has a “useful” function because it provides agents with a pressure to return to a certain equilibrium, or what I would like to call
a certain norm (1990, p. 96). Davis describes the Dutch norm towards cosmetic surgery: ‘In a culture with a Calvinist tradition which cautions against frivolity and excess, cosmetic surgery tends to be problematic, requiring some explanation on the part of the would be recipient’ (1995, p. 6). She later describes how her informants felt ashamed for feeling so ashamed for their looks that they choose cosmetic surgery. One of Davis’ informants describes for example that she was told by her family not to complain about her looks since she was healthy and that was the important part (1995, p. 85-86).

The last ‘structural property’ providing women with conditions to have cosmetic surgery is the medical gaze (Giddens, 1979). This concept is introduced by Michel Foucault in his book *The birth of the clinic* (1973). He analyzes medicine and medical science as a powerful institution with an authority on knowledge. He describes the medical gaze as ‘… no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention’ (1973, p. 89). In other words: individual doctors have “power over knowledge”. Also, “the gaze” is ‘…always receptive to the deviant’ (1973, p. 89). Thus, medical institutions partly decide when something is “not normal”. An example of this is offered by the psychologist Virginia Braun when she writes about vaginal tightening. In the procedure of vaginal wall tightening, the wall of the vagina is tightened through laser burning (4). Braun writes:

…sexual pleasure was often (although not exclusively) framed as being derived from coitus, particularly in the case of vaginal tightening, and the sexual pleasure that is derived was typically orgasmic. In this sense, it [LF: vaginal tightening] 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. (2005, p. 418)

Because it is considered “normal” for women to orgasm trough penile-vaginal penetration alone, the practice of vaginal tightening is offered for women who are not naturally able to do this. In this thesis I view the “power over knowledge” as the influence medical practitioners have on the decisions and choices of my informants.

Although these are ‘structural properties’, women who want cosmetic surgery do act under the conditions set by beauty ideals, medicine, and shame following certain social norms (Davis, 1995; Giddens, 1979). According tot Davis, when a woman suffers because of her looks she does not necessarily has to be “ugly” according to cultural norms, she can even be
considered “pretty” (1995, p. 91). Davis’ informants’ general main motivation for cosmetic surgery was that they wanted to look “ordinary” (1995, p. 90). ‘Ordinariness is, first and foremost, a matter of experience’ (1995, p. 91). This is what Davis means by ‘private suffering’: it does not have to have anything to do with how “pretty” a woman looks according to cultural norms and thus it is very subjective. This suffering made it understandable for Davis that her informants wanted to have cosmetic surgery. For them, cosmetic surgery was the best possible way to enlighten their suffering.

I hypothesize that women’s motivations for labia reductions do not emanate only from ‘structural properties’ (i.e. beauty ideals, medicine or shame) or from ‘agency’ (i.e. women’s individual motivations) (Giddens, 1979). I suspect to find that there is a ‘middle ground’ where structure and agency both have effects on women’s choices. My hypothesis is best represented by Giddens’ concept of the ‘duality of structure’ (1979). He writes: ‘The concept of structuration involves that the duality of structure, which relates to the fundamentally recursive character of social life, and expresses the mutual dependence of structure and agency’ (1979, p. 237-238). My interpretation of his ‘duality of structure’ is that structure and agency mutually form each other. First of all, in the ‘duality of structure’ structure does not necessarily have to be something that represses agency:

It is an essential emphasis of the ideas developed here that institutions do not just work “behind the backs” of the social actors who produce and reproduce them. Every competent member of society knows a great deal about the institutions of that society: such knowledge is not incidental to the operation of society, but is necessarily involved in it. (1979, p. 238)

Thus structure also enables agency. A good example of this is the way cosmetic surgery provides for women a possibility to enlighten their ‘private suffering’, as I described above (Davis, 1995, p. 90-91).

The above quote by Giddens contains a second characteristic of what the ‘duality of structure’ looks like: social actors produce and reproduce structural forces and institutions (Giddens, 1979, p. 238). So individual actors can make structural changes. I would like to argue that structure and agency work with and within each other in individual actors’ choices for labia reductions. This is what I designate as the “middle ground” between structure and agency. As described above individuals may internalize certain social norms and then it becomes part of the “structure of the self” (Bartky, 1990, p. 77). I imagine that the
motivations of an individual woman come forth out of this “structure of the self” which consists out of certain internalizations and certain individual traits and thoughts. Therefore motivations for a labia reduction are also a mix of these internalizations and individual thoughts. For an individual who makes a choice in everyday life, like a woman who chooses to have cosmetic surgery, it is probably not possible to make a clear division between these internalizations and her individual motivations.
3. Used methods

The main part of my data consists of in depth interviews. Another smaller part of my data consists of emails and informal conversations I have had with a range of people. I had some email contact with people working in the Dutch sex industry. I contacted these people to find women who had a labia reduction for professional purposes. When they could not help me (and some tried very hard) I realized I could use their opinions on the subject of labia reductions as well.

I conducted two in depth interviews with plastic surgeons and four in depth interviews with Dutch women who had a labia reduction. I met Dr. Ozer through Gert Hekma, one of my teachers at the University of Amsterdam. I came into contact with Dr. Buncamper through Peter Velthuis; owner of a number of private clinics in The Netherlands called the Velthuis clinics. Dr. Buncamper works in one of these clinics. It was Dorine Greshof, one of my teachers at the University of Amsterdam, who brought me into contact with Peter Velthuis. I met Jeanne through one of her colleagues, who is the father of my boyfriend. Deborah responded to my post on the internet forum of the magazine “Cosmo girl”, the Dutch variant of the magazine Cosmopolitan aimed at teenage girls and young adolescent girls. I met Suzanne through Dr. Buncamper, one of my informants. He is the one who performed Suzanne’s labia reduction and they are also very close friends. They met because they both work at the same private clinic. Anne responded to my post on “marktplaats.nl” (literally translated: “marketplace.nl”), a Dutch web community where people trade all kinds of goods and services, comparable to “eBay”. She emailed me that she would like to talk to me, but rather not in person. Therefore I interviewed Anne via the telephone twice. At the time of the first interview Anne had had the surgery just two days before. Therefore I called her again a month later to talk about the result of the surgery and how she was doing. All the interviews were conducted in Dutch, the mother language of my informants and me.

I had much difficulty finding women who had a labia reduction and when I found them it was very hard to find them willing to speak to me about it. I have posted around thirty posts on several internet forums, including medical forums, forums about plastic surgery, and forums from women’s and girl’s magazines. From all these posts I got two responds, from Deborah and Anne. I also told everyone in my social surroundings who was willing and sometimes less willing to hear what my research was about and that I was looking for women to interview. This way I came into contact with Jeanne and Suzanne. There were several other people in my social surroundings who knew a woman who had a labia reduction. Either they did not know this person well enough to ask them if they were willing to be interviewed or the
woman in question did not know that my friend knew about her labia reduction. In the latter case my friend knew about the woman’s labia reduction through other people whom the woman had confided. My last resource, snow ball sampling, also proved to be quite unhelpful. I asked all my informants whether they knew other women who had a similar surgery. Only Suzanne knew someone but unfortunately this woman was not willing to speak to me.

I think it is important to introduce my informants before I move on. Dr. Ozer almost finished her education to become a plastic surgeon. She is also a sexologist. She works in the Amsterdam Medical Centre (Amsterdam Medisch Centrum). Dr. Buncamper is a plastic surgeon in the Medical Centre of the Open University (Vrije Universiteit) in Amsterdam. He is specialized in transgender surgeries (female to male and male to female) and in genital plastic surgery. Jeanne (a pseudonym) is 49 years old and works at the Dutch police. She had a labia reduction about five years ago, when she was 44 years old. Deborah (a pseudonym) is 20 years old and is currently studying. She had a labia reduction about three years ago, when she was 17 years old. Suzanne is 30 years old and works in a clinic for plastic surgery as a consultant, which means she escorts the patients through the process of having surgery. She had a labia reduction about a year ago, when she was 29 years old. Anne (a pseudonym) is 27 years old and works at the service desk of a large Dutch supermarket chain. I realize that the information about my informants is somewhat concise. I choose to do this because my informants all valued their privacy very much. They had reasons not to tell certain people in their social surroundings about their labia reduction. I decided I did not want to violate their trust by revealing their identity by describing too many personal characteristics.

After the interview with Anne, which was the last interview, I made a decision. Although I initially aimed to interview at least ten women who had a labia reduction it was simply too difficult and time consuming to find this many informants. Financial reasons played a role in my decision to stop searching for informants fulltime. Still I believe the data I gathered to be rich enough to base an analysis on it. It is not the aim of this thesis to make generalizations about Dutch women who have labia reductions. My aim is to provide insight into the process of choice of some Dutch women who had a labia reduction. Therefore I decided to forget about the quantity of my interviews and focus on the quality of my data. This proved to be good enough to write a thesis based on six interviews. Moreover, the fact that women who had a labia reduction are so hard to find is a research result in itself. It indicates the big taboo surrounding labia reductions. I will elaborate on the subject of taboo in chapters 4 and 6.
Before I began with my research I operationalized my variables, thus creating sub questions from which I then derived the questions I posed to my informants during the interviews. My variables were: age, geographical location, ethnicity, gender, sexual orientation, sexual practices/habits, social class, and level of education. Some of these variables turned out not to be very important for the choice my informants made. These variables were geographical location, ethnicity, and level of education. However from the sub questions I made that were operationalized from the other variables (age, gender, sexual orientation, sexual practices/habits, and social class) I was able to obtain much information. The sub questions were such that I could later easily divide the content of my interviews over the different sub questions, at the same time categorizing them per variable. I made a verbatim of the interviews with Dr. Ozer, Dr. Buncamper, Jeanne, Deborah, and Suzanne. It was not possible to literally translate the interview with Anne since this was an interview over the telephone. From this data analysis the concept of shame came forth. Shame turned out to be of major influence in the process of choice my informants went through.

I would now like to explain how I intend to measure my main concepts. The influence ideals of beauty have had on my informants is measurable from their perception of a “beautiful” vagina and where they have seen “beautiful” vaginas. Their perception of what a “normal” vagina looks like is also an important indicator for the concept of beauty ideals. I intend to measure shame through the amount of persons my informants confided with the information they had a labia reduction. What is also important is why they told specifically these persons and why they do not tell certain other people. I would like to measure the influence of doctors and medical institutions through my informants’ account of what happened when they first went to a medical practitioner. I am especially interested which medical practitioners they went to and what these practitioners said to them or asked them. This of course will mainly clarify the influence of individual doctors. The influence of medical institutions is measured through my informants’ experiences with the Dutch health care insurance system. What is especially important to look at is whether my informants received health care coverage for their surgery and on which grounds.
4. Structural properties

In this chapter I present some of the most important data from my research. This chapter revolves around the influence of ‘structural properties’ on my informants’ decisions (Giddens, 1979). First I will describe the effects of ideals of beauty on my informants. Then I will describe the shame my informants felt because they had a labia reduction. Finally, I will describe the influence of medical practitioners on my informants’ decisions for a labia reduction.

§ 4.1 A “beautiful” vagina

As I already described in the introduction there exists an idea of what a “beautiful” vagina looks like. A “beautiful” vagina is hairless, has tight outer labia, and inner labia that do not ‘peek out’ between the outer labia. In the documentary ‘Over the hill’ this is described as the ideal image of a vagina. With the help of photoshopping, every vagina in the media such as Playboy and American porn is made to fit this ideal. Pictures like the ones below (5) leave women with unrealistic notions of what a vagina should look like. According to Bergman, the maker of the documentary, this is the reason why the practice of labia reductions has become more and more common in the United States and is becoming very popular in The Netherlands as well (1).

Because I heard the designation “Playboy pussy” so much during the interviews, I decided to contact people from the Dutch porn industry. I assumed many women who work in this industry had had a labia reduction. This assumption is also ventilated in ‘Over the hill’. However, the people I contacted did not know any women working in the Dutch sex industry who had had a labia reduction. Some of them even tried really hard to find women I could interview, without any results. Dutch porn star Kim Holland explained to me why over email. I translated her email from Dutch to English:
Hi Lilian,
Labia reduction in porn is something typical American. I do not know of any such case in The Netherlands. It is just like this: if you are pleased with it [LF: your labia] you will join a short movie sooner. Girls who have a labia reduction in The Netherlands mostly do it because they really have physical strain. But I do not know anybody like that in porn as well. There is no ideal. The girls are real Dutch girls [LF: as opposed to “fake American porn actresses”] in all shapes and sizes. I am sorry I cannot help you.
Good luck!
Sweet regards Kim

Thus, Kim Holland thinks labia reductions are not at all common in the Dutch porn industry. With the words “real Dutch girls” she suggests that in The Netherlands the porn actresses have a more “natural” look as opposed to porn actresses in the United States. What I could detect from the emails I received from editors of Dutch porn magazines is that the size and shape of inner labia are just not that important in the Dutch porn industry. One of the editors of a Dutch porn magazine even sent me magazines which were centred on women with quite large inner labia. This is especially interesting since ‘Over the hill’ presents the ‘porn vagina’ as an ideal which causes many young women to have a labia reduction. Bergman went to the United States to interview American women. Since labia reduction in porn is more of an American practice according to Kim Holland, it is understandable ‘Over the hill’ focuses on the representation of vaginas in porn. However, this documentary is Dutch and thus reaches for a large part only Dutch people. The ideal porn vagina is represented as a problem to Dutch women while in general it seems to be no issue in the Dutch porn industry. Of course, American porn is also highly available in The Netherlands and therefore could influence Dutch women’s view on what a “beautiful” vagina looks like. What I would like to emphasize is that ‘Over the hill’ displays the presumption that all porn actresses had labia reductions based on research in the United States. But for Dutch porn actresses this does not seem to be true. This way, the documentary creates a distorted image about the influence of porn actresses on the beauty ideal regarding vaginas.

I asked the four women I interviewed what they thought a “beautiful” vagina looks like. Indeed, they all described a “Playboy pussy”. They told me that a “beautiful” vagina should have inner labia that are smaller than the outer labia. Suzanne said: ‘It’s stupid because
I like the vagina of Pamela Anderson, which is a real “Playboy pussy” by the way. She uses the word ‘stupid’ here because she choose a technique of labia reduction which pointedly does not create a “Playboy pussy”. I will proceed further on this subject below. What is important to note for now is that Suzanne had a labia reduction for aesthetic reasons only and choose for a technique which does not create what she would call a “beautiful” vagina. Suzanne told me that she liked a vagina that is a bit girlish: tight and small labia, because it looks so “perfect”. Jeanne gave me a very similar description of a “beautiful” vagina (tight, small labia). Anne said she thinks a vagina is “beautiful” if the inner labia do not peek out much only to follow this by saying that her inner labia do not peek out at all anymore and that this is just perfect to her. Thus, according to Anne, there is a “beautiful” vagina, namely a vagina that does not have inner labia that peek out between the outer labia.

When I asked my informants where they had seen these “beautiful” vaginas they all mentioned the internet and porn. Jeanne thinks especially young girls and women are influenced by the pictures they see on the internet:

> You only have to open the internet and type in the word vagina. This could not be done in my days. Girls who are exploring their sexuality find it important to look good “down there”. Maybe they compare themselves to the pictures they see on the internet.

In Deborah’s case this is certainly true. She searched the internet to see what “normal” labia looked like. Before her search, she thought the “Playboy pussy” was “normal”. When she was a child her inner labia were not hanging out between her outer labia and she thought that her inner labia grew “abnormally” during puberty. She decided to search the internet and discovered there are a lot of sides and shapes with regard to vaginas. She then decided for herself that she had larger inner labia than the average woman. But she also decided that the “Playboy pussy” was not “normal” either. Anne told me she knew that vaginas in magazines, like Playboy, are photoshopped. She started searching these pictures on the internet after she began to think about having a labia reduction. She told me that these pictures did not aggravate the issues (that had mainly to do with sexual inconveniences) she already had about her labia. Thus indeed, my informants do believe a “beautiful” vagina looks like a “Playboy pussy”. At the same time, they believe this ideal is not what a “normal” vagina looks like.

Before moving on with my argument it is necessary to describe the two surgical ways with which a labia reduction can be performed. Dr. Buncamper explained to me there are an
“easy” method and a “hard” method. In the “easy” method, a straight cut is made in both inner labia, removing a large part of the whole inner labia but of course also removing that part of the inner labia that peek out between the outer labia. This method creates a “Playboy pussy” because the inner labia are made completely invisible when a woman stands. Dr. Buncamper calls this method the “easy” method because the patient will afterwards have a smaller chance the stitches will let loose and thus a smaller chance they will have to come back for an after treatment. The “easy” method also provides less risk that the wounds get infected than the “hard” method. In the “hard” method cuts in the shape of triangles are made in both inner labia. The ends of the triangle are then stitched together. This method preserves the natural curves of the inner labia while at the same time making them smaller. This is the “hard” method because there is a lot more tension on the wounds, often causing stitches to let loose. According to Dr. Buncamper, most women who have surgery where the “hard” method is used have to come back for an after treatment.

Jeanne, Suzanne and Deborah choose the “hard” method because they wanted a more “natural” result, although they believe a “Playboy pussy” to be “beautiful”. Suzanne said: ‘When I have to go to the family doctor for a smear test I do not want him to think like: wow!’ In other words: Suzanne did not want her family doctor to think she had had a labia reduction. This indicates that my informants rather look “normal” than “beautiful”, a topic I will describe in further detail in chapter 6. Suzanne also told me: ‘In the time that I work here, I have never seen women who choose the “Playboy method”, everyone chooses the “natural” method’. For now I would like to argue that my informants choose this method because they did not want inner labia that look surgically altered but rather inner labia that look “natural”.

§ 4.2 Shame
The fact that I could only get four women to talk to me about their labia reduction, despite my many efforts, already suggests a taboo in The Netherlands about the subject of labia reduction. I do suspect that, in The Netherlands, not many labia reductions are performed, although it is hard to tell because of the absence of national statistics on labia reductions. However some women who had a labia reduction that were asked by people I know if they wanted to talk about their surgery with me expressed that they were not comfortable with this. Anne only wanted to do an interview over email or telephone because she was too ashamed to speak about it in person with somebody she did not know. Instinctively I completely understood that my informants and other women were ashamed to talk about their labia reduction. It is something I would probably not talk easily about as well. What I did not
I understand was where this shame came from. So I tried to find an answer to this question. I discovered that my informants seemed to have two kinds of shame about their labia reduction. The first kind of shame is expressed through my informants’ unwillingness to talk about their surgery because they did not want people to think they used to have “large” inner labia. I define this kind of shame as shame because of feelings of bodily “deviation”. When I asked Deborah why she told such few people about her labia reduction she said:

I was afraid people would create an image about me, like: “Look there is the girl with the large labia”. That was something I was very afraid of. That is why I did not want anybody else to know because I think if people hear such a thing about somebody, then you get labelled [LF: as “the girl with the large labia”].

Deborah was very afraid to become stigmatized. She compared this to the stigma of people who have a harelip. She says: ‘Then it is also like: “look there is the girl with the harelip”. It is shitty [LF: …to think that way] but that is how one thinks’. Suzanne told me something similar. When I asked her if she told many people about her labia reduction she instantly told me that she had told a lot of people. But then she said:

When I am at a party or something and people know where I work they often ask: “What have you had done?” Well, I tell them quite easily about my breast enlargement, but this [LF: the labia reduction] I do leave out of the story.

When I asked Suzanne why she could talk more easily about her breast enlargement than about her labia reduction she said she did not want people to think her labia used to be that big. It is apparently more shameful to Suzanne that people think she had “large” labia than that people think she had unevenly sized and “small” breasts. She had a labia reduction for aesthetic purposes only and she is afraid that people might think her labia were bigger than they actually were. In other words: Suzanne is afraid people will think she had a labia reduction because her labia were so big that she had physical strain because of them. She had a breast enlargement because her breasts were unevenly sized. Apparently this is an acceptable reason to have a breast enlargement. According to Suzanne, breast enlargements are also considered as more “normal” than labia reductions. What is similar in the accounts of Suzanne and Deborah is that they are afraid to be defined by a “deviation” their bodies once had. This could also explain why both of them choose the “hard” method because they wanted
a “natural” result. It is more important to them to be “normal” than to be “beautiful”. It is interesting to note that Suzanne easily talks about her breast enlargement, but not about her labia reduction. Apparently, the fact that she used to have “deviating” labia is more shameful to her than the fact that she used to have “deviating” breasts. What is it about the labia specifically that causes shame for my informants? I think this can be explained through describing the second kind of shame my informants feel.

I define the second kind of shame as shame because of a certain negative female image. Thus another reason why my informants do not tell many people about their labia reduction is because they are afraid to be defined as a sexually loose woman, or “this blonde pretty girl”. They are afraid to be defined as a type of woman they are not and do not want to be. This type of woman is a negative one. According to Suzanne, this is also the reason why many women who want a labia reduction say they want it because of physical strain while other motivations are often equally or even more important such as sexual or aesthetic motivations. Jeanne did not tell people at work that she had a labia reduction partly because of the abundance of male co-workers. She was afraid people would think she had sexual reasons for her surgery while this was not the case. Thus, Jeanne was afraid her male co-workers would think of her as a sexually explicit or sexually loose woman. The labia are usually only seen by another person during sex. Jeanne is afraid her co-workers will think: “What other reasons could she possibly have for such a surgery than sexual reasons?” The fear of particularly this image could have something to do with the fact that Jeanne has a managerial position and wants to be taken seriously by her male co-workers. I commented that it is interesting that this has to do with the fact that she has a lot of male co-workers. She then says: ‘Yes, but I think many women judge as well. When I talk with women… and especially in this culture like: “If you act normal you act already crazy enough” [LF: in Dutch: “Doe maar normaal dan doe je al gek genoeg”]. “If you act normal, you act already crazy enough” is a familiar Dutch saying, meaning people should not do too many things out of the “ordinary”. It implies that acting and being “normal” is already hard enough and people should not try to distinguish themselves by acting “crazy”. I believe it is telling that this saying has come up in the interview with Jeanne. It seems that labia reductions are something out of the “ordinary” in The Netherlands and therefore something one should be ashamed of.

Suzanne indicates this as well when she talks about women who want a labia reduction at her work in the clinic:
People always have the urge to talk things right. That is why I hear about physical strain all the time. Because people think aesthetic reasons are still a bit embarrassing, that it would only be about that. So it is hard for me to tell whether these women really have physical strain.

Suzanne was the only one of my informants who said she had the surgery for cosmetic purposes only. My other informants all mentioned physical strain as their main reason. They mentioned this towards me during the interviews, but also towards their doctors. I am not in the position to judge whether or not my informants really did have physical strain. Since I take the words of my informants seriously, I presume they did have physical strain. Nevertheless, it is interesting to note that physical strain is a “good” reason to have a labia reduction (or any form of plastic surgery for that matter) and that any other reason (that has to do with beauty or sex) is a “bad” reason to have a labia reduction. When I talked with my informants, this became evident as well.

Deborah was very afraid to tell people about her problems with her labia. She told her mother first, after which they went to the doctor together and ultimately made an appointment for a labia reduction. Deborah had the urge to tell some of her friends about her operation. After careful consideration, she decided to tell three friends (all girls) about it. She told these girls because she trusted them on keeping her labia reduction a secret. She says:

To my own amazement they understood it really well. Because I had physical strain, they did not think it was weird at all. They all said “If you had done it to look pretty, maybe then I would have thought it to be weird”.

So for Deborah’s friends a labia reduction is “normal” when it is done because of physical strain, but it is “weird” when it is done for reasons of beauty. This is how Deborah herself feels about it as well. When she first heard about labia reductions she did not think this was something for a girl like her. She imagined the kind of girl who would have a labia reduction as “…this blonde pretty girl who wants a perfect body and who would also have all other kinds of cosmetic surgery”. Deborah does not want people to think she is such a girl.

§ 4.3 Medical interventions
Despite the fact that the “easy” method would decrease the chance on infections, something especially Anne, Deborah and Suzanne were afraid of, Deborah, Jeanne and Suzanne had a
labia reduction through the “hard” method. Only on Anne was the “easy” method used. But this was not her own choice: her gynaecologist told her that particular method was the best for her and Anne decided to go along with this. Because Suzanne already knew how a labia reduction could be done, because of her job in a clinic for plastic surgery, she knew that she wanted the “hard” method. Jeanne did not mention she could choose between two methods: her gynaecologist explained to her how the “hard” method was done and Jeanne decided to do it. Deborah was 17 years old when she had her labia reduction. Her gynaecologist explained to her that there were two methods but that she would prefer to use the “hard” method on Deborah so it would look more “natural”. Deborah agreed with her because she wanted a “natural” result. All the doctors who performed the surgery on my informants seemed to have had a substantial influence on the choices my informants needed to make regarding their labia reductions.

The doctors Deborah approached attached much importance to the reasons why Deborah wanted a labia reduction. They clearly favoured reasons of physical strain as more “just” than aesthetic reasons. The first doctor she visited was the family doctor:

My family doctor understood it pretty well. But I did notice that she kept asking questions, because I was so young [LF: Deborah was 17 when she had the surgery]. She kept asking questions to make sure that I did not want it because of a beauty ideal. She asked me: “Do you really have physical strain?” and: “When do you have physical strain?” and: “Where does this physical strain come from?”

Deborah does not think her family doctor had a lot of experience with labia reductions. While talking, she suspected she knew more about it than her family doctor. She already had read much about labia reductions on the internet. Still her doctor wanted to take a look at Deborah’s vagina to see if she thought it was “necessary”. She then advised Deborah to make an appointment with a gynaecologist and according to Deborah told her: ‘… he/she can take a look and tell you whether it is normal and if there is something you could do about it’. The gynaecologist looked at Deborah’s vagina as well and also asked her questions similar to those from the family doctor: to make sure Deborah wanted the surgery because of physical strain only.

Dr. Ozer told me that she and her colleagues also always talk with women about their motivations to have a labia reduction. She tells me that they follow the principle of ‘doing no
harm’. The “harm” being that there is very little to no data about the consequences of labia reductions on sexual sensation. In the next chapter I will elaborate on these “sexual consequences” for my informants. Now I would like to focus on medical practitioner’s dealing with different motivations women have for desiring a labia reduction. Evidently, Deborah’s family doctor and gynaecologist wanted to make sure Deborah did not want a labia reduction because of aesthetic motivations. Dr. Ozer told me she tries to discourage some of her patients as well, mainly women of whom Dr. Ozer suspects they have BDD (Body Dysmorphic Disorder). ‘Body dysmorphic disorder (BDD) is defined as a preoccupation with an “imagined” defect in one’s appearance. ‘Alternatively, where there is a slight physical anomaly, then the person’s concern is markedly excessive’ (Veile, 2004, p. 67). Dr. Ozer always has three talks with her potential patients prior the possible surgery. During the first talk Dr. Ozer asks her patient why she wants to have a labia reduction. During this talk, women can explain why they want the surgery and Dr. Ozer does not speak much. In the second talk, Dr. Ozer does the bulk of the talking by giving psycho sexual education. What she means by this is that she shows her patients pictures of different vaginas in order to answer their question whether or not they are “normal”. Some time goes by between the second and third talk in order to provide the women with some time to deliberate their decision to have a labia reduction. The third talk is about the decision a patient has made and which steps have to be taken after this. About half of Dr. Ozer’s patients by then have decided not to have a labia reduction and the other half decides to go through with the labia reduction.

Dr. Ozer identifies four different groups of women who want a labia reduction. The first group consists of women who “just” do not like the way their vaginas look. The second group consists of women who want to know if their vagina looks “normal”. The third group consists of women who have BDD. Dr. Ozer is talking mainly about women with BDD who are preoccupied with their labia. The fourth group consists of women who had a traumatic experience, usually sexual abuse. The women from the first group usually are “allowed” to have the surgery without relative problems. Dr. Ozer shows “normal” vaginas to the women from the second group. She shows pictures of different vaginas to her patients to show them that their vaginas are not “abnormal”. Dr. Ozer says:

What I do is I explain them which purposes a vagina/vulva has en I watch pictures together with them. When they watch those they often say: “So I am not that weird” and often they do not think surgery to be necessary anymore.
Women with BDD (the third group) are very difficult to identify. Since BDD is usually not diagnosed, Dr. Ozer identifies women with BDD on basis of her instincts. She told me that it is the policy of her workplace to filter out the BDD patients and that is one of the main reasons they have talks with women before surgery. Another reason for the talks is to give women information. Some women have physical complaints because they do not wear the right kind or size underwear, wear tight pants or wash their vaginas with soap every day. By giving these women information, a labia reduction is often prevented.

Jeanne, Deborah, and Anne all mentioned physical strain as their main motivation and were all operated by a gynaecologist. Suzanne, the only one who had the surgery for cosmetic purposes only, was operated by a plastic surgeon. Doctor Buncamper told me that plastic surgery gets labelled as “for aesthetic purposes only”, while the larger part of earnings in plastic surgery is gathered through reconstructive surgeries. Still, gynaecologists get their surgeries covered by health care insurance whereas plastic surgeons do not. Dr Buncamper says:

> When they read ‘plastic surgery’ then it gets denied immediately. A letter [LF: a request for health care insurance to cover a labia reduction] is not really read. They just fill in “denied, denied, denied” and send it back to the patient. Then fifty percent of the patients say: “Well ok, denied, they will not pay it and I am not able to pay for it so I will not do it”. The other fifty percent are in my office, crying that they cannot have the surgery. Well then an appeal is handed over to the health care insurance company. Most of the times, in about 75 percent of the cases, they ultimately do get their surgery covered. But this way they [LF: health care insurance companies] do not have to cover 50 %.

Here, Dr. Buncamper suggests that health care insurance companies usually do have legal obligations to cover a large part of Dutch women’s labia reductions. Otherwise, they would not cover about 75 % of the surgeries of women who handed in a second appeal. By denying the bulk of first appeals for labia reductions performed by plastic surgeons health care insurance coverage companies actually save money for a surgery which they often do have to cover in the end.

What is also interesting to note is that both Dr. Ozer and Dr. Buncamper estimate that half of the women applying for a labia reduction actually go through with it. Dr. Ozer thinks one half does not go through with it because they actually can solve their “problems” in
another way, for example wearing different underwear. Another reason according to Dr. Ozer is that the women feel they have “normal” vaginas after the second talk with Dr. Ozer or one of her colleagues. Dr. Buncamper’s experience however is that half of the women does not go through with a labia reduction because their initial appliance for health care insurance coverage gets denied. An explanation for the differences between the stories of the doctors could be that Dr. Ozer works in a public hospital while Dr. Buncamper performs labia reductions in private clinics. It indicates that plastic surgeons working in hospitals have less difficulty obtaining health care insurance coverage for their patients than plastic surgeons working in private clinics. In many public hospitals, gynaecologists perform labia reductions. Whether the exact same surgery is performed by a gynaecologist or a plastic surgeon is decisive of the fact whether or not a woman gets health care insurance coverage. I will now explain what influence this has had on the decisions of my informants.

Jeanne and Deborah both got their labia reductions fully covered because their gynaecologists filled in the forms to make a plea for health care coverage because of medical necessity. Suzanne did not have her surgery covered by health care insurance, as she did not make a plea. She says:

I did not involve health care insurance because I do not know if it would have been applicable to my case anyway. We do not have insurance care here anyway [LF: in the clinic Suzanne where Suzanne works] and I think they [LF: the health care insurance company] would have told me to go to a hospital.

Suzanne wanted to be operated by a plastic surgeon who is also a good friend of hers and she wanted to have the surgery in the clinic she works at. She explains why:

For me it was all about Marlon [LF: first name of friend/plastic surgeon], about the fact that my friends [LF: Suzanne’s co-workers] were there to help me. That whole picture was the reason for me to think: “Ok I will do this”. Otherwise I would not have done it as easily.

Suzanne later explains that she trusts this plastic surgeon because he is her friend but also because she had seen several women’s vaginas he had performed a labia reduction on and she was impressed by these results. In the clinic where Suzanne works, employees get a 50 % discount on all surgeries. Nevertheless, she was willing (and able) to pay for a surgery exactly
as she wanted performed by the plastic surgeon of her choice. She paid for her surgery with a financial bonus that employees of her clinic get every year.

In The Netherlands, plastic surgery is only covered when it is “necessary”. On the website of VGZ, one of the Dutch health care insurance companies, the following is written about inclusion of plastic surgery in the general basic health care facilities (this basic health care is provided by every Dutch health care insurance company so not only by VGZ):

[De ingrepen die wél verzekerd worden in het kader van de Zorgverzekeringswet, worden alleen vergoed als er sprake is van een medische noodzaak. Daarvan is sprake bij:

- Een aandoening met een aantoonbaar lichamelijke klacht die u fors beperkt in uw lichamelijk functioneren. Er zijn natuurlijk genoeg klachten die hinderlijk of vervelend zijn, maar als deze u verder niet fors beperken in uw lichamelijk functioneren, zijn ze geen reden voor een vergoeding.

- Verminkingen door een ziekte, ongeval of een geneeskundige verrichting. Het gaat hier om een ernstige misvorming van een lichaamsdeel. Dan moet u denken aan brandwonden, ernstige reumatische vervormingen, zaagverwondingen of borstamputaties. Een zichtbare verandering is daarbij niet zonder meer hetzelfde als een verminking.

- De volgende aangeboren misvormingen:
  - spleten in lip, kaak of gehemelte, misvormingen van de botten in het gezicht, goedaardige woekeringen van bloedvaten, lymfevaten of bindweefsel, geboortevlekken en misvormingen van de urineweg of geslachtsorganen. Bedenk, niet elke aangeboren aandoening is een misvorming!

- Correctie van uiterlijke geslachtskenmerken bij vastgestelde transsexualiteit. De plaatsing van een borstprothese valt hier niet onder.] (6)

In (short) translation, conditions considered medical necessities are: physical pain; deformities caused by an accident, illness or medical performance; inborn mishaps, and transformations necessary because of confirmed transsexuality. Apparently it is acceptable for the Dutch national health care system to have plastic surgery because of medical necessity and unacceptable to have it for the pure purpose of enhancing the body.

The Dutch health care insurance regulations can influence for a big part a woman’s decision where to have the surgery and by whom this surgery will be performed. Deborah and Anne both went to their family doctors first and they both got redirected to a gynaecologist working in a public hospital. Because they got redirected, they did not really have the opportunity to choose where they wanted to be operated and by whom. Jeanne and Deborah both got their surgeries covered because of medical necessity and this probably would not have happened if they were operated by a plastic surgeon. Thus, labia reductions are placed
under the label of plastic surgery, but many women are not operated by a plastic surgeon, for a large part because then they will not get the surgery covered by health care insurance.

The question rises whether there is a qualitative difference between a labia reduction performed by a plastic surgeon and a labia reduction performed by a gynaecologist. This is what Dr. Buncamper told me after I commented that a plastic surgeon surely is more capable of doing a labia reduction than a gynaecologist is:

Yes, maybe that is true. But a gynaecologist, who performs these surgeries for many years, will probably have more experience than one of my colleagues who is graduating next year. What is important is: which techniques do you control? And: How many times have you performed the surgery?

Thus, according to Dr. Buncamper, the doctor who is most experienced and controls the most techniques is the better doctor, no matter what this doctor’s speciality is. This seems to be a medical guideline as well. A medical specialist is qualified to perform any medical surgery if this specialist finds himself or herself to be capable to do it (3). The Dutch law of occupations in individual health care (article 36.15) states the following:

De personen, genoemd in het eerste tot en met het veertiende lid, zijn tot het verrichten van de desbetreffende handelingen uitsluitend bevoegd voor zover zij redelijkerwijs mogen aannemen dat zij beschikken over de bekwaamheid die vereist is voor het behoorlijk verrichten van die handelingen. (7)

Freely translated: ‘The persons [LF: medical practitioners], mentioned in the first to 14th part, are only authorized to such actions if they may reasonably assume they are competent enough in order to reasonably accomplish these actions’. If however a surgery goes wrong, the medical specialist in question is in trouble. He or she must appear for a disciplinary board. If the disciplinary board decides the doctor was not qualified there are consequences for the doctor. If the disciplinary board decides the doctor had a lot of experience with that particular form of surgery, then the failed surgery is considered a consequence of human error (4).

Dr. Buncamper measures good surgery with the amount of experience a doctor has with that particular type of surgery. The question now rises if my informants also measure good surgery with an experienced doctor. Jeanne, Deborah, and Anne did not choose their gynaecologists because of their experience with labia reductions. Both Deborah and Anne
were redirected by their family doctors to gynaecologists they did not know. The hospitals were also chosen for them. Deborah would have preferred another hospital: ‘There is another hospital which I would have preferred, which is in Blaricum. But my family doctor recommended this hospital [LF: in Hilversum] and then it became self-evident [LF: … to choose the recommended hospital]’. Jeanne went to her gynaecologist, whom she knew very well, to ask what she could do about her problems with her labia. Jeanne did not know a labia reduction was possible and when her gynaecologist offered to do it for her, she agreed. Only Suzanne deliberately choose the person who would do her labia reduction. Even more so: she would only have a labia reduction if he would perform the surgery.

It is important for a woman to choose a doctor wisely, says Dr. Buncamper. In this instance he was talking only about plastic surgery performed in private clinics. He states that if a surgery goes wrong when performed by an unqualified doctor, the doctor is wrong in all possible ways. But a woman comparing clinics where the surgery is performed also has to think logically. If the prices are the same in many clinics and then she finds a clinic which offers a much lower price for the same surgery, there must be something qualitatively wrong with this clinic. Therefore, Dr. Buncamper finds that a potential patient also has a certain kind of responsibility. But in three of my informant’s cases, they did not have the possibility to compare different clinics and choose the one they were most comfortable with. Of course, these three informants were operated in a public hospital and not a private clinic.

Now I am returning to Suzanne’s view on physical strain and how this is a socially acceptable reason for labia reduction. My informants did have other reasons for desiring a labia reduction beside physical strain. I will elaborate on these motivations and reasons in the next chapter. However, the reason they all stressed while talking with medical practitioners was physical strain. It is hard to imagine what would have happened if they would have shared their other motivations with the medical practitioners. In Deborah’s case, it is quite safe to assume that she would not have had a labia reduction, since her family doctor and gynaecologist were so keen to ascertain that she did not want it to look prettier. I would like to argue that because my informants gave reasons of physical strain, the doctors who would perform their labia reductions were chosen for them, instead of by them. My informants got a certain type of medical specialist, based on their motivations. The women who stressed physical strain got redirected to gynaecologists. Suzanne, who stressed she wanted to look more “beautiful”, choose a plastic surgeon. She did this because she suspected that her surgery probably would not be covered if it was performed by a plastic surgeon and at a
private clinic. Because she wanted to make those choices herself, she had to pay for her surgery herself.

Then there is also the issue of money. Jeanne and Deborah do not know exactly how much their labia reductions had cost because their surgeries were fully covered by health care insurance. Suzanne paid 800 euro’s for her surgery. The regular price would have been 1600 euro’s but Suzanne got a 50% discount because she works at the clinic where she had the surgery. According to the website of this clinic however, the price is 2250 euro’s, a substantially higher amount. It is of course possible that at the time of Suzanne’s surgery the prices were lower than they are now. Anne did not know at the time of both our interviews if her surgery would be covered. At the time of the interviews, she told me that she should have been given approval by her health care insurance company before she had a labia reduction and she did not know this. She estimated the costs of her labia reduction somewhere around 1500 euro’s. She told me she saved money for the surgery should she have to pay for it herself.

Jeanne and Deborah could not have had the labia reduction at the time they had, if their surgeries were not covered by health care insurance. Jeanne even told me she would not have had a labia reduction if she would have had to pay it herself. When I asked why, she stated:

Well, it is not as much about the “paying it yourself” as about the consideration I then would have had to make. Then it would have been like: “I am going to do something about it because I think it is more beautiful”.

Thus, if Jeanne would have had to pay for her labia reduction herself, her main motivation would have changed from physical strain to wanting to look more “beautiful”. On my question that Jeanne’s main motivation was indeed physical strain, she answered: ‘Yes what is strain?’ She continues:

It is more about the road I took to get it, do you understand? It sort of happened to me. And I think because of the threshold of paying it yourself… Then I would have thought: “I would rather spend that kind of money on something else”. Then it [LF: A labia reduction] would not be that necessary.
I believe it is interesting that Jeanne equals health care coverage with necessity in her own individual case. Getting health care coverage or not is not a decisive factor in the diminishment of Jeanne’s complaints. However if her health care insurance company would have decided not to cover her labia reduction, Jeanne would not have thought it to be necessary enough to receive health care coverage and thus also not necessary enough to pay for a labia reduction with her own money. It seems Jeanne incorporates the classification system which distinguishes “necessary” from “unnecessary” of Dutch health care insurance companies in her decision for a labia reduction. It seems that if health care insurance classifies her labia reduction as “necessary”, she has a “legitimate” reason to have the surgery.

In this chapter I demonstrated the influence of three ‘structural properties’ on my informants’ decisions around having labia reductions (Giddens, 1979). I defined these ‘structural properties’ as beauty ideals, shame, and medical interventions or the ‘medical gaze’ (Giddens, 1979). The beauty ideal regarding vaginas does seem to have had an influence on my informants’ perception of what a “beautiful” vagina looks like. In all their descriptions of what a “beautiful” vagina looks like I recognize the “Playboy pussy”. And indeed, they all saw these “beautiful” vaginas in porn and on the internet. However, three of them choose to not be operated with the surgical technique which creates this “ideal” vagina. They rather choose another technique because this would give their vaginas a more “natural” look. They were especially worried that otherwise their vaginas would look surgically altered. Thus, in this respect, my informants rather have a “normal” vagina than a “beautiful” vagina. Apparently, the “ideal” image of a vagina is not considered “normal” in The Netherlands.

Social constructions of shame seem to have a profound effect on my informants’ deliberations about their labia reductions. It causes them to keep their labia reductions almost a secret. My informants seemed to feel two kinds of shame about their labia reductions. The first kind of shame is shame because of feelings of bodily deviation. My informants wanted to have “normal” labia and felt that their labia were not “normal” before they had the surgery. The second kind of shame is shame because of negative female image. This image is described by one of my informants as “this blonde pretty girl who would do anything to look pretty”. Another informant described this image as a sexually loose woman. These negative images seem to be summoned most when a woman has had a labia reduction because of aesthetic reasons. Three of my informants stressed that their main motivation was physical strain. Physical strain is considered a “good” reason to have a labia reduction, whereas other reasons revoke the negative female image.
Medical practitioners and health care insurance have had a substantial amount of influence on my informants’ decisions around their labia reductions. Medical practitioners influenced my informants’ choice for one of the two surgical techniques, usually in favour of the technique which leaves their vaginas more “natural” looking. They also decided in which hospitals some of my informants would be operated and by whom. In Deborah’s case, two doctors (one family doctor and one gynaecologist) clearly wanted to make sure she did not want the surgery because of aesthetic reasons. The Dutch health care insurance companies influenced the kind of medical practitioners who would perform the surgeries of my informants. Labia reductions performed by gynaecologists are almost always covered because health care insurance companies presume that women operated by gynaecologists are suffering from physical strain. Labia reductions performed by plastic surgeons often get denied coverage because health care insurance companies presume that women operated by plastic surgeons have aesthetic reasons only. Without doubting the truth of my informants’ statements, this could indicate why all of them stressed their physical strain so much while they also had other motivations. These other motivations were then set aside as less important.
5. Personal motivations

The former chapter primarily dealt with structural forces such as beauty ideals, shame, and Dutch health care insurance regulations. In this chapter I would like to concentrate on events in my informants’ lives which influenced their decisions to have a labia reduction. Instead of focusing on influences from the “outside”, I focus on the accounts of ‘private suffering’ of my informants, which led them to have a labia reduction (Davis, 1995). Then I would like to describe how my informants experienced the actual surgery. I believe this to be an important addition to the paragraph about medical interventions in the former chapter. In that paragraph I described how medical practitioners and health care insurance companies influenced my informants’ decisions. I believe it is also important to describe how my informants experienced the actual surgery. This provides a more subjective perspective from the points of view of women who have had a labia reduction. Finally I will describe my informants’ feelings about the result of the surgery and whether or not they think it was worth it. I believe this is important because the contentment of my informants with the results of the surgeries sheds light on my informants’ motivations. It reveals whether it has decreased their ‘private suffering’ and therefore, if having a labia reduction was a good choice for them (Davis, 1995). The expectations my informants had from the surgery influenced their decision to have the surgery. They expected the surgery to enlighten their ‘private suffering’ (Davis, 1995).

§ 5.1 Private suffering

In the former chapter, my informants’ motivation for a labia reduction because of physical strain is mentioned often. To follow, I would like to explain what this physical strain entails for my informants. Jeanne and Deborah both were especially impeded by their inner labia when they played sports. Deborah says: ‘It always hurt when we [LF: Deborah and her parents] went biking. And at one point it became so bad that it was really hampering me in daily life. That I was unintentionally thinking about it all day long’. Deborah tells me that her labia pained her during biking when she had not even left the street where she then lived. Jeanne also told me her inner labia especially pained her during spin biking:

I have a slender body and those things [LF: her inner labia] were just in the way. I tried to tuck them back in with a pant-liner; well they got stuck on that. It was just extremely dreary and after biking they were damaged and they were bleeding.
Jeanne and Deborah both described quite painful experiences which they endured on a daily basis.

What is interesting is that Jeanne, who was 49 years old at the time of the interview, had a labia reduction when she was 44 years old. Deborah (20 at the time of the interview) was 17 years old when she had her labia reduction. Deborah had physical strain from her labia since she reached puberty. Jeanne however, did not have difficulties with her labia when she was younger. Jeanne’s complaints started after giving birth to a stillborn son, when she was 36 years old. The day before her son would be born through a planned Caesarean section; Jeanne woke up in the morning and sensed that the baby inside her was not alive anymore. For reasons still unclear to me, she then gave birth to her son the “natural” way. Because the baby was fully developed and because it was “dead weight” the gynaecologist who was leading her delivery had to make big cuts in her labia in order to make enough room to get the baby out. These cuts were not sewed back together after; leaving Jeanne with inner labia that had big openings where she had been cut. Jeanne gave birth two years later to a healthy son.

Childbirth was the cause for Jeanne’s physical strain. She describes her labia reduction as something good that just happened to her by chance. She said ‘I do think it was chance. Because I have that good relationship with her [LF: her gynaecologist] en because I felt free to complain about it and then that she told me that she could do something about it’. Because of Jeanne’s gynaecological past she goes for a check up to her gynaecologist every year. She and her gynaecologist know each other very well and get along with each other as well. She made the decision to have a labia reduction herself, without involving other people. She thinks she also did it because: ‘….it has been reparation of what has been’. Through the labia reduction she erased the marks the birth of her first child left on her body.

Anne also mentioned physical strain as a consequence of her labia, especially during biking. However, this physical strain alone did not bother her that much as to choose a labia reduction. The main reason she had a labia reduction was because her labia interfered with her sex life. Her labia were “in the way” during penetration especially. The problem became so big for her that she did not want to have sex at all. She has a new boyfriend since a couple of months and they did not have sex because of her problem with her labia. She had had two relationships before she met her present boyfriend. During her second relationship she started to feel uncomfortable about her labia. When this relationship ended a couple of other things in Anne’s life went wrong as well. After some time, she managed to overcome these problems
but her problem with her labia did not go away. She then searched the internet and discovered that a labia reduction might be a solution for her problem.

Deborah experienced similar problems with sex. Although Deborah mentioned physical strain as her main motivation for a labia reduction, she had sexual problems as well. At the time of the surgery, Deborah was 17 years old and had had little sexual experience. As it turned out, this was not because she did not want to have sex:

At a certain time I started kissing and stuff. But my girlfriends started to do other stuff as well. I did not want that, because I thought: “If they [LF: boyfriends] see that [LF: her labia] they will laugh at me”. I was very afraid that that would happen. I did not want boys to see that. I thought: “Maybe these boys have seen other ones as well”.

Deborah was afraid her labia would stand out in a negative way in comparison with other girls’ labia. She then proceeds to tell me about an experience with a boyfriend who almost touched her vagina. At the last moment, she told him not to do it after all. She found this very hard because: ‘Of course you can tell him “I do not want to” but I did wanted to but there was a reason why I did not do it’. The reason being fear that her boyfriend might think she was not “normal” and might laugh at her.

Suzanne did not have her labia reduction for sexual reasons. She said that since her boyfriend and she have been together for such a long time, her labia were not really an issue during sex. Her labia were not in the way during penetration and she was also not ashamed to show her boyfriend her labia. Her motivation was:

It is something I knew for years. I have seen them [LF: inner labia] more extreme [LF: …on other women] but I just thought mine were hanging out a bit and I just did not think it was pretty. I just wanted to have that part removed.

Suzanne calls the story of her labia reduction a ‘purely cosmetic story’. A couple of years before her labia reduction she had a breast enlargement:

There was a big difference between my breasts right and left and I just wanted to get rid of that. That was something I was insecure about for a longer time. I already approached several clinics in the past. So I was more serious about that.
But I always found it scary. When I began to work here [LF: the private clinic where she currently works] I had to watch the surgeries and I saw how something like that [LF: a breast enlargement] is done. Because of that I did not find it scary anymore. Then I thought: “I am finally going to do it”.

During the whole interview, Suzanne links her workplace with her choices to have plastic surgery. Before she worked there she did not know what to expect from plastic surgery and thought it was scary. By being surrounded all day long by women having plastic surgery, she dared to have some surgeries herself. Suzanne had her breasts enlarged because she was very insecure about her breasts. She describes her labia reduction as something less serious to her than her breast enlargement: ‘Before I worked here, I never seriously made plans to have a labia reduction. So I did it a little bit because I worked here and because I have a certain curiosity for procedures’. I interpreted this “curiosity” as a desire to experiment with plastic surgery and what it would do to her body. Suzanne goes on to state that she probably would not have had a labia reduction had she not worked there.

However Suzanne did feel embarrassed because of her labia. She was not even aware of her labia before the following happened:

It was my ex boyfriend who made me aware of it. Because that was, you do not know what is “normal” of course. So I was not aware of it for a long time. He sometimes made a joke about it, you know. And because of that I became aware that he was right.

Suzanne did not think her labia to be large or “not normal” until her ex boyfriend made her aware of it through a joke. Thus, although Suzanne was not very insecure about her labia, from that time on she was aware her labia were not “normal”. Thus, I think her decision to have a labia reduction does not emanate from the fact she works in a private clinic alone.

§ 5.2 Surgical experiences

In the former chapter, I described the effects medical practitioners and health care insurance companies have had on my informant’s choices to have a labia reduction. Now I would like to describe my informant’s experiences with the actual surgery and the care after the surgery. I believe this to be important for two reasons. First, surgical experiences provide subjective accounts of the way a labia reduction is performed. It reveals, for example, whether my
informants were well informed about the amount of pain they would have after the surgery. Second, it reveals my informants’ feelings during the most critical point of their process of choice. How does it feel to actually have the surgery they have deliberated about for (in some cases) such a long time? The fact that they have the surgery shows what my informants are willing to endure to enlighten their ‘private suffering’ (Davis, 1995). The pain and inconvenience my informants expected from the surgery was also one of the deliberations influencing their decision to have a labia reduction.

Every surgery usually starts with the patient being given some kind of anaesthetic. Although I fully realize my data are not even nearly representative for all the Dutch women who had a labia reduction, I thought it was striking that there was a wide variety of methods of anaesthetics used to sedate my informants. Four women were sedated through three different methods. Jeanne and Deborah both had an epidural. Deborah tells:

She [LF: the gynaecologist] said to me: “Plastic surgeons usually do complete or local anaesthesia, but I am not in favour of that, because I do touch your leg and you might feel that and you might surge. So I would rather sedate you from your back and down. That way you will not feel a thing but you will also not run such a risk as with the risk of complete anaesthesia”.

Deborah then goes on to tell that the sting of the epidural hurt more than she thought beforehand. At that point she did think: ‘Why did I start this, if it is all going to hurt this much’. Later, she calmed down as the epidural started working and she did not feel anything.

Suzanne was sedated through local anaesthesia. Suzanne told:

Of course it was all local anaesthesia, so that was not so nice, because one has to be sedated first. That is not nice but it lasts so short, so it is doable. But it is done with quite thick needles. You get stung there and fluid is injected. Quite quickly after that it is sedated while one is awake. So he starts cutting and one can feel that. I mean, the blood is streaming out and that is warm so one can feel that. Further… you do not feel… It is not that bad a feeling. It feels like a rubber band that gets pulled or something.

What is interesting is that Suzanne seems to think it is self evident that local anaesthesia is used during a labia reduction. She is the only one of my informants who was sedated this way.
The fact that she was sedated this way does correspond with the remark of Deborah’s gynaecologist that plastic surgeons often use local anaesthesia. Suzanne found the actual stung of the needle quite painful. Especially so because it got stung in her labia. She was also sedated (short narcosis) but she did not sensed this very much. Anne had complete anaesthesia so she did not consciously experience her surgery. She had a talk with an anaesthetist a couple of weeks prior the surgery. He offered her two options: an epidural or complete anaesthesia. Anne choose the latter because she was very afraid she would be in pain during the surgery. Interesting to note is that Anne was the only one of my informants given the opportunity to choose the manner of anaesthesia.

Right before the surgery especially Jeanne and Deborah were excited. Deborah says:

I was very nervous but I also looked forward to it in some way. I was nervous but I felt like: “Finally, it is finally going to happen.” Like: “Then I do not have to do all those nonsense things anymore, I do not have to think about it all the time anymore.”

For Deborah, the surgery was going to solve a problem from which she had endured much inconvenience and shame. It was a very big step for her to confide her mother with her problem and to go to the doctor together. And now she was finally going to have the surgery. Jeanne said something similar:

I was a bit excited, like: “Now they are going to make something different.” (…..) I was very aware that this was my own choice so what should I be afraid of? It will get better and I am not a person who is afraid quickly.

Once under sedation, all my informants experienced the surgery itself as very quick and painless. Deborah thought her surgery lasted about twenty minutes and Suzanne thought her surgery lasted a little less than an hour. Twenty minutes to an hour seems to be the range of the duration of a labia reduction. Of course the statements of my informants are not totally reliable since they were sedated and possibly did not realize the flowing of time as much as they normally would have. According to Dr. Ozer, surgery using the “easy” method lasts about half an hour and surgery using the “hard” method lasts about an hour. This is quite consistent with my informants’ indications.
Three of my informants were sent home on the same day they had the surgery. Only Deborah stayed for one night in the hospital, probably because the following happened:

At one point I felt totally fine and I had to pee. The nurse had told me that if I wanted to go by myself I could just go. And the toilets were around the corner of my room so I thought: what the hell I am just going. Alone, because I did not want a nurse with me who would probably bring a chamber pot. So I went by myself with the stick with this bag on it [LF: a drip] through the hallway, and walking actually went quite well. But once on the toilet I really could not pee. I thought that it was going to hurt so much. The nurse told me to pour a glass of water past it en that the peeing would then start out of its own. I do not know what happened but five minutes later I was in the bed and had three nurses around me. I probably passed out on the toilet because it hurt so much. Or maybe it was the fear that it would hurt so much.

After this incident Deborah had to urinate on a chamber pot after all. She was then told by the nurses that because she could urinate, she could go home the next day.

Urinating after the surgery was a very critical act for all my informants. Anne told me she also had to urinate before she was allowed to leave the hospital. She did it, despite the fact she was very scared, but it went well and she had no pain at all. All my informants got the advice to pour water over their genitals while urinating, to lighten the pain. Suzanne was especially struck by the amount of effort this took. She poured water during every urination, and then also blew her genitals dry because a wet spot is more prone to attract bacteria than a dry spot. She tells:

It was quite a lot of care, I have to say. And one has to keep this up for about two weeks. At one point I went back to work. So every time I went to pee I had this water jug with me.

The recovery period lasted much longer than expected for Suzanne. Suzanne had dissolvable stitches and these dissolved after three months. She was able to have sex three to four months after the surgery while the instructions read that she could have sex after three weeks. According to Suzanne this instruction was very optimistic and in her case impossible. A week after her surgery she had to come back for an after treatment because one of the stitches had
let loose. It was really frustrating for her that she had to come back because she was already recovering for a week and she felt she had to start over again. What was more was that one of the stitches was stitched through a nerve during the after treatment. Because of this, Suzanne endured terrible pain for two days. All in all, the recovery period was much harder than Suzanne expected.

For Jeanne, the pain was also more than she expected. She had to come back for an after treatment as well because she was in much pain. One of the stitches was sewn in wrong and the gynaecologist cut this stitch loose. Thus Jeanne did not get new stitches like Suzanne had. Two weeks after the surgery, the stitches were removed and then Jeanne’s wounds healed quickly. So Jeanne’s recovery period was not nearly as long as that of Suzanne. Jeanne associated her recovery period very much with the recovery period she experienced after giving birth. She says:

I sat in a bath of “Badedas” [LF: a brand of shower gels and the like]. That smell is very typical, I associate that smell very much with giving birth. It is a “cosy” smell, maybe this is weird. I sat in this twice a day if possible because it hurt very much.

Later in the interview she says: ‘I had a huge amount of stitches after the delivery because they cut me in as far as my leg. That pain from those pulling stitches…’ The stitches from her labia reduction were the same kind of stitches as those from her delivery. Thus both the smell from the bath and the stitches reminded her of giving birth. This indicates the way in which Jeanne linked her labia reduction with the birth that damaged her labia.

Overall my informants were quite comfortable during the surgery itself. The recovery period was however very painful and worse than some of them thought it would be beforehand. What is interesting is that all my informants seem to think that the way the surgery is performed on them is the “normal” way, as it happens everywhere in The Netherlands. There are however quite some differences in the ways the surgeries of my informants where performed. Especially the manners of anaesthesia and the healing periods differ. Now I would like to elaborate on the results of the labia reductions and my informants’ feelings about it.
§ 5.3 Was it worth it?

Aside from indicating whether or not the surgery has taken away my informants problems surrounding their labia, their contentment with the results also reveals the consequences of a labia reduction on their sexual pleasure. As I already described in the introduction, there is little known on the subject of sexual pleasure regarding labia reductions in medical and social sciences. Therefore, this paragraph could contribute to research on this topic.

All my informants said they were very happy with the result of the surgery and would have done it again. Suzanne and Anne even stated they are prepared to have another labia reduction if they are to have children and the childbirths will enlarge their labia. Anne only wants to do this if her labia interfere with her sex life again. Suzanne told me: ‘I already made a pact with Dr. Buncamper that he will be there when I deliver a child. He can come and restore the damage when it is time’. Suzanne is very happy with the result but has noticed a little flaw:

I do see a little beauty flaw, where a little piece of the stitches has let loose and then you get some kind of… what we call a “dog ear” [LF: in Dutch: “ezelsoortje”]. So it is not perfect but at least nothing is hanging out any more.

Suzanne also said her plastic surgeon/friend may just as well remove these “dog ears” when he restores the damage after Suzanne's future childbirth. According to Suzanne, almost every woman who has had a labia reduction in the clinic where Suzanne works ends up with a “dog ear”. Most women choose to have an after treatment in order to have the “dog ear” removed. Suzanne thinks these “dog ears” come into being because the stitches are under much tension. Shortly after the surgery the labia are also swollen, causing more tension. Because of movement, which is inevitable (one has to get up and go to the toilet once in a while); stitches are often caused to let loose. Suzanne says:

What you should do if you have had this surgery is just lay on your back for a week with your legs apart. That would be the best treatment. One should not move at all, do nothing at all, just lay still.

Thus, it is almost inevitable that some stitches let loose. Despite this, Suzanne is happy with the result of her labia reduction because her main problem has been solved: her inner labia do not peek out between her outer labia anymore. This made her labia reduction worth it.
Jeanne also described something similar to what Suzanne calls a “dog ear”. Jeanne speaks of a little cut at the back of one of her labia. She does not know why this cut is still there: ‘She [LF: the gynaecologist] probably could not reach it’. This does not bother her. The fact that Jeanne does not seem bothered by the “dog ear” because the surgery has eliminated her physical strain shows that a “dog ear” is merely a cosmetic irregularity. Suzanne wants her “dog ear” to be removed eventually because she thinks her labia are not as “beautiful” as without. This is probably the reason why most clients at Suzanne’s clinic want to have it removed as well. All in all, all my informants think their vaginas are more “beautiful” after the surgery. Anne said that although her main reasons for her labia reduction were sexual she also was very ashamed for the way her labia looked. Deborah does not think vaginas to be “beautiful” in general. So she does not find her vagina more “beautiful”, but she is more satisfied about the way her labia look now: they look “normal”. Jeanne is very happy with the result of the surgery. She says: ‘If it is whole again then I think there is less strain’. Jeanne uses the words ‘whole again’ because the cuts that were made at the birth of her first child are now stitched back together. Jeanne does not have any strain while spin biking or playing other sports. To her, that made the labia reduction worth it.

The first weeks after the surgery, Deborah was worried about the way her labia healed. One of her labia stayed swollen longer than the other one and she was afraid they would turn out to be not of the same size. Then she says:

But those worries were soon gone because I did not have any strain anymore. I think it was one and a half month after the surgery that I first went biking. It was such a revelation! I thought: “Wow it does not hurt anymore”.

Because her main problem of physical strain was gone, she did not worry too much about the potential uneven size of her labia anymore. Her labia reduction also changed her sex life: ‘After the surgery I thought: “Now it [LF: sex] is just possible because it [LF: her labia] is not different from other people”’. To Deborah, the absence of physical strain and the fact that she felt “normal” made her labia reduction worth it. Sex became a possibility after the surgery. Since Deborah did not have much sexual experience it is hard to tell whether or not the surgery has changed her sexual pleasure. It could of course be argued that the surgery has changed her sexual pleasure in a positive way since she can experience sexual pleasure with a partner whereas this was not an option for her before.
The same goes for Anne. When I spoke with her on the phone a month after her labia reduction her happiness with the result of the surgery almost beamed through the telephone receiver. She told me she felt much more confident and that the surgery contributed a lot to her being able to have sex and enjoy it. The physical strain of the coming along of her inner labia during penetration had disappeared as well. It was really striking how happy Anne sounded, even happier than my other informants. This probably has to do with the fact that her surgery was the most recent. When I spoke with her, I could not do anything else than to feel happy for her myself.

Jeanne’s sexual pleasure was also influenced in a positive way. Beside the fact that her labia do not pain her anymore, Jeanne finds it an adventitious circumstance that she finds her vagina more “beautiful” as well. Her husband especially thought her vagina to be more “beautiful” after the surgery. She says:

When you know each other for 32 years then you have to keep the relationship exciting in all ways, not just the sexual part but also other things within your relationship. And when something like this happens, then it feels like a little present. It is a change from outside and he [LF: her husband] liked it a lot. And I liked it that he liked it. Yes, there was a second reason why it was good that I had done it.

The sexual experience itself has not changed for Jeanne. She does not experience more sexual pleasure or less sexual pleasure since she had the surgery for example. The only thing that has changed is that her labia do not “come along” during penetration. Before her surgery, she sometimes had to interrupt sex to rearrange her labia. But she never felt hampered because of this. So although the surgery has had a positive influence on her sex life, she did not notice any changes in the feeling of sexual sensation itself after the surgery.

Suzanne told me that she does not feel any change in sexual pleasure or sensation after the surgery. The surgery has influenced her sex life and her sexual pleasure in a negative way right after the surgery. She could not have sex for three to four months because her stitches had not dissolved and sex was too painful for her. When her labia were completely healed however, her sexual pleasure and her sex life were back to as they were before the surgery. Overall it could be concluded that the surgery has not caused changes in the sexual sensation my informants feel. On other aspects of their sex lives, such as self confidence, the surgery mainly has had positive effects.
In this chapter I provided the views on labia reduction from the perspectives of my informants themselves. First I described the personal motivations my informants had for their labia reductions and how they experienced their problems with their labia: their ‘private suffering’ (Davis, 1995). Then I described the way they experienced the actual surgery. To end, I described the way the surgery has changed my informants’ lives and whether they thought the surgery was worth it.

Two of my informants explicitly listed physical strain as their main motivation. I described what this physical strain entailed for these women in daily life. It showed that it bothered them very much and beside the fact that it was painful it also was a nuisance for them. For one of them, the strain was caused by a childbirth that had gone wrong. For her, the surgery not only alleviated her physical problems but also erased the marks of this negative experience from her body. Sex turned out to be an important motivation for two of my informants. Before the surgery, both their sex lives became inhibited to the point that they did not have sex at all because they felt too ashamed about their labia. Only one of my informants lists purely cosmetic reasons as her motivation for a labia reduction. She thought her inner labia were hanging out a bit and that a labia reduction could make her labia more “beautiful”. She works at a private clinic and this made it easier and less scary for her to have a labia reduction. She even states that had she not worked there, she probably would not have had a labia reduction.

The four women I interviewed were sedated in three different manners. Two of my informants had an epidural, one had local anaesthesia and one had complete anaesthesia. This is interesting since all my informants seem to think that the way their labia reduction was performed, is the way labia reductions are usually performed in The Netherlands. My informants all experienced the surgery as relatively comfortable and quick. Two of them described their feelings of excitement before the surgery. They were happy that their labia would be changed and that their related problems would be solved. The recovery period proved to be quite painful for my informants and harder than they expected beforehand.

The surgery changed my informants’ lives in different ways. For some it meant that the physical strain they felt before was now gone. The surgery influenced the sex lives of all of my informants in a predominantly positive way. Two of them now have enough self confidence to have sex in the first place. However, none of my informants experienced changes in feelings of sexual sensation itself. One of my informants has noticed a little beauty flaw, a so called “dog ear”. She is thinking about having an after treatment to have this “dog
ear” removed. Overall my informants are very happy with the result of the surgery and would have done it again. The surgery has had the effects they desired and expected beforehand.
6. Analysis

In chapter 4 I discussed the ‘structural properties’ that influenced my informants’ decisions (Giddens, 1979). In chapter 5 I discussed their personal motivations which led them to have a labia reduction. In this analytic chapter, I would like to bring structure and agency together in a middle ground. First I will analyze the Dutch ideal of normality. Then I will analyze the shame my informants felt and the taboo on labia reductions (in The Netherlands). Thirdly, I will analyze the power of medicine over my informants’ decisions. Conclusively, I will argue for a middle ground where structure and agency come together in the formation of a decision to have a labia reduction.

§ 6.1 The beauty of normality

The beauty industry has influenced my informants’ view of what a “beautiful” vagina looks like. According to all my informants this ideal is: a tight vagina with smaller inner labia than outer labia. This ideal is visible on porn sites on the internet and in soft porn magazines such as Playboy. Wolf points out that women’s magazines provide an unrealistic notion of beauty (1990, pp. 81-85). Especially the practice of “computer imaging” confuses women to the extent that they do not know and can not know what a “normal” woman looks like and therefore think they are the “abnormal” ones (1990, p. 83). With regard to my data, this does not seem to be true. Although my informants are influenced by pictures of “beautiful” vaginas they do seem to realize what has been done to make these vaginas look this way. They know that many pictures in the media are “photoshopped” and that many American porn actresses had had a labia reduction. What is more, they do not think that these are “normal” vaginas. Their descriptions of “beautiful” vaginas always differed from their descriptions of “normal” vaginas. Finally, all my informants but one did not aspire to have a vagina that resembled the ideal. They did not choose the method which creates such an ideal vagina because they pertinently did not want a vagina that looked surgically altered. My informants wanted “natural” labia.

Davis’ account of her informants’ desire to look “normal” or “ordinary” is very similar to what my informants described (1995). Davis writes: ‘Many of the women I talked to explained that they always felt that they looked different than other women. This sense of being different took the form of comparing their own appearance against other women’s bodies’ (1995, p. 80). This comparing with other women is something Deborah has done extensively. On the internet, she found that a “Playboy pussy” was not “normal” but also that
large labia such as hers were not “normal” either. She established for herself that a “normal” vagina has inner labia that slightly protrude the outer labia. This is the “normal” vagina described by Anne as well. Suzanne described a “normal” vagina as having natural labia that do not “hang out” between the outer labia. Jeanne defines the “normal” through describing the “abnormal”: mutilated vaginas because of sexual abuse or other reasons are “abnormal” according to her. Davis writes: ‘… being ordinary seems to have little to do with standards of normality in physical appearance’ (1995, p. 90). This does not resonate with my informants’ statements about a “normal” vagina. Three of them have a very concrete idea of what an “ordinary” or “normal” vagina looks like. This suggests that there are indeed standards with regard to a “normal” vagina. In light of my informants’ statements, Davis might be right that: ‘Ordinariness is, first and foremost, a matter of experience’ (1995, p. 91). What Davis means by this is that women who want cosmetic surgery may suffer because they experience their bodies as “abnormal” or “deviant” whereas other people do not find them to be “abnormal” at all. Most of my informants did not get comments about their labia from past and present sexual partners for example. Davis writes:

> Even the most enthusiastic plastic surgeon is likely to admit that appearance is hopelessly subjective. Women who are beautiful according to cultural standards can, nevertheless, decide to have their bodies changed, while individuals with more obvious bodily defects may be unbothered by their appearance and could not imagine having cosmetic surgery. (1995, p. 91)

Thus appearance, and especially a “normal” appearance, is very hard (or to say impossible) to define objectively. Davis argues that it is therefore also very hard to define what is “normal” for a medical practitioner. She calls this the ‘…discrepancy between public appearance and private suffering…’ (1995, p. 91). The ‘private suffering’ for some of my informants being that they felt their labia were different from other women’s labia. But also physical strain that interfered with their daily activities and a negative influence on some of their sex lives.

Dr. Ozer estimates that the inner labia protrude the outer labia in 90% of women. Suzanne’s, Deborah’s and Anne’s descriptions of a “normal” vagina exclude many vaginas, including their own before their surgeries, as not “normal”. All vaginas with protruding inner labia (according to Suzanne), and more than slightly protruding inner labia (according to Deborah and Anne) are not “normal”. There is an interesting paradox present in my informants’ desire to have a “normal” vagina. This paradox is described by Anne Balsamo,
Professor of Interactive Media at the University of California School of Cinematic Arts (1996). Her research focuses on the relationship between culture and technology (9). In her book ‘Technologies of the gendered body: Reading cyborg women’, she writes: ‘When cosmetic surgeons argue that the technological elimination of facial “deformities” will enhance a woman’s “natural” beauty, we encounter one of the more persistent contradictions within the discourse of cosmetic surgery: namely, the use of technology to augment “nature”’ (1996, p. 71). In my research, the women who had a labia reduction through the “hard” method themselves, rather than the medical practitioners, argue that the surgery will make their labia look “normal” as well as “natural”. This shows that normality is just as well an ideal as beauty is.

Applying Foucault’s logic of censorship I would like to argue that there is no censorship with regard to “beautiful” vaginas (1998, p. 84). The logic of censorship has three forms: affirming that something is not permitted, preventing that such a thing is talked about, and denial of its existence. Some of my informants searched the internet and found that the “Playboy pussy” is not “normal”. Deborah thought a “Playboy pussy” was “normal” before she searched the internet. She thought this because her vagina changed when she reached puberty. When she was a child, her inner labia were not peeking out. She thought puberty enlarged her inner labia “abnormally”. So the internet, instead of confirming Deborah’s thoughts, made her aware that there are different kinds of vaginas. According to my data, Foucault’s logic of censorship is not applicable to the beauty ideal of vaginas. It is however applicable to the ideal of normality. Since this censorship with regard to normality is linked to the taboo in The Netherlands on labia reductions, I will explain this censorship in the following paragraph about shame and taboo.

§ 6.2 Shame and taboo
To attain the above mentioned ideal of normality is a difficult task when one is living in The Netherlands. Davis writes:

It could be argued, for example, that their disclaimers merely reflect the prevailing discourses of Dutch Calvinism – discourses which make excessive vanity reprehensible, at best, and sinful, at worst. In The Netherlands, it is difficult to even admit to having cosmetic surgery at all. (…) However, the desire to be just ordinary is not only acceptable, but, indeed, a moral must. (1995, p. 90)
Although Davis wrote this fifteen years ago, I believe this is still true in The Netherlands of today. It is what I found in my informants’ statements about wanting to look “normal” and in their statements about their shame about the fact they had a labia reduction. However, I do believe some forms of cosmetic surgery are more accepted and that labia reduction is not one of those forms. This is for example evident in the case of Suzanne who tells people about her breast augmentation but is too ashamed to tell people about her labia reduction. It is shameful to have a surgical augmentation of the labia but not as shameful to have a surgical augmentation of breasts. Thus, in The Netherlands, it is a cultural ideal to look and act “normal”. At the same time it is a taboo to attain this ideal of normality through something as “abnormal” as labia reductions.

Instead of a cultural ideal of beauty, my informants act according to an ideal of normality prevalent in The Netherlands. The situation is so contradictory that my informants experience shame no matter what they do. When they do not have a labia reduction they experience shame because of the way their labia look. When they do not have a labia reduction they experience shame because they had surgery on their labia. I derived the concept of shame from the interviews with my informants. Again and again it proved to be a very important factor with regard to their labia reductions.

With regard to structure and agency, shame is difficult to place in either one of these concepts. Shame is personal. ‘Shame can be characterized in a preliminary way as a species of psychic distress occasioned by a self or a state of self apprehended as inferior, defective, or in some way diminished’ (Bartky, 1990, p. 85). Thus, shame is a feeling occasioned by a self that signals one is deviating or “abnormal”. This is the kind of shame my informants experienced. Before the surgery, they were ashamed because they found that their labia were different from “normal” vaginas. After the surgery, they were ashamed because of a negative female image that deviates from the ideal image of a “normal” woman. This negative female image was described by Deborah as ‘this blonde pretty girl who would do anything to look pretty’ and by Jeanne as a sexually loose woman.

Although my informants were afraid of a “sexy” image, sexual difficulties were an important motivation for especially Deborah and Anne. Deborah, who had the surgery when she was 17, never had sex before her surgery because she was ashamed of her labia. Deborah was especially afraid that guys would stigmatize her as ‘the girl with the large labia’. Anne did not have sex with her current boyfriend, with whom she had a relationship since a couple of weeks, because she was ashamed for what he might think. Davis writes about the problems
her informants experienced with sex: ‘Still, others avoided sex altogether in anticipation of negative reactions. In many cases, a husband or present boyfriend was cited as the first person who was allowed to see or touch a particular body part’ (1995, p. 84). But in Deborah’s and Anne’s cases, their boyfriends were not allowed to see or touch “the particular body part”, namely their labia/vagina. Living in a western society where sexual pleasure occupies a status of almost unquestioned good, it is hard to have no sex at all because of feelings of bodily deficiency (Braun, 2005, p. 414). For Anne, sexual problems even were her main motivation for a labia reduction. PJ McGann, a sociologist, writes about the shift from orientation on procreation to orientation on pleasure in the western sexual ideal (2006, p. 371). Especially emphasized in this new ideal is the representation of a couple’s sexual pleasure as an essential part of a healthy sex life. Since Anne’s relationship had recently come in existence, it was very hard for her that she could not have sex. She described the problems that ensued a couple of weeks in her relationship. Every time her boyfriend initiated sex, Anne was too ashamed to have sex and she did not dare to tell him why. She described this as a real problem. I recognize McGann’s argument that experiencing sexual pleasure is considered important for a “healthy” relationship in Anne’s story. Being too ashamed to have sex with her new boyfriend was a real problem for her. This could be because the sexual ideal proscribes having sex and experiencing sexual pleasure as essential for a good or healthy relationship.

Anne and Jeanne mentioned physical pain or inconveniences during penile-vaginal penetration:

Although physical pain [LF: because of the ‘going in and out of the inner labia during penetration] 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. (Braun, 2005, p. 411)

Thus, according to Braun, psychological factors construct feelings of sexual pleasure for an important part. Indeed, psychological problems before the surgery such as embarrassment, self-consciousness, and shame were frequently mentioned by my informants. Dr. Ozer says there is very little known about the consequences of labia reductions on sexual sensation. My informants did not notice any differences in the feelings of sexual sensation itself before and after the surgery. However, the surgery did have a positive effect on their sex lives. Physically, the ‘coming along’ of the inner labia during penetration was cited as a positive change by my informants. For Deborah and Anne, it became possible to have sex because
they were no longer ashamed. For Jeanne, her sex life became more exiting because her husband thought her labia to be very “beautiful”. Braun writes:

In these extracts [LF: from articles about female genital cosmetic surgery in women’s magazines], 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. (...) Thus, the body is situated as ontologically prior to the mind, but the mind is located as the crucial variable, in sexual pleasure terms. (2005, p. 416)

Although Braun is critical of the way women’s magazines construct female sexual pleasure, her description of the psychological as an important influence on pleasure fits my informants’ experiences. The surgery took away their psychological problems, such as shame and self-consciousness.

When one is deviating, one is usually deviating from some kind of norm. Shame comes into existence when one has internalized this norm:

Something is “internalized” when it gets incorporated into the structure of the self. By “structure of the self” I refer to those modes of perception and of self-perception which allow a self to distinguish itself both from other selves and from things which are not selves. (Bartky, 1990, p. 77)

A second sense of internalization is that ‘…one knows how to do’ (1990, p. 77). Thus acting according to social norms and morals can be internalized as part of oneself. Bartky calls shame ‘profoundly disempowering’, because: ‘The experience of shame may tend to lend legitimacy to the structure of authority that occasions it, for the majesty of judgment is affirmed in its very capacity to injure’ (1990, p. 97). Thus individual shame confirms the authority (which I imagine as some kind of social moral standard) that makes a certain act shameful in the first place. Therefore, shame has a useful function because it provides agents with a pressure to return to a certain equilibrium (1990, p. 96). I would like to use the term ‘norm’ instead of ‘equilibrium’. In my informants’ case this certain norm is the norm of normality.

I mentioned how my informants experience shame because they had a labia reduction, but also experienced shame before they had a labia reduction. In a way, some of them had a
labia reduction because they were so ashamed only to be ashamed for the fact they had a labia reduction afterwards. All my informants said that they felt the subject of labia reductions is a taboo. By viewing this taboo on labia reductions as a form of censorship, this taboo can be analyzed and explained, as Foucault argues (1998, p. 84). Although Foucault’s logic of censorship was not applicable to the beauty ideal of vaginas, I believe it is applicable to the taboo on labia reductions in The Netherlands. This taboo states that it is not “normal” to have a labia reduction.

The first form is the affirmation that labia reductions are not permitted. This is especially visible in the regulations of Dutch health care insurance companies which state that labia reductions (and most other forms of plastic surgery) will only be covered when it is a medical necessity. If a woman does not have physical strain, she does not get coverage. Of course, she is still permitted to have a labia reduction. For most Dutch women however, 1500 euro’s is a substantial amount of money. Dr. Buncamper told me that many women do not have a labia reduction because their first appliance for coverage gets denied. The second form of censorship is that talk about labia reductions is prevented. In my search for informants, this form of censorship affected me personally. It took me much trouble to find four women who wanted to talk to me about their labia reductions. Although people in my social environment knew women who had a labia reduction, these women were either unwilling to talk about it or my social contacts did not dare to start a conversation about labia reductions themselves. The third form of censorship is that the existence of labia reductions is denied. This form of censorship logically follows from the second form because when one does not talk about something chances are less likely people know that that something exists. I experienced this myself when I told people what my research would be about. In most cases, I had to give a thorough explanation of what labia reductions entail. I encountered another example of this form of censorship while I was sitting in the waiting room of a private clinic for cosmetic surgery. I had an appointment there with Suzanne because she works there. Through miscommunication I was half an hour too early and thus had time to watch the promotion video that was repeatedly played. In this promotion video the procedures offered by the clinic were explained. Since I already saw that information about labia reductions was provided on the website of the clinic, I waited in anticipation for the promotion video to begin about labia reductions. However, labia reductions were not mentioned in the promotional video. Information brochures about labia reductions were also not available whereas information brochures about all the other procedures were. Suzanne told me that they do have these brochures, but they only give them to people when they ask for it. When a woman wants a
labia reduction, she does get the information from one of the employees. In a way, existence of labia reductions is denied even by some private clinics themselves.

The only thing that seems to make a labia reduction (and plastic surgery in general) acceptable in The Netherlands is when a woman has it because of physical strain. Three of my informants stated that they had physical strain; two of them told me physical strain was their main motivation. Even so, these two women still keep their labia reductions a secret, telling only good friends and family about it. The people they told were all very understanding, but only because my informants had reasons of physical strain. In The Netherlands, there seems to exist a boundary between “necessary” surgery and “unnecessary” surgery. This is reflected in a research about acceptance of plastic surgery in The Netherlands, done by TNS NIPO, a Dutch market research company. According to this research, half of the Dutch population wants plastic surgery to be forbidden for people younger than 25. One of the reasons is that many Dutch people (78 percent) believe plastic surgery is unnecessarily performed. There is relatively much understanding for corrections of lop ears, scars, eyelids and breast reductions. There is little understanding for labia reductions, lip filling, and facelifts. Researchers measured this by asking people from different age groups whether or not they agreed with a proposition (8). Apparently, a correction of lop ears is considered more “necessary” than a labia reduction.

Before 2006, every Dutch citizen earning less than 33000 euro’s a year was obliged to get a health care insurance through the Dutch national health service, a national collective. Citizens earning more than 33000 euro’s a year had the option to insure themselves through the private sector. Davis calls this system the welfare model. She writes that this in theory meant that ‘…a patient has a right to any form of health care he or she needs….In practice, however, many health care services are too expensive for the state to fund’ (1995, p. 32). Therefore there existed a discourse in The Netherlands about whether or not a medical service or surgery is really necessary. In 2006 a new health care system was introduced which made one basic health care insurance obligatory for every citizen. In this basic health care, plastic surgery is only covered when it is a “medical necessity”, as I already explained in chapter 4. When one needs or desires care that is considered “extra” by the Dutch government, one can choose a complementary insurance. I believe the discourse about whether or not a medical service is necessary still exists in The Netherlands. Although the health care model has changed it is still based on the principles of the welfare model. Every citizen pays the same amount for the same forms of health care. People who have a low income get subsidies in order to pay their health care insurance. People who do not need much medical care pay the
same amount as people who do need much care. Therefore, the discourse on necessity Davis writes about still exists in The Netherlands.

Labia reductions are taboo because they are considered “unnecessary”. Many people in The Netherlands have little understanding for labia reductions. Because of this taboo, my informants are too ashamed to tell people about their labia reductions. Because women do not talk about their labia reductions, there is little known about the subject and many people do not even know what a labia reduction entails and why some women choose to have it. I believe that because of this, the public opinion that labia reductions are unnecessary remains intact: shame and taboo preserve each other.

§ 6.3 The power of medicine
Medical practitioners combined with the Dutch health care system have influenced substantially the decisions my informants made surrounding their labia reductions. Medical practitioners wanted to make sure that they really needed the surgery. For some of them, it was decided where they would have the surgery and by whom. It was also decided for some of them which surgical method (the “hard” method with the “natural” result or the “easy” method with the “artificial” result) would be used during their surgery.

The ideal of normality also seemed to be sustained by the medical practitioners consulted by my informants. Deborah and Anne went to their family doctors first. These doctors wanted to make sure that Deborah and Anne really had reasons of physical strain. They also felt the need to tell them that indeed their labia were quite large and that they could imagine they were having strain because of this. Deborah and Anne both got redirected to a hospital and to a gynaecologist that were not of their own choice. Three of my informants choose the surgery which would result in smaller but still “natural” looking labia. Among them was Deborah. Deborah’s gynaecologist only wanted to perform the surgery on her using the “hard” method resulting in “natural” looking labia. Thus Deborah could choose to have a labia reduction resulting in “natural” looking labia (and thus not a “Playboy pussy”) or not having a labia reduction at all. Foucault writes about the way medical science acts within the existing social system and thus according to the social norms of this system:

In the medicine of species, disease has, as a birthright, forms and seasons that are alien to the space of societies. There is a ‘savage’ nature of disease that is both its true nature and its most obedient course: alone, free of intervention, without medical artifice, it reveals the ordered, almost vegetal nervure of its
essence. But the more complex the social space in which it is situated becomes, the more *denatured* it becomes. (1973, p. 16)

Of course, I would not call protruding inner labia a disease. I regard disease in this context as similar with “deviant”. Janice Irvine, a sociologist, writes: ‘Disease designations connote discomfort, deviance, treatment, and cure’ (2002, p. 399). This is the way I would like to define Foucault’s use of the word ‘disease’. What Foucault is arguing is that the inherently simple nature of disease or deviation becomes complicated by medical science. It is medical science that denaturalizes disease and turns it into something “men made”. Medical science acts according to the rules of the social system in which it is situated. This rings very true for the experiences my informants had with medical science. The medical practitioners acted according to the Dutch ideal of normality by wanting to make sure there was physical strain and that my informants would have a labia reduction resulting in “natural” looking labia. Foucault further writes:

> There is (…) a spontaneous and deeply rooted convergence between the requirements of political ideology and those of medical technology. (…) …the Faculties, which recognize that which is true only in theoretical structures, and turn knowledge into a social privilege. Liberty is the vital, unfettered force of truth. It must, therefore, have a world in which the gaze, free of all obstacle, is no longer subjected to the immediate law of truth: the gaze is not faithful to truth, nor subject to it, without asserting, at the same time, a supreme mastery: the gaze that sees is a gaze that dominates… (1973, p. 39)

Thus medical science does not only act according to social norms, it helps constructing these social norms as well. Also, medical science has a monopoly over medical knowledge. This means that only people who have legitimacy in medical science, such as medical professors and doctors, are entitled to produce and reproduce medical knowledge.

The Dutch health care system seems to have incorporated social norms as well. Plastic surgery is only covered when it is a medical “necessity”. In the case of labia reductions, physical strain is considered a medical necessity. Of course, what is medically “necessary” is decided by medical practitioners who fill out the form for coverage. In my informants’ cases their doctors looked at their labia and decided that they had quite large labia. What the doctors of my informants would then do was asking them many questions like: Do you really have
physical strain? and: How often? and: when? This reminds me of a scene described by Davis: ‘In addition to the precarious business of convincing the Inspector that they needed surgery, applicants often had to undergo the embarrassing ritual of a physical examination’ (1995, p. 71). When Davis wrote her book, the Dutch health care regulations for coverage of plastic surgery were different. Next to reasons of medical necessity plastic surgery was also covered when a person had… ‘A physical imperfection which falls “outside a normal degree of variation in appearance” (the patient’s appearance does not meet certain aesthetic standards as determined by the medical inspector)’ (1995, p. 35). Although the Dutch health care regulations are different nowadays, I still recognized in my informants’ accounts the need to convince a medical practitioner of the fact that they were “really” suffering and the undergoing of physical examination. The only difference being that “the Inspector” searches for appearance outside the realm of the “normal” and that my informants’ family doctors and gynaecologists search for medical “necessity”. However, looking at labia does not necessarily have to tell the doctors anything about medical necessity. Dr. Ozer mentioned a woman with labia that were both eleven centimetres long and she did not have physical strain at all. ‘When scientific guidelines fail (…) medical professionals seek refuge in cultural norms concerning what constitutes an acceptable feminine appearance’ (1995, p. 91). This is what the gynaecologist did when she said that Deborah’s labia were ‘longer than other girls’ labia’. Although there are no scientific guidelines used, these medical practitioners do have an authority on knowledge.

Suzanne deliberately choose to have the surgery performed by a plastic surgeon who is also a colleague and a good friend of hers. Because he operates in a private clinic where there usually is not given insurance care, she had to pay for the surgery herself. She said that if she would have had it covered she would have had to go to a hospital and be operated by an unknown surgeon. Suzanne did not want that. This indicates two things. One is that she could have gotten coverage even though she did not have physical strain. Had she told a gynaecologist that she had, she probably would have gotten coverage. This suggests that the covered surgeries and the uncovered surgeries do not differ much. It also suggests the institutional spatialization of disease as described by Foucault: ‘Good medicine would be given status and legal protection by the state; and it would be the task of the state ‘to make sure that a true art of curing does exist’ (1973, p. 20). The institutional spatialization being that women with physical strain get surgery in a hospital and this is usually performed by a gynaecologist. Women with aesthetic or other motivations get surgery in a private clinic and this is usually performed by a plastic surgeon. In the case of labia reductions in The
Netherlands the state makes sure that women with physical strain get their surgeries covered, whereas women with other motivations do not. However, women who get their surgeries covered pay the price on another level: they do not get to decide where the surgery will be performed and by whom.

With regard to plastic surgery, the patient also has a certain responsibility according to Dr. Buncamper. The “patient” must remain suspicious with regard to procedures that are much cheaper than similar procedures performed in other clinics for example. Suzanne Fraser, a theorist in gender and cultural studies, writes about the way agency with regard to cosmetic surgery is presented in medical texts (2003). The patient is required to weigh up risks and benefits (2003, p. 35). Patients are considered free agents and therefore they are held responsible for their own consumer choices (2003, p. 36). Dr. Buncamper’s statement was probably meant to be about women who choose to have a labia reduction in a private clinic. However, informants who are classified as having the surgery because of medical necessity have very little choice, as I already described above. Fraser writes:

This decidedly individualist version of agency sits rather strangely in a context where women are advised to look for their ideals in women’s magazines, and are subject to the surgeon’s judgment on how much information they are given, and, to some extent to the surgeon’s power of final say on the shape of the nose, the size of the breast implants, or whether the operation is appropriate at all. (2003, p. 36-37)

Although my data do not correspond with Fraser’s statement that women look for beauty ideals in women’s magazines, my informants do act according to an ideal of normality. What this citation is mainly about however is the influence of medical practitioners on the choices women have to make surrounding their surgery, such as which surgical method will be used. This influence from medical practitioners appears to be larger for women having surgery in a public hospital with all expenses covered than for women having surgery in a private clinic who pay the surgery themselves. In both instances however, women seeking a labia reduction are dependant on the information doctors and clinics give them. This is an example of the monopoly over medical knowledge as I described above.

All my informants valued the opinion of a medical practitioner very much. During their processes of choice for a labia reduction they all visited a doctor to see what could be done about the problems they had with their labia. Iain Morland, an English literature scientist
and theorist in sexuality studies, writes: ‘The defining negation constructs the patient as one who cannot know their own body; their body may be known only by medicine’ (2001, p. 534). Morland writes from the point of view of medical science but his argument rings true with regard to my informants’ statements. Jeanne thinks she probably would not have had a labia reduction, had health care insurance not covered her surgery. If she would have had to pay for it herself she would have done it to look more “beautiful” instead because of physical strain. Thus her main motivation is dependant on the fact whether or not she gets health care insurance coverage. What is more, Jeanne believes that if health care insurance would not find her case a medical necessity, then it probably would not have been “necessary” after all. Jeanne internalized the classification system between “necessary” and “unnecessary”, maintained by Dutch health care insurance companies.

§ 6.4 The middle ground

My informants act under ideals of normality, social constructions of shame and taboo, and influences from medical science. These are examples of ‘structural properties’ which provide my informants with conditions according to which they act (Giddens, 1979). In my informants’ lives, events occurred which also influenced their decisions to have a labia reduction. These personal life stories represent the way my informants act under structural relations of power: it shows their amount of agency.

Theorists like Wolf (1990) emphasize structural forces as the main reason why women have plastic surgery. The beauty industry and beauty ideals are usually the ‘structural properties’ that are designated as the most influential (Giddens, 1979). Beauty ideals are unrealistic and this is aggravated by practices such as plastic surgery and photoshopping. Because images of unrealistic beauty are so widespread, women come to believe that the ideal portrayed by the beauty industry is what “normal” women look like. Therefore the practice of plastic surgery is usually seen as negative for women and as evoked by ideals of unrealistic beauty. Davis describes the problem with theories that lay too much emphasis on structural forces. She describes it as ‘the problem of the cultural dope’ (1995, p. 56-58). Davis argues that such theories view having plastic/cosmetic surgery as a disembodied experience because they are ‘…devoid of women’s experiences, feelings, and practical activities with regard to their bodies’ (1995, p. 57). Plastic/cosmetic surgery is then seen as ‘…a transformation of the body as object, never as self’ (1995, p. 57). Furthermore, such theories rest on a faulty conception of agency.
An example of the neglect or denial of women’s agency with regard to plastic surgery and viewing it merely as a transformation of the body as object is displayed by Jeffreys. In ‘Beauty and misogyny: Harmful cultural practices in the West’ one of Jeffreys’ main arguments is that western beauty practices, and plastic surgery in particular, should be included in the United Nations definitions of harmful cultural practices:

This concept [LF: harmful cultural practices] is a useful antidote to the debate on agency versus subordination that I have covered here because it is founded on an understanding of the power of cultural enforcement of practices that harm women and children. For practices that are identified as harmful, “choice” is no defence. (2005, p. 27)

Thus, Jeffreys seeks to make the ‘structural property’ of beauty ideals less harmful by prohibiting it by using the ‘structural property’ of the UN definitions of harmful cultural practices (Giddens, 1979). When this is done, agency or choice will no longer be an issue according to her because when something is harmful, one loses the option to choose. She seeks to ban arguments of agency from the feminist discussions about plastic surgery.

Theorists like Davis (1995) emphasize agency and a process of deliberation and choice as the main reason why women have plastic surgery. Women suffering because of their looks can find ways to become an embodied subject, someone who takes control of her life, instead of an objectified body, objectified (justified or not) by that one feature that does not fit (1995, p. 114). Fraser describes the problem with theories that lay too much emphasis on agency (2003, p. 39). She writes that this is especially evident in medical texts celebrating the individual who makes her own choices and takes control of her life. Women who are having plastic surgery are portrayed as individuals taking control over their lives. Women who are unhappy about their looks and who do not have plastic surgery are portrayed as passive. It is often presupposed that no woman is entirely happy with her looks. Thus follows that every woman not having plastic surgery is passive. Having plastic surgery is then portrayed as the one and only way for women to perform agency with regard to their bodies.

Overall, my arguments are in some aspects very similar to those of Davis (1995). I am indeed much indebted to her for her publication of ‘Reshaping the female body’. Both of us interviewed Dutch women who had plastic surgery with a focus on their motivations. Another similarity is the dissatisfaction with arguments that stress ‘structural properties’ too much as an influencing factor in the decision for cosmetic surgery (Giddens, 1979). There are however
also some differences. Davis focuses on cosmetic surgery in general with a special emphasis on procedures that were new in 1995 such as face lifts, breast augmentations, fat removal, and body contouring (1995, pp. 23-27). I choose to focus on one procedure instead, namely labia reductions. I also believe that labia reductions cover a more “touchy” subject than the procedures described by Davis: it invokes other forms of shame. An example of such another form of shame is shame because of fear of the negative female image of an oversexed woman. A final difference is that I tried to build further on Davis’ argument for more recognition for ambivalence in women’s choices for cosmetic surgery (1995, p. 181). This is what I will show in the remainder of this paragraph.

I would like to use another theoretical concept in the structure/agency debate: the middle ground. Fraser opts for a view that sees individual subjects as influenced by structural forces, but still having agency:

> The recognition that the subject is not only culturally produced in very complex ways but is fleeting and fragmentary, is crucial for a politics that seeks to avoid a reification of the subject that can occur even where ‘cultural construction’ is assumed. (2003, p. 32)

Thus by viewing women who have plastic surgery as cultural subjects the middle ground can be formed. I regard the choice for labia reduction itself as a form of agency. My informants all endured an individual kind of ‘private suffering’ (Davis, 1995). They had physical strain, were ashamed, or were not able to have sex anymore. All these forms of suffering impeded with their daily activities. By choosing a labia reduction they were able to do something about their problems and decrease their suffering. At one point in almost all of my informants’ lives, something happened which led them to think about having a labia reduction. Suzanne told me that had she not worked in a private clinic for cosmetic surgery, she probably would not have had a labia reduction. The idea of having surgery did not scare her anymore when she was surrounded by people having surgery every day. Also: she was not aware that her labia were not “normal”, until a former boyfriend made a joke about her labia. If Jeanne’s first son had not been stillborn she would have had a Caesarean section and her labia would not have been damaged during childbirth. Jeanne works for the Dutch police and is therefore obligated to maintain a certain physical endurance. Jeanne especially mentioned the pain she had during spin biking and playing other sports. If she was not such an active person, she maybe would not have had a labia reduction either. Anne experienced a difficult time in her life when
‘everything went wrong’. This was also the time she started to feel insecure about her labia. She managed to overcome all her problems but the only problem that remained were her labia. She decided to take charge of this problem as well by making a doctor’s appointment.

A labia reduction was not the first thing my informants thought about when they started searching for a solution for their problems with their labia. Jeanne and Anne were not aware of the existence of labia reductions. Deborah and Suzanne were aware of the existence of these surgeries before they decided they wanted to have a labia reduction. However, before making their decisions, they both did extensive research on the subject, Deborah with the help of the internet and Suzanne by being involved with actual surgeries. Once having made the decision for a labia reduction my informants all visited a doctor. At this point, the doctors got a lot of power by influencing my informants’ decisions. In a way, medical practitioners and Dutch health care insurance regulations ensure my informants will confirm to the ideal of normality. My informants often agreed with the doctors to use the surgical method which results in “natural” looking labia because they wanted to confirm to the ideal of normality as well. After all, they wanted “normal” labia rather than “beautiful” labia. What became apparent is that women who get their labia reductions covered by health care insurance have less say on the conditions of their labia reduction than women who pay for the surgery themselves.

Whether my informants had a say or not, they were all very happy with the results of their labia reductions. For all of them, the strain they endured before (both physically and emotionally) was gone after the surgery. The recovery period was hard for some of them but in the end they all told me that it was worth it and that they would have done it again. In terms of sexual desire my informants did not experience any change in feelings of sexual sensation itself. However after the recovery period, the sexual experience had changed for the better for most of them. Especially in Deborah’s and Anne’s cases, this had to do with increased self confidence and the disappearance of shame during sex.

So, both structural factors and agency factors influenced my informants’ decisions for a labia reduction. I would like to argue that for my informants these factors are not divided between structural factors and agency factors. These factors come together in a middle ground in which an individual woman deliberates her choice to have a labia reduction. In some instances, structural factors have made agency possible. The choice for labia reduction for example, has been made possible by the fact that Jeanne and Deborah received health care insurance coverage. Had this not been the case, Deborah would have had to wait and save money for the surgery while Jeanne would not have had the surgery at all. In these instants,
agency (having a labia reduction) has been made possible by a ‘structural property’ (health care insurance coverage) (Giddens, 1979).

Therefore I believe it is incorrect to argue that women’s choices are influenced by ‘structural properties’ only (Giddens, 1979). It is also incorrect to argue that women’s choices for labia reduction are pure acts of agency. ‘Structural properties’ did partially influence my informants’ choices to have a labia reduction (Giddens, 1979). They did not however single handily formed my informants’ decisions. Rather, the amount of agency my informants had depended on the ‘structural properties’ of beauty ideals, shame, and the medical gaze (Giddens, 1979). As I already mentioned before, I consider the decision to have a labia reduction itself as an act of agency. This choice was the outcome of the desire to have “normal” labia and to end ‘private suffering’ and shame (Davis, 1995). The desire to look “normal” and the experience of shame are directly linked to the ideal of normality prevalent in The Netherlands. After my informants made the choice for a labia reduction they came into contact with medical practitioners and health care insurance regulations. Medicine decreased their agency in many ways. Nevertheless, medicine also made their act of agency possible: to have a labia reduction. ‘Structural properties’ can have a negative impact on agency, but at the same time they enable acts of agency to actually happen (Giddens, 1979).

Fraser writes: ‘The cultural subject, reconsidered, does not exercise an internalized or possessed agency; rather, he or she is produced through those forms of agency available in culture at any given moment’ (2003, p. 32). Thus, within a socio-cultural context, women perform agency within the boundaries that the given culture has set. Culture or ‘structural properties’ enable acts of agency while at the same time it hinders acts of agency (Giddens, 1979). Thus, ‘structural properties’ provides individuals with circumstances according to which to act. This is comparable to Giddens’ definition of agency as the capability of individuals to act under structural relations of power (1979, p. 237). These circumstances offered by ‘structural properties’ together with accounts of ‘private suffering’ and individual live stories make up the space or junction where the choice for a labia reduction is made (Davis, 1995; Giddens, 1979). It is this space that I call the middle ground.
7. Conclusion

The argument of this thesis is built around the structure-agency debate surrounding plastic surgery. With regard to labia reductions in The Netherlands I described the ‘structural properties’ influencing my informants’ decisions for labia reduction (Giddens, 1979). I also described my informants’ personal accounts which led them to have a labia reduction. The central question I set out to answer in this thesis is: Which factors influence Dutch women’s decisions to have a labia reduction?

I divided the factors influencing my informants’ decisions into ‘structural properties’ on the one hand and personal motivations on the other hand (Giddens, 1979). One of the ‘structural properties’ that influenced my informants’ decisions turned out to be ideals of normality, rather than ideals of beauty. My informants expressed the desire to have a “normal” vagina rather than a “Playboy pussy” which was considered “beautiful” by my informants. They also expressed complaints because of physical strain more than sexual or aesthetic complaints as the main reason for a labia reduction. They did this because they did have physical strain but also because in The Netherlands, a labia reduction is acceptable only when it is because of medical necessity.

The shame my informants felt because of their labia turned out to be an important factor in their decision to have a labia reduction. My informants felt shame because of feelings of bodily deficiency. However, after having had the surgery my informants are still ashamed. Now they are ashamed for the fact they had a labia reduction. This shame has to do with my informants’ fear to be viewed as a sexually loose woman or ‘this blonde pretty girl’. They are afraid to be stigmatized with a negative female image.

Another ‘structural property’ influencing my informants’ decision was the power of medicine, both from medical practitioners and Dutch health care insurance regulations (Giddens, 1979). Medical practitioners seem willing to make sure my informants will confirm to ideals of normality by influencing the decisions for which surgical method to use, which hospital to visit, and which doctor to choose. Dutch health care insurance regulations do this by only covering labia reductions for women who endure physical strain. The presumption that plastic surgeons only perform surgery on women to make them more “beautiful” has led to the practice of denying coverage for women who have a labia reduction in a private clinic. Labia reductions, performed by medical practitioners working in a public hospital are usually covered.

My informants’ personal accounts revealed the ‘private suffering’ my informants endured before they had a labia reduction (Davis, 1995). For some of them, physical strain
was impeding with their daily activities. For others, shame impeded with their sex lives up to the point that two of my informants did not have sex at all until after their labia reduction. Because of these accounts of ‘private suffering’ my informants described feelings of excitement prior to the surgery because they finally would have something done about their problems with their labia (Davis, 1995). They experienced the surgery itself as quite comfortable, short and painless. The recovery period after the surgery was however experienced as harder and more painful than expected beforehand. All my informants were very happy with the results of their labia reductions and would have done it again. They were especially happy that their ‘private suffering’ or the complaints they had before the surgery were now gone (Davis, 1995). The surgery also has had a positive effect on their sexual pleasure. The sexual sensation itself has not changed but for some of them the surgery has taken away their self confidence problems and they are able to enjoy sex more or to have sex in the first place.

In the analysis of my research data I offered theoretical support for my findings. I explored the paradox of the desire for “natural” or “normal” labia and the way this desire is satisfied: plastic surgery. I then applied Foucault’s logic of censorship to the supposed censorship on “normal” vaginas (1998, p. 84). I concluded that there is no censorship with regard to “beautiful” vaginas (the showing of only “beautiful” vaginas in porn and on the internet) but that there is a censorship with regard to the ideal of normality. The ideal of normality is one of the reasons my informants seek plastic surgery in order to get “normal” labia. This is apparent when one looks at the taboo on labia reductions in The Netherlands.

This taboo is one of the reasons my informants were ashamed for the fact they had a labia reduction. I linked the concept of shame to some arguments made by Bartky (1990). Shame is a very personal feeling, but at the same time it is also a ‘structural property’ because one is usually ashamed when one does not confer to certain norms (Giddens, 1979). Shame is personal because certain norms are internalized as part of oneself. Shame also played an important negative part in the sex lives of my informants before their labia reductions. I linked this shame to theories by Braun (2005) and McGann (2006) arguing that in western society a good sex life is considered very important. Since my informants’ labia interfered with their sex lives it became a problem to them. Then I argued that labia reductions had a positive effect on my informants’ sex lives although their feelings of sexual sensation itself had not changed. I linked this to Braun’s theory on sexual desire and the psychological (2005). The labia reductions have taken away my informants’ psychological problems such as low self-confidence and shame, which has increased their sexual pleasure. Then, again using
Foucault’s logic of censorship, I described the taboo in The Netherlands on labia reductions. Labia reductions are not permitted, are not talked about, and the existence of labia reductions is denied. The only condition which makes a labia reduction acceptable in The Netherlands is when it is done because of medical necessity and thus out of reasons of physical strain. I linked this to Davis’ theory that in The Netherlands there exists a discourse on necessity because of the welfare model of health care insurance. Labia reductions are not considered “necessary” and are therefore taboo. Because of this taboo my informants are too ashamed to speak about their labia reductions and this way shame and taboo preserve each other.

The ideal of normality is an ideal prevalent in The Netherlands and is applicable to both looks and behaviour. My informants felt they did not have “normal” labia and were ashamed because of this. They choose a surgical method which would make their labia smaller but also “natural” looking because this is what a “normal” vagina looks like according to them. In order to obtain “normal” looks however my informants had to behave “abnormally” by having a labia reduction. So by having the surgery they once more felt like not conforming to the ideal of normality. As such, the Dutch ideal of normality creates paradoxical situations.

The power of medicine is apparent from the amount of influence doctors have had on my informants’ decisions. I linked this to a theory by Foucault which argues that medical science acts according to the rules of the social system in which it is situated (1973, p. 16). This is for example the case with doctors who advised my informants to have the surgery using the “hard” method because it ensures a more “natural” result. This way, they sustain the ideal of normality prevalent in The Netherlands. I used Foucault’s institutional spatialization of disease to analyze the difference Dutch health care insurance companies make between gynaecologists and plastic surgeons (1973, p. 20). Women who have physical strain get their surgeries covered but are usually operated by a gynaecologist they cannot choose themselves, in a hospital that is also not of their choice. In my informants’ cases, it were their family doctors who decided this for them. This way my informants lost agency. Women who seek for a labia reduction performed in a private clinic are expected to be smart and choose a good clinic. I linked this to Frasers’ argument about the role of agency in medical texts (2003). It is presupposed that women having plastic surgery in a private clinic have much agency but their amount of agency is dependant on the information that medical practitioners provide them with. I linked this to Morland’s argument that medical science portrays itself as the only institution that knows people’s bodies, knowing it better than people themselves (2001, p. 534).
To answer my central question, I would like to argue that the factors influencing my informants’ decisions to have a labia reduction come together in the middle ground which is the space between structure and agency. Their decisions were influenced by at least three ‘structural properties’: ideals of normality, shame, and medical science (Giddens, 1979). These factors alone were however not the reason for their choices for labia reduction. In their personal lives, certain events occurred that were the reason that their ‘private suffering’ with regard to their labia started (Davis, 1995). Ideals of normality (the desire to have “normal” labia) aggravated their ‘private suffering’ (Davis, 1995). Their decisions to have a labia reduction, and therefore their agency, depended on the ‘structural property’ of the medical gaze (Giddens, 1979). Health care insurance coverage made their labia reductions possible (and thus their agency), but it also meant they had to surrender agency. Shame and taboo also decreased their agency. This is for example apparent in the fact that my informants stressed motivations of physical strain so much because this is a socially acceptable reason to have a labia reduction. On the other hand, shame because of feelings of bodily deficiency also aggravated their ‘private suffering’ with regard to their labia (Davis, 1995). Thus shame was also one of the reasons why they had a labia reduction. Women having a labia reduction must be considered cultural subjects, acting out agency within the confines of ‘structural properties’ (Giddens, 1979). I hope the concept of the middle ground can take away the negativities that lie in theories that lay too much emphasis on either structure or agency with regard to plastic surgery.

It was one of the aims of this thesis to describe the process of choice women who have a labia reduction go through. For my informants, this process of choice started with their feelings of discomfort because of their labia. They endured physical strain. They also experienced shame because they felt that their labia were “not normal”. The first moment of agency occurred when my informants started to search for information about labia reductions, mostly on the internet. Another moment of agency was when my informants decided to see a doctor in order to see what could be done about their problems with their labia. The next moment of agency was when my informants decided they wanted to have a labia reduction because they regarded this as the best solution to their problem. I consider these moments of agency important because my informants made the choice for labia reduction, realizing that there exists a taboo in The Netherlands on labia reductions. Thus, despite feelings of shame because they wanted to have a labia reduction, they were still persistent enough to know that they wanted to have the surgery. Shame and taboo were however also reasons why they stressed the physical strain they endured much more than their other motivations. They did
this because physical strain is considered a socially acceptable reason to have a labia reduction. This meant that they could have their surgeries covered by health care insurance because of medical necessity. Although this made it possible to have a labia reduction, this in turn meant their agency was decreased as to in which hospital they would have the surgery and by whom this surgery would be performed. Very little agency was also visible during the moments my informants had to “choose” the conditions of their surgeries such as which form of anaesthetics and which surgical method would be used. They often agreed with what the doctors thought would be best for them. In retrospect, the moment were my informants displayed the most agency was prior to their first appointments with medical practitioners. Their agency was reduced most during their encounters with medical practitioners.

I believe that women in The Netherlands who want a labia reduction should be offered more options to express their agency during their encounters with medical practitioners. There seems to be a problem with informed consent. Doctors should explain both surgical methods and what the results of these surgical methods will be. The women themselves then can decide which method they prefer. I do not believe that doctors should express a clear preference for one particular method, as some of the doctors did who spoke with my informants. It is even worse when a doctor poses an ultimatum by stating that they will only perform the surgery using one particular method, as what happened to Deborah (although Deborah would have probably chosen the “suggested” method herself as well). Since it will influence the way the women’s labia will look, it seems logical to let them decide for themselves after giving them complete and correct information first. With regard to anaesthetics, I think it is important for doctors to provide their informants with information on the different options as well. I do believe that a doctor is right in suggesting a particular form of anaesthetics as the best option because it provides less risk for implications during the surgery. The risks of every form of anaesthetics should however be explained to women seeking plastic surgery, as should be the risks of the two surgical methods.

Another recommendation I would like to make is for Dutch health care insurance companies to not make a distinction between women who prefer to be operated by a gynaecologist and women who prefer to be operated by a plastic surgeon. I understand there has to be some indication of suffering or physical strain in order for women to receive health care insurance. It is however a very strange prejudice to presuppose that plastic surgeons perform aesthetic surgeries only, as is indicated by the fact that requests for coverage of a surgery performed by a plastic surgeon are often denied immediately. As for women who are redirected by their family doctors I would like to suggest that they should be offered options
with regard to the different hospitals where the surgery is performed. A doctor can make suggestions as to in which hospitals labia reductions are performed often and which medical practitioners are experienced in the performance of labia reductions. Again, when a woman has received complete and correct information, she can make a choice she is most comfortable with. Regardless of the fact whether or not a woman receives health care coverage, she should be informed properly about all options surrounding a labia reduction.

With regard to the taboo in The Netherlands on labia reductions, I believe it is important that labia reductions will become a topic of discussion in the public debate. During the past year I noticed that many Dutch people do not know what a labia reduction exactly entails. People should be informed about the motivations and reasons women have for a labia reduction. A good way of doing this is for example by making a documentary on labia reductions which focuses entirely on accounts of women who had labia reductions themselves, and not as much on the opinion of the documentary makers themselves. The women interviewed should be representative of all women having a labia reduction, for example according to age, social class, and different motivations (physical strain/sexual reasons/aesthetic reasons). Another good way to open the public debate would be the publishing of articles about labia reductions in women’s magazines, but also newspapers for example.

I would like to conclude this thesis with some recommendations for further research. It appears from my research that women in the United States are more influenced by ideals of beauty whereas women in The Netherlands are influenced more by ideals of normality. Since I have not interviewed enough women to make any statements about this, I think a large comparative study of labia reductions in the United States and in The Netherlands would be very interesting. Another suggestion for further research is a study entirely on the Dutch health care insurance system and the way it deals with coverage for plastic surgery. Although I touched this subject, I did not have the opportunity to investigate this thoroughly. What I thought was especially interesting was the influence of a doctor’s often very subjective view on whether or not a labia reduction was “necessary”. I believe a research focused on the relation between “necessity” and plastic surgery in The Netherlands could be very revealing. By all means, I hope (social) scientists will explore the largely untouched ground of the topic of labia reductions. There is so much to discover.
8. Notes

1. http://www.beperkthoudbaar.info/docu
3. Dr. Ozer, personal communication, 4th of February, 2010
4. Dr. Buncamper, personal communication, 19th of April, 2010


9. Literature


